THE INFLUENCE OF TRADITIONAL HEALING PRACTICES ON ANTI-RETROVIRAL TREATMENT ADHERENCE IN VHEMBE DISTRICT, SOUTH AFRICA.

BY

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DECLARATION

I, ***Faith Mary Musvipwa***, declare that this research thesis is my original work and has not been submitted at any other university or institution. The thesis does not contain other persons' writing unless specifically acknowledged and referenced accordingly.

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ABSTRACT

The purpose of the study was to investigate the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District. This qualitative study used an explorative design to envisage the aim. A cross-sectional snowball sample was used to draw a sample of 9 participants from the 4 municipalities of Vhembe District. The data collection methods were; in-depth interviews, focus group discussions and key informants' interviews. The 3 data collection techniques ensured triangulation for more complete and well-validated outcomes of the study. The researcher used the Van Manen method to analyse data. Contrary to popular belief that THPs promote non-adherence among people living with HIV/AIDS (PLWHA), the study found out that the majority of Traditional Healing Practitioners (THPs) encourage and positively influence PLWHA to adhere to anti-retroviral treatment. Apart from a minority of participants who claimed to cure HIV/AIDS, the majority acknowledged and admitted that traditional healing practices do not cure HIV/AIDS but it only heals opportunistic infections. As a result, the majority of THPs influences PLWHA to adhere to anti-retroviral therapy (ART). However, the positive influence of THPs is challenged by individual and social-cultural factors that are beyond THPs' control which influence treatment adherence such as; traditional and cultural beliefs, side effects of ARVs, nurses' attitude, inconveniences, lack of transport, personal choices, lack of trust in ARVs and fear of loss of the Disability Grant. It is on this backdrop that study findings prompted devising of a model and a 5 phase support program for intervention.

Keywords: Traditional Health Practitioners (THPs), People living with HIV/AIDS (PLWHA), Anti-retroviral Treatment adherence, Anti-retroviral,

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DEDICATION

This research is dedicated to my late mother who departed on earth on the 23rd of May 2016. I love you and miss you so much, mother. Thank you so much for being there for me always, for encouraging me, for constantly reminding me that I can do it, the wound you left will never heal and some tears never dry it still feels like a second ago time changes nothing. It is sad that you are no longer with us to celebrate the success of your little girl. You fought so hard to be where I am today, I greatly appreciate the love and effort. May your soul continue to rest in eternal peace.

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ABBREVIATIONS

THP	Traditional Health Practitioner
ATR	African Traditional Religion
ART	Anti-retroviral Treatment
ARVs	Anti-retrovirals
PLWHA	People living with HIV and AIDS
AIDS	Acquired immune deficiency Syndrome
STD	Sexually Transmitted Disease
RDP	Reconstruction and Development Program
SANAC	National AIDS Council
HCT	HIV Counselling and Testing
SOAHA	South African Healers Association
LUTHPA Association	Limpopo Unified Traditional Health Practitioners

CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction and background

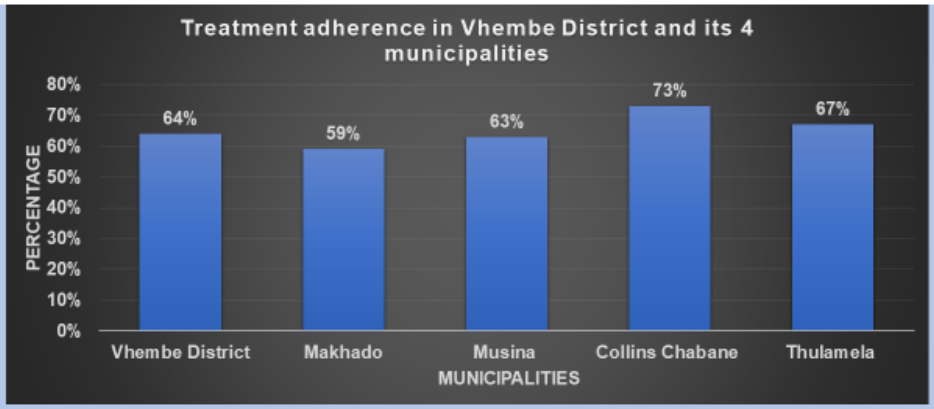
The 2018 UNAIDS reported that about 6 million South Africans, that is almost 12% of the country's population of 60 million people had HIV/AIDS. In the past 10 years, it was estimated that between 42%- 47% of all deaths among South Africans were HIV/AIDS-related. Enhanced access and take-up of antiretroviral (ARVs) in South Africa has empowered HIV positive people to live longer and healthier, bringing about a steady decrease in AIDS-related deaths between 2006 (48%) and 2016 (28%). Despite these recent victories against the HIV/AIDS pandemic, that is, lessened AIDS-related deaths and declining HIV frequency rates, South Africa has already paid a vast cost of death of young adults. (Demographic and Health Survey 2016).

Although there have been important medical and technological breakthroughs in the early identification and diagnosis of HIV using recent laboratories and techniques, the AIDS epidemic continues its relentless spread in many remote and poor communities in the world (Nemakonde, 2016). Traditional African healing is a method of healing and curing illness, sickness, and diseases founded in Traditional African Religion (Flint, 2015). The African traditional healing distinguishes various ways to deal with illnesses and has different religious experts whose task is to discover the reasons for disharmony in the universe. Traditional Health Practitioners (THPs) are not only expected to know the sources but also to prescribe antidotes or therapies for these problems. Their main commission is to look for measures to be taken to reinstate the force of life and they believe that HIV/AIDS is like any other disease that they can cure (Magesa, 2013). In African Traditional Religion, there is a belief that HIV/AIDS is linked with witchcraft. It is believed that somebody must be accountable and a person can be bewitched so as to contract the HIV virus (Van Dyk, 2012). As a result, witchcraft and sorcery are frequently blamed for illness, and bad luck in traditional societies. However, the fact is that HIV/AIDS has nothing to do with witchcraft and there is no treatment for it (Van Dyk, 2012).

Similarly, religion also has a negative effect on people's perceptions regarding HIV/AIDS. The proliferation of churches in Africa which claim to have the power to heal any disease including HIV/AIDS, is continuing. There are numerous prophets, fortunetellers and bishops who claim to

possess spiritual divine powers which enable them to heal individuals (Ruele, 2013). However, the problem is that it is difficult to verify such claims. There are testimonies given by individuals that they received miraculous cures or healing from certain churches. Others claim that their positive HIV status changed to negative after being prayed for (Ruele, 2013). Some churches preach abstinence, faithfulness and the use of condoms as a last resort, while others totally reject the use of condoms (Ruele, 2013). Refusal by some churches for their members to use condoms clearly shows that religion influences individuals when it comes to HIV/AIDS-related matters.

Clearly, African Traditional Religion and some variants of Christian churches that claim to miraculously cure HIV/AIDS have an impact on the complications related to the spread of the disease. According to Idowu (2013), most adherents of African Traditional Religion view therapy as part of their religion, culture, and tradition. It is not only practiced during illness, but it is part of their living. Some Christians have faith in God who is above everything else and is the creator and can heal all ailments. (Nemakonde, 2016). The foregoing shows that people's traditional beliefs and religion have a great influence on what people think they know about and their attitudes towards HIV/AIDS. Therefore, there is an urgent need to disseminate accurate and scientific information about HIV/AIDS and its treatment so that people can make decisions based on facts and not unfounded religious and traditional beliefs. Therefore, investigating the influence of traditional healing on anti-retroviral treatment adherence is important because of its potential usefulness in developing strategies that might help to induce positive attitudes and curb the prevalence of HIV/AIDS in the Limpopo Province of South Africa.



The table shows that Vhembe District had 64% treatment adherence in 2018, which is a shortfall compared to UNAIDS targets by 2020 as follows:

- 90-90-90 for treatment: 90% of people living with HIV knowing their HIV status; 90% of people who know their status on treatment; and 90% of people on treatment with suppressed viral loads.

Only if these targets are met then it will be possible to achieve the next set of goals to end AIDS by 2030:

- 95-95-95 for treatment: 95% of people living with HIV knowing their HIV status; 95% of people who know their status on treatment; and 95% of people on treatment with suppressed viral loads (Health Systems Trust, 2018) (District Health Information Software DHIS 2018).

1.2 Statement of the problem

Non-adherence by people living with HIV and AIDS (PLWHA) in South Africa is prevalent despite the fact that patients are therapeutically required to take at least 95% of the ART for the treatment to work. Evidence shows that there is a problem with reaching this high level of adherence because of many social-cultural and individual factors that influence adherence such as traditional beliefs, culture and lack of transport (Ganle, 2015). Of significance is that the World Health Organisation (WHO, 2018) estimates that approximately 80% of South Africans utilise the services of THPs. Ironically, the traditional healing practices have been claimed to be unscientific and deficient in both scientific validity and appropriate policies for its products and practices, yet the majority (80%) of people consult THPs. The problem is that, despite PLWHA knowing the danger linked to poor adherence, what is strange is to find PLWHA non-adhering to treatment in favour of traditional medicine. Still, the negative effects of non-adhering such as death from opportunistic infections do not seem to influence PLWHA to adhere to treatment. This is evidenced by Bishop (2017) who found that even though PLWHA can access ART, they often continuously use THPs to complement ART and for other motives not directly linked to HIV. This clearly shows THPs have an undisputable influence on PLWHA. Therefore, it was imperative to explore how THPs evaluate and manage sickness in PLWHA and how such practices counterpart or deter the broader scale rollout of ART in view of constant changes in HIV care and administration. Exploring the influence of traditional healing practices was important for its potential usefulness in coming up with intervention measures and strategies that help to improve anti-retroviral treatment adherence among PLWHA.

1.3 Aim of the study

The aim of the study was to investigate the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of South Africa.

1.4 Objectives of the study

The objectives of the study were:

1. To explore traditional healing practices on anti-retroviral treatment adherence.

2. To establish socio-cultural and individual factors that influence anti-retroviral treatment adherence.

3. To investigate interventions intended at improving anti-retroviral treatment adherence.

4. To identify strategies to support anti-retroviral treatment adherence compliance through Traditional healer, allopathic clinicians, and community member partnerships.

1.5 Research questions

The study attempted to answer the following questions:

1. What influence do traditional healing practices have on anti-retroviral treatment adherence?

2. Which socio-cultural and individual factors influence anti-retroviral treatment adherence?

3. What interventions may help to improve the knowledge and practices of traditional health practitioners with regards to anti-retroviral treatment adherence?

4. What strategies can be used to support anti-retroviral treatment adherence compliance through Traditional Health Practitioner, allopathic clinicians, and community member partnerships?

1.6 Significance of the study

The significant of the study is that it contributes new knowledge with regards to traditional healing practices because western practices of treatment dominate HIV/AIDS treatment. The mainstream media and academic researches focus on western practices than traditional. This is ironic given the fact that 80% of South Africans consult Traditional Healing Practitioners (THPs). As a result, there was a need for more research that focuses on traditional healing practices since it also

caters for the majority of the population. The problem is that the traditional aspect is not well documented like western hence there's a knowledge gap. The few studies that exist on traditional healing practices are shrouded in unawareness, prejudice, and also a misrepresentation. Thus, there was a need to conduct the research in Vhembe District to dispel some of the prejudice, misrepresentation, and unawareness associated with traditional healing practices. Of significance is that the traditional aspect exists in the community and has been passed verbally from previous generations yet there are few well-documented knowledge and research about it. Even in the mainstream media on television, traditional healing is not celebrated as much as western biomedical treatment. For example, world aids day is more western treatment orientated as covered in the media. Hence, this study was significant.

Furthermore, traditional healing practices methods of managing people living with HIV (PLWHA) have been met with skepticism by some biomedical practitioners amid increasing access to Anti-retroviral Therapy (ART). Kloos (2006) states that even though traditional healing practitioners are still not extensively acknowledged, traditional medicine is being trained further in medical schools and pharmacy schools. More health care benefactors are learning about the positive and potentially negative effects of using traditional medicines to help treat health conditions. That being the case, studying the influence of traditional healing practices help in assimilating traditional healing practices and western medications to improve adherence. Assimilating traditional medicine into mainstream health care would necessitate research to comprehend the efficacy, safety, and mechanism of action of traditional healing systems. Thus the study contributes new useful knowledge which may help in integrating traditional healing practices and mainstream healthcare with adequate knowledge regarding the efficacy, safety, and mechanism of practice.

1.7 Definition of operational terms

Acquired immune deficiency Syndrome (AIDS)

The aforementioned refers to the latter stage of the HIV virus in the human body characterized by lowered immunity and a collection of diseases or a group of clinical signs and symptoms. (WHO, 2017).

African traditional healing

Is defined as a process of therapeutic and curative illness, sickness and ailments that originate in the African Traditional Religion (ATR) (Magesa, 2013). The African Traditional Healing identifies numerous ways to deal with conditions and takes diverse religious specialists whose duty is to determine the explanations for unrest in life (Magesa, 2013).

Treatment (ART)

Refers to medications that treat HIV. The drugs do not destroy or cure the virus. However, once taken in combination they can avert the advance of the virus. When the virus is slowed down, so is HIV disease (Nemakonde, 2016).

Human Immunodeficiency Virus (HIV)

Is the virus that causes AIDS (WHO, 2008).

Adherence

Refers to a phrase that means taking HIV drugs that are prescribed. Treatment adherence is tremendously imperative since it affects how well HIV medications reduce the viral load. The lower the viral load, the healthier and longer an individual is to be. In medicine, compliance (also adherence, capacitance) defines the extent to which a patient properly follows medical advice. Most commonly, it refers to medication or drug compliance, but it can also refer to other circumstances such as medical device use, self-care and self-directed exercises (Maimela, 2015).

Allopathic medicine

Is the term used by homeopaths and proponents of additional methods of alternative medicine to denote to the mainstream medical practice of pharmacologically vigorous agents or physical interferences to treat or overcome indications or pathophysiologic progressions of diseases or conditions (Mbiti, 2014).

Traditional Health Practitioner (THP)

The Traditional Health Practitioner Act 22 of 2007 Section 1 defines a traditional health practitioner as a person who is 'registered under this Act in one or more of the categories of

traditional health practitioners'. Any person who engages in traditional health practice without first registering commits an offense.

1.8 Delimitations of the study

The study was limited to Traditional Health Practitioners (THPs) who reside in Vhembe District of Limpopo Province in South Africa. Vhembe District is made up of four municipalities that involve the following; Musina, Thulamela, Makhado and Collins Chabane. The study focused on Traditional Health Practitioners only in line with the aim of the study, which sought to explore the influence of traditional healing practices on anti-retroviral treatment adherence. The study only focused on the Traditional Health Practitioners (THPs) who are registered with the Traditional Health Practitioners Council of South Africa. Therefore, the study was only limited to registered, Traditional Health Practitioners (THPs) from Vhembe District of Limpopo Province of South Africa.

1.9 Overview of chapters

Chapter 1: Introduction: focuses on the background, the significance of the study, problem statement, objectives, and definition of operational terms and limitations of the study. The traditional healing practices that influence anti-retroviral treatment adherence were exposed.

Chapter 2, Literature Review: focuses on past and present literature that dealt with the phenomenon under study. More so, the literature reviewed enabled the researcher to plot, define the research topic and validate the research questions. In addition, there is a discussion of the adopted theoretical framework.

Chapter 3, Methodology: covers the methodology which comprises the research approach, research design, description of the study area, study population, data collection methods, and data analysis techniques.

Chapter 4, Data Presentation, Analysis, and Interpretation: presents the empirical findings and an analysis of the data in relation to the influence of traditional healing practitioners on anti-retroviral treatment adherence.

Chapter 5, Conclusion and Recommendations: covers policy recommendations and general conclusions derived from the research. Future directions and possible recommendations of the study follow this.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Adherence to treatment is fundamental to attaining the greatest outcomes in the administration of HIV and AIDS. Productive treatment adherence may perhaps stop the replication of the HIV virus and end the scientific development of the sickness (DOH, 2010). In order to obtain the best results of ART, above 95% of the medicine is required (Adrew, 2006). The results of poor adherence influence individual and general prosperity that may moreover put a strain on the compelled social resources (DOH, 2010). Review of literature insinuates the path toward scrutinizing, comprehension and forming choices about composing with regards to the issue examined (Brink, 2012). This area analyses pertinent writing remembering the ultimate objective to set up what has been accepted by various authors with the aim to review the reasons behind ART non-adherence and the subsequent influence.

Non-adherence indicates failure to take medicine as required and documented as one of the crucial basis of treatment malfunction. This can be both calculatingly not adhering to ART or not taking ARVs as required. Non-adherence to medications is complex and several dimensions of health problems (UNESCO, 2010). The reasons could be patient, health care benefactor and or treatment-related. As a corollary, a considerable number of patients fall short to benefit optimally from pharmacotherapy, consequentially augmenting morbidity, mortality and amplified societal costs. Thus, regardless of the many labours made, there has been little advancement made as yet in embarking upon the predicament of non-adherence. It is fundamental to grasp that somewhat adherence barriers ought not to be convicted since if given the assistance, PLWHA can follow treatment well (WHO 2008).

Indigenous health systems have been providing care to individuals for many years, well before western health systems were integrated into traditional beliefs, Mackian (2013) indicated that “when an African patient consults a biomedical doctor, a third figure (this “third figure” being a traditional healer) is often present, albeit unseen”. Moreover, WHO proclaimed that sixty percent of African patients consult traditional healers before or after they consult with a biomedical doctor (Maimela, 2015). With the existence of modern health-care options, like local government clinics,

health centres and hospitals that are accessible in South Africa, patients continue to visit traditional healers. The prevalence of appointments with traditional healers is intensified by views and classification of diseases. Traditionally diseases are classified according to causes. There are those diseases that are thought to be instigated by supernatural powers or the gods (vhadzimu), and those that are triggered through witchcraft and sorcery (Magesa, 2013). Hawker (2014) indicated that in the Swazi culture, there are diseases or conditions viewed as African (indigenous) and those that are foreign (western). In addition, Swazi THPs believe that indigenous diseases can be treated better by traditional healers while western diseases are treated more effectively by biomedical doctors.

2.2 Statistics on HIV/AIDS

The UNAIDS Fact Sheet 2016 showed that twenty million individuals were getting anti-retroviral treatment in 2016 in South Africa. While a gauge of 37 million (31-43 million) individuals globally was living with HIV in 2016. 2 million individuals turned out to be recently infected with HIV in 2016. 1 million individuals died from AIDS-related diseases in 2016. 35 million (31-42 million) individuals have died from AIDS-related diseases since the begin of the pestilence. The fact sheet indicated that in 2016 there were around, 37 million people living with HIV. Beginning of 2016, 20 million individuals living with HIV were receiving anti-retroviral treatment, an increase from 17 million in the year 2015 than 8 million in the year 2010. In the year 2016, about 53% that constituted people who survived HIV were getting access to treatment (UNAIDS, 2016).

In the year 2016, about 76 of pregnant females who were living with HIV had access to anti-retroviral treatment to avert spread of HIV to the unborn babies. UNAIDS 2016 fact sheet disclosed that 2 million people were discovered to have been infected with HIV in the year 2016. Meanwhile, in 2010, new HIV infections among adult population lessened by an anticipated 11 %, from 1 million in the year 2016. AIDS-associated decreases reduced by 48% subsequently in 2005.

South African Statistics implied that the total number of people living with HIV in South Africa increased from 5 million in the year 2002 to 7 million by the year 2016. Shisana *et al*., (2012) projected that the HIV prevalence for the year 2012 was 12%.

According to the South African Department of Health prenatal facility-based evaluations, 5 million individuals are as of now living with HIV/AIDS in the nation, majority of them amid the ages of 15-49, which signifies 19% of the collective South African population in that age segment (Department of Health, Republic of South Africa 2016). The frequency among Black South Africans is 13%, Whites 1%, Coloured 2%, and Indian 2%. 17% of the 5 million people in Limpopo tested for HIV between April 2015 and March 2016 were said to be HIV positive (Medical Research Council, 2016).

According to Statistics South Africa 2016 the number of people who had HIV and on treatment was a total of 71 161 in Mopani which had the highest proportion, Capricorn had 52 868, Vhembe had a total of 52 408, Sekhukhune 49 037 and Waterberg had 38 560. New infections per district from April 2015 to March 2016 were Capricorn District 57 408 from the total of 387 676 people who got tested for HIV/AIDS and Sekhukhune had 49 037 out of 251 543 who got tested for HIV/AIDS while Waterberg had 38 560 from a total of 177 030 who got tested.

2.3 Role of traditional healing in the medical system

South Africa is made up of a unique and dynamic health care system and is a de facto pluralist system comprised of a Western biomedical sector and a large array of traditional healers (Dickson, 2008). The phrase "traditional healers" refers to the broad domain of non-Western trained private health practitioners, who operates as herbalists, diviners, or a combination of the two categories (Flint, 2015). Traditional healers are important to the population and culture of South Africa because they serve as counsellors, mediators, spiritual protectors, and teachers of traditional African religion, customs, and culture (Du Plessis, 2015). However, traditional healers are most important to South Africa because of their wide-spread prevalence, their current relationship with Western healthcare, and their potential to address many of South Africa's healthcare issues by increasing interaction between the two sectors.

Large numbers of traditional healers service much of South Africa. As indicated by Barret (2014) The nation's population of just over fifty million is home to an estimated 300 000 traditional consultants in clear-cut dissimilarity to its nearly 33 000 biomedical practitioners (South African Department of Labour). Furthermore, traditional healers are widely popular. The World Health Organization (WHO) approximate that close to 80% of South Africans utilise the services of traditional healers. The high prevalence and usage of traditional healing in South Africa can be

ascribed to a multitude of factors, such as significant barriers to healthcare. Maimela (2015) analysed the efficacy of Western health centres in rural South Africa. Maimela (2015) found that Western clinics had a shortage of nurses and supplies which led to the long wait for treatment of the chronic disease. Moreover, the nurses lacked adequate training to properly deal with the chronic disease of their patients. In addition to resource deficiencies of medical centres, South Africa poor populations often do not have the financial resources to access the costlier and better private health care. Consequently, they rely on traditional healers to supplement the lesser public health services, which are fraught with a lack of necessary resources (Maimela, 2015).

The deficiencies of the Western healthcare service contribute to the prevalence and relative importance of traditional healing. Rivera (2009) studied the health-seeking behaviours among Latino America immigrants, who are analogous to rural South Africans as both populations place emphasis on the role of religion in healing and both face similar barriers to health care. Rivera (2009) found that much of their studied population never received care, because of structural barriers, and resultantly resorted to cultural alternatives.

Furthermore, many rural individuals utilise traditional healers because of their greater accessibility than Western medical centres. Kolk (2005) studied health-seeking behaviours in a rural Zambian population. Kolk (2005) indicated that on average, traditional healers were located closer to rural villages and had a much faster response time than Western biomedical centres. Furthermore, traditional healers often utilised a no cure, no pay system, and they would also accept commodity payment like cows (Stekelenberg, 2005). These economic factors likely appeal was more to rural poor people who are not involved in the cash economy. Despite not studying specifically South African populations, these studies can provide explanations for the important role of South Africa's traditional healers.

Additionally, many South Africans express a high level of trust and happiness with traditional healers. Some South African men refuse primary health care services because they do not trust the public state counsellors to confidentially deal with private and stigmatized subjects such as a patient's HIV/AIDS status. They instead trusted traditional healers to safeguard their sensitive information (Mambanga, 2016). Furthermore, many South Africans self-report increases in subjective well-being and reduce mild symptoms of depression and anxiety after attending a traditional healer (Nortje, 2016). This, in combination with high levels of trust, contributes to a high satisfaction rate with traditional healers, which is only slightly below Western medical centres (Stekelenburg, 2005).

There are some debates as to what reasons cause an individual to seek out services of traditional healers. Aboa (2010), in a study of Cameroonian traditional healing, found that lack of money or geographical access is not the reason why large numbers of rural Cameroonians utilise the services of traditional healing. Aboa (2010) found that proximity was not that significant of a barrier, and individuals were prepared to travel long distances to receive treatment from a traditional healer, even when a Western Health Facility was nearby. They attributed the discrepancy to traditional healer's more culturally-focused and patient-centered interactions (Labhardt, 2010).

Local conceptions of illness and religious beliefs strongly affect healthcare-seeking behaviour and decision making (Labhardt, 2010). Western biomedical centre's attitude towards patients' culture and beliefs often form another barrier towards accessing formal health care. Ganle (2015) studied the health-seeking behaviour of Muslim females in Ghana and found that despite the fact that Muslim females desired to receive healthcare in a formal setting, their providers lacked the sensitivity to Muslim women's religious and cultural practices. Thus, because of religious and cultural obligations, Muslim women had difficulty utilizing such services (Ganle, 2015). Heisler (2011) found a similar assertion among the Muslim American community. When Western healthcare centres disregard their patients' cultural needs it can drive them to utilise the services of traditional healers. Ultimately, the economic and religious barriers to healthcare, coupled with the resource-deficient Western biomedical system, vastly increase the relative importance of traditional healing in South African society.

Additionally, South Africa's serious health issues further complicate the healthcare environment and bolster the role of traditional healers. According to the 2015 UN AIDS Health Gap Report, an approximation of six million or nineteen percent of South Africans was said to be living with HIV/AIDS. Furthermore, South Africa also saw three-hundred and forty thousand new infections and two hundred thousand AIDS-associated bereavements in the year 2013 (UN AIDS Health Gap Report 2015). South Africa's significant lack of Western medical resources only exacerbates the nations' HIV/AIDS epidemic. 58% percent of HIV-infected individuals have access to anti-retroviral medication (UN AIDS Health Gap Report 2015). Moreover, HIV/AIDS in South Africa is geographically unevenly distributed. HIV incidence is virtually forty percent in KwaZulu Natal equated with eighteen percent in Northern Cape and Western Cape, highlighting a significant disparity between the disease's prevalence in urban and rural provinces (National Department of Health Annual Report South Africa 2012). Because of traditional healers' increased presence and importance in rural areas (Semenya, 2014), they subsequently work in locales, which have the

highest prevalence of diseases like HIV/AIDS and also the fewest resources to adequately prevent, manage and treat the afflicted individuals.

Traditional healers could greatly benefit rural South Africa's HIV/AIDS problem. Flint (2015), in a study which compares Native American and traditional healing in South Africa, postulated that traditional healers in Northern America have had great success in reducing HIV/AIDS infection rates. Native American traditional healers are effective at treating infections relating to substance abuse, which in turn, limits HIV/AIDS-related risks behaviours and reduces infection of the disease. Flint holds that South Africans could also achieve similar results by enabling traditional healers to help reduce HIV/AIDS infections. Traditional healers would not replace the superior biomedical treatment of HIV/AIDS, but it would rather supplement the Western healthcare centres in addressing the disease (Flint, 2015). Additionally, traditional healers could serve as disseminators of sexual education to reduce HIV/AIDS infection rates. The Western medical healthcare sector's increased education and regulation of traditional healers could enable the propagation of sexual health education to individuals who visit exclusively traditional healers (Gow, 2013).

Traditional healers also have the potential to improve other health areas of rural South Africans such as water quality. Limpopo is a rural province in South Africa and is one of the poorest and most resource-deprived in the country. Notably, 90% of Limpopo residents have limited access to potable water and sanitation, which likely contributes to Limpopo's high presence of water-borne disease, like early childhood diarrhea (Netshandama, Boissevain, Richardson, and Dillingham 2011). In a joint Uva- Univen project, Mellor, Smith, Learnmonth, Netshandama, and Dillingham (2011) conducted a comprehensive study into water quality, hygiene, and health in Limpopo, South Africa, their findings indicated that traditional healers play a vital role in society and they could assist in implementing interventions that can improve water facilities. Similarly, Mellor et al. (2012) suggested that traditional healers could be used to help implement interventions, in areas such as boiling frequency and source water quality and could drastically reduce water-related health issues on a local level in rural areas.

In addition to direct intervention, traditional healers have the great potential to encourage patients to seek out Western biomedical healthcare by referral. Okeke (2006) investigated the perceptions and referral practices of traditional healers in Nigeria. Okeke (2006) postulated that traditional healers could greatly benefit Nigerian malarial treatment if they would refer their patients to

Western biomedical centres. The insertion of traditional healers into the well-being care system greatly aid in the early detection and management of chronic diseases (Maimela, 2015).

While there is some degree of interaction currently, there is a lack of trust between the two sectors (Campbell, 2011). Western medical providers are often doubting traditional healers. In South Africa, only 58% of Western health practitioners believe that it is safe (Mokgobi, 2014). This distrust often manifests itself in lack of cooperation between the two groups. While in certain cases traditional healers were likely to refer their afflicted patients to Western doctors, however, Western health practitioners often did not reciprocate, and the collaborations were one-sided (Dagher and Ross, 2004). Additionally, approximately 76% of Western healthcare practitioners report that they would on no occasion refer their own patients to a traditional healer (Sorsdahl, 2009). Conversely, a vast number of traditional healers view alliance between traditional practitioners as an imperative (Summerton, 2006). Traditional healers reported a desire to increase cooperation between the two entities, however, they felt that Western healthcare providers did not give them appropriate reciprocation and respect (Campbell, 2011).

Admittedly, Western biomedical centres' incorporation of traditional healers into South Africa's healthcare system does have limitations. Chowdhury (2016) conducted an analysis of the effects of training rural traditional healers in India on healthcare provisions. Das (2016) found that training did not decrease traditional healer's use of unnecessary medicines or raise the level of healthcare to that of formal healthcare providers. While not a long-term solution, training traditional healers could offer an operative rapid-run policy to expand healthcare, especially in areas which lack adequate health resources. Ultimately, an expansion of the South African social welfare system to decrease this rural healthcare group would be too costly for the South African government (Bhorat, 2014). However, traditional healers could potentially bridge the gap in South Africa by working in tandem with Western biomedical centres to fill the healthcare deficiencies in rural areas (Campbell, 2011).

2.4 Antiquity of endorsed government HIV/AIDS Strategy in South Africa

2.4.1 The HIV/AIDS crisis emerges: responses of the apartheid government

The first instance of AIDS, in South Africa, was accounted for in 1992 in a gay male who had gotten the disease while in California, United States. Thereafter, 250 unpredictable body fluid tests were taken from gay men who lived in Johannesburg, of which an astonishing thirteen percent were infected (Shneider, 2002). The politically-authorized racial isolation organization led by President P.W. Botha afterward held a meeting to report the probable hazard the illness postured for the country. In the year 1987, controls were dispensed that dealt with additional AIDS to the official South African rundown of transmittable maladies (Avert, 2011). These controls required an obligatory fourteen-day disconnect for individuals persisting, or connected with misery linked to AIDS. The disconnect may perhaps be prolonged uncertainty if a circumstance was acknowledged. From that point, the first black South African was confirmed to have AIDS (Shneider, 2002).

Fassin (2003) specified that in the year 1988, an assembly is known as the AIDS Unit and National Advisory Group was raised inside the Department of Health to propel care regarding HIV/AIDS. It contained a touch of the social event of specialists who were put in charge of keeping an eye on the emerging pandemic. The degree of these early attempts by the politically-endorsed racial isolation association remained insignificant, in any case, also by 1990 seventy-four thousand to one hundred and twenty thousand South Africans were surviving with HIV (Butler, 2011). In the same year, a national prenatal audit was found that one percent of prenatal females were infected with the pandemic. In April, the issue was discussed at the Fourth International Conference on Health in South Africa. A report was compiled after the meeting to deliberate the utmost relevant parts of contending the infection, as well as evasion and human rights protections for the defiled. This chronicle was entitled 'The Maputo Statement on HIV/AIDS' (Seager, 2004).

As showed by Mbali (2005) in mid-1991, a nationwide social event was done and another body called the National Advisory Group (NACOSA) was developed to develop more thorough government approaches for HIV/AIDS. NACOSA was expected to convey performing craftsmen from an extent of parts organized to put through a firm reaction to the predicament. The organization's AIDS Unit was pulled apart later that spring and supplanted with the National AIDS Program. In July, the number of AIDS cases gotten through heterosexual sex was identical to that

of individuals contracted by gay individual sex, an estimation that negated expansive favouritism that HIV/AIDS was a 'gay infirmity' (Mbali,2005).

2.4.2 A new democratic era: responses of president Nelson Mandela's administration

Nelson Mandela was the president-elect, and Dr. Nkosazana Clarice Dlamini-Zuma was assigned as Minister of Health. Following one month, battling HIV/AIDS was made one of twenty-two lead exercises of the new government's Reconstruction and Development Program (RDP). Three new structures were planned in the RDP that engrossed on enabling meetings with basic culture in creating government HIV/AIDS plan, which included (i) an HIV/AIDS and STD Advisory Group; (ii) a Committee on NGO Funding; (iii) a Committee of HIV/AIDS and Sexually Transmitted Disease (STD) Research (Seager, 2004). In August, President Mandela's governing body recognized 'The National AIDS Plan for South Africa' impelled by NACOSA. The plan focused on the repugnance of HIV through government-subsidized preparing endeavors, decreasing transmission of HIV through appropriate care, treatment and support for the defiled, and amassing adjacent, normal, national and worldwide resources for the fight to battle HIV/AIDS (Fassin, 2003).

The following year, from 6-10 March the 7th annual International Conference for People Living with HIV and AIDS was held in Cape Town. More than 476 individuals attended from 84 nations. This was addressed as an imperative moment in advancing South Africa's inclusion with the worldwide group in contending the epidemic (Bodile, 2012). By August, nonetheless, positive thinking started to transform into thwarted expectation. The Department of Health consumed through fourteen million Rands that was given by the European Union to battling HIV/AIDS in South Africa on a theatrical production called Sarafina II. This venture was intended to teach general society, especially youth, about the ailment. In any case, critiques and HIV/AIDS activists alike reviled the production's content as wrong and vague, and conspicuous AIDS associations communicated profound dissatisfaction over being prohibited from the arranging and execution of the venture (Bodile, 2012).

Along these lines, government sponsoring for the play was ended in 1996, and its conclusive disenchantment insisted generating understanding among regular society performing craftsmen that the response of the recent majority rule South African government to the cumulative epidemic was winding up being terribly lacking (Shneider, 2002). Certainly, Nelson Mandela himself later

summoned the misinformed and mishandled Sarafina II one of the remarkable blunders of his association. In 1996, Rose Smart was selected as an official of HIV/AIDS and STD executive. Regardless, this appointment was put under the association of the Health Department, instead of being given an all the additional skilled seat in the President's Office. This mishandled the conditions put forward by the National AIDS Plan and recommended that the organization sustained overview the epidemic as exclusively an issue of general prosperity, slightly than a vital societal catastrophe that desired more broad government consideration (Butler, 2011).

On 22 January 1997, one more high-level government scandal occurred when Mandela's bureau received a presentation from specialists of the South African AIDS drug Virodene. Trials of the medication had been prohibited in South Africa by the Medicines Control Council (MCC) because of noteworthy proof that its primary dynamic fixing a modern dissolvable was greatly dangerous (Noar, 2007). Be that as it may, Health Minister Dlamini-Zuma upheld open trials of the medication notwithstanding these worries over its wellbeing. Soon thereafter, the Department of Health surveyed the NACOSA Plan and revealed that there was a concerning absence of political authority in battling HIV/AIDS. A new arrangement is known as 'The National AIDS Control Program' was in this manner made by the Department of Health. Its objectives included lessening HIV/STD spread by giving suitable maintenance, treatment, and sustenance for tainted people. By requiring an assembly and unification of nearby, commonplace, national and global assets, this arrangement accentuated the destinations of behavioural change, human rights security of infected people (Fassin, 2003).

At that point, in late pre-winter, a first historically high-level state body was generated to create a durable reaction to the pestilence from a huge number of various divisions. It was known as the 'Between Ministerial Committee (IMC) on AIDS,' and the then Deputy President Thabo Mbeki was selected as its head. Towards the commencement of 1998, a contest for the supply of anti-retroviral drugs (ARVs) by the South African government that would keep going for a significant part of the next span started (Mbali, 2005). South African AIDS campaigners and analysts alike requested upon the administration to convey an ARV tranquilizer called Zidovudine (AZT) to prenatal ladies. In any case, all ANC-drove areas dismissed the utilization of AZT, construct essentially with respect to claims that it was excessively costly, making it impossible to disseminate. Additionally, Health Minister Dlamini-Zuma straightforwardly restricted the medication and attested that the South African government's dogma was to concentrate on counteractive action as opposed to treatment. This contention appeared to be nonsensical to the

Health Minister's faultfinders, be that as it may, as the medication has been appeared to drastically lessen HIV transmission from prenatal ladies to their unborn youngsters (Bodile, 2012).

Towards the end of the year, on 10 December, the Treatment Action Campaign (TAC) was launched by HIV-positive dissident Zachie Achmat and ten different people. This association expected to challenge the administration's rejection to disperse ARVs. The gathering's individuals dressed in trademark shirts with 'HIV-POSITIVE' written in huge letters and Achmat made a well-known promise to not utilise ARVs until the point that they would be noticeably accessible to every South African (Avert, 2011).

On 14 June 1999, President Thabo Mbeki was chosen as the second post-politically-sanctioned racial segregation President of South Africa. Dr. Manto Tshabalala-Msimang was chosen as Minister of Health in his government. After taking office, President Mbeki called upon all divisions of humanity to end up noticeably associated with combatting the HIV/AIDS pandemic (Seager, 2002). Be that as it may, the President straightforwardly held the position HIV did not cause AIDS, also confronted negligible difference in his bureau for his numerous open explanations on the issue. Actually, toward the start of the year, 2000 Mbeki sent a letter to world pioneers asking them to rethink financial issues as the genuine reason for AIDS. He set up together a board of researchers who concurred with his position, in spite of the fact that whatever is left of the worldwide academic group viewed such perspectives as profoundly dissenter (Avert, 2011). In fact, official South African HIV/AIDS approach had plainly expressed the view that HIV caused AIDS for over 10 years.

In January 2000, The National AIDS Council (SANAC) was created, supplanting the Inter-Ministerial Committee on AIDS. The foundation of this chamber was facilitated by Health Minister Tshabalala-Msimang. It meant to solidify political authority and increment common society contribution in the battle against HIV/AIDS. In February, two noteworthy projects were propelled under the protection of the committee (Fassin, 2003). The National Integrated Plan (NIP) was formed to deal with HIV positive children and it also consisted of the divisions of health, training and social improvement. It advanced three intercessions which included, fundamental abilities training for youth, home/group-based care, and sustenance for HIV-positive youngsters through NIP funds. Second, the HIV/AIDS/STD National Strategic Plan for South Africa 2000-2005 advanced the two essential objectives of decreasing new contaminations especially midst young people, and lessening the effect of HIV/AIDS on people, families, and community (Bodile, 2012).

On 19 April 2001, the South African government implemented a law to permit the supply of ARVs through public health structures even though they were extremely low (Avert, 2011). Subsequently, after a year the South Africa High Court requested the legislature to make the reproductive medication Nevirapine accessible to HIV-positive antenatal ladies. In spite of the request by the High Court, no mass-scale delivery of Nevirapine was implemented. The Treatment Action Campaign subsequently sorted out a development toward the begin of 2003 to question the South African government's general inability to execute a legitimate reaction to the pandemic (Seager, 2002). In February, the association coordinated a march of thousands of individuals to parliament in objection to the nonexistence of universally accessible ARVs through the public health system. After one month, a common rebellion campaign was launched to intensify pressure on the Ministry of Health to make available a wide-ranging ARV treatment design (Butler, 2011).

Partially for the reason that this increased pressure from communal humanity, the South African Bureau affirmed prearrangement for all-embracing ARV treatment in August 2003. The program started in March 2004 in Gauteng and extended to different areas shortly afterward (Fassin, 2003). In March 2005, the objective of the 2003 plan was met to have no less than one administration centre for AIDS-associated care and treatment in each of the nation's 53 areas. Notwithstanding, the number of individuals basically getting ARV treatment stayed far beneath the goals delineated in the prearrangement (Shneider, 2002). The administration responded to this matter in the pre-winter of 2005 with an alternative strategy system in which a promise to enhancing community to ARVs was announced (Avert, 2011).

Researchers have termed this package 'patriot', or "ameliorative" interestingly by all the more globally acknowledged and experimentally demonstrated biomedical reactions to HIV/AIDS (Fassin, 2003). The Health Minister upheld the utilization of African sustenance, for example, garlic, lemon and beetroot by HIV-positive people as a reasonable contrasting option to ARV treatment in the commencement of AIDS. Likewise, she kept on putting forth open expressions intimating that ARVs were lethal, with minimal logical confirmation to back her cases (Seager, 2004). The Health Minister's advancement of option, "African" cures and her feedback of a universally authorized ARV reaction created warmed contention from South African also global AIDS activists alike (Bodile, 2012). In May 2006, the Health Department started the advancement of another 5-year National Strategic Plan (NSP) by SANAC, under the authority of Deputy President Phumzile Mlambo-Ngcuka.

The arrangement was propelled on 12 March 2007 and required a multi-sectoral reaction that developed the NSP of 2000-2005. It concentrated on four key need ranges, (i) Prevention; (ii) Treatment, care and support; (iii) Human and legitimate rights; and (iv) Monitoring, research and observation (Avert, 2011). While it was intended to spill out of the NSP for 2000-2005, this arrangement comprised a generally substantial accentuation on ARV arrangement. All-inclusive access to ARV treatment, be that as it may, stayed a long way from acknowledged (Avert, 2011). On 25 September 2008, President Mbeki resigned from office due to having lost the backing of the ANC. Kgalema Motlanthe was chosen as interim president, and Tshabalala-Msimang was supplanted by Barbara Hogan as Minister of Health.

2.4.3 President Jacob Zuma's responses: revolving the poor policy

In the year 2009, on 22 April Jacob Zuma was nominated President of South Africa, and Dr. Aaron Motsoaledi was delegated as Health Minister. AIDS campaigners at first reacted to the appointment of Zuma with profound doubt and carefulness, as he was accused of the assault of an HIV-positive lady in December 2005 (Butler, 2005). He was declared not blameworthy on 8 May 2006, but rather created various disputable open articulations about HIV/AIDS amid the pilot. For example, in court, he asserted that after intercourse with the lady he had washed up on the grounds that "It" would limit the danger of getting the infection" (Motsoaledi, 2011). However, it soon turned out to be certain that the disagreeing logical perspectives and denialism that characterized Mbeki's Presidency would not keep on prevailing under the new government. By the late harvest time of 2009, President Zuma's bureau plugged a promise to assess all adolescents exposed to HIV and offer all HIV-positive youngsters with ARVs (Motsoaledi, 2011). Also, according to the objective set by the National Strategic Plan of 2007-2011, the scope of HIV-positive mothers with AZT treatment was evaluated at more than 95% by the year 2010. Spread from mothers to their children was accordingly diminished to only 4% (Motsoaledi, 2011).

In April, an HIV Counselling and Testing (HCT) broadcasting canvass was propelled by the legislature to expand dialog of HIV in South Africa. It worked by the use of door-to-door crusading and billboards to advance the accessibility of free testing and directing in wellbeing centres, and in addition to decrease the myths and shame encompassing the disease (Avert, 2011). Likewise, that month, KwaZulu-Natal turned into the main territory to give male therapeutic circumcision

given proof that it decreases danger of the spread of HIV from men to women by 60% (Avert, 2011).

On 1 December 2011, a third National Strategic Plan (NSP) on HIV, STDs, and TB was produced for 2012-2016. The five objectives of the arrangement were as per the following: (i) Halve the quantity of new HIV contaminations; (ii) Ensure that no less than eighty percent of individuals qualified for HIV treatment are accepting it; (iii) Halve the quantity of new TB diseases and losses from TB; (iv) Safeguard that the privileges of individuals existing with HIV are secured; and (v) Halve humiliation connected to HIV and TB. This arrangement has brought about an expansion in general spending designation for ARV treatment, to guarantee that its second focus of 80 percent scope is met by 2016 (Motsoaledi, 2011). Dr. Thobile Mbengashe, leader of the Health Department's HIV and AIDS program indicated out to a news journalist in April that critical advance that has been made over the most recent eight years, by expressing that "It's quite phenomenal that in 2004 we had just 47 000 individuals on treatment and that number has truly expanded.

Starting in early April, R5 billion had been consumed in 2012 on the management of HIV treatment. At last, the introduction of widespread ARV treatment in the wide-ranging health care has increased ground in modifying arguments of interpretation of HIV/AIDS midst South Africans (Motsoaledi, 2011). Whereas a diagnosis of HIV used to be comprehended by several as capital punishment, it is gradually viewed as a remediable and reasonable illness. The NSP for 2012-2016 will along these lines keep on influencing this pattern, in its progression of a mix of multidimensional projects for behavioural avoidance, biomedical treatment, and societal de-belittling (Motsoaledi, 2011).

2.5 Traditional healers, Sangomas and HIV/AIDS

Experts of traditional medication can be found across an extensive assortment of settings, including herbalists, bonesetters, village midwives, traditional mental health practitioners, herb sellers, and others (Brown and Brown 2000). It ought to be noticed that albeit certain premises associate the standards of recuperating all through Africa, practices and ideas fluctuate from nation to nation, and crosswise over ethnic or tribal gatherings. Along these lines, for instance in South Africa, the Xhosa and Zulu customs of mending, whereas evidently comparable in numerous regards, at the same time contain extensive contrasts. Besides, conventional mending

practice in Africa is adaptable and versatile, and varieties seem subject to social and political variables, the result of a consistently evolving praxis (Kuper, 2007).

The reaction of South Africa's administration to the test of HIV/AIDS has been portrayed as loaded with 'missed open doors, insufficient examination, bureaucratic disappointment and political failure (Nattrass, 2004). Regardless of the appeals of grassroots associations, for example, the Treatment Action Campaign (TAC) and the Congress of South African Trade Unions (COSATU), the organization failed on its choice to give Nevirapine to prenatal HIV positive women (Leclerc-Madlala, 2002), also lacking a guarantee of access to unrestricted anti-retroviral treatment (ARVs) all through the nation stays just halfway satisfied (Hassan, 2004). The organization rejects a selective dependence on regular biomedical for HIV/AIDS and backs the assimilation of traditional customary pharmaceuticals in its "entirely encompassing" approach. To this end, the Minister of Health has required an elevation of the profile of customary healers and proposed that 'conventional and Western prescription should work as one' (Tshabalala-Msimang, 2004).

Rather than this hesitance to grasp the biomedical treatment of ARVs, the administration has eagerly supported the advancement of vaccination for HIV/AIDS. While at first glance this may appear to be confusing, the clear irregularity can be better comprehended when considered with regards to government bolster for a conventional solution. Sangomas have long consolidated the idea of the 'conventional infusion' in which a solution is regulated to a cut made in the skin with a porcupine plume or all the more as of late, a disposable cutter. The organization's responsibility regarding the advancement of vaccination might be seen at the same time as proof of its affirmation to customary therapeutic practice, and, of the benefits of inoculation over the self-regulated, and along these lines hard to screen ARVs (Hassan, 2004). The response of South Africa's governing body to the trial of HIV/AIDS has been depicted as stacked with “missed open entryways, lacking examination, government frustration and political mess up” (Nattrass, 2004).

2.5.1 Divination, diagnosis and healing practices

Sangomas assume the essential part in the public eye of guaranteeing that the society is shielded from deceitful spirits that bring sickness, in which the healer intervenes in the connection amongst the patient and the precursors (Mawere, 2011). A patient consults the sangomas, who decide the idea of the pain or the purpose behind the patient looking for their help. The seer tosses bones (ditaola) on the floor that may incorporate creature vertebrae, dominoes, dice, coins, shells, and

stones to find out the reason for the affliction and the suitable treatment. Each one has alternate importance, which only the healer can translate. Ditaola has certain ramifications for human life, similar to a hyena bone recognizes a hoodlum and will give data regarding stolen property. The sangomas or the patient tosses the bones, however, the progenitors regulate how they are translated as far as the patient's infirmity (Mawere, 2011).

The National Health Plan for South Africa (1994) and Mathonsi (2013) indicated that the advantages of coordinated effort and collaboration amongst contemporary and traditional health experts should be cultured, given that customary specialists are frequently more open and acceptable than the advanced social insurance segment and would thus be able to help in advancing health care. On 12 February 2013, an Interim Traditional Health Practitioners' Council (ITHPC) authoritatively incorporated customary healers into the National Health Insurance (Mathonsi, 2013). The assembly advocated for shared training between western health care and customary healers.

The Interim Traditional Health Practitioners Council works under the authority of Abram Conrad Tsiane and comprises of twenty individuals from an assortment of orders, for example, botanists, soothsayers, customary specialists, conventional birth chaperons, scholastics and analysts from the Department of Health (Mathonsi, 2003). The goal of this committee is to enlist conventional wellbeing specialists with the Health Professional Council of South Africa and to secure general society against deceitful healers who misuse people in general. It is additionally in charge of ensuring the protected innovation privileges of customary healers, to shield any organization or individual from obtaining such a solution without recognizing or repaying conventional healers. Research into customary drug must profit the group and the makers of learning (Mathonsi, 2013).

Mathonsi (2013) contends that the 1978 Alma Ata Declaration, supported by the World Health Organization, accommodated the joining of the conventional drug into the essential human services framework. There has been a level of cooperation amongst Western and conventional frameworks. Numerous primary healthcare facilities and clinics have been working as an inseparable unit with customary wellbeing experts to regard adolescence sicknesses, for example, looseness of the bowels, heaving, HIV and AIDS, tuberculosis and dysfunctional behavior (Mathonsi, 2013).

Mawere (2011) attests that African nations need to perceive the significant part that conventional and faith healers play in healthcare since such a variety of individuals incline toward customary prescription to Western pharmaceutical. In a study piloted in the Northern Cape among doctor's

facility patients and staff; church individuals; and college understudies uncovered that most ailments are cured with customary recuperating. These illnesses incorporate witchcraft, (like Sejeso and Sefolane) and progenitor (badimo) related issues; conventional ailments, as hlogwana (throbbing fontanel, "little head"); makgoma (collection of infirmities, the consequence of the infringement of specific taboos); barrenness and sexually transmitted ailments; asthma; mental clutters; epilepsy; and looseness of the bowels. Biomedicine was discovered to be effective in ailments, for example, tuberculosis, chickenpox, AIDS, hypertension, diabetes, intestinal sickness, measles, malignancy, frailty, mental hindrance, and ulcers (Mawere, 2011).

Sagan (2013) postulates that understanding customary treatments entails a careful examination of the lives and perspectives of Africans. The sentiments of Africans contrast and frame a complex association in which suppositions around acquired spirits, enchantment, magic, witches and contamination exist together. The implication provides a typical method for seeing misfortune and gives direct responses to the bewildering inquiries of the motivation behind life. Wellbeing to the conventional African is being in agreement with astronomical imperativeness/vitality, respecting predecessors to forestall hardship in life. Conventional healers recuperate both physical and profound/social diseases by diagnosing basic ailments; offering and apportioning solutions for therapeutic protests, and divining the reason and giving answers for otherworldly or social protestations. It is moreover trusted that sicknesses identify with the mental, profound and physical requiring all-encompassing treatment (Sagan, 2013).

2.5.2 Types of Traditional Health Practitioners

Motsei and Freeman (2002) distinguish 4 classes of conventional healers which are, inyanga, sangoma, customary specialist and conventional birth assistance. A Sangoma is a traditional medicine practitioner, who communicate with ancestors, work with plant medicine (herbalism) and use the power of prayer for healing. A customary specialist works in utilizing herbs for the cure of afflictions. The dingaka (Sotho) or isangoma (Zulu) is typically a lady who works inside a customary religious powerful setting and goes about as a medium to the familiar spirits. Individuals who are called by the progenitors can move toward becoming soothsayers. At that point, there is the faith healer, called umprofethi or umthandazi, who incorporates conventional practice into Christian customs. Faith healers are prevalently Christians who utilise blessed water

or mirrors for treatment or to anticipate the forthcoming and has a place with the Independent African Churches (Motsei and Freeman, 2002).

Kale (2005) states that conventional birth orderlies are for the most part elderly ladies who help amid work to guarantee that the infant and mother securely endure the birth. Conventional birth chaperons are respected within the community for their skills and work in partnership with an inyanga, particularly when complexities emerge amid birth. Beside these customary birth specialists, there are additionally conventional specialists (rathipana) who are in charge of circumcision and taking young men to the mountain for initiation. There they educate initiates about culture and their parts in the public eye. Regardless of the presence of these customary specialists, absence of joint effort remains a challenge (Kale, 2005).

Customary healers have the information and abilities to treat sexually transmitted illnesses and adolescents' sicknesses (tlhogwana, letshollo le khujwana le amangwe). On the other hand, faith healers concentrate on substance mishandle and ceaseless situations and additionally societal issues. Most conventional health specialists would be keen on helping the legislature in the treatment of infections emerging from AIDS, yet they would need to work outside of anyone's ability to see of the group to maintain a strategic distance from potentially annoying the precursors (Rhodes and Rhodes, 2004).

The components of traditional medicine incorporate plants and creatures aims for keeping up the prosperity of Africans. Mapara (2009) sets out an approximation of individuals who counsel Western specialists and the individuals who pick conventional healers. In the Kwahu locale of Ghana, for example, a larger number of individuals go to traditional healers than to Western specialists and in Swaziland, there are 110 000 individuals for each customary healer, and just 10 000 for the university-trained medical doctors (Hakim, 2010).

The propensity to alternate on conventional recuperating can be credited to the high cost of Western pharmaceuticals and the unavailability of Western administrations, making customary wellbeing experts the main wellspring of therapeutic treatment for some Africans. Conventional healers offer important experience and also moderate and successful treatment (even in connection to AIDS), as indicated by a customary healer and equipped dental practitioner in Uganda (Mapara, 2009). Rhodes and Rhodes (2004) demonstrate the clear distinction amid customary healers as indicated by the specific capacities they perform and in South Africa, each culture has its own terms for a soothsayer. The Xhosa conventional healers are identified as amagqira, in South Sotho they are called ngaka and in Northern Sotho Selaoli and Mungome in

Venda and Tsonga. Usually, customary healers alluded as sangomas (from the Zulu word izangoma) in South Africa.

As of late Western health care practitioners has communicated an interest for the viability and effectiveness of traditional medicine and more prominent research is being conducted on the traditional medicine (for example, aloe, buchu, and fallen angel's paw). Public health care practitioners recognize the part of traditional specialists in the treatment of illnesses, for example, HIV and AIDS, diarrhea and pneumonia, which are real reasons for death in rural communities (particularly in adolescents). Conventional wellbeing experts have kept on aiding the battle against the scourge of HIV and AIDS in Africa. Claude El Fox (2010) states that conventional healers in Africa fall under the umbrella of botanists. Their practices fixate on treating diseases by methods for homegrown pharmaceutical, while soothsayers utilise supplication, expectation, and soul directing. Conventional African recuperating centres around the body, soul and social prosperity of people. Any unsettling influence on these levels shows in sick wellbeing, recuperating will along these lines address the patient in connection to the earth, society, and universe.

2.5.3 Diviner/sangoma

Concurring to Kayombo (2007), diviners must experience a function of spirit possession that basically highlights music, dancing, society participation and elucidation of dreams. Soothsayers are transcendently female who go about as go-between amongst people and ancestors or the heavenly. This customary practice is a calling and not a decision. Such calling may happen through dreams, prescience, and dreams or now and then the individual called this administration will abruptly fall sick for a timeframe and will at that point, after consulting a conventional healer, learn of the calling to this calling (Ramokgopa, 2013). Diviners help by interceding unexplainable conditions, and the message is granted through bone tossing. Prophecy is another strategy a soothsayer utilises to interface with badimo (progenitors), to decide the effect of ailment and medicine use. This training involves the perusing of palms, water and mirrors; moving; daze; tossing bones or shells; and petitions (Hakim, 2010).

Turning into a customary healer (go thwasa) can happen in various ways. Witchdoctors learn of this aptitude while getting this sort of treatment and afterward set out to become healers upon recuperation (mental confusion may be an indication of otherworldly calling). There are likewise

cases that include profound calling and finding and treatment will in this way be heavenly in nature (Ramokgopa, 2013). Successful learning and aptitudes casually from an immediate relative, for example, a father or uncle or considerable mother or close relative (case of midwives), is one more way it might happen. It is a sort of apprenticeship in which a customary wellbeing professional passes on the aptitudes and information to the more youthful era (Ramokgopa, 2013).

2.5.4 Herbalists/ngaka

A botanist can be viewed as a drug specialist who apportions solution made of natural ingredients containing the bark of trees, roots, leaves, creature skin, blood or parts of creatures, herbs, and seawater. Their services do exclude prediction (Latiff, 2010). Herbalists have broad information about extraordinary methods. They additionally utilise observational learning to analyse certain sicknesses and endorse the best possible remedial herbs; avert cataclysm within a village, give protection against bewitchment, hardship and bringing riches and satisfaction (Latiff, 2010). Latiff (2010) indicated that conventional wellbeing specialists utilise customary medication, for example, crocodile skin for fever, to treat an assortment of ailment. Becoming an herbalist requires seven years of strict practicing, under a qualified botanist, from that point the learner is tested during a ceremonial ritual on his or her knowledge of herbal remedies.

2.6 Traditional Healing Practices and indigenous knowledge systems

Struthers and Eschiti (2004) demonstrated that Traditional healers have what it takes and experience to treat a number of illnesses, this was also supported the World Health Organization and the United Nations Conference on Environment and Development (UNCED). For instance, conventional wellbeing professionals utilise herbs, for example, the African willow (South Africa), the hoodia plant (Namibia) and "iboga" (Gabon and Cameroon) Floyed (2009) to treat conditions like cancer, obesity, and drug addiction. Western pharmaceutical organizations have turned out to be mindful of the competence of the herbs applied as a fragment of customary medication and have now and again stolen these plants to pitch them to indigenous individuals at extraordinarily expanded costs.

2.6.1 Traditional conceptualization of health and illness in Africa

Wilkson (2010) clarifies the colossal social and political part that traditional healers play in society through their recuperating of otherworldly, emotional illness, help with childbearing, whereabouts of property and elucidation of the past and future. Conventional wellbeing experts are profoundly considered in the society, in view of their capacity to cure disease related to witchcraft and the disappointment of predecessors that outcomes in hardship being gone by on a family or group. Customary wellbeing professionals conciliate these progenitors by methods for specific ceremonies that incorporate consuming imphepho (Helichrysum petiolare) or play drums and humming. They likewise recommend muti (medicine), arranged from vegetation and faunae, and implanted with profound significance. Muti is regularly fundamentally illustrative of the objective it plans to accomplish, for example, giving lion fat to children to advance boldness. There are medicines for all types of physical and maladjustment, social contradiction and otherworldly challenges and in addition elixirs for insurance, love, and luckiness (Padayachee, 2004).

2.6.2 Traditional treatments

Healing is characterized as the redressing of clutters influencing the body, psyche, and soul for which customary wellbeing specialists have an assorted scope of conventional mending strategies. Cases of such medications incorporate taking green tea orally (natural cures), blend of high temp water and herbs where the vapor upgrades unwinding and washes off misfortune (steaming); conventional prescriptions that enhance blood flow (blood purifying and entry point) and others that achieve favourable luck (charms); and correspondence with predecessors, through drums and music (dancing) (Campbell, 2010).

African culture credits illness to a wronged association with the society and the precursors or rebellion to seniors and progenitors, breaking social standards and rankling God. A case of this is the point at which someone neglects to grieve her better half's demise an entire year and goes into marriage before that period has passed. The factors are multi-faceted, with complex ramifications on how individuals comprehend their reality and their place in it. Socially endorsed relational guidelines control conduct among individuals from the family, social gatherings and the more extensive group (Hakim and Chishti, 2010).

Healing and disease are interconnected and cannot be isolated. The hypothesis of sickness is mind-boggling and does not just identify with agony or breaking down of the cells, however, cuts over the entire of the individual and the society. Mending is, along these lines, re-establishing wholeness in human connections including the mental, social, moral, financial, political and otherworldly full request to realize such reclamation, the progenitors are counseled for answers for the ailment (Hakim and Chishti, 2010).

Manner of greeting, interaction with associates of the communal, precise responsibilities and societal tasks are instilled from childhood. Duty to family and society is key in traditional life and respect for the important members of society such as community leaders, older people, professors, and doctors is heavily emphasized. It is supposed that lack of respect for social norms and standards leads to headaches, mental illness and bad luck (Brodnicka, 2003).

2.6.3 The Relationship between ancestors and African Christianity

It is trusted that most African Christians likewise venerate their predecessors, a training that goes before the acquaintance of Christianity to the continent. While incense is burned to speak with predecessors, Christians speak with the Creator through prayer and immersion in the Holy Bible. Numerous scholastics, evangelists and theologians portrayed the precursors and spirits as instruments of the devil, in past circumstances, thinking of it as basic to destroy this faith in predecessors at the earliest opportunity, in spite of the love of progenitors additionally being an element of monotheistic religions like Judaism, Islam and Christianity (Kale, 2005).

There are subsequently numerous who are both committed individuals from a congregation and keep on communicating with their precursors, who they esteem to be the living dead or resting and ready to speak with the living. Christians do not view the predecessors as divine beings and such a claim would be a twisting of their way of life, nor do they connect the precursors with Christian holy people, which would be a hazardous and befuddling comparison (Kale, 2005).

