THE APPROACHES OF TRADITIONAL HEALERS IN THE TREATMENT OF HIV/AIDS, THE CASE OF CHRIS HANI DISTRICT MUNICIPALITY, CALA, TSENGIWE, EASTERN CAPE, SOUTH AFRICA

BY

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DECLARATION

I Similo Mati hereby declare that this research report, entitled “The approaches of traditional healers in the treatment of HIV/AIDS, the case of Chris Hani District Municipality, Cala Tsengiwe, Eastern Cape, South Africa,” is my own work, and that I have given due acknowledgements to the diverse sources that I have utilized.

Signature

Date

Witnessed by

MRS. N.S. SANDLANA

Signature

Date
DEDICATION

I dedicate this research project to my mother, Thembeka Mati for her never ending support and faith in my abilities throughout this journey, my children for being my source of inspiration especially during the most challenging times.
ACKNOWLEDGEMENT

Firstly, I would like to thank God, my Creator, for giving me the fortitude and strength to write this dissertation to the finish. To my supervisor, Mrs.N.S. Sandlana, for her motherly guidance and insightful comments throughout this journey I would like to send a word of gratitude. Also a word of profound gratitude to my co-supervisor, Dr. L.N. Mlisa, for her firm but constructive guidance and mentorship during this process and sharing with me the lessons about community engagement which I shall cherish for the rest of my life. To Prof. J.G. Kheswa for being a never ending source of support and advice from undergraduate level to this day. I would also like to thank a man that I consider to be a brother, Mr. Thanduxolo Nomngcoyiya for his immeasurable generosity of spirit, advice, loyalty and sticking with me even during the bleakest of times. To my colleague and friend, Mrs. Simani and her family, I honestly do not have enough words to thank you for your support and spiritual guidance throughout this journey, especially during tough times, thank you Qwathi. To my participants at the Tsengiwe One Stop Centre for Development and traditional healers in Tsengiwe, the village headman and NRF for the financial support. To my brother, Mr Mthombolwazi Dimbaza, your vast knowledge on a wide range of topics especially the technical aspects of writing have come in handy during the final stages of this process.
ABSTRACT

In South Africa, just like in any other country within the African continent, traditional healing remains an integral part of many communities and this is not just restricted to the rural communities only, as is sometimes assumed. The main aim of this research was to explore the approaches of traditional healers in the treatment of HIV/AIDS in the Chris Hani District Municipality, Eastern Cape. The following research objectives were followed regarding the approaches of traditional healers in the treatment of HIV/AIDS: (i) to assess how traditional healers and people living with HIV/AIDS in Tsengiwe village understand HIV/AIDS, (ii) to investigate the reasons people living with HIV/AIDS consult traditional healers in Tsengiwe village, (iii) to assess Tsengiwe village traditional healers’ treatment strategies for HIV/AIDS, (iv) to establish how traditional healers view their role in the treatment of HIV/AIDS in Tsengiwe village. A qualitative research design was utilized, using in-depth interviews with traditional healers and focus group discussions with caregivers and people living with HIV/AIDS respectively. A type of non-probability sampling known as purposive sampling was used. A total of sixteen (16) participants were interviewed. The findings in this research revealed the following themes: (i) HIV/AIDS is incurable and it is understood by symptoms, (ii) belief system entrenched in traditional healing, (iii) cleansing rituals and traditional medicinal remedies and, (iv) strengthening relations between stakeholders. While traditional healers expressed a willingness to work with biomedical professionals in the management of HIV/AIDS, caregivers and people living with HIV/AIDS preferred going to clinics and hospitals for treatment. Furthermore, people living with HIV/AIDS in this research never admitted to consulting traditional healers for their ailments, only saying that they choose to self-medicate.
LIST OF ACRONYMS AND ABBREVIATIONS

AIDS - Acquired Immune Deficiency Syndrome

ARV – Antiretroviral

HIV - Human Immune Deficiency Virus

TM - Traditional Medicine

THP - Traditional Health Practitioner UN - United Nations

WHO - World Health Organization
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CHAPTER ONE
ORIENTATION AND BACKGROUND OF THE STUDY

1.1. Introduction and Background

In South Africa, especially among the Black African population, traditional healers form an integral part of the community in areas such as townships and villages. These are normally individuals who are treated with respect because of the services they provide within their communities, such as the treatment of a wide range of diseases and warding off evil spirits. Therefore, Samie, Tambeni, Harshfield, Green, Ramalivhana and Bessong (2010) state that an estimated 80% of people in the developing countries use traditional medicine as their main source of health care and this has been the case for hundreds of years. Within the South African context, traditional healers have been known to be involved in the treatment of a wide range of ailments including the Human Immune Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS).

Semenya and Potgieter (2014) posit that a significant number of traditional healers among the Bapedi communities in the rural areas of the Limpopo province in South Africa provide treatment remedies for a number of illnesses such as diarrhea, swollen limbs, gonorrhea and HIV/AIDS. Against this background, then, the researcher explored the traditional healers’ approaches in the treatment of HIV/AIDS in Tsengiwe village in the Chris Hani District Municipality, Eastern Cape.
1.2. Problem statement

Throughout the world, traditional healers are involved in the treatment of HIV/AIDS, even though their efforts are not acknowledged by other stakeholders in the fight against the disease. However, globally, in India and China, for example, the system of traditional healing is used in the treatment of many chronic medical conditions including HIV/AIDS. Therefore, this demonstrates that Asian countries have their own unique approaches to healthcare and HIV/AIDS. In South Africa, specifically, it has been noted that traditional healers provide relief on the healthcare system which is under pressure (Devenish, 2005; Orisatoki & Oguntibeju, 2010; Wang, Zou & Liu, 2010; Littlewood & Vanable, 2011; Bacon, Rourke & Wilson, 2013).

However, Dickenson, 2008; Damonti, Dykos, Wanless & Kline (2012) argue that traditional healers are generally concerned about being excluded from debates on the treatment of HIV/AIDS and are put in a subservient position by the biomedical practitioners. Therefore, the main focus of this research is to identify traditional healers’ approaches in the treatment of HIV/AIDS practically so that they could be relevantly published for the public to note.
1.3. The research question

What are the approaches of traditional healers in Tsengiwe village, Chris Hani District, Municipality in the treatment of HIV/AIDS?