Donmoyer (2006) postulated that to the African badimo are close family-like guardians, grandparents or faction who care for the living. Predecessors have unlimited abilities, as far as the living, and have the ability to intercede among people and in addition the Creator. It is trusted that badimo speak to the Creator of earth. Numerous African Christians love both the

predecessors and God, trusting that the precursors have achieved divine status. African dialects are loaded with convictions and standards alluding to progenitors.

Death is the change from natural to profound life. The deceased may not be physically there anymore, but rather they stay in and around the living and keep up a parental part. It is such a profound situated association, to the point that many keep on worshiping the departed paying little mind to their Christian convictions (Kale, 2005).

The predecessors speak with the society through dreams, visions, commotions, seers, priests; the incarnation of a dead individual; and even through the appearance of creatures such a snake, butterfly and lion. Predecessors serve to bind together families and different individuals from the society, to administer to each other; enable; favour; compensate and motivate and secure families against devils. Customary wellbeing specialists comparably endeavor to join families with the divine and encourage comprehensive mending. Any individual from the group that is has been reviled by the progenitors is to admit to his inconveniences, whereupon the older folks intercede to realize compromise with the predecessors (Richter, 2006).

2.7 Co-existence of African traditional medicine and biomedicine

The Journal of Pan African Studies (2009) states that amongst the Yoruba tribe comprehensive mending includes the body, mind and the otherworldly world. This comprehensive approach is, at last, the qualification between customary recuperating and Western methods of treatment. Customary recuperating in Africa utilise natural medication and also incarnation and conjuring of spirits for entire body mending. African conventional prescription is, emphatically associated with the social faith in the powerful.

Orthodox medicine is allopathic, while African Traditional prescription is homeopathic in nature. The Journal of Pan African Studies (2009) clarifies that allopathic solution depends on the guideline, counteractive action is superior to cure. Conventional restorative standards advance concentrated dosages of the drug to treat disease, which regularly has serious reactions, concentrated on the easing of side effects (Campbell, 2010).

Doctor's facilities in rural areas are overcrowded and regularly do not have the required medicine, nor are patients legitimately educated of the reason and extent of their ailment (Mander et al., 2007). Treatment is then likewise now and again sub-standard because of the absence of

legitimate innovation and the cost of acquiring appropriate care. The approach taken in Western medication has estranged indigenous individuals from their way of life and convention, separating them from their families and society, whereby numerous Africans never again rehearse profound mending as per their way of life (Mander et al., 2007).

The enthusiasm for the properties and advantages of medicinal plants is on the expansion and Western pharmaceutical organizations have come to deliberate natural prescription as a wellspring of reference for the readiness of engineered drug. Some of these organizations are, be that as it may, utilizing conventional solution without the authorization of customary healers. This is the aftereffect of the absence of acknowledgment managed conventional healers and licensed innovation rights staying forbidden in the customary human services area (Ramokgopa, 2013).

2.7.1 Herbal medicine in the treatment of HIV/AIDS

Traditional herbal utilization has been accounted for to be regular among people with moderate and propelled HIV infection. In Africa, conventional home-grown pharmaceuticals are recurrently utilised as a crucial treatment for HIV/AIDS and for HIV-related matters as well as dermatological disarranges, sickness, misery, a sleeping disorder and weaknesses (UNAIDS 2010). The utilization of conventional natural solution by AIDS patients after HIV diagnosis was noted in a study in Uganda. According to Weiser (2013), despite lack of validation on the adequacy and the prospect of genuine reactions, some African services of wellbeing at present advance customary pharmaceuticals for the treatment of HIV and associated side effects. On the interpretation of South Africa, the Ministry of Health is effectively proceeding the utilization of conventional drugs with anti-retroviral medications. Two vital African natural mixes utilised for HIV/AIDS treatment in sub-Saharan Africa incorporate Hypoxis hemerocallidea (African potato-an insusceptible stimulant) and Sutherlandia. These two natural cures are as of now prescribed by the South African Ministry of Health for HIV administration (UNAIDS 2010).

Medical professionals and researchers should be educated about the utilization of natural prescription for both HIV-related diseases and other diseases. Inability to do as such may cause medicinal services specialists to unintentionally ignore the full range of potential herb-medicate collaborations that might be experienced by an AIDS understanding (Fogarty et al..2007). For illustration, a study in Canadian discovered that over 53% of HIV outpatients who used traditional

herbs did not report its utilization to their treating doctor. Additionally, anti-retroviral treatment beneficiaries have been accounted for to utilise herbs to mitigate a portion of the negative reactions of anti-retroviral (ARV) medications, for example, queasiness and diarrhea (UNAIDS 2010).

As said by Grierson, et al., (2000) the most widely recognized reasons patients gave for utilizing herbs included general wellbeing, relaxation, pain, stress, spiritualism, and healing prosperity. Grierson et al., proclaimed that 9% of outpatients trusted that it was conceivable to treat HIV exclusively with the utilization of herbs, while others utilise it to enhance vitality level, to supplement dietary admission and to improve reaction. Be that as it may, in a US study, the most widely recognized treated conditions utilizing natural pharmaceutical incorporate uneasiness/fear, wretchedness, agony and neuropathy (Grierson, et al 2000). Fogarty et al. (2007) likewise found that 44% of an Australian HIV tolerant example announced blended utilization of marijuana for restorative and recreational purposes. Although western medicine is gaining popularity, traditional medicine has frequently kept up their popularity for social reasons, so such individuals see traditional healers as a service not contrasting option to modern medicine (Dahab, 2008). There are a few difficulties in the effort to coordinate integration between traditional medicine and western medicine particularly in developing nations fundamentally because of deficiency of shared trust and gratefulness between the two health care frameworks (Dahab, 2008).

A patient's level of learning about HIV infection, a conviction that ART is successful and drags out life and acknowledgment that poor adherence may bring about viral resistance and treatment disappointment all effect adversely upon a patient's capacity to follow. Convictions about the solutions (counting customary) themselves likewise assume a part in adherence. Patients who report low trust in the viability of the medication and see insignificant advantages coming about because of ART are more averse to be a follower (Dahab, 2008). Bekker et al. (2006) assessed that no less than 30% of patients on ART will use any type of customary corresponding and alternative medication. Be that as it may, the correct level of hazard or potentially benefits coming about because of customary home-grown solution and anti-retroviral sedate co-treatment among AIDS patients is to a great extent obscure, the worries raised about herb-ARV drug interaction, contact amongst patients and doctors about natural pharmaceutical is significant in empowering doctors to address matters of probable herb-drug connections and guaranteeing proper medicinal care (Peterson, 2004).

South Africans living with HIV/AIDS are presently urged to settle on their own educated decisions about the sorts of treatment they wish to look for, as well as anti-retroviral (ART), work out, nourishment and also customary and integral solutions (TCAM). The staggering effect of HIV/AIDS pandemic in the Southern African region combined with the serious deficiency of wellbeing workforce may have constrained the tenants to create ways of dealing with stress by embracing elective wellsprings of essential medicinal services, one of which has been the utilization of natural treatments (Davey, 2006). An investigation, mutually led by Makerere University's therapeutic school and the Joint Clinical Research Centre, investigating the reason behind non-adherence to ART. The study discovered that 1 out of 5 patients examined interfered on their treatment and 1 of every 4 changed no less than 1 segment of their medication program, risking lessened adequacy of medication treatment.

Makerere University's school of medicine and the Joint Clinical Research Centre found that cost was the most noteworthy factor in the discontinuation of ART, trailed by negative symptoms and poor supply. Use of a customary therapeutic healer made patients twice as liable to abandon the medications, which can add a long time to a patient's life. Of the individuals who discontinued, 4 out of 10 cited the high cost of the medications as their explanation behind ending the treatment. Marginally more than 20% said they had halted to maintain a strategic distance from symptoms. Others quit in light of the fact that they were drained, felt discouraged, could rest easy or were far from home. Adherence to ART regimens is critical to keeping the improvement of medication resistance, which diminishes the viability of the medicine (Davey, 2006). The World Health Organisation 2013 suggests a time of education and preparation aimed at expanding adherence before starting ART.

2.8 Anti-retroviral treatment adherence

An individual who takes ARVs improperly will get an insignificant advantage, however, will endure side symptoms and will limit their future ART choices (Nwokike, 2014). It is fundamental that all patients ought to exhibit a comprehension of the significance of adherence to ART before beginning the treatment. Patients must be given complete information about ART as a deep-rooted treatment procedure. Enabling patients and surveying their comprehension may be viewed as tedious yet it is fitting with a specific end goal to accomplish the normal outcomes. Different elements can influence persistent adherence to ART that impacts treatment results. These

variables are extensively isolated into tolerant related, sociocultural, wellbeing labourer related, and medicine sorts related issues (Holstad, Pace, De and Ura, 2006).

2.9 The goal and role of Anti-Retroviral Therapy

The overview of ART was a noteworthy achievement in the world for the battle against the Human Immunodeficiency infection and complex AIDS conditions. Be that as it may, the selection of ART changes the scene of HIV contamination from a profoundly deadly ailment to a chronic medical issue in which individuals on ART have begun to live longer/generally more healthy lives (Biressaw, Erku Abegaz, Abebe, Taye and Belay, 2013).

Anti-retroviral treatment is a brilliant standard for HIV and AIDS presently. It is not a cure but rather it prolongs lives of individuals infected and enhances their quality of life as well. The treatment comprises of medications that must be taken each day for whatever is left of a man's life. The fundamental part of anti-retroviral treatment is to keep the level of HIV in the body at a low level. It limits any debilitating of the resistant framework and enables it to recuperate from any harm that HIV may have caused already. Each class of medications incursions HIV in an unexpected way. Usually, drugs from a few classes are joined to guarantee a capable assault on HIV diseases. The essential objective of anti-retroviral treatment is to enhance the quality of life with the lessening of morbidity and expedient recuperation of the immune system (Gauri and Lieberman, 2004). The principal part of ART is depicted as the change of the patient's quality of life, diminishment of HIV-related morbidity and mortality, rebuilding and additionally safeguarding of immunologic capacity and maximal and delayed concealment of the viral replication (Ministry of Health 2010). Legitimate adherence directing is essential and ought to incorporate concentrate on continuous deep-rooted treatment is fundamental and the regular advantages of treatment.

2.9.1 Adherence to HAART

Conferring to numerous studies individuals do not care for taking medicines and have frequently doubtful mentality towards them (Enlund, 2013). It is realized that negative or suspicious mentality towards pharmaceutical is frequently identified with poor adherence (Enlund, 2013). Drug adherence implies taking HIV medicines when and how one should take them. Normal rates for

adherence in clinical trials have been observed to be high, yet rates of adherence for chronic conditions are just observed to be forty-three to seventy-eight percent (Osterberg, 2005). Strict adherence is the way to fruitful anti-retroviral treatment (ART). Ideal adherence to HAART prompts HIV concealment, diminished danger of medication resistance, enhanced general wellbeing, personal satisfaction, and survival, and in addition, diminished danger of HIV transmission (AIDS data 2015). Patients must take ninety-five percent of their pills to accomplish an 80 percent probability of HIV concealment. With under ninety-five percent adherence, the likelihood of concealment to imperceptible levels drops to under fifty percent (Lesho, 2003; Moitra, 2011; Syrjänen, 2005). Inability to take medication routinely and dependably purposes the infection to be presented to imperfect medication serum focuses (Lesho, 2003). Non-adherence to ART may prompt an expansion viral load which may prompt medication resistance and loss of future treatment choices (Syrjänen, 2005; AIDS data, 2015). Poor adherence is the real reason for therapeutic failure. Accomplishing adherence to ART is a basic determinant of long haul result in HIV contaminated patients (AIDS data, 2015). The adherence for ART is more challenging and more noteworthy than in numerous other chronic infections, for example, diabetes or hypertension, their medication regimens stay viable even after treatment is continued after a time of intrusion (Syrjänen, 2005; AIDS data 2015,). It is different when it comes to the case of HIV.

2.9.2 Drug resistance

Health care practitioners should assume a more prominent part in surveying and planning patients to guarantee long haul adherence to treatment. This part incorporates data about utilizing drugs soundly to make future treatment alternatives conceivable, guaranteeing consistent and satisfactory observing of patients, overseeing inconveniences of treatment, and having the capacity to change or suspend treatment (DOH, 2010).

2.9.3 Measurement of ART adherence

Various techniques are utilised to quantify adherence. For the most part, this estimation is comprehensively named either target information acquired freely from the patient or subjective information that depends on the conclusion of the patient (Wilson, Cotton, and Bekker, 2008). Different distinctive systems are used to measure adherence.

2.10. Objective ART adherence assessments

2.10.1 Pill counts

This strategy is utilised by tallying returned pharmaceutical to appraise the number of measurements taken by the patient and regularly used to compute adherence. To figure adherence, human services experts need access to four factors; i.e. the number of tablets returned, number of tablets apportioned, number of days between the visits (e.g. 28 days), and the number of dosages of the drug every day. In spite of the fact that pill numbers at home may diminish the danger of pill dumping, it requires a devoted team of counselors to visit the patients at home and may not be a reasonable plan when checking adherence on an expansive scale (Wilson et al., 2008).

2.10.2 Pharmacy refill data

This is the sort of adherence appraisal in which the quantity of times a patient gets drug over an established period is expressed as a level of the number of times they ought to have collected pharmaceutical. This is the least demanding technique for impartially recording adherence and is suited to observing adherence in expansive anti-retroviral programs. (Wilson et al., 2008).

2.10.3 Electronic monitoring

This system requires electronic gadgets that record each time a container is opened and the data recorded in the gadgets are dissected electronically when the container is returned. The strategy is costly since it utilises sophisticated computer programming. In any case, it is extraordinary compared to other methods for dispassionately evaluating adherence in developed nations. (Wilson *et al*., 2008).

2.10.4 Therapeutic drug monitoring

It is utilised by deciding plasma grouping of anti-retroviral sedates and might be helpful on account of preferred patients. The utilization of this instrument to gauge adherence on a huge scale is not practical in light of the fact that it quantifies the present plasma level of medications that may not be a genuine impression of the patient's adherence status. Here and there it might even overestimate adherence, especially when a patient takes the recommended prescription nearer to the date of a facility visit. (Wilson *et al*., 2008).

2.10.5 Subjective adherence methods

These strategies are not faultless but relatively comes about by embracing a non-judgmental state of mind and picking up the patient's trust. These strategies include the following:

2.10.6 Recall questionnaires

The most well-known and broadly utilised devices to gather adherence information ordinarily request that the patient review measurements missed in the course of recent days. At the point when asked by the medicinal services group, many individuals neglect to confess to missing a dosage. This technique could be valuable as a research tool since more open and precise responses may be expected when results are not reported to the clinical group. (Wilson *et al*., 2008). The technique usually uses the 30-day visual simple scale which requires a graphic recording that measures how the patient has taken medication for as far back as one month. (Wilson *et al*., 2008).

2.11 Factors associated with ART Adherence

Different variables such as age, education, employment status, salary, family type, distance from a hospital, accessibility of transportation, cost of prescription, uneasiness about disclosure of HIV status, utilization of liquor and medications, spiritual beliefs, presence or absence of AIDS symptoms can influence adherence levels (Nakiyemba et al., 2005). Also, levels of health education and healthcare satisfaction, as well as the presence of co-morbid conditions and levels

of health awareness can influence adherence (Hostad et al., 2006). In spite of the fact that community ART distribution may diminish stigma, it may hinder some individuals from seeking ART because of the fear of losing concealment and thereby, along these lines, lessen consistence (Fredlund and Nash, 2007). The multifaceted nature of numerous medications (an excessive number of pills) and dosing may likewise prompt diminishing ART adherence (Wang et al., 2008) that may additionally be aggravated by undesirable and reactions (Nakiyemba et al., 2005).

Social and psychological help is additionally a vital persuading factor for treatment adherence (Holstad et al., 2006). Elements that impact adherence to ART may shift from place to place. Many studies in the USA and European nations classify components to adherence to ART into (i) individual elements, for example, substance use, age, state of mind towards treatment, and mental qualities; (ii) medicine attributes, for example, dosing complexity, and number of pills or nourishment prerequisites; (iii) relational qualities, for example, the specialist tolerant relationship and other social help; and (iv) the general frameworks where mind is regulated (Holstad et al., 2006). A study in Zambia about adherence to anti-retroviral treatment indicated that there are three primary factors that influence adherence. (i) Factors that are identified with patients' beliefs and conduct which incorporate forgetfulness, encountering better wellbeing, occupied work routines, living alone, excessive liquor utilization, opinions about ART, and side effects. (ii) Factors that are identified with financial and social impacts, for example, stigma and discrimination, disclosure of one's status as HIV-positive, concerns about confidentiality, utilization of alternative medications, and lack of food. (iii) Health service-related components assume a portion, for example, lack of communication about ART between human services experts and patients, time imperatives during the consultation, lack of counseling skills and follow-ups, lack of infrastructure to conduct counseling, and long distances to wellbeing centres.

Clinical outcomes identified with enhanced quality of life with ART incorporate lower CD4 cell count at ART start expanded CD4 cell count after some time, and lower initial viral load and the presence of side effects at ART start. One investigation discovered that adherence of at least 80% is essentially connected with change of quality of life after some time Mannheimer et al., (2005) while another demonstrates no relationship amongst adherence and quality of life (Liu, Miller, Hays, Golin, Wu, Wenger and Kaplan, 2006). Various socio-demographic factors are related to poorer quality of life among PLHA taking ART, including old age (Mannheimer et al., 2005).

A study by Liu et al., (2006) postulated that the adverse impacts of medications add to 50% of non-adherence to ART. Variables that are reliably identified with non-adherence incorporate side effects and depression; poor social support; patient supplier relations; and attitudes, for example, distrust and skepticism about treatment and medicine.

Literacy level and age are recognized as vital indicators of consistency in ART. Amnesia is the most widely recognized reason given by patients followed by running out of drugs. Different indicators of poor adherence distinguished are the multifaceted nature of dosing regimens and pill weakness. Another group inclined to adherence issues is the ones with low education levels (Holstad et al., 2006). A few studies discovered that individuals living with HIV/AIDS who have low health education indicate poor treatment adherence and more adverse health outcomes.

A study by Mills et al., 2006 analysis of systematic review finds that while a higher educational level is related with better adherence, such patients still experience issues with work-time dosing, and in addition with misery and negative reflections about treatment (Fredlund and Nash, 2007). A few discoveries show that patients' information of an enhanced CD4 count and viral load brings about positively affects adherence.

2.11.1 Individual-level barriers to adherence

The vast majority of the literature on ART adherence so far has concentrated on individual-level determinants, like perceived social help (Holstad et al. 2006); psychiatric unsettling influence, most notably depression (Kilbourne et al. 2005); substance abuse (Tucker et al. 2004); and worries about stigma (Klitzman et al. 2004). In a meta-investigation of patient-revealed obstructions and facilitators to adherence, it was discovered that dread of divulgence, substance abuse, neglect, doubts of treatment, treatment multifaceted nature, the number of pills required, diminished quality of life, work and family obligations, were among the significant hindrances to ART adherence (Mills et al. 2006).

2.11.2 Patient beliefs related barriers

Lack of knowledge on the ART, religious beliefs, influence by traditional healers and the use of herbal medication were cited as contributing to non-adherence (Beer, 2014 and Brown, 2013). According to Musumari, (2013;) Oku, (2013;) Peltzer, (2010) the use of traditional herbal medicine as a barrier was mentioned in three articles which were all conducted in African countries. Religious beliefs were discovered to be both a facilitator and a barrier to ART adherence. Musumari (2013) postulated that beliefs that one's disease result from witchcraft would make some participants defaulting their treatment in an effort to utilise prayers and traditional medicines in search for a potential cure. However, Badahdah (2011) found religious beliefs to be a facilitator to adherence to medication in contrast to Finocchario-Kessler (2011) discoveries that religious beliefs predicted lower adherence.

2.12 Factors that influence ART adherence

Furthermore, to the boundaries to anti-retroviral treatment, a few elements which affect adherence were specified by Vissman (2013) in which great social encouraging group of people was said as impacting anti-retroviral treatment adherence. The advantages of a solid social encouraging group of people were likewise specified by Curioso, (2010) who demonstrated that family and companions remind the members to cohere to their ART. Enormous research was done about the explanations for poor adherence to anti-retroviral treatment. Anti-retroviral treatments accessible in the 1990s included a high pill burden and complex timetable schedules. The viability of the treatment was constrained as successive unfriendly occasions and the noteworthy impedance of treatment in patients' lives made adherence troublesome (Fumaz, 2008).

At the beginning of HAART Proctor et al. (1999) discovered the main five hindrances to HAART to be recurrence and seriousness of symptoms, clashes with every day normal, dietary necessities, recurrence of taking a prescription, number and dose of solution. In the present decade signs of progress have been made in HAART, for example, once-daily regimens have been produced to reduce the negative effect of treatment on quality of life and the presence of less intricate and poisonous anti-retroviral drugs has enhanced the administration of HIV contamination extensively (Fumaz, 2008), yet even with the advances influenced adherence still remains an issue. Adherence is a multi-dimensional idea that incorporates logical, intrapersonal

and behavioural elements (Fumaz, 2008). Late research has discovered a few obstructions influencing adherence to ART. These incorporate structural boundaries, for example, food insecurity or geographic seclusion and absence of resources to pay for transportation to health centres (Ketz, 2013).

A study which was done in Botswana by Weiser (2003) discovered that general financial circumstances were one of the fundamental hindrances, notwithstanding the cost of the ART, other financial imperatives incorporated extra drug costs, absence of nourishment, absence of cash for sustenance and lack of income for clothes for patients and for their children. As investigations of hazard factors in resource-poor settings have concentrated on access to anti-retroviral and nourishment and have demonstrated these to be a portion of the primary boundary for adherence to anti-retroviral treatment. In an investigation by Harris et al (2011), it was discovered that non-adherent participants felt less upheld by family and saw having less help for adherence itself. Adherence has been discovered (Fumaz, 2008) to be identified with convictions about wellbeing and ailment than to the attributes of pharmaceutical or level of learning about treatment. Fumaz (2008) found that adherent patients displayed a higher view of the danger of building up the disease and of the advantages of treatment, higher self-viability and expectation to follow and were more impacted by the occasions that rouse pharmaceutical intake. Moreover, incorrect beliefs about the drug and dosing, sporadic day by day plan, stigma, absence of social help, poor provider-patient relationship, health care framework boundaries, for example, cost and prescription symptoms (Murphy, 2000; Murphy, 2004; Sherr, 2008; Welsh, 2001).

There are numerous adherence procedures that have been investigated, direct observation of all or a few doses of anti-retroviral treatment is one of them. In an investigation by Munoz (2011) executed community-based accompaniment with managed anti-retroviral treatment in a resource-poor setting and found that it had an effect on adherence as well as on mortality within the initial two years, moreover, participants proclaimed more prominent social help and decreased stigma contrasted and controls.

2.12.1 Non- adherence effects

Non-adherence to ART can prompt poor clinical, immunological, and virology results. At an individual level, the result of non-adherence incorporates fragmented viral concealment, proceeded with pulverization of the immune system, lessening of CD4 cell count, the progression of an illness, development of resistant viral strains, constrained future therapeutic option, and higher expenses for individual treatment. These results all mean higher ART program cost (Phelps et al., 2010). Appropriate education of patients before the start of and amid ART is vital for the achievement of adherence with a specific end goal to counteract undesirable impacts (Orell et al., 2003).

2.12.2 Structural barriers to adherence

Whereas adherence to care has customarily been hypothesized as an individual endeavor, adherence behaviour is from time to time simply volitional and is frequently administered by bigger structural matters that might be impervious to change. Structural components are especially remarkable in low-income nations, for example, South Africa, where financial, social and political realities are regularly more constraining on individual conduct than in developed countries. It is recognized that at a smaller scale level, individual mental and behavioural issues assume a critical part in adherence. Nonetheless, much concern is on the social, financial, institutional, political and social spaces that all in all make up the social structures that, to a more noteworthy or lesser degree, impact the conduct of patients (Shriver et al. 2000).

In terms of a conceptual paradigm, Bronfenbrenner's Ecological Systems Theory (1972) and Ewart's Social Action Theory (1991) are valuable ways to deal with conceptualize the route in which structural variables impact individual conduct. Ecological Systems Theory (Bronfenbrenner 1972) proposes three levels of environmental impact that shape behaviour, in particular, the immediate environment, for example, the family in which a person operates, social institutions, for example, the medicinal services framework, transportation framework, and local economy, and the larger cultural and political setting in which individuals live. This hypothesis fits well with Social Action Theory (SAT), which underlines contextual impacts on conduct by describing settings and frameworks as far as the objectives they initiate and the individual abilities, social interactions, motivational evaluations, and activity techniques they bolster (Ewart, 1991). The

theory partitions the most remarkable structural boundaries into (i) poverty-related elements, (ii) institutional related elements, and (iii) communally and politically-related elements. It incorporates the issue of sex imbalance as an extra structural factor on the grounds that each of alternate hindrances could differentially impact men and women.

2.12.3 Poverty-related structural barriers

Impoverishment perhaps influence adherence to care, as economic assets may be coordinated somewhere else, travel funds for going to a medicinal facility that gives ART may not be accessible, and childcare may not be promptly open for guardians who attend clinical appointments. The joined anxieties related with poverty, for example, inadequate housing, community violence, joblessness, and constrained relocation, may deter an affirmation of the significance of general facility visits, and what might be seen as unbending treatment regimens (Ewart, 1991).

2.12.4 Access to transport problems

Low and middle-income nations are associated with poor infrastructures and insufficient transport. Many people who utilise public hospitals do not have private transport and they depend mainly on public transport, that is in many cases time consuming and risky, and in a few rural areas inaccessible (Kagee et al. 2007). In many circumstances, hospitals are located far away from residential places, patients regularly need to walk, which may require extensive energy, especially on the chance that they feel sick, this may be problematic and also led to treatment defaulting (Dima, 2013).

2.12.5 Food insecurity

In a qualitative investigation amongst ART clients in Uganda, Tanzania and Botswana, participants announced that they were not able to manage the cost of nourishment expected to fulfill their expanded hunger following initiation of treatment, particularly in the beginning times of

treatment when their bodies required additional sustenance to recover lost weight and strength (Hardon et al. 2007). Nourishment uncertainty may influence the consistency of ART doses, as a few patients revealed taking their medication just when they have sustenance accessible (Hardon et al. 2007).

2.12.6 The threat of losing employment and lost wages

With regards to high joblessness in some low-income nations, numerous patients lacking general work make themselves accessible as day workers to employers willing to pay them a wage. Regularly, the requirement for a day's wages overshadows the potential advantage of a facility visit (Kagee et al. 2007). The hindrance to looking for clinic contact is aggravated if patients are asymptomatic and need to wait for a long period of time to collaborate with a health professional so as to get a supply of the drug. Likewise, regular absence from work make circumstances under which companies may terminate employment in the event that they don't have a clue about the purpose behind such nonattendances. The risk of losing work thus, accordingly, frequently obstructs clinic attendance.

2.12.7 Disability grants as a disincentive to adherence

In South Africa, AIDS infection is combined with qualification for disability grants, and patients are qualified for a state-financed month to month income in view of their sickness-related inadequacy to work. In any case, across the board joblessness has implied that disability awards are an essential and now and again the main source of income, regardless of the possibility that patients are well enough to work. At the point when disability awards are attached to AIDS-related pointers, for example, CD4 count or viral load, non-adherence may turn into an alluring alternative for patients who fear to lose their grant if their CD4 count were to increase (Nattrass, 2006).

2.12.8 Absence of social support

Positive social and family bolster have been indicated to be related to great prescription adherence (Holstad et al. 2006). In any case, troublesome living conditions in low-income nations, added to by habitation in informal settlements, the absence of basic essential, high rates of relocation, overcrowded living circumstances, family viciousness, and substance abuse, regularly make conditions under which the nature of social help to patients is poor. Additionally, the yearning for discretion because of HIV stigma can be an obstruction to getting to societal help from inside a patient's interpersonal network (Holstad et al. 2006).

2.13. Institution-related factors

2.13.1 Logistical barriers to accessing treatment

Breen et al. (2007) showed that among patients accepting treatment, strategic issues included lining up in darkness outside the health centres as ahead of schedule as 4 a.m., waiting numerous prior hours before they could get their medicine, and being in fear of being assaulted by criminals while holding up in lines. Particular patients, trying to lessen the recurrence of health centre visits, would diminish their measurements with the goal that their provisions would last more. In this way, public wellbeing facilities are constituted in a way that may regulate the nature and level of access patients have (Breen et al. 2007).

2.13.2 Insufficient medical care services

Numerous health centres in Southern African nations have long patient waiting times, lacking infrastructure and facilities, and insufficient staff (Medicines Sans Frontiers 2007). The fact that the extent of routine with regards to medical attendants utilised in public wellbeing facilities in a few cases has now been extended to incorporate HIV counseling may prompt wear out, work disappointment and even migration among centre staff. Serious staff deficiencies in public wellbeing facilities have necessitated just quick trades amongst patients and their suppliers. At the point when the workforce is accessible, they may get themselves ineffectively arranged for

the requests of progressing associations with patients who might be chronically sick (Swartz and Dick, 2002).

2.13.3 Insufficient training of lay counseling

With an end goal to ease the weight put on professional medicinal services laborers, lay advocates have been utilised to help with pre-and post-test HIV counseling. However, with regards to contending requests on resources, deficient accentuation is frequently set on sufficient training and continuous supervision, and support for such workforce and counseling is diminished to the dissemination of data, instead of handling of patients' feelings and perceptions, to reduce trouble and change long-standing behaviour patterns, including non-adherence (Rohleder and Swartz, 2005).

2.14 Political and cultural barriers

2.14.1 Political controversies surrounding AIDS care

In South Africa, AIDS denialism has been enunciated by the previous president; nourishment as a better option than ART has been supported by a previous health minister, and nutritious supplements have been hawked by business visionaries guaranteeing their adequacy in treating AIDS. Such battles have sown disarray among people in general and numerous people living with AIDS (Nattrass, 2006), which is detrimental to care-seeking behaviour.

2.14.2 Voluntary and forced migration

Inward migration for financial reasons is common in some low-income nations, as individuals regularly look for work in regions a long way from their places of origin. Guaranteeing progression of care to individuals who relocate looking for work openings is regularly troublesome, and such people are viewed as 'lost to follow-up' or "defaulters" by wellbeing specialists. Political precariousness and civil contention nations, for example, the Democratic Republic of Congo, Uganda, and Sierra Leone, have likewise given ascend to substantial quantities of displaced

people. Displaced people infected with HIV might not approach health care facilities in the event that they are an occupant in a host nation unlawfully, as it is troublesome for undocumented people to become integrated into local medicinal services systems and many dread deportations if they somehow managed to introduce themselves for care. Moreover, refugees regularly encounter linguistic limitations when looking for care that represses compelling patient-provider communication and results in a poor understanding of medical instruction. Without satisfactory interpretation administrations, which is valid for various public wellbeing centres in the sub-Saharan region Swartz (2008), miscommunication is likely, prompting further hostility for some patients.

2.15 Traditional beliefs as a barrier to AIDS care

Deficient public health care services, and commonality with and faith in the cultural system inside which traditional healers work, make these service providers an alluring choice for some patients (Walker et al. 2004). Despite the fact that in many cases the interventions rendered by traditional healers may supplement those of biomedicine, now and again these may block full adherence to ART, either by fiat or by unwittingly making vulnerability among patients about their feasibility.

2.15.1 Cultural barriers

2.15.1.1 The concurrent use of concoctions from traditional healers while on Anti-Retroviral Treatment

Concurrent use of medicine from traditional healers while on ART was a culturally related factor that was found to have been unconstructively influencing adherence to treatment. It was accounted for that a few respondents were all the while utilizing blends arranged by traditional healers for cleansing their bodies internally and additionally taking ART medications (Kalichman and Simbayi, 2004).

2.15.1.2 Low levels of health literacy

In various resource-constrained nations, health education is low (Kalichman and Simbayi, 2004). There should be sufficient information concerning HIV and the requirement for ART treatment. Numerous patients view medicine just as a tertiary measure subsequent the beginning of side effects, as opposed to as a prophylactic medication. Wellbeing proficiency is connected to education level, and in many low and middle-income nations is mediocre amid non-world class sections of the populace (Kalichman and Simbayi, 2004).

2.15.1.3 Stigma

Individuals living with HIV are regularly subject to stigma and discrimination. On the off chance that patients are seen by individuals from their social group, for example, neighbors, relatives or companions, to be taking ART or going to an HIV centre, it might flag that they are HIV-positive. Frequently HIV-positive people go to facilities a long way from their neighborhood groups to abstain from being seen and distinguished as HIV-positive by others, subsequently exacerbating the issues of transportation and absent time from work (Bekker et al. 2006).

2.15.1.4 Gender inequalities

Inescapable sexual orientation disparities make it possible that the impacts of the other basic obstructions on adherence are distinctive for females and males. Females encounter higher levels of poverty and experience more noteworthy hindrances to getting to care than men due to different work and child-rearing difficulties, restrained movability, and financial reliance upon men (Walker et al. 2004. Commencement anxieties that the quantity of HIV-positive women getting ART may be low relative, to their extent in the populace, have been alleviated by studies demonstrating that HIV-positive women are less likely (and might be all the more so) to be on ART (Braitstein et al. 2008, Nattrass 2006).

For instance, in South Africa, men who enroll for ART on average are sicker as compared to their female counterparts, proposing delays by men in getting tested or care-seeking after being tested (Bekker et al. 2006). An investigation of HIV positive men in the Cape Town area found that extra

obstructions incorporated the idea that centres are 'places for ladies' and HIV/AIDS is 'a ladies' issue'. Developments of masculinity encouraged dissent of ailment since this indication of "fragilities" clashed with desires that a man is the family provider (Beck, 2004). One US study discovered that females more frequently than men revealed experiencing difficulties taking drugs openly at home (Sayles et al. 2006), which might be identified with the probability that ladies are at more serious danger of suffering adverse consequences if their status ends up plainly known, including the likelihood of physical abuse, end of a relationship, and loss of economic help. Contrarily, men's adherence challenges might be identified with opinions about masculinity.

2.16 Economic barriers to adherence

A Report of the Commission on HIV/AIDS and Governance in Africa (2004) recommends that the absence of money for transport and managing enough quality sustenance as a fiscal boundary to ART adherence. PLWHA who start ARVs encounters a lifted hunger, which leads into nervousness about the absence of nourishment, a factor in resulting non-adherence. The time and costs involved in getting to access medicine also contribute to defaulting. The World Bank (2001) reported that economic obstacles play an essential part in defaulting ART as it is connected with stresses of expenses of diagnosis, medicine, food, and transport.

2.17 Social barriers to adherence

UNAIDS (2005) stipulates that stigma targeted at PLWHA and the results of testing positive negatively impacts on adherence to ART. It is a risk to the societal texture of connections since women often cover their status inspired by a paranoid fear of rejection and separation. Socially if females unveil their HIV status the outcome is divorce which causes loss of their children and their financial dependability since they will be compelled to leave the family home. Feminization of HIV and AIDS brings about women feeling progressively the expansive influences of stigma and separation in the group subsequently influenced more by non-adherence to ART as proclaimed by Black et al (2002). Due to a paranoid fear of rejection or exposure which will bring about social alienation and exclusion by the society women will default treatment. Catz (2000) attests that uneasiness with disclosure of HIV status is also a barrier to adherence. Some care suppliers noticed that PLWHA select ART settings where nobody would know them. Konkle-

Parker et al (2008) proclaim that sexual orientation contributes as a hindrance to nonadherence since socio-cultural and financial limitations put upon women makes it entangled for them to grapple treatment than men.

2.17.1 Patients-provider challenges

UNAIDS (2003) suggests poor communication and conflicts with medicinal services suppliers may likewise overwhelm persistent adherence. Patients more often than not protest about the absence of concealment and poor treatment by hospitals facility staff. Care suppliers have challenges in making great compatibility hence conversing data about HIV to patients turns into an obstruction to treatment adherence. The vernacular hindrance includes more challenges in guaranteeing that patients genuinely appreciate the significance of treatment adherence or how to take their medicine appropriately (Catz, 2000).

2.17.2 Alcohol intake

Sherer (2008) postulate that liquor intake was said by PLWHA as adding to treatment nonadherence. Ongoing purchasers of liquor admit inability to take their measurements of pharmaceutical routinely. Liquor utilization may affect the survival of PLWHA because of liquor inflamed resistant concealment that heightens the HIV associated immune concealment, expanded hepatotoxicity, and expanded mortality from non-HIV related causes. Specifically, liquor utilization may decrease adherence to treatment, prompting reduced treatment viability and, at last, expanded HIV related mortality. Along these lines, liquor connected non-adherence may represent a considerable measure of preventable mortality among PLWHA. Epidemiological and sociological outcomes indicate that liquor utilization has an upright and generous relationship with levels of treatment non-adherence, bringing about pre-develop morbidity and mortality in PLWHA. The edge at which liquor utilization impacts medicine adherence might be brought down in HIV-contaminated individuals than in non-contaminated individuals, particularly for those patients who have fluctuating levels of utilization or who are at expanded hazard for hypertonicity define or potentially cognitive impairment (Walker et al. 2004).

2.17.3 Religion and rituals

Peterson (2004) postulates that some PLWHA needs to keep their neighborhood customary and religious ceremonies, which can control treatment adherence. It has been noted by health care providers that some PLWHA do not take their morning doses in light of the fact that their way of life required fasting from dawn to dusk. Religious limitations would appear to remain the most noteworthy obstruction to adherence. Generally, there has been an expansion in patients ceasing taking treatment after prophetic deliverances that claim to "liberate" them from HIV. They assert that they have been 'healed or delivered from HIV' which is viewed as an evil spirit. Therefore, this is an obstruction to adherence since a few patients frequently like to look for care where their worries are given regard and powerful correspondence is simpler in local vernacular (Peterson, 2004).

2.17.4 Lack of family support

As indicated by Tadios and Davey (2006) absence of family support is a barrier to adherence since additionally, family quarrels hinder a few patients from taking drugs. It has been observed that patients without family support have low adherence levels. Green (2006) emphasizes the mix of many-sided quality in access to healing facility and an uncooperative family can skeptically encroach on adherence while family bolster expands adherence. Non-revelation of HIV positive status impedes collaboration by relatives in reminding PLWHA about the correct time and amount to take their ART. This illustrates the essence of ART accomplices or associates in ART adherence to individuals living with HIV.

2.17.5 Lack of education about ART

Drainoni et al (2007) state that insufficient learning about sickness and viability of drugs or health living; including a patient's absence of faith in his or her capacity to take pharmaceutical frequently goes about as an obstruction to adherence. Non-adherence is nearly connected with the absence of or nonattendance of adherence counseling which prepares PLWHA about the advantages and

demerits of consistency to treatment. Absence of information about the presumed reactions and perceived issues related to treatment add to defaulting (Drainoni et al 2007).

2.17.6 Distance

Long distances journeyed by PLWHA to and from treatment locations stay one of the adherence challenges (Cobb, 2009). ART administrations are situated in a set number of healing centres which is a noteworthy issue for HIV treatment since the administrations are still not reaching the needy. Poor people, who experience issues traveling long distances for treatment, may have an advantage from the decentralization of treatment facilities. In any case, the fear of disclosure may make patients keep on traveling to additional faraway destinations (WHO 2003).

2.17.7 Insufficient drugs

Pills in Shell Pack Bottles Discrepancies in labeling and the number of tablets in a pack or container is an obstruction to adherence (Dahab, 2008). Now and again, there were fewer pills in a pack than expressed on the mark bringing about inadequate medications to maintain the resupply review date henceforth making patients miss maybe a couple of dosages. This will be seen as non-adherence and causes skipping dosages which will bring about the replication of the infection.

2.17.8 Side effects

WHO (2003) refers to undesirable symptoms of treatment as macrocosm to non-adherence in PLWHA since a large portion of the ARVs regimens can have unfavorable health consequences. Regular symptoms, for example, retching, diarrhea, body torments, skin rashes, and lipodystrophy define to make a few patients quit taking their prescription. Absence of detailed information about the apparent undesirable impacts of the lifesaving drugs builds the odds of not taking or wrongly taking treatment in PLWHA (WHO, 2003).

2.17.9 Age

Age may impact adherence. Studies have discovered that apart from the most elderly adherence increments with age (Wenger, Gifford, Liu, Chesney and Golin, 2009). In two examinations related to HAART adherence, non-adherence demonstrated a positive connection with a more youthful age (Klosinski and Brooks, 2008; Jones, Nakashima and Kaplan, 2009).

2.17.10 Educational level

Lower levels of general education and low literacy levels effects undesirably on some patient's capacity to follow treatment (Moralez, Figueiredo, Sinkoc, Gallani and Tomazin, 1999; Sipler, Cross, Lane, Davis and Williams, 1999) while a more elevated amount of instruction has a positive effect (Catz, Heckman, and Kochman, 2009; Schilder, et al., 2008).

2.17.11 Financial constraints

As revealed by literature patients on higher salaries have less trouble with adherence (Pratt, Robinson, Loveday, Pellowe and Franks, 2008; Martinez, Marques, Valdes, and Santana, 2008). In any case, destitution is an expanding highlight of the substance of HIV particularly in the third world countries where many individuals are living beneath the poverty line (Grierson, et al 2000). In a study conducted by Katabira, which surveyed 924 Australian HIV positive individuals, the greater part of the respondents detailed encountering some trouble in meeting the cost of day by day living (Grierson, et al., 2000). Medication and facility visits cost cash and may push an officially extended spending plan. In most of the developing nations, there are no therapeutic insurance or disability benefits for individuals living with HIV infection (Katabira, 2002).

2.17.12 Social support

Staying alone and absence of help have been related to an expansion in non-adherence (Williams and Friedland, 2007) and social disengagement is prescient of non-adherence (Besch, 2005). Not staying alone, having an accomplice, social or family bolster, peer association, and better

physical cooperation and connections are qualities of adherent patients (Eraker, et al., 2004; Pratt, et al., 2008; Motashari, Riley, Selwyn and Altice, 1998; Brown, Inouye, Powell-Cope, Holzemer and Nokes, 2008).

2.18 Side effects of HAART on adherence

2.18.1 The drug regimen

Virtually all PLWHA who are presently utilizing hostile to HIV drugs is on a regimen of at least 3 drugs (HAART) (Grierson, et al., 2000). The probability of a patient's adherence to a given regimen decays with polypharmacy, the recurrence of dosing, the recurrence and seriousness of symptoms, and the many side effects of the regimen (Williams and Friedland, 2007). Drug hypersensitivity is significantly more typical in patients with HIV (Carr and Garsia, 2007) and regimen related poisonous quality is a typical indicator of, and purpose behind, non-adherence crosswise over many investigations (Murri, et al., 2009; Ickovics and Meisler, 2007). Symptoms related with every individual anti-retroviral medicate are very much shown, and while not all-inclusive for each patient can be anticipated after the initial few weeks of treatment yet for a few, they hold on. Expectation and dread of reactions likewise impact adherence (Broers, et al., 2004). Poor adherence has been related with patients' desire to abstain from humiliating symptoms in specific circumstances, for instance, while on a date or going to a prospective employee meet-up (Burgos, et al., 2008).

A typical HAART blend regularly comprises of three specialists or medications (Stavudine, Lamivudine, and Nevirapine or Efavirenz) and in addition to other prescription for prophylaxis of opportunistic contaminations. This can come about into a high pill stack, thrice-every day dosing, dietary and dosing idiosyncrasies, large capsules or tablets, and particular stockpiling guidelines. This regimen multifaceted nature essentially impacts upon a patient's capacity to follow (Ickovics and Meisler, 2007; Cockburn, Gibberd, Reid and Sanson-Fisher, 2007; Haynes, Taylor and Sackett, 2009; Mehta, Moore and Graham, 2007; Eldred, Chaisson and Moore, 2007). Extra medication is taken for symptomatic alleviation like analgesics, cough cures and others normal in patients with advanced HIV sickness, additionally, add to the pill burden and toxicity. In Uganda, the regimen requires Lamivudine, Stavudine, and Nevirapine or Efavirenz as the first line. Second-line Stavudine, Didanosine, and Kaletra or Zidovudine, Didanosine and Kaletra.

2.18.2 Dietary restrictions attached to a drug

Nutritional situations contribute to the complication and frequently necessitate alterations in lifestyle. Patients can find their meal plan altered by anti-HIV drugs that involve dosing on a fasted stomach. This can be predominantly problematic if work-mates, family or friends are uninformed of the patient's HIV status (Grierson, et al., 2000). Complicated regimens with inflexible dosing intervals may also disturb sleep. The physical aspects of precise medication (taste, size, formulation, etc.) may also have a bearing on a patient's ability to be adherent (Crespo-Fierro, 1997).

2.19 Characteristics of treatment that affect ART adherence

2.19.1 Disease stage and physical state

Aforementioned opportunistic infection (Singh, et al., 2006), indication seriousness (Bond and Hussar, 2001) and low CD4 counts (Erlon and Mellors, 2009) can anticipate adherence. Seeing a change in the immune and virology indices used to screen HAART (T-cells and HIV viral load) might be an intense motivation to maintain adherence (Kaplin, Golin, Beck, Lui and Hays, 2009; Pratt, et al., 2008). Alert ought to be worked out, in any case, in focusing on a patient's enhanced research centre records without confirmation that adherence is practically impeccable. These qualities, temporarily, may enhance notwithstanding sporadic adherence and this may fortify a patient's level of poor adherence. Absence of indications (in spite of research facility confirmation of the requirement for HAART) may influence adherence (Jones, et al., 2009; Murri, Ammassari, DeLuca, Cingolani and Antinori, 2009; Ickovics and Meisler, 2007). Most patients with untreated HIV infection have a median AIDS-free time of eleven years, and HAART is regularly started when patients have laboratory confirmation of sickness advancement yet are basically asymptomatic and feeling healthy. In Uganda, the policy is to start in patients with reported HIV infection and stage IV illness irrespective of CD4 cell count.

Advanced stage III ailment including persistent or recurrent oral thrush and obtrusive bacterial diseases irrespective of CD4 cell count or total lymphocyte count. Depression and severe uneasiness are factors that foresee non-adherence (Klosinski and Brooks, 2008; Ickovics and

Meisler, 2007; Besch, 2005; Hirschhorn, Quinones, Goldin and Metras, 2008). Many people with HIV, eventually over the span of their sickness, encounter a psychiatric issue (Buhrich and Judd, 2007) and misery and additionally tension are accounted for in up to seventy percent of patients with symptomatic HIV-infection (Hayman and Buhrich, 2004). Adherent patients exhibit fundamentally less depression or other psychiatric frustration (Singh, et al., 2006; Pratt, et al., 2008; Catz, et al., 2009).

HIV association of the central nervous system can influence memory. AIDS related dementia (AIDS Dementia Complex – ADC) is a typical finding in patients with advanced HIV illness and is portrayed by irregularities in psychological and additionally motor function (Wright, Brew, Nurrie and McArthur, 2007). Despite the fact that studies portraying adherence and ADC were not discovered, cognitive deficiencies do affect negatively on adherence to a HAART regimen (Meisler, et al., 2003). Notwithstanding when cognition is healthy, it is hard to make sure to take drugs.

2.19.2 Knowledge and beliefs

A patient's convictions concerning their sickness and the adequacy of pharmaceutical are prescient of adherence (Wenger et al, 2009) A patient's level of knowledge about HIV infection, a conviction that HAART is worthwhile (Klosinski and Brooks, 2008) and prolongs life (Stone, et al., 2008), and an acknowledgment that poor adherence may bring about viral resistance and treatment setback (Wenger, et al, 2009) all effect positively upon a patient's capacity to adhere. Then again, an absence of enthusiasm for becoming well-informed about HIV (Kammann, Williams, Chesney and Currier, 2009) and a conviction that HAART may in reality cause hurt unfavorably influencing adherence (Johnston, Ahmad, Smith, and Rose, 2008; Brigido, et al., 2008; Horne, Pearson, Leake, Fisher, Weinman, (2009).

2.19.3 Features of the clinic and service provision

The impact that the facility setting has on adherence ought not to be underestimated. Hospitals features that effect on adherence include: proximity to the patient's home or work environment, the cost of transportation, extensive deferrals between appointments, facility opening and shutting times, long waiting times, absence of administrations, for example, childcare, confidentiality,

privacy, and unsympathetic or impolite staff (Kammann, et al., 2009; Crespo-Fierro, 2007; Nemecheck and Tritle, 2008).

2.19.4 Difficulties with HAART re-supply

Acquiring a prescription before a hospital visit is accounted for as an obstruction to adherence (Weidle, et al., 2008; Burgos, et al., 2008). Half of the PLWHA get prescriptions for HAART medication that lasts for three months in developed nations, however, 40% get medicine for 1 month supply and 12% for 2 months (Grierson, et al., 2000). Likewise, some pharmacies will just issue 1 month's prescription. Not all pharmacies can issue HIV drugs, accordingly, some PLWHA goes to their nearby pharmacies for most doctor prescribed medication and a particular pharmacy for their ART drugs. In developing nations, the case is extremely difficult since people also have to queue for many hours in many of the health care centres while some do not open after hours and may likewise hinder adherence (Grierson, et al., 2000).

2.20 Challenges in the HIV Care

2.20.1 The impact of traditional practitioners

Customary medicine has a reasonable part to play in the public arena, and even the World Health Organization bolsters the act of conventional pharmaceutical to supplement contemporary prescription. The respectability and nobility of people come from a sense of pride and confidence (Crossman and Devisch, 2002). The act of customary prescription professionals can help advance such conditions from multiple points of view. It fills in as an essential concentration for global specialized participation and offers the potential for major break thorough forward in therapeutics and health care delivery. Exertion ought to be taken to keep the act of customary pharmaceutical alive, applicable and sustainable (WHO 2008).

Diagnosis and treatment from traditional healers usually last for weeks, coupled by the inability to determine the issue hence it can lead a patient to visit an alternate healer (in this way additionally postponing testing or treatment) or prompt allopathic health care-seeking. On the other hand, healers can inspire an early diagnosis by referring speculated HIV-contaminated patients to

testing facilities. Healers, if legitimately trained and propelled, can go about as a screening framework for serious infections and perpetual ailments among their patients. Notwithstanding their auspicious referral, healers could be an asset for clinicians and give applicable insights about patients' restorative history that may point to a diagnosis (Sagan, 2013).

While scientists regularly feature the negative effect of healers, additionally scientists serve a positive part as patient health advocates, psychological wellness specialists, and essential care suppliers. Cases incorporate preparing customary healers as referral operators or adherence mentors for HIV and tuberculosis in South Africa, Tanzania, and Lesotho. South African healers who got training in HIV/AIDS, STI and TB counteractive action were found to have a critical increment in HIV/AIDS learning and HIV administration techniques (Dahab, 2008). In an assessment of the current allopathic medicinal training model for healers in rural Nepal, trained healers kept up learning about the roots, anticipation, and treatment of HIV/AIDS, expanded referrals to health care providers, and enhanced associations with government health laborers. Interestingly, untrained healers proceeded to exclusively use customary medications without referral to allopathic suppliers. A few studies have shown that conventional healer intercessions result in the absorption of new abilities and learning, however, few investigations have connected these mediations to enhanced wellbeing results for HIV-infected patients (Sagan, 2013). Given the benefit of starting treatment in resource-poor settings, tolerant referral to treatment facilities by traditional healers is a basic technique for enhancing the predicament of HIV in society (Dahab, 2008).

Notwithstanding enthusiasm for helping PLWHA, healers regularly need ART/HIV information and familiarity with herb-ART collaboration. Key contrasts in illness causation convictions can make it troublesome for clinicians and conventional experts to convey adequately and concur on a strategy. Moreover, joint efforts between allopathic medication and conventional pharmaceutical can be one-sided and paternalistic, and healers have revealed feeling an absence of regard for their commitments (King, 2000).

2.20.2 Collaborative efforts

In 1978, the World Health Organization 'Alma Ata' conference (WHO 1978) called for official acknowledgment of traditional health practitioners in Africa and upheld their incorporation into national biomedical health frameworks, especially at the level of primary health care. The meeting

contended that as 'a component of the local culture, society, and traditions', customary wellbeing experts constituted an important asset for cheap essential medicinal services provision. The idea of customary healers as 'community health workers', committed to the adjusting of rural places, was particularly appealing for health care facilities which were simultaneously cash-strapped and in shortage of trained health workforce. In spite of these admonishments, a seminar on African medicine in 1986 exhibited that, aside from some preparative research into the African *materia medica,* the WHO recommendations had to a great extent 'failed to be noticed (Maclean, 2006). With the beginning of HIV/AIDS, there has been an extra driving force to calls for collaborative interventions, with unique accentuation on the potential part of traditional healers as society health instructors (King, 2000).

Acquaintance with and inclusion in the 'capacity building' perspective of Indigenous Knowledge Systems Crossman and Devisch (2002) has however energized significant enthusiasm for different parts of traditional healing on the continent (Crouch et al 2009; Dold and Cocks 2009; Hutchings 2006; Simon and Lamla 2001; van Wyck et al 2007). In South Africa, national research establishments are associated with broad scientific investigations of the medicine, frequently in association with pharmaceutical corporates, and exhorted by enhancing sangoma (Anderson and Kaleeba 2002; Felharber and Mayeng 2009; Gericke 2006; Mayeng 2006; Medical Research Council 2004). As Maclean (2006) and others have noted, concentrate on the traditional pharmacopeia is seldom joined by a proportional distraction with the spiritual supporting of customary healers (Crossman and Devisch 2002; Green 2006, 2009).

2.21 Health policy and strategy for establishing collaborative efforts between traditional and biomedical practitioners

2.21.1 Traditional Health Practitioner Bill of 2003 (Act 22 of 2007)

The Traditional Health Practitioners Bill of 2003 permits traditional wellbeing experts to endorse prescription and sick leave to patients, like Western specialists. The Bill restrains impostors (fake healers who utilise human body parts to make muti and claim to cure an assortment of sicknesses) from practicing. The government implemented the Traditional Health Practitioners Act (22 of 2007) to guarantee that traditional health specialists possess an indistinguishable right from other health care practitioners in South Africa and furthermore that all human services professionals

are working legitimately, meeting all norms of medicinal services set out by the Department of Health. The Traditional Health Practitioner Bill (2003) was passed in 2003 by parliament. The goal of the Bill is to perceive the traditional health care framework in South Africa and in addition to give a structure to guaranteeing adequacy and nature of traditional health care administrations and give patients plan of action in occurrences of misbehavior (Sagan, 2013).

The Traditional Health Practitioners Bill (2003) was evaluated by the late Ms. Manto Tshabalala Msimang who stressed that the procedure would bring nobility and regard of traditional medication to general society part (Matomela, 2013). Amid the general population seminars of 15 September 2004, it was stated that the Bill will bring traditional healers, for example, soothsayers (sangomas), botanists (izinyangas), conventional birth specialists and conventional specialists (iingcibi) nearer to the primary health care framework and the Bill will profit more than 200 000 traditional wellbeing experts (Matomela, 2013).

The Council was entrusted with conveying an administrative system to shield the efficiency, prosperity, and magnificence of traditional health practitioners for the controller and specifying the recording, arrangement, development, and conduct of specialists and in addition characterize the classes of the traditional medication calling (Matomela, 2013).

The of Bill (2003) relates the arrangement, objectives, functions, and structure of the Council that advances greatness in medicinal services inside the traditional health sector. It protects the benefits of the public population and sanctuaries specific morals for traditional wellbeing specialists, offering a set of accepted rules that fit in with for the most part acknowledged benchmarks and standards (Matomela, 2013).

2.21.2 The Traditional Health Practitioners Act (22 of 2007)

The Traditional Health Practitioners Act (22 of 2007) demonstrates that all traditional wellbeing specialists in South Africa must enroll with the Health Professional Council. The Act additionally settled a lawful system known as the Board of Traditional Health Practitioners. The order of the Council is to offer help for traditional wellbeing professionals and distinguish false experts who fiscally misuse the general population (Traditional Health Practitioners Act 22 of 2007).

The purpose of the Council is to:

•Promote health awareness to defend the quality of wellbeing administrations inside the customary wellbeing framework;

•Encourage and protect moral and capable wellbeing guidelines required from traditional wellbeing experts;

•Improve interest and revitalize research and training;

•Set and safeguard the set of principles

•Ensure that traditional practice adjusts to universal health care principles.

2.21.3 South African Healers Association (SOAHA)

The South African Healers Association (SOAHA) is an assembly of healers, involved with the task of promoting change and support of improving health care in South Africa. SOAHA is an entirely registered Non-Profit Company (NPC), working in Pretoria, with the purpose of selecting all fascinated Multifaceted Healers Provincially, Nationally and internationally to advance African Healing through Research, Education and Publications. SOAHA has identified Five Pillars within which it will operate which includes the following;

- Research and Education (Create cohesion and Relationship between Indigenous Healing and Modern Medicinal Healing Practices and Models).
- Profound Healing and Transformation
- Ancient Wisdom and Interconnectivity
- Associating the Past to the Present to estimate what's to come
- Association of Indigenous Healing Models to the Modern Healing Practices

Its major objectives are:

(i) To unite all Spiritual, Physical and Intellectual Healers.

(ii) To advance Western, African and Primitive Healing in South Africa.

(iii) Be the voice of all Healers Registered with SOAHA in different platforms National and International

(iv) Conduct Research on different issues that are confronting people, to discover healing solutions that will make life incentive to mankind.

(v) Organize and mastermind different seminars or Conferences for the benefit of members.

(vi) Run different scholarly programs for the strengthening of different individuals in their different methods for Healing.

(vii) Promote different types of healing in South Africa.

(viii) Create tolerance for various healing techniques or frameworks they are discovered in South Africa.

2.21.3 Limpopo Unified Traditional Health Practitioners Association (LUTHPA)

Limpopo Unified Traditional Health Practitioners Association (LUTHPA) is a wide dialogue for traditional healers of all disciplines. It is situated in Polokwane and achieves its aims through key strategies promotion activities like roadshows, mass media campaigns, and outreaches. LUTHPA perceives the value of Traditional Health Practitioners to their society paying little detail to specialization. LUTHPA advocates for professionalization and set measures in the training. LUTHPA reports to all traditional healer professionals and the groups they serve. LUTHPA prepares and works with all experts. LUTHPA fills in as a unifier in the THP sector. Traditional Health Practitioners are basically individuals from society and families in various working environments. They take an interest in the dynamic economy as Professionals, Executives, officials, researchers, business, and political pioneers; -in particular, the above classifications include their categories base. Indeed, Traditional Health Practitioners have a part to play in HIV work environment programming (Matomela, 2013).

2.22 Theoretical Framework

The theoretical framework of this study was based on the Health Belief Model (HBM). It is considered to be the most applicable to the study due to its description of threat perception and behavior evaluation components that aid describe findings. In terms of treatment adherence, the HBM would predict that an individual who believes that HIV/AIDS is severe, sees more benefits of ART than barriers, and has confidence in taking the pills even in difficult situations such as when drinking or using drugs, will adhere to the regimen. The HBM is one of the most widely used models in public health. Developed in the 1950s by Hochbaum and associates from the U.S. Public Health Service, it served to explain people's participation in health screenings. Its aim is to predict whether or not people choose a healthy action in order to prevent or reduce the chance of disease or premature death.

Among the four models for health-seeking behavior and treatment theories that will be discussed, the HBM offers the most suitable approach for the study of treatment adherence. The other three relevant theories that were used are namely, Health Care Utilization Model, The Four A(s) Model, and the Information Motivation Behaviour Skills. All of these are essential analytical tools for further exploring treatment adherence. In the course of their studies, scholars have come up with different approaches and models to explain health-seeking behavior. Such models draw on social psychology, medical sociology, and medical anthropology to explain factors that enable or prevent people from making healthy choices. Their basic assumption is that human behavior is shaped by the individual perception of the social environment (Mackian, 2013). The Health Belief Model has roots in social psychology and is the most widely used model in public health. The Health Care Utilization and the Four "As" Models are largely associated with medical anthropology and medical sociology. These models, as applied in public health, serve to identify variables that need to be considered in the research design rather than as behavioral models themselves (Hausmann-Muela et al 2013).

2.22.1 The Health Belief Model (HBM)

The HBM is used in health behavior that can be grouped into 3 main categories: Preventative health behaviors, sick role behaviors, and clinical use (Mackian, 2013). Some of the studies that

have employed HBM include predicting behaviors such as risky sexual behavior, exercise, and fried foods, smoking and driving while intoxicated (Nejad et al., 2015).

The HBM initially focused on 3 elements, namely: threat perception, behavioral evaluation, and socio-demographic and psychological variables. In its later evolution, health motivation and cues for action were added (Sheeran and Abraham 1995 in Hausmann-muela et al (2013). Threat perception is about beliefs on the impact and consequences of illness (perceived severity and susceptibility to illness or health problem); behavior evaluation consists of perceived benefits of a health practice and barriers to it; health motivations refers to the readiness of the individual to be concerned about health matters; cues to action refers to internal and external factors, which influence action (mass media, family, illness symptoms) and finally, beliefs and health motivation are conditioned by individual socio-demographic and psychological characteristics (Munro et al. 2014). Various studies can be identified as having utilised the HBM.

For example, studies have found that in areas prevalent of malaria the disease was not considered as a severe condition by those affected, and that mosquito nets were not seen as effective in the control of malaria because mosquitoes bite day as well as night (Hausmann-Muela et al. 2003; Mackian, 2013). This study used the threat perception and behavior evaluation components of the HBM to help explain findings. In terms of adherence, the study found out that an individual who believes that HIV/AIDS is severe sees more benefits of ART than barriers, and has confidence in taking the pills even in difficult situations such as when drinking or using traditional medicine will strictly adhere to the regimen.

The HBM has, however, been subjected to considerable criticism. For instance, Munro et al. (2014) observe that the relationships amongst variables in the model are not clearly defined. The assumption is that these variables do not moderate each other. For instance, if perceived seriousness is high and susceptibility is low, the model assumes that the likelihood of action would still be high when the reverse could be true. In addition, despite the fact that perceived severity, susceptibility, benefits, and barriers are important, the theory neglects other factors such as social influence, previous experience, behavior intentions and perceived control (Munro et al. 2014).

2.22.2 The Health Care Utilization Model

The Health Care Utilization Model (HCUM) was originally developed by Andersen and Newman (1973 cited in Hausmann- Muela et al 2013) to explore the use of biomedical health services, although it has been applied by Weller *et al.* (1997) to the utilization of traditional and home treatment. It groups the factors that influence health care utilization into three sequential factors which are predisposing factors, enabling factors and need factors. It defines these three areas as predisposing factors as socio-demographic variables (age, sex, education); prior experience with illness; knowledge about illness; attitudes towards health service, enabling factors as availability of services, financial resources, health insurance, social networks and need factors as perception of severity, duration of illness, number of days missed from work. A further addition by Weller *et al.* (1997) is treatment actions, which include home treatment, over the counter drugs, traditional healers, and modern health services. The merit of the HCUM is that it provides a variety of factors that are organized in categories making therapeutic interventions feasible. However, it does not specify how and why different factors affect the selection of treatment.

2.22.3 The Four A's Model

This model proposed by Good (1987 in Hausmann-Muela et al. 2013) groups key factors of health-seeking into four groups, Availability (geographic distribution, etc.); Accessibility (Transport etc.); Affordability (of treatment costs, i.e. direct and opportunity costs); and Acceptability (cultural and social distance, etc.). The emphasis of this model is on social, economic and geographical factors. However, it has been criticized by Mackian (2013) for placing too much emphasis on barriers to treatment at the expense of other health-seeking behavioral factors.

2.22.4 Information Motivation Behaviour Skills model

In an effort to move from a uni-variate focus of factors that affects ART adherence at the individual level to a multivariate analysis, Fisher et al (2014) have proposed an Information Motivation

Behaviour Skills model (IMB). The IMB model, which borrows heavily from other health-seeking models such as HBM, TRA, and TPB, has been used in a wide range of health-related studies such as contraceptive use and HIV/AIDS prevention (Munro et al. 2014). The IMB model posits that information, motivation and behavioral skills are principle determinants of health-related behavior (Amico et al. 2015). In terms of treatment adherence, this model holds that people living with HIV/AIDS (PLWHA) who are well informed, motivated to act and possess the behavioral skills that enable them to act effectively, will adhere to the ART program (Fisher et al. 2014). Conversely, highly motivated individuals who lack the requisite skills to take medications as prescribed, or lacks confidence in his or her ability to perform recommended medication intake would have problems with adherence (Starace et al. 2014).

For PLWHA, consequently, adherence linked statistics comprises precise evidence on certain regimens, accurate ART intake and optimal adherence, and side effects connected with the regimen (Starace et al. 2014). In addition, it could be inaccurate information such as the belief that skipping medication here and there would help the body to fight the virus on its own (Amico et al. 2015; Fischer et al. 2014). On its part, adherence-related motivation includes attitudes towards outcomes of adherence, perceived social support for adherence behavior and the ability of the person to comply with the wishes of their significant others (Munro et al. 2014). Behavioral skills, however, include such factors as the skills, tools, and capabilities to adherence as well as the belief that they can effectively accomplish the adherence behavior (Starace et al. 2014; Munro et al. 2014). Finally, this model states that the three components can be moderated by contextual factors such as living conditions or access to health services (Munro et al. 2014; Fischer et al. 2013).

It is perceived that the IMB model has the benefit of being simple, as it isolated adherence connected factors from other health-seeking behavior models. Given its current development, not much has been done to gauge its applicability and effectiveness in visualizing adherence (Munro, 2014). Nonetheless, this model can be critiqued up-front for not satisfactorily dealing with social-cultural and structural adherence-related factors. For instance, problems such as stigma linked with HIV/AIDS in countless settings in the developing world does have a bearing on patient adherence to ART. It can be detected that the health-seeking behavior model shares common and overlapping variables. On the contrary, there are fundamentals in these theories that are peculiar to certain models only.

2.23 Summary

The theoretical framework and literature demonstrated that non-adherence to treatment is more common in societies that are financially burdened. Some poor backgrounds associated with informal trading, gold-panning and communal subsistence farming. A large number of people in these communities do not have formal education and work. Lack of education and poverty are problems that prevent patients from taking treatment properly. Economic necessities have likewise brought about patients on treatment failing to afford transport costs and food subsequent to meager medication adherence. Stigma and segregation have brought about patients on treatment taking their medication in disguise to cover their HIV positive status now and again defaulting treatment or discarding refill dates than to experience disparagement. ART adherence requires support from drug institutions, society based associations, and family. Traditional healing practices also play a role in treatment adherence.

The literature demonstrates that adherence to ART is not only an issue in nations with limited resources, subsequently it likewise affects developed countries. Various studies showed that adherence to treatment in HIV patients is affected by system interrelated components, condition-linked components, treatment-associated components, and patient-allied components.

The centrality of formation of upgraded contact amongst clinicians and patients from various social ethnic milieu enhances ART adherence. The mixture of traditional and religious healers into the healing framework helps to find treatment and co-diseases of HIV administration since it manufactures a remedial organization together which is useful given the recurrence with which their administrations are looked for HIV and non-HIV related conditions alike. To counter non-adherence at the grassroots level engagement of expert patients can viably empower new patients to effectively adhere to their treatment.

Traditional healers are exceedingly valued and broadly consulted by societies. Nevertheless, traditional healers may perhaps be equipped on how not to interfere with western medicines for instance by not giving herbs that may decrease the adequacy of anti-HIV drugs. Additionally, they could be taught with the goal that they do not spread myths and misperceptions, and in fact, they can assist to counter them. The other concern is poor regulation of traditional prescription, leaving individuals living with HIV exposed to abuse by deceitful healers who advance cures for AIDS or

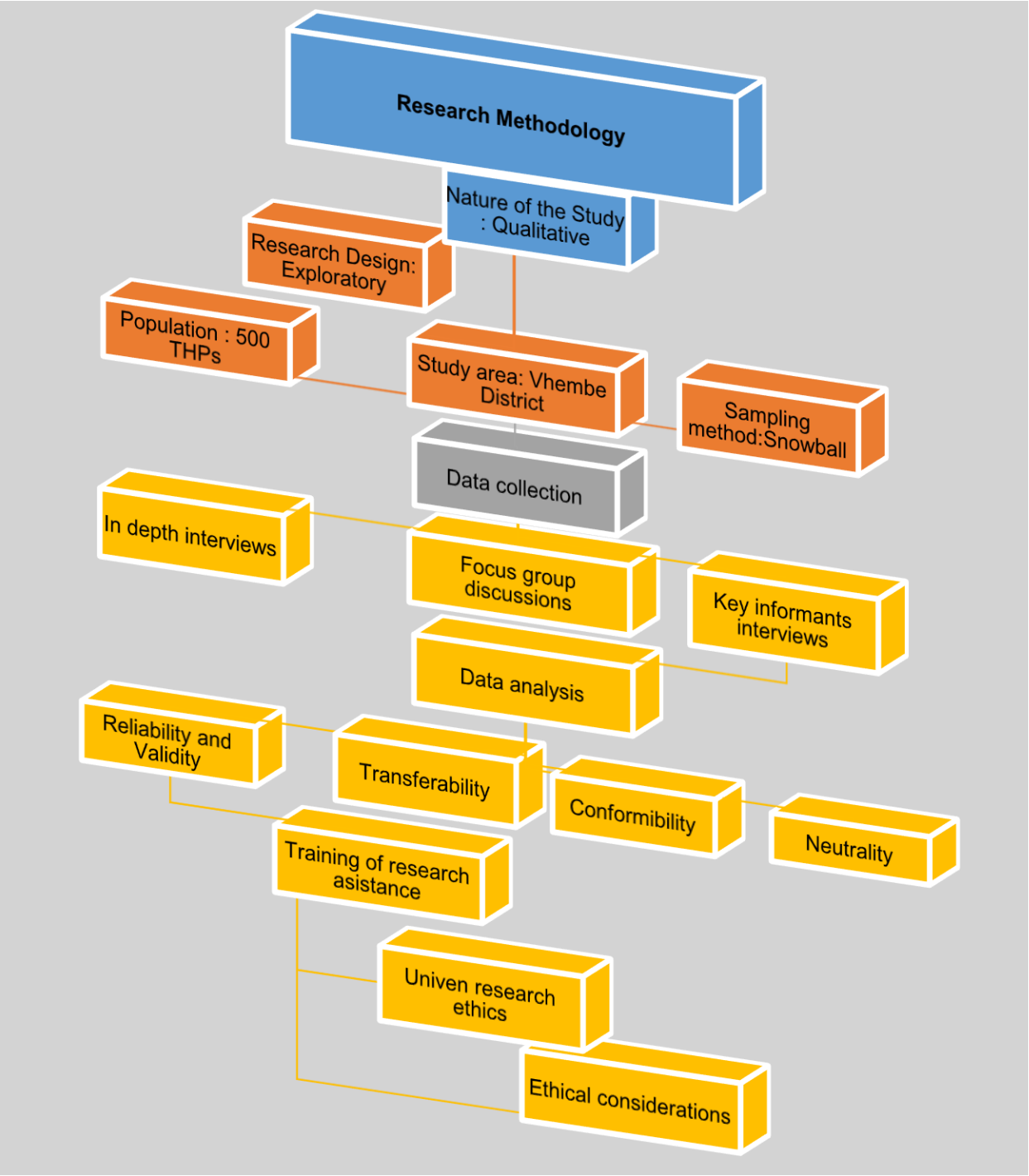
convince their patients to stop life-prolonging medications, for example, the anti-retroviral treatment.

Among the four models for health-seeking behavior and treatment theories that were discussed the HBM offers a most suitable approach for the study of treatment adherence. The other three relevant theories were also used are namely, Health Care Utilization Model, The Four A(s) Model, and the Information Motivation Behaviour Skills. All of these are essential analytical tools for further exploring treatment adherence. Scholars have come up with different approaches and models to explain health-seeking behavior. Such models draw on social psychology, medical sociology, and medical anthropology to explain factors that enable or prevent people from making healthy choices.

CHAPTER 3

METHODOLOGY OF THE STUDY

Figure 3.1 Schematic representation of the researcher's methodology steps



3.1 Introduction

This section introduces the research methodology of how the researcher conducted the study. De Vos, Strydom, Fouche and Delport (2011) define research methodology as a description of the specific techniques employed, the specific measuring instruments utilised and the specific series of activities conducted in making the measurement. As shown in Figure 3.1, the methodology of the study trailed the following steps; nature of the study, research design, nature of the study, population and location of the study, sampling procedure, data collection method, data analysis, and ethical considerations.

3.2 Nature of the study

The study was qualitative in nature. Bless (2016) states that qualitative research is a study which is conducted using a range of methods which are qualifying words and descriptions to record and investigate social reality. To this effect, through the use of this approach, the researcher wants to gain an in-depth understanding of the influence of traditional healing on anti-retroviral treatment adherence. According to Mitchell (2015), qualitative research deals with subjective data that are produced by the minds of participants of the study. In the context of this study, the participants were Traditional Health Practitioners (THPs). The researcher tried to understand the significance which participants attach to their environment or situation. As a result, the researcher tried to understand the influence of traditional healing practices from Traditional Healing Practitioners (THPs) around the Vhembe District of Limpopo Province. The data are presented in language instead of numbers.

Bless (2016) states that qualitative research focuses on how individuals and groups view and understand the world and contrast meaning out of their experiences. It typically studies people or systems by interacting with and observing the participants in their natural environment and focusing on their meanings and interpretations, and the emphasis is on their quality and depth of information and not on the scope or breadth of the information provided, (Maree, 2012). To that effect, the researcher interviewed and interacted with participants individually in interviews and in groups in the focus group discussions. Interviewing participants individually and interacting with them in focus group discussions enabled the researcher to observe their interaction in their natural environment and focus on their meaning as postulated by Maree (2012). This enabled the

researcher to gather in-depth information with regards to the influence of traditional healing practices in Vhembe District of Limpopo Province.

3.3 Research design

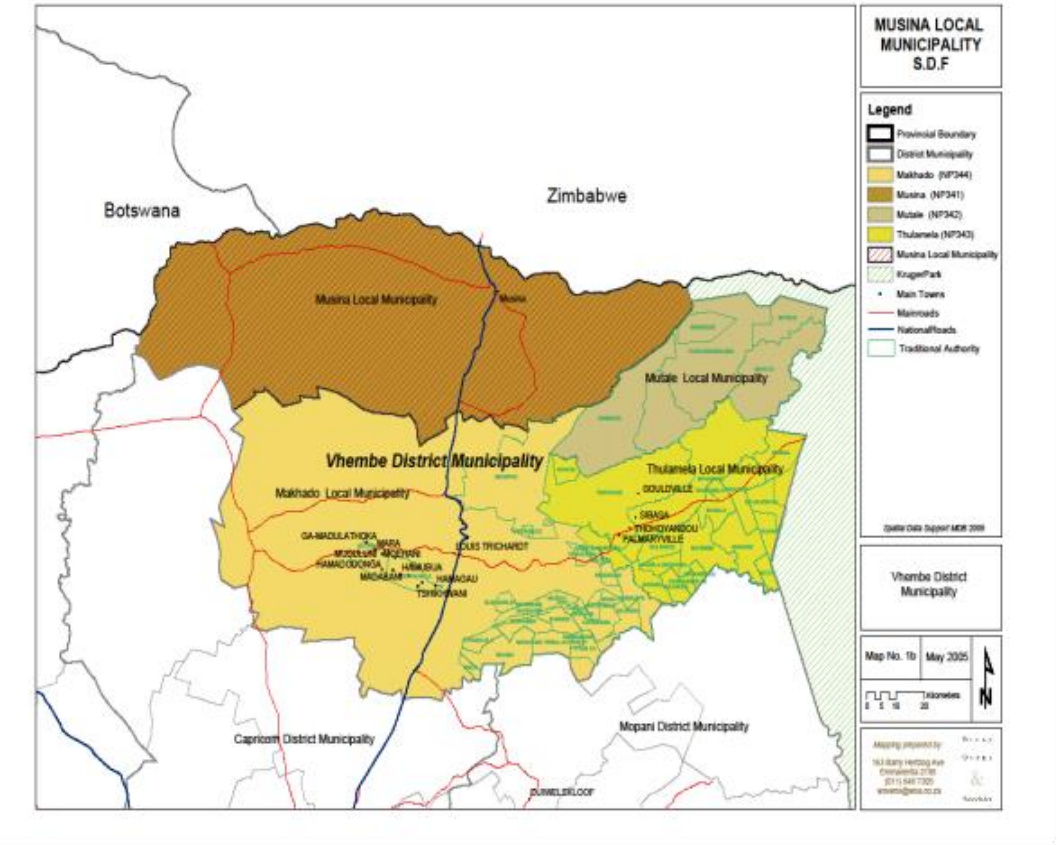
The study used an exploratory research design. The researcher used the exploratory research design to find answers to the questions of ‘what' or ‘who'. The researcher's choice to use the exploratory research design was influenced by its nature of data collection and analysis within the context of the phenomenon and the ability to capture complexities of real-life situations so that the phenomenon can be studied in greater levels of depth. As indicated by Yin (2014:23) due to the nature of their in-depth, multi-sided approach exploratory studies often shed light on aspects of human thinking and behavior that would be unethical or impractical to study in other ways. They generate new ideas that might be tested by other methods. Exploratory studies are an important way of illustrating theories and can help show how different aspects of a person's life are related to each other. In the context of this study, explorative research design assisted in illustrating how the Health Belief Model (HBM) theory influences traditional healing practices in influencing anti-retroviral treatment adherence amongst People living with HIV/AIDS (PLWHA) in Vhembe District of Limpopo Province, South Africa.

Moreover, Stebbins (2001) states that exploratory research design is a methodological approach that is primarily concerned with discovery and with generating or building theory. In a pure sense, all research is exploratory. In the social sciences, exploratory research is wedded to the notion of exploration and the researcher as an explorer. In this context, exploration might be thought of as a perspective, ‘a state of mind, a special personal orientation' toward approaching and carrying out social inquiry (Stebbins, 2001). Exploratory research design is usually characterized by a high degree of flexibility and lacks a formal structure. To that effect, there is a lack of formal structure with regards to traditional healing practices influence on anti-retroviral treatment adherence. The influence of traditional healing practices varied from one Traditional Healing Practitioner (THP) to another depending on their own personal beliefs and how they see the word thereby making the explorative research design perfect gather new different ideas from participants.

Furthermore, Bless (2016) states that the aim of exploratory research is to identify the boundaries of the environment in which the problems, opportunities or situations of interest are likely to reside, and to identify the salient factors or variables that might be found there and be of relevance to the research (Stebbins, 2001). That being the case, explorative research design enabled the researcher to explore new qualitative data from Traditional Healing Practitioners (THPs) who reside in remote villages. That being so, an explorative research design was the most ideal research design to explore the influence of traditional healing practices of treatment adherence in the Vhembe District of Limpopo Province of South Africa.

3.4 Study area

Figure 3.2. Vhembe District Municipality map



As shown in Table 3.2, Vhembe District is located in the northern part of the Limpopo Province. It shares borders with Zimbabwe and Botswana in the north-west and Mozambique in the south-east through the Kruger National Park. The Limpopo River valley forms the border between the district and its international neighbors. The district includes the Transvaal, and areas that were

previously under Venda and Gazankulu Bantustan's administration. It is comprised of four local municipalities: Musina, Thulamela, Makhado and Collins Chabane (Limpopo District Profile, 2018). The district municipal offices are located in the town of Thohoyandou. It covers a geographical area that is predominantly rural. It is a legendary cultural hub and a catalyst for agricultural and tourism development. Vhembe District has a total population of 1 300 people with 53% females and 47% males. Thulamela is the most populated municipality in Vhembe District and the fourth populated municipality in South Africa.

It has a population of 680 000, followed by Makhado with 516 000. Collins Chabane has a population of 91 000 and Musina has 68 000 (Statistics SA, 2018). The main languages spoken are Tshivenda (69%) and Xitsonga (27%), Sepedi (2%), Sesotho (1%) and Afrikaans (one percent) (Limpopo District Profile, 2018). The study area of Vhembe District of Limpopo Province of South Africa provided a natural setting for participants of the study because there were no changes or manipulation of the environment and no special treatment was given to the participants which might affect the results. Therefore, for the purposes of this study, Traditional Health Practitioners (THPs) residing in Vhembe District of Limpopo Province four Municipalities namely Thulamela, Makhado, Musina and Collins Chabane, were selected for data collection purpose of the study.

3.5 Population of the study

According to Bless *et al*., (2013), the population is a collection of objects, events, or individuals having some common characteristics that the researcher is interested in studying. De Vos, Strydom, Fouche and Delport (2011) also defines a population as the totality of persons, events, organisations units, case records or other sampling units with which the research problem is concerned. An accessible population is a group of people or objects that are available to the researcher for a study (Polit and Beck, 2009). This study's accessible population were Traditional Health Practitioners (THPs) in Vhembe District of Limpopo Provinces' four municipalities namely; Thulamela, Makhado, Musina and Collins Chabane.

There are 500 registered Traditional Healing Practitioners in Vhembe District of Limpopo Province (Limpopo District Profile, 2018). However, Street and Rautenbach (2019) dispute this figure by stating that there are more than 10 000 registered and unregistered Traditional Health Practitioners (THPs) in Vhembe District. Street and Rautenbach (2019) argues that the majority

of the 10 000, Traditional Health Practitioners are not registered with the Traditional Health Practitioners Council of South Africa. The reason being that it is difficult for most of the Traditional Health Practitioners (THPs) to register with the council because of their challenging eligibility requirements such the need for educational certificate and training (Street and Rautenbach, 2019). That being so, the number of THPs may even be more than 10 000. However, for the purposes of this study, the population of the study was 500 Traditional Health Practitioners (THPs) as stated by the Limpopo District Profile. Eligibility criteria specify the characteristics that people in the population must possess in order to be included in the study (Polit and Beck, 2004). The eligibility criteria were that participants were Traditional Health Practitioners (THPs) registered with the Traditional Health Practitioners Council of South Africa.

3.6 Sampling techniques

According to Burns and Grove (2010), a sample is a part or fraction of a whole, or a subset of a larger set, selected by the researcher to participate in a research study. Creswell defines a sample as a subgroup of the target population that the researcher plans to study for generalising of the target population (Creswell, 2009). Qualitative sampling methods make use of non-probability sampling techniques. According to Unrau, Gabor and Grinnell (2007), each unit in a non-probability sample does not have a random chance of selection and the odds of selecting a sample are unknown because the researcher does not know the population size. Denzin and Lincoln (2005) state that qualitative researchers seek out individuals, groups and settings where the specific processes are mostly going to take place or occur. Although sampling use is rife in qualitative studies, it is less structured and less strictly applied than in the case of quantitative research (Burns and Grove, 2010). This difference arises from the methods of qualitative data collection such as observation and interviewing, which are unstructured. They focus on gathering in-depth information from participants of the study (Babbie and Mouton, 2010).

Creswell (2009) states that there are no rules for sample size in qualitative research, but sample size depends on what the researcher wants to know, the purpose of the qualitative study, what will be useful, what will have credibility and what can be done with the resources at the disposal of the researcher. For the purposes of this study, the researcher used the snowball sampling method. Snowball sampling is a non-probability sampling technique that is used by researchers to identify potential subjects in studies where subjects are hard to locate. Researchers use this

sampling method if the sample for the study is very rare or is limited to a very small subgroup of the population (Patton and Quinn, 2015). This type of sampling technique works like a chain referral. After observing the initial subject, the researcher asks for assistance from the subject to help identify people with a similar trait of interest (Patton and Quinn, 2015). To this effect, the researcher was referred from one Traditional Health Practitioner to another since they knew each other and have the characteristics that the researcher was looking for. Thus, the snowball sampling method was the ideal sampling method to use since Traditional Health Practitioners (THPs) are hard to locate but at the same time, they know each other.

A snowball sample of 9 participants was used in the study. The researcher drew a non-representative, cross-sectional snowball sample of 2 participants from 3 municipalities of Vhembe District of Limpopo province and 3 participants from the most populated municipality in the Vhembe District namely Thulamela, to make a total sample size of 9 participants of the study. The reason for choosing 3 participants from Thulamela municipality was because it is the most populated municipality in the Vhembe District of Limpopo Province, South Africa with a population of 618 000, followed by Makhado with 516 000 (Vhembe District Profile, 2018). Thus, the total sample size was 9 participants. Normal sample size would have been 6 participants as stipulated by Creswell (2017) and Morse (2009) because the goal of qualitative researchers should be the attainment of saturation. The 9 participants of the study enabled the attainment of data saturation across all the 4 municipalities of Vhembe District of Limpopo Province in interviews. Furthermore, a focus group snowball sample came up with 2 focus groups discussions of 5 participants in Group A and 4 participants in Group B. All the 9 members who participated in the 2 focus group discussions are the same respondents who had participated in the interview. The rationale for using the same participants from the interviews was to explore more information from the same participants through assessing divergence or convergence between their individual views in the group and observation of responses of participants in the groups. The 2 groups of participants enabled the researcher not only to consider participants own experiences and views in interviews, but also the way participants negotiated these views and experiences with others. Burns and Grove (2010) state that focus group discussions allows the researcher to explore topics that have appeared in the analysis of the interviews and to illuminate areas that seem yet to have a point of view without consensus.

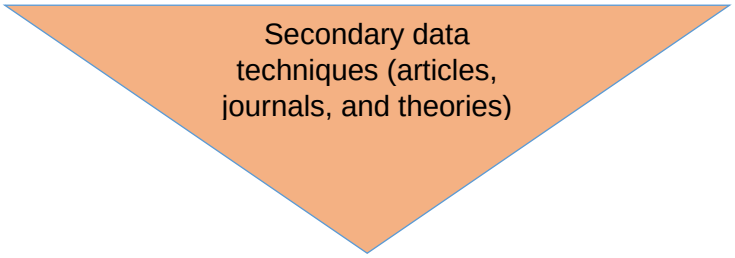
Thus, focus group discussions offered the researcher a perfect platform to explore themes that in-depth interviews revealed and enabled assessment of the themes in the groups. Therefore, focus group discussions complemented the weakness of in-depth interviews. In addition, the

study made use of key informant purposive sampling. According to Marlow (2005), key informant sampling relies on people in the community identified as experts in the field of interest. As a result, the sampling frame was limited to a male and a female Traditional Health Practitioner (THP) working for a reputable organisation that deals with traditional healing. The reason for considering gender was to avoid gender biases with regards to the influence of traditional healing practitioners on anti-retroviral treatment adherence. To that effect, the key informants of the study was a male and a female from the following organisations; African Young Eco-Minds Dialogues (AFYEMD) and Dzomo La Mupo. Thus, the chairman and founder of African Young Eco-Minds Dialogues (AFYEMD) was the first key informant.

African Young Eco-Minds Dialogues (AFYEMD) is an organisation which works with young people on developing them to have ecological minds and embrace their cultural heritage. The second key informant is the Executive Director of Dzomo La Mupo. Dzomo La Mupo is an organisation that preserves numerous sacred sites, indigenous forests and nature in Soutpansberg mountains of the Vhembe Biosphere Reserve. Both key informants of the study were from Vhembe District of Limpopo Province of South Africa. The purpose of interviewing key informants was to gather in-depth information about the influence of traditional healing practices from a professional point of view because they have organisations which deal with matters related to traditional healing and ARV data in Vhembe District. Therefore, the study employed in-depth interviews, focus group discussions and key informant's interviews for triangulation, which enabled complete and well-validated results and outcomes of the study.

3.7 Data Collection

Figure 3.3 Triangulation of Data Collection Techniques



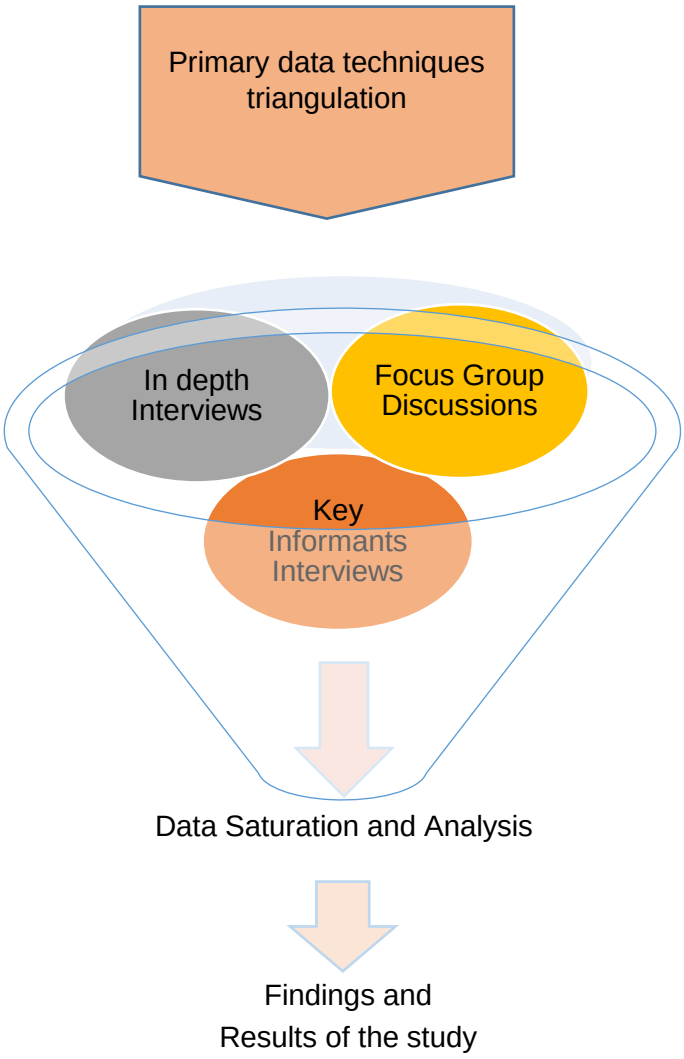


Figure 1.3 illustrates the data collection methods that were used by the researcher. Data collection methods are procedures specifying techniques utilised in conducting a research study (De Vos *et al*., 2011). Burns and Groves (2010) define data collection method as a clear and accurate systematic gathering of information that closely relates to the research purpose, objectives, question or hypothesis of the study. Data were derived from two sources namely primary and secondary sources. The first data collection method that was used was secondary data sources such as articles, journals, and theories. According to Kothari (2009), secondary data is information

collected previously for some other research purpose. The data may be available in written, typed or in electronic forms. Denzin and Lincoln (2005), states that secondary data analysis is a formal and systematic qualitative method of obtaining data, which involves the selection of relevant documents to analyse in-depth narrative.

Thus, the researcher used secondary data sources that comprised of the following; books, journals, articles, legislation, newspaper reports and scholarly materials from the internet. Secondary sources are generally accounts written after the fact with the benefit of hindsight. They are also interpretations and evaluations of primary sources. Secondary sources are not evidence, rather a commentary on and discussion of evidence (Bhutta, 2013). The second data collection method that used was primary data. According to Kothari (2009), primary data is original information collected by a researcher specifically for a research study through various methods such as interviews, focus group discussions and key informant interviews Thus, the researcher used qualitative primary data collection techniques that involve; in-depth interviews, focus group discussions and key informant interviews.

3.7.1 In-depth interviews

The researcher used in-depth interviews to gather data. According to Maree (2007), an interview is a dialogue or conversation in which the interviewer asks the participants questions to collect data and to learn about the views, ideas, opinions, experiences, and behaviours of the participants. The aim of qualitative interviews is to see the world through the eyes of the participants and they can be a valuable source of information if used correctly. The study made use of an in-depth interview guide to ask questions from the participants (see Appendix C). Maree (2007) states that an in-depth interviews guide helps a researcher to conduct qualitative research by interviewing a small number of participants about the research topic. Therefore, the researcher made use of an in-depth interview guide to explore the influence of traditional healing practices on anti-retroviral treatment adherence in the Vhembe District of Limpopo Province, South Africa. The in-depth interview guide enabled the acquisition of rich in-depth information and ideas.

During the in-depth interviews, the level of questioning varied to fit the context of what the participants were saying and understanding. The researcher made follow up questions and deeply interrogated participants on specific issues raised in the interviews. Given that Traditional Health

Practitioners (THPs) are difficult to locate, the researcher took advantage of the Indigenous Knowledge System Symposium Find New Words Workshop held at the University of Venda in 2018. The workshop was organised by the Directorate of Community Engagement and more than 20 Traditional Health Practitioners (THPs) attended the workshop. The researcher also attended the workshop and got the opportunity to participate in the workshop and interact with Traditional Health Practitioners who attended. Through, interaction, the researcher managed to exchange contacts with some of the Traditional Healing Practitioners who showed interest in participating in research studies concerning the influence of traditional healing practices on anti-retroviral treatment adherence.

A few days after the workshop, the researcher called the participants to inform them about the study and asked them if they could participate in the study. Thereafter, the researcher arranged interviews with the participants in the presence of 2 research assistants at the participants' convenient time and place. All interviews were conducted in the backyard of their homes. The researcher respected and followed the dressing, language, and etiquettes that were asked by the participants in entering their surgeries such as removing shoes on the entrance, hands clapping and wearing long skirts. Fortunately, all 9 participants agreed to meet at University of Venda, Research Conference Centre for the focus group discussions which were scheduled at a different date from the in-depth interviews that were held at their home places.

Before each interview, the researcher explained to each participant the ethical considerations and rights of the participants that need to be observed such as; voluntary participation, informed consent, privacy, and confidentiality, before and during the interviews. Thereafter, the researcher asked the participant to sign the consent form and to find out if the researcher can record the interview process (See Appendix A). Thus, observing all ethical considerations were followed. The researcher also took notes on a note-pad during the interviewing process regarding non-verbal responses, such as gestures, smiles, and frowns, which carry information that supplement or even sometimes contradict the verbal responses. Burns and Groves (2010) posit that working in the field with real people entails an understanding of how they make sense of their world through multiple methods that are interactive and humanistic. Humanistic methods focus on talking with people, listening to them, observing their physical behaviors, clothing, decorations, and space, and reading them. During the in-depth interviews, the researcher likewise observed participants very closely. Talking and listening to the participants as they narrated their stories generated the researcher's imagination and understanding of their experiences and knowledge with regards to the influence of traditional healing practices on anti-retroviral treatment adherence.

According to Frankfort-Nachmias and Nachmias (2009), observing non-verbal responses helps the researcher to understand and consciously share participants' beliefs, values and emotions as far as circumstances allow in the interview. The non-verbal responses enabled the researcher to understand how Traditional Healing Practitioners (THPs) make sense of their world and how they manage to cope with their plight. Some participants could not understand the questions asked in English. Therefore, the researcher made use of 3 guidelines in Tshivenda, Xitsonga, and Sepedi. Fortunately, the 2 research assistants were multilingual and helped with translating the questions into the participants' different languages that comprised of Tshivenda, Xitsonga, and Sepedi. The interview sessions with each participant lasted between 45 minutes to 1 hour. Lastly, the researcher informed participants of the follow-up group discussion to complete the data collection process.

3.7.2 Focus group discussions

Burns and Groves (2010) define a focus group as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. According to Morgan (2009), focus groups are a research technique that collects data through group interaction on a topic determined by the researcher. Study participants from interviews were later on grouped into 2 focus group discussions. The rationale for conducting focus group discussions was to complement the weaknesses of in-depth interviews to enable yielding of complete and well-validated results. Duggleby (2005) states in-depth interviews may not yield all desirable information because that individual might be reluctant to give information face to face, unlike when they are interacting in a focus group discussion. Thus, to complement the weakness of in-depth interviews, the researcher conducted focus group discussion to explore more information from participants through assessing divergence or convergence between their individual views in the group, stimulation of ideas in a group and observation of responses of participants in the groups. The reason for choosing the same participants was to solicit more information and observe participants behavior in their respective groups. Unlike, in individual interviews, focus group discussions create a conducive and informal environment for participants to open about their experiences and circumstances.

According to Morgan (2009), focus group discussions create a sense of belonging to a group, which can increase the participants' sense of cohesiveness and help them to feel safe to share

information. In addition, Duggleby (2005) denotes that interactions that occur among the participants can yield important data, can create the possibility for more spontaneous responses and can provide a setting where the participants can discuss personal problems and provide workable solutions. Burns and Groves (2010) state that focus group discussions allows the researcher to explore topics that have appeared in the analysis of the interviews and to illuminate areas that seem yet to have a point of view without consensus. Thus, focus group discussions offered the researcher a perfect platform to explore themes that individual interviews revealed and enabled assessment of how participants agree and disagree with in-depth interviews themes in the groups. The focus group discussions took place in at University of Venda, Research Conference Centre. The centre had enough space to accommodate 9 participants, divided into 2 groups of 5 and 4 members.

After explaining to the participant the ethical considerations and rights of the participants, they signed a consent form. The participants gave consent to the researcher to record the focus group discussions. The focus group discussions time frame was one hour with a 10 minutes break after the first 30 minutes. The researcher addressed the purpose of conducting the focus group discussions and introduced the co-facilitators. They comprised of; two research assistants from the University of Venda. The research assistant's job was helping with co-facilitating. Both the research assistants were also helping the researcher with language translation since they were both multi-lingual. The researcher-initiated an icebreaker that enabled participants to introduce themselves. The icebreaker helped create a relaxed and friendly environment. The researcher cut small pieces of paper labeled from number 1 to 9 and mixed them in a container. All the 9 participants picked one small piece of paper from the container and revealed their number. 2 groups emerged from the activity. The first group emerged from the first 5 participants who picked from number 1 up to 5. The second group prevailed from the 4 participants who picked the last 4 numbers.

Thus, the breakdown of 9 participants into 2 groups took place in an unbiased and transparent way. The focus group discussions guideline had 4 versions of different languages namely; English, Tshivenda, Xitsonga, and Sepedi (see Appendix C). The focus group discussions guideline helped to keep the discussions on track and on time. During the focus group discussions, the researcher was able to deal tactfully with outspoken group members and made sure that every participant opinion mattered. After 1 hour, there was data saturation and all questions had been answered by the participants. The researcher wind-up the group discussions and thanked the participants for coming.

3.7.3 Key informants interviews

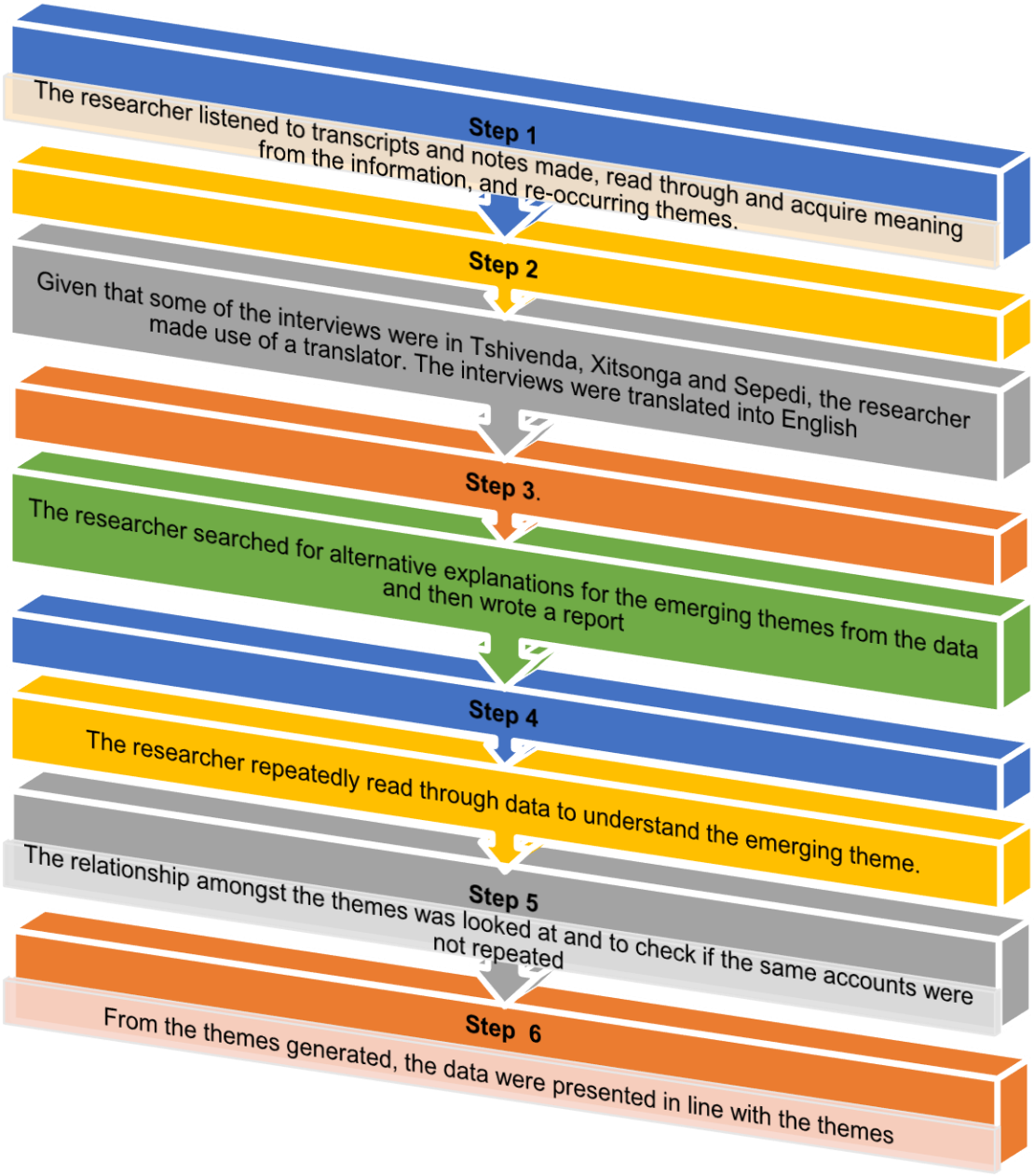
Finally, yet importantly, the last stage of the data collection process was interviewing key informants of the study. This was necessary and very important because it enabled the researcher to gather views of experts on the influence of traditional health practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa. This enabled an assessment and comparing the data gathered from different viewpoints. The researcher was able to produce complete and well-validated results and outcomes of the study. Marlow (2005) states that key informants are people in the community identified as a specialist in the field of interest of the researcher. As a result, the chairman and founder of African Young Eco-Minds Dialogues (AFYEMD) were selected who is also a Traditional Health Practitioner. The organisation work with young people on developing them to have ecological minds and embrace their cultural heritage. In addition, Executive Director of Dzomo La Mupo was the second key informant of the study. Dzomo La Mupo is an organisation that preserves numerous sacred sites, indigenous forests and nature in Soutpansberg mountains of the Vhembe Biosphere Reserve.

Of significance is that the 2 key informants were Traditional Health Practitioners (THPs). The key informant's selection criteria were that one was supposed to be male and the other one female to avoid gender biases. Secondly, they were supposed to be attached to organisations that deal with issues related to traditional healing practices in Vhembe District of Limpopo Province, South Africa. The interviews took place in the comfort of their offices for a period of forty-five minutes to one hour. Key informants' inputs were helpful because they all have in-depth information and experiences with regards to traditional healing practices influence on anti-retroviral treatment adherence. Thereafter, the data collection process was completed. The researcher managed to conduct in-depth interviews, focus group discussion and key informant's interviews. These 3 different data collection techniques enabled triangulation of data, which enabled complete and well-validated data concerning the influence of traditional healing practitioners on anti-retroviral treatment adherence in Limpopo Province of South Africa.

3.8 Data analysis

Munhall (2011) defines data analysis as the process of bringing order, structure, and meaning to the mass of collected data. The data were analysed in a qualitative manner. Qualitative data analysis tries to establish how participants make meaning of a specific phenomenon by analysing their perceptions, attitudes, understanding, knowledge, values, feelings, and experiences in an attempt to approximate their construction of the phenomenon Maree (2012). The researcher used Van Manen's method to analyse data. Van Manen's method of data analyses was applied to the in-depth interviews data, focus group discussions and key informants' interviews. The findings were assessed, compared and contrasted to achieve well-validated findings of the study. The steps are taken when using the Van method to analyse data are illustrated in Figure 1.4 below.

Figure 3.4 Data analysis steps



3.9 Reliability and validity

According to Leedy and Ormrod (2004), the validity of a measurement instrument is the extent to which the instrument measures what it is supposed to measure. On the other hand, Babbie and Mouton (2010) define reliability as the ability of an instrument to measure the same variable more than once and produce the same results or outcomes. The researcher used methodological triangulation of qualitative techniques to improve validity and reliability. There was a triangulation of results from in-depth interviews, focus groups discussions and key informant interviews. Patton and Quinn (2015) state that if conclusions from different qualitative methods concur or are the same it means that the validity of the study is established. Hence, the researcher triangulated in-depth interviews, focus group discussions, key informants' interviews and document analysis. This added depth to the results, which would not have been possible using a single strategy. As a result, it ensured well-validated results and outcomes of the study.

Burns and Groves (2010) postulated that triangulation of mixed qualitative methods findings allows for complete knowledge through uncovering significant insights that a single research design may overlook or miss completely. Therefore, the researcher ensured validity through triangulation of qualitative techniques that comprised of; in-depth interviews, focus group discussions, key informants and document analysis. Furthermore, the researcher ensured against bias in interviews by allowing free flow of information and emotional responses, unlike close-ended questions, which are fixed. In conducting focus group discussions, the researcher guarded against bias. One form of ensuring credibility entails honest participants (Lincoln and Guba, 2014). To ensure that the participants are honest, only those participants genuinely willing to take part in and prepared to offer data towards research freely, have been involved and encouraged to be honest. The researcher clearly indicated that no right or wrong answer to the questions existed and each participant approached had the opportunity to refuse.

3.9.1 Transferability

To ensure that the study is transferable, the study methodology and results are well detailed and described for transfer purposes to other similar researches. Burns and Groves (2010) postulate that for a study to be transferable, researchers must supply a highly detailed description of their

research situation and methods. Transferability invites researchers of research to make connections between elements of a study and their own experience. Researchers note the specifics of the research situation and compare them to the specifics of an environment or situation with which they are familiar (Burns and Groves, 2010). If there are enough similarities between the two situations, readers may be able to infer that the results of the research would be the same or similar in their own situation.

3.9.2 Conformability

The researcher ensured conformability by reviewing the findings of the study by replaying the recordings and re-reading responses of the participants. Thus, ensuring accuracy giving of findings of the study and the true reflection of the views of the participants. Conformability refers to the point to which the results are the product focus of the research study and not of the biases of the researcher (Babbie and Mouton, 2010). In other words, it refers to the objectivity or neutrality of the data. Thus, ascertained through checks and balances on whether the data is relevant and meaningful. Confirmability ensures that the data is the true reflection of what the participants have said, and it should not be a reflection of the researchers' perspectives, views, beliefs, image interpretation, and experience when interpreting the data.

3.9.3 Neutrality

Nachmias (2014) refers to neutrality as not supporting either side or being impartial in conducting a research study. It means that the researcher should not take sides when carrying out the research. Therefore, to ensure neutrality, the findings of the study influenced by the participants and not by the researcher's bias, interest, and motivation during all the interviewing processes. In carrying out the study and compiling the findings, the researcher kept the duty of good faith and reported the findings without any attachments of the feelings of the research.

3.9.4 Training of research assistants

To ensure quality data collection processes, the research made use of 2 Masters Students from University of Venda's (UNIVEN) School of Human and Social Sciences. The researcher conducted 2 training sessions for the 2 research assistants on how to collect data from the Traditional Health Practitioners (THPs) around Vhembe District of Limpopo Province. Practical demonstration sessions ensure competence and mastery before the commencement of the data collection processes. The researcher also notified the research assistant to mind their dressing, language, and etiquettes during the visits to the participant's homesteads to avoid offending Traditional Health Practitioners (THPs) during interviews and at their homesteads. That being so, the research assistants and the researcher made sure to follow etiquettes such as clapping hands and removing shoes when entering Traditional Health Practitioners surgeries.

3.10 The University of Venda research ethics

The University of Venda (UNIVEN) policy research ethics were adhered to throughout the study in each and every step of the way which involved research techniques, policy, procedures, and ethical guidelines. The researcher was cleared and issued an ethics clearance certificate by the UNIVEN's Ethics Committee to conduct the research study (see Appendix F). The researcher presented and submitted the research proposal to the University of Venda Higher Degrees Committee (UHDC). It scrutinizes all proposals for conducting human research under the auspices of the institution. The UHDC involves a panel of lecturers who scrutinize the research proposal before approval. This board, which is made up of scholars and researchers across a broad range of disciplines, checks proposed research studies to ensure that the procedures are not unduly harmful to participants, that appropriate procedure is followed to obtain participants' informed consent and that participants' privacy and anonymity are assured.

In line with UNIVEN's Ethics Committee requirements to conduct a research study, the researcher got permission to conduct the study around Vhembe District of Limpopo, Province of South Africa. Of significance is the fact that it is very difficult to find Traditional Health Practitioners (THPs), especially in large numbers like they were at the Indigenous Knowledge System Symposium Find New Words Workshop held at the University of Venda in 2018. The reason why it is difficult to

access Traditional Health Practitioners (THPs) is that people in the community consult them in secret mostly during the night. That being the case, during the day it is only a few people in the community who can refer to a Traditional Healing Practitioner or admit that they consult them. Fortunately, the researcher managed to interact with Traditional Health Practitioners (THPs) and capitalise the opportunity for future networking for the purpose of conducting the study.

3.11 Ethical considerations

Pearson (2013) describes ethics as a set of moral principles which are suggested by an individual or group is subsequently widely accepted, and which offers rules and behavioral expectations about the most correct conduct towards experimental subjects or respondents. Ethics are about conforming to the standards of conduct of a given profession or group and is generally a matter of agreement among the members of a group of individuals (Babbie and Mouton, 2001). The study was sensitive given that the researcher was dealing with human beings who were traditional and cultural oriented. Therefore, it was vital to maintain confidentiality. Pearson (2013) states that participants are more likely to provide honest responses when their identity is not going to be exposed. To that effect, the researcher maintained the confidentiality of the participants. Informed consent was asked from participants before conducting the in-depth interviews, focus group discussions and key informants interviews. The consent to participate in the study was clearly outlined on the purpose of the study and what the information gathered would be used for.

3.11.1 Principle of respect

This study considered the principle of respect for the participants. Principle of respect for persons recognizes participants or people as autonomous agents and requires that their choices be observed. Gostin (2013) stipulates that for participants or persons who are not fully autonomous, the principle of respect for persons requires that they are protected from risks and adverse consequences of research and even some- times excluded from research. Therefore, this study addressed the principle of respect by observing the choices of the nine participants of the study.

3.11.2 Principle of beneficence

According to Heider (2013), beneficence (do good) and non-maleficence (do no harm) are complementary ethical principles that impose affirmative duties on researchers to maximize any

benefits for subjects and minimize any risks. Thus, researchers must go beyond mere respect for a person's choices. The researcher was vigilant to ensure that the subject received all possible benefits and avoids all possible harms from participating in the research. The participants may benefit from the methods that the researcher seeks to develop that may help to improve treatment adherence amongst PLWHA.

3.11.3 Principle of justice

The Principle of Justice requires that human beings be treated equally unless there is a strong ethical justification for treating them differently (Neuman, 2013). Thus, the distribution of benefits and burdens in research should be equitable. Therefore, the researcher ensured equitable selection of the nine participants on the basis of factors clearly relevant to the study. The researchers ensured equitable distribution of advantages to research subjects and others who could benefit from the knowledge gained by the research, through sharing the results of the study and developing methods that may help to improve treatment adherence.

3.11.4 Procedures and mechanisms for protecting human rights

According to Bhutta (2013), ethical principles help support autonomy and self- determination, protect the vulnerable, and promote the welfare and equality of human beings. Ethical issues were addressed to protect the rights of respondents. Participants in this study were approached about the research with an explanation of what the study was all about after the approval from the Research Ethics Committee of the University of Venda, before the commencement of the study. All subjects signed and return a copy of a letter of consent, indicating their willingness to participate in the study and accepting the conditions thereof. The researcher had an obligation to ensure that the respondents remained unharmed during the study. The researcher did not do anything that would endanger the respondents. Every respondent has the right to his or her identity being kept undisclosed. In this study, the identity of the respondents was not disclosed. Confidentiality of information was maintained by storing the recorded information in a locked safe place. After the analysis, original data was stored in a safe place and destroyed after the completion of the study. Publication of the findings would be done with permission from the participants.

3.11.5 Referencing

The researcher reported findings in a complete and honest manner, without distortion of the truth or misrepresentation thereof. The researcher did not fabricate data to support the conclusions and acknowledged all sources, to avoid plagiarism or academic theft (see Appendix G). In that regard, all the work of other scholars or authors used in this thesis was properly referenced in accordance with the University of Venda Human and Social Sciences approved style. Moreover, some of the sources used in this thesis were collected from newspaper articles, journals, books, and the internet. These were also referenced as such.

3.12 Summary

This chapter has explored qualitative research techniques methods. Furthermore, the chapter has outlined in detail the population, study area setting and sampling techniques that were used in the study. It has also dealt with qualitative data collection tools namely; in-depth interviews, focus group discussions and key informants interview. The chapter highlighted the strength and weaknesses of each data collection tools and how they complement each other. The administering of these tools in collecting data was aimed at producing quality and valid results. Triangulation of qualitative tools and process was conducted to enable the researcher to produce complete and well-validated results and outcomes of the study. This chapter also assessed the research ethics which the researcher rigorously observed during the data collection processes and after. The next chapter provides the data analysis, interpretation, and discussion of the findings from qualitative techniques that comprised of; in-depth interviews, focus group discussions and key informants' interviews.

CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

4.1 Introduction

Chapter 4 deals with the presentation of data obtained from the interviewed participants about the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa. The data gathered in the interviews, focus group discussions and key informants interviews were presented and analysed. The chapter includes the following sections: demographic profile of participants; presentation of data and analysis of data. Firstly, the presentation of demographic information was in a table form. The last part is the presentation and analysis of data on the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa.

4.2 Demographic Information

Table 4.1 Demographic Information of the Participants

Pseudo Name	Age	Sex	Marital Status	Level Of Education	Municipality
Participant A	74	Male	Married	No formal education	Thulamela
Participant B	61	Female	Divorced	Secondary	Collins Chabane
Participant C	59	Female	Widow	Tertiary	Makhado
Participant D	52	Male	Married	Tertiary	Musina
Participant E	49	Female	Married	Secondary	Thulamela
Participant F	54	Female	Married	Secondary	Musina
Participant G	71	Male	Married	Tertiary	Thulamela

Participant H	53	Female	Married	Tertiary	Makhado
Participant I	75	Female	Widow	No formal Education	Collins Chabane
Key informant A	78	Male	Married	Secondary	Thulamela
Key informant B	49	Female	Married	Tertiary	Thulamela

A total of 9 participants and 2 key informants participated in the study. 6 of the participants were females while 3 were males. 6 participants were aged between 49 to 61 years, whilst 3 participants were above 71 years. This exhibits that the majority of participants were middle-aged whereas a minority of participants were geriatrics between the age of 71-75. However, the oldest participant was key informant A, who was 78 years old and the youngest participant was key informant B who was 49 years. A total of 6 participants were married, 1 was divorced and 1 participant was a widower. Of significance is that 4 participants reached the tertiary level of education, 3 participants attained secondary level whilst 2 participants did not access any formal education. Both key informants attained tertiary education. All the 9 participants and 2 key informants hailed from Vhembe District of Limpopo province, South Africa.

4.2.1 Profile of Key Informants

Key informant A is a traditional healer who has organic intellectual expertise in indigenous knowledge systems and skills. The key informant is the founder of African Young Eco-Minds Dialogues (AFYEMD). The organisation work with young people on developing them to have ecological minds and embrace their cultural heritage. Since 1987, key informant A has been working with students, pupils, teachers, academic researchers from a national and international university on indigenous knowledge systems and skills. In 2012, key informant won the organic intellectual award from the National Heritage Council of South Africa. The key informant A specializes in indigenous trees medicine on different diseases such as HIV/AIDS, sugar diabetic,

cancer, boosting immune system herbs, baby sicknesses and advice on a healthy diet. Moreover, key informant A does initiation schools for rites of passage like *Domba* (python dance) and assists communities to revive the healing and sacred rituals according to an ecological calendar, reviving the value of (*thevhula and u phasa*) through finger millet. The expertise of key informant A in indigenous knowledge systems and skills provided in-depth information concerning the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa.

Key informant B is a traditional healer with a great intellectual background. Key informant B was a recipient of the Bill Clinton Fellowships, to study leadership at the United Nations and at Tufts and Harvard University in the United States of America (USA). Furthermore, key informant B is the Executive Director of Dzomo La Mupo. Dzomo La Mupo is an organization that preserves numerous sacred sites, indigenous forests and nature in Soutpansberg mountains of the Vhembe Biosphere Reserve. The organization also works with teachers and students to revive cultural biodiversity and it also works with people living around sacred areas to preserve certain seeds such as finger millet, maize, beans, and sesame. Subsequently, key informant B prowess in traditional healing and experiences in cultural biodiversity enabled the provision of expert knowledge concerning the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa.

4.3 Presentation of Data

4.3.1. The responses of traditional health practitioners on the influence of traditional healing practices on anti-retroviral treatment adherence

This section addresses the responses of traditional health practitioners concerning the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa. In line with the objectives, the study sought to answer four major questions. The first question was about the influence that healing practices have on anti-retroviral treatment adherence. The second question was on which socio-cultural and individual factors that influence anti-retroviral treatment adherence. The interventions that may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence was the third question. The last major question was on strategies that can be used to support anti-retroviral

treatment adherence compliance through traditional health Practitioner, allopathic clinicians, and community member partnerships. Of significance is that all the major 4 questions are in line with the four objectives the study sought to achieve. As a result, the influence that healing practices have on anti-retroviral treatment adherence was the first question to be asked. The responses of the participants are presented in detail in the upcoming section.

4.3.1.1 What influence does traditional healing practices have on anti-retroviral treatment adherence?

Participant A had this to say**, "***I don't tell them that they have that sickness. I only ask them if they sometimes go for a check-up for medical healing about their sickness about the sickness that they will be suffering but I do not tell them that they have AIDS. I recommend them that they should also go to consult medical doctors and tell me what they found out after consulting. Then if they found out that it is HIV/AIDS, I tell them that continue with the hospital medicine and stop my medicine as a healer until you find out that the medicine of the hospital is not working, then you can start my treatment. I don't recommend him or her to use both".*

Participant B asserted that **"***There are people who go to the clinic and hospital to get ARVs. After drinking ARVs, when they see that they are getting better, they stop and say the disease is gone. They think that the virus is dead. They know that because when they go to the clinic doctors or nurses tell them that their CD4-count has improved or not. When they hear this news they stop taking ARVs. I am talking about this from experience. I have helped many HIV/AIDS people here who were very sick. I give them medicine to recover. I also tell them to go to the clinic to get ARVs and for clinics machines to check their CD4 count. The problem is that I do not have a machine to check the CD4 count myself. Those who are taking ARVs, I tell them not to stop because when the virus attacks them again it will be too much and too strong. It's like both ARVs and traditional medicine help each other to heal AIDS. People suffering from this disease must use both*".

Participant C articulated that, **"***Its medication that was prescribed by the government and I don't see any reason why my patients should stop taking ARVs. The reason is that as individuals we are under the government, like if they say we are immunizing young children that means everybody must take their child to that immunization. If they (government) say those who are affected by HIV they must go to the clinic or hospital, those certain groups of people, then it is worth it. They must go and take the medication. They must go and take lessons, they must go*

and attend workshops, whereby they will understand the issue of ARVs better. People are ill-informed sometimes that is why they do not take important issues seriously. They are ill-informed not by the government but by their colleagues. People believe in friends than the relevant people who know more about the disease. So as a traditional healer it is also my duty to inform people that they must take ARVs on top of my medicine".

Participant D said, **"***According to our culture we don't believe that there is HIV. Our culture encourages people to use only traditional medicine. The reason being that, we believe that traditional medicine is very strong than that medicine that you are talking about (ARVs). Even when I see they are too sick, I encourage them to take my traditional medicine only. It is good and it is the best. In healing sick people who come here, I believe in myself and ancestors. I won't be healing them alone but it will be with the help of my forefathers. So why should I doubt them that they are not good? No, I don't doubt them and why should my patients waste their time by going to the clinic when I can heal HIV myself. They (ancestors) can heal AIDS through me. Given that I am a traditional healer, I have a strong belief that the medicine that I give my patients will make them regain their health. So, in the end, they will be in good condition*".

Participant E asserted that "*The person does not have to use the medicine from the clinic and my medicine at the same time. The two medicine must be used at different times, after two or three weeks. I also recommend the person to go back to the clinic to check the status whether the sickness is still the same or there are some improvements, but I do not recommend them to drink the medicine at the same time. I don't think that it can work at the same time. It is like water and oil. It does not mix and it can never mix. It must be used at different times so that they can be healed*".

Participant F clarified that **"***These days' people understand that they can use both traditional medicine and western medicine. What I tell my patients does not matter that much because everyone now knows about AIDS these days and that it can kill. My traditional medicine can heal HIV/AIDS but that does not mean that they must stop taking ARVs. They must use both and sometimes it depends on the person. So I tell my patients not to take chances by stopping to use ARVs because you never know. I believe in traditional medicine. That is my belief and to them, that belief may not work in healing their sickness, so it is better to be safe".*

Participant G elucidated that, "*Many people both many men and women come to me who are suffering from this disease. I am very honest with them. I tell them to continue using ARVs and not to stop. They must use both. It's dangerous to stop taking pills because traditional medicine alone cannot cure HIV/AIDS. It helps to treat some other disease but it does not completely kill the virus. Many people have died because they stopped taking the pills that they got from the clinic. When it comes to my clients, some of them recover very well but other clients it can be difficult for them to recover and they take more time to recover. It is only for the best to take both. They must follow instructions from the hospital about the medication that they get and at the same time they must also follow my instructions. That is what I believe is the best because this HIV/AIDS thing, it's a new disease with our ancestors did not know about. This HIV/AIDS diseases it's more like a punishment for immoral behavior, so anything can happen. To simply everything, my clients should take both western medicine and my medicine but the most important thing is that they must follow the instructions given at the clinic and the instructions that I give. Many people die and some become serious because they do not follow instructions. My grandchild, you are at University because you followed instructions given by your teachers. If you had not listened and followed instructions, you would have dropped out. It is the same thing with healing client's people must follow instructions. It is as simple as that. So I say they must take both the western and my traditional medicine".*

Participant H emitted, "*I tell the people who come to consult me to use both traditional medicine and white people medication. You know, I attended tertiary institutions and I am educated. I am not ignorant. I know that ARVs help in treating HIV. I am smart enough to tell my patients that they must use both traditional and western medication. What you have to know is that traditional medicine and western medicine is more like one and the same thing. They both heal and they both come from these trees (pointing at trees). My daughter isn't it that white people's medicine came from our traditional medicine. There is no problem in taking traditional medicine and western medicine because they are both medicines. There is no poison here. Traditional medicine is not poison and white peoples medicine is not poison. I even think that taking both kinds of medicine makes HIV/AIDS patients stronger than when they are taking traditional medicine only or ARVs only".*

Participant I stated that **"***I specialize in curing the disease HIV. When a person comes to consult, I tell them straight that I can deal with the sickness. I tell them that if they want they can leave the ARV and use my traditional medicine only. After taking my medicine, people leave them and say I am no longer drinking ARVs. If my traditional medicine starts working on them they won't be any*

need to continue using western medicine. Our traditional medicine is much more powerful than the western medication. The patients will see that my medicine is working and they will stop taking them".