1.3.1. Research sub-questions

How do traditional healers and people living with HIV/AIDS in Tsengiwe village understand HIV/AIDS?

What are the reasons for the consultation of traditional healers by people living with HIV/AIDS in Tsengiwe village?

What are the treatment strategies used by Tsengiwe village traditional healers to treat HIV/AIDS?

How do traditional healers view their role in the treatment of HIV/AIDS in Tsengiwe village?

1.4. Aim and Objectives of the study

The aim of this study is to explore the approaches used by Tsengiwe village traditional healers in the treatment of HIV/AIDS.
1.4.1. Objectives of the study

To assess how traditional healers and people living with HIV/AIDS understand HIV/AIDS in Tsengiwe village.
To investigate the reasons people living with HIV/AIDS consult traditional healers in Tsengiwe village.
To assess Tsengiwe village traditional healers’ treatment strategies for HIV/AIDS.
To establish how traditional healers view their role in the treatment of HIV/AIDS in Tsengiwe village.

1.5. The Theoretical Framework

According to Punch (2014), the role of theoretical framework includes the description and the explanation of the phenomenon being researched. The dominant theoretical framework used within this research was the sociocultural perspective.

1.5.1. Sociocultural perspective

According to Wang et al. (2011), historically, sociocultural theories were first applied by Lev Vygotsky in the 1920s, addressing the importance of cultural
context in human cognitive development. Hence, Leclerc-Madlala, Simbayi and Cloete (2009), in a study investigating the sociocultural aspects of HIV/AIDS, posit that the various sociocultural contexts within which HIV/AIDS occurs in South Africa must be considered when tackling the scourge of this disease. Hence, the Global perspectives (2013) and Wang, Bruce & Hughes (2011) posit that the sociocultural perspective is guided by the following principles: (i) Human behaviour takes place within a cultural context. (ii) Knowledge is constructed through social interaction. (iii) Mental constructions of reality are based on people's experiences and views.

According to Bougeois and Perkin, (2003), as well as Robbins (2007) criticism levelled against the sociocultural theory is that different labels have been used to refer to it, resulting in confusion and that it ignores the rules of science. However, in this research, the focus is not so much on the criticism but on the relevance of the sociocultural theory to the research and how it was utilized to best articulate the experiences of the participants regarding the approaches of traditional healers in the treatment of HIV/AIDS.

1.6. Significance of the study

The Traditional Health Practitioners Act of 2007 was established for the purpose of establishing the Interim Traditional Health Practitioners Council of South Africa, to provide a regulatory framework to ensure the efficacy, safety and quality of traditional
health care services, to provide for the management and control over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners’ profession, and to provide for matters connected therewith” (Government gazette, 2008).

Through this research, the provision of primary health services, especially relating to HIV/AIDS, is going to involve all stakeholders at grassroots level in an equal footing, especially when it comes to the design and implementation of such services. This research proposes the consolidation of the current legislation, notably, the Traditional Health Practitioners Act of 2007 with regards to stating clearly what the expectation of every stakeholder, notably traditional healers, is regarding the treatment of HIV/AIDS so as to avoid conflict with biomedical practitioners. Hopefully, this will help influence current policies to simplify the role and approaches of traditional healers in the treatment of HIV/AIDS.

1.7. Chapter outline

Chapter one – Orientation and Background of the Study
Introduction: This is the background and introduction to the study.

Chapter two – Literature Review
Previous literature that is related to the study was reviewed.

Chapter three – Theoretical Considerations
This chapter is about the theoretical perspective that the researcher used in the research.
Chapter four – Research Methodology

This chapter concerns the methodology utilized within the research which was the qualitative research design.

Chapter five – Presentation, Analysis and Interpretation of Findings

Analysis and interpretation of findings: Findings in this chapter were analysed and interpreted using thematic coding.

Chapter six – Study Discussions, Recommendations and Conclusions

In this chapter, the researcher engaged in the discussion of findings, conclusion, limitations, recommendations and the necessary annexures were attached.

Chapter seven – Study Finding Summary

This chapter provided a summary of the research and the recommendations.

1.8. Conclusion

In this chapter, the researcher sought to provide a comprehensive introduction to the topic so as to provide a window into how the entire research project evolved. Against this background, following chapter dealt with the relevant literature related to the research.
CHAPTER TWO

OVERVIEW OF THE APPROACHES OF TRADITIONAL HEALERS IN THE TREATMENT OF HIV/AIDS

2.1. Introduction

According to De Vos, Strydom, Fouche and Delport (2011), a literature review in a qualitative study is an indication of the researcher’s knowledge about related studies that have been conducted before. Therefore, having critically engaged with the available literature on traditional healing and HIV/AIDS, the researcher discusses the following: the conceptualization of traditional healing and the history of traditional healing. Then, policies that regulate the traditional healing practice, traditional healers’ understanding of HIV/AIDS and reasons for the consultation of traditional healers are explored in detail. Subsequently, the evolvement of HIV/AIDS, the treatment strategies of traditional healers in the treatment of HIV/AIDS globally, in Africa and South Africa, traditional healer’s views regarding their role in HIV/AIDS treatment are explored. Subsequently, the global view on HIV/AIDS infections, the African view on HIV/AIDS infections, and the South African view on HIV/AIDS infections all come under scrutiny. Finally, the biomedical versus the traditional health practitioners’ approach to healthcare, the challenges of traditional healers concerning their treatment of HIV/AIDS, traditional healing, and HIV/AIDS are dealt with.
2.2. Understanding traditional healing

Within the South African context, many villages, townships and big cities have someone in their midst who possess the natural ability to heal a number of ailments, including witchcraft, and these are known as traditional healers. “The World Health Organization (WHO) defines a traditional healer as a group of persons recognized by the community in which they live as being competent to provide healthcare by using vegetable, animal and mineral substances and other methods based on the social, cultural and religious backgrounds as well as the knowledge, attitudes, and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability” (Lopez-Levers, 2006).

While some tend to use these definitions interchangeably, Sobiecki (2014) states that “The World Health Organization (WHO, 2008) defines traditional medicine as: the health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to diagnose, treat and prevent illnesses or maintain wellbeing”. Therefore, Beslisle et al. (2015) assert that as part of providing psychosocial support, traditional healers would seek the intervention of the client’s ancestors to provide guidance on the client’s journey to healing. Hence, a traditional healer will often invite the presence of the ancestors to ward off evil spirits and to seek protection on behalf of his or her client. However, biomedical practitioners do not normally consider their client’s spiritual wellbeing as relevant; for example, a
medical doctor focuses on the physical aspects of a condition and would give medication specifically for that condition.

According to Williams, Guenther and Arnott (2011), Aboriginal communities define traditional healing as involving emotional as well as spiritual issues and taking cognisance of the nature of the individual’s immediate environment. What this definition implies is that the notion of wellbeing in indigenous communities involves many aspects of the individual’s life rather than only the physical. In the South African context there are different types of traditional healers performing different functions for different reasons in their respective communities and these are known as amagqira, amaxhwele and abathandazeli, to mention but a few.

Mlisa and Nel (2010) assert that the advent of Christianity among the indigenous people of Africa resulted in the emergence of abathandezeli within the amaXhosa grouping using the Bible to analyse and treat their patients. Furthermore, Petersen et al. (2014) assert that herbalists referred to as amaxhwele possess and utilise herbal plant materials and roots to treat a wide range of ailments afflicting their clients. Mlisa and Nel (2010) further proclaim that the process of ukuthwasa, which is the calling from the ancestors, which, when avoided, can result in an individual experiencing illness that can mystify biomedical professionals even after numerous tests.

Mothibela, Egan, Du Plessis and Potgieter (2015) assert that the calling to be a traditional healer emanates from the visit from the ancestors which comes in the form
of a dream experienced by a member of the family being instructed to follow the calling. Subsequently, in South Africa, contrary to popular belief, amaqirha are not only based in the rural areas but they can also be found in the big cities such as Johannesburg, Cape Town, and Durban, often with a significantly high client base. However, many of these city dwellers do not often readily admit that they do consult traditional healers as it does not suit their westernized lifestyles.

2.3. **The historical development and evolution of traditional healing**

Traditional healing and medicine has, and continues being, a part of humanity throughout the world as it has been for many years. Hence, Kang’ethe (2012) contends that traditional healing has been in existence since the earliest centuries and will continue to be utilized for the foreseeable future. In a similar vein, McFarlane (2015) posits that the use of indigenous forms of healing and medicine has defied the rigours of time and continues to thrive within the African continent and the global community at large. The advent of colonization and globalization has, therefore, not succeeded in eradicating traditional healing and medicine despite the scepticism of Europeans regarding its efficacy. What all this means is that there is no specific recorded time as to the beginning of the use of traditional healing with the logical conclusion being that it has been in use since the existence of mankind.
2.4. **Policies that regulate traditional healing practice**

Although traditional healing has been around for a long time, there has been an instance whereby it has faced hostility through legislation from various governments throughout the centuries. Kale (1995) states that historically, in South Africa, the Health Act of 1974 sought to abolish traditional healing. However, the traditional healing profession in South Africa is highly active in the care and treatment of a number of ailments and diseases as well as social conditions such as witchcraft and cultural rituals. As a result, one of the key pieces of legislation established to regulate the conduct of all traditional health practitioners in South Africa is the Traditional Health Practitioners Act of 2007.
“The Traditional Health Practitioners Act of 2007 provides for the establishment of the interim Traditional Health Practitioners Council of South Africa and for the training and practice of Traditional Health Practitioners. It also aims to protect the interests of the members of the public who are the clients of the Traditional Health Practitioners. The Act is a valuable start and may need to be reviewed in the context of a more comprehensive and integrated legislative framework arising from the finalization of this policy and appropriate strategies arising from there from”. (Government gazette, 2008).

What this draft policy document seeks to address is the problem of the mushrooming of the peddlers of lies and those who claim to have the so called cures, especially in the area of HIV/AIDS. Consequently, De Andrade (2011) advances the view that the regulation of traditional health practitioners could assist in fostering good ethical practices. However, the implementation of these key pieces of legislation practically on the ground has left a lot to be desired because many traditional health practitioners simply could not be bothered to familiarize themselves with such legislation.

2.5. Traditional healers’ understanding of HIV/AIDS

There is no questioning the fact that traditional healers are involved in the management of HIV related infections globally, in Africa and in South Africa, however, little is known regarding their understanding of HIV/AIDS. Therefore, Sobiecki (2014) asserts that indigenous diviners often make use of counselling, traditional medicine
and cultural rituals to ameliorate the severe effects of the conditions their clients suffer from. Traditional healers seldom deal with the actual physical ailment in isolation, preferring to attend to a client’s entire family issues as well. In addition, issues such as seeking protection from the ancestors for the entire family are normally done through rituals and sacrifice. Iwelunmor, Newsome and Airhihenbuwa (2013) assert that the PEN3 model is based on the belief that culture is important in the understanding of disease and the ensuing execution of relevant interventions to alleviate suffering from a particular condition such as HIV/AIDS.

Traditional rituals that are performed by traditional healers tend to involve everybody within the family, which helps in alleviating stress even for those that are affected by a family member’s illness. Moreover, Moonsamy et.al (2011) posit that sociocultural understanding and ethnical genealogies have a bearing on an individual’s understanding of diagnoses and illness. Consequently, in this regard, it is not uncommon for a traditional healer or someone conducting a traditional ceremony to call on all the names of the ancestors so as to invite their presence to intervene on the patient or on the family’s behalf.