Analysis of participants' responses on the influence that traditional healing practices have on anti-retroviral treatment adherence

The response of the participants to the interview question shows that Traditional health practitioners (THPs) have both positive and negative influence on ARVs treatment adherence. All nine participants showed knowledge about ARVs and their impact on people living with HIV/AIDS. Although all nine participants displayed knowledge about ARVs, seven out of the nice participants recognize and acknowledge the use of ARVs in treatment of HIV/AIDS, whilst two participants did not acknowledge the use of ARVs in treating HIV/AIDS but they believe traditional healing practices can completely cure the virus. Despite their ignorance of ARVs, Of significance was that seven out of the nine participants admitted that traditional healing practices do not completely cure HIV/AIDS and they encourage their patients to take ARVs. This evidences that the majority of participants positively influences people living with HIV/AIDS to take both ARVs and traditional medicine. Participant E reiterated that the patients must take both ARVs and traditional medicine at different times since it may cause complications to the patient. This shows that Traditional health Practitioners are aware of the dangers that mixing ARVs and traditional medicine may cause to the body of people living with HIV/AIDS and they try to minimize the danger.

Although Traditional health Practitioners encourage people living with HIV/AIDS to take ARVs, some of their patients tend to relax and decide not to adhere to treatment especially if they recover from sickness. People living with HIV/AIDS end up believing that they are completely healed of HIV/AIDS whilst the virus will be just dormant in their body. This is evidenced by Participant B who revealed that patients stop to take ARVs when their CD4 count is high. It is good to note that Participant B highlighted the importance of encouraging the patients to continue using ARVs since the HIV/AIDS virus can be more dangerous after deferring ARVs treatment. This shows that the majority of participants encourages people living with HIV/AIDS to take both ARVs and traditional medicine. Traditional health Practitioners influence on anti-retroviral treatment adherence was positive but to a lesser extent, some patients may stop ARV treatment based on false hope of full recovery when the HIV/AIDS is dormant in the body.

Nevertheless, to a lesser extent, traditional healing practices negatively influence treatment adherence. 2 out of 9 participants revealed that they encourage their patients to stop taking ARVs and to use traditional medicine only. This shows that to a lesser extent, a minority of Traditional Health Practitioners influences people living with HIV/AIDs to stop taking ARVs and it impacts negatively on their health. This influence comes from Traditional health practitioners who claim to cure HIV/AIDS. Participant D and Participant I showed ignorance by claiming that they can cure HIV/AIDS and that they have the superpowers to heal HIV/AIDS. This was evidenced by Participant I who confidently claimed expertise in curing HIV/AIDS and expressed staunch beliefs in mighty powers of ancestors in healing HIV/AIDS. If a person living with HIV/AIDS comes across a Healing practitioner such as Participant I, there may be chances of being influenced to stop taking ARVs depending on the person's level of beliefs in traditional healing or the person's characters. Of significance is that people have different characters. As a result, some are the gullible type which can be influenced easily to the extent of believing that HIV/AIDS can be cured against the nurses or doctors' orders. However, to a greater extent, the response of the participant's shows that the majority of traditional leaders encourages people living with HIV/AIDS to take both ARVs and traditional medicine. Therefore, all 9 participants displayed knowledge about ARVs. 7 out of the 9 participants recognize and acknowledge the use of ARVs in treatment of HIV/AIDS whilst 2 participants did not acknowledge the use of ARVs in treating HIV/AIDS and they discourage their patients to use traditional medicine.

4.3.1.2 Which socio-cultural and individual factors influence anti-retroviral treatment adherence?

Participant A revealed that "*People do not want ARVs because when they drink the pills it makes out another odour like smell. The reason being that they have to drink it a lot, it changes the shape of their bodies. They will no longer be themselves. It causes many side effects. People do not want it because it is easy for people to see that, a person is drinking ARVs. When they are sitting here, you can sense a smell a person was not having before taking ARVs. I remember at a funeral people were gossiping that there was a lady with an ARVs pill odour. People did not want to sit next to her. This is the reason why people do not want this ARVs. The traditional medicine is better because it is from the tree and when you use them they don't change your body, they don't have any other side effects like having a bad odour or change of body shape. Many people also complain that the nurses tell them to eat food before taking ARVs.*

They complain that sometimes they will not be having sufficient food to eat so it will be better for them not to drink the ARVs. They say if they force to drink the pills without eating they vomit and feel very weak and sick. Dzi khou vhuya badi (it is tough for them). Most of the people around here they do not have jobs and money which means that sometimes they don't have plenty of food. These ARVs they have many side effects but with my muti(medicine) I don't give them those conditions that they must eat food before drinking it. In fact, after drinking my muti (medicine) they feel full".

Participant B said, *"You know what my daughter (smiling). Do not be surprised, I am calling you my daughter because I have a daughter who is of the same age as you. People stop taking ARVs for many reasons. One of the reason is that we traditional healers tell people that we heal AIDS. The moment they start getting better they stop taking the pills because they believe that it is not the ARVs that healed them, but it is the traditional medicine that healed them alone. So this misleads and creates confusion in our patients. If a patient has strong traditional beliefs then he or she will think that Maine (traditional healer) healed me and that the ARVs are useless. The problem is that we traditional healers don't completely heal AIDS that is why I always recommend my patients to continue taking ARVs and to go to the clinic for check-ups for CD4 count because I personally don't have the machines. I don't know how far true it is and I am not sure if it is true. One patient once told me that he is getting a disability grant from the government. He said at the clinic they are always checking his CD4 count and if it is high they will no longer give him the money. He said that sometimes he stops taking the ARVs so that his CD4 count doesn't become high. I do not know how far true that is because I don't have much information about the grant.*

Another reason is that people are afraid to be seen going to the clinic to take ARVs. Imagine meeting your neighbor at the clinic. The first thing that the neighbor would ask the patient the cause of the sickness and what the neighbor is doing at the clinic. What do you think an HIV/AIDS patient say when they are asked about their sickness by their neighbor? People in this area they gossip a lot. The whole community in the area will know that their neighbor is sick. Some of the people around here pretend to be Christians during the day. Imagine if he or she meets her pastor at the clinic and ask them the cause of sickness? You know these fake pastors of today they are too fast. The next thing the pastor will visit the sick person house saying that I want to pray for you or announce in the church that you are sick or claim that he can heal the HIV/AIDS. So, it is tough for people with HIV to get their medication because there is no privacy. A clinic or hospital is a public place. That is why the moment that sick people start feeling ok, they stop taking ARVs because they will be avoiding to go to the clinic".

Participant C explained that "*I am sure when you came here you saw how bad is this road. You even parked your car far away from here because this road is bad and we stay in a place like a mountain. What I am trying to say that, sometimes people with HIV, they stop taking medication because it is difficult to get transport to the clinic and the transport is expensive. People won't be having the money. The road is bad and sometimes taxis don't reach our place. You know when it is rainy season here, this place will be full of mad. It will be very hard to go to the clinic when it's muddy. Many cars and taxis they sink in the mud. If it is true what they say that they go and take their medication every month, then how do they manage to take their medication when it's raining and there are no taxis to go to the clinic. Even those with cars they won't even be able to drive to the clinic and take the medication. The clinic is far away so it must be close to the people in the community so that they will not struggle with taking ARVs. Our councilor tshidaila (useless) tsa kukhuma (very true). These are the things that he is supposed to address with the government. People don't want to take ARVs because they believe in our traditional medicine and culture. Even though we encourage them to take ARVs some of the people believe that only traditional medicine can heal their sickness. You know, I don't blame them for thinking like that because they are blacks. Traditional medicine is our culture and we grew up using traditional medicine to heal sickness. People still believe in that, so that is why sometimes they stop taking the medicine that they get from the clinic.*

Another thing is that eish....the nurses at our hospital are very rude, so people don't like going to the clinic. They are not lying, I once visited my neighbor who had been admitted at the hospital...yoooo yooo, it, I to myself that if I get sick please don't let me be admitted in the hospital. The nurses were very rude even to us the people who had visited our neighbor. Ever since that day, I don't like nurses at all. They do not respect patients. This goes to show how nurses are rude. I feel for the sick people who have to go to the clinic every month to get medication from the nurses. I think people are afraid or don't like to go to take ARVs at the clinic because they mistreat them as if they are young children. This is different from us traditional healers. We treat patients with respect. That is why sometimes they decide to leave ARVs and stick to traditional healers because we take great care of them".

Participant D stated, "*Sometimes It could be a belief that even if I use ARVs, I won't be in a good condition. Another reason is that, if patients want to take ARVs, they must go to the clinic to a see*

Doctor and their situation gets known by everybody. If the people know, they will be isolated and regarded somehow unlike if they come to us traditional healers for treatment. Traditional healers won't say your health status to the public. If they go to a Doctor, they take statistics, the patients name and so on. This affects people with HIV/AIDS emotional".

Participant E articulated that, "*It depends on the person herself or himself, that he can be having some of the things that block him or her to drink those ARVs. I always recommend patients to continue with ARVs and also to use my medicine that I get from the trees. It's only that they cannot take my medicine and the western one at the same time. The blockage can be a person himself or herself to say that I am not drinking the ARV. No one can be blamed for stop taking ARVs. These people are not children but adults who know what is right or wrong. So no one should be blamed for stop taking the pills from the clinic. I am a traditional healer. If I give my patient medicine to go-to drink at home and he or she decides not to drink should I be blamed? No. I cannot be blamed. It is not my fault.it is the fault of the sick person. I have my limitations I cannot force the patient to drink my medicine when they are far from me. The same applies to ARVs. Those nurses and doctors decide to give patients, their pills. Then when they are at home they decide not to take them. Whose fault is it? It is the patients' fault and not the doctors. So, I can say I know what stops sick people to take ARVs but is their decision*".

Participant F explained that "*It is not us traditional healers who influence people not to take ARVs. Inability to go out and accept or seek for help, it can also prevent someone from taking treatment because they will be afraid of being judged by the society or they are afraid of losing friendships and relationships. There are also beliefs that are cultural that can also prevent treatment adherence beliefs like the tablets that they will be taking are the ones that make them worse or the medicine is not working because they have been bewitched, some they have beliefs of saying that if you engage in sexual activities with a young child or an albino you will be automatically healed. If a person believes that sleeping with a child makes them be cured of AIDS, there is no way that they can take pills from the clinic. They will just go and look for a child to sleep with and believe that they are healed after. Beliefs like that are dangerous and many children have been raped in the society. I remember one client came to wanting muti (traditional medicine) so that he won't go to jail. He said that he had raped his nephew's child and the case had been reported to the police. Now he wanted my help so that the case would not go to the police. I refused I told him that even though I have the muti that can make him not go to jail. I was not going to jail because I don't help evil people. No.my ancestors won't allow that. How can a person rape a child and expect to get help from me? I do not like or associate myself with clients*

like him. I don't like a rapist. Another problem is this so-called man of God (Laughing). They tell people that they can cure AIDS and some people believe them I have seen on v people eating snakes and some grasses so that they can be cured of AIDS. These prophets are fake and they use people".

Participant G was quoted verbatim, **"***You know there are many barriers for people not taking ARVs. My patients tell me many stories about why they do not like to take HIV. Can you believe that I have treated many pastors here of HIV/AIDS and much popular church member? It is hard for you to believe, I know but it is true. They tell me that Maine (THP), it is difficult for us to go and take those pills at the clinic because people see them. Imagine a church pastor being seen on the line to take ARVs. One of the church pastors even told me that he goes to take his ARVs from a clinic far away in Tshitandani (Makhado) every month to avoid the nurses and people around here to know about his status. The problem is that the nurses around here they stay in this community, so he is scared that they will tell people and members of his church. It is hard for these people to go to the clinic but easy for them to come to me because usually, they come at night.*

I treat them very well and I keep their secret. They feel safe to talk about their sickness and problems they will be facing in their lives. They love their uncle and some of them buy me gifts when they feel better but I also tell them not to get carried away but to continue taking ARVs. One patient from around here once told me that he doesn't like taking ARVs because he is a drunkard, most of the time he will be drunk and sometimes it is hard for him to drink ARVs. He said sometimes he sleeps at night clubs and go out to drink with friends for days. He said that usually when they go out they will be sleeping with girls and sometimes he would not use condoms because he will be drunk. So ARVs inconvenience him because he cannot carry them around when he went to drink with his friends. Remember people who drink alcohol blind, blind (too much), usually passes out and people search them and pour water on them to wake up. Imagine if they would search his pockets after passing out and if out that, he has some ARV pills in the pocket. He would be embarrassed. That is why he prefers my medicine because he does not need to carry it around and no know can see him when he comes here to collect the medicine. The problem with ARVs is that a person has to drink them at certain times and people will be having various things to do. People go to work, so does it mean that a person should carry ARVs to work or even to carry them to a funeral. ARVs complicates the life of these people unlike our traditional medicine".

Participant H asserted that **"***There are many reasons that make people not to take ARVs. I think one of the reason it is because of the choice that they make between ARVs and our traditional medicine. In the end, it is a personal choice that one makes after comparing the two medicines. It is a personal choice that does not have anything to do with anyone be it the traditional healers, our beliefs in the community or the nurses. It is about what a person believes in and what they think can work for them. So when people stop taking ARVs it is because they do not trust the ARVs. They think that they do not work for them. Seriously, no normal person can stop taking a medication that they trust and that they know that it can heal them. They stop taking it because it doesn't work for them. The reason that they don't trust ARVs it is because our culture has always used traditional medicine for all the sicknesses. So they choose what they trust more between ARVs and traditional medicine. So sometimes, they think that the ARVs are not working and they decide to take traditional medicine alone that they trust. I don't encourage them to stop taking ARVs but if they decide to stop taking them, there is nothing that I can do because it is their personal choice. People trust and believe in different things. Patients are free and they can also stop taking my medication the moment that they start thinking that it is not working for them. They can leave me and go to another traditional healer to get medication. If they do that, it will be because the sick person no longer trust or belief in my medicine, so they will be looking for a better traditional healer. So I think it is the same when sick people stop taking ARVs".*

Participant I divulged that **"***I said before, I can treat HIV with my muti, so there is no reason for my patients to continue with western medicine. Before me, western medicine is nothing because I can do, what they can do. There is nothing western medicine can do that I can't. It's up to the patient to decide after taking my medicine, but most of them end up living western medicine when they discover that I have healed the disease. What is the reason for continuing to take medication when you are healed? I believe that there is no reason. If you continue taking the medication you will be hurting your body for nothing*".

Analysis of participants' responses on which socio-cultural and individual factors that influence anti-retroviral treatment adherence

The responses of the participants show that there are many social-cultural and individual factors which influence treatment adherence. One of the most outstanding influence on anti-retroviral treatment adherence was strong cultural and traditional beliefs. People living with HIV/AIDS who have strong cultural and traditional beliefs may believe that traditional medicine alone may heal HIV/AIDS. In addition, to their strong traditional beliefs, their beliefs are reinforced by Traditional Healing Practitioners who claim that they can heal HIV/AIDS. As a result, the tragic combination of a staunch traditional believer and an overzealous Traditional Healing Practitioner who claim to treat HIV/AIDS leads to non-treatment adherence by people living with HIV/AIDS. This is evidenced by participant I who claimed to heal HIV/AIDS and outlined that people living with HIV/AIDS should stop taking ARVs after being healed by traditional medicine because ARVs may hurt their bodies. Strong traditional beliefs like that act as barriers to anti-retroviral treatment adherence. Furthermore, use of traditional medicine and ARVs hinder anti-retroviral treatment adherence because it misleads and creates misconception to people living with HIV/AIDS when they are feeling better and when they go to the clinic and find out that their CD4 count is high. They may end up believing that it is traditional medicine that has exclusively healed them of HIV/AIDS, whilst it will be ARVs because they would be taking both. Therefore, it creates misleads and creates a misconception that traditional medicine heals HIV/AIDS. This is revealed by participant B revealed who elucidated that those people living with HIV/AIDS when their CD4 count is high and when they feel better they attribute the healing to the traditional medicine that they get from the Traditional health practitioner without realizing the importance of taking ARVs. Nevertheless, Participant B highlighted the need to continue encouraging people living with HIV/AIDS to adhere to ART despite their misconceptions and traditional beliefs.

In-depth interviews revealed that people living with HIV/AIDS stop taking ARVs for fear of losing their disability grant. This is evidenced by participant B quotation that one of the clients stated that they stopped taking ARVs to have a low CD4 count so that the client can continue to have access of the disability grant from the government. This shows that the fear of losing disability grants acts as a barrier to anti-retroviral treatment adherence. Participants of the study cited the side effects of ARVs as a barrier to anti-retroviral treatment adherence. Traditional healing practitioners revealed that people living with HIV/AIDS complain that ARVs makes them gain weight, change their body shape and some complain about an unpleasant odour. As a result, people leaving with

HIV/AIDS would stop taking ARVs and resort to the use of traditional medicine only since they encounter any side effects related to traditional medicine as highlighted by participant A. In the interviews, participants revealed people living with HIV/AIDS stop taking ARVs because they do not have enough money to afford a well-balanced diet that is required when one is on ART. Participant A revealed that people living with HIV/AIDS in the community because of being poor cannot afford to have consistent meals every day. As a result, sometimes they sleep on an empty stomach. Participant B revealed that lack of consistent meals compromises uptake of ARVs because when they drink them on an empty stomach they will be risking side effects such as feeling weak and nauseated. This shows that poverty or lack of food acts as a barrier against anti-retroviral treatment adherence.

The effects of poverty were also reflected when participants indicated that people living with HIV/AIDs do not have money for transport to go and take ARVs from the clinic. Participants also revealed that it is difficult to access clinics because they are far away. The villages that some people living with HIV/AIDS are very remote and some are not even accessible by cars as evidenced by Participant C who revealed that she stays in a mountain and cars and taxis cannot get to her place. Participant C also mourned the bad state of the roads in the villages. This shows that lack of transport and inaccessibility of clinics by people staying in remote areas acts as a barrier to anti-retroviral treatment adherence. Participants in the interviews reveal that people living with HIV/AIDS have some reservations when it comes to going to the clinic because there is a lack of confidentiality.

They have reservations because a clinic is a public place. They would be in danger of exposing themselves to members of the community unlike their nocturnal visits at Traditional Health Practitioner to get medicine. The interviews revealed that confidentiality was of paramount fundamental importance to people living with HIV/AIDS as conveyed by Participant G, who stated that a church pastor in their village goes to take his ARVs from a clinic far away from their village in Tshitandani (Makhado), which is a distance of more than eighty kilometres. This indicates how far people living with HIV/AIDS can go just keep their confidentiality. This shows that confidentiality act as a barrier to anti-retroviral treatment adherence. In, addition people living with HIV/AIDS do not feel comfortable when nurses and doctors take their names for statistical purposes. Participant D revealed that people living with HIV/AIDS they get affected when the nurses and doctors took their names for statistical purposes. As a result, it makes them not to feel comfortable with going to take medication at the clinic.

Furthermore, the interviews revealed that people living with HIV/AIDS are mistreated by nurses when they go to take medication. They revealed that nurses have a negative attitude towards people living with HIV/AIDS. People living with HIV/AIDS they dread to go to take ARVs because of ill-treatment by nurses. This is unlike Traditional Health Practitioners who treat patients with care and respect as evidenced by Participant G who highlighted that some of his patients buy him gifts to thank him for taking care of them. This shows that Traditional Health Practitioners build a good rapport with people living with HIV/AIDS, unlike nurses who mistreat them. Therefore, mistreatment by nurses acts as a barrier against treatment adherence by people living with HIV/AIDS.

The in-depth interviews revealed that inconveniences influence anti-retroviral treatment adherence. People living with HIV/AIDS just like everyone else participate in different activities during the day and also at night. Given that ARVs comes with stringent conditions and adherence practices it inconveniences people living with HIV/AIDS in their day to day activities. This is evidenced by Participant G who stated that one of his patients was a drunkard who found it difficult to carry ARVs to the beer hall or each time he goes out with his friends to drink beer. Thus, inconveniences act as a barrier for people living with HIV/AIDS to adhere to anti-retroviral treatment.

Participants in the interviews revealed that individual and personal choices act as a barrier to treatment adherence. Traditional Health Practitioners revealed that some people living with HIV/AIDs decide on their own to stop taking ARVs. They are not influenced whatsoever by Traditional Health Practitioners but it is their choices which they have to respect because there is nothing that they can do about it because at the end of the day it is their lives and decided to make. This is evidenced by Participant E who clarified that as Traditional Healers Practitioners they encourage participants to continue taking ARVs but their patients do not listen to their advice. They decide to stop taking ARVs on their own by choice. This indicates that individual and personal choices act as barriers to anti-retroviral treatment adherence. Therefore, the interviews revealed many socio-cultural factors that act as barriers to anti-retroviral treatment which includes the following, cultural and traditional beliefs, inconveniences, side effects, lack of transport, lack of food, inaccessibility of clinics, mistreatment by nurses, confidentiality, personal and individual choices.

4.3.1.3 How do you heal HIV/AIDS-related sicknesses?

Participant A had this to say**, "***When a person comes here I could see from the face that this one is affected by HIV, but I don't tell that person. When he comes or she comes here, I recognize it. My duty is to go to the bones because the person will say I am coming here to get assistance from you as a healer because I am sick. Already as a healer, I see that from the face, there are signs of this disease, then I go to the bones and throw the bones. The bones will tell me that this person has that disease. I do not tell that person that you have AIDS. I mix medicine and give that person to go and boil the medicine at home. I do not boil the medicine here. So this medicine is for drinking in the morning, afternoon and evening.*

Then there are other signs that I see that the sickness is now severe. I see the signs through sores on the mouth, legs and all over the body. Sores are a sign that HIV/AIDS is now becoming severe to the patient. Patients with severe sickness and sores all over their body, I give them medicine for drinking and also another medicine for washing. They must bath in order to deal with the source of the disease. There is also a sign which I see that a person is affected by HIV/AIDS. You find a person complaining about a stomach ache up to here, saying that I feel something going up and down. Like there is something which moves in their stomach. This, I see that this is the sign of the disease. That's why I recommend that they must have the drinking medicine and these people I do not tell them that they have HIV/AIDS sickness, I just deal with the sickness.

*I don't tell them that they have that sickness. I only ask them if they sometimes go for a check-up for medical healing about their sickness about the sickness that they will be suffering but I do not tell them that they have AIDS. HIV/AIDS sicknesses come from the sex organs, whether it's a man or women. The sickness comes through here and here (*pointing the groin area of the body). *Here* (groin) *this sickness is like a liquid. It starts to boil inside and when it boils, it goes to the skin. It goes to all layers of the skin. After the layers of the skin that is where you find a person starting to scratch outside because now it develops into sores. It goes to the whole body through the skin until the person starts to scratch all over the body. That is why I give them the medicine to drink. When they drink this medicine, it comes and works here* (groin area of the body)*. The medicine also goes to the skin and the layers of the skin. That why we also give them medicine to bath, so that we can deal with this sickness which is liquid inside the body and already affecting the skin. Thus, we try to stop this one which has already developed. Whether is a man or women, all the sicknesses come here (groin area). The other thing is that sickness when it is here* (groin area)*, it starts itching inside. It is like a wound inside here (groin area). There will be that liquid*

and it makes them feel like scratching but they can't reach there. That is why most of them they want to do sex always because when they do sex it's like it scratches the inside. This is what is driving them to want to have sex always".

Participant B revealed that "*To be honest it easy not easy to find out that a person has HIV because I do not have the machines and my ancestors they do not know that there is a disease called HIV. I throw my bones to see the various sickness that a person will be suffering. After throwing the bones my ancestors can reveal to me the different kind of sicknesses that a person will be suffering and the kind of medicine that I should give them. It is through knowing all the different kinds of medicine that a sick person needs that I treat AIDS. That is how I treat AIDS. After giving my patients the different types of muti (traditional medicine), I tell them to go to the clinic to get tested of HIV/AIDS also*".

Participant C stated that "*I can heal HIV/AIDS. This is what a person who comes to consult here do. Before they come here I can already see them in spirit. My ancestors give me a vision. This hut is the one that I use. When they come here they sit outside the hut at the bench. I have long queues of people here. People can be with for me even the whole day because sometime I would have to go to the river to perform some rituals when others are waiting. Other rituals I do them in the mountain. I am a busy man and you are lucky to find me here. When they are waiting outside, I call the patients to come in. They must remove their shoes. After sitting down I tell them about their problems before they even say a single word. After telling them, I ask them if what I will be saying it is true or not. I am never wrong.*

If it is witchcraft I can see it and if it is AIDS I also see it. Obvious my ancestors don't know what AIDS is but they show me the vision. How I know that it is AIDS, my ancestors show me a vision when the person was sleeping with the person who gave him or her AIDS. From there that's when I know that a person is HIV/AIDS. If it is witchcraft they also show me. This muti here is the one that I use for cleansing the HIV/AIDS. They have to bathe with this muti when they are here and it is very itchy. There is a bathroom outside. They go to bath there and they don't have to use soap. I keep some brand new razor blades, so after bathing, I have to cut their skin and put this muti. This muti helps with killing all the unwanted things in the body that causes sicknesses. I made the cuts at the stomach, the legs and at the back of their neck so that the muti can be distributed all over the body to kill the virus. I also give them muti to drink and to bathe when they go home. That is how I treat HIV/AIDS".

Participant D expounded, "*I treat HIV by throwing bones. Through the bones, I can see that a person is having HIV. Like I said before, I do not doubt my ancestors. I can heal by giving them medicine. There is medicine to burn, drink and bath. I take medicine and I burn it in a hot pan. After burning it I take the ashes and make some small cuts with a razor and then put the medicine. That medicine is very painful and helps a lot in healing AIDS. I treat many diseases, bad spirits and even problems that people will be having. More especially if for example if you don't make a child and I can make you get a child through giving you medicines. Even when the time for delivering the baby comes, I can see it by throwing the bones. The bones can tell me that the person is left with two or three days to deliver the baby. When a person is wounded, for example being cut by a knife or axe and blood is coming out strongly, I can also stop that blood from coming out unlike sending that person to the hospital to be stitched the place which is wounded. I have to give them the medicine which stops bleeding*".

Participant E enunciated*, "I help my patients and diagnose diseases and all the evil spirits through the use of a mirror. I will show you before you what the mirror is like. It is through the mirror that my ancestors communicate with me. I can see a person who is in Johannesburg through this mirror. I also see a patient before he or she comes here via this mirror. The mirror communicates with me and instructs the types of medicines that I will have to administer to my patients*".

Participant F revealed that **"***It is not easy for me to diagnose AIDS but I do throw bones on the floor. These bones reveal to me the types of disease that a person will be suffering. After knowing the different kinds of diseases that a person is suffering, that is when I can make a decision that, no, I think this person is HIV positive. After I refer them to the hospital. To those who have already been tested at the clinic, I just give them medicine*".

Participant G outlined that, "*I heal AIDS through boiling hot stone from the river. I take big stones from the river and I heat them on fire until them will be red. I take a dish with boiling water, put some herbs and hot stones. I then instruct the patient to put his face and upper body on top of the dish with muti (traditional medicine) and hot stones and cover him or her with a blanket so that he can inhale the steam and release the sweat. The more the person will be sweating that is the more that he or she will be cleansed of the sickness. I cut them all over the body with a razor blade and squeeze some medicine on the cuts so that the medicine can get into their body. After I will give the person traditional medicine to bath and drink. That is how I treat AIDS*".

Participant H stated that "*It is simple for me because I know various herbs that can help to treat HIV/AIDS. The herbs do not necessarily cure the disease totally but they can manage to boost the body to make it strong against many infections. So if a person takes my herbs and also take ARVs they can be very strong and they won't be sick. I can say my herbs and ARVs they help each other to cure AIDS. That is why I recommend my clients to take ARVs*".

Participant I articulates that**, "***Thanks a lot for asking that question. Treating AIDS is my specialty. All the people around here they know that I can treat this disease. You know one thing that you have to understand about AIDS is where it comes from. AIDS is caused by immorality. People these days sleep around. They even have sex even in sacred places and mountains. So, AIDS is a shameful disease that was brought to punish immoral people. Do you know that? Haven't you heard of people who get locked after sleeping with someone's wife? Do Doctors treat that at the hospital? No, they do not treat that but the only option for them is to cut the men's genitals. They cannot even explain it but myself I know how to unlock people who got stuck and I also know how to lock them. I just take an Okapi knife, do my things and lock someone's wife. That is how it's done. So, you see what I mean that traditional healing has power.*

This is the same thing with AIDS. White people believe that it cannot be cured when people like me a traditional healer can cure it. Yes, of course, they cannot treat and remove it from the body because AIDS is not really a disease but a curse to immoral people by ancestors. So, how can you treat a curse with some pills, a big no, you cannot. There is no way you won't win. AIDS needs spiritual treatment and cleaning of the body. It is as simple as that. Firstly when a person with HIV comes to me, they have to first apologize to the ancestors through offering a lamb, a white lamb on that matter to the ancestors. They have to offer a white lamb and money and apologize to the ancestors for their immoral behavior. Thereafter, I go with the person to the river where I perform rituals with the blood of the white lamb. The blood of the white lamb helps with cleansing the person of the virus. We don't eat the meat from the white lamb but we burn it. That is how to cleanse people of HIV. After that, I give them muti (traditional medicine) that that makes the body strong and makes them recover from the sickness. I also protect them from further HIV infection through incisions on their bodies with a razor blade. I know you may not understand some of these things but that is how I treat HIV".

Analysis of participants' responses on how they treat and diagnose HIV/AIDS

The in-depth interviews revealed many methods and process that African healing Practitioners use to diagnose and treat HIV/AIDS. Understanding the methods, processes, and diagnosis of HIV/AIDS helped in getting to understand how people living with HIV/AIDS are influenced and what they go through when they visit a Traditional Health Practitioner (THPs). The participants used different methods, processes, and diagnosis of HIV/AIDS. Of significance is that 7 of the participants indicated that their methods do not completely cure HIV/AIDS but it helps people living with HIV/AIDS to recover. THPs revealed uncertainty that their medicines completely heal HIV/AIDS and acknowledged referring patients to the clinic for further test and they encourage them to take ARVs. This is evidenced by participant H who stated herbs do not necessarily cure the disease totally but they can manage to boost the body to make it strong against many infections as a result if a person takes both traditional herbs and ARVs from the clinic it boosts their immune system against HIV/AIDS.

However, 2 participants revealed that they completely cure HIV/AIDS and they do not even encourage their patients to take ARVs or refer them to the clinic. This is evidenced by participant I who outlined his specialty in treating HIV/AIDS and believes that HIV/AIDS is a curse brought upon on people by the ancestors for their immoral behavior. According to participant I, the treatment of HIV/AIDS lays on spiritual cleansing and healing than any medical treatment. Participants in the interviews revealed many different ways and diagnosis of HIV/AIDS. A total of 6 participants revealed that they make use of throwing bones to diagnose and treat HIV/AIDS. It is through the throwing of bones that they can diagnose and be able to prescribe traditional medicine to give people living with HIV/AIDS. However, they outlined that they encourage and refer people living with HIV/AIDS to go to the clinic for further check-ups. Participant G pronounced that he makes use of a mirror to diagnose HIV/AIDS and to prescribe traditional medicine to people living with HIV/AIDS. Two participants revealed that they make use of rituals to cure HIV/AIDS.

4.3.1.4 What are the advantages of using traditional medicine in treating HIV/AIDS?

Participant A was quoted verbatim, "*There are many advantages that come with traditional medicine than your western medicine. You know we live in the community and we treat in the community and our ancestors have been treating people ever since. They died without knowing clinics. When people are sick they come and consult us before they go to the clinic. Like I said before, when a person comes here, when I see that he or she is HIV positive, I don't tell them but I advise them to go to the clinic for HIV test and come back to tell me the result. In most cases the nurses find them to be HIV/AIDS positive. Besides even if they want to go to the clinic, they first come to me because remember the clinic is far away but as for me, I stay in the community near the people living with HIV who may want help. I receive patients who are very sick in my area. When they knock on my door. I open for them and help them. Imagine if a person gets sick at 11 in the evening, how you will go to the clinic when you do not have the car.*

Remember taxis they stop operating around 7 so how will be the sick person get to the clinic. That means that you would have to hire a person or a taxi to the clinic or hospital which costs a lot of money. Many people have died on their way to a clinic or hospital. Many people have died on their way to the hospital in a wheelbarrow or scotch cart. Do you know a scotch cart? It is a transport used by people in this village when they don't have a car to transport a person to the clinic. Imagine when a person cannot walk and you need to carry them to the hospital. If you don't have a car the only option is a wheelbarrow or scotch cart. So a scotch cart is better but still, you are going to take much time to get to the hospital. So people end up dying on their way to the hospital. So, we traditional healers we help people in the community a lot than what clinics may even do for the community but the problem is that our efforts and works are not recognized. Besides we do not help in the treatment of AIDS only but the treatment of many health problems such as spiritual problems in the community and various other diseases that do not need western medication".

Participant B stated, "*It is good to come to me as a traditional healer because I can be trusted and the people's secrets will be safe. Like is said before that people don't like to go to the clinic for fear of knowing that they are positive, so it is a good thing when they come here because no one can know that they are positive except me. No one can ask them many questions because this is not a public place, unlike the clinic where there is a chance to meet other people in the*

community. They know that going to clinics is like taking chances but here they won't be taking any chances because people won't see them. They can even come here at night and most of the HIV/AIDS patients come at night when its dark and no one will see them. Another advantage is that our traditional herbs help to fight HIV/AIDS infection the same way that ARVs do. That is why I said before that it is good to take both traditional medicine and ARVs. Truth is traditional medicine cannot cure HIV/AIDS but it helps with healing. What traditional medicine cannot heal the ARVs will heal and what ARVs cannot heal, traditional medicine can heal. So that way people living with HIV/AIDS can be safe if they take both.

What you have to know is that ARVs come from traditional medicine but it is just because they are beautified by whites. All the medicine you see come from traditional medicine. So, ARVs and traditional medicines are one and the same thing. It's not poison or holy water that these fake pastors of today use to fake people that they heal AIDS. In your opinion where have you seen water healing a person (laughing) but traditional medicine is there to treat all the diseases and to be processed into beautiful pills that heals different sicknesses. Those who stop taking ARVs, they will be taking chances because I tell them not to stop taking ARVs. The ones who come here, whom I see that they have HIV/AIDS, I refer them to the clinic so that they can be tested since I don't have those things that they use to test HIV/AIDS. I have a book with referral letters that I write for the patients to go to the clinic or hospital with (taking and opening the referral letters). So we need to work together and help each other with the nurses and doctors because traditional medicine is also important. Traditional health it does help to fight infection just like ARVs so they need to take both. Another good thing about traditional medicine is that it is always there.

It can never run out because it is from these natural trees, unlike those pills which they have to put in machines to beautify them. They also buy them from other countries and sometimes they run out of stock. There are many times that people say that the clinic has run out of medicine. I can never run out of traditional medicine. No. There is no traditional healer that can run out of traditional medicine. There is no way one person can finish the whole tree alone. Traditional medicines are God-given gifts which you can have or take at any time and you can also plant them. Another good thing about traditional medicine is that there are no side effects, unlike western medicine. They beautify those pills too much to the extent that they affect people, but why? It is not supposed to be like that. Medicine is supposed to heal and not to make things worse. People complain of headaches, odours and all sort of funny stories that they say about ARVs. It is not the same as traditional medicine. There is no way that it can affect you but it can only heal you because it does not have side effects".

Participant C outlined that, "*I live in a mountain so traditional healing is good because I can heal people who stay around this mountain. Even if they may want to build a clinic around here, it is hard for them because it is a mountain. That is one of the advantages of traditional healing. It is easy for people to come to us and get help. I told you before that nurses are rude. This is unlike us traditional healers. We take care of our patients. Our clients are, our kings. We respect them so much. In fact, that is who we are. Remember we are Africans with Ubuntu. This is something that lacks when it comes to nurses because they are very rude when it comes to treating people and attending to people living with HIV when they go to collect their ARVs pills. It is as if nurses do not have any sense of Ubuntu.*

That is not African. Where I come from, in this community you don't do that. Generally, people no longer have respect, especially the young people of today. When I grew up we were taught that when you meet an elder in the street you must great them and show respect. If he or she is holding something heavy you must help them but this day it's different. It is the same thing with nurses. They must treat their patients with respect. Why were they even doing that job if they knew that they would mistreat patient but for us traditional healers, healing is our thing? Healing is a calling. Healing is a calling to us we don't need to go to school to practice it, unlike nurses who do it for money. The first thing you do is to respect and care for your patients. If you are rude the ancestors won't like it and they will be angry with you".

Participant D stated that "*The good that thing that I have as a traditional healer is that the people trust traditional medicine more than they trust ARVs. It all starts with the trust. I think the reason is that our people are African. They all grew up in these villages. Growing up, they were always given traditional medicine. They always believe in it for treatment of their sicknesses unlike white people's medicines like ARVs. You see. So it is hard for them to believe it. Another problem is that a clinic is a public place and when they go there, Doctors takes their blood for testing. They take people living with HIV's information like names and make them sign some documents yet most of these people don't know how to read or write. All these things make them feel uncomfortable. It is something that we traditional healers don't do. We don't write down our patients names or share their information with anyone. Another thing is that when patients go to the clinic they must wait in long queues and open some fails which is something that as a traditional healer can not do. I don't need a file at all. Everything will be here (pointing in the head)".*

Participant E articulated that, "*Traditional healers assist many people in the community. We are doing the healing which was there a long time ago before even our great, great, great grandparents were born. There were people and there were sicknesses and there was healing. We are doing the healing which is not in a book, which you don't go to be trained by the book. It is a knowledge of our culture and it's been practiced since long, long years ago. It has helped people long, long time ago. Even now it is still helping. This healing is not only about just coming here to drink this medicine. It is also about eating wild fruits and the air which we breathe that comes from the tree. It is part of traditional healing which emphasis that this healing started a long time ago by the unknown and not by the book".*

Participant F expounded**, "***The traditional medicine is better because it is from the trees. When you use traditional medicine, it does not change your body like what ARVs do. Traditional medicine does not have any side effects like having a bad odour or change of the shape of the body. The people who are using traditional medicine than ARVs are better because traditional medicine keeps the body the same not like when a person using ARV*".

Participant G highlighted that "*The use of traditional medicine is good because most of the people who come here, they come from this village. I know them. The people from this area do not have money and they are struggling a lot. They even struggle with transport money to go to the clinic to take pills. The people from around here, I don't charge them a lot of money. I know they are very poor and they cannot afford to pay me a lot of money. All that I want and what makes me happy most is to heal my people. So, sometimes they pay using livestock like goats and chicken. The ones that I charge the standard price of about four hundred Rands are those who come from places that are far like Johannesburg or Kimberly. I get clients all over South Africa. So for people here in the village, I am very cheap and we can always negotiate but for those from far, no, we don't negotiate. I charge four hundred for consultation. Do you know that I can treat cancer but I have heard that treatment of cancer is very expensive in these white hospitals? So many people also come here to be healed of cancer from all over South Africa*".

Participant H stated that "*I think that traditional medicine is good because people naturally love it. It is and it has been part of our lives. I think it is easy for people to accept traditional medicine than western medicine. People accept it more because there are some sicknesses that can only be healed by traditional medicine, for example, if a man sleeps with a woman who has just aborted, he can die if he do not go to the traditional healer for cleansing. You see. Everyone in the community knows that. In a case like that, if a man discovers that he slept with an unclean*

woman, where will he go to seek help first? Does he go to see the Doctor to get pills or he will go to the Traditional healer for cleansing? It's obvious he will come to me and even the community member can advise him to do that. If he do not he will die. We grew up with traditional medicine, in a traditional way so there is nothing foreign about traditional medicine than pills".

Participant, I revealed that "*To be honest with you, there are many beneficial things that emanate from traditional medicine. It may sound crazy but the truth of the matter is that western medicine poses some health problems to the patients. Where do you think diseases like cancer comes from? It comes from the use of western things. Traditional medicine is a hundred percent healthy and good for the body than ARVs. Those things (ARVs) are not good that is why I don't encourage my patients to take ARVs. The problem is that whites they underrate us traditional healers but if they had wisdom, they were supposed to come to me so that I can tell them how I cure HIV/AIDS. There is a lot that they can learn about traditional health that can help them to find a cure in their own western way because on my side, the African way, I am ok because I can cure HIV".*

Analysis of participants' responses on the advantages of using traditional medicine

The response of the participants show that there are many advantages that come with using traditional medicine in treating people living with HIV/AIDS. One of the most prominent advantages of using traditional medicine that came up in the interviews was the lack or absence of side effects. Participants revealed that traditional medicine was very safe to use and people living with HIV/AIDS do not complain about side effects unlike when they take ARVs. Participant B stated that people living with HIV/AIDS of complain of headaches and unusual odours after taking ARVs. The interviews revealed that Traditional Health Practitioners act as the first port of call before people go to the clinic for testing and treatment. When people living with HIV/AIDS feel sick they consult a Traditional Health Practitioner about the nature of their sickness. They first consult Traditional Health Practitioners because they trust and believe that they can heal their sickness. Another reason why they first consult Traditional Health Practitioners is because of their proximity. In some areas, clinics are very far from some villages and transport is expensive for people to go and consult at the clinics. However, Traditional Health Practitioners are located in the remote villages and they are easily accessible at any time of the day given the point that most people living with HIV/AIDS consult at night. Participant A pointed out that people living with HIV/AIDS come to consult him first and he refers them to the clinic for HIV/AIDS. It is encouraging to note that 7 out of 9 Traditional Health Practitioners who participated in the interviews refer to

people living with HIV/AIDS to the clinic for those who do not know their status. To those who know that they are HIV/AIDS, they encourage them to continue taking ARVs and traditional medicine.

Participants of the study revealed that the advantage of using Traditional Health Practitioners was that there is confidentiality and people living with HIV/AIDS are treated better than by nurses on a clinic set up. Participant C revealed that Traditional Health Practitioners have an absence of Ubuntu and treat people living with HIV/AIDS with care, unlike nurses. In the previous section, lack of confidentiality and mistreatment by nurses was cited as one of the major barriers of treatment adherence. Therefore, the advantage of consulting Traditional Health Practitioners is that people living with HIV/AIDS consult them in confidence and at the time that is convenient to them especially at night unlike at clinics where they have to collect ARVs during the day thereby exposing themselves to the public. Furthermore, the advantage of consulting Traditional Health Practitioners is that there are no administrative issues such as waiting in a queue, taking of statistics and the opening of a file. These administration issues make people living with HIV/AIDS uncomfortable. In addition, the advantage of consulting Traditional Healing Practitioners is that it is less expensive and there are no transport costs because the Traditional Health Practitioners lives amongst the community members, unlike clinics which may be far.

Traditional Health Practitioners are less expensive as indicated by Participant G who stated that he accepts livestock such as goats and chickens as forms of payment. Another advantage of traditional medicine is that it helps to fight infections in the bodies of people living with HIV/AIDS. Given their traditional beliefs, they trust traditional medicine over ARVs and it is more acceptable to them than ARVs because they are associated with the western world. Participant H proclaimed people living with HIV/AIDS like traditional medicine because it is part of their lives, legacy and they have been exposed to eat since they were young, unlike ARVs which are foreign to them. Therefore, participants revealed many advantages of Traditional Health Practitioners and traditional medicine which involves the following; lack of side effects, accessibility, the first port of call, referrals to clinics, trust, confidentiality, proximity, less expensive and of administrative issues.

4.3.1.5 What are the disadvantages and challenges of the use of traditional medicine in treating HIV/AIDS?

Participant A stated that "*It is not easy to be a traditional healer in the world that has been hijacked by the white people and their ways. Long back it was easy but now it is difficult. You have to know that most of the people with AIDS first consult from us before they go to the clinic like what I have said before. This means as a traditional healer I have the power to tell them to go to the hospital or not. At least in my case, I tell them to go to the hospital. Imagine when they go to those traditional healers who tell them that they can cure AIDS and they should not go to the hospital. So, you see, we the traditional healers we have power. In a way, we can determine whether a person with AIDS should go to the clinic or not. Most of these people get delayed by their traditional beliefs and traditional healers who tell them that they can cure HIV. In cases like that, you may find that when they go to the hospital, it may be too late and they may die. Their CD4 count would be too low. Traditional medicine can heal but it also has its limit so they must use both to avoid being killed by this disease.*

Another thing is that it is difficult to register with those Traditional healers in Johannesburg. What do they call it (Asking)? Ohh it's a board. So it is difficult to register with them. I have many friends, who failed to register with the board. They always ask for educational certificates which is very hard for many Maines (Traditional Hearth Practitioners). That's just crazy. Although I don't have educational certificates, I was lucky enough to register because I have been trained to conduct circumcisions at the initiation schools. I have a certificate for that. I also have many recommendations. After denying at first they later accepted my certificate and recommendations to register me as a Traditional Health Practitioner. That is how I registered. It was by chance. So imagine another Maine (THP) at my age of seventy-four years being asked to go back to school to get certificates, so that they can be registered?

Chipengo hecho (crazy). A person's life has have been a Maine (THP), well known everywhere and now at an old age being asked an educational certificate it's an insult. No that is just wrong. The government must change that law if they or they call it a bill if they really want us, traditional healers, to be part of it. Traditional healing is not a course you learn in class but it's a calling. We are different from their nurses and doctors that they train to have certificates. We don't need certificates to be a traditional healer. So, these government people must listen to us traditional healers when it comes to the issue of registration. So, this so-called bill about us traditional healers it doesn't work for us. They have to change it so that we can all collaborate to heal the sick people".

Participant B explained that "*God gave us beautiful trees were we get our medicine but the challenge is to make our traditional medicine to be acceptable by the government without also making it have side effects like the ARVs. Our biggest challenge is on how traditional medicine can be accepted without being looked down upon. Western people make their pills from the trees but after processing them it will be hard to see that it comes from the tree. We also need our own African science, so that we can process our traditional medicine in a more standard way so that people can buy it in the shops. This will help to improve our standard and to show the world that we can help in healing HIV/AIDS. So, we lack the science and that science is needed now to move forward because everything is now modern. You see we don't have the machines to test the blood of people with AIDS. So we lack the science. We don't use injections and we make incisions cut by razor blades and the people they criticize us that it is not safe and some say that we are always dirty and not clean.. So those are the things that we need to improve on and prove the world that we can heal better than even the western doctors. Our children and grandchildren are being swallowed by the western way, so with time they will not consult traditional healers but depend on pills only*".

Participant C elucidated that, "*The main challenge that we face is of recognition. They only talk about it but the action is dololo (nothing). I am in Vhembe District Traditional Association but still people they don't give us that much recognition like nurses and doctors have. Why don't they recognize us the same since we also offer healing services to the people in the community? We give health services in remote areas where even the Department of health services can't even reach. Although the government passed the Traditional Practitioners Bill nothing much has been done. It is just a document with little or no implementation at all especially with regards to the treatment of people living with HIV/AIDS. I can write some referral letters for my AIDS patients to go to see the clinic but it doesn't help that much because the doctors and nurses do not say anything in return. To them, we don't exist. They don't see us. The government must do more so that we can be recognized and so that our work can be appreciated. Another thing is we hear that there is a bill about us traditional healers but we are not part of it. We just hear it works shops that there is a bill about us but that bill has not helped us in any way. It seems as if they don't take us seriously. They take us for granted*".

Participant D stated that "*The problem that I have or let me say that we have because I think it applies to all traditional healers, is that misunderstanding and pre-judgment by people. People see us as witchdoctors, which is not right. They think that we are witches when we are not. We are traditional healers and we heal not kill people. This thing about curing HIV/AIDS people don't*

believe it because it is coming from a Traditional doctor. If it was coming from a white man people were going to believe it and even paying a lot of money for it. We cure many diseases but not even a single talk about it in the media. No one at all. All that we hear is that we are witches. My sons and daughters at school are even judged at school that your father is a Traditional healer can you imagine. That is how bad it can be to be a traditional healer but I don't care about that. All that I care about is the patients that I help".

Participant E mentioned, ***"****As I said before that we are doing the healing of our great, great grandfathers that have been passed down to us. Traditional healing is not written in a book. That is the main challenge we have. We do not have a book like Christians who have a bible. Every church that people go they will be reading a bible. They have their own laws and rules that they follow. You must be also a Christian (Laughing). You Christians some of your laws in the bible say that you should not eat pork, some Christians say we go to church on Saturday and some Sunday. So you see, how good it is to have a book that you can look up to or that can guide you. Do you think all those rules will be there if Christians did not have a bible? It helps a lot to have a book. The problem we have is that our knowledge of traditional healing has been passed from one generation to another. Our ancestors speak to us through visions and dreams, so it is very hard to write a book that contains knowledge about traditional healing.*

Another challenge is that although there are many traditional healers, our ancestors are different. How we heal and the methods of healing AIDS are different, so it's very hard and difficult. How can we prove to the world or compete with these whites when we don't have a book written about our methods of healing? If they ask which book are you using and then say, I am using my dreams and vision they will say ni a penga (you are crazy). You see how difficult it is. They believe Christians because at least they have a bible. Our inspiration with Christians is the same because they also have dreams and visions but they have never seen the God that they believe in. They trust their God but if I ask them, have you seen the God that you trust in, the answer is no. So, why do they look down upon us when I say I believe and trust in my ancestors because it is the same thing? This means the biggest challenge is that we do not have a book about traditional healing".

Participant F said that "*People these days they have forgotten about us traditional healers and our importance in the society. People criticize and judge us. They call us Witchdoctors, no, we are not witch doctors but traditional healers. We don't practice witchcraft but we heal. You know, some people think that we are fake when we say that we can help in the healing of HIV/AIDS. I*

think one thing that contributes is that there are many fake pastors who claim that they can heal HIV/AIDS. They claim that they can do many miracles and people believe them. The good thing is that after some time people will know that it is fake. I remember there was a fake prophet who used to make miracle money around Ha-lambani and people rushed to him. He also claimed that he can cure AIDS but after some time people realized that he was fake. He was performing his fake miracles for money and because of that people now think that traditional healers are also fake yet traditional healing has been there before we were born. Traditional healing has been there before the whites came. There is no way we can be fake because we have been healing people different kinds of sickness. We are not after money but after taking care of the sick. People should not judge us and say that we are fake without proof".

Participant G stated that "*The problem that we have is that people criticize the methods that we use about treating people living with HIV/AIDS. I told you that time that I take hot stones put them in hot water with traditional medicine and I ask the patient to put his heard and cover with a blanket so that the heat can get to his face so that he or she can sweat and be cleansed. That is how I do it but people criticize me for that and no one can die from doing that. The people criticize that I cut my patients with a razor blade and put medicine but what is wrong with that. In the hospitals they use injections and for us, we use razor blades. What you have to know is that I am not ignorant. I always keep new razor blades. I don't use one razor blade for many patients. I know that HIV can be transmitted through blood contact so I make sure that I throw away the razor after cutting a patient*".

Participant H stated that **"***There are many tourists that come to my village. Many white people have visited me to ask about the kind of trees that I use to heal AIDS. I remember one of them said that he would want to start a project with me for planting the type's tree around here in Limpopo. After that day he vanished and never came back to me. He took the knowledge of the trees that I use to make my traditional medicine and just vanished. I once attended this other workshop of traditional healers that is when they opened my eyes about the intellectual material staff. I did not know about it and I regret giving him my knowledge. So, I think that is the challenge that we face, that these white people steal our knowledge and we don't get recognition for it*".

Participant I stated that "*The main challenge that we face as traditional healers is that we are criticized a lot. People criticize us. They don't want to accept who were are and if we can cure the disease. I can cure HIV/AIDS. Instead of people learning from me how I cure AIDS, they go around saying bad things about me. They say that I am fake and that misled people. Why not ask the*

people that I have healed so that they can give their testimonies. No. They do not do that at all. All that they are good at, is to criticize me. They say what I do is evil. Tell me, is it evil to heal a person who is HIV. No, it's not evil. Let me tell you something, the people who are evil are those nurses who have a bad attitude towards patients, not us Traditional healers. People must stop with this criticism and appreciate what we do to the sick people".

Analysis of participants' responses to the challenges and disadvantages of using traditional medicine to treat HIV/AIDS

The responses of the participants show that there are many challenges and disadvantages that come with using traditional medicine in treating people living with HIV/AIDS. Given that Traditional Healing Practitioners are the first port of call for people living with HIV/AIDS, the interviews revealed that Traditional Health Practitioners delay people living with HIV/AIDS to sick treatment at the clinic. When the early symptoms show people living with HIV/AIDS first consult traditional healers and they believe that they are healed. It is only when the sickness persists when they consult the clinic. They can also consult the clinic when a traditional healer refers them to the clinic. This is evidenced by Participant A who indicated that he refers to people he suspects to be HIV/AIDS positive to the clinic. However, sometimes it may be too late when the people living with HIV/AIDS goes to the hospital because their CD4 count will be too low.

Another disadvantage of Traditional Practitioners Healing is the unsafe methods they use to treat HIV/AIDS. Traditional Practitioners Healers use a wide range of methods such as boiling medicine, making use of hot stones, immersing patients in water for cleansing and making use of razor blades to cut patients bodies to impart traditional medicine into their bloodstreams as evidenced by Participant G. These unsafe practices may transmit HIV/AIDS to other patients because Traditional Healing Practitioners surgery is not sterilized and there are no hospital standards such as sterilization of razor blades and disposal of used instruments. There is also lack of scientific validity and standardization of traditional medicine as evidence by Participant B who said that Traditional Healing Practitioners need to process their traditional medicine in a more scientific and standard way so that people can buy it in the shops.

Furthermore, the wide acceptance of traditional medicine suffers from lack of documentation. There are many Traditional Health Practitioners with no book or guidelines that stipulate how

HIV/AIDS is healed. Participant E lamented that it is hard to have proper documentation of the healing of HIV/AIDS since the knowledge is passed from one generation to another and they also get the knowledge from dreams and visions which makes it hard to document it and present to the world for standard verifications processes. Of significance was that Traditional Health Practitioners face a challenge of intellectual theft by medical doctors and researches. Participant H revealed an encounter whereby a medical researcher asked about the types of trees that heals HIV/AIDS. The medical researcher duped Participant H into thinking that they would start a tree planting project but never came back after getting the knowledge. Therefore, there is a lack of acknowledgment of Traditional Health Practitioners knowledge with regards to discovering the treatment of HIV/AIDS. Furthermore, the interviews revealed that there is a lack of recognition of the role that Traditional Health Practitioners play in treating HIV/AIDS.

This is evidenced by Participant C who mourned the lack of recognition even though the government passed the Traditional Practitioners Bill. Participants C noted that the Traditional Practitioners Bill lacks implementation because there is still no clearly defined role a Traditional Practitioner can play in the treatment of people living with HIV/AIDS. Furthermore, Traditional Health Practitioners faces a challenge of misinterpretation, prejudice and some people see them as fake. Participant D lamented that some people in the community call them witch doctors and they face a lot of criticism which is not fair on their side because they play a very important role in the society. Therefore, the interviews of the study show that Traditional Health Practitioners faces many challenges in treating people with HIV/AIDS which involves the following, lack of recognition, intellectual theft, lack of scientific validity, misinterpretation, prejudice and lack of proper documentation. Traditional Practitioners disadvantages people living with HIV/AIDS because they delayed them in seeking medical help and they lack safety practices in discharging their treatment methods which may be harmful to their health.

4.3.1.6 What interventions may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence?

Participant A enunciated that, "*People must get lots of information from the media and also through parents at home especially the young people of today. As traditional healers, the government and clinics must involve us in their programs of promoting the use of ARVs. They do HIV/AIDS meetings sometimes around here at the clinic but they do not involve us as a traditional*

healer. It will only be nurses and doctors and they will be busy telling people that don't take medicine from traditional healers. Information should come directly from us traditional healers, sometimes we do have traditional healers who are very, very active and they have their own communities and own clients".

Participant B voiced that, **"***There should be a gathering of people but not the patients who have HIV. It must include all people both with HIV and without. The gathering should announce that we are holding a meeting about health and not saying about HIV. People will go there because everybody is conscious of health. If they call the meeting for people with HIV/AIDS only, they would not come. It will be like exposing them to the public. In this gathering, there should be knowledge share that this virus cannot be treated and go away like what people believe. People must be told that ARVs are important to drink every day. They should know that they must not stop it even if they come to consult us, traditional healers. It must be clear to the general people, including those with HIV/AIDS that traditional medicine does not cure HIV/AIDS*".

Participant C explained that "*I have a book that I write referrals letters of sick people to the hospital. They go with the letter to show the nurses or doctors that my traditional healer has referred me. You know the government must make us agents who refer people with AIDS to the clinic. If it becomes official it will help and also if the nurses acknowledge our letter it would motivate us traditional healers to want to do more and encourage them to go and get tested at the clinic. It will also force those traditional healers who claim to cure AIDS to refer their patients to the clinic. Sometimes the government is reluctant or ignorant because you may find that a person who is HIV infected are not treated in a good way. At times when they go to the clinic to take medication, you find that nurses they discriminate them. Instead of treating them good they don't. To nurses, HIV/AIDS seems to be like an insult disease because patients complain that nurses will be shouting. They will also do awkward things like those who come to take ARV line up this side and that side which is very, very awkward. They must also be treated with care or to be taken to their clinics separately. They didn't choose to have AIDS. Do you choose to be infected by flue? A big no. The same applies, so they must be treated with care because that disease affects everybody. If they are treated with care they would also co-operate and like to drink ARVs. This would improve their chances of taking ARVs*".

Participant D articulated that, **"***I don't want to hide or to keep this as a secret, I have to voice it out. We black people, do not recommend each other or appreciate each other. What we do is to criticize each other. If healers and other people gather together to talk about this disease it will*

help and improve people knowledge. We cannot reach a common understanding, but if we can agree to gather together and talk about this disease, it will help many people. I will also benefit and understand more about the disease because I believe that I can cure AIDs but at the end of the day what I believe in is not important. I may learn one or two things about AIDS that I may not know. What is important is to come together and share our knowledge as one people and one community. The problem is that nowadays young people go to schools. After school, they become educated and start to criticize traditional healing. They say we are educated, we no longer consult the traditional healer and we only go to hospitals and clinic. When they go to the hospital, they get defeated there, then the sickness becomes severe, they turn back to us the healers. They come here at the later stage when the sickness is more severe.

Even the chiefs of today, they are now too modern. These Chiefs have time to go to the church. They say that they have repented and they are Christians now who cannot go to a traditional healer. They say we no longer use traditional medicine because we are church people. That is why the solution will be difficult, it is fortunate to the person who feels that I have a sickness and quickly go to the healer. These are people whom we are able to treat, not those who come when the sickness is still severe. Patients come here and say I have some sore and I am feeling pain here. When we see that this is a sign of that disease, we start treating them. It is a big problem for those who don't come early because the disease will be severe. I will wish if we can gather people together and have a common understanding. If we gather together we may be able to find solutions on the sickness".

Participant E enlightened that, "*It is bad that in sermons pastors are saying that HIV can be healed through miracles. It's boring because people are desperate and they fall for it. Through faith, you are healed ngalutendo (faith). They must have workshops where they teach people. it's better to be taught by a nurse than an ordinary person. The best ways are for workshops so that they can have knowledge about the consequences of not using ARVs*".

Participant F revealed that "*We the healers, we carry that responsibility. If only the patient comes here, I will check on whether the patient is still using ARV or not, if he says that I have stopped, I can encourage the person to continue with ARVs. I usually recommend that when a patient is here, he or she should drink those ARVs after two hours. I will then give the traditional medicine because the body has to accommodate the strength of both medicines but I can only assist a person who comes here. The patient who is outside there I don't have the mandate to go there*

and tell them not to stop taking ARVs. I will have the mandate to advise a person who comes here but we recommend that patients must take ARVs".

Participant G verbalized that, "*I think the government must be honest with people that they are allowed to use both traditional medicine and ARVs. They must spread the information that traditional medicine and ARVs complement each other to avoid confusion. If people know that then they would not stop taking ARVs in favour of traditional healers. All that we hear from the government is that people must take ARVs only not traditional medicine. The government will be trying to act very special yet in reality, traditional medicine is very important as much as the ARVs are important. So that is what I think it must be done*".

Participant H expressed that**, "***There is a need to encourage them to take ARVs and to share information about HIV/AIDS. I learned from the workshop that I attended that knowledge is power. So, there is a need for sharing of information and workshops that involve us, Traditional Healers. The problem is that the government has been excluding traditional healers in these workshops thinking that they can do it alone. No, they cannot do it alone. They also need us the traditional healers because these people don't come from heaven. They did not fall from heaven but they come from the communities. They stay in the communities where traditional healers live. Nurses and doctors stay in the suburbs, they do not stay in our remote villages. So you see that traditional healers are important in sharing knowledge about this HIV*".