Hence, Moodley (2013) found that some people living with HIV/AIDS exhibited an unwavering belief in the efficacy of traditional medicine to ameliorate the adverse effects of HIV/AIDS. Motje (2014), for example, found that some of the people living with HIV/AIDS have a firm belief that their blood has been contaminated and there is a need for it to be purified using traditional medicine. Flint and Payne (2013) further note that traditional healers often understand illness as being the work of supernatural
forces which necessitates the intervention of the ancestors on behalf of the person that is sick. Wang, Bruce and Hughes (2011) proclaim that some of the basic principles of the socio-cultural perspective regard reality as a social construction which is common among members of a particular society. Therefore, this is contrary to what biomedicine entails, which is starkly different as to how they interpret diseases especially HIV/AIDS. However, Karim and Karim (2010) state that in fostering a deep scientific understanding of HIV/AIDS, an analysis of the structure of the virus as well as the diagnostic tests administered for HIV/AIDS have to be clarified.

2.6. Reasons for the consultation of traditional healers

There is a multiplicity and complex reasons as to why people consult traditional healers and these include HIV/AIDS. Therefore, Mbatha (2012) found that one of the reasons traditional healers are consulted is because of their close proximity to their clients and similar cultural bonds. Even in contemporary South African society, a significant number of traditional healers reside among the people in their communities, unlike some medical doctors who live in suburban areas away from their clients.

In South Africa traditional healers have been known to be involved in the treatment of diseases such as STDs and opportunistic infections related to HIV/AIDS such as severe skin rash, diarrhoea and deteriorating body weight (Ndhlalambi, 2009; Moodley, 2013). Moodley and Sutherland (2010) state that some of the fundamental reasons for the consultation of traditional healers include mental relief from the
physical condition and worry because of the client’s unquestionable faith in the powers of the traditional healers.

Hence Bayat, Shojaeezadeh, Baikpour and Heshmat (2013) suggest that the health belief model reflects on the individual’s perceived efficacy of what he or she chooses to do concerning an illness, which is often based on an entrenched belief system. However, this is contrary to the popular view by some, especially biomedical professionals, that traditional healers are peddlers of sorcery and quackery, proving that there is evidence pointing to the opposite.

2.6.1. The treatment strategies of traditional healers in HIV/AIDS globally

Globally, traditional healers have always found ways of treating a number of ailments throughout centuries and, contrary to popular belief, this is not only an African phenomenon. Consequently, Littlewood and Vanable (2011) advance the view that the use of alternative therapies, traditional and spiritual healing in the management of HIV/AIDS is prevalent in America and within the global community. Hence, according to Kalwinsky (2008) the treatment strategies of the traditional healers of the Chammarro communities of Guam islands which is the USA territory involve the use of therapeutic massages for pain relief associated with HIV/AIDS and herbal remedies such as the betel nut and melon soup to purify the client’s contaminated blood.
Borrel-Carrio, Suchman and Epstein (2004) posit that the bio psychosocial model favours a holistic approach to treatment as opposed to the individualized nature of western medicine. This dispels the notion that indigenous treatment strategies are only used within the continent of Africa with all the negative stereotypes surrounding such efforts. Furthermore, Kalwinsky (2008) notes that the use of herbal remedies and the physical interaction of HIV positive survivors with traditional healers has a special cultural significance which is absent from their interaction with biomedical professionals, which tends to be formal and in a sanitary environment.

Internationally, there are countries that use indigenous medicine for a variety of diseases since time immemorial and HIV/AIDS is not excluded. Furthermore, Amzat and Abdullahi (2008) state that traditional medicine in China accounts for 40% of all healthcare that is available. Additionally, Gang (2006) argues that, since 2004, the State Administration of Traditional Chinese Medicine conducted an experimental pilot project with traditional Chinese medicine in five provinces, namely, Henan, Hebei, Anhui, Hubei and Guangdong. Furthermore, from August 2004 to June 2005, 2007 AIDS patients received Traditional Chinese Medicine therapy.

Gang (2006) further asserts that analysis of the therapeutic effect of the traditional medicine in 2477 patients who received the therapy for a period of over six months indicated that preliminary effects was achieved, thereafter the frequently seen symptoms in HIV/AIDS patients such as sweating, diarrhoea,
nausea and short breath were tremendously relieved. This indicates that there is a need for governments around the world to put more effort into researching the effects of traditional medicine on HIV/AIDS. However, perhaps the popularity of antiretroviral medication in the treatment of HIV/AIDS has diminished many governments' enthusiasm to research the efficacy of traditional medicine.

Strupart (2012) asserts that a significant number of people in India use traditional medicine through the Ayurveda traditional healing system for their most basic healthcare needs, with the World Health Organization in 2003 estimating that 65% of the rural population are making use of this service. Furthermore, Fritts et al. (2008) state that in India there is an estimated 2.5 million people infected with HIV/AIDS and one of the oldest systems of traditional healthcare which is being used for some of the conditions related HIV/AIDS is the Ayurveda indigenous medical system.

Thomas (2012) states that Ayurveda and other indigenous and complementary medicines have been used to treat opportunistic infections of HIV/AIDS and symptoms such as diarrhoea, weight loss and nausea through the use of herbal remedies. In this respect, he concurs with Patel, Bessong and Liu (2011) who provide an example of a clinical trial involving fourteen people living with HIV/AIDS using a formula of Ayurveda for a period of three months resulting in an increase in the CD4 count and a notable increase in body weight.
Wang, Zou and Liu (2010) advance the view that some of the motives for using traditional and complementary medicine among the Chinese include the enhanced quality of life and the expectation to ameliorate the side effects of antiretroviral medicine. The above literature indicates that traditional healing, through the use of traditional and complementary medicine, is being used to bring relief to those afflicted with HIV/AIDS around the world. This is contrary to popular belief that such indigenous therapies are used only by Africans. Oloyede (2010) posits that an estimated 80% of the population in Africa are in use of traditional and complementary medicine for a wide range of illnesses including HIV/AIDS. This proves that the notion of traditional healthcare being in existence for centuries is based on proven and well documented facts.

2.6.2. The strategies of traditional healers in the treatment for HIV/AIDS in Africa

In the continent of Africa and the developing world, due to the insufficient supply of resources, traditional healers are active in the management of chronic illnesses as well as infections related to HIV/AIDS, such as gonorrhoea, syphilis, skin conditions and diarrhoea (Bessong, Patel and Liu 2011; Cheikhyoussef, Shapi, Matengu and Ashekele, 2011). Bignante (2015) points out that in some parts of Senegal people consult traditional healers for conditions such as skin diseases, haemorrhoids, lifestyle diseases and rheumatism. Hence, Belisle et al. (2014) assert that within the African continent, because of the rampant
poverty and the inaccessibility of health care services, traditional healers become the first option for treatment including for those afflicted with HIV/AIDS.