Participant I enunciated that, "*I have said it before and to many people that I can treat HIV/AIDS but since the government they like this idea of encouraging people to take ARVs, it is ok. I will co-operate and tell my patients to take them but I know that it won't help much because in the long run they will leave it and take my traditional medicine because the ARVs will not be working for them***".**

Analysis of participants' responses on interventions that may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence

The responses of the participants show that there are many interventions measures that may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence. One of the major intervention measures that came out of the interviews is the need to gather people in the communities teach and share knowledge about the importance of adhering to anti-retroviral treatment. This may help to spread information to the community to people living with HIV/AIDS

and those who are not. The gathering must involve all major health stakeholders such as Traditional Health Practitioners, nurses, and doctors. Participant H pointed out that the weaknesses of the previous gathering in the communities were that it excluded traditional healers. The community gatherings were spearheaded by doctors and nurses and its main emphasis was only on the use of ARVs without acknowledging the existence of traditional medicine. As a result, it alienated people from their dear traditional medicine which they have always believe in since time immemorial. Therefore, the interviews revealed that traditional healers must be at the forefront of community gatherings and workshops that teach people in the community about treatment adherence.

The interviews revealed that the media must be used as a tool to inform the public that Traditional healers advocates for ART adherence and the important role that Traditional Health Practitioners play in treating HIV/AIDS. Participants of the study bemoaned the mistreatment of people living with HIV/AIDS by nurses. Participant C postulated that if nurses change their negative behavior on people living with HIV/AIDS it may have a positive impact on anti-retroviral treatment adherence. Therefore, nurses have an important role to play in influencing and motivate people living with HIV/AIDS directly and indirectly in dealing with people living with HIV/AIDS. The influence of churches was cited as one of the reasons that influence people living with HIV/AIDS. Participants stated that people living with HIV/AIDS may be desperate to the extent that they believe everything that pastors and prophets say such as claiming that they can heal HIV/AIDS. As a result, pastors and prophets must also help in teaching and sharing knowledge about the need for people living with HIV/AIDS to adhere to anti-retroviral treatment. Therefore, the interviews revealed many interventions that include the following; community gatherings, workshops, use of the media, positive attitude of nurses, the positive influence of churches and pastors.

4.3.1.7 What strategies can be used to support anti-retroviral treatment adherence compliance through Traditional healer, allopathic clinicians, and community member partnerships?

Participant A explained that **"***One thing that should happen is that Traditional healers, Doctors, and Nurses must come together. It is possible but the problem is that doctors do not recommend people to go to traditional healers. The doctors always want people to go to clinics and hospitals.*

They do not recommend people to the traditional healers. If there was a recommendation from the doctors and nurses for people to consult traditional healers we would be in collaboration because many patients belong to them. The clinic and the hospitals they belong to the doctors, but you find that the doctors do not tell the patients to go to traditional healers. They say to them, do not go to traditional healers, we are the ones who can cure this sickness. They should be the ones who explain the importance of traditional healing, but they want to own the healing on their own. I remember one day I was having a patient from Tshakhuma, I can't mention the name.

This person was having sores, in the legs which were having water in the legs. It's like the legs were getting rotten, then that person comes to me. He told me that he had already signed at the hospital that they were going to transfer him to Polokwane Mankweng hospital. They were going to remove the legs. He showed the document that he had signed with his signatures for them to cut his legs. He did not want his legs to be cut and that is why he had come to me a traditional healer. He said he was referred to him by another person. I treated the patient's sores until he was completely healed. Then I told him to go to the hospital, to show them that those sore have gone. At the hospital, they looked at him to see whether the sickness is still there or not. It was no longer there, he was completely healed, but the doctors never, never recommend me or call me to ask, what did I do, I have a stamp here I have my book which I write the names of patients, I wrote and explain that this person came when he was about to be taken off legs and they described the nature of the sickness and I healed him. I put all the contacts but until today the hospital never called me. He said there must be a collaboration, between the traditional healers, doctors, and nurses, this is very important because traditional healing if we work with the doctors and nurses we could solve this problem but they don't want. The person who came with the sore had a different sickness and not HIV/AIDS".

Participant B elucidated that**, "***If the people who give ARVs are centred somewhere in the community and it's announced that that's where they can get the medicine people will go there. You must not forget that everybody is looking for and wants good health. People will just go on their own without telling anyone that I am going there. The centre or clinic must be available in the community where people can go there anytime. If they cannot have an HIV/AIDS centre in the community or build more clinics, why not working with traditional healers. They should train us and give the ARVs medication to us traditional healers so that we can give people when they come to consult because we stay in the community. I think that way it can save them a lot and many people will be able to get ARVs without worrying about the long distances to go to the clinic. They will not worry about people seeing them because they can just come to take at any time of*

the day. They should form a forum like we have muhulu (Circumcision for man) there, which is part and parts of our culture. In the past doctors where not there. They were not allowed to go there but only those who have passed through initiation are allowed to go there to assess the situation. So it's not every Doctor who go there. So in circumcision, traditional leaders and doctors are working together to avoid unnecessary death. Even some of the doctors can tell you in private that this disease we cannot do anything about it but just go to a traditional healer they can help you. There must be a forum that should be formed so that people can share knowledge. The forum must involve doctors, nurses and traditional healers on how to destroy the enemy HIV that is killing people. Like I said before, I once heard one of my patients saying that I don't want my CD4 count to be high because the government won't give me the disability grant. So I think that the government must introduce a grant that gives people with high CD4 count money, to encourage them to take ARVs. This will motivate people or else they will continue to stop taking ARVs so that they can have a low CD4 count".

Participant C enlightened that, "*There is nothing so important than people coming together to look for a solution. If all these people gather together, traditional healers come with their opinion on ARVs, people who are not infected come with their ideas, and nurses come with their ideas, doctors with their ideas. I think at the end of the day, including those who are infected with HIV, if all these come together and speak, we can have a solution. We can find a way of fighting this disease. I think us traditional healers we must also try to use and find a way of using things like injections unlike cutting our patients with razor blades. I don't know how but I think it's something that we can do if we exchange ideas and work together with nurses and doctors. They will tell us how they do it so that we can also try it. Nowadays again we also have children who are highly learned they may come up with other technologies that may bring healing. More especially if the government may put an award of finding a cure. People will come forward with solutions. Sometimes people are reluctant because they won't get anything in return".*

Participant D stated, "*Like I have said people, those people you have mentioned they, must come together to find ways of assisting. Personally, I have the cure for healing AIDS but since people, they don't believe, there is no problem. What I can say in response to your question is that these people need to come together and encourage the community, members to take ARVs because they believe that they work. It is their belief so I respect their belief those western doctors. You know, you cannot judge people on their beliefs, so they have to teach people".*

Participant E explained that **"***All the people that you mentioned should gather. People who have HIV/AIDS and those who do not have must be called to the gathering. When they come together with us Traditional healers in front of the Nurses and Doctors should explain to people that when we do traditional healing, we do not stop people from drinking ARVs. We would tell them that the medicine from the tree does not contradict with the ARVs. We tell them that, you can continue both because people will be dying without assistance. People will be suffering without assistance whilst there is assistance in traditional healing, only that it needs the people, doctors, nurses and everybody you mentioned, to gather and call the people so that we can explain traditional healing and that they must not stop taking their pills".*

Participant F stated that **"***Thy must have workshops with traditional healers, they must train us traditional healers so that our things are clean and to make sure that we don't cause harm to patients. I am clean myself but I am saying that because some of my colleagues are not that clean and they can use the same razor blade to cut different patients which is not healthy. They need to also educate and train us about HIV/AIDS so that people will feel free to work with us, traditional healers. Maybe if we become clean even those nurses and doctors who look down at us will be willing to work with us. I don't think that it can be that much difficult or complicated. Isn't it that it is all about giving the ARVs to people? So if they were, to train us, traditional healers, to distribute ARVs in the community, I don't think that it would be difficult. Even to train us on how to test HIV/AIDS, I don't think that we can fail to do that. Is it not that you just take a needle and prick a patient wearing gloves. Our process as traditional healers is even complicated because we use a razor blade to cut a patient all over the body. I don't think those nurses and doctors can be able to do what we do, so why not training us to do what they and share knowledge*".

Participant G said**, "***People need to be encouraged to take ARVs" I think the government must put pressure on us traditional healers to refer patients to the clinic. They must find a way of encouraging us to refer patients to the clinic and encourage them not to stop taking ARVs even after giving them our traditional medicine. One of the things that government can do is to give us traditional healers an incentive so that we can be motivated to refer people to the hospital. Imagine if they can say that if a traditional healer refers to 100 patients to the clinic they can give them R500, many traditional healers would refer patients. It would even be like competition. The problem is that there is no motivation. What's in it for traditional healers to benefit if they refer patients to the clinic? Nothing. You see. Motivation is important. Doctors and nurses do well their job because they are being paid. They get salaries. So, in a way, they must find a way to pay us so that we can refer patients to the hospital and help to fight HIV. There is nothing for mahala*

(free) these days (laughing). I am not lying. If those Doctors and nurses don't get their salaries they strike. They even strike to get some increments. So you see, money is needed to motivate".

Participant H clarified that "*They must all work together; doctors, nurses and traditional healers. They must work together to tell people that they must take ARVs. Through working together people can do more? You know what, working together is a good thing. It is something that even our forefathers taught us and pass on to us. Long back if a community has a problem, all the community members would sit down and find a solution. That is how problems in society must be solved. That means that even with HIV/AIDS all community members, traditional healers, nurses, and doctors must come together, sit together in the community and discuss solutions for drinking ARVs. That way it is easy unlike just to impose that people should use ARVs without first consulting and informing the people. So, coming together is the best strategy to make people use ARVs. I also think that there must be teaching people, you call it what. Yes, I remember, it's called workshops. There must be workshops that teach people so that they will not stop taking ARVs. On top of that, they must advertise of radio and Television that traditional healers are now helping nurses to encourage people taking ARVs. This would help a lot. The media have a big role to play. They must also write it in newspapers. People also read newspapers around here. They must not put traditional healers in newspapers for wrong reasons like muti murders but they also have to put us the real healers for the right reasons for supporting people to take ARVs".*

Participant I stated that "*The best strategy is that government must open to us traditional healers and get our ideas. They must give everyone a chance whether you are a Traditional healer or a Doctor. They don't value us, traditional healers. I say I heal HIV/AIDS but no one cares from the government. They think I am crazy yet I am not. If they don't want to accept other people's ideas, how are they going to find the cure for HIV/AIDS? I know the cure for AIDS. I have it and I am willing to work with the government. I am very open and fair*".

Analysis of participants' responses on strategies that can be used to support anti-retroviral treatment adherence compliance through Traditional healer, allopathic clinicians, and community member partnerships

Participant B suggested forums should be created and modeled in the way that circumcision is done whereby medical doctors visit circumcision schools to help them and monitor hygiene and safety practices. This evidences that it is possible for partnerships and collaboration to take place amongst Traditional healer, allopathic clinicians, and community member partnerships. Through

these partnerships and collaborations, the aforementioned stakeholders can be able to share, information, knowledge and train each other. Participants indicated that one of the challenges and disadvantages of Traditional Health Practitioners is a lack of safety and hygiene. Of significance is that if Traditional healers, allopathic clinicians, and community member make partnerships they can be able to train each other and share the knowledge that can increase anti-retroviral treatment adherence. Participant F stated that it can be a great development if the allopathic clinicians can train them on how to test HIV/AIDS and share knowledge about ARVs and how they should be given to people living with HIV/AIDS. Given that accessibility was cited as one of the barriers to treatment adherence, Traditional Health Practitioners stated that it would be a good strategy if they were to be trained and given responsibility to distribute it to community members when they come to consult. This means that people in remote will be able to access ARVs since they face transport challenges to go to clinics to collect ARVs.

However, for partnership and collaboration to take place, Traditional Health Practitioners revealed that there is a need for full recognition of Traditional Health Practitioners and a clearly well-defined role for them by the Department of Health. Participate C stated that although the Traditional Practitioners Bill was enacted, there is a lack of implementation and Traditional Health Practitioners are still left out. The interviews revealed that giving Traditional Health Practitioners some rewards, financial packages or incentives may strategically motivate them to refer and encourage people living with HIV/AIDS to adhere to treatment. Participant G stated that even though they may want to help the government to encourage people living with HIV/AIDS there is nothing that motivates them to refer patients to the clinic and to make follow up. This means at the end of the day it will be upon the patients' discretion or choice either to go to the clinic or not which can be avoided if Traditional Health Practitioners are given the mandate to instruct people living with HIV/AIDS to go straight to the hospital.

The interviews revealed that there is a need to change the terms and conditions of the Disability grant which can only be accessed by people living with HIV/AIDS who has a low CD4 count. Participant B said that people living with HIV/AIDS stop taking their ARVs to keep their C count at a minimum level to avoid forfeiting their Disability grant. Therefore, participants in the in-depth interviews suggested many strategies to support adherence that includes the following; forming partnerships, partnerships, collaborations, forums, knowledge sharing and training, incentives, and revising of the Disability Grant with regards to people living with HIV/AIDS.

4.3.2 Response of Traditional Health Practitioners in Focus group discussions

This section addresses the responses of Traditional Healing Practitioners in two different focus group discussions. The first group was made up of 5 members and the second group was made up of four members. The purpose of conducting focus group discussions was to solicit more information and observe participant behavior in their respective groups. Unlike, in individual interviews, focus group discussions create a conducive and informal environment for participants to open up about the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa.

The focus group discussions allowed the researcher to explore topics that had appeared in the analysis of the interviews and to illuminate areas that seem yet to have a point of view without consensus. Thus, focus group discussions offered the researcher a perfect platform to explore themes that individual interviews revealed. It enabled the assessment and observation of participants' behavior in their respective groups. As a result, the upcoming questions enquired about the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa.

4.3.2.1 What influence does traditional healing practices have on anti-retroviral treatment adherence?

Group A Discussion

All 5 participants in Group A indicated that THPs has an influence on anti-retroviral treatment adherence of PLWHA in the community because the people in the community look up to them for healing and health advice. The participants in the group indicated that members of the community trust them and believe in what they say since they treat them various sicknesses that they will be suffering including HIV/AIDS. There was a heated debated because 2 participants in the group claimed that he can heal HIV/AIDS out of the 5 members of the group. The other 3 members of the group disagreed with their claim that they can heal HIV/AIDS. 3 participants indicated that they refer and encourage their patients to adhere to anti-retroviral treatment because traditional medicine does not completely cure HIV/AIDS but it complements ARVs. 2 of the participants said that there may be dangers of drinking both traditional medicine and ARVs at the same time. As a

result, they advise their patients to take traditional medicine and ARVs at a different time so that their bodies won't be affected. However, 2 participants revealed that they do not encourage their patients to take ARVs because they can cure HIV/AIDS. Of significance is that the participants admitted and recognized the existence of ARVs. The 2 participants argument was that since they can cure HIV/AIDS there was no need for them to refer or encourage their patients to take ARVs. Therefore, the focus group discussion revealed that traditional healing practices have a direct and indirect influence on anti-retroviral treatment adherence of PLWHA.

Group B Discussion

Participants were eloquent in narrating the influence of traditional healing practices on anti-retroviral treatment adherence of PLWHA. Each participant narrated how important traditional healing has been to people in the community and how traditional healing shapes the beliefs of people in societies. The four group members revealed that they refer and encourage PLWHA to adhere to anti-retroviral treatment and to always go for a medical check-up at the clinics. However, two participants cited that it is difficult sometimes for PLWHA to go to clinics because some of the clinics are far and some of the patients won't be having money for transport. Three participants revealed that PLWHA lack consistency in taking ARVs. The reason being that when their CD4 count becomes high after taking ARVs some believe that they have been completely cured of the virus. This is not true because the virus may be dormant in the body. All the 4 members concurred that it is one of their duties as responsible members of the community to continue encouraging PLWHA to take ARVs. Thus, the focus group discussion revealed that traditional healing practices have a direct and indirect influence on anti-retroviral treatment adherence of PLWHA.

Analysis of responses in focus group discussions concerning the influence that traditional healing practice have on anti-retroviral treatment adherence

The focus group discussions revealed that traditional healing practices have a direct and indirect influence on anti-retroviral treatment adherence of PLWHA. In all 2 groups, participants revealed that THPs influence the beliefs of the people in the community. THPs plays a very important part

in the lives of the community members because they look up to THPs for healing and health advice since traditional healing has been practiced way back before the coming of western medicine. In Group A discussion, 3 out of 5 members indicated that they encourage their patients to adhere to treatment. However, two members in Group A discussion claimed that they can cure HIV/AIDS and that they do not believe in the use of ARVs. As a result, the 2 participants asserted that they do not encourage their PLWHA. On a positive note, all the members in Group B discussions revealed that they encourage their patients to take ARVs. They bemoaned that some PLWHA lacks the consistency of adhering to anti-retroviral treatment because some believe that they would be completely cured of HIV/AIDS when their CD4 count becomes high. Inaccessibility of clinics and lack of transport money was cited as one of the reasons that make PLWHA be inconsistency with anti-retroviral treatment adherence. Nevertheless, all 4 group members concurred that it is their duty as THPs to encourage participants to continue taking treatment. Consequently, the focus group discussions revealed that traditional healing practices, directly and indirectly, influence anti-retroviral treatment adherence of PLWHA.

4.3.2.2 Which socio-cultural and individual factors that influence anti-retroviral treatment adherence?

Group A Discussion

Participants in Group A discussed that culture and religious beliefs were the most common factors that act as the barrier to anti-retroviral treatment adherence. Participants indicated that the majority of the community people are religious and they believe that ARVs do not work. Even though THPs encourage PLWHA to take ARVs, they do not trust them because they believe and trust in traditional medicine. All group members concurred that alcohol abuse is a barrier to anti-retroviral treatment adherence because PLWHA usually forgets to take their ARVs after drinking beer. Group members also said that when PLWHA are drunk they become reckless and sleep around with girls without using protection which spread HIV/AIDS in the villages. Other social-cultural and individual factors that came up in Group A discussions involves the following; fear of being seen at the clinic by a member of the public, mistreatment by nurses, inconveniences, the side effects of ARVs and individual choices by PLWHA and lack of transport to go to the clinic. Thus, Group A discussion came up with many social-cultural and individual factors that are intertwined to act as barriers to anti-retroviral treatment adherence.

Group B Discussion

The side effects of ARVs was the most prominent barrier to anti-retroviral treatment adherence that emerged in Group B discussion. All 4 members took turns to narrate and illustrate the side effects of ARVs on PLWHA bodies. They prided themselves in providing traditional medicine to PLWHA which they claimed that it does not have any side effects on the bodies of patients. Another dominant barrier was the bad attitude of the nurse when they attend to PLWHA at the clinic. All participants indicated that PLWHA dreads to go to the clinic to collect their ARVs because of the mistreatment they suffer in the hands of nurses. All group members indicated that people stop taking ARVs just because they don't trust ARVs and the nature of HIV/AIDS. They don't understand what HIV/AIDS is and why they have to take a bunch of pills every day to survive. They said that some people still believe that HIV/AIDS is a disease of white people only. One group member mentioned that some PLWHA stop taking ARVs for fear of losing their disability grant when the CD4 count is high. Other social-cultural and individual factors that act as barriers to anti-retroviral treatment adherence mentioned in the group discussions comprises of the following; secrecy, confidentiality, alcohol abuse, traditional beliefs, accessibility, inconveniences, transport cost and the stubbornness of PLWHA of not wanting to take ARVs against advice by THP and nurses. This shows that there are many social-cultural and individual factors that act as barriers to anti-retroviral treatment adherence.

Analysis of responses in focus group discussions concerning the social-cultural and individual factors that influence anti-retroviral treatment adherence

The focus group discussions revealed that there are many social-cultural and individual factors that influence anti-retroviral treatment adherence. There were social-cultural and individual factors that came up in both group discussion 1 and group discussion 2 which involves the following, traditional beliefs, clinics being far from the villages, failure to trust ARVs, secrecy, confidentiality, inconveniences, transport cost, personal choices, the side effects caused by ARVs, alcohol abuse, the attitude of nurses and fear of being seen by the public when PLWHA go to collect ARVs from the clinic. In the Group A discussion, the group member raised a concern

that when PLWHA are drunk they become reckless and sleep around with women in the villages. This shows that alcohol abuse acts as a barrier and at the same time it can lead to the spread of HIV/AIDS in the community. There was one factor that emerged in group discussion two only. The barrier was that PLWHA stops taking ARVs because they do not want to lose the money that they get from the Disability Grant if their CD4 count becomes high. Consequently, the Group A discussion and the Group B discussion show that there are many social-cultural and individual factors that act as barriers to anti-retroviral treatment adherence.

4.3.2.3 How do you heal HIV/AIDS-related sicknesses?

Group A discussion

How THP heal HIV/AIDS-related sickness was an interesting and informative question since it gave members in Group A an opportunity to share knowledge about how they treat HIV/AIDS. Three participants in the group revealed that even though they treat HIV/AIDS, they do not completely cure it. Traditional medicine must be complemented by ARVs for the PLWHA to be healthier. Contrastingly, 2 participants revealed that they can completely cure HIV/AIDS and do not recommend their patients to take ARVs. 4 participants revealed that they throw bones to diagnose the sickness of patients, whilst one group members diagnose using visions from their ancestors. The treatment methods group members use involves the following, use of traditional medicine to treat different sicknesses through drinking, bathing, use of hot stones, hot water, cleansing ceremonies and the use of razor blades to insert medicine into the bloodstream. The methods show THP uses many ways of treating HIV/AIDS-related sickness of PLWHA.

Group B discussion

All 4 group members revealed that they treat HIV/AIDS but their methods and traditional medicine has some limitations. The limitation was that it cannot completely cure HIV/AIDS but it is very helpful because it can help critically ill PLWHA to recover very well. Majority of the group member make use of bones to diagnose sickness in PLWHA, whilst one participant makes use of a mirror to diagnose sicknesses. Group members indicated the following methods of treatment, use of

traditional medicine to cleanse and treat PLWHA, cleansing ceremonies such as sacrificing lambs and the use of razor blades to insert medicine into the bloodstream. Therefore, all these methods help in treating PLWHA.

Analysis of responses in focus group discussions concerning how THP heal HIV/AIDS-related sicknesses

Group A and Group B discussion revealed a different kind of methods that THP use to treat HIV/AIDS-related sicknesses. In Group A, 2 participants indicated that they can completely cure HIV/AIDS and do not recommend their patients to take ARVs. Fortuitously, 3 members of the group revealed that they heal HIV/AIDS but they cannot completely cure it, hence they recommend PLWHA to complement traditional medicine and ARVs. In Group B discussion, all the four members concurred that they can heal HIV/AIDS but they cannot completely cure it. As a result, they encourage and recommend their patients to take ARVs. In both groups, the most common method used for diagnosis of HIV/AIDS was throwing of bones. The other diagnosis methods that THP use was making use of the mirror and getting revelations from the ancestors. The healing methods that THPs use comprises of the following; use of traditional medicine to treat different sicknesses through drinking, bathing, use of hot stones, hot water, cleansing ceremonies and the use of razor blades to insert medicine into the bloodstream. Therefore, THPs make use of many different methods of diagnosis and treatment of HIV/AIDS.

4.3.2.4 What are the advantages of using traditional medicine in treating HIV/AIDS?

Group A discussion

Participants in the group managed to come up with many advantages of using traditional medicine in treating HIV/AIDS. All 5 members of the group were delighted to be asked about the advantages of using traditional medicine since it gave them a platform to express the benefits that traditional members have on PLWHA and all the community members. Participants exhibited great pride in being THPs because they are the custodians of African traditional culture that is under threat from modernization and western centred health care systems. All 4 group members concurred

that THPs preserves the local people culture and tradition. Thus, community members and specifically PLWHA they trust traditional medicine over ARVs. There was a big argument with regards to affordability of traditional medicine and how much THPs charge their patients. 3 members said that they accept other forms of payment such as livestock like goats, cows, and chickens because the people in their villages are poor. 2 members said that they charge more than R400 to their patients for their services which is a bit expensive.

However, all the group members concurred that traditional medicine was more affordable than western medication given that there may also be transport costs to go to the clinic when they run out of the ARVs. Group 4 members pointed out that one main advantage of using traditional medicine than western medication is because it does not have side effects. Traditional medicine blends very well with the body of PLWHA, unlike ARVs whereby members took turns to give examples of the effects of ARVs such as change of body shape. Group members said that traditional medicine is accessible than ARVs whereby PLWHA must go to collect from the clinic which may be far away from where they stay. Other advantages of traditional medicine mentioned by THPs includes the following; it helps to treat HIV/AIDS and there are no administrative issues related to it unlike the processes when PLWHA wants to collect ARVs from the clinic. The aforesaid advantages of traditional medicine show that there are many benefits that come with the use of traditional medicine to PLWHA.

Group B discussion

Members in Group B discussion lauded the lack of side effects of traditional medicine as the main advantage of traditional medicine over western medication. They all pointed out that the side effects of ARVs are one of the main reason why they stop using ARVs and chose to use traditional medicine only. All 4 participants indicated that PLWHA takes care of participants better than at the clinic whereby PLWHA are subjected to mistreatment by nurses. The main reason why THPs treat PLWHA better it is because they are guided by the spirit of Ubuntu and they feel that it is their responsibility to take care of the sick members of their communities. Group members felt great pleasure in treating PLWHA because they see it as part of their heritage which has been passed on by their ancestors from one generation to another. Other advantages cited by group members comprise of the following; traditional medicine is accessible and acceptable, there is

confidentiality, THPs acts as the first port of call of PLWHA, THPs act as referrals of PLWHA to the clinic and that traditional medicine is affordable than western medication.

Analysis of responses in focus group discussions concerning the advantages of using traditional medicine in treating HIV/AIDS

Members in Group A and Group B mentioned many advantages of using traditional medicine in treating HIV/AIDS. One major advantage of the use of traditional medicine is that it is not associated with any side effects with regards to the treatment of HIV/AIDS unlike the use of ARVs. The side effects of ARVs are so significant to the extent that some PLWHA stop using them in favour using traditional medicine only. Members in both groups indicated that another prominent advantage of using traditional medicine is that it is part of PLWHA and community member's life since it is part of their heritage. In the communities, there has always been a disease in the past and people have always turned to THPs for traditional medicine to solve their illness. As a result, PLWHA trust and believe in the use of traditional medicine. Other advantages that emerged in group discussions comprises of the following; affordability of traditional medicine, confidentiality accessibility, THP act as the first port of calls and referrals to the clinic, THP treats PLWHA better than nurses and there are no administration issues when it comes distribution of traditional medicine the PLWHA.

4.3.2.5 What are the disadvantages and challenges of the use of traditional medicine in treating HIV/AIDS?

Group A discussion

Members of Group A indicated that there are many disadvantages of using traditional medicine and challenges that are associated with being a THP. All 5 group member's bemoaned the criticism that they receive in the mainstream media and from Christians. Group members indicated that Christians label them as witch doctors which is not fair because they are THP, not witches. They pointed out that it is an insult for them to be called witches when they help community members to treat different ailments. Group members revealed that it is their wish to try to process traditional medicine so that it can be more acceptable and standardize to sell in the

pharmacies but it is difficult for them to do that because they do not have the technology to do it. Furthermore, they acknowledged that there is a lack of documentation and manuals of the use of traditional medicine which makes it difficult for them to prove to the western world that they can heal HIV/AIDS. Members of the group admitted that directly and indirectly, the use of traditional medicine delays PLWHA to seek treatment at the clinic and some of them relax when their CD4 count becomes high. 2 members of the group confessed that they directly delay their patients from getting tested or taking ARVs because they believe that they can cure HIV/AIDS, so according to they don't see the need for their patients to go to the clinic for testing. They would be thinking that they have been cured of HIV/AIDS whilst the virus would just be dormant in their body. Other disadvantages and challenges pointed out by Group A members comprise of the following; lack of safety, lack of recognition, loss of intellectual property rights, misinterpretation and prejudice.

Group B discussion

Group B member indicated that one major challenge that THPs face is lack of recognition by the government. They pointed out that they contribute so much to the health of community members and treatment of HIV/AIDS but up to date there is no proper recognition of THPs by the government. One group member stated that although the Traditional Health Practitioners Bill was passed there has been no proper implementation of the bill by the government. The role of THPs in healing HIV/AIDS has not been clearly defined by the Department of Health. 2 group members stated that that western medical researchers stole their intellectual property and it is a big challenge to them to try to have exclusive rights over traditional medicine property. All the four members of the group admitted that some other THPs lack hygiene and some safety practice standard that is associated with clinics. Other disadvantages and challenges that THPs face involve the following; criticism, misinterpretation, prejudice, delaying of PLWHA to seek treatment, lack of proper documentation and lack of scientific methods to standardize traditional medicine.

Analysis of responses in focus group discussions concerning the disadvantages and challenges of using traditional medicine in treating HIV/AIDS

All focus group discussions mentioned many disadvantages and challenges that THPs face in treating HIV/AIDS. Both group members admitted that the use of traditional medicine, directly and indirectly, delay PLWHA to seek treatment from the clinic since THPs are the first port of call when community members are sick. 2 members from Group A confessed that they delay their patients from going to the clinic to get tested or to take ARVs because they believe that there is no need for that because they can cure HIV/AIDS. Another major challenge that THP members face is lack of recognition by the government and criticism that they face. All group members mentioned that they are misinterpreted and they suffer from prejudice. Other sections of the community such as Christians label them to bewitch doctors, which is not fair since they are THPs who treat members of the community who are sick. Other disadvantages and challenges that they face in treating HIV/AIDS involve the following, lack of proper documentation and HIV/AIDS treatment manuals, lack of scientific methods to standardize traditional medicine, lack of safety and loss of intellectual property rights. Therefore, there are some disadvantages that come with the use of traditional medicines and many challenges that THPs face in treating HIV/AIDS.

4.3.2.6 What interventions may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence?

Group A discussion

All 5 group members suggested many interventions measure that may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence. The group members mentioned that most programs that have been done in past excluded traditional healers yet the majority of PLWHA consult them. The program only involves nurses and doctors which alienated community members. Other intervention measures mentioned in the group comprise workshops that encourage community members not to stop taking ARVs, nurses should treat PLWHA with care, THPs must be encouraged to refer PLWHA to the clinic and that there must be some gatherings in the community that allows information and knowledge sharing with regards to anti-retroviral treatment adherence.

Group B discussion

In Group B discussion, group members indicated that nurses need to change their bad attitudes towards PLWHA to improve treatment adherence. All the group members concurred that nurses have bad behavior towards PLWHA and as a result, some PLWHA dread to go and collect ARVs from the clinic. The group members revealed that there was a need for workshops in the community that provides people with knowledge about ARVs because some PLWHA are just given ARVs by nurses without the proper explanation about the ARVs and the implications of not adhering to treatment. Other intervention measures cited by group member comprises of the following; encouraging THPs to refer PLWHA to the hospital, community gatherings that involve THPs and building of many clinics in the communities so that PLWHA would have easy access to ARVs rather than traveling for long distances.

4.3.2.7 What strategies can be used to support anti-retroviral treatment adherence compliance through Traditional healer, allopathic clinicians, and community member partnerships?

Group A discussion

All the 5 members in Group A concurred that there was a need for collaboration and partnership amongst THPs, allopathic clinicians and community members. If THPs, allopathic clinicians and community member partner together it would create a united front against non-treatment adherence by PLWHA. Another strategy that came out of the discussion is that the government need to recognize THPs and spell out the specific role they should play in improving anti-retroviral treatment adherence of PLWHA. This would give THPs a mandate and motivation to refer PLWHA to the clinic. This would motivate THPs to refer and encourage PLWHA to refer patients to the clinic.

Group B discussion

In Group B discussion, members mentioned many strategies that can be used to support anti-retroviral treatment adherence compliance through THPs, allopathic clinicians and community member partnerships. The group members concurred that THPs, allopathic clinicians and community member must come together and share knowledge on how to improve anti-retroviral treatment adherence. 3 participants suggested that THPs must be trained on how to test HIV/AIDS, safety practices, hygiene, and they should be trained on how to give ARVs to PLWHA since they stay in the community. This would save PLWHA transport cost since THPs lives in the community. PLWHA would not also worry about confidentiality because THPs places are not public places like a clinic where they can be seen by everyone. 1 group member suggested that the government must revise the terms and conditions of the Disability grant because some PLWHA they stop taking ARVs to keep their CD4 count at a minimum level to avoid losing the Disability Grant. Other strategies mentioned include the following: the use of technology to find a cure of HIV/AIDS and recognition of the THPs by the government.

Analysis of responses in focus group discussions concerning the strategies that can be used to support anti-retroviral treatment adherence compliance through Traditional Health Practitioner (THP), allopathic clinicians and community member partnerships

Group A and Group B members mentioned many strategies that can be used to support anti-retroviral treatment adherence compliance through Traditional Health Practitioners, allopathic clinicians and community members. Members in both groups they suggested that collaboration and partnership amongst THPs, allopathic clinicians and community member partnerships were very important in coming up with strategies that may be used to support anti-retroviral treatment adherence. As a result of collaboration and partnership, THPs and allopathic clinicians may help train each other and teach THPs safety practices, how to test HIV/AIDS and how to administer and distribute ARVs in the community. Group members suggested that it can be a good strategy if THPs were allowed to distribute ARVs since they stay in the community where PLWHA live. Other strategies suggested by the two groups comprise of the following; revising of the Disability Grant with regards to PLWHA, promoting the use of technology to find a cure for HIV/AIDS,

recognition of the THPs by the government and their adoption into Department of Health to support anti-retroviral treatment adherence compliance by PLWHA.

4.3.3 Response of key informants concerning the influence of traditional healing practices on anti-retroviral treatment adherence

This section addresses the responses of key informants of the study. The key informants comprise of 2 Traditional Health Practitioners (THPs) from around Vhembe District of Limpopo Province, South Africa.

4.3.3.1 What influence does traditional healing practices have on anti-retroviral treatment adherence?

Key Informant A said, "*I encourage my patients to take ARVs because I don't know it. I don't want to talk about something that I don't know so I encourage patients to take ARVs. What is the mixture of ARVs? I don't know it but they bring it to us because they are undermining our African medicines? It is the same plants that they are bringing to us, as you are doing research now, we give them raw materials and from there they produce some tablets. When they come back to us they are so expensive to us, but if you use that tablet, I don't say that he or she must stop. What I do is only to say don't leave that tablet, use it including my medicine also. My medicine has got my time and scale such as a quarter cup. If it's a full cup it's a full cup, but you see now a person change. The skin is the one which can speak to a person. It shows now that life is coming especially those patients who come to me when they are critically ill".*

Key Informant B expounded that, "*I will talk from experience. I am a healer but I have never treated HIV/AIDS or a patient with that but I have seen my big sister treating them. I have also seen my husband treating them. My big sister was a traditional healer and she passed on two years back. She was in Soweto for many, many years, she used to get patients from Paraganwaka. I saw her when she was treating people but not as a healer but I was just assisting. At home also, they used to visit my husband. They contact my husband. My late brother, also he is a healer, I have a brother who is also HIV/AIDS positive. My brother who is affected by HIV, my late brother used to assist him. He is ok, even though the virus is still there but he is very ok. I*

also have my big sister, who is also HIV. It was very severe but at home they treated her. She is fine even though she lost weight sometimes but she is able to walk. All this stuff about diarrhea and everything has stopped since she started to pay attention to traditional healing. I have seen a lot because I have spent a lot of time with my big sister. When people with HIV/AIDS come she would tell them to continue with their medicine which they get from the hospital, but she would give them her own medicine. I can say that patients have to take both traditional medicine and pills from the hospital to help fight against many diseases that people with AIDS. Traditional medicine helps like I said that my big sister diarrhea stopped when she started to be given traditional medicine at home, so patients must use both".

Analysis of key informants responses on the influence that traditional healing practices have on anti-retroviral treatment adherence

The responses of the 2 key informants show that they encourage and refer PLWHA to the clinic. Of significance was that key informant B was a Traditional Health Practitioner (THPs) but she does not treat HIV/AIDS. However, key informant B has experiences of being around other THPs who treat HIV/AIDS such as her husband and sister. Key informant A indicated that he encourages PLWHA to take ARVs. One of the main reason why the key informant encourages PLWHA to take ARVs is that he is not a medical expert in ARVs. Therefore, it would be unfair to judge or discourage PLWHA from taking ARVs when he doesn't have the full medical knowledge about ARVs. A person should be in a position to judge the merits or demerits of using medicine when they have the full knowledge and facts about it. However, when it comes to traditional medicine, key informant A has expert knowledge about traditional medicine and he uses it to treat HIV/AIDS. Therefore, the responses of the key Informants shows that they both encourage PLWHA to use both ARVs and traditional medicine.

4.3.3.2 Which socio-cultural and individual factors that influence anti-retroviral treatment adherence?

Key informant A said that "*I wouldn't recommend on that because that's western thinking but I will come to it but I would say that to us when we have these patients, firstly I let the patient feel that he or she is going to be cured by your attitude. It helps a lot but if you come here and then I*

start harassing you saying that you are going to die because you are having some TB, gonorrhea what what,…..it's not good. So we don't talk about someone. I should look at you and talk about the disease only. That you are going to be healed. If you believe, that's number one, but if you don't believe I can give then that can be a problem. A patient may not be healed because he or she will be undermining my medicine that saying that I cannot be cured by this tshigomamutanda (witch doctor). We have been called witchdoctors. They call us a lot of names. White people classified us under witchcraft and damage the energy and knowledge of the African people".

Key informant B articulated that, "*They say that when they drink the medicine from the hospital, they don't feel ok. They complain about western medicine a lot. They call it side effects. So, some people stop the medication from the hospital because of the effects of the side effects. My sister recommends them not to stop but when the patients come every time complaining she would end up saying ok it's your choice if you feel that you want to stop just stop it a little bit. To those patients who stop to take ARVs a little bit, they don't feel the side effects. It is only the sickness that you can see that it is still there, but they no longer feel irritated every time. At home, people used to come every day for healing because it is near unlike the clinic which is far because people do not have the money to go there anytime that they want to. Most of them were boys, men, and adults. I remember the other one came with sours like pimples all over and he was not able to stand. He came and sit there (pointing where he was seated). My husband went to boil this thing to give him to drink and also the other medicine he has to wash his body, He went home, another weekend and came back with his parents. The parents were saying that he looks better, but he was complaining about medicine from the hospital. His complaints were that the medicine from the hospital was irritating him a lot. He wanted to stop taking the medicine from the hospital but my husband said that he should continue with it. This is the experience which I saw about the side effects of ARVs.*

I have a brother who comes after me. He was born in 1970 and I was born in 1969, and he was born in 1970. He was not able to share information about his HIV status with anyone. He was working in Johannesburg and he resigned from work. He came back and stay at home. He did not want to tell people about his status until the other day when he called me and told me. He said he went to the clinic and the clinic referred him to the hospital. In Johannesburg, they tested him and found him to be HIV positive. Knowing that he was positive it started to eat him a lot deep inside because he didn't want to tell people. On the day that he called me that is when he told me about the whole story. He told me that he is having this problem and that is why he resigned at work. At home, we were having problems because sometimes he would try to commit suicide

sometimes in the bedroom. He would also drink beer a lot. Most of the time he would come back home drunk and he would say that alcohol helps him to get over his stress. When they would ask him about the problem he would not share. When he told me that he is HIV positive, I told him that he can survive the sickness. He said that he was afraid to tell people at home. Then I said it is ok I will keep your secret. I recommended him to go and chop some barks and also to drink other medicine that my father used to give people who were sick.

Then he said he will try that. I told my big brother that it is a secret and he does not want to share. This is when my brother started to boil him medicine, He said I will just boil medicine and put the other medicine in the soft porridge to give him. He was bothering everybody at home by saying that he no longer eat meat. He said he would want to eat spinach. That was the time of Manto Tshabalala when she talked about beetroot and spinach. That is the sign when we saw that ohhh… he always wants beetroot and spinach. That's the problem. So, he was trying to cure himself and then my little brother started to give him some medicines until he later opened up to my big brother. My brother advised him to go to the hospital to get ARVs but he refused to say that he doesn't trust western medicine. He said he would cure himself with beetroot and the traditional medicine my older brother was giving him. After many months my elder brother managed to convince him to go to the hospital for treatment. At the hospital, they told him that his CD4 count was too low and he needs to take treatment seriously and come for check-ups. They also advised him to apply for a disability grant so that he can have money to take care of himself since he had stopped working. He applied and every month he was getting the grant. It was a lot of money. After taking the medicines for many months, he later went back to the hospital.

At the hospital, they said he is no longer HIV positive and they stopped giving him the disability grant. I don't know if indeed he was no longer HIV/AIDS because I did not see the paper from the hospital. He said the hospital found out that was no longer positive. I have never seen the document but he is fit now. It is unlike before when his secret was eating him inside and he was stressed and thin. He was not taking medication from the hospital before. He only got tested and got angry and come back home from Johannesburg. So, he was not using ARVs but after opening up to my big brother he started to get this treatment. He struggled when it comes to taking the treatment because sometimes when he would go out with friends he would come back late and miss the time to take the pills. I advised him to carry the pills around but he didn't want for fear that people would see him drinking the pills. He was always missing the times of taking his pills, especially on weekends. So he had difficulties with times to drink pills and he was also suffering from the side effects of the pills.

So, what I have seen from these patients is that they complain about the side effects of ARVs. The daughter of my big sister also used to complain about the side effects of ARVs. Every time she takes ARVs, she will be touching herself and screaming. At one time she stopped taking ARVs. My sister tried to force her to drink pills but she refused. Sometimes she would pretend to drink the pills and wash them down the sink when she looks away. I also face the same problem when my children are sick. They don't want to eat food and I force them. Refusing to eat food is better than refusing to take ARVs pills because the person will end up dying. My sister's daughter ended up passing away. People are also afraid of those nurses. They are scared to go and take the ARVs pills from the clinic. My sister's daughter used to say that when she goes to the clinic, those nurses used to ask her funny questions which would make her feel uncomfortable. She said that they were rude. She was also scared that her friends will see her at the clinic taking ARVs and gossip about her. She would wear a hat and sunglasses to disguise herself from the people. You see these young girls with pride.

The other thing which I see is that there is some kind of belief that traditional medicine can kill alone. The reason being those other patients when they come, they want to continue with traditional medicine alone and stop western medicine. They don't have trust in western medicine. They have the belief that this traditional medicine will cure them because these people who come already they are taking treatment from the hospital but they find out that it is not working".

Analysis of key informants responses concerning the social-cultural and individual factors that influence anti-retroviral treatment adherence

Key informant B revealed many social-cultural and individual factors that influence anti-retroviral treatment adherence. The most prominent were the side effects of ARVs. PLWHA complain about the side effects of ARVs and they stop taking them because of the effects. However, of significance was that the THP encourages PLWHA to continue taking ARVs despite the effects of the ARVs. Key informant B revealed that PLWHA has some kind of belief that traditional medicine can cure HIV/AIDS alone. As a result, they stop taking ARVs. Secrecy for fear of stigmatisation and confidentiality acts as a barrier to anti-retroviral treatment adherence. PLWHA are afraid to disclose their status and seek help. They may take time in seeking treatment and sometimes it may be too late for the ARVs to boost the immune system of PLWHA. This is evidenced by the story of key informant B's brother, which she articulately narrated and at least her brother later managed to get treatment before it was too late. Nevertheless, key informant A

indicated that he cannot comment on the social-cultural and individual factors that act as barriers on anti-retroviral treatment adherence because it is western thinking and he doesn't know issues that have to do with western medication. However, key Informant A has knowledge about traditional medicine and the social-cultural and individual factors that act as barriers to traditional healing. Key informant A stated that for a patient to be healed by a Traditional Health Practitioner (THP), they need to have a positive attitude, the THP must approach them in a good way and above all they need to believe in being healed and they do not have to look down upon the THP and not judge, criticize or label them with names such as calling THP *tshigomamutanda* (witch doctor).

4.3.3.3 How do you heal HIV/AIDS-related sicknesses?

Key Informant A stated that "*In our traditional practitioner or healing, what we do we firstly we examine patients with divine eyes…..you cannot just come to me and say that you have HIV or AIDS. I need to divine you, sometimes it can be HIV, and sometimes it can be AIDS. Always when we start we divine to find out what kind of diseases you have. I use bones. When we talk about divine, it's the bones, that's the one which can examine your body or what kind of disease you have. You may be having some TB or other kinds of diseases. This is good so that when I go for medicines, I need to know what kind of medicines I should give you. I don't like to call ourselves traditional healer that's not a nice word. As an African Health Practitioner, firstly we don't just see on your arrival, I have to look on your face, so I can see clearly before divining. On divining a patient, I can see clearly how severe the patient is affected by the disease. When I get there the bones will tell me that you have such a disease. If it's what we call in Tshivenda that Ndongondela, its AIDS.*

Some of us do not like the name because when we say Ndongondela (AIDS), it's a disease which cannot be cured by anything or any medicines. It's a combination of diseases, the TBs are there. Pneumonia is there, diarrhea is there, so many diseases on you. So that is why we call it Ndongondela (AIDS). When a person has HIV, it's would be a minor disease because it can be cured anytime, say for example we find out that you have Gonorrhea, it falls under HIV because it can be cured anytime. I can give you some days so that within 4 to 5 days you will be cured. That is for HIV only and not Ndongondela (AIDS). So it goes according to what kind of HIV you have or you have this what we call Dorobho, which is also a minor Tusula in Venda, You find

these diseases towards the border to Mussina. It's some kind of pimples we call Tusula. So you rub it yourself because it's itchy. So you see a person scratching his body. We also have what we call, Tshimbambaira. We also have diseases like Madhevhu. When a woman has had an abortion and you as a man you sleep with her, we can see on your face here. There is a big vein that comes out, that will show that owila madhevhune (sleeping with a lady who has aborted). Then we have a disease like Tshikuluvimba falls under sexual diseases. Doctors say it's caused by the liver but to us, it's not like that. Maturity of women to give birth its 45 years and going up it's a risk because the blood which gets into your womb it's not going to produce something. It is rotten inside, so your stomach starts to expand and become big. We have Lufiya it's like TB. We also have Pakwani. It falls under TB it is a very strong type of TB. If you don't blow out from the back….now dzitsola passi. Then you may cough for more than 1 hour nonstop. It is one of the most dangerous diseases. All these diseases that I have mentioned. When they come together they find out that the white cells don't have more power to fight with the disease. So, in other words, we say it's Ndongondela (AIDS). It's a combination of diseases".

Key informant B revealed that "*Myself from experience I have seen traditional healers helping a lot of people with HIV. I see them they give them the medicine which is boiled. I am also able to boil that medicine because I used to assist my sister. There are different roots from the forest which they boil. Leaves are also boiled and they put it in a bottle so that the patient can drink the medicine. They recommend that patients must not skip taking the medicine that they give them. They must continue taking the medication. They tell them before they eat and it must vice versa with western medicine. They recommend that they said before you eat first drink the message. There is also the other medicine which we grind, it's the roots and the barks. We grind them to become powder. We would boil that medicine and put them in the bath where these people have to wash their bodies. While they will be washing their bodies with medicine, they recommend that they must not use lotion. They only use that medicine, especially those who are starting to scratch because many of them they start to scratch. Another thing is that they recommend sick patients to have a good diet.*

There is a medicine which they mix with their food to build their immune system. I see it from my big sister who I come after me. She is there at home and very strong, but when she was using the western medication she was not. The other day when we were burying another relative and when we were at the funeral, my other big sister said after we finish this weekend, next weekend we must know that we will burry Alupfani. Everybody said yes, they even removed the hair, but my big brother went there to make mutapu, mutapu is pap, which they put some roots. She was

having a running stomach. They went there after the funeral and force her to eat, then she started to gain energy. She is there now".

Analysis of key informant responses concerning how THP heal HIV/AIDS-related sicknesses

Both key informants revealed many methods that are used by THP heal to HIV/AIDS-related sicknesses of PLWHA. Throwing of bones is the method that key informant A uses to diagnose if whether a patient has HIV or if the HIV has developed into AIDS. Key informant A was very eloquent about the different types of sicknesses that are associated with HIV/AIDS and how he can treat them. Explanation of the methods and the different kinds of sickness that are associated with HIV/AIDS shows that traditional medicine can be used to treat PLWHA. The different kind of medicines heals the following diseases or sickness; madhevhu, dorobho, pakwani, Tshimbambaira, lufiya, and tusula. Of significance was that despite, the alleged success of the methods in treating sickness, Key informant A admits that traditional medicine does not completely cure HIV/AIDS and encourages PLWHA to take ARVs. Key informant B emphasized the importance of diet in recovering of PLWHA. The methods of treatment that she observed and experienced around her involved the following; the use of boiled medicine, roots, drinking medicine and bathing medicine in healing PLWHA. Therefore, the key participants revealed different kinds of methods that are used by THPs to heal PLWHA.

4.3.3.4 What are the advantages of using traditional medicine in treating HIV/AIDS?

Key informant A stated that "*There are many advantages of using traditional medicine. One of the major advantages is that it is very healthy and it does not have any known side effects, unlike western medicine. It is very easy to use and there are very strict conditions associated with it and we can easily get it from the trees. Traditional medicine is part of us the black people. It is part of our culture and our heritage. It is the root of us black people and defines who we are. It teaches us the good things and how to live in the community, how to care and love one another in the community something that you can never find in the western community because there is individualism. That is why you see that how we treat patients is different from how they are treated at the clinic or hospital. The way that patients are treated is inhuman sometimes. I am sorry to*

say that but that is the best word that describes it because why does a nurse have to mistreat a patient who is sick and dying. They mistreat patients and find pleasure in it but with us Traditional Health Practitioners, we are different and we treat patients with dignity.

All those western medicines are new to us the African people. When a person becomes sick they first go to a Traditional Health Practitioner. It is our responsibility to heal the sick in the community. There are those kinds of sicknesses that one does not even need to go to the clinic to consult for example if you have diarrhoea is it necessary to go and consult at the clinic. It is not because I can just give patient muti (traditional medicine) and within a few hours the person will be ok. So imagine the hustle for going to a clinic that is far when a person has diarrhoea (laughing). A person can soil his pants whilst waiting to go to the clinic that is far but if they come to me, I can heal them fast because I stay in the community. Get me right we do not just offer them medicine because they come to us. No. It doesn't end there. The sicknesses that I am able to heal as a Traditional Health Practitioner I hear, but some sicknesses like HIV/AIDS I ask my patients to go to the clinic for testing and to get ARVs. I am well aware that there is HIV/AIDS and my medicines help to heal the different sickness but it can't cure it so I refer them to the clinic for further tests. Like I said that HIV/AIDS is called Ndongondela which means a combination of diseases such as TB's, Pneumonia, etc. So, the benefit of traditional medicine is that it helps in healing all these different kind of disease. It helps to fight all the infections and make the white cells to be strong".

Key informant B had this to say, "*Traditional medicine is assisting a lot. It does not cure completely this sickness but missing verb brings? sick patients to life. It is one of the major advantages of traditional medicine. Another advantage is that people who take ARVs are always complaining about their side effects. I gave you many examples of sick peoples' complaints with regards to the side effects of ARVs. I am not saying this so that people can stop taking ARVs but those are the negative effects of ARVs. So, the advantage of traditional medicine is that traditional medicine does not have any side effects on the body of a sick patient. Another good thing about traditional medicine is that people trust it more than ARVs. People like traditional medicine because they can come and consult at any time. Sick patients are embarrassed and shy to go to the clinic where people can see them. They are also afraid that those nurses may reveal their status to people around here in the community. Another advantage for us traditional healers is that we don't charge a lot of money especially for people in the community here whom we know. You know I can't let my neighbour die because she doesn't have money to pay me. No, we have to help each other*".

Analysis of responses key informants concerning the advantages of using traditional medicine in treating HIV/AIDS

The key informants of the study revealed some advantages with regards to the use of traditional medicine on PLWHA. Both key informant A and key informant B praised traditional medicine for not having any side effects on people living with HIV/AIDS (PLWHA). The reason being that most of the PLWHA complaint to THPs about the negative effects of ARVs on their body. Furthermore, traditional medicine helps to heal different sicknesses that are associated with HIV/AIDS. Key informant B admitted that although traditional medicine does not completely heal HIV/AIDS it helps a lot in healing many sicknesses related to HIV/AIDS. Another advantage of traditional medicine was that it was part of the people culture and heritage. Key informant B indicated that PLWHA trust traditional medicine more than they trust ARVs. Other advantages cited by key informants interviews involves the following; easy to use and accessibility.

4.3.3.5 What are the disadvantages and challenges of the use of traditional medicine in treating HIV/AIDS?

Key informant A was quoted verbatim, "*Like what I have said before one of the major challenges is that people they undermine us and call us Tshigomamutanda (witch doctor). It is very disrespectful. Who is supposed to protect our culture and heritage if our very own black people call us Tshigomamutanda (witch doctor)? The problem was that during apartheid white people classified us under witchcraft because they said they don't believe African traditional beliefs. This took away the confidence that people had in Traditional Health Practitioners. It damaged the energy and knowledge of the African people. That is the main challenge that we have. That is why I founded an organisation called the African Young Eco-Minds Dialogues to work with young people on developing them to have ecological minds and embrace their cultural heritage because it is under siege from the western world. At the end of the day, we may end up not even having a culture and some beliefs, so we really need to embrace our cultural heritage. One thing that you have to know is that there is nothing special about western medication because it comes from traditional medicine. The only difference is that western medication is processed into pills and*

packaged nicely. The main problem is that we lack the technology or science to develop our traditional medicine into those nice pills".

Key informant B said, "*The problem is that some Traditional Health Practitioners claim to cure HIV/AIDS and they discourage people from going to get tested. People trust in us Traditional Health Practitioners, so some end up believing them and they stop taking their pills or refuse to go and get tested. I saw that on my younger brother. He really believed that traditional medicine and following what Mantho Tshabalala was saying about eating beetroot would cure Aids. This made him take a long time before he agreed to go and take treatment from the clinic. That minister who talked about beetroot really fooled people. I am glad that at least my brother he later went to get treatment and that he is still alive.*

People also don't want to disclose that they go to traditional healers. It is because of the religion which is contradictory. The church people say going to traditional healers is evil. They don't promote it, but people need the help of traditional healers. They don't want other people to go. It's a serious thing. It's very, very serious. A person will die, while the traditional healer is there to assist. Another challenge is that people have become too modern and they are destroying heritage sites and places that used to be scared like the Phiphidi waterfall. It is a big problem and a big challenge and it is my job to protect these heritage sites. I have an organisation called Dzomo La Mupo that preserves numerous sacred sites, indigenous forests and nature around Vhembe District of Limpopo province.

Analysis of key informant responses concerning the disadvantages and challenges of using traditional medicine in treating HIV/AIDS

Both key informant A and key informant B indicated that there some disadvantages that come with the use of traditional medicine in treating HIV/AIDS. One of the major challenges is that THPs are looked down upon by the people in the community. Instead of respecting them as the healers and custodians of African traditional culture they are called by derogatory names such as witch doctors. Key informant B indicated that even Christians are one of the groups of the society that criticizes and undermine THPs. Key informant A highlighted that traditional medicine and culture is under attack from modernization. The challenge was that people and including young people are leaving their cultural heritage in favour of western ways of living. To counter this challenge,

key informant A formed an organisation called the African Young Eco-Minds Dialogues to work with young people on developing them to have ecological minds and embrace their cultural heritage. On the other hand, key informant B established an organisation called Dzomo La Mupo that preserves numerous sacred sites, indigenous forests and nature around Vhembe District of Limpopo province. Therefore, the response of the key informants shows that there many challenges concerning traditional medicine. As a result, key informant A and key informant B took it upon themselves to establish organisations that aim to solve the problems that traditional medicine and culture were facing.

4.3.3.6 What interventions may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence?

Key Informant A had this to say, **"***If we connect the people, let people connect to their African culture but if they disconnect you go to the churches and to the funerals, they are talking about a traditional healer nonstop, undermining them that this is not good, There is no luck, there is no what, what, there are so many things which after the burial, an African person is supposed to do but they do not do it anymore. They believe that this is the grace of God which they don't know him. It's the Jewish culture, why you left your culture and follow some other culture, which you don't know, what does it mean to you. If I can ask you the question what is the name of Jesus Christ, define me the name Jesus Christ, you don't know*. *We help these people by referring our patients to the clinic for testing and treatment but they don't recognise us for the help that we will be giving. It demotivates that you refer patients to the clinic and in turn those nurses they will be making fun of us yet we are helping them. It's high time that they must recognise and also refer some patients to us traditional healers*".

Key informant B articulated that, "*Myself I have the experience of many of my relatives coming for curing through traditional medicine because in my family we have lots of people who are affected. I think the advice is for traditional healers to get the knowledge about the sickness because in traditional healing we see sickness as the thing which we can treat with different medicines but not to pay attention to the outcome of it. The traditional healer can also be affected because my aunt was having a daughter, a younger sister to my mother. Her daughter was affected by HIV and she used traditional healers. She denied to wear the glasses and she denied to eat the food the daughter was eating. She always wanted to eat with her and she has passed*

away my younger sister. My aunt now is affected, she is HIV, and she is sick. .So for me when I look at it we need to get serious knowledge about the sickness because when the patient comes there it's not like a hospital. On top of getting the knowledge, Traditional Health Practitioners must take an active part in campaigns in the community to tell people to adhere to treat not excluding them. Isn't it that there is an AIDS activist? So why can't Traditional Health Practitioners be ART adherence activists? They don't want they only want nurses and doctors to talk about HIV/AIDS forgetting that we as traditional healers we stay with these people in the community, so they listen to us, even more than them.

Traditional healers don't want to use gloves. They don't feel comfortable to wear gloves when they treat these people. There is a lot of things that they need to get knowledge about and also the issue of medicine to give patients. I don't know how it is going to happen but we know the impact of the western medicine in the body of a person and also what we are doing is relevant or ok to a person but what I am seeing, I am not seeing the complete cure of healing the people. They still have to continue with the sicknesses. The other thing which is an advantage is that it assists the other way of healing. The people who are infected by HIV, they are free to share their problems with us. They open up and say the truth because the healer also wants to know how you are. They can see from the bones; they can see from vision. They can see a person. Once they open up and say I see this and this the patients would open up and say that I know where I get this. Like I said before, patients complain about the rough that nurses subjects to them. Nurses must be friendly and nice to patients so that they won't be scared to go to the clinic. They must smile all the way to the clinic and not to be sad as if they are going to the funeral.

They can even say I know which women I slept with, they are comfortable. My other advice also is that the people who are HIV in the hospital, I don't think they are getting a good treatment besides the medication that they get. People when they are at that stage they don't want to be closed like here in the room. They want to be outside. They don't want to be alone. They want people. They don't want to be inside closed rooms because it is suffocating. They need fresh air. My uncle was having HIV. I was very close to him. We used to go to visit him with my younger sister and always in the morning she would want to sit outside until sunset. He said I would only go to the room when I want to sleep. He was very strong and he was walking. When he had diarrhoea, he will go to the toilet walking using a stick. When we go to assist him he will deny and say that I will walk on my own but there in the hospital where there is this diarrhoea, they give them this thing to those who are not able to walk. I think it suffocates them, even the smell of their poo, everything".

Analysis of responses of key informants concerning interventions that may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence

The two key informants suggested many intervention measures that may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence. Key informant A stated that there is a need for people to connect to their African culture and people must desist from the habit of undermining and criticizing THPs. Key informant B suggested the following intervention measures; sharing of knowledge, safety practices by Traditional Health Practitioners hygiene and ventilation in the hospitals where PLWHA would be admitted. Therefore, the key informants suggested interventions that may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence.

4.3.3.7 What strategies can be used to support anti-retroviral treatment adherence compliance through Traditional healer, allopathic clinicians, and community member partnerships?

Key Informant A expounded that, **"***I would say that it takes years and years speaking about this. We need to connect, we as African Health Practitioners and the doctors from the hospital and the department of health, we have debated this for many, many years. We don't want to go to the hospital straight, let us work at our home, let us share. If you as a Doctor, if you see that I am not able to cure it, send the person to a traditional healer, and not stay with a person, then that person will end up dying on the bed. Ever since I started working on traditional healing from 1961 until now, I have never killed anyone, some of the people can come here with having a balanced walk, being exhausted, with diseases and we give them African medicines. They get cured but in the hospital, they die every day.*

So, we must work with the department of health. We must share knowledge with Doctors and nurses because if that fellow person he or she dies, he won't come back. He is gone forever. No matter what we can do that person will be gone but who is killing him or her. It's you as a doctor or pastor or bishop who killed the person because you said don't go to a traditional healer. We have been hated for many, many years. We have been trying to convince, the Department of Health that let us work hand in glove. We agreed to work hand in glove with them but we don't

say that we should not go to the hospital because you may find that some of us are not that clean. I have been trying ever since to bring back the mind of the people that they have to connect. We must reclaim our culture because our culture is disappearing. Let us go back, starting with your food. Some would say I don't eat masonja (mopani worms), what's wrong with masonja, because it's a portion of African food? I can't eat this but who said you must not eat it. I can't eat pumpkin and all this. All these food are helping us not to be affected by any diseases.

You know, remember we have some seasons like winter, summer and these other two. There is a need for a joint venture with this government about health. People wouldn't die but people are dying because you point someone with a finger and yet as traditional healers, we don't have a problem with them. Let's say a person has a broken leg of which we do have that medicine. We can join the bones back to be normal but if we don't have the medicine we can send them to the hospital. Let me tell you something very simple. Do you think us as Traditional Health Practitioners would fail to test HIV/AIDS in our healing surgeries or give HIV patients the ARVs when they come to consult if the government can give us the equipment and train us to do that? No, we cannot fail. I don't think that it is very difficult because nurses do that, not because they are too intelligent but because they are trained. So if they train us we can do that. They train us and give us ARVs to give to HIV patients and they can monitor or supervise us through the Department of health. I think it is possible.

It is not that difficult. Another strategy is of media campaigns. You know, all my life as a Traditional Health Practitioners, I have never seen a Traditional Health Practitioner teaching about or promoting testing of HIV/AIDS and adherence to ARVs. Why is it like that because they think we cannot help them or give a bad image to those AIDS activists? It is wrong. They have excluded us in these media campaigns. They must stat to involve us so that the people can also believe that Traditional Health Practitioners are also supporting the use of ARVs not being negative to us.

The rest of the human body we can cure we don't have to worry about ourselves. This is our library, of which even in our awards are here and all the books are here. Some of them we write to them, some it's by other people like Mandela's. Most of the books are related to culture and local tradition and healing. So this is the awards which I won in 2012 from the National Heritage Council. I was the winner in 2012 on organic intellectual. This is the award of Mphatha from United Nations, New York. She got it in 2013. This one is coming from Kenya. It's for Mphatha. I lecture people to install the Domba dance in initiation schools for the girls because I have also been trained by UNESCO, trainer of trainees of the girl's initiation schools. If you can read about this,

here we say reclaiming our root, if you can read about this, you will never go to church anymore. I am telling you. We are not saying you must not go to church, go to the church but if you can see that our root has been cut off.

Another problem is that I feel like, the requirement for Traditional Health Practitioner (THP) is too much to be registered with the board. It was easy for me to register because I have educational qualifications and I am known international but I feel sorry for my other colleagues who are not educated. They are not supposed to ask for that kind of requirements because we are Traditional Health Practitioners and not western professionals. That one alone makes us unique because it's through calling and not how good one is on writing English. They should not measure our standards against the western standards".

Key informant B explained that **"***Both sides the medical and the traditional healer if a patient is taking both medications they must open up. He or she must mention that there is a traditional healer who is treating me when he or she gets the western medication. They must work together on treating that person because if they do not open up there is going to be a problem.*

They should share knowledge about the dosages of the two medicines from traditional healers and from western medication since both medicines will be working on the person's body. At the end of the day, it is all about the health of a patient. I have seen that other people don't disclose that they take traditional medicine. They don't do it. it is difficult for them to disclose. When people come to traditional healers they hide it. They don't even want the community to know that they consult traditional healers. If they go to church, they don't want the church to know that they go for traditional healers. If they go to traditional healers, family members or relatives there are people who cannot share with the family that they go to traditional healers. That's why traditional healing treatment is something very, very private to the patient".

Analysis of responses of key informants concerning the strategies that can be used to support anti-retroviral treatment adherence compliance through Traditional Health Practitioner (THP), allopathic clinicians and community member partnerships

The 2 key informants suggested many strategies that can be used to support anti-retroviral treatment adherence compliance through Traditional Health Practitioner (THPs), allopathic clinicians and community member partnerships. Both key informants suggested that Traditional

Health Practitioner (THPs), allopathic clinicians and community member partnerships must share knowledge and training. Key informant B said that THPs working together with the Department of Health may help to complete each other weakness and reduce the number of deaths in the hospitals since some of the sicknesses THPs can heal them. Key informant B suggested that PLWHA they must be honest and disclose to both THPs and nurses that they make use of traditional medicine because most of PLWHA do not want to disclose. This may enable THPs and nurses to be aware of the different treatment that the patient would be getting and they work together for the betterment of the patient's health.

4.4 Summary

The presentation of demographic information was in table form. Thereafter, the data from interviews, focus group discussions and key informants interviews were presented. Thereafter, data were analysed to explain and interpret it to find meaning in relation to the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo province, South Africa. The study found out that traditional healing, directly and indirectly, influences anti-retroviral treatment adherence of PLWHA. Traditional healing practices have a positive and negative influence on anti-retroviral treatment adherence. The positive influences of traditional healing practices involve the following; encouraging PLWHA to take ARVs, encouraging PLWHA to take both traditional medicine and ARVs, Acknowledging the existence of ARVs, Admitting the lack of scientific machines to detect the HIV/AIDS virus and admitting the limitations of traditional healing practices. The individual and social-cultural factors that influence anti-retroviral treatment adherence involve the following; traditional and cultural beliefs, side effects of ARVs, nurses attitude, inconvenience, lack of transport, personal choices, lack of trust in ARVs and fear to loss Disability Grant. All the aforementioned factors act as barriers to anti-retroviral treatment adherence which consequently influence PLWHA to stop adhering to anti-retroviral treatment.

The Traditional Health Practitioners (THPs) revealed many traditional methods that they use to treat HIV/AIDS which involves the following; diagnosis methods, different types of traditional medicine, the healing process, sacrifices, cleansing processes and the traditional foods that help to fight the HIV/AIDS infections. The study found out about the advantages of using traditional healing practices that comprise the following; acting as the first port of call, accessibility,

confidentiality, helping in fighting against infections, the usefulness of THPs as referrals, respect, and care of PLWHA, preservation of indigenous culture and tradition, inexpensive and acceptable. On the other hand, the study found out that there are many disadvantages and challenges that come with the use of traditional healing practises that includes the following; delaying PLWHA to go to clinic, misinterpretation and prejudice, lack of safety practices and hygiene, lack of scientific validity and standardization, lack of documentation, lack of recognition, criticism and being under threat from modernization.

Participants of the study suggested many intervention measures that may help to improve anti-retroviral treatment adherence that comprises of the following; use of THPs to advocate for treatment adherence, use of THPs as referrals of PLWHA to the clinic, use of community gatherings to share knowledge and urged nurses to treat PLWHA with care and respect. The in-depth interviews, focus group discussions and key informant interviews revealed and suggested strategies that can be used to support anti-retroviral treatment adherence compliance which involves the following; collaboration, accessibility, the formation of forums, training of THPs, taught safety practices and hygiene, incentive and revision of the Disability grant by the government.

CHAPTER 5

DISCUSSIONS OF THE FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

This study sought to explore the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa. In this chapter, discussion of results, recommendations and conclusions are drawn from the study on the influence of traditional healing practices on anti-retroviral treatment adherence. The findings are discussed in line with the study's 4 research questions. The first question was about the influence that traditional healing practices have on anti-retroviral treatment adherence. The second question was about the social-cultural and individual factors that influence anti-retroviral treatment adherence. The third question was about the interventions that may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence. The last question was about the strategies that can be used to support anti-retroviral treatment adherence compliance through Traditional Health Practitioners (THPs), allopathic clinicians and community member partnerships. The findings presented in the previous chapter anchors the discussion of the findings in the present chapter. The researcher describes the findings and links them with the reviewed literature. In addition, the recommendations on the intervention measures and strategies that may be used to support anti-retroviral treatment adherence and compliance of PLWHA in the Vhembe District of Limpopo Province, South Africa, are made.

5.2 Overview of the study

The aim of the study was to investigate the influence of traditional healing practices on anti-retroviral treatment adherence in Vhembe District of Limpopo Province, South Africa. As a result, this study had 4 objectives. Literature was reviewed in Chapter two and formed the theoretical framework of the research. The theoretical framework of this study was based on the Health Belief Model (HBM). The Health Belief Model (HBM) helps in predicting the beliefs and perceptions of an individual who believes that HIV/AIDS is severe, sees more benefits of taking ARVs than

barriers than the barriers that are associated with it. As a result, the individual may have more confidence in taking ARVs even in difficult situations to avoid the severity of HIV/AIDS.

The study was qualitative in nature. The researcher drew a cross-sectional snowball sample of 2 participants from 3 municipalities of Vhembe District of Limpopo province and 3 participants from the biggest municipality in the Vhembe District called Thulamela, to make a total sample size of 9 participants of the study. The reason for choosing three participants from Thulamela municipality was because it is the biggest municipality in the Vhembe District of Limpopo Province, South Africa. The 9 participants of the study enabled the attainment of data saturation across all the four municipalities of Vhembe District of Limpopo Province in the interviews and 2 focus group discussions. In addition, two prominent Traditional Health Practitioners (THPs) from African Young Eco-Minds Dialogues (AFYEMD) and Dzomo La Mupo organisation, were chosen for interviews as key informants of the study. Therefore, the data collection methods were; in-depth interviews, focus group discussions and key informant interviews. The researcher used Van Manen method to analyse the data in Chapter 4.

5.3 Overview of the study findings

Traditional healing practices have a positive and negative influence on anti-retroviral treatment adherence. The positive influences of traditional healing practices involve the following; encouraging PLWHA to take ARVs, encouraging PLWHA to take both traditional medicine and ARVs, acknowledging the existence of ARVs, admitting the lack of scientific machines to detect the HIV/AIDS virus and admitting the limitations of traditional healing practices. On the other hand, traditional healing practices negatively influence anti-retroviral treatment adherence because of the followings reasons; discouraging PLWHA from taking ARVs, encouraging PLWHA to take traditional medicine only, Traditional Health Practitioners (THPs) claim to cure HIV/AIDS, Ignorance on lack of scientific machines to detect the HIV/AIDS virus and failure to admit on the limitations of traditional healing practices.

PLWHA to take ARVs, to take both traditional or to stop taking ARVs. All the nine participants who participated in the study admitted and acknowledged the co-existence existence of ARVs and traditional healing practices in the community and how it positively and negatively influence treatment adherence of PLWHA. The study found out that the negative influence of traditional healing practices is determined by the individual and social-cultural that exist in the community.

These individual and social-cultural factors that influence anti-retroviral treatment adherence. The individual and social-cultural factors that influence anti-retroviral treatment adherence involve the following; traditional and cultural beliefs, side effects of ARVs, nurses attitude, inconvenience, lack of transport, personal choices, lack of trust in ARVs and fear to lose the Disability Grant. All the aforementioned factors act as barriers to anti-retroviral treatment adherence which consequently influence PLWHA to stop adhering to anti-retroviral treatment.

The Traditional Health Practitioners (THPs) revealed many traditional methods that they use to treat HIV/AIDS which involves the following; diagnosis methods, different types of traditional medicine, the healing process, sacrifices, cleansing processes and the traditional foods that help to fight the HIV/AIDS infections. The study found out about the advantages of using traditional healing practices that comprise the following; acting as the first port of call, accessibility, confidentiality, helping in fighting against infections, the usefulness of THPs as referrals, respect, and care of PLWHA, preservation of indigenous culture and tradition, inexpensive and acceptable. On the other hand, the study found out that there are many disadvantages and challenges that come with the use of traditional healing practices that include the following; delaying PLWHA to go to clinic, misinterpretation and prejudice, lack of safety practices and hygiene, lack of scientific validity and standardisation, lack of documentation, lack of recognition, criticism and being under threat from modernisation.

Participants of the study suggested many intervention measures that may help to improve anti-retroviral treatment adherence that comprises of the following; use of THPs to advocate for anti-retroviral treatment adherence, use of THPs as referrals of PLWHA to the clinic, use of community gatherings to share knowledge and urged nurses to treat PLWHA with respect. The in-depth interviews, focus group discussions and key informant interviews suggested strategies that can be used to support anti-retroviral treatment adherence compliance which involves the following; collaboration, accessibility, formation of forums, proper Implementation THP Bill, training of THPs, taught safety practices and hygiene, incentive and revision of the Disability grant by the government. The health belief model (HBM) anchors study findings. The Health Belief Model (HBM) helps in predicting the beliefs and perceptions of an individual who believes that HIV/AIDS is severe, sees more benefits of adhering to ART than barriers than the barriers that are associated with it. The upcoming Table 5.1 shows the questions asked from participants, themes, and subthemes that emerged from the inputs of participants and from data analysis.

Figure 5.1 Overview of findings of the study

Research Question	Themes	Sub-themes
1. What influence does traditional healing practices have on anti-retroviral treatment adherence?	Positive Influence of traditional healing practices	• Encouraging PLWHA to take ARVs • Encouraging PLWHA to take both medications • Acknowledge the existence of ARVs • Admitting the limitations of traditional medicine • Admitting the lack of scientific machines to detect the HIV/AIDS virus
	Negative Influence of traditional healing practices	• Discouraging PLWHA from taking ARVs • THPs claim to cure HIV/AIDS • Ignorance on the existence of HIV/AIDS • Failure to admit the limitations of traditional healing practices.
2. Which socio-cultural and individual factors that influence anti-retroviral treatment adherence?	Barriers on anti-retroviral treatment adherence	• Traditional and cultural beliefs • Religious beliefs • Side effects of ARVs • Nurses attitude

		• Inconvenience • Lack of transport and accessibility • Personal choices • Alcohol abuse • Lack of trust in ARVs • Loss of Disability Grant
3. How do you heal HIV/AIDS-related sicknesses?	Healing Methods of HIV/AIDS	• Diagnosis methods • Different types of traditional medicine • Healing and cleansing process
4. What are the advantages of using traditional medicine in treating HIV/AIDS?	Advantages of using traditional medicine	• First port of call • Accessibility and confidentiality • Helps in fighting against infections • Absence of Side effects • The usefulness of THPs as referrals • Respect and care of PLWHA • Preserves indigenous culture and tradition • Inexpensive and acceptable
5. What are the disadvantages and challenges of the use of traditional medicine in treating HIV/AIDS?	Disadvantages and challenges of using traditional medicine	• Delay PLWHA to go to the clinic • Lack of safety practices and scientific validity • Lack of recognition and documentation • Criticism, Misinterpretation, and Prejudice • Intellectual property theft and the threat from modernization

6. What interventions may help to improve the knowledge and practices with regards to anti-retroviral treatment adherence?	Intervention measures that improve anti-retroviral treatment adherence	• ARVs use advocating by THPs • THPs referrals of PLWHA to the clinic • Community gatherings to share knowledge • Nurses must treat PLWHA with respect
7. What strategies can be used to support anti-retroviral treatment adherence compliance through Traditional healer, allopathic clinicians, and community member partnerships?	Strategies that support anti-retroviral treatment adherence	• Collaboration and formation of forums • Accessibility • Training of THPs and Proper Implementation THP Bill • Taught safety practices and hygiene • Revision of the Disability grant

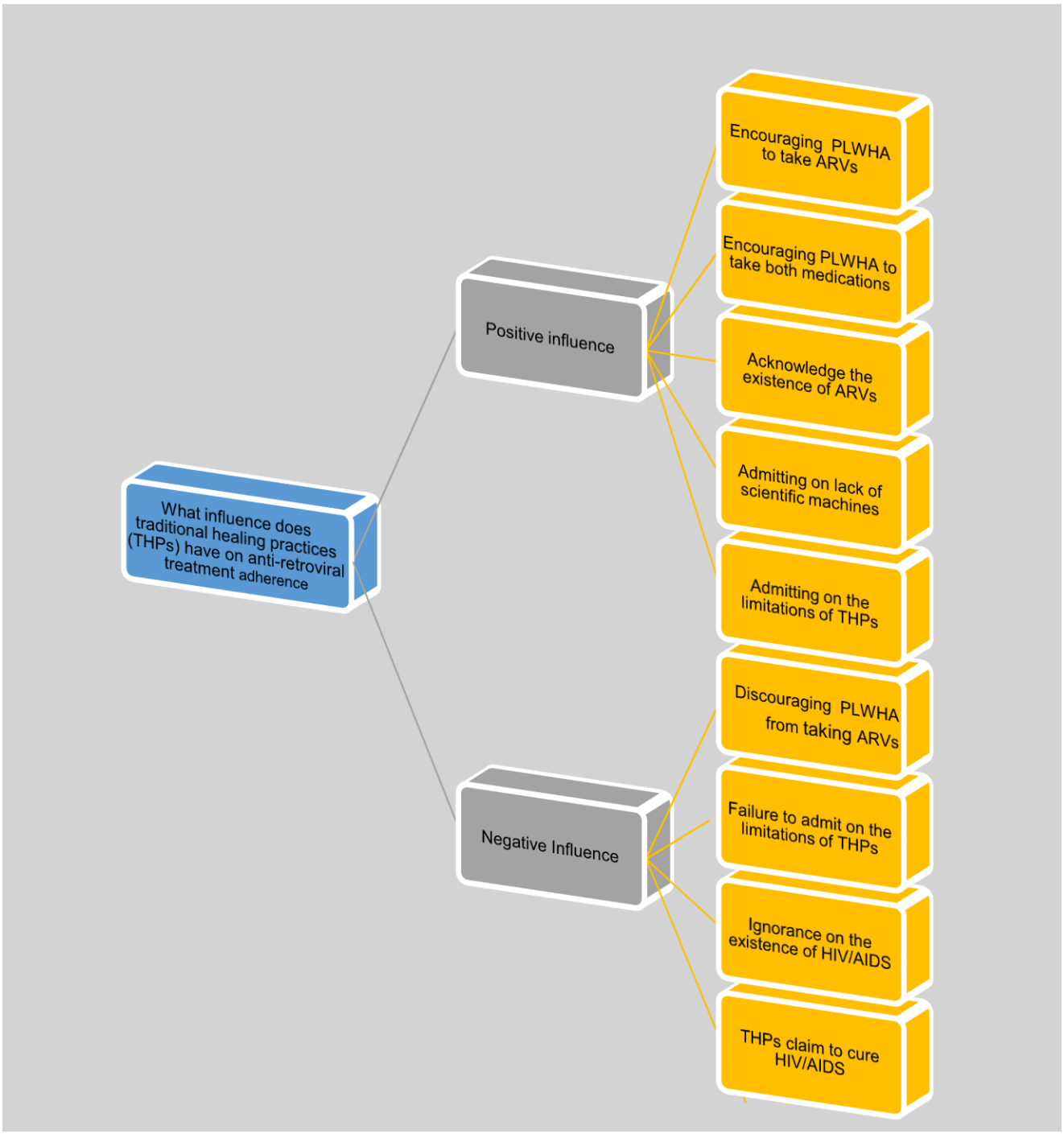
5.4 Discussion of study findings

In this section, the researcher deliberates the findings of the study presented in Chapter 4. The findings were derived from inputs of nine Traditional Health Practitioners (THPs), two focus group discussions and two key informant's interviews with two prominent Traditional Health Practitioners (THPs) from African Young Eco-Minds Dialogues (AFYEMD) and Dzomo La Mupo organisation. The researcher links the findings of the study with reviewed literature in the upcoming sections.

5.4 1 Influence of traditional healing practices on anti-retroviral treatment adherence

The study found out that traditional healing practices have a positive and negative influence on anti-retroviral treatment adherence. Figure 5.2 below, illustrate the positive and negative influence of traditional healing practices.

Figure 5.2 Influence of traditional healing practices on anti-retroviral treatment adherence



5.4.1.1 Positive Influence

Contrary to western popular belief that traditional healing practices have a negative influence on anti-retroviral treatment adherence (Barret, 2014), the study found out that there are some positive influences that are associated with traditional healing practices in the Vhembe District of Limpopo Province of South Africa. The positive influence factors involve the following; encouraging PLWHA to take ARVs, encouraging PLWHA to take both medications, acknowledge the existence of ARVs, admitting on the lack of scientific machines to detect the HIV/AIDS virus and admitting the limitations of traditional medicine. All the aforementioned factors influence Traditional Health Practitioners (THPs) to refer PLWHA to the clinic and encourage them to adhere to ART. The positive influences shall be separately discussed in the upcoming sections starting with encouraging of PLWHA to take ARVs by Traditional Health Practitioners (THPs).

5.4.1.1.1 Encouraging PLWHA to take ARVs

As shown in Figure 1.2, traditional healing practices encourage PLWHA to take ARVs. 7 out of 9 participants of the study revealed that they encourage PLWHA to take ARVs. Traditional Health Practitioners (THPs) encourage PLWHA to take ARVs from the clinic. One of the main reason why they encourage people to take ARVs it was because of failure to adhere to ART results in death. This shows that THPs have knowledge about the value of testing and the consequences that come from non-adherence. The same sentiments were shared in focus group discussions. In Group A, 3 participants revealed that they encourage people living with HIV/AIDS (PLWHA) to go and get tested, whilst 2 participants in Group A claimed that they can cure HIV/AIDS. As a result, they do not encourage their patients to go to the clinic for testing or to adhere to anti-retroviral treatment. In Group B, all 4 participants revealed that they encourage their clients to go for HIV/AIDS testing at the clinic and they encourage them to adhere to anti-retroviral treatment. Thus, the majority in focus group discussions revealed that they encourage their patients to go for HIV/AIDS and to adhere to anti-retroviral treatment.

Similarly, the key informants of the study revealed that they encourage their clients to adhere to anti-retroviral treatment and to go to the clinic for HIV/AIDS testing. People living with HIV/AIDS (PLWHA) are encouraged to take ARVs because key informant A does not have expertise in ARVs to stop them from taking it. Given the lack of expertise in ARVs, key informant B cannot judge ARVs but can only comment about traditional healing practice since it's his field of expertise.

Thus, key informant A encourages patients to take ARVs and the traditional medicine that he is familiar with. Nevertheless, key informant A believes that ARVs and traditional medicine are both the same because they come from plants but the only difference is that ARVs are purified into tablets which unfairly makes people perceive them as more superior than traditional medicine. That being so, a triangulation of in-depth interviews, focus group discussions and key informants interviews show that Traditional Health Practitioners (THPs) encourages People living with HIV/AIDS to take ARVs.

The findings of this study are in support of Wanger and Audet (2018) assertion that Traditional Health Practitioners (THPs) refer their patients for HIV testing at public health facilities and encourage them to adhere to ART. Although Traditional Health practitioners (THPs) heal HIV/AIDS and the associated opportunistic infections, Wanger and Audet (2018) note THPs are well aware that they cannot cure HIV/AIDS hence they encourage patients to adhere to anti-retroviral treatment and to go to the clinic for testing. This shows that Traditional Health Practitioners have knowledge about ART adherence and the consequences of non-adherence. Remarkably is that the theoretical framework of this study was based on the Health Belief Model (HBM). The Health Belief Model postulate that perceived severity and susceptibility to illness or health problem motivates an individual to take cues of action to get the perceived benefits of the health practice and avoid the consequences.

Applying the HBM to the context of this study, shows that Traditional Health Practitioners (THPs) encourage PLWHA to take ARVs because they know that if they stop taking ARVs it may lead to serious consequences such as death as indicated by participant G. As a result, Traditional Health Practitioners' (THPs) knowledge that their patients may die from non-adherence treatment motivates them to encourage their patients to continue taking ARVs. This is in line with the Health Belief Model. Therefore, the Health Belief Model forms the theoretical framework of this study. That being so, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that Traditional Health Practitioners positively influence and encourage PLWHA to adhere to anti-retroviral treatment and to go to the clinic for HIV/AIDS testing.

5.4.1.1.2 Encouraging PLWHA to take both medications

The study found out that Traditional Health Practitioners (THPs) encourage people living with HIV/AIDS (PLWHA) to take both traditional medicine and Anti-retroviral drugs (ARVs). Traditional Health Practitioners (THPs) believe that PLWHA must use both ARVs and traditional medicine. THP admits that traditional medicine on its own cannot cure HIV/AIDS but it needs to be supplemented by ARVs and vice –versa. In focus group discussions, 3 out of 5 participants said that they encourage their patients to take both ARVs and traditional medicine at different times. Also, the other two participants believe that they can cure HIV/AIDS and do not encourage their patients to take ARVs.

In Group B, all 4 participants indicated that they encourage their patients to take ARVs because traditional medicine alone cannot heal HIV/AIDS but it needs to be supplemented by ARVs. This shows that the majority of members in focus group discussions, encourage people living with HIV/AIDS to take both medications. Likewise, the key informants of the study encourage PLWHA to take both medications to heal and fight against opportunistic infections. Traditional Health Practitioners (THPs) influence and encourages their patients to take traditional medicine and ARVs to heal and fight HIV/AIDS-related sicknesses. Given that Traditional Health Practitioners (THPs) encourage patients to take both, it evidences that THPs knows that traditional healing practices cannot sorely heal HIV/AIDS without assistance from ARVs. As a result, THPs influence and encourage their patients to adhere to anti-retroviral treatment in sync with traditional medicine. Thus, a triangulation of in-depth interviews, focus group discussions and key informants interviews show that Traditional Health Practitioners (THPs) encourage PLWHA to take both ARVs and traditional medicine.

The findings of this study concur with Wanger and Audet (2018) who notes that Traditional Health Practitioners (THPs) and health professionals such as nurses often treat patients concurrently. People living with HIV/AIDS (PLWHA) choose to use one or the other or both THP and Health professionals. This leads to a “ping-pong” effect of patients moving between traditional healers and health care facilities. Wanger and Audet (2018) conclude that it results in a “ping-pong” effect of PLWHA moving between Traditional Health Practitioners (THPs) and clinics. Therefore, The ping pong effect in the context of this study means that PLWHA going to both Traditional Healing Practitioners (THPs) and health professionals which results in moving back and forth between both in search of treatment. Nevertheless, Cingolani and Antinori (2009) found out that there are dangers in using traditional medicine and ART concurrently. Traditional Health Practitioners

(THPs) are also aware that drinking traditional medicine and ARVs at the same time may be harmful to the body of PLWHA. Participant E compared taking traditional medicine and ARVs at the same time to mixing water and oil which may be incompatible.

Therefore, the findings of this study support Cingolani and Antinori (2009) assertion that there are harmful consequences that are associated with taking traditional medicine and ART concurrently. However, Wanger and Audet (2018) argue that the dangers of taking traditional medicine and ART concurrently are not yet scientifically proven and it may depend from one individual to another. Despite the fact that the harmful effects of concurrently taking traditional medicine and ARVs are not scientifically proven, Traditional Health Practitioners (THPs) must be very careful and cautious when administering traditional medicine to PLWHA on treatment to avoid the consequences that may arise from using both traditional medicine and ARVs at the same time. Conclusively, the study through a triangulation of in-depth interviews, in-depth interviews and focus group discussions, found out that Traditional Health Practitioners (THPs) influence and encourage people living with HIV/AIDS (PLWHA) to take both traditional medicine and ARVs to treat HIV/AIDS.

5.4.1.1.3 Acknowledge the existence of ARVs

All 9 participants of the study acknowledged the existence of HIV/AIDS but a minority of 2 out of the 9 participants claimed that they can cure HIV/AIDS and do not encourage their patients to take ARVs. However, Of significance is that the majority of 7 out of 9 participants admit that they cannot cure HIV/AIDS and they encourage their patients to adhere to anti-retroviral treatment. Majority of participants have knowledge about ARVs and they encourage and influence PLWHA to adhere to anti-retroviral treatment. They admit that traditional healing practices on its own cannot cure HIV/AIDS but it can help ARVs to fight infections in PLWHA. The same sentiments were shared in focus group discussions. In Group A all 5 members acknowledged the existence of ARVs but 2 participants said that despite the existence of ARVs, they believe they can cure HIV/AIDS and they do not encourage their patients to adhere to anti-retroviral treatment.

In Group B, 4 group members acknowledge the existence and usefulness of ARVs and they indicated that they encourage their patients to adhere to ART and influence them to go and get tested at the clinic. Similarly, key informants acknowledged the existence of ARVs and they both encourage their patients to get tested and adhere to anti-retroviral treatment. Thus, the study

through a triangulation of in-depth interviews, focus group discussions and key informant interviews show that Traditional Healing Practitioners (THPs) acknowledge the existence and usefulness of ARVs in treating HIV/AIDS. The findings of this study support a quantitative cross-sectional study of 186 THPs by Gavin, Chitindingu, and Gow (2013) in rural Northern Cape Province of South Africa. The study found out that 61% of THPs agreed that they have knowledge about ARVs and the participants outlined that HIV can become resistant if ART medication doses are missed by PLWHA. Thus, THPs with knowledge about ARVs influence PLWHA to take ARVs as indicated by Participant H, unlike THPs who are ignorant about ARVs effectiveness in treating HIV/AIDS. To a lesser extent, only 2 participants out of 9 participants believed that traditional healing practices can exclusively cure HIV/AIDS. Participant D and Participant I believe that they have the supernatural powers to cure HIV/AIDS and they do not encourage their patients to take ARVs. Nevertheless, the majority of the participant's acknowledged the existence of ARVs and their knowledge about ARVs helps in influencing PLWHA to adhere to anti-retroviral treatment. That being the case, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that the majority of THPs admit that traditional healing practices cannot singularly cure HIV/AIDS and they influence their patients to take ARVs and to go for HIV/AIDS testing at the local clinics.

5.4.1.1.4 Acknowledging the lack of scientific devices to detect the HIV/AIDS virus

The in-depth interviews, focus group discussions and key informants interviews revealed that Traditional Health Practitioners admitted to lack scientific machines to detect the HIV/AIDS virus in people living with HIV/AIDS (PLWHA). As a result, they refer PLWHA to health professionals for diagnosis and management of the HIV virus. Traditional healing practices lack the scientific expertise to diagnose, manage and monitor the HIV virus. In focus group discussion, all group members of Group A and Group B admitted that they do not have the necessary technology to test HIV/AIDS but they use their own traditional diagnosis practices such as the throwing of bones, visions, and checking of physical signs.

Given the lack of scientific devices to check HIV/AIDS, 3 members in Group A indicated that they refer their clients to the clinic for further testing , whilst the other 2 members revealed that they do not refer their patients because, despite the lack of technology to test HIV/AIDS, they cure HIV/AIDS, hence there is no need for them to refer their patients to the clinic. In Group B, all 4 participants indicated that they lack the technology to test HIV/AIDS and consequently they refer

their patients to the clinic for further testing. Likewise, the key informants revealed that they do not have the devices to test HIV/AIDS or the knowledge on how they test HIV/AIDS at the clinic. Resultantly, they refer their patients to the clinic for further testing and HIV/AIDS and encourage anti-retroviral treatment adherence. Thus, triangulation of in-depth interviews, focus group discussions and key informant interviews show that Traditional Healing Practitioners lack scientific devices to test HIV/AIDS, hence they refer their clients to the clinic for HIV/AIDS testing. On the other hand, health professionals through the use of scientific methods and sophisticated devices are able to detect, monitor and manage the HIV/AIDS virus. According to, Ford, Meintjes, and Pozniak (2015), health professional have relied on the CD4 count for more than 3 decades as being central to key issues in managing HIV-positive patients.

A cluster of Differentiation 4 (CD4 count) which is a test that measures how many CD4 cells an individual has in the blood. These are a type of white blood cell called T-cells. The T-cells move throughout a person's body to find and destroy bacteria, viruses and other invading germs (Ford, Meintjes and Pozniak, 2015). A normal CD4 count is from 500 to 1400 cells per cubic millimeter of blood (Cohen, Chen, and McCauley, 2011). Ford, Meintjes, and Pozniak (2015) assert that CD4 counts decrease over time in persons who are not receiving anti-retroviral therapy. At levels below 200 cells per cubic millimeter, patients become susceptible to a wide variety of opportunistic infections, many of which can be fatal. Cohen, Chen, and McCauley (2011) states that the CD4 count is an important predictor of HIV/AIDS progression. It informs health professionals when to start anti-retroviral therapy (ART), Opportunistic Infection (OI), especially in late-presenting patients. Furthermore, CD4 count informs health professionals when to start and stop Opportunistic Infection (OI) prophylaxis or management, as well as in monitoring response to treatment (Cohen, Chen, and McCauley, 2011). In contrast, traditional healing practices lack the scientific methods and understanding of the structure or anatomy of the HIV virus.

All that they do is to administer traditional medicine to PLWHA and hope for the best that the patient would recover without checking the CD4 count of patients. The main indicator used by Traditional Health Practitioners was checking on the physical recovery of patients without monitoring the response of treatment in the blood. Due to lack of scientific methods and sophisticated devices, Traditional Health Practitioners (THPs) are voluntary and involuntary forced to refer PLWHA to the clinic where patients can get access to thorough diagnosis, management and monitoring of the HIV virus in the body of PLWHA. Therefore on that account, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out, lack of scientific methods and machines, directly and indirectly,

influence Traditional Health Practitioners (THPs) to encourage PLWHA to go to the clinic and take ARVs.

5.4.1.1.5 Admitting the limitations of traditional medicine

In-depth interviews, focus group discussions and key informant interviews revealed that Traditional Health Practitioners (THPs) have limitations when it comes to healing HIV/AIDS. Given that they know the limitations of Traditional Health Practitioners, they refer and encourage people living with HIV/AIDS to go to the clinic and adhere to ART. Traditional healing practices help to treat HIV/AIDS, it does not completely cure HIV/AIDS. In the focus group discussions, three members of Group A revealed that traditional healing practices do not completely cure HIV/AIDS, whilst two members were defiant that they can cure HIV/AIDS.

In Group B, all 4 members concurred that traditional healing practices do not completely cure HIV/AIDS, hence they influence and encourage their patients to adhere to anti-retroviral treatment. This shows that the majority of group members concurred that traditional healing practitioners do not completely HIV/AIDS. Likewise, the key informants also revealed that traditional healing practices are limited to only healing HIV/AIDS-related sicknesses but it does not completely cure HIV/AIDS. Thus a triangulation of in-depth interviews, focus group discussions and key informant shows that participants are aware of the limitations of traditional healing practices and they refer and encourage PLWHA to take ARVs. Participant G highlighted that failure to adhere to anti-retroviral treatment may result in the death of PLWHA. This is in support of Ford, Meintjes, and Pozniak (2015) who notes that effective anti-retroviral treatment can hold off symptoms and complications of HIV and help PLWHA to live longer. In fact, studies by Cohen, Chen, and McCauley (2011); Eshleman, Hudelson, and Redd (2017); Bavinton, Pinto,Phanuphak (2018) have found out that patients who adhere to regular treatments can achieve a life span similar to persons who have not been infected with HIV. However, the same cannot be said to traditional healing practices. There are no scientific studies that prove that regular use of traditional healing practices may lead to PLWHA to have a life span similar to persons who have not been infected with HIV. Despite the lack of scientific studies and limitations of traditional medicine, Of significance is that traditional healing practices also help to heal and fight against HIV/AIDS-related sicknesses. The study through a triangulation of in-depth interviews, focus group discussions and key informant found out that participants are aware of the limitations of traditional healing practices and they refer and encourage PLWHA to take ARVs.

5.4.1.1.2 Negative Influence

Although traditional healing practices have some positive influence on influencing anti-retroviral treatment adherence, Of significance is that to a lesser extent the study found out that there some negative influences associated with traditional healing practices. The negative influences comprise of the following factors; discouraging PLWHA from taking ARVs, THPs claim to cure HIV/AIDS, ignorance on the existence of HIV/AIDS and failure to admit on the limitations of traditional healing practices. All the given negative factors discourage PLWHA to seek treatment at clinics and adhere to anti-retroviral treatment. The negative influences shall be separately discussed in the upcoming sections starting with discouraging of PLWHA to take ARVs by Traditional Health Practitioners (THPs).

5.4.1.1.2.1 Discouraging PLWHA from taking ARVs

The study found out that 2 out of 9 participants discourages people living with HIV/AIDS (PLWHA) to adhere to ART. Traditional Health Practitioners (THPs) discourage people from taking ARVs because they believe that they can cure HIV/AIDS. In the focus group discussion, 2 out of the participants in Group A revealed that they can cure HIV/AIDS and they do not encourage their patients to adhere to anti-retroviral treatment. They only encourage their patients to take traditional medicine only which they claim it cures HIV/AIDS. Of significance is that no key informant of the study claimed to cure HIV/AIDS. They both revealed that HIV/AIDS is incurable and traditional healing practices only treat HIV/AIDS-related infections. As a result, they encourage their patients to adhere to anti-retroviral treatment. Thus, a triangulation of in-depth interviews, focus group discussions and key informants interviews reveal that a minority of two participants out of nine participants claim to cure HIV/AIDS and they discourage their patients from taking ART. According to Roberts (2017), the belief that HIV/AIDS can be cured by traditional healing practices is rife amongst many Traditional Health Practitioners (THPs).

This belief that they can cure HIV/AIDS can easily be passed to PLWHA who in turn think that it is not necessary to go to the clinic or to continue taking their anti-retroviral treatment. Beliefs by Traditional Health Practitioners (THPs) that they can cure HIV/AIDS negatively impact on the

chances of PLWHA going to seek treatment at the clinic and their adherence to anti-retroviral treatment. As indicated by Participant D, taking ART medication and going to the clinic to seek anti-retroviral treatment is seen as a waste of time. This shows how far Traditional Health Practitioners can go in discouraging People living with HIV/AIDS (PLWHA to adhere to ART and go to the clinic to seek treatment. That being the case, the study through a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that a minority of two participants out of nine participants claim to cure HIV/AIDS and they discourage their patients from taking ART.

5.4.1.1.2.2 Ignorance on the existence of HIV/AIDS

The study found out that 2 out of 9 participants were ignorant about the existence of HIV/AIDS which has a negative influence on anti-retroviral treatment adherence. Some Traditional Health Practitioners (HIV/AIDS) are ignorant that HIV/AIDS exists. They have the knowledge that ARVs treat HIV/AIDS but they chose not to believe that it exists. Instead, they interpret HIV/AIDS in cultural terms and dismiss it as a nonentity. The reason being that there is no history of HIV/AIDS in traditional culture. In the focus group discussion, 2 out of 5 members of Group A showed ignorance about the existence of HIV/AIDS and they claimed that they can cure it because it is just like any other disease. Fortunately, both key informants of the study acknowledged that HIV/AIDS is real and incurable. They revealed that they influence and encourage their patients to adhere to ART and test for HIV/AIDS at the clinic. Nevertheless, a triangulation of in-depth interviews, focus group discussions and key informants interviews show that a minority of participants were ignorant about the existence of HIV/AIDS and claimed to cure it. Ignorance of 2 participants of the study about the existence of HIV/AIDS is in support of the sentiments and policies of former Health Minister of South Africa Manto Tshabalala-Msimang and former President Thabo Mbeki. Nattrass (2007) branded Manto Tshabalala-Msimang and former president Thabo Mbeki as ignorant and HIV/AIDS deniers.

The reason being that they both denied that HIV causes AIDS Nattrass (2007) states that Manto Tshabalala-Msimang promoted vitamins, beetroot, garlic, and traditional foods as a treatment for AIDS. Watson (2006) postulated that the promotion of certain foods was at the expense of promoting and encouraging Highly Active Anti-retroviral Therapy (HAART). According to Cohen (2007), Manto Tshabalala-Msimang and former President Thabo Mbeki denied sentiments and

policies were accused of homophobia. Cohen (2007:1554) states that homophobia in the context of HIV/AIDS ignorance means that the "scientific ignorance of truly staggering proportions, conspiracy theories and the dogmatic repetition of the misunderstanding, misrepresentation of certain scientific studies". As a result of Manto Tshabalala-Msimang and former president Thabo Mbeki denier sentiments and policies, Cohen (2007) states that South Africa only managed to establish its national policy on ART after a court action started by AIDS activists because a lot of people were dying because of HIV/AIDS.

Gow (2009) states that the total lost benefits of ART not reaching the people who need it are estimated at four million life years for the period between 2000 to 2005. The economic cost of those lost life years over this period has been estimated at more than fifteen billion United States of America (USA) dollars (Gow, 2009). The aforementioned statistics show how ignorance has cost lives of people and billions of dollars which could have been used for other purposes to develop South Africa. Ignorance and denialism about HIV/AIDS still continue especially amongst Traditional Health Practitioners (THPs) as proven by the findings of the study. That being so, the study through a triangulation of in-depth interviews, focus group discussions and key informants interviews, found out a minority of two out of nine participants were ignorant about the existence of HIV/AIDS and claimed to cure it which influenced their patients not to adhere to anti-retroviral treatment or go for HIV/AIDS testing at the clinics.

5.4.1.1.2.3 THPs claim to cure HIV/AIDS

Some Traditional Health Practitioners claim to heal HIV/AIDS despite the scientific fact that HIV/AIDS is not curable. The misguided claims by THPs negatively influence People living with HIV/AIDS to stop adhering to ART.

In a focus group discussion, 2 out of 5 members of Group A also claimed that they can cure HIV/AIDS because they have the supernatural powers to cure it through traditional healing practices. Fortunately, both key informants of the study said that HIV/AIDS is incurable and they encourage their patients to take both ARVs and traditional medicine to harmoniously heal HIV/AIDS-related sickness. Thus, triangulation of in-depth interviews, focus group discussions and key informants interviews reveal that two out on nine participants claim to cure HIV/AIDS and it negatively influences their patients to stop adhering to anti-retroviral treatment because they would be believing that they are healed of HIV/AIDs. According to Roberts (2017), reported claims

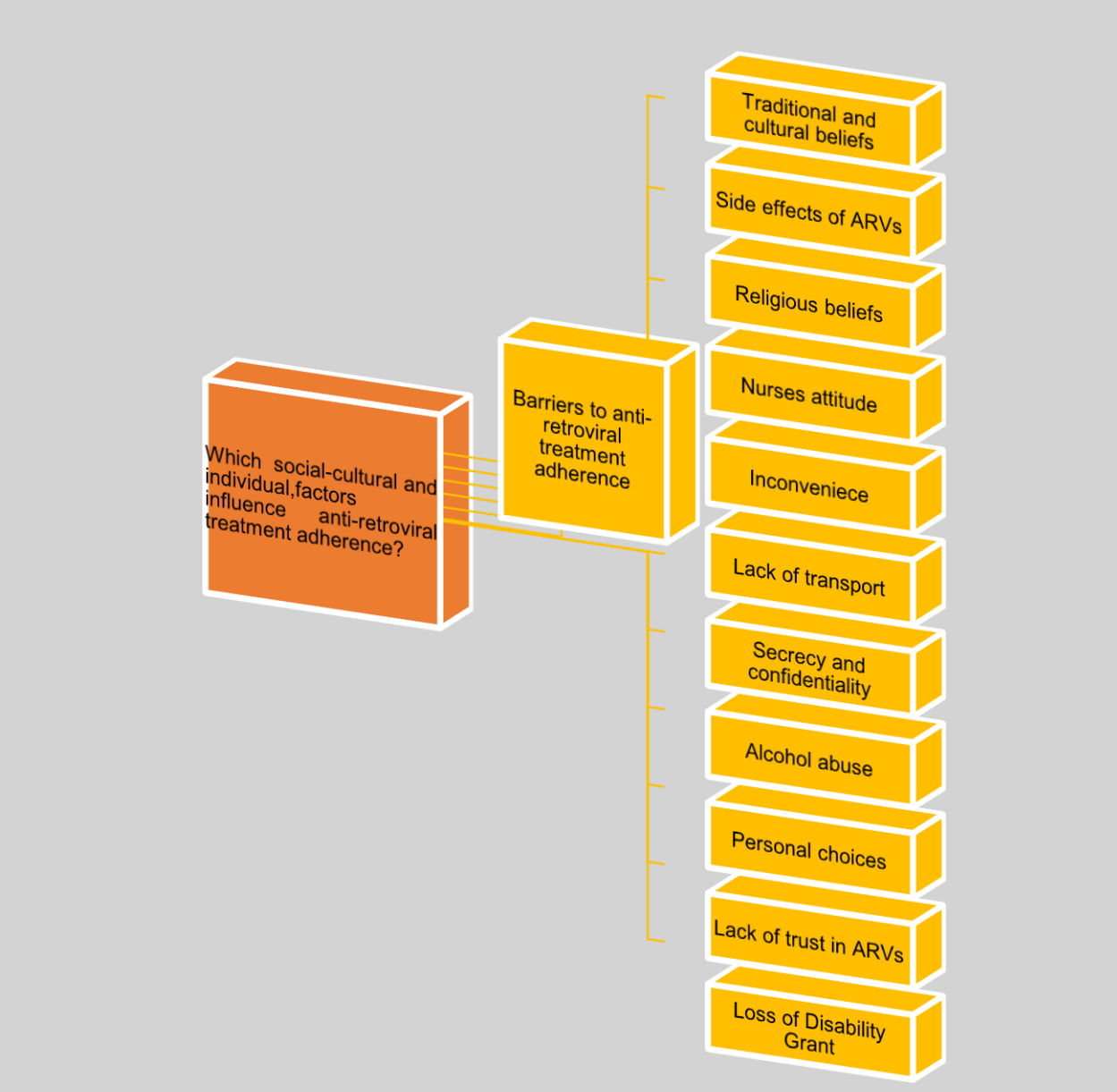
of the ability to cure HIV/AIDS by some traditional health practitioners influences PLWHA to stop adhering to ART or seeking treatment at the clinic.

The reason being that PLWHA would be under the illusion that they are cured of HIV/AIDS when it would not be true. Engle (2018) states that THPs who claim to cure HIV/AIDS have received strong criticism from both health professionals and some authorities of traditional healing sector. Roberts (2017) postulate that mainstream Traditional Health Practitioners (THPs) treat HIV/AIDS-related infections but admit that they do not completely cure the HIV/AIDS virus (Roberts, 2017). To that end, the study through a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that 2 out on 9 participants claim to cure HIV/AIDS and it negatively influences their patients to stop adhering to anti-retroviral treatment because they would be believing that they are healed of HIV/AIDS.

5.4.2 Social-cultural and individual factors which influence anti-retroviral treatment adherence

The study found out that there are many social-cultural and individual factors which influence anti-retroviral treatment adherence. As shown in Figure 5.3 below, the factors comprise of the following; traditional and cultural beliefs, side effects of ARVs, healing processes, inconvenience, lack of transport, personal choices, lack of trust in ARVs, fear to loss Disability Grant. Understanding the relative importance of different barriers to anti-retroviral treatment adherence would help in informing the targeting of different interventions and strategies that improve anti-retroviral treatment adherence.

Figure 5.3 Barriers to anti-retroviral treatment adherence



5.4.2.1 Traditional and cultural beliefs

Triangulation of in-depth interviews, focus group discussions and key informants interviews revealed that traditional and cultural beliefs act as barriers on anti-retroviral treatment adherence on people living with HIV/AIDS (PLWHA). Traditional and cultural beliefs act as a barrier to anti-retroviral treatment adherence. The same sentiments were shared in the focus group discussions, whereby all members of Group A and Group B concurred that traditional and cultural beliefs act as barriers to anti-retroviral treatment adherence. Likewise, both key informants of the study were

of the view that traditional and cultural beliefs among People living with HIV/AIDS (PLWHA) acts as a barrier to adhere to anti-retroviral treatment.

As indicated by Participants C, the use of traditional medicine to heal sicknesses have been part of people's culture since ancient time. Therefore, the use of ARVs appears to be alien to some members of the community especially those who have strong traditional beliefs. Participant C indicated that even though they encourage PLWHA to take ARVs, some of them choose to stop adhering to anti-retroviral treatment because of their strong traditional beliefs that only traditional medicine can heal them. This shows that taking both traditional medicine and ARVs may be a risk factor for non-adherence to PLWHA with strong traditional beliefs. Kalichman and Simbayi (2004) state that the simultaneous use of concoctions from Traditional Health Practitioners (THPs) while on ART has a negative influence on anti-retroviral treatment adherence. Kalichman and Simbayi (2004) study found out that a minority of the participants were using concoctions prepared by Traditional Health Practitioners (THPs) for cleansing their bodies internally whilst taking ARVs at the same time.

According to Van Dyk (2012), there is a belief that HIV/AIDS is linked to witchcraft in rural communities. It is believed that somebody must be accountable and a person can be bewitched to get the HIV virus (Van Dyk, 2012). As a result, witchcraft and sorcery are all the time being blamed for illness, bad lucks in traditional societies but worth noticing is the fact that HIV/AIDS has nothing to do with witchcraft and there is no treatment for it (Van Dyk, 2012). These religious beliefs and perceptions lead to non-adherence of ART. Furthermore, strong cultural and traditional beliefs lead to a negative influence on adherence. Some people have some extreme traditional beliefs which may lead to non-adherence to ART. The beliefs such as raping a minor or an albino are extreme, strange and borders on insanity as indicated by Participant F. There is no way that HIV/AIDS can be cured by raping a minor or an albino. The findings of this study are in support of the virgin cleansing myth postulated by Nora and Reshma (2014). According to Nora and Reshma (2014), the virgin cleansing myth is also referred to as the virgin cure myth, virgin rape myth, or simply virgin myth. It is the belief that having sex with a virgin girl cures a man of HIV/AIDS or other sexually transmitted diseases. Madlala and Suzanne (2012) state that the virgin cleansing myth is one of the factors that contribute to infant raping myth by HIV-positive men in South Africa.

Furthermore, Nora and Reshma (2014) state that HIV/AIDS positive men who believe in virgin cleansing rape target the following; young girls who are perceived to be virgins because of their age, people with disabilities or mental health disabilities. These groups of people are raped under the outrageous assumption that individuals with disabilities are sexually inactive and therefore virgins (Nora and Reshma, 2014). However, it is unknown exactly how common the myth is and to what degree rapes happen because of the belief in it. Epstein and Jewkes (2010) argue that the claim that the myth drives either HIV infection or child sexual abuse in Africa is disputed by researchers such as Mullins (2009) and Mtibo, Kennedy, Umar (2011), who found no evidence to support the idea that the virgin cleansing myth causes any rapes. Nevertheless, this study found out that extreme religious and cultural beliefs lead to some rapes which influence PLWHA to stop taking ARVs. It is totally wrong for people with strong and strange beliefs to rape minors and disabled people because of their strange beliefs. People with extreme and strange beliefs like that should face the full wrath of the Criminal Justice System and their actions must be condemned in all ways possible. On that account, the study through triangulation of in-depth interviews, focus group discussions and key informants interviews found out that strong traditional and cultural beliefs influence PLWHA to stop adhering to anti-retroviral treatment.

5.4.2.2 Religious Beliefs

The study found out that religious beliefs make people living with HIV/AIDS (PLWHA) to stop adhering to ART. Some religious beliefs and pastors claim that they heal HIV/AIDS through undertaking their bizarre rituals. As a result, PLWHA believes that they are cured of HIV/AIDS and they stop adhering to anti-retroviral treatment. In a focus group discussion, all group members in Group A and Group B concurred that religious beliefs act as a barrier to anti-retroviral treatment adherence. Group member revealed that in these modern days, people are too gullible that they believe and do anything that they are told by the so-called "men of God". This can blind them to the extent that they stop adhering to anti-retroviral treatment. Similarly, both key informants of the study bemoaned the influence of religious beliefs as a barrier to anti-retroviral treatment adherence. Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews revealed that religious beliefs act as a barrier to ART.

The findings of the study support a New Zimbabwean newspaper story written by Tapfumaneyi (2018). On the 28th of October 2018, a popular self-styled prophet known as Walter Magaya proclaimed to the world that he found a cure for HIV/AIDS (Tapfumaneyi, 2018). Magaya claimed

that the cure for HIV/AIDS was a herb called Aguma and that it would destroy the HIV virus within fourteen days. However, Magaya was arrested and the Criminal Justice System found Magaya guilty of contravening the Medicines and Allied Substances Control Act of Zimbabwe by selling a drug that had not been approved (Tapfumaneyi, 2018). He was convicted and fined over false claims that he had found a herbal cure for HIV and AIDS. After, the court processes, Magaya retracted his claims that he had found a cure for HIV/AIDS and apologized for making the announcement. The New Zimbabwean newspapers story about Walter Magaya shows that prophets make false claims that they cure HIV/AIDS which misleads people and result in non-ART adherence. If the law enforcement agencies of Zimbabwe had not intervened and arrest Magaya, many people would have believed that the so-called Aguma medicine can cure HIV/AIDS and stop taking anti-retroviral treatment. A newspapers article by Ramothwala (2018) in Sunday Times about a self-styled prophet called Rabalago, who sprayed his congregates with insect spray that is known as doom to be healed of HIV/AIDS. This newspaper article shows that these self-styled prophets are misleading people concerning HIV/AIDS cure with compromise their ART adherence. It also shows that people living with HIV/AIDS are too desperate and gullible to believe everything that they are told by the self-styled prophets. The level of gullibility and submissiveness to these self-styled prophets shows that they even believe more in these Prophets than ART. Therefore, a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that religious beliefs act a barrier acts as a barrier to ART.

5.4.2.3 Side Effects of ARVs

Participants in both groups revealed that participants prefer to take traditional medicine than ARVs because of side effects. Similarly, the side effects of ARVs were revealed in the key informant's interviews. Therefore, a triangulation of in-depth interviews, focus group discussions and key informants interviews assents that the side effects of ARVs act as a barrier to anti-retroviral treatment adherence. The findings of this study concur Williams and Friedland (2007) assertion that the Highly Active Anti-retroviral Therapy (HAART) has many side effects on PLWHA because it contains at least 3 regimens of drugs to fight all different kind of infections in a person's body.

The probability of PLWHA adhering to a given regimen decays because of the following reasons; the concurrent use of multiple medications by a patient, the recurrence of dosing, the seriousness

of symptoms and the many-side effects of the regimen (Williams and Friedland, 2007). Carr and Garsia (2007) state that drug hypersensitivity is significantly more typical in patients with HIV and regimen related negative effects leads to non-adherence by PLWHA in many studies such as studies by Murri, 2009; Ickovics and Meisler, 2007). Symptoms related to every individual anti-retroviral medicate are very much depicted, and while not all-inclusive for each patient can be anticipated. Normally they malformed after the initial few weeks of ART but for other HIV/AIDS patients the side effects continue. As a result, the expectations of HIV/AIDS patient to be well and the frustration that comes with the side effects of the ARVs impacts negatively on anti-retroviral treatment adherence (Broers, 2004). HIV/AIDS patients end up stop taking ARVs because the side effects will be persisting and when they stop taking them they feel better in the short term.

Although they feel better in the short term, in the long run, the HIV/AIDS patients would become worse because of the strong attack by the virus. Burgos (2008) states that poor anti-retroviral treatment adherence has been related with patient's desire to abstain from humiliating symptoms in specific circumstances, for instance, while on a date or going to a prospective employee meet-up. A typical HAART blend regularly comprises of three specialists or medications that involves the following; Stavudine, Lamivudine, and Nevirapine or Effavirenz. It also involves other prescription for prophylaxis of opportunistic contaminations. This can come about into a high pill stack, thrice-every day dosing, dietary and dosing idiosyncrasies, large capsules or tablets, and particular stockpiling guidelines. This regimen multifaceted nature essentially impacts a patient's capacity to follow (Ickovics and Meisler, 2007). Extra medication is taken for symptomatic alleviation like analgesics, cough cures and others normal in patients with advanced HIV sickness, additionally, add to the pill burden and toxicity. As a result, taking the ART medication becomes a daunting task which led to non-adherence by PLWHA. Therefore, this study through a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that side effects of ARVs act as a barrier to anti-retroviral treatment adherence.

5.4.2.4 Nurses Attitude

The in-depth interviews, focus group discussions and key informant interviews revealed that nurses attitude towards people living with HIV/AIDS (PLWHA) act as a barrier to anti-retroviral treatment adherence. The same sentiment was shared in discussions in both Group A and Group B. All member of the 2 groups revealed that nurses have a negative attitude towards PLWHA and every patient in general. Similarly, the key informants also bemoaned the abuse of PLWHA by

nurses at the clinic. PLWHA must be taken care of and feel loved when they go to the clinic to consult and take medication.

If they feel loved and cared for it may increase their adherence level to ART. Therefore, a triangulation of in-depth interviews, focus group discussions and key informant interviews shows that people living with HIV/AIDS are afraid to go to the clinic because of the nurses' negative attitude towards them. The findings of the study concur with Ganle's (2015) assertion that health professionals especially nurses attitude towards HIV patients' culture, beliefs, and health status often form another barrier towards treatment adherence. Ganle (2015) study found out the health-seeking behavior of Muslim women in Ghana was compromised by the nurse's attitude towards them. Muslim women wanted to receive healthcare in a formal setting but the nurses lacked the sensitivity to Muslim women's religious and cultural practices. As a result of religious and cultural obligations, Muslim women had difficulty in utilizing such services (Ganle, 2015). Heisler (2011) found a similar assertion among the Muslim American community. When Western healthcare centres disregard their patients' cultural needs it can drive them to utilise the services of traditional healers. The same can be said of HIV positive patients who have traditional beliefs. Nurses lack sensitivity towards their traditional religion and mistreat them. As a result, they end up opting for the use of traditional medicine than going to the clinic. Therefore, the study through a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that nurses negative attitude towards PLWHA acts as a barrier to treatment adherence by PLWHA.

5.4.2.5 Lack of transport and inaccessibility of clinics

The study found out that inaccessibility and lack of transport for people living with HIV/AIDS (PLWHA) to go to the clinic act as a barrier to anti-retroviral treatment adherence. Lack of transports acts as a barrier for people living with HIV/AIDS to go to the clinic to take ARVs or consult.

Some villages were PLWHA stay, are remote and far away from the clinic. The roads are also bad and some places are muddy during the rainy season. All these factors make it difficult for PLWHA to have access to the clinic. The same sentiments were shed in the focus group discussions in Group A and Group B. All the participants indicated that PLWHA are poor and sometimes they do not afford to go to the clinic. The group revealed that the state of roads in the villages is bad and they blamed the councilors for not doing their job. Likewise, key informants

they also mentioned that the clinic is too far from people and they struggle to get money for transport to go to the clinic. The clinics are not accessible, unlike the Traditional Health Practitioners (THPs) who are very accessible to PLWHA as evidenced by key informant B who stated that people come to consult every day and at any time, unlike the clinics. Therefore, a triangulation of in-depth interviews, focus group discussions and key informant interviews shows that inaccessibility of clinics and cost of transport acts as a barrier to treatment adherence.

The results of the study support a study by Rosen, Ketlhapile, Sanne and DeSilva (2017) on the attendance of pre-ART and ART patients in public clinics and hospitals. The study used a random sample of participants from peri-urban areas clinics, town clinics, and rural clinics. The mean and median costs for attending the clinics were calculated for each site. Rosen et al., (2017) study found out that ninety-one percent of the HIV positive patients paid for transport to attend the clinic. The average cost of transport to go to the clinic in town was between 10 to 20 Rand whilst the cost to attend a rural clinic was high between 35 Rands and 70 Rands per trip. Rosen et al., (2017) states that the cost of transport to go to a rural clinic was too high given that the ART patients must visit a treatment clinic at least six times in the year which they start to get ART medication. Furthermore, Rosen at al., (2017) found out that PLWHA also spends considerable time and money between visits for refreshments since they will have to spend some hours in the clinics' lines. This shows that it is expensive for those living in rural areas to seek treatment and collect ARVs at the clinics. As a result, the cost of transport compromises their adherence to ART. Therefore, through a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that that inaccessibility and transport cost acts as a barrier to treatment adherence to PLWHA in the rural areas.

5.4.2.6 Inconvenience

The study found out that taking ARVs inconvenience people living with HIV/AIDS (PLWHA) which leads to non-adherence. ARVs inconveniences PLWHA which compromise their anti-retroviral treatment adherence. People have everyday activities and taking pills at certain times it interferes with PLWHA daily routines. Despite some day to day activities, unexpected circumstances and unfortunate events can happen such as funerals as mentioned Participant G which makes it difficult for PLWHA to take their medication. The same view was shared by group members in both Group A and Group B. Group members revealed that it is hard for PLWHA to carry around pills especially when they are interacting with other people because sometimes people can notice.

Similarly, the key informants also brought up inconvenience as a barrier to anti-retroviral treatment adherence.

It is very difficult for PLWHA especially during the early days to adjust their day to day activities and taking pills every day. Therefore, a triangulation of in-depth interviews, focus group discussions and key informant interviews shows that taking ART medication inconveniences PLWHA which in turn compromises anti-retroviral treatment adherence. The findings of this study are in support of Burgos (2008) who notes that poor anti-retroviral treatment adherence amongst people living with HIV/AIDS (PLWHA) is related to individuals desires to abstain humiliating symptoms in specific circumstances such as when one is going out for a date or going for an interview. Given the different circumstances that individuals find themselves in, it becomes difficult for PLWHA to take their medication. This leads to poor adherence amongst PLWHA. To sum up, the study through a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that taking ARVs inconveniences PLWHA which leads to poor adherence.

5.4.2.7 Personal choice

The study found out that personal choice by people living with HIV/AIDS (PLWHA) acts as a barrier to anti-retroviral treatment adherence. PLWHA chose not to adhere to anti-retroviral treatment in spite of the advice that they get from the nurses and traditional healer. As a result, it puts nurses and traditional healers in a difficult position because they cannot force PLWHA to take ARVs. At the end of the day, the nurses and traditional healers are supposed to respect the choice of HIV/AIDS patient. In the group discussions, members in Group A and Group B revealed that some people chose not to take ARVs because of the side effects and it is difficult to force them. The key informants also revealed that in some cases PLWHA chose to stop taking ART on their own account.

PLWHA chose to stop adhering to anti-retroviral treatment. Even though the family members may try to encourage PLWHA to take anti-retroviral treatment, sometimes they don't take heed of their advice and encouragement. Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews show personal choices may act as a barrier to anti-retroviral treatment. The findings of this study are in support of Uuskula (2012), who notes that individual

may have some personal beliefs and reasons about not taking ARVs such as the belief that the medication does not work.