2.6.3. The strategies of traditional healers in the treatment of HIV/AIDS in South Africa

Peltzer (2013) asserts that other stakeholders having an interest in HIV/AIDS care such as traditional healers do have a role to play in the treatment of HIV/AIDS and their input must be considered in this regard. Moreover, although current research into traditional medicine in the treatment of HIV/AIDS and its results are not enthusiastically published in contemporary literature as those of biomedicine, there is evidence of their involvement in the treatment of illnesses associated with HIV/AIDS.

De Wet, Nkwanyana and Van Vuuren (2010), in a study documenting medicinal plants used for the treatment of diarrhoea, which is one of the symptoms of HIV/AIDS in Maputaland, KwaZulu-Nata, I found that plants such as Spidium guajava, Catharanthus roseus and Melia azedarach were effective in its treatment and such information emanated from traditional healers. Furthermore, Samia et al. (2010), in a study documenting various indigenous medicinal plants utilized for the treatment of fungus related illnesses by the local traditional healers with some plants such as P capens observed as having anti-fungal activities against C albicans.
According to Belisle et al. (2014) traditional healers offer therapies such as making incisions on the client’s skin, invoking the spirits of the ancestors so as to seek guidance regarding the origin of the illness. Furthermore, these rituals indicate that a one size fits all approach can never be sufficient in managing the crisis of HIV/AIDS. Hence, Simbayi (2009) proffers that the cultural aspects of HIV/AIDS have to be considered in efforts to fight the scourge of this disease. Some of the crucial services provided by traditional healers in the management of HIV/AIDS are the much needed psychosocial support as well as counselling to those infected with HIV/AIDS (Meel, 2010).

Chitindingu, George and Gow (2014) advance the view that in South Africa, especially among the rural population, traditional healers tend to treat many chronic diseases including HIV/AIDS because of their closeness to the rural communities. Sodi et al. (2011) further assert many traditional healers in South Africa use a mixture of herbs to treat HIV/AIDS, medicine to induce vomiting and clean the blood, powders and ointments derived from animal fat and counselling is also provided.

Subsequently, there is evidence that a significant number of traditional healers base their intervention when treating HIV/AIDS on the observed physical symptoms of their clients. Furthermore, they tend to play a critical role in treating illnesses of a social nature such as bad luck and poisoning which is called idliso. Therefore, Peltzer (2013) proclaims that the burden concerning the
treatment of HIV/AIDS symptoms requires a multidisciplinary approach involving spiritual as well as indigenous practices.

2.7. Traditional healer’s views regarding their role in HIV/AIDS treatment

According to Belisle, et al. (2010), many traditional healers held the belief that their herbal mixtures are effective in treating HIV related infections such as swollen glands, oral thrush and diarrhoea and these should supplement ARV medication. Furthermore, traditional healers tend to view their role as equal partners in the fight against HIV/AIDS with most resenting the notion that their role must be secondary to that of biomedical professionals. Schuster, Sterk, Frew and del-Rio (2009) conducted a qualitative study in the Lukhanji District Municipality of the Eastern Cape to judge the traditional healer’s willingness to work with the bio-medical practitioners regarding the treatment of HIV/AIDS using ARV medication.

According to Schuster et al. (2009), 25 traditional healers were acknowledged and interviewed with most traditional healers expressing a desire to continue working with the bio-medical practitioners with the hope of gaining knowledge about HIV/AIDS. It is against this background that traditional healers in such partnerships perform secondary roles such as the distribution of condoms, referrals to clinic and counselling services. According to Wreford, Esser and Hippler (2008), the HOPE (HIV Outreach Program and Education) Pilot Traditional Healer Project is a collaborative project between biomedical practitioners in the Western Cape and traditional healers which, among its programs, involves training traditional healers in voluntary testing.
and counselling, maintaining a referral network with clinics on HIV/AIDS cases and the distribution of condoms.

Gale (2014) proclaims though that, often where such collaboration between biomedicine and traditional medicine exists, the design, language and implementation strategies of such partnerships tend to favour biomedicine. Subsequently, Mbatha, Ngwenya, Ngcobo (2004) state that the collaboration project involving the AMREF traditional healers and healthcare professionals in UMkhanyakude District in Northern KwaZulu-Natal to measure the knowledge, attitudes and perceptions of healthcare professionals regarding the work of traditional healers, yielded some encouraging results such as making referrals to clinics and hospitals and educating their clients on HIV/AIDS and VCT services despite the challenges.

Mbatha (2012) asserts that most traditional healers display a willingness to work with biomedical professionals in the management of HIV/AIDS. Furthermore, Gqaleni et al. (2011) state that traditional healers in KwaZulu-Natal were partnered with healthcare workers to play a role in the HIV/AIDS prevention and awareness campaigns in which they were trained on how to deal with HIV/AIDS in their respective consultation rooms. Hence, Gqaleni et al. (2011) found that the project resulted in the traditional healers being open to referring their clients to clinics and promoting HIV/AIDS prevention behaviour among their clients.

Although the current available literature regarding traditional healers and
HIV/AIDS acknowledges that they have a crucial role to play, the situation on the ground in South Africa practically points to their rejection as a potential ally. As a result, Mbatha (2012) found that some traditional healers resent the lack of recognition as equal partners from the South African government in the fight against HIV/AIDS. Evidence indeed indicates that traditional healers are not trusted as equal partners in the treatment of HIV/AIDS and most biomedical professionals are sceptical about traditional healing’s participation in the healthcare system.