Beer (2014) states that some HIV/AIDS patients may personally choose not to completely adhere to ART because of the following reasons; perceiving adherence as difficult, lack of knowledge, religious beliefs, influence by Traditional Health Practitioners (THPs) and the use of herbal medication. A study by Musumari (2013), found out that, participant belief that one's disease was caused by witchcraft led a few participants to interrupt their medication and to use prayers and traditional medicines in search for a potential cure. This shows after all has been done and said about anti-retroviral treatment adherence, it is an individual choice for one to decide to adhere or not to adhere to anti-retroviral treatment. It is not given that when an individual is given ARVs or encouraged to take ARVs they do likewise. Therefore, a triangulation of in-depth interviews, focus group discussions and key informant interviews shows that personal choices may act as a barrier to anti-retroviral treatment despite encouragement to adhere to ART.

5.4.2.8 Alcohol abuse

The study found out that alcohol abuse act as a barrier to ART. Alcohol abuse act as a barrier against treatment adherence and at the same time as a risk factor for unprotected sex which leads to the spread of HIV/AIDS. People living with HIV/AIDS (PLWHA) who abuse alcohol sometimes think that they are inconvenienced to take ARVs when they are on their drinking sprees as outlined by Participant G. These drinking sprees are often associated with unprotected sex with girls. In some cases, PLWHA who abuse alcohol pass out after heavy drinking. After passing out there is no way that they would remember or would be able to take ARVs. The same sentiments were shared in the focus group discussions. Both Group A and Group B participants in the discussions revealed that alcohol abuse act as a barrier and a risk factor for the spread of HIV/AIDS in the community.

Likewise, key informants also revealed that alcohol abuse acts as a barrier to ART adherence. People living with HIV/AIDS (PLWHA) engage in alcohol abuse as a coping mechanism to deal with stress especially in the early days when they find out that they are positive. Of significance is that dealing with stress through abusing alcohol is an unhealthy way of coping up with stress. Alcohol abuse by PLWHA act as a barrier to treatment adherence because they may forget to take their medication when they are intoxicated and engage in risky behaviors such as

unprotected sex. Thus, the in-depth interviews, focus group discussions and key informant interviews revealed that alcohol abuse act as a barrier to ART and a risk factor to engage in risky behaviors such as unprotected sex which spread HIV/AIDS in the villages. The findings of this study concur with Sherer (2008), who notes that alcohol abuse may decrease ART adherence and prompt reduced treatment viability which results in expanded HIV related mortality. Alcohol abuse affects the survival of PLWHA because of liquor inflamed resistant concealment that heightens the HIV associated immune concealment, expands hepatotoxicity and expanded mortality from non-HIV related causes. Sherer (2008) assert that epidemiological and sociological outcomes indicate that alcohol abuse has an upright and generous relationship with levels of treatment non-adherence, bringing about pre-develop morbidity and mortality in PLWHA. Furthermore, Mnyika, Klepp, Kvale, and Ole-Kingóri (2017) states that alcohol abuse is associated with sexual risk behaviors, such as having multiple sexual partners. Alcohol abuse leads to risk behaviors because of the addictive and intoxicating effects of alcohol, which can alter judgment. Alcohol leads people to be involved in unsafe and risky behaviours without first thinking about it or consider the dangers of it (Mnyika *et al*., 2017). This means that alcohol abuse acts as a treatment barrier and a risk factor for the spread of HIV/AIDS if drunk PLWHA engages in unprotected sex. Therefore, the study through in-depth interviews, focus group discussions and key informant interviews revealed that alcohol abuse act as a barrier to ART and a risk factor to engage in risky behaviors such as unprotected sex which spread HIV/AIDS.

5.4.2.9 Secrecy and confidentiality

The study found out that concerns about secrecy and confidentiality in attending public clinic acts as a barrier to ART adherence. People living with HIV/AIDS (PLWHA) do not like to go to the clinic because they are afraid that other community members will fight out about their status.

It is very difficult for them to go to the clinic during broad daylight because there will be many people and well-known members community members such as pastors. The citation from Participant G shows that prominent members of the community such as teachers, pastors, and headmasters are HIV/AIDS positive and they seek treatment from Traditional Health Practitioner (THPs).

People do not like to go to the clinic to take ARVs due to fear that they will expose themselves to the community members and the nurses who stay in the community. Of significance is that

PLWHA does not want the community members to know their status for fear of being stigmatized. Confidentiality issues were also raised in focus group discussions. The same sentiments about secrecy were shared by key informants. As a result, some PLWHA ends up changing how they look and wear clothes that disguise them from the public when they go to take ARVs. Therefore, a triangulation of in-depth interviews, focus group discussions and key informant interviews revealed that secrecy and confidentiality issues act as a barrier to ART adherence.

The findings of this study concur with a study by Sheri and Weiser (2016) which found out that secrecy and stigma was a commonly cited barrier to ART adherence reported by the majority of the participants. A study by Dapaah and Senah (2016) found that the mere presence of a person at the HIV counseling centre or clinic is enough for the person to be labeled as or suspected to be an HIV patient. It demonstrates that stigmatization may occur not only in the community but also in overtly or covertly, in the clinic itself. Consequently, for many HIV/AIDS patients, access to anti-retroviral therapy and treatment of related infections are problematic. Besides, the study found that many clients and potential users of services were uncomfortable with the quality of care given by some health workers, especially as they overtly and covertly breached confidentiality about their clients' health status. This shows that people living with HIV/AIDS do not like to go to the clinic due to fear of exposing themselves to community members and nurses who may breach confidentiality about their health status. PLWHA prefer that their status be a secret for fear of being stigmatised. Therefore, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that secrecy and confidentiality issues act as a barrier to ART adherence.

5.4.2.10 Lack of trust in ARVs

The study found out that lack of trust in ARVs by people living with HIV/AIDS acts as a barrier to ART adherence. People living with HIV/AIDS (PLWHA) do not trust ARVs the same way that they trust traditional medicine. The reason being that traditional healing practices have been part of their lives, unlike ARVs which is alien to them. The same point was raised in focus group discussions. Both members of Group A and Group B revealed that people have trust issues when it comes to taking ARVs.

In the same manner, key informants also revealed that PLWHA does not trust ARVs that is why they stop taking them. They believe that traditional medicine works better than ARVs. Thus, a

triangulation of in-depth interviews, focus group discussions and key informant interviews revealed that PLWHA do not trust in ARVs and it leads to poor adherence.

According to Dahab (2008), although the use of present-day medication exists one next to the other with such customary practice, traditional medicine has frequently kept up their popularity for recorded and social reasons. That being the case, Enlund (2013) states that some individuals have frequently doubtful mentality towards modern medicine. It is realized that negative or suspicious mentality towards modern medicine is frequently identified with poor adherence (Enlund, 2013). Drug adherence implies taking HIV medicines when and how one should take them. Normal rates for ART adherence in clinical trials have been observed to be high, yet rates of adherence for chronic conditions are just observed to be 43-78% (Osterberg, 2005). Strict adherence is the way to fruitful anti-retroviral treatment (ART). Ideal adherence to Highly Active Anti-retroviral Therapy (HAART) leads to HIV concealment, diminished danger of medication resistance, enhanced general wellbeing, personal satisfaction survival and diminished danger of HIV transmission (AIDS data, 2015). Patients must take 95% of their pills to accomplish an eight percent probability of HIV concealment.

Adherence rate under 95% leads to a drop of concealment level under 50% (Moitra, 2011). Inability to take medication routinely and dependably purposes the infection to be presented to imperfect medication serum focuses (Lesho, 2003). Non-adherence to ART may prompt an expansion viral load which may prompt medication resistance and loss of future treatment choices (Syrjanen, 2005). Inability to take medication routinely and dependably purposes the infection to be presented to imperfect medication serum focuses (Lesho, 2003). Non-adherence to ART may prompt an expansion viral load which may prompt medication resistance and loss of future treatment choices (AIDS data, 2015). Poor adherence is the real reason for therapeutic failure. Accomplishing adherence to ART is a basic determinant of long haul result in HIV contaminated patients (AIDS data, 2015). The adherence for ART is more challenging and more significant than in numerous other chronic infections, for example, diabetes or hypertension.

Their medication regimens stay viable even after treatment is continued after a time of intrusion (Syrjanen, 2005). This is not the case with HIV. That being so, people living with HIV/AIDS (PLWHA) need to trust in the use of ARVs and the importance of ART adherence because HIV/AIDS is a unique disease. HIV/AIDS is unlike other diseases like hypertension when a patient can default treatment and still remain healthy. Thus, trust in the use of ARVs and ART adherence is of paramount importance. To that end, the study through a triangulation of in-depth interviews,

focus group discussions and key informant interviews, found out that lack of trust in the use of ARVs acts as a barrier to ART adherence.

5.4.2.11 Disability Grant

The in-depth interviews, focus group discussions and key informants interviews revealed that unwillingness to lose the disability grant acts as a barrier to ART adherence. People living with HIV/AIDS (PLWHA) who are recipients of the disability grant do not want to lose their grant if their Cluster of Differentiation (CD4) becomes high. PLWHA would stop taking ART to compromise the CD4 count so that when they go to the clinic it would be low. It is surprising to note that PLWHA is willing to risk their health for a little sum of money. The same point was raised in Group B discussion that PLWHA stops taking ARVs so that they can continue to be a recipient.

Similarly, key informant interviews also revealed that the loss of disability grant acts as a barrier to ART adherence. The quotation from key informant B shows that indeed HIV/AIDS patients are legible to get Disability grants when their CD4 count is low so that they can take care of themselves and eat a well-balanced diet.

Nonetheless, the hardest part is when they will have to lose the disability grant when their CD4 count becomes high. As a consequence, some recipients of the disability grant stop taking the ARVs to manipulate their CD4 count. Thus, a triangulation of in-depth interviews, focus group discussions and key informants interviews revealed that fear of loss of disability grant act as a barrier to ART adherence. According to Nattrass (2006), in South Africa, AIDS infection is combined with qualification for disability grants. HIV positive patients are qualified for a state-financed month to month income in view of their sickness-related inadequacy to work. The South Africa Social Security Agency (SASSA) lists the total number of disability grant beneficiaries as one million and four hundred thousand. An article by Nkuna (2019) claims that HIV/Aids patients who have a CD4 count of two hundred or less qualify for a monthly disability grant of eight hundred and seventy Rands per month. A normal CD4 count is from 500-1400 cells per cubic millimetre of blood (Cohen, Chen, and McCauley, 2011). Ford, Meintjes, and Pozniak (2015) assert that CD4 counts decrease over time in persons who are not receiving anti-retroviral therapy.

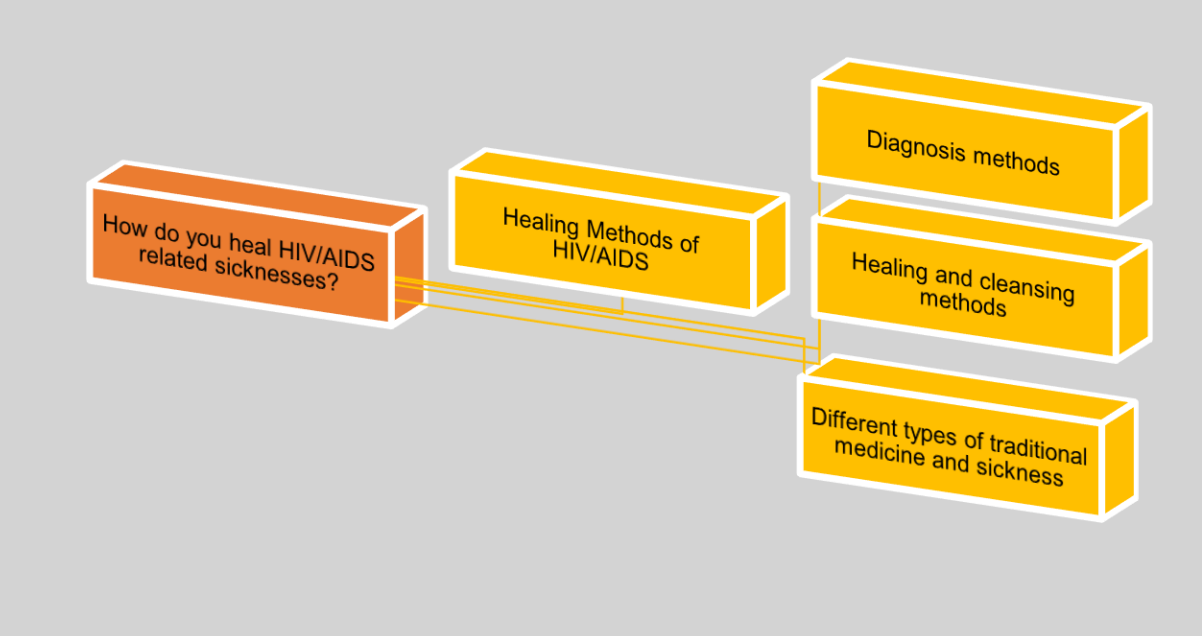
At levels below two-hundred cells per cubic millimetre, patients become susceptible to a wide variety of opportunistic infections, many of which can be fatal. At the point when disability awards

are attached to AIDS-related indicators, for example, CD4 count or viral load, non-adherence may turn into an alluring alternative for patients who fear to lose their grant if their CD4 count were to increase (Nattrass 2006). Nattrass (2006) states that disability awards become an essential main source of income regardless of the possibility that patients may be well enough to go to work. As a result, some HIV positive patients who receive the disability grant sometime stops the ART so that they can continue to get the grant. Nkuna (2019) states that the Department of Social Development was aware of reports that HIV-positive people were deliberately getting ill to qualify for a grant, but knew of no evidence. Nkuna (2019) postulate that the disability grants contribute greatly to people's quality of life and SASSA should teach skills that people living with HIV/AIDS (PLWHA) could use to earn a living when their grant money dries up. PLWHA needs to be taught that the grant will only cover you for a short period of time, not forever so that they won't stop taking treatment. That being so, non-adherence shows that recipients of the disability grant are willing to risk their lives for a mere R870 per month which is equivalent to about US$58. Significantly person's life is precious and worth more than a few Rands of money to risk. That being so, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out reluctance to lose the disability grant acts as a barrier to ART adherence.

5.4.3 Healing methods of HIV/AIDS-related sicknesses

The study through in-depth interviews, focus group discussions and key informants interviews, found out that there are many healing methods of HIV/AIDS-related sicknesses used by Traditional Health Practitioners (THPs). As shown in Figure 5.4 below, the healing methods of HIV/AIDS-related sicknesses themes involve the following; diagnosis methods, different types of traditional medicine, healing and cleansing process. Understanding the different types of healing methods by Traditional Health Practitioners (THPs) helped would help in informing the targeting of different interventions and strategies to improve ART adherence among people living with HIV/AIDS (PLWHA).

Figure 5.4 Healing methods



5.4.3.1 Diagnosis Methods

The study found out that Traditional Health Practitioners use many methods to diagnose HIV/AIDS. The methods that they use to diagnose HIV/AIDS involves the following; throwing bones, visions from the ancestors, signs of the body and using a mirror to diagnose HIV/AIDS. A total of 6 out of 9 participants in the study indicated that they use bones to diagnose HIV/AIDS. The citation from Participant B shows that Traditional Health Practitioners (THPs) make use of throwing bones to diagnose the sickness of patients.

It is through throwing bones that their ancestors communicate and show them the kind of sickness inflicting a person and the kind of traditional medicine to administer to the patient. Of significance is that Participant B acknowledged the unavailability of advanced machines to test HIV/AIDS and refers patients to the hospital for testing. Acknowledging the lack of machines shows that Participant B cannot cure HIV/AIDS but only help to heal the different kind of diseases that affects an HIV/Aids patient. As a result, it positively influences people living with HIV/AIDS (PLWHA) to visit the clinic for testing and encourages treatment adherence. In the focus group discussions, participants from group A and Group B revealed that they also make use of throwing bones to diagnose HIV/AIDS. They took turns in the groups to demonstrate how they throw the bones to diagnose HIV/AIDS. However, two participants in Group A revealed that even though they don't

have machines to conduct blood test of HIV/AIDS, throwing bones is good enough for them because they do not refer their patients to the clinic for further test. That being the case, it influences PLWHA not to go to the clinic for testing and leads to poor adherence.

However, the bottom line is that they make use of bones to diagnose HIV/AIDS. Similarly, key informants also revealed that they make use of throwing bones to diagnose HIV/AIDS. The quotation from key informant A shows that throwing bones is an important aspect of diseases diagnosis in traditional healing practices. It gives Traditional Health Practitioners the guideline on how they can heal their patients. Analogically, in a hospital setting, doctors conduct various tests on a patient to diagnose diseases and in traditional healing set up THPs throw bones to diagnose the disease which key informant call, "divining a patient". Therefore, a triangulation of in-depth interviews, focus group discussions and key informant interviews revealed Traditional Health Practitioners (THPs) make use of throwing bones to diagnose HIV/AIDS patients.

However, they lack the machines to conduct HIV/AIDS blood test so throwing bones is one of their diagnosis methods. Given that they lack the equipment to conduct a blood test, seven participants indicated that they refer their patients to the clinic for further testing, whilst two participants indicated that diagnosis through bone throwing is good enough for them because they do not need to refer patients to the clinic since they cure HIV/AIDS. Nevertheless, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that Traditional Health Practitioners (THPs) make use of throwing bones to diagnose HIV/AIDS patients. Furthermore, one participant indicated the use of a mirror to diagnose HIV/AIDS.

The quotation from Participant E shows that supernatural powers can be used to make an ordinary mirror into a device that diagnoses HIV/AIDS Participant G outlined the use of visions to diagnose HIV/AIDS whilst Participant A makes use of bones and physical symptoms on the body like sores. The extracts show that Participant B checks the physical symptoms on a patient body as indicators on whether a patient is HIV/AIDS or not. Therefore, this study through triangulation of in-depth interviews, focus group discussions and key informant interviews found out that Traditional Health Practitioners (THPs) make use of the following methods to diagnose HIV/AIDS; throwing of bones, use of a mirror, visions from ancestors and checking physical symptoms patients.

5.4.3.2 Healing and cleansing methods

The study found out that Traditional Health Practitioners (THPs) make use of different healing and cleansing methods to heal HIV/AIDS sicknesses. Of significance is that seven of the participants indicated that their methods do not completely cure HIV/AIDS but it helps people living with HIV/AIDS to recover. They were not sure that their medicines completely heal HIV/AIDS and acknowledged that they refer their patients to the clinic for further test and they encourage them to take ARVs. The excerpt from Participant H shows that the majority of participants acknowledge that they do not necessarily cure HIV/AIDS totally but they can manage to boost the body to make it strong against many infections. As a result, if a person takes both traditional herbs and ARVs from the clinic it boosts their immune system against HIV/AIDS and ensures that they live a long life.

The same sentiments were shared in focus group discussions. Group A and Group B discussion revealed a different kind of methods that are used to treat HIV/AIDS-related sicknesses. In Group A, 2 participants indicated that they can completely cure HIV/AIDS and do not recommend their patients to take ARVs. Fortuitously, 3 members of the group revealed that they heal HIV/AIDS but they cannot completely cure it, hence they recommend PLWHA to complement traditional medicine and ARVs. In Group B discussion, all 4 members concurred that they can heal HIV/AIDS but they cannot completely cure it. As a result, they encourage and recommend their patients to take ARVs. Similarly, key informants encourage and recommend their patients to take ARVs.

The extract from key informant B shows that Traditional Health Practitioners (THPs) make use of traditional medicine to heal HIV/AIDS-related sicknesses. The use of traditional medicine has some conditions that are attached to it. Patients must eat food first before drinking the traditional medicine and they must not skip drinking it. This draws some similarities between ARVs and traditional medicine because HIV/AIDS patient must not skip taking ARVs once they start the ART. Participant B said that patients are advised to eat a well-balanced diet before drinking the traditional medicine thereby drawing another similarity with ARVs because HIV/AIDS patient on ART must eat a well-balanced diet. However, the difference lays on the medicine to bath since ARVs only make use of pills. Participant B said that after bathing patients are not allowed to apply lotions and it is seen as a way of cleansing the body without making use of modern products like lotions. On that account, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews, found out that Traditional Health Practitioners (THPs) make use of traditional medicine to heal patients through drinking and bathing.

The study found out that THPs make use of incisions with a razor blade to heal and cleanse HIV/AIDS patients. Excerpts from Participant D shows that THPs cut openings with a razor blade on the skin of patients to apply for traditional medicine. Nevertheless, cutting HIV positive patients may lead to transmission of the virus to other people especially if one razor blade is used on various patients. Therefore, Traditional Health Practitioners (THPs) need to be careful incising patients with razor blades. Participants of the study revealed that they make use of rituals and sacrifices to heal and cleanse HIV/AIDS.

Another healing method that came out of the in-depth interviews, focus group discussions and key informant interviews were that THPs make use of boiling water and hot stones to heal and cleanse HIV/AIDS from the patient's body. Extract from Participant G shows that the healing and cleansing method is based on induced sweating through boiling hot water and stones in a blanket with the face of the patients covered with a blanket. This shows that Traditional Health Practitioners are unique and they use different methods to heal and cleanse HIV/AIDS.

A quotation from Participant I shows that traditional healing practices make use of rituals and sacrifices to heal HIV/AIDS. Participant I believes that HIV/AIDS is a curse brought upon people because of their immoral behavior. As a result, HIV patients need to ask for forgiveness and rituals and sacrifices must be done to be cleansed of the disease. Participant I beliefs about HIV/AIDS as a curse for immoral behavior goes to show that people have different theories about the origins and cause of HIV/AIDS and some of the theories are misleading and leads to poor ART adherence. Nonetheless, the study through a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that there are many healing and cleansing methods which involve the following; drinking and bathing with traditional medicine, razor blade incisions, induced sweating through the use of hot stones and hot water, use of rituals and sacrifices to heal and cleanse HIV/AIDS.

5.4.3.3 Different types of medicine and sickness

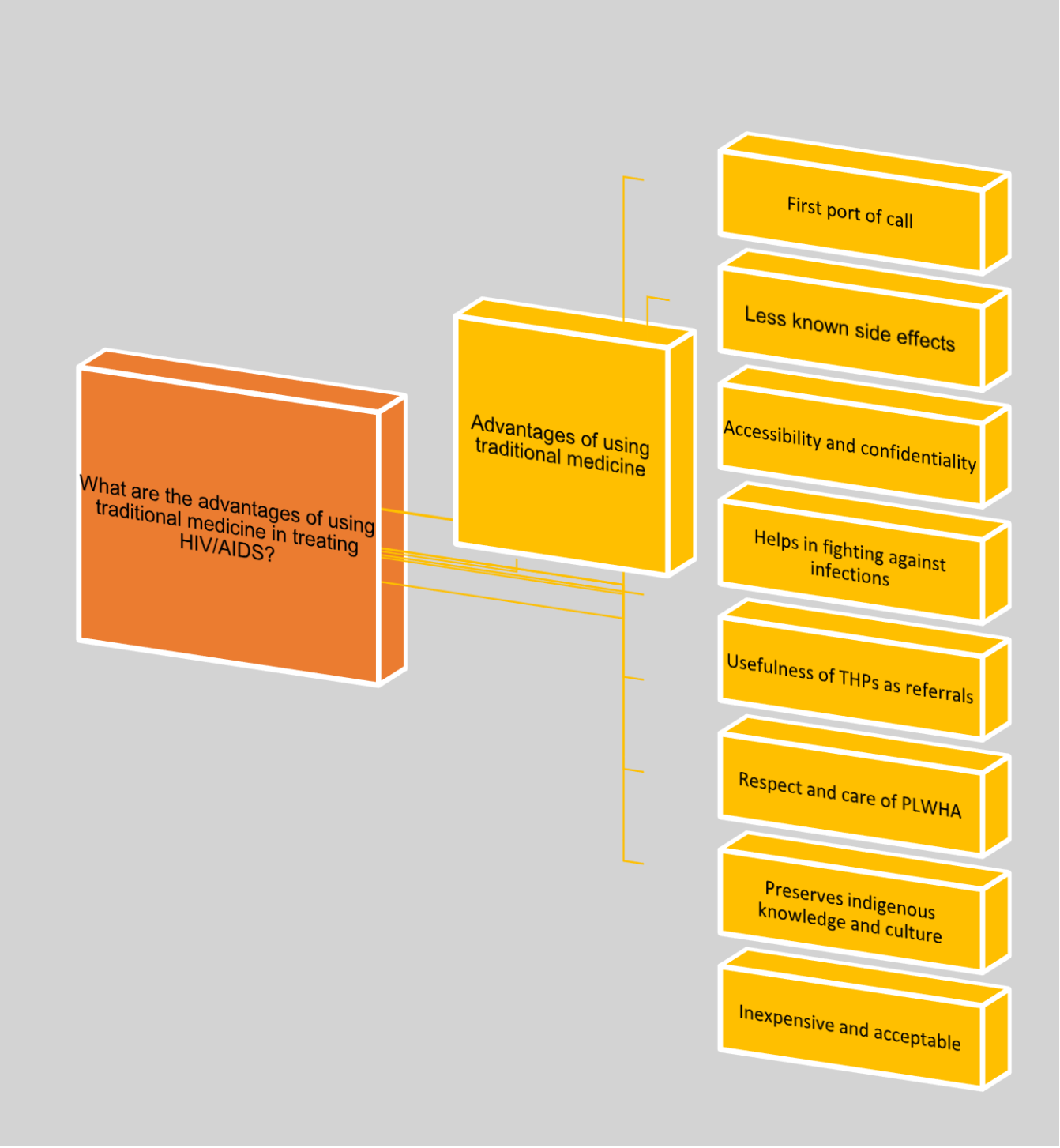
The study found out that Traditional Healing methods use different types of medicines to heal different types of sickness related to HIV/AIDS. In-depth interviews and focus group discussions revealed many different kinds of traditional medicine and the diseases that they heal. However, the key informants were more eloquent when it comes to the types of traditional medicines and the diseases that they can cure. A citation from key informant B shows the use of expertise to

explain a different kind of medicines and sicknesses that they treat when a person is HIV/AIDS positive. Every sickness or disease that attacks an individual who is HIV/AIDS positive there is a traditional medicine that can heal it according to key informant A. Although key informant B has the knowledge about the medicines and the different sicknesses it heals, patients still need to go to the clinic for HIV/AIDS testing and they need to adhere to anti-retroviral treatment. The use of these different types of traditional medicine and ARVs may help to boost the immune system of an HIV/AIDS patient. Therefore, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out there are many different kinds of medicines which heals some diseases or sicknesses such as; *madhevhu, dorobho, pakwani, Tshimbambaira, lufiya and tusula*.

5.4.4 Advantages of the use of traditional healing practice

The study found out that there are many advantages that come with the use of traditional healing practices as depicted in Figure 5.5. There are some positive impacts that come with the use of traditional healing practices that involve the following; acting as the first port of call, accessibility, confidentiality, helps in fighting against infections, the usefulness of THPs as referrals, respect, and care of PLWHA, preserves indigenous culture and tradition, inexpensive and acceptable. Understanding the advantages of traditional healing practices helped in, informing interventions measures and strategies that help in making partnerships with health professionals THPs and community members to support ART adherence.

Figure 5.5 Advantages of the use of traditional healing practice



5.4.4.1 Acting as the first port of call

The study found out that Traditional healing practices act as the first port of call for people living with HIV/AIDS. Excerpt from Participant A shows that Traditional Health Practitioners (THPs) act as the first port of call when people living with HIV/AIDS (PLWHA) are sick. Before patients think of going to the clinic they first consult a Traditional Health Practitioner.

The major reason for first consulting THPs it is because historically and culturally people in the community rely on Traditional Health Practitioners (THPs) for any kind of sicknesses. The same cannot be said for ART medication because it is new and alien to the community people. Participant A outlined that some of the reasons for being the first port of call is because of the proximity and accessibility of THPs at any time of the day even during the night unlike clinics which are far and they would have to incur transport costs. In focus group discussions, Group A and Group B participants also enunciated that Traditional Health Practitioners (THPs) act as the first port of call for PLWHA. The same sentiments were shared by key informants citation from key informant A shows that Traditional Health Practitioners have a very important role to play in the community as the first port of call. They save lives through treating some sicknesses before people living with HIV/AIDS (PLWHA) go to the clinic. An individual may die whilst on the way to the clinic or when they are waiting to be treated in the queue. Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews found out there are THPs acts as the first port of call for PLWHA.

According to Ndaki (2004), the effects of HIV/AIDS have exacerbated demands on the public health care system in South Africa. The health system post-apartheid continues to be sharply divided between elite multiracial clientele who have access to the best biomedical health care and the black majority who cannot afford to access mechanized and sophisticated health care. As a result, the South African health system is having challenges to fulfill the health requirements of the black majority. Karim (2007) postulate that HIV/AIDS is putting an already overburdened system under immense strain (Abdool Karim 2007). Nonetheless**,** Pretorius (2009) states that between sixty and eight percent of the South African population continues to make the Traditional Health Practitioner its first point of call for diagnosis and treatment (Pretorius 2009). This preference is especially true in the case of STDs and HIV/AIDS (Leclerc-Madlala, 2002). This shows that traditional healing is very important and beneficial to the majority of blacks in South Africa because it acts as the first point of call especially in minor sickness given that the majority of blacks cannot afford the elite health care. On that account, the study through triangulation of

in-depth interviews, focus group discussions and key informant interviews found out that traditional healing acts as the first port of call for PLWHA.

5.4.4.2 Usefulness of THPs as referrals

The study found out that Traditional Health Practitioners (THPs) can be used as referral agencies to the clinic since they are the first port of call for people living with HIV/AIDS. Excerpt from participant B shows that Traditional Health Practitioners help people living with HIV/AIDS (PLWHA) by referring them to the clinic and hospital. This helps by encouraging PLWHA to go and get tested and it also influences those on ART to continue to take their medication. The reason being that THPs admits that they do not have the standard equipment to test HIV/AIDS as mentioned by Participant B. This helps to clear the myth and claims by some other bogus THPs that they can cure HIV/AIDS. In focus group discussions. Group A and Group B participants revealed that they refer PLWHA to the hospital for testing and encourage them to adhere to ART.

Similarly, key informant interviews also outline that they refer PLWHA to hospital for further testing and treatment. Quotation from key informant A shows that THPs refer PLWHA to the clinic for testing and treatment when they consult them first before going to the clinic. Therefore, the study through a triangulation of in-depth interviews, focus group discussion and key informant interviews found out that PLWHA consults Traditional Health Practitioners first because they are the first port of call and thereafter THPs refer PLWHA to the clinic for HIV/AIDS testing and ART.

According to Maimela (2015), Traditional Health Practitioners (THPs) have the great potential to encourage people living with HIV/AIDS to seek out ART at the clinic and hospital by referral. Okeke (2006) investigated perceptions and referral practices of Traditional Health Practitioners with regards to people living with HIV/AIDS. Okeke (2006) study found out that Traditional Health Practitioners (THPs) could greatly benefit South Africa's HIV/AIDS treatment if they would refer their patients to health care centres. The inclusion of Traditional Health Practitioners into the health care system greatly aid in the early detection and management of HIV/AIDS (Maimela, 2015). Therefore, the study through a triangulation of in-depth interviews, focus group discussion and key informant interviews found out that PLWHA consults Traditional Health Practitioners first because they are the first port of call and thereafter THPs refer PLWHA to the clinic for HIV/AIDS testing and ART.

5.4.4.3 Assist in fighting against infection

The study found out traditional healing practices helps in the fight against HIV/AIDS infection. Quotation from Participant B exhibits that traditional healing practices help in the fight against HIV/AIDS infections. Participant B encourages the use of both traditional medicine and ARVs so that these 2 different kinds of medicine can complement each other in the fight against infections. Of significance is that Participant B articulated that ARVs and all different kind of medicines are processed from traditional medicine. As a result, traditional medicine was meant to heal all types of infections that infect people living with HIV/AIDS (PLWHA). The same sentiments were shared in focus group discussions. Group A and Group B members all indicated that traditional medicine helps to fight infections and strengthen the immune system against infections. Similarly, key informants also revealed that traditional medicine helps in the fight against infections. Quotation from key informant indicates that traditional medicine helps in the fight against different kinds of infections that key informant refers to as "*Ndongondela*" (HIV/AIDS).

Therefore, the study through in-depth interviews, focus group discussions and key informants interviews found out that traditional medicine helps to fight HIV/AIDS-related infections. According to Gow (2013), Traditional Health Practitioners could greatly benefit rural South Africa's HIV/AIDS problem. Flint (2015), in a study which compares Native American and South African traditional healing, found that traditional healers in Northern America have had great success in reducing HIV/AIDS infection rates. Native American traditional healers are effective at treating illnesses involving substance-related abuse, which in turn, limits HIV/AIDS-related risks behaviours and reduces infection of the disease. Flint (2015) holds that South Africans could also achieve similar results by enabling traditional healers to help reduce HIV/AIDS infections. Traditional healers would not replace the superior biomedical treatment of HIV/AIDS, but it would rather supplement the Western healthcare centres in addressing the disease (Flint, 2015). Additionally, traditional healers could serve as disseminators of sexual education to reduce HIV/AIDS infection rates. The Western medical healthcare sector increased education and regulation of traditional healers could enable the propagation of sexual health education to individuals who visit exclusively traditional healers (Gow, 2013). This shows that traditional medicine can go a long way in helping in the fight against HIV/AIDS and transmission in South Africa. To that end, the study through a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that traditional medicine helps to fight against HIV/AIDS-related symptoms.

5.4.4.4 Less known side effects

The study found out that traditional medicine does not have any known side effects on people living with HIV/AIDS, unlike ART medication. Citation from Participant B shows that traditional medicine does not have side effects on people living with HIV/AIDS (PLWHA) because they complain of headaches and odours after taking them. The same sentiments were shared in focus group discussions. Group A and Group members indicated that traditional medicine is safe to use and it does not negatively affect PLWHA. They are all proud of traditional medicine because they see it as a natural gift from God to take care of his sick people.

Likewise, key informants praised the use of traditional medicine and the absence of side effects. That being so, the study through depth interviews, focus group discussions and key informants interviews found out that traditional medicine has fewer side effects on HIV/AIDS patients, unlike ARVs. The findings of this study concur with a study by Tshibangu, Worku, De Jongh, et al., (2014). The study found out that traditional medicines have fewer side effects and HIV/AIDS patients report an improved quality of life when they are taking both traditional medicine and ARVs unlike when they are taking ARVs only. Taylor, Dolezal, Tross *et al*., (2008) also found out that individuals taking herbal remedies ad ARVs reported better quality of life, compared to those taking ARVs alone.

According to Tshibangu et al., (2014), studies in South Africa have shown that herbal remedies are good supplements to anti-retroviral therapy because of their immune boosting properties. A study in western Uganda found that thirty-eight percent of HIV positive patients used traditional medicines and anti-retroviral drugs at the same time for the management of HIV infection. The major reasons for the use of traditional medicines were perceived as additional efficacy, improvement in the quality of life and a feeling of control over the disease. The most commonly used herbal remedies in Southern Africa which do not have any proven side effects on HIV/AIDS patients are *Hypoxis hemerocallidea* (African potato), and *Sutherlandia* (Langlois-Klassen, Kipp, Jhangri et al., 2007). This shows that traditional medicine has fewer side effects than ARVs. Consequently, the study through in-depth interviews, focus group discussions and key informants interviews found out that traditional medicine has fewer side effects on HIV/AIDS patients, unlike ARVs.

5.4.4.5 Accessibility and confidentiality

The study found out that Traditional Health Practitioners (THPs) are accessible and people living with AIDS (PLWHA) can consult them in private any time of the day, unlike clinics. Extracts from Participant B shows that Traditional Health Practitioners (THPs) are accessible to PLWHA at any time of the day, unlike clinics which are far and have opening and closing times. THPs are also confidential about the sicknesses of their patients and they do not reveal PLWHA status to anyone in the community. The same sentiments were shared in focus group discussions. Group A and Group B members revealed that they help PLWHA at any time of the day, unlike clinics which are very far and some people stay in the mountains where there are no clinics nearby. All the participants in focus group discussions revealed that they are very secretive about their patient's statuses and they respect their privacy. Similarly, key informants also said that they are accessible and very confidential.

Quotation from a key informant is reflecting that Traditional Health Practitioners (THPs) are accessible to PLWHA and they respect the privacy of their patients. That being the case, the study through the use of in-depth interviews, focus group discussions and key informants interviews found out that traditional healing practices are confidential and accessible to PLWHA at any time of the day. The findings of this study are in support of Cobb (2009) assertion that long distances journeyed by PLWHA to and from treatment locations stay one of the adherence challenges. Traditional Health Practitioners (THPs) are situated in the community, unlike nurses and doctors who are located in a number of clinics and hospitals that are far from the communities (Cobb, 2009). Poor people, who experience issues traveling long distances for treatment, benefits from the advantages of having Traditional Health Practitioners in the community. This shows that traditional healing practices are easily accessible to PLWHA. Therefore, the results of the study through the use of in-depth interviews, focus group discussions and key informants interviews found out that traditional healing practices are confidential and accessible to PLWHA at any time of the day.

5.4.4.6 Respect for PLWHA

The study found out that Traditional Health Practitioners (THPs) have more respect for people living with HIV/AIDS (PLWHA), unlike nurses. Extracts from Participant C shows nurses mistreat people living with HIV/AIDS but Traditional Health Practitioners are very caring and respectful of PLWHA when they go to consult. Participant C confidently said that traditional healing is like a calling to them, unlike nurses who go to school to do practice nursing. This means that for nurses they do not have passion for their job and they do it for the benefits that come with being a nurse, unlike THPs who are chosen by their ancestors to practice traditional healing.

The same sentiments were shared in the group discussions. Both Group A and Group B member concurred that nurses mistreat PLWHA unlike THPs because they have a sense of Ubuntu. Similarly, key informants lamented the mistreatment of PLWHA by nurses and praised how THPs treat patients with care and respect. Quotation from key informant A shows that the participants of the are pained by the level of mistreatment that PLWHA suffer in the hands of nurses at the clinics and hospitals. That being so, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that one of the advantages of traditional healing practice is that THPs have care and respect for PLWHA, unlike nurses.

The findings of this study are in support of Ganle (2015) study which found out that nurses in clinics mistreat patients and disregard their patients' cultural needs which can drive them to utilise the services of Traditional Health Practitioners because they treat patients very well and respect culture and traditions. Labhardt (2010) notes that one of the major reason why Traditional Health Practitioners treat nurses with care and respect it is that they are more culturally focused and they have patient-centered interactions, unlike nurses who meet patients at public clinics where there are no individual centred interactions. The advantages of using THPs is that they treat patients with care and respect unlike at the clinic with nurses. Therefore, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that one of the advantages of traditional healing practice is that THPs have care and respect for PLWHA, unlike nurses.

5.4.4.7 Inexpensive and acceptable

The study found out that traditional healing practices are inexpensive and acceptable to people living with HIV/AIDS, unlike ARVs. Citation from Participant G demonstrates that traditional healing practices are cheap compared to ARVs despite the fact that they are free because participants are allowed to use livestock as a payment method.

ART is expensive because of the transport cost required to collect the pills as outlined by Participant G. This is in support of a study by Rosen, Ketlhapile, Sanne and DeSilva (2017) which found out that an average cost of transport to go to the clinic in town was between 10-20 whilst in the cost to attend a rural clinic was high between R30-70 per trip. Therefore, the cost of transport to go to a rural clinic was too high given that the HIV positive person must visit a treatment clinic at least 6 times in the year in which they start to get ART medication (Rosen *et al*., 2017). However, of significance is that participant G said that patients who come from far places like Johannesburg and Kimberly are charged four hundred Rands for consultation. This shows that contrary to popular belief that traditional healing is cheap, some Traditional Health Practitioners are expensive. Nevertheless, in the context of this study, it depends on where the HIV/AIDS patient is coming from. If the patient is coming from the community is inexpensive because they are even allowed to use livestock for payment but patients from afar they have to pay about R400.

Furthermore, the study found out that the advantage of traditional healing is that it is acceptable to people living with HIV/AIDS than ART medication. A quotation from participant H shows that traditional healing practices are acceptable to PLWHA and there is some sickness that is believed to be cured by traditional healing practices only. In the focus group discussions, all Group A and Group B members indicated that traditional healing practices are acceptable and inexpensive especially for people around the community, unlike those patients who come from far places. Similarly, key informants also verbalized that traditional healing practices are less costly than western medicine. Quotation from key informant B shows that traditional healing practices are cheap to PLWHA. Thus, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that traditional healing practices are inexpensive compared to ART. The findings of this study are in support of Stekelenberg (2005) who postulated that rural South Africans consult Traditional Health Practitioners (THPs) because principally they are effortlessly accessible, acceptable and inexpensive. Furthermore, traditional

healers often utilised a no cure, no pay system, and they would also accept commodity payment like cows (Stekelenberg, 2005). As a result, these economic factors likely appeal more to rural poor people who are not involved in the cash economy.

However, of significance is that Participant G stated that people with HIV/AIDS (PLWHA) who come to consult from places that are far like Johannesburg or Kimberly are charged about R400 for consultation. This exhibits that traditional healing practices are cheap depending on where the patients would traveling from. Thus, traditional healing practices are inexpensive to patients who come from the village of the THPs whilst expensive to patients who come from places that are far from the THPs. Conclusively, traditional healing practices are inexpensive, accessible and acceptable to rural HIV/AIDS patients more than ART. That being the case, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that traditional healing practices are inexpensive, acceptable and convenient to rural PLWHA than ART.

5.4.4.8 Preserves indigenous knowledge and culture

The study found out that traditional healing practices preserve the indigenous knowledge and culture in the healing of people living with HIV/AIDS. Extracts from Participant E shows that traditional healing practices are the pride of indigenous people and it preserves their culture and tradition, unlike the ART which they do not trust.

Traditional healing practices have been passed from one generation to another and it has helped to heal indigenous people throughout the centuries before they knew western medication. In the focus group discussion, all Group A and Group B members stated that traditional healing practices preserve indigenous culture and tradition in healing. Traditional Health Practitioners (THPs) in group discussions indicated that they have a duty and responsibility to preserve it for future generations, the same way their ancestors preserved it for them. Likewise, key informant's share the same sentiments that traditional healing practices preserve indigenous culture and tradition. Quotation from key informant B in a way describes the indigenous traditional society and how traditional healing practices is part of the culture and heritage of indigenous people. According to key informant B, an indigenous traditional society is based on love, peace and care for one another, unlike the modern-day society which is based on individualism. Thus, traditional healing practices help to reinforce the culture of love, peace, and care for the community. Therefore,

Traditional Health Practitioners (THPs) tries to preserve indigenous culture, traditions, and knowledge through healing people living with HIV/AIDS (PLWHA). Thus, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that traditional healing practices preserve indigenous knowledge and culture of indigenous people. According to Zuma, Wight, Rochat, and Moshabela (2016), Traditional Health Practitioners (THPs) are important to the population and culture of South Africa, because they serve as counselors, mediators, spiritual protectors and teachers of traditional African religion, customs, and culture. They are important to South Africa because of their wide-spread prevalence, their current relationship with Western healthcare and their potential to address many of South Africa's healthcare issues by increasing interaction between the two sectors.

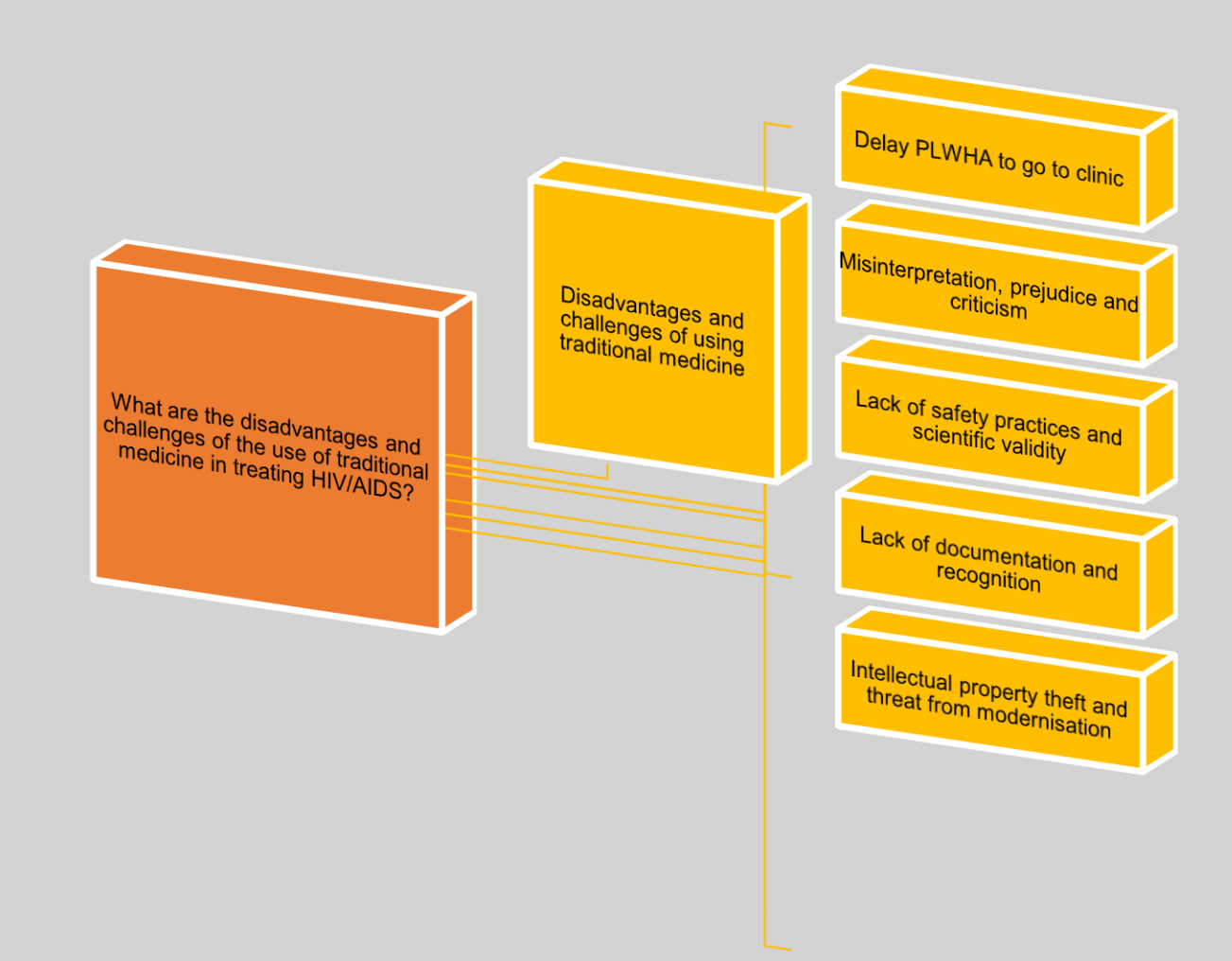
Of significance is that large numbers of traditional healer's service much of South Africa. Liddel, Barret, and Bydawell (2004) state that South Africa's population of just over 50 million is home to an estimated 300 000 Traditional Health Practitioners compared to approximately 33 000 medical professionals (South African Department of Labour, 2008). Moreover, Traditional Health Practitioners are widely popular. The World Health Organization (WHO) estimates that approximately 80% of South Africans utilise the services of Traditional Health Practitioners (WHO, 2008). The high prevalence and usage of Traditional Health Practitioners (THPs) in South Africa can be attributed to a multitude of factors that acts as barriers to accessing healthcare such as; the cost of transport, inaccessibility of clinics in remote rural areas. This shows that Traditional Health Practitioners play a very important role in South Africa health sector, healing PLWHA and preserving indigenous knowledge and culture. To that end, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that traditional healing practices preserve indigenous knowledge and culture of indigenous people and they play a very important role to South Africa's health sector.

5.4.5. Disadvantages and challenges of the use of traditional healing practices

The study found out that there are many disadvantages and challenges that come with the use of traditional healing practices. They involve the following; delay PLWHA to go to clinic, misinterpretation, prejudice, and criticism, lack of safety practices and hygiene, lack of scientific validity and standardization, lack of documentation and recognition, under threat from modernization. Understanding the disadvantages and challenges of traditional healing practices

helped in, informing interventions measures and strategies that help in making partnerships with health professionals THPs and community members to support ART adherence.

Figure 5.6 Disadvantages and challenges of the use of traditional healing practices



5.4.5.1 Delay PLWHA to go to the clinic

The study found out that the disadvantage of using traditional healing practice was that it delays people living with HIV/AIDS (PLWHA) to go to the clinic to consult and get tested. Extracts from Participant A shows some traditional healers who claim to cure HIV/AIDS delay and discourage people from living with HIV/AIDS. Of significance is that 2 out of 9 participants of the study claimed

that they cure HIV/AIDS and confessed that they do not encourage their patients to go and get tested at the clinic or to take ARVs.

This shows that a minority of participants of this study delay PLWHA from going to get and discourage ART adherence. Besides the delay by THPs who claim to cure HIV/AIDS, PLWHA are indirectly delayed to get tested because getting medication from THPs gave them a false sense of hope that they are healed and they would personally see the need to go to the clinic after. It would seem true that they are healed especially the period when the HIV/AIDS would be dormant in the system of their body. Consequently, by the time that the HIV/AIDS virus become active and attack them, it may be too late to go to the clinic and for the ARVs to be effective as participant A indicated that sometimes patients go to the clinic when their CD4 count is too low. In the focus group discussions, both Group A and Group B member admitted that they, directly and indirectly, delay patients from getting tested and taking ARVs.

2 members from Group A confessed that they directly delay patients from getting tested at clinics because they believe that there is no need for treatment from clinics because they can cure HIV/AIDS. Similarly, key informants also revealed that traditional healing practices delay people living with HIV/AIDS (PLWHA) from going to get tested and getting ART medication. Citation from key informant B shows that Traditional healing Practices (THPs) delays HIV/AIDS patients to get tested and seek treatment at the clinic because a minority of THPs claim to cure HIV/AIDS which negatively influences PLWHA. PLWHA believes and trusts in THPs even though some of them misled them. Key informant cited Mantho Tshabalala as one of the people who mislead PLWHA into believing that eating beetroot treats HIV/AIDS.

As a result of the former South African Health Minister, PLWHA stopped going to the clinic to get tested and seeking ART. This shows that traditional healing practices delay PLWHA from getting tested and seeking treatment. Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that traditional healing practices delay PLWHA from getting tested and seeking treatment. The findings of this study concur with Zuma (2017) assertion that the usage of traditional health practitioners (THPs) lingers to delay individuals from timeously procuring care, and adhering to ART. By the time that the individual goes to consult, it may be too late for them to recover because their CD4 count would be below two hundred and they will be very susceptible to many opportunistic infections. Therefore, a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that traditional healing practices delay PLWHA from getting tested and seeking ART.

5.4.5.2 Misinterpretation, prejudice and criticism

The study found out that Traditional Health Practitioners are misinterpreted, prejudiced and criticized for conducting traditional healing practices of people living with HIV/AIDS. Quotation from Participant F shows that Traditional Health Practitioners are misinterpreted, judged and criticized for healing people living with HIV/AIDS (PLWHA). Sadly, there are people who see them as witch doctors and not Traditional Health Practitioners (THPs) who helps in healing PLWHA. Participant F justified that Traditional Health Practitioners are not wicked doctors or fake because they have been healing the sick in traditional society even before the coming of western medication. The same sentiments were shared in focus group discussions.

All members of Group A and Group B revealed that they are disappointed that some member of the society sees them as witch doctors which is unfair. Likewise, the key informant also bemoaned the misinterpretation, prejudice, and criticism of THPs in society. Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that traditional healing practices are misinterpreted, prejudiced and criticized. According to Giarelli and Jacobs (2003), a traditional healing practice phenomenon is interestingly shrouded in unawareness, prejudice also a misrepresentation.

People do not understand it, especially from the western world. Besides the western world, even indigenous people they label Traditional Health Practitioners with all sorts of names such as wizards and witch doctors. As a result, traditional healing practice methods of treating people living with HIV/AIDS are met skepticism by some biomedical practitioners amid increasing access to anti-retroviral therapy (ART). This shows that Traditional Health Practitioners face a huge challenge in treating PLWHA given the misinterpretation, prejudice, and criticism that they are subjected to in society. To that end, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that traditional healing practices are misinterpreted, prejudiced and criticized.

5.4.5.3 Lack of safety practices, hygiene, and scientific validity

This study found out that lack of safety practices, hygiene, and scientific validity are challenges that traditional healing practices face in healing HIV/AIDS patients. Quotation from Participant B

shows that traditional healing practices lack safety practices, hygiene and the science that is needed to develop it and prove to the world that traditional healing practices heal HIV/AIDS. Participant B was well aware of these challenges and hope that they can improve especially in the science that is needed to develop traditional medicine given the fact that many young people now opt for western medication that traditional medicine. The same challenges were also raised in a focus group discussion. All participants in both Group A and Group B revealed that they lack the science that is needed to develop traditional medicine into treatment that is acceptable to western societies. All 5 members of Group A revealed that they wish to process their traditional medicine so that it can be sold in pharmacies. All 4 members in Group B admitted that traditional healing practices lack hygiene and safety practices because they make use of razor blades and needles in treating HIV/AIDS patients. However, they all said that they are improving in hygiene and safety practices.

Similarly, key informants also stated that traditional healing practices lack safety practices, hygiene, and science to develop it. Citation from key informant A shows that traditional healing practices lack the technology to process traditional medicine into pills. THPs have knowledge about traditional medicine but they have to develop and process it into acceptable standards by Health officials. Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews show that Traditional Health Practitioners lacks safety practices, hygiene, and science needed to develop it. According to Giarelli and Jacobs (2003), traditional healing practice has been claimed to be unscientific, deficient in both scientific validity and appropriate policies for its products and practices. Yet, further research proposes how THPs can be advantageous in the milieu of HIV/AIDS. Indigenous belief systems drive momentous echelons of therapeutic diversity with the continual usage of traditional healing in conjunction with ART care, predominantly in countryside populations (Giarelli and Jacobs, 2003).

According to the WHO (2012), the quantity and quality of safety and efficacy facts on traditional medicine are not sufficient to meet the standards desirable to support its usage globally, hence this study will contribute to this knowledge gap. As a result, numerous policy procedures should be applied to the use of traditional medicine, in order to upsurge its acceptability, safety, and efficacy to HIV/AIDS patients. This shows that traditional healing practices they need to improve their safety practices, hygiene, and scientific validity. Therefore, the study through triangulation of in-depth interviews, focus group discussions and key informant interviews found out that Traditional Health Practitioners lacks safety practices, hygiene, and science needed to develop it.

5.4.5.4 Lack of documentation

The study found out lack of documentation as one of the challenges that were faced by traditional healing practices. Citation from participate E shows that traditional healing methods are not documented because it is the knowledge that has been orally passed on from one generation to another without anything written down. As a result, it lacks a blueprint or framework that Traditional Health Practitioners can follow, for example, participant E stated that Christians follow the bible but THPs do not have a blueprint document to guide them in the healing of HIV/AIDS. The same sentiments were shared in the focus group discussion. All participants in Group A and Group B indicated that traditional healing practices lack documentation because the indigenous people lacked the ability to read and write. Likewise, the key informants of the study reveal that Traditional Health Practitioners have challenges in documenting their traditional healing practices because it has been passed from one generation to another through oral tradition.

Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews show that traditional healing practices lack documentation and recognition in healing HIV/AIDS patients. According to Giarelli and Jacobs (2003), traditional healing practices exists in the community and has been passed verbally from previous generations yet there are few well-documented knowledge and research about it. Even in the mainstream media like on television, it is not celebrated as much as western biomedical treatment, for example, World AIDS day is more western treatment orientated (Giarelli and Jacobs, 2003). This shows that there is a lack of research and documents that gives the framework to guide traditional healing practices. That being so, the study through triangulation of in-depth interviews, focus group discussions and key informant interviews found out that Traditional Health Practitioners lacks documentation that proves and act as a guideline for traditional healing practices.

5.4.5.5 Lack of recognition and revision of the THP Act

The study found out that Traditional Health Practitioners (THPs) face a challenge of lack of recognition as far as HIV/AIDS issues are related and they face challenges to register with the Traditional Health Practitioner Council. Traditional Health Practitioners (THPs) are having difficulties in registering in the official board of THPs because of the minimum requirements that

are needed for a THP to register as a member. As a result, they have to revise the requirements so that they can be able to in co-operating those Traditional Health Practitioners (THPs) so that they can officially help in the fight against HIV/AIDS. Furthermore, traditional healing practices lack recognition. Although there is a Traditional Health Practitioners Bill, excerpts from participate C shows that there is a lack of implementation of the bill. Traditional Health Practitioners (THPs) feels like they are not recognized enough by the government and the Department of Health (DOH).

Participant C write referral letters to the clinics as a way of reaching out to the Department but they have no response or some sort of partnerships with the nurses or doctors at the clinics and hospitals. This shows that Traditional Health Practitioners puts some efforts in reaching out to health professionals but they feel frustrated because they do not reciprocate, acknowledge or recognize Traditional Health Practitioners when they refer to a patient. The same sentiments were shared in the focus group discussion. Both Group A and Group B members concurred that nothing much has been done by Traditional Health Practitioners (THPs) besides rebranding them from being called traditional healers to being called Traditional Health Practitioners but when it comes to the healing of HIV/AIDS, the bill does not help them in a way because the health professional is not yet recognising them.

They also indicated that they face difficulties in registering as Traditional Healers Practitioners because of the requirements such as educational certificate and training. They requested that if the government could reduce the requirements that are needed for many THPs to be registered by the council. Of significance is that all Traditional Healing Practitioners (THPs) who participated in this study were registered with the council because the participant's sampling criteria for legibility to participate in the study was for only registered Traditional Healing Practitioners with the council. Likewise, key informants also revealed a lack of recognition and registration as a challenge facing THPs. Traditional Health Practitioners are facing difficulties to register with the national board. The government must revise the requirements that are needed to be registered as a THP since traditional healing practice is through calling and aptitude in education. Thus a triangulation of focus group discussion, in-depth interviews and focus group discussions show that Traditional Health Practitioner (THPs) face a challenge of lack of recognition and registration with THP board.

In 2014, the Traditional Health Practitioners Act was passed to standardize and regulate the affairs of all traditional healers (Street and Rautenbach, 2019). However, after additional regulations were published to give effect to the act. The government has invited public comment

on the regulations. The act and the proposed regulations have been criticized by some Traditional Health Practitioners who believe that they are unrealistic and unworkable. The act has established an interim council to provide a regulatory framework. This allows for traditional healers to be registered and categorized according to their different healing specialties (Street and Rautenbach, 2019). These include; a diviner (those who have a calling from ancestral spirits), a herbalist (someone practising herbalism), student (someone training to be a traditional healer), traditional birth attendant (a midwife), traditional tutor (a traditional healer trainer) and traditional surgeon (someone performing cultural operations such as circumcision). Street and Rautenbach (2019) states that regulations place several additional responsibilities on Traditional Health Practitioners (THPs), which could be costly and time-consuming. First and foremost, the proposed regulations require Traditional Health Practitioners (THPs) to undergo education or training at an accredited training institution or educational authority.

This is to ensure that the profession complies with universally accepted health care norms. However, the practicalities of how, when or where this training will take place remains indeterminate (Street and Rautenbach, 2019). This is particularly challenging as because currently there are no accredited training institutions. A prospective trainer would have to register at a cost of R500. They would need to provide a list of their qualifications and details of the course modules, practical skill that would be acquired and duration (Street and Rautenbach (2019). Nevertheless, the minimum skills or qualifications are not defined in the regulations. One of the most bizarre requests is for Traditional Health Practitioner (THPs) trainers to produce copies of their teaching or learning materials. This may have serious implications for intellectual property rights. The tutors or training institutions will also need to keep in mind that there are different categories of traditional healers that are recognized in terms of the Act. Each category has different training needs. Diviners, herbalists and traditional birth attendants need to train for a minimum of one year while traditional surgeons need to train for at least 5 years (Street and Rautenbach, 2019). The onus will be on trainers to ensure that their students are registered with the council. At the end of their training, students need to submit a logbook to the council, providing details of the observations and procedures they undertook during their training. The regulations place several additional responsibilities on Traditional Health Practitioners (THPs), which could be costly and time-consuming.

This shows that it is difficult for Traditional Healing Practitioners to register with the council since there are many requirements and technicalities that are involved in the process. As a result, most of the Traditional Healing Practitioners end up failing to register with the council. Jordaan (2018)

states that Traditional Healing Practitioners (THPs) has called on the government to scrap the Traditional Healing Practitioners Act which regulates because it tramples their rights to practice. As a result, they want to be self-regulated. In a Sunday Times newspaper article by Jordaan (2018), Phepsile Maseko, the National co-ordinator of the Traditional Healers Organisation said that "*We have been saying that the best methodology is self-regulation. When we talk about traditional healing, there is nothing as important as self-regulation. They [government] called us in 2016 to talk about the regulations. They brought a draft and asked our input but they did not take any of our suggestions. Traditional healers should not be regulated as they were born with the gift of healing and did not go to school for it"* (Jordaan, 2018).