As has been pointed out, despite the good intentions of these collaborative initiatives between traditional healers and biomedical professionals, traditional healers remain marginalised in terms of the design and planning of such initiatives. As a remedy against this marginalisation, Littlewood and Vanable (2011) advance the view that traditional healers should provide support in the care of HIV/AIDS survivors so long as they do not ignore antiretroviral medication. All in all, what the evidence suggests is that the traditional healer’s role in the treatment of HIV/AIDS is tolerated but not appreciated as it should.
2.8. The evolution of HIV/AIDS

Much has been written and spoken about the scourge of HIV/AIDS for decades and advances in the field of research and treatment have been accomplished. Moreover, the search for an effective vaccine against HIV/AIDS continues to this day. Be that as it may, it would be prudent to examine the origins of HIV/AIDS and how it came to be one of the most devastating epidemics in modern history.

According to De Cock, Jaffé and Curran (2011), one of the earliest cases of HIV/AIDS on a global stage was discovered in Los Angeles in 1981 through the publication of the Morbidity and Mortality Weekly Report in which pneumonia was discovered in 5 gay men in what later on was described as the acquired immunodeficiency syndrome (AIDS). Furthermore, Pepin (2012) traces the origins of HIV/AIDS in Africa to the spread of the simian immunodeficiency virus (SIV) in the early twentieth century which was then common in chimpanzees adding that HIV was contained until the 1950s when its spread was detected in humans.

2.8.1. Global view on HIV/AIDS infections

The issue of the spread of HIV/AIDS has recently received the attention that it deserves even from the global institutions such as the United Nations. In this regard, research has been conducted all over the world to determine the extent of the problem. Shisana et al. (2014) state that in the South African National HIV prevalence, incidental and behaviour survey 2012,
approximately 12.2% of the population was infected with HIV/AIDS reflecting a
1.2 million increase more that recorded in 2008. Thus, Zinhle Maphumulo (City
in the comparison of deaths from viral hepatitis, states that globally per annum,
deaths from hepatitis are increasing, with HIV/AIDS recording 1.1 million of
those for the year 2015.

The fact that different countries around the world continue to experience
the HIV/AIDS epidemic differently in terms of prevalence rates means that a one
size fits all approach in terms of fighting the virus can never work. Therefore,
based on their uniqueness in terms of culture, countries have to devise strategies
that are innovative in their fight against the scourge of HIV/AIDS. Consequently,
Alga, Kylma and Nikkonen (2009) assert that the key to the effective
management of HIV/AIDS lies in the understanding of indigenous beliefs about
care and treatment.

2.8.2. The African continent’s view on HIV/AIDS infections

According to Belisle et al. (2015), the African continent continues to
experience the severe ravages of the HIV/AIDS pandemic compared with other
places around the global village. Hence, UNAIDS (2011) state that the HIV/AIDS
epidemic continues to be severe in southern Africa with South Africa accounting
for an estimated 5.6 million people living the disease, which is more than any
other country in the world. This means that all these statistics represent the fact
that in the continent of Africa, especially the sub-Saharan region, the HIV/AIDS epidemic has reached the status of a crisis. Therefore, Kaufman, Cornish, Zimmerman and Johnson (2014) proclaim that multilevel approaches to the treatment of HIV/AIDS are characterized by an emphasis on the context within which the disease is encountered.

2.8.3. The South African view on HIV/AIDS infections

Shisana et al. (2009) noted variations among adults over a period of time, from 2002 to 2008; KwaZulu-Natal had an increase of 8.6% from 14.9 to 23.5%. Moreover, the Eastern Cape had a difference of 7.5%, in Mpumalanga 3.5% and in Limpopo 2.7%. Subsequently, Belilse et al. (2015) assert that the South African Government’s ‘Mid- Year Population Estimates’ reflected an infection rate estimated to be 15.9 per cent for people between the ages of 15 to 49 years for the year 2013 with Kwazulu-Natal recording the highest infection rate of 37.4 per cent in pregnant women.

These variations in terms of the rates of infection place the responsibility towards those in positions of authority to investigate the reasons behind these and also come up with context based solutions towards reducing further infections. For example, in some areas such as Limpopo that have got a huge rural population, language and cultural intricacies are critical when introducing intervention strategies for HIV/AIDS. Hence, Swartz et al. (2011)
argue that the socio-cultural approach demands that human behaviour be evaluated based on the specific cultural practices of a particular community.

This is why it is of vital importance to take cognisance of the cultural nuances of the targeted audience of the message of prevention. As a result, Visser and Moleko (2012) contend that high risk sexual behaviour in some communities is accepted as part of a community’s culture; as a result, having multiple concurrent partners is seen as normal. This is most common especially when it concerns males whose promiscuity is revered while with females such behaviour is frowned upon.

2.9. The biomedical versus the traditional health practitioners’ approach to healthcare

While a significant number of different stakeholders have acknowledged that there are other role players within the health system working towards the goal of providing wellness to the sick, one cannot ignore the fact that the western or biomedical sector remains the most popular sector in terms of its authorized recognition. Consequently, Campbell-Hall et al. (2010) state that biomedical practitioners are western trained officially recognized approved healthcare professionals. As Mendoza (2009) points out, the biomedical profession is based on the germ principle of illness as opposed to traditional healing with its holistic outlook which includes individual’s cultural practices and the entire family. This means that a traditional healer would focus on the entire household after dealing with the individual
that is sick, which is unlike the western medical approach, which, in most cases, only
deals with the patient presenting symptoms of an illness. Flint (2015) avers that
biomedicine is heavily reliant on pathology as opposed to spirituality and rituals in its
approach to treatment. However, Sobiecki (2014) proclaims that traditional healers
tend to acknowledge that human beings and their existence are firmly embedded in
their environment and the ancestral world. Furthermore, with traditional healers, a
series of rituals are performed involving slaughtering an animal to cleanse the entire
household in which the presence of the family’s ancestors is invited.

Waldram and Hatala (2015) assert that biomedicine is characterized by
scientific knowledge obtained from formal settings such as universities and has been
observed over a period of time. Consequently, Sobiecki (2015) asserts that a
significant number of biomedical practitioners have been dismissive of traditional
healing as having no scientific basis. However, another aspect of biomedicine that
distinguishes it from traditional healing is the issue of testing. Benghiac, (2013)
advances the view that clinical trials involving vaccines to be used on humans must
adhere to strict scientific values and regulatory framework.

Such trials are normally conducted in strictly controlled environments in which
stringent hygienic standards are adhered to. According to Kangwa (2010), biomedical
practitioners in a hospital setting subscribe to the western view of science which is
fixed in logic and valid principles. This means that a typical medical doctor, based on
proven medical research would diagnose HIV/AIDS in a patient according to what a
physical examination based on blood tests reveals. However, Lesolang (2012) posits
that traditional healers tend to involve the entire family of the patient in their treatment and they do whatever is required to help their patients as opposed to biomedicine which is individualistic in its treatment approaches.

2.10. The challenges of traditional healers concerning the treatment of HIV/AIDS

The relevant literature points to the fact that many stakeholders involved with HIV/AIDS and its complex dynamics are of the view that traditional healers must be involved in the treatment of HIV/AIDS. Be that as it may, traditional healing practice is beset by many challenges emanating from within and different sources in society. Belisle et al. (2015) proclaim that the involvement of traditional healers in the treatment of HIV/AIDS has always elicited a great deal of controversy and acrimonious debate among the relevant stakeholders. These challenges point to a crisis of legitimacy caused by a few individuals with dishonest intentions.

In South Africa, recently, the media has been vocal in its criticism of traditional healers and dismissive of their interventions generally within the healthcare system. Hence, Vuvu Vena (Daily Dispatch, 2016: September 06) condemned the treatment of pregnant women and infants in the Eastern Cape area of Mqanduli by traditional healers using indigenous medicine to induce labour and cure certain illnesses, dismissing these as unsafe and embedded in myths. Such brazen criticism from the media points to a general lack of constructive engagement regarding the involvement of traditional healers within the healthcare system in South Africa, despite the
existence of some progressive policies in this regard. Gale (2014) asserts that such negative sentiments emanate from the historical labelling of indigenous healing practices from the biomedical practitioners using words such as ‘quackery’ and ‘mysticism’ to describe indigenous medicine which has existed for centuries. Subsequently, such terms tend to diminish the image of traditional medicine with some within the public sphere portraying it as unreliable and embedded in fables. Sobieckie (2015) further asserts that such blatant criticism points to a failure by the biomedical sector to appropriately interpret traditional medicine concepts resulting in their rejection of them as myths.

Banyini (2010) argues that HIV/AIDS treatment in South Africa has always been mired in controversy. As an example, Decoteau (2013) refers to how the media heavily criticised the former Minister of Health Dr. Manto Tshabalala-Msimang for promoting indigenous medicine and nutrition as a substitute for antiretroviral medication for those living with HIV/AIDS with the former president being branded an AIDS “denialist” by the media. In a newspaper article, Bongani Mthethwa (The Sunday Times, 2015: April 12) found that a woman traditional healer in Kwazulu-Natal who had made claims of having a vision of a mass grave in a sugar cane farm the previous month had also claimed recently that she could cure HIV/AIDS by using medicine chosen by her ancestors.

According to Belisle et al. (2015), some biomedical practitioners blame traditional medicine for the HIV/AIDS patient’s delay in taking antiretroviral medication because of delusions of an improved immune system. Furthermore, Sorsdahl, Stein
and Flisher (2010) posit that a number of medical doctors do not want to work with traditional healers because they perceive their treatments as ineffective and of inferior value to the medical profession. Hence, Flint (2015) asserts that the enthusiasm often expressed by traditional healers to work with biomedical professionals has not been generally reciprocated.

Bishop (2010) advances the view that the South African media has been vocal in portraying traditional healers as backward and posing a threat to efforts towards the treatment of HIV/AIDS. Consequently, Atindanbila and Thompson (2011) state that some of the reasons for the scathing criticism of traditional healers include, lack of knowledge about how the human body functions which causes them to heavily rely on the client’s physical symptoms and their spiritual interpretation of illness which cannot be verified. Furthermore, Moshabela, Pronyk, Williams (2010) found that the use of alternative forms of care causes a delay in accessing antiretroviral medication for those living with HIV/AIDS.

Soai (2012) asserts that traditional healing remains largely unregulated and this makes it vulnerable to the infiltration of charlatans falsely claiming to have a cure for HIV/AIDS with disastrous consequences. However, Sobiecki (2014) contends that the biomedical practitioner’s concerns about the perceived toxicity and effectiveness of traditional medicine is often ill informed and unjustified as the same intense scrutiny as to the poisonous nature of some biomedicine is not as vigorously applied in this regard.
This seems to demonstrate why even those within the biomedical profession who support collaboration prefer traditional healers to refer their clients to hospitals or clinics especially for chronic diseases such as HIV/AIDS. Thus, Belisle et al. (2015) posit that some biomedical professionals and people living with HIV/AIDS expressed a dissatisfaction with the fact that the temporary relief from some of the symptoms of HIV/AIDS resulting from using traditional medicine deceives those living with HIV/AIDS into thinking the strength of their immune system has been improved.

According to Evenson and Stokke (2010), South African society has experienced a shift from a toxic and often controversial debate concerning the right of HIV/AIDS survivors to access antiretroviral treatment. The debate involving HIV/AIDS, especially regarding treatment in South Africa in the early year 2000s has been characterized by a great deal of disharmony and protests often with the protagonists hurling insults at each other. Furthermore, Belisle et al. (2015) posit that such conflicts were compounded by the government’s drawn out debate concerning whether HIV causes AIDS, resulting in the accusations of the so-called AIDS denialism being attached to the government. Hence, Obadare and Okeke (2011) proclaim that HIV/AIDS has managed to bring to the spotlight simmering tensions between the state machinery and its citizens as well as the contrast in terms of scientific medical knowledge between the west and the developing countries.
2.11. Traditional healing and HIV/AIDS

Campbell et al. (2013) assert that groups that have a strong focus and are embedded within communities need to be integrated into the management of HIV/AIDS so as to lessen its impact on those infected and affected by the disease. Thus, within the context of this research such sentiments find resonance with the character of the participants which include traditional healers, caregivers and HIV/AIDS support group members. Subsequently, Waldram and Hatala (2015) advance the view that there must be a deeper understanding of the indigenous healing methods of the traditional healers by the biomedical sector so as to foster better collaboration especially regarding areas reflecting similarities between the two sectors.

Such cooperative efforts can only go a long way in providing a holistic approach to the fight against HIV/AIDS. Thus, Semenya and Potgieter (2014) proclaim that in the region of Chiawa in Zambia, traditional healers were recognized by primary health officials because of their involvement in the treatment of sexually transmitted diseases hence the recommendation by the health authorities to incorporate them into the healthcare system. Partnerships such as these are a clear indication that traditional healers, when treated as equal partners in the fight against HIV/AIDS could be beneficial to all those involved. Langwick (2010) states that the use of herbal medicine by traditional healers in north eastern Tanzania through the
cooperation with certain NGOs to treat some of the ailments associated with HIV/AIDS has the blessing of the Tanzanian government.

Considering the crisis of HIV infections in the Sub-Saharan region, this demonstrates that there is a case for meaningful cooperation between the biomedical professionals and traditional healers. Such cooperative efforts can only go a long way in providing an all-inclusive approach to the fight against HIV/AIDS. Although the current minister of health in South Africa has not shown his predecessor’s enthusiasm to work with traditional healers on HIV/AIDS, there are signs, albeit slim, that things might be changing.

However, this is indeed a significant shift considering the apathy demonstrated towards the publication of traditional medicine research findings in the mainstream daily media. Thus, in a study documenting exotic plant species used by Bapedi traditional healers to treat various human illnesses in the South African Limpopo province, it was found that indigenous plants such as Caranthus roseus for gonorrhoea, Punica granatum for diarrhoea and Rincus communis for sores is prevalent (Semenya, Potgieter, Tthisikhawe and Shava, 2012, p. 648).

Dominic Skelton (The Herald, 2015: January 29) notes that the Medicines Control Council has issued a directive stating that all traditional medicines that are currently being sold, including those at the so called “muthi markets”, be tested for safety, efficacy and quality, for example, indigenous medicines such as the African wormwood (Artemisiaasteracae) which has been known to be used for clearing the
respiratory tract. Subsequently, Semenya et al. (2012) further assert that indigenous medicinal plants found in South Africa in the Limpopo province such as Eriobotrya japonica used to treat tuberculosis are also used by traditional healers in Asian countries such as China as well as Japan.

Sorsdahl, Stein and Fischer (2013) advance the view that in most projects that involve collaboration between the biomedical practitioners and traditional healers regarding the treatment of HIV/AIDS, traditional healers always express a willingness to cooperate. Nevertheless, Campbell, Peterson, Bhana and Mjadu (2010) assert that doctors and nurses are generally not enthusiastic to work hand in hand with traditional healers, preferring to deal with patients themselves than being in a partnership. Consequently, these negative attitudes are the result of widely held beliefs by those subscribing to western cultural influences which regard indigenous methods as backward and inferior. Jali (2012) asserts that Africans continue to use the biomedical system of healthcare simultaneously with traditional medicine, with the former being publicly recognised compared to the latter. Furthermore, Flint (2015) asserts that many traditional healers acknowledge that some illnesses are best left to the biomedical practitioners to deal with.

Thus, this could be because of the whole system of governance in South Africa, which is largely western in its outlook, leading to the favouring of biomedical approach to HIV/AIDS treatment. Moreover, South African society mostly models the western contemporary culture in their everyday lives. Gale (2014) asserts that traditional healing can act as a forceful expression of cultural identity against the
hegemonic tendencies of the western societies emanating from centuries of colonialism and oppression.

2.12. Conclusion

Although, a significant number of South Africans, especially in the urban areas, have assimilated a western influenced lifestyle, there is evidence that most of them do visit traditional healers for a number of ailments including HIV/AIDS. Even though there is legislation regulating the operations of traditional healers through the Health Practitioners Health Act of 2007, implementation and monitoring remains a challenge. As a result, the profession of traditional healing has in the recent past received a bad name as charlatans continue to make claims of a cure for HIV/AIDS.

However, some traditional healers express a genuine in the welfare of their clients. The current state of affairs in which traditional healers are marginalized even in the area of research does not bode well for future collaborative relations between biomedical professionals and traditional healers. Therefore, traditional healer's interventions must be investigated well and be given publicity results they deserve. In addition, they must be engaged as a matter of urgency as equal partners in the fight against HIV/AIDS so that the two interventions could be given an opportunity to complement each other as both have their side effects and weakness to treatment of health care related factors. None should be treated inferior to each other but what is needed is constant research on how they manage humankind illnesses.
CHAPTER THREE

THE STUDY THEORETICAL FRAMEWORKS

3.1. Introduction

Babbie (2011) asserts that a theory is an organised set of statements seeking to explain a phenomenon. Accordingly, various theoretical frameworks that are relevant to this research are explored in this chapter. These theories will provide the context within which the research is conducted. Corbin and Strauss (2015) advance the view that theories serve the purpose of assisting the researcher and participants to understand their experiences. Consequently, the researcher uses the sociocultural perspective, social support theory, the health belief model, the PEN3 Model and the bio-psychosocial model. These theories are essential to the phenomenon under study and put the participant’s experiences into their everyday context.

3.2. The socio-cultural perspective

This study is reinforced by the socio-cultural model because this approach can best explain in rich detail the approaches of traditional healers regarding the treatment of HIV/AIDS in Tsengiwe village, Eastern Cape, South Africa. Consequently, the details of the participants’ experiences are put into context through this theory. Wang et.al (2011) assert that some of the basic principles of the socio-cultural perspective regard reality as a social construction which is common among members of a particular society. Moreover, Wang et al. (2011) assert that, earlier, it was Vygotsky who first
applied the socio-cultural perspective scientifically in Russia in the early 1920s. Mahn and John-Steiner (2005) define the socio-cultural perspectives depicting the mutual dependence of social and individual processes in the formulation of knowledge. The socio-cultural approaches are guided by the notion that human behaviour occurs within the cultural context and is mediated by language and other cultural symbols. Therefore, in this research, it was demonstrated that the participants’ knowledge of the traditional healer’s approaches