Furthermore, Thoko Mkhwanazi-Xaluva the chairperson of the Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities rallied that, "*We need to rise up and fight against being regulated. This system is going to swallow us. We are in trouble. They do as they please with us. It's time we stood up. We are a religion - it's time you treat us like a religion. Let's demand the same treatment*" (Jordaan, 2018). In addition, Thobeka Kentane, the deputy general secretary of the National Unitary Professional Association for Traditional Health Practitioners of South Africa articulated that, "*There is no person who is a traditional health practitioner who chose to be a healer. This is a calling. Where is legislation that speaks to us, to who we are and what we do? We need to interrogate this act and ask what competencies government has to regulate us*" (Jordaan, 2018:1). The given quotations from three different prominent Traditional Health Practitioners (THPs) shows that the THP bill is a contentious issue between Traditional Health Practitioners and the government. There are a lot of shortcomings in the bill that trample the rights of Traditional Health Practitioners. Of significance is that the THP Act requirement for professionalization is too western-oriented than indigenous oriented because THPs are gifted natural. Thus, they do not need any professional qualifications like nurses and doctors. Therefore, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews, found out that Traditional Healing Practitioner is not recognized as far as HIV/AIDS issues are related and they face challenges to register with the THP council. As a result, there is a need for the revision of the THP Act.

5.4.5.6 Intellectual property theft and a threat from modernization

The study found out that there was theft of intellectual property of traditional healing practices and it is under threat from modernization. Traditional Health Practitioners have been victims of intellectual theft from medical professionals. One of the reasons why they have been victims of

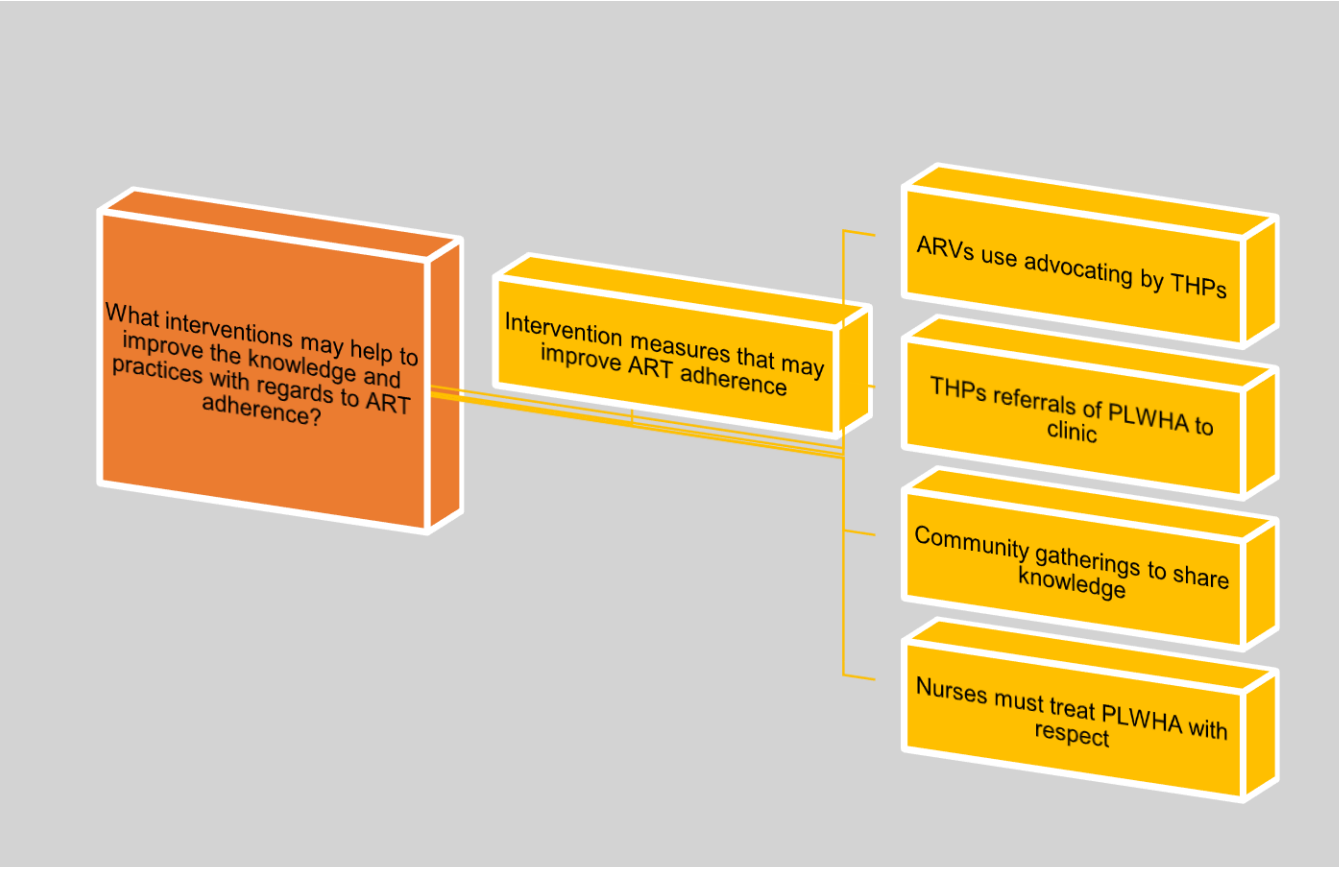
intellectual theft is because they were not aware that they have exclusive rights to their knowledge with regards to traditional healing. In the focus group discussion, both Group A and Group B member revealed that traditional healing practices are under threat from modernization. They bemoaned that traditional healing practices have been pushed in the background in favour of western medication. 2 members in Group B indicated that they have been victims of intellectual theft by western health professionals. Similarly, the key informants share the same sentiments about the theft of intellectual property and threat by modernization. Indigenous people have been sought of brainwashed by the Apartheid regime to stop believing in traditional healing practices. One way of brainwashing indigenous people was by classifying Traditional Health Practitioners under witchcraft which stigmatized them. Consequently, it led to a loss of self-esteem, doubting of the knowledge of Traditional Health Practitioners and preference of western medication.

As a result, key informant A, founded an organisation called the African Young Eco-Minds Dialogues to work with young people on developing them to have ecological minds and embrace their cultural heritage because it is under threat from modernization. According to Ramokgopa (2013), enthusiasm for the properties and advantages of medicinal plants is on the expansion and Western pharmaceutical organizations have come to consider natural prescription as a wellspring of reference for the readiness of engineered drug. However, some of these organizations are, be that as it may, utilising conventional solution without the authorization of customary healers. This is the aftereffect of the absence of acknowledgment managed conventional healers and licensed innovation rights staying forbidden in the customary human services area (Ramokgopa, 2013). This shows that Traditional Health Practitioners (THPs) are victims of intellectual property theft and traditional healing practices are under threat from modernization.

5.4.6 Intervention measures that improve anti-retroviral treatment adherence

The study found out that there are many intervention measures that can help to improve anti-retroviral treatment adherence. Intervention measure comprises of the following; THPs advocating of the use of ARVs, THPs referrals of PLWHA to the clinic, community gatherings to share knowledge and nurses must have a positive attitude towards people living with HIV/AIDS (PLWHA). Understanding intervention measures would help in improving ART adherence amongst PLWHA in the Vhembe District of Limpopo Province, South Africa.

Figure 5.7 Intervention measures that can improve anti-retroviral treatment adherence



5.4.6.1 Advocating of ARVs use by THPs

The study found out that Traditional Health Practitioners (THPs) must be advocates of ART adherence in the community because they have a big influence on people living with HIV/AIDS. Traditional Health Practitioners are excluded in the health meetings that are held in the

community. In the meetings, the health professional would be discouraging people from using traditional medicine. However, discouraging people in the meetings to stop taking traditional medicine doesn't help much in the long run because people living with HIV/AIDS (PLWHA) still continue to consult THPs and use traditional medicine.

Therefore, the best way like participant A said is to involve THPs in the meetings and use them as advocates for ART adherence since they have an influence on their patients. The same sentiments were shared in focus group discussions. All members in Group A and Group A indicated that they are excluded in health-related meetings in the community and they wish to be also involved and use as advocates for ARV adherence in the community. Likewise, key informants revealed that THPs are excluded in health-related meetings in the community and that must change because health officials would be denouncing the use of traditional healing practices. THPs are excluded in HIV/AIDS-related matters but they must be used as activists for ART adherence because they stay in the community and they have an influence on people living with HIV/AIDS.

Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews show that THPs are excluded in meetings about ART adherence and there is a need to involve them and utilise them as advocates for ART adherence in the community. The finding of this study corroborates a study by Centre watch (2019) which found out that involving THPs healers as anti-retroviral therapy (ART) adherence advocates and counselors can help to improve ART adherence among people living with HIV/AIDS. Centre watch (2019) found out that Traditional Health Practitioners are often accused of encouraging patients to abandon HIV care, but they can also serve as strong advocates for ART adherence. In the study, when THPs were engaged as ART adherence counselors and advocates in South Africa, their patients were more successful than those supported by non-Traditional Health Practitioners counselors. As a result, there is a need for an innovative solution that should engage and train Traditional Health Practitioners (THPs) as ART partners to support ART adherence. On that account, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews show that THPs are excluded in meetings about ART adherence and there is a need to involve them and utilise them as advocates for ART adherence in the community.

5.4.6.2 THP referrals of PLWHA to the clinic

The study found out that Traditional Health Practitioners (THPs) must be used as referral agents for people living with HIV/AIDS (PLWHA) to the clinic to improve ART adherence and prevent delay of PLWHA from seeking ART from the clinic or hospital. South African government must make Traditional Health Practitioners (THPs) official referral agents of HIV/AIDS patients to improve HIV/AIDS testing and ART adherence. Making Traditional Health Practitioners (THPs) official referral agents would make people living with HIV/AIDS to seek ART early from the clinic unlike delaying them.

The same sentiments were shared in focus group discussions. Group A and Group B members concurred that Traditional Health Practitioners must be used as official referral agents of PLWHA to the clinic. Similarly, key informants also indicated the need for Traditional Health Practitioners (THPs) to be recognized as official referral agents to the clinic. Traditional Health Practitioners they are willing to help the Department of Health through referring PLWHA to the clinic and hospital but the Department do not recognize their help and efforts which in the end it de-motivates and frustrate Traditional Health Practitioners. This would result in people living with HIV/AIDS delaying to go seek treatment at the clinic because THPs are not motivated enough to encourage and influence them to go to the clinic to be tested and adhere to ART. Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews show that THPs should be used as referral agents of PLWHA to clinics.

The findings of this study corroborate with Okeke (2006) statement that Traditional Health Practitioners (THPs) have the great potential to encourage and refer patients to the clinic to get tested and adhere to ART. Utilising Traditional Health Practitioners (THP) as referral agents may go a long way in improving ART adherence because the majority of South Africans consult Traditional Health Practitioners. The World Health Organization (WHO, 2018) estimates that approximately 80% of South Africans utilise the services of traditional healers. This shows that if THPs can become referral agents of HIV/AIDS patients to the clinic, they can be able to reach 80% of the population of South Africa. Therefore, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that THPs should be used as referral agents of PLWHA to clinics to improve antiretroviral treatment adherence and delay PLWHA from seeking treatment from the clinics and hospitals.

5.4.6.3 Community gatherings to share knowledge

This study found out that there is a need for community gatherings to share knowledge about HII/AIDS and ART adherence so that people can know the importance of adhering to ART. Sharing of knowledge in community gatherings would also help in dispelling some myths and beliefs about HIV/AIDS in the community such as some THPs beliefs that they can cure HIV/AIDS. There is a need for community gatherings that share knowledge about HIV/AIDS because some people like participant D still believe that HIV/AIDS can be cured by traditional healers. These community gatherings must involve Traditional Health Practitioners and Health professional such as nurses so that people can share knowledge and be taught about HIV/AIDS and the importance of ART adherence. In focus group discussions, participants shared the same idea that there is a need for community gatherings where people share knowledge about ART adherence.

Likewise, key informants also highlighted the need for community gatherings to improve ART adherence. Citation from key informant B shows that there is a need to share knowledge about HIV/AIDS in the community because some Traditional Health Practitioners (THPs) do not understand the nature of HIV/AIDS as evidenced by key informant B narrative. Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews show that there is a need of community gatherings that share knowledge about HIV/AIDS because some people in the community including THPs do not have the knowledge about HIV/AIDS and the importance of treatment adherence. The findings of this study are in support of Klosinski and Brooks (2008) statement that a patient's level of knowledge about HIV infection and a conviction that ART adherence is worthwhile as it leads to a prolonged life. The reason being that an HIV/AIDS patient with knowledge would acknowledgment that poor ART adherence may bring about viral resistance and treatment setback (Wenger, 2009).

Consequently, there is a need for Traditional Health Practitioners, Health professionals and community members to come together and share knowledge about the nature of HIV/AIDS so that myths and beliefs about HIV/AIDS in the community can be dispelled given that there are some THPs such as participant B who believes that they can cure HIV/AIDS. That being the case, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews shows that there is a need of community gatherings that share knowledge about HIV/AIDS because some people in the community including THPs do not have the knowledge about HIV/AIDS and the importance of ART adherence.

5.4.6.4 Nurses must treat PLWHA with respect

The study found out that nurses should treat people living with HIV/AIDS (PLWHA) with respect so that ART adherence may improve. The reason being that some PLWHA dreads going to take medication at the clinic because of the nurse's negative attitude towards them. A quotation from participant C shows that nurses have a negative attitude towards people living with HIV/AIDS. As a result, they are frightened to go to take ART medication at the clinic.

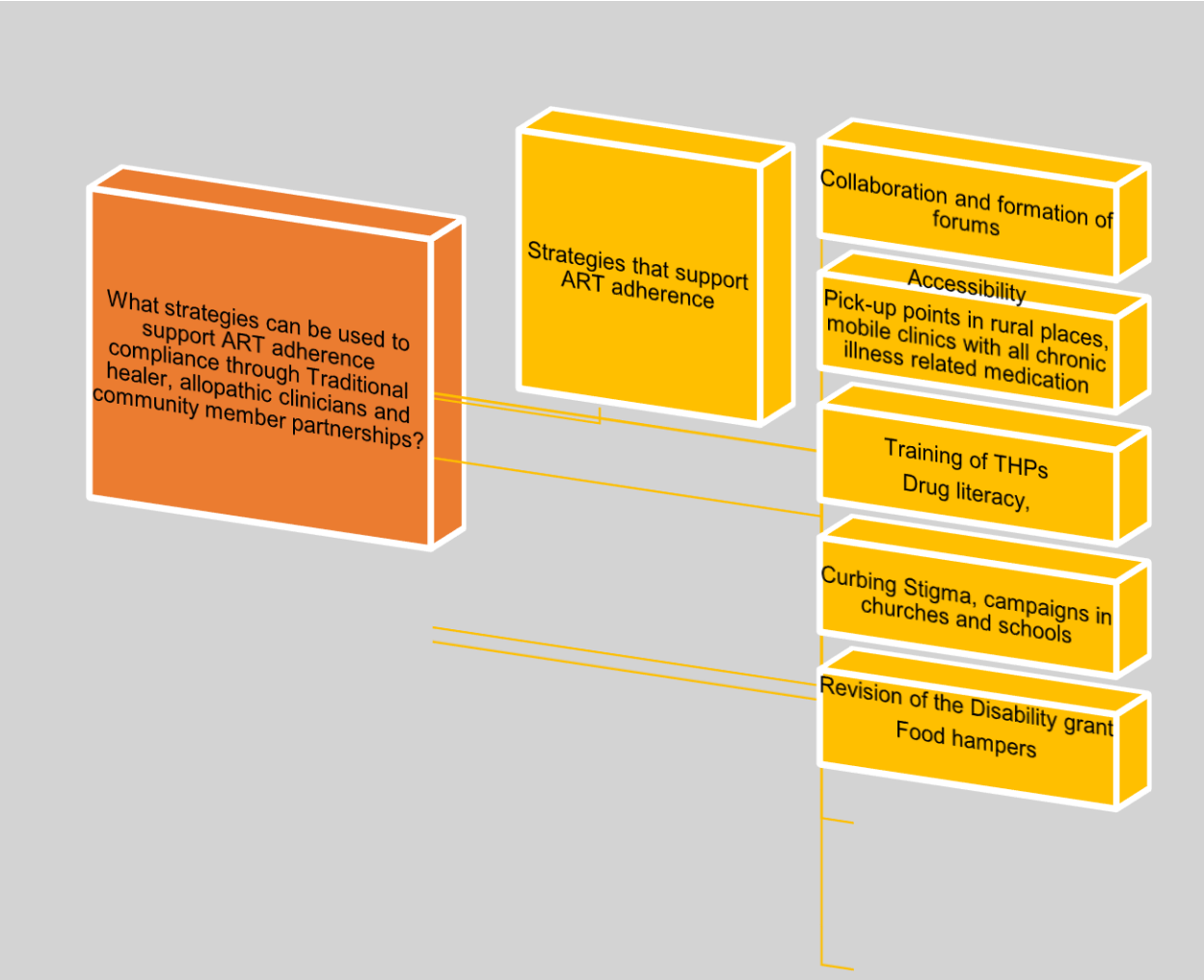
A change in attitude by nurses may lead to improvement of ART adherence by PLWHA. In the focus group discussions, all participants in Group A and Group B revealed that nurses have a negative attitude towards PLWHA. They suggested that in order for PLWHA to improve ART adherence, nurses need to respect patients. Similarly, key informants lamented about the negative attitude of nurses towards people living with HIV/AIDS (PLWHA). Citation from key informant B reiterates the need for a nurse to change their attitude towards PLWHA. Nurses must be friendly, caring and welcoming to the PLWHA so that they improve their ART adherence. Thus, a triangulation of in-depth interviews, focus group discussion, and key informant interviews show that there is a need for nurses to change their attitude towards PLWHA because they complain about mistreatment when they go to the clinic to collect ART medication. The findings of this study corroborate Ganle (2015) assertion that nurses have a negative attitude towards people living with HIV/AIDS (PLWHA). Consequently, it has a negative impact on ART adherence because some patients they dread to go to the clinic to get tested and take ART medication. That being so, the study through a triangulation of in-depth interviews, focus group discussion, and key informant interviews shows that nurses should treat people living with HIV/AIDS (PLWHA) with respect and care so that ART adherence may improve because they complain about mistreatment when they visit the clinics or hospitals for testing, treatment and taking medication.

5.4.7 Strategies that support anti-retroviral treatment adherence

The study found out that there are many strategies that can be used to support ART adherence compliance through Traditional Health Practitioner (THP), allopathic clinicians and community member partnerships. As shown in Figure 5.8 in the upcoming page, the strategies involve the following; collaboration and formation of forums, accessibility, training of THPs, media campaigns

and revision of the Disability grant. Understanding the strategies that participants of the study suggested may help in improving ART adherence.

Figure 5.8 Strategies that support treatment adherence



5.4.7.1 Collaboration and formation of forums

The study found out that collaboration and formation of forums can be a strategy that can be used to improve ART adherence amongst people living with HIV/AIDS. A quotation from participant A shows that there must be a collaboration and partnership of Traditional Health Practitioners and Health professionals to heal HIV/AIDS. Participant A narrated a story of healing a patient's leg

which the doctors had recommended for amputation at Mankweng hospital. The ability of Traditional Health Practitioners (THPs) to heal the leg shows that both THPs and Health professionals should share knowledge, learn from each other and collaborate to heal HIV/AIDS. It is mainly through collaboration that both THPs and health professional can improve ART adherence. Furthermore, Participants of the study suggested the formation of THPs and health professional forums.

Excerpts from Participant B shows there is a need to form some forums of Traditional Health Practitioners (THPs) and Health professionals to share knowledge and assist on how to heal HIV/AIDS. Participant B suggested formations of the forums emulating the model of circumcision schools where medical doctors and THPs work together to circumcise people. It has been a success story worth emulating because ever since the circumcision forums started, initiates are no longer dying in the circumcision than before THPs and Medical doctors collaborated. The same sentiments were shared in focus group discussions. All participants in Group A and Group B concurred that there is a need for collaboration and the formation of forums between THPs and medical forums to heal HIV/AIDS.

Similarly, the key informants suggested the need for collaboration to heal HIV/AIDS. Quotation from key informant A shows that there is a need for collaboration between Traditional Health Practitioners (THP) and Health professional to heal HIV/AIDS. The sharing of knowledge between THPs and health professional on HIV/AIDS sicknesses is very important. Key informant A revealed that some patients, unfortunately, die in hospital because Health professionals would have been defeated but some of these sicknesses THPs are able to heal them. At the end of the day, the most important thing is the life of the patient which is supposed to be saved regardless of the fact that it's a doctor or a THP who saved it. Thus, the most important thing is to collaborate and share knowledge to save lives and improve ART adherence. That being so, a triangulation of in-depth interviews, focus group discussions and key informant interviews show collaboration and formation of forums between Traditional Health Practitioners (THPs) can be a strategy that can be used to improve ART adherence amongst People living with HIV/AIDS. According to Struthers and Eschiti (2004), Traditional Health Practitioners have what it takes and experience to treat a scope of illnesses, which has been perceived by the World Health Organization and the United Nations Conference on Environment and Development (UNCED). For instance, conventional wellbeing professionals utilise herbs, for example, the African willow (South Africa), the hoodia plant (Namibia) and "iboga" (Gabon and Cameroon) to treat conditions like cancer, obesity and drug addiction (Floyed, 2009). Therefore, there is a need for collaboration between Traditional

Health Practitioners (THPs) and health professionals to heal HIV/AIDS and improve ART adherence amongst PLWHA. That being the case, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that collaboration and the formation of forums between Traditional Health Practitioners (THPs) can be a strategy that can be used to improve ART adherence amongst people living with HIV/AIDS.

5.4.7.2 Accessibility

The study found out that the Department of Health (DOH) must make ARVs more accessible to people living with HIV/AIDs (PLWHA) through building more clinics in remote areas and utilizing Traditional Health Practitioners (THPs) as distribution agents for ARVs in the community. Excerpts from participant B shows that there is a need to improve the accessibility of ART medication in the community through building more clinics to reach out PLWHA staying in remote villages and training THPs to distribute ARVs so that PLWHA will not have to travel for long distances to take ART medication. In this regard, there should be pick-up points in rural places for ARVs. Currently, pick-up points are only found the in CBD area. However, the pick-up point should have all chronic illness related medication to avoid stigma and conceal who will be going for ART or for cancer medication.

Another advantage of using THPs as distribution agencies is that PLWHA would not have to worry about confidentiality issues or being seen at a public clinic by other community members. In focus group discussions, all Group A and Group B members revealed that more clinics are needed in the community and that THPs must be trained about how to test HIV/AIDS and be used to distribute the medication to HIV/AIDS positive patients. Similarly, key informants also bemoaned the lack of clinics in remote villages and the need to improve the accessibility of ARVs to PLWHA who stay in the isolated villages. Citation from key informant A shows that there is a need for Department of health to collaborate and train Traditional Health Practitioners (THPs) on testing HIV/AIDS and to use them as distributing agencies of ARVs to reach out to people living with HIV/AIDS (PLWHA) in secluded places.

Thus, a triangulation of in-depth interviews, focus group discussions and key informant interviews show that there is a need to improve the accessibility of clinics and ART medication in the rural areas through building more clinics and utilizing THPs as distributors of ARVs to PLWHA in the community. According to Maimela (2015), many people living with HIV/AIDS (PLWHA) use

traditional medicine because clinics are far away and public transportation is non-existent. Consequently, they rely on traditional healers to supplement the lesser public health services, which are fraught with a lack of necessary resources (Maimela, 2015). Kolk (2005) states that many rural individuals utilise traditional healers because of their greater accessibility than Western medical centres. This shows that there is a need to build more clinic in rural areas and Traditional Health Practitioners (THPs) must be used as distributive agents of ARVs to reach out to PLWHA who cannot afford to go to the clinic to take their ARVs. Therefore, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that there is a need to improve the accessibility of clinics and ART medication in the rural areas through building more clinics and utilising THPs as distributors of ARVs to PLWHA in the community.

5.4.7.3 Training of THPs

The study found out that there is a need for training of THPs on HIV/AIDS testing, hygiene, safety practices and embracing the use of technology. Excerpt from Participant F shows that there is a need to train THP in hygiene and safety practices so that they can help in the fight against HIV/AIDS and also anti-retroviral treatment adherence because some of the THPs lack the knowledge about ART adherence, safety practices, and hygiene. There is also a need for THPs to be trained in drug literacy. ART usually takes some time to start working and when patients begin the ART it usually has a lot of side-effects. It is only after a period of weeks that it begins to work after building up in the system. If such drug literacy knowledge is shared it will help patients not to panic and adhere to ART.

Furthermore, participants of the study revealed that it is high time that Traditional Health Practitioners (THPs) embrace or adopt some modern technologies in traditional healing practices. Participant C was open to the idea of adopting and embracing western technology in healing people living with HIV/AIDS such as the use of injections instead of razor blades. The adoption of new technologies is possible if THPs, nurses and medical doctors collaborate, share and exchange some ideas on treating HIV/AIDS and improving ART adherence. In focus group discussions. All participants in Group A and Group B outlined that some THPs lack hygiene, safe practices and that there is a need to adopting some of the modern technologies in traditional healing practices As a result, there is a need for THPs to be trained about safety practices so that they can collaborate with other health professional to improve treatment adherence. Similarly, key

informants also spelled out the need for training of THPs of HIV/AIDS testing, hygiene and safety practices. Thus, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews show that there is a need for training of THPs on HIV/AIDS testing, hygiene, and safe practices. According to WHO (2018), the quantity and quality of safety and efficacy facts on traditional medicine are not sufficient to meet the standards desirable to support its usage globally, hence this study will contribute to this knowledge gap. As a result, numerous policy procedures have been and are being applied to the use of traditional medicine, in order to upsurge its acceptability, safety, and efficacy. This shows that Traditional Health Practitioners (THPs) need to be trained in all HIV/AIDS-related matters and on the quality of their safety methods in the fight against HIV/AIDS and improving treatment adherence amongst people living with HIV/AIDS (PLWHA). That being the case, the study through a triangulation of in-depth interviews, focus group discussions and key informant interviews found out that there is a need for training of THPs on HIV/AIDS testing, hygiene, and safe practices.

5.4.7.4 Media campaigns and workshops

The study found out that there is a need for workshops and media campaigns which involves Traditional Health Practitioners (THPs) that promote ART adherence. Quotation from participant H shows that there is a need for workshops and media campaigns that involves Traditional Health Practitioners (THPs) in supporting ART adherence. The problem with existing media campaigns is that they exclude THPs in supporting ART adherence. The same sentiments were shared in both Group A and Group B. All participants in the groups concurred that THPs have been excluded in media campaigns that teach about HIV/AIDS and it's high time that they must be involved so that they can help. Likewise, key informants also share the same views about media campaigns. Citation from key informant A shows that Traditional Health Practitioners have been pushed in the background in all HIV/AIDS related matters in favour of western health professionals. As a result, this has made people believe that THPs have no role to play in the fight against HIV/AIDS yet indigenous people consult them on a daily basis. That needs to be corrected in the media. THPs must be given an active role to participate in media campaigns that support ART adherence. According to (Matomela, 2013), Traditional Health Practitioners should have an active part to play in media campaigns that seek to promote testing of HIV/AIDS in the community and ART adherence for people living with HIV/AIDS. All HIV/AIDS promotional activities such as roadshows, mass media campaigns, and outreaches must involve Traditional

Health Practitioners because rural folks listen to them more than all the health professionals in South Africa. Therefore, the study through a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that there is a need for workshops and media campaigns which involves Traditional Health Practitioners (THPs) that promote ART adherence. In this regard, there should be campaigns to curb stigma. It would be helpful if there are campaigns in churches and schools. Stigma is still a huge problem. People are not comfortable with their relatives or friends knowing that they are on ART.

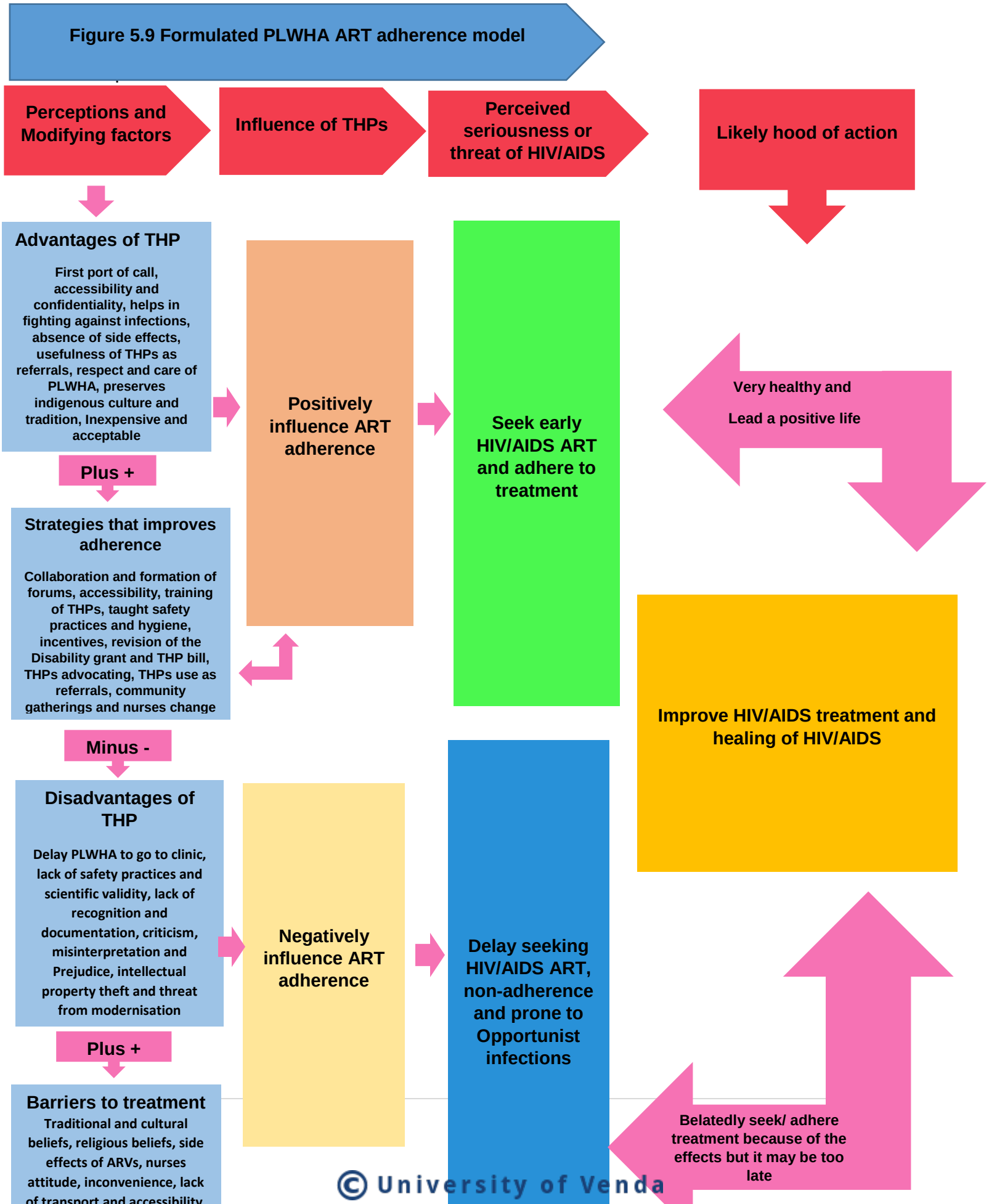
5.4.7.4 Revision of the Disability Grant

The study found out that there is a need for revision of the Disability Grant to prevent people living with HIV/AIDS (PLWHA) from defaulting treatment to manipulate the CD4 count in their body. Excerpt from Participant B shows that PLWHA they stop taking ARVs to keep their CD4 count at minimum levels so that they can continue to be recipients of the disability grant. As a result, there is a need to revise the grant in a way that promotes PLWHA to adhere to ART than doing the opposite. Therefore, a triangulation of in-depth interviews, focus group discussions and key informants interviews found out that there is a need for revision of the Disability Grant to prevent people living with HIV/AIDS (PLWHA) from defaulting ART to manipulate the CD4 count in their body.

5.5 Formulated PLWHA treatment model that improves anti-retroviral treatment adherence

The findings of the study informed people living with HIV/AIDS (PLWHA) ART model that is illustrated in the upcoming Figure 5.9. The model improves ART adherence among PLWHA.

Figure 5.9 Formulated PLWHA ART adherence model

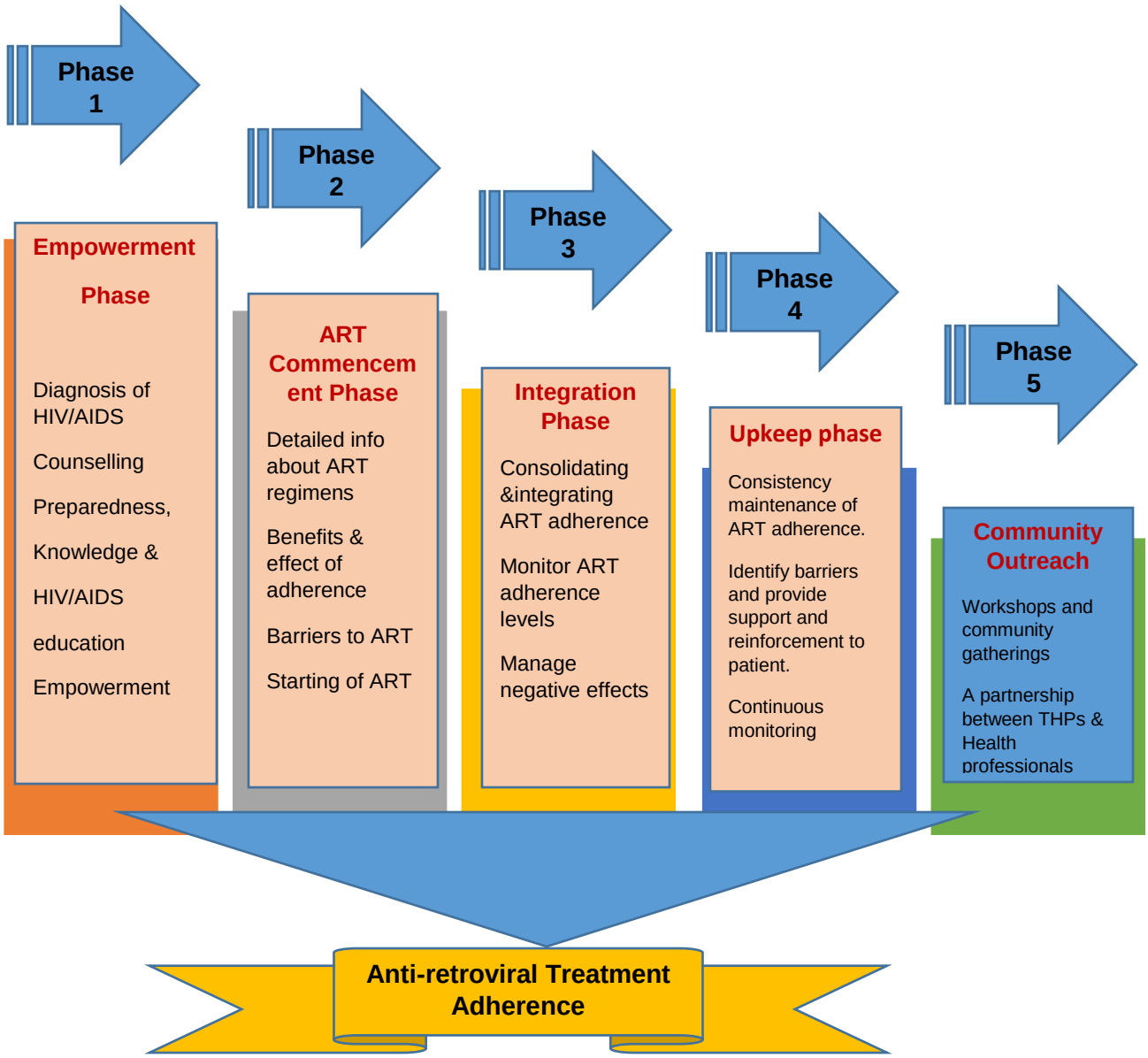


The study's PLWHA ART model was inspired by the Health Belief Model which formed the theoretical framework of the study. As shown in Figure 5.9, there are perceptions and modifying factors that promote ART adherence and non-adherence amongst people living with HIV/AIDS (PLWHA). Advantages of traditional healing practitioners, intervention measures and strategies that improve ART adherence positively influence ART adherence amongst PLWHA such as collaboration and formation of forums. Contrastingly, disadvantages of ARVs and barriers to treatment such as traditional and cultural beliefs negatively impact on ART adherence. As a result, it delays PLWHA from seeking ART. To those already on ART it may lead to non-adherence. Consequently, it exposes PLWHA to opportunistic infections and HIV/AIDS-related sicknesses. The effects of non-adherence are so severe that, it may lead to death because the patient's CD4 count would be below 200. Given the severity of the effects, PLWHA will be forced again to seek ART at the clinic or resume taking ARVs. However, unfortunately for some patients, it may be too late because they may succumb to the HIV/AIDS-related infections and sickness. Fortunately, PLWHA who adhere to ART do not go through the aforementioned stages of denial to take ARVs and suffer the consequences. Sadly and interestingly, the outcome of adhering and non-adhering, in the end, is the same because PLWHA who chose non-adherence would ultimately be forced to take ARVs because of the severity of the effects of non-adherence. Thus, the theoretical framework of the study was anchored by the Health belief model.

5.6 Formulated Anti-Retroviral Treatment adherence support programme that improves treatment adherence

The intervention measure and strategies that came out from the in-depth interviews, focus group discussions and key informant's interviews informed the Anti-retroviral Treatment adherence support programme of the study. The Anti-Retroviral Treatment adherence support programme improves ART adherence for people living with HIV/AIDS (PLWHA). PLWHA need to go through 5 phases that are illustrated in Figure 5.10.

Figure 5.9 Anti-retroviral Treatment adherence support programme



Study results revealed that there is a lack of education and preparation for people living with HIV/AIDS (PLWHA) by health professionals. When individuals are diagnosed with HIV/AIDS, much emphasis is given on counseling of patients to accept that they are positive and to help them cope with post-traumatic stress that comes with being diagnosed with HIV/AIDS. HIV/AIDS patients are also encouraged to live a positive lifestyle and to adhere to ART. In the short term, it helps patients to accept that they are HIV/AIDS positive but in the long run, there is a lack of support programs for ART adherence. HIV/AIDS patients will only be expected to go to the clinic at regular intervals to collect ART medication. Whether or not they are adhering to ART it is up to them. Of importance is that getting counseling and ARVs from the clinic is a one-day event but adhering to ART is a lifetime phenomenon that needs proper education, preparation, and support for HIV patients for infinite adherence to ART. That being the case, there is a lack of proper education and preparation of HIV/AIDS patients for adherence when they are diagnosed with HIV/AIDS.

Furthermore, there is a lack of on-going support for PLWHA to adhere to ART and social support from the community. As a result, the lack of education, preparation, and on-going support, HIV/AIDS succumb to different factors that act as barriers to ART such as the influence of culture, negative effects of ARVs, negative influence by THPs and negative attitude of nurses when they go to collect ARVs at the clinic. Consequently, PLWHA stops adhering to ART and make use of traditional medicine. It is on this backdrop that the study seeks to propose a support program that PLWHA should follow from the moment that they are diagnosed with HIV/AIDS until the end of time. The support program is made up of 5 phases which include the following; empowerment phase, treatment commencement phase, integration phase, upkeep phase and community outreach phase.

Phase 1: Empowerment phase

In the empowerment stage, HIV/AIDS are given counseling to accept their status, empowered with the relevant ART knowledge and education about HIV/AIDS. This prepares them to take ARVs and are given information about ART adherence and the dangers that are associated with non-adherence. The health professional should teach them about all the possible barriers of ART adherence such as the influence of culture and the side effects that are associated with the use of ARVs. This prepares PLWHA so that they would not succumb to non-adherence when they are exposed to barriers to ART. Of importance is that the health professional should treat patients with care and respect. This would help in preparing them for adherence and the patient's

subsequent visit to the clinic to collect ARVs. The empowerment stage should be offered first when a patient is newly diagnosed with HIV/AIDS. However, it must be repeated each time that the patients go to take ARVs from the clinic. This would open two-way communication between the HIV/AIDS patient and the health professional on the challenges that the patient would be facing on ART adherence.

Phase 2: Treatment commencement

The second stage is the ART commencement stage. The second stages is a continuation of the first stage. The main difference is that HIV/AIDS patients would be given more detailed information about ART. This stage provides the HIV/AIDS patients with the know-how about ART adherence and the different kinds of ART regimens that exist before starting the treatment. The health professional should assess the commitment of the HIV/AIDS patient's commitment to treatment adherence. Before the ART begin the risks and benefits must be discussed. The potential and actual factors that could influence adherence are again addressed and intervened as appropriate prior to initiation of therapy. The main purpose of the ART commencement stage is that HIV/AIDS patients should understand the benefits of ART and the possible side effects associated with the treatment. At the end of the ART commencement stage, the Health professional should make a choice on whether to start ART or repeat the stage again depending on the level of understanding of the patient. At the end of the treatment commencement stage, an agreement with the HIV/AIDS patient on the ART plan must be made. The Health profession must furnish the HIV/AIDS patient with the drug information sheet and the schedule. The schedule should be given to the HIV/AIDS patients to reinforce their memory so that they would not forget.

Phase 3: Integration phase

The first 2 stages are very important for HIV/AIDS patients since they help in establishing confidence in adhering to ART. They form the foundation in ART adherence. That being the case, the third stage helps in consolidating and integrating ART adherence schedules in the life of HIV/AIDS patients. HIV/AIDS may be unfamiliar with the ART schedule and encounter negative effects. As a result, the support of the Health professional is important enhancing HIV/AIDS patient's ART adherence and their management of negative effects. That being the case, consolidation and integration counseling is started once the anti-retroviral therapy is initiated and within the period of one to three months. The objectives of the consolidation and integration counseling involve the following; to monitor the ART adherence level of a patient, to reinforce

HIV/AIDS patient's ART adherence behavior and to assess and manage the negative effects of the treatment.

Phase 4: Upkeep

After the first three stages, there is a need for HIV/AIDS patients to maintain ART adherence. That being so, there should be frequent and regular monitoring of ART adherence by health professionals maintain consistency. As a result, the Health professional monitor and assess adherence on an ongoing basis to allow comparison of a given patient's adherence across time. This also serves as an opportunity to evaluate side effects, identify barriers and provide support and reinforcement to patient. The objectives of maintenance of counseling include the following; optimizing HIV/AIDS patient's adherence to treatment and reinforcing the patient's ART adherence behavior.

Phase 5: Community involvement

The last phase involves reaching out to the community. Of importance is that the aforementioned four phases are only between a health professional and an HIV/AIDS patient. In order to consolidate ART adherence amongst the PLWHA, there is a need to involve the community and Traditional Healing Practitioners (THPs). This will encourage and motivate patients that they are not alone in adhering to ART but the whole community, THPs, health professionals and the general populace are in support of ART adherence. To that end, a health professional in partnerships with THPs must do workshops and community gatherings at least twice in six months in each and every village. This would help to improve treatment adherence among PLWHA in the community. Community involvement will also help to curb stigma.

5.7 Study Limitations

There were a handful of limitations encountered in conducting this study. The scheduling of appointments with participants was a challenge. Some participants canceled appointments and some would arrive late for the interviews. The reason being that they were facing transport challenges because they stay in remote villages. However, the researcher would re-schedule in the unfortunate incidences of participants canceling or not showing up for the interviews. To the interviews that were scheduled at the participant's home, it was difficult for the researcher to get to their places because of transport problems and harsh weather conditions given that some of

the interviews were conducted during the rainy season whereby some roads were muddy and slippery. As a result, in some cases, the researcher would walk by foot for some long distances to get to the place of participants because vehicles wouldn't pass through the muddy and slippery roads.

Since Traditional Health Practitioners (THPs) receive patients on a regular basis, some participants had some expectations that the researcher had come to consult and they would be paid consultation fee. Nonetheless, the researcher thoroughly explained that the interviews were not for consultation purposes but for the purpose of a research study for a University of Venda student completing a thesis. The researcher experienced problems with the languages that were used. Some of the participants could not understand the questions when they were asked in English, so multi-lingual research assistant was helping in translating and interpreting languages. The interviews, focus group discussion and key informant guidelines had 4 different languages that involve; English, Tshivenda, Xitsonga, and Sepedi to cater for all the languages. This enabled participants to give relevant information and express themselves in the language of their choice.

5.8 Conclusion

The study revealed that traditional healing practices, directly and indirectly, influence anti-retroviral treatment adherence among PLWHA. Traditional healing practices have a positive and negative influence on ART adherence. The positive influences of traditional healing practices involve the following; encouraging PLWHA to take ARVs, encouraging PLWHA to take both traditional medicine and ARVs, acknowledging the existence of ARVs, admitting the lack of scientific machines to detect the HIV/AIDS virus and admitting the limitations of traditional healing practices. On the other hand, traditional healing practices negatively influence ART adherence because of the followings reasons; discouraging PLWHA from taking ARVs, encouraging PLWHA to take traditional medicine only, Traditional Health Practitioners (THPs) claim to cure HIV/AIDS, ignorance on lack of scientific machines to detect the HIV/AIDS virus and failure to admit the limitations of traditional healing practices.

All 9 participants who participated in the study admitted and acknowledged the co-existence of ARVs and traditional healing practices in the community and how it positively and negatively influence ART adherence among PLWHA. The study found out that the negative influence of traditional healing practices is determined by the individual and social-cultural factors. The

individual and social-cultural factors that influence ART adherence involve the following; traditional and cultural beliefs, side effects of ARVs, nurses attitude, inconvenience, lack of transport, personal choices, lack of trust in ARVs and fear of losing Disability Grant. All the aforementioned factors influence treatment adherence which consequently influences PLWHA to stop adhering to ART.

The Traditional Health Practitioners (THPs) revealed many traditional methods that they use to treat HIV/AIDS which involves the following; diagnosis methods, different types of traditional medicine, the healing process, sacrifices, cleansing processes and the traditional foods that help to fight the HIV/AIDS infections. The study found out about the advantages of using traditional healing practices that comprise the following; acting as the first port of call, accessibility, confidentiality, helping in fighting against infections, the usefulness of THP as referrals, respect, and care of PLWHA, preservation of indigenous culture and tradition, inexpensive and acceptable. On the other hand, the study found out that there are many disadvantages and challenges that come with the use of traditional healing practices that include the following; delaying PLWHA to go to clinic, misinterpretation and prejudice, lack of safety practices and hygiene, lack of scientific validity and standardisation, lack of documentation, lack of recognition and registration processes, criticism and being under threat from modernisation.

Participants of the study suggested intervention measures that may help to improve ART adherence that comprises of the following; use of THPs to advocate for ART adherence, use of THPs as referrals, use of community gatherings to share knowledge and urged nurses to treat PLWHA with respect. The in-depth interviews, focus group discussions and key informant interviews revealed and suggested strategies that can be used to support ART adherence compliance which involves the following; collaboration, accessibility, the formation of forums, training of THPs, taught safety practices and hygiene, and revision of the Disability grant by the government. The health belief model (HBM) anchors study findings. The Health Belief Model (HBM) helps in predicting the beliefs and perceptions of an individual who believes that HIV/AIDS is severe, sees more benefits of adhering to ART than the barriers that are associated with it.

5.9 Recommendations of the study

The recommendations in this study are based on the findings of the study and the body of literature reviewed and presented in chapter 2. This study recommends intervention measures which may help to improve to improve anti-retroviral treatment adherence among people living with HIV/AIDS (PLWHA) in Vhembe District of Limpopo province, South Africa.

The traditional healing practices that improve ART adherence (Objective One)

- There is a need to address non-adherence and change people's beliefs concerning traditional and cultural beliefs in the community through utilising Traditional Health Practitioners (THPs) as advocates of HIV/AIDS initiatives and ART adherence programs. Engaging THPs in intervention programs as advocates build a sense of ownership and trust amongst PLWHA in the society since they historically look up to them for the healing of sicknesses.

- The Department of Health must utilise Traditional Health Practitioners (THPs) as referral agencies since they are the first port of call for people who are sick in the community. This avoids delaying PLWHA in getting tested and getting ART at the clinic.

The socio-cultural and individual factors which influence ART adherence (Objective Two)

- There is a need to apply numerous policies to the use of traditional medicine, in order to upsurge its acceptability, safety, and efficacy to HIV/AIDS patients. Traditional Health Practitioners (THPs) need to improve their safety practices and hygiene practices in healing people living with HIV/AIDS.

- There is a need for an innovative solution that should engage and train Traditional Health Practitioners (THPs) as ART partners to support adherence for people living with HIV/AIDS (PLWHA). THPs must be trained on how to test HIV/AIDS and be used to

distribute the medication to HIV/AIDS positive patients in the community under the supervision of local nurses or health personnel.

- There is a need for Traditional Health Practitioners (THPs) to adopt and embrace some of the western technologies in traditional healing practices such as the use of injections instead of razor blades when administering medicine to the body of patients. Of importance is that adoption of new technologies is possible if THPs, nurses and medical doctors collaborate, share and exchange some ideas on treating HIV/AIDS and improving ART adherence. This helps THPs in improving safety practices and hygiene which improves the standard traditional health practices. If the traditional healing practices become high, in the long run, it may entice the Health Department to collaborate with THPs in the fight against HIV/AIDS and efforts to improve ART adherence.

Interventions methods that can improve ART adherence (Objective 3)

- There should be an increase in the number of clinics that provides health services to people in the community. Participants outlined that clinics are far and many people face transport challenges. As a result, some people living with HIV/AIDS end up defaulting ART because they would not be having money to go to the clinic to take medication.

- There is a need for community gatherings to share knowledge about HIV/AIDS and ART adherence so that people can know the importance of adhering to ART. The community gathering should involve Traditional Health Practitioners, health personnel and the community. Sharing of knowledge in community gatherings would also help in dispelling some myths and beliefs about HIV/AIDS in the community such as some THPs beliefs that they can cure HIV/AIDS.

- There is a vital need to educate people in the communities about the benefits and consequences of not adhering to ART. Society as a whole needs to be aware of how they would be risking their lives by not taking ARVs because some villages are remote and people lack the knowledge about the nature of HIV/AIDS and the dangers of non-adherence. The education of people in the community may be through some workshops

in the communities in solidarity with Traditional Health Practitioners (THPs) since people trust THPs and have a big influence on community people than.

- There is a need for nurses to change their attitudes towards people living with HIV/AIDS (PLWHA) and treat them with respect so that ART adherence may improve. The reason being that some PLWHA dreads going to take medication at the clinic because of the nurse's negative attitude towards them. The negative attitude of nurses is one of the factors that makes PLWHA prefer to go to Traditional Health Practitioners because they treat them with respect, unlike nurses.

Strategies to support ART adherence compliance through Traditional healer, allopathic clinicians and community member partnerships (Objective Four)

- There is a need for collaboration and formation of forums between Traditional Health Practitioners (THPs) and health professionals to heal HIV/AIDS and improve ART adherence among people living with HIV/AIDS (PLWHA). Participants suggested emulating the collaboration of THPs and medical doctors in conducting circumcision in initiation schools. Thus, ART adherence initiatives must emulate the circumcision collaboration of medical doctors and THPs in improving treatment adherence amongst PLWHA.
- There is a need for public campaigns that try to dispel the myths about HIV/AIDS in the society in solidarity with Traditional Health Practitioners. THPs are the custodians of tradition and culture in the society so doing public campaigns with them will positively influence community members who have strong beliefs that traditional healing practices can sorely cure HIV/AIDS. Public campaigns will raise community awareness about ART adherence and it may also subsequently change myths and beliefs about HIV/AIDS in the Vhembe District of Limpopo Province, South Africa.

- There is a need for a revision of the Disability Grant to prevent people living with HIV/AIDS (PLWHA) from defaulting ART to manipulate the CD4 count. The disability grant conditions should be crafted in a way that promotes recipients to continue taking ARVs than defaulting ART.

All in all the health belief model (HBM) which made the theoretical framework of the study anchors the findings. The Health Belief Model (HBM) helps in predicting health-seeking behaviors and perceptions of individuals hence in terms of ART adherence it predicts that individuals who perceive that HIV/AIDS is severe, see more benefits of adhering to ART than the barriers that are associated with it.

Appendix A: Informed consent for participation in the study

This study aims to investigate the Influence of Traditional Healing Practices on Anti-Retroviral Treatment Adherence in Vhembe district, South Africa. The researcher is a Ph.D. student completing a thesis in the Department of African Studies majoring in Sociology at the University of Venda. The researcher seeks to interview Traditional Health Practitioners. The interview will take around one and a half hours. Your conversation will be tape-recorded to help the researcher recall your comments and to analyse the data accurately. The content of the conversation will be used only for this research study and will not be shared with others, except in summary form in the final thesis and in any publication that might result from it. There are no known benefits for participating; however, the researcher hopes that in the near future the research will be influential in amending HIV/AIDS policies. No costs or payments are associated with participating in the study. Based on the information provided regarding the research project, I understand that:

1. The time required for the interview is about one and a half hours.

2. The nature of my participation is an interview.

3. My participation is entirely voluntary and I may terminate my involvement at any time without penalty.

4. All my data are confidential and the data will be destroyed within five years after completion of the study.

5. The discussion may be tape-recorded if I accept it to be so.

6. All data are for research purposes only.

7. If I have questions about the research, or if I would like to see a copy of the final findings of the study, I can contact the researcher by calling him on the number given or write him on the address given.

I agree to participate in this study.

Name of Subject: _____

Signature of subject

_____

Signature of investigator: _____ Date: _____

Further information is available from

Name of investigator : MUSVIPWA FAITH MAARY

Telephone : +27735610744

Email : fmusvipwa@yahoo.com

Appendix B: Interview Guide for Traditional Health Practitioners

1. What influence do traditional healing practices have on anti-retroviral treatment adherence?

2. Which socio-cultural and individual factors influence anti-retroviral treatment adherence?

3. What interventions may help to improve the knowledge and practices of traditional health practitioners with regards to anti-retroviral treatment adherence?

4. What strategies can be used to support anti-retroviral treatment adherence compliance through Traditional Health Practitioner, allopathic clinicians, and community member partnerships?

Thank you for participating in the study

Appendix C: Tshivenda Interview Guide for Traditional Health Practitioners

1. Ndi tsutsumedzo ifhio ine phodzo ya tshirema ya vha nayo kha uri vhathu vha shumise mishonga ya ARVs?

2. Ndi mini zwa mvelele na zwinwe zwiitise zwine zwi nga ita uri mulwadzwe a sa dzhie dzilafo la dzi ARVS nga ndila yo fanelaho?

3. Ndi mini tshine tshi nga itwa u thusa u khwinifhadza ndivho na kushumele kwa malafhele a Tshivenda zwi tshi kwamana na u dzhiela ntha dzilafho la ARVs?

4. Huna ndila dzi fhio dzine dzi nga shumiswa u tikedza vhalwadze uri vha nwe dzipilisi dzavho hu sina u kundelwa vha tshi khou tikedzwa nga vho maine, Vhakoni vha malwadze na u farisana sa tshitshavha?

Ndi khou livhuwa tshifhinga tsavho na u dzhenelela kha heyi tsedzuluso ya pfunzo.

Appendix D: Xitsonga Interview Guide for Traditional Health Practitioners.

1. Hi yihi hlohlomento leyi tinanga ta xintu ti nga na yona eka thiritimente ya art?

2. Hi shihi swilo swa shintu na leswi yena munhu anga swi enldaka leswi swi sivelaka ku tira/ kulandelella matirisele ya art?

3. Hi nga ngenelela njani ku kota ku antswisa vutivi na maendlele ya vutsunguli bya xintu e ka thiritimente ya art?

4. Hi tihi tindlela leti hi nga ti tirisaka ku seketela matirisele a thiritimente ya art loko hi tirhisa matsungulele a xintu, a tliliniki na vaaka tiko?

Nzi khensa nkarhi wa nwina ni ku ngenelela ka dyondo leyi.

Appendix E: Sepedi Interview Guide for Traditional Health Practitioners

1. Ke khuwetso e feng ene phodiso ya setso ya ba le yona mo go reng balwetse ba shumise kalafi ya di ARVs?

2. Ke dilo tse dif eng tsa setso le tse ding tseo di dirago gore molwetse a seke a nwa ditlhare ka tshwanelo?

3. Go ka dirwa eng go tlhabolla tsebo le ka mo kalafi ya setso e ka thusang go dira gore balwetse ba se ke ba tlogela kana go lesa go nwa dipilisi tsa ARVs?

4. Ke tsela tse difeng tseo re ka di shumisang go fa thego batho bao ba nwang dipilisi tsa ARVs jwale ka dingaka tsa setso, ditsibi tsa maphelo le tshwaragano ya setshaba?

Ke leboga nako ya lena le ka moo le tsereng karolo mo dipatlisisong tsa thuto e.

Appendix F: University of Venda ethical clearance

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms FM Musvipwa

Student No:
15018005

PROJECT TITLE: **The influence of traditional healing practices on treatment adherence in Vhembe District, South Africa.**

PROJECT NO: **SHSS/18/AS/06/2905**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr R Tshifhumulo	University of Venda	Promoter
Dr PE Matshidze	University of Venda	Co - Promoter
Prof J Braithwaite	University of Virginia (UVA)	Co - Promoter
Dr J Richardson	University of Virginia (UVA)	Co - Promoter
Ms FM Musvipwa	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: June 2018
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
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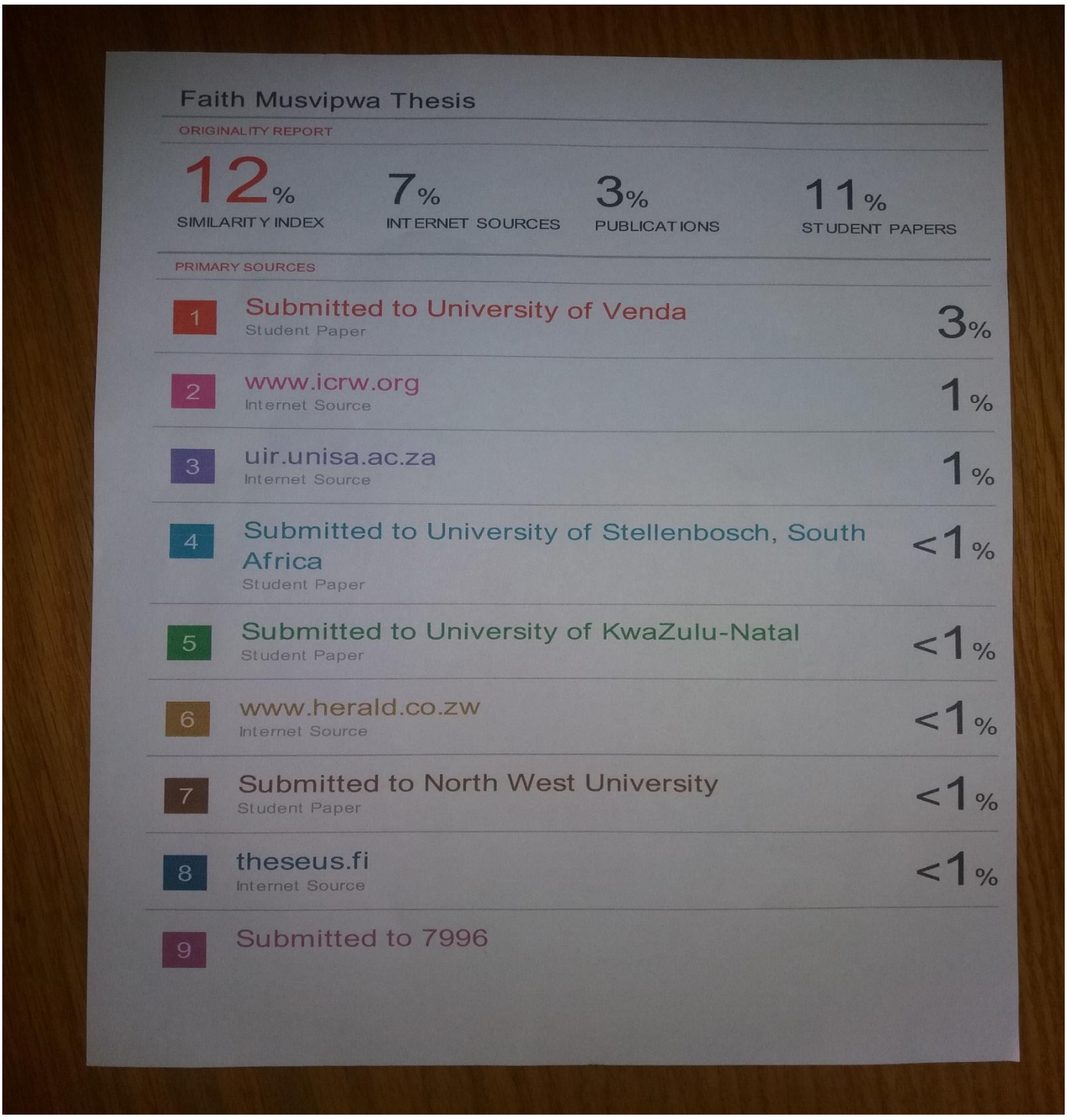
Appendix G: Plagiarism (turnitin) certificate



Faith Musvipwa Thesis

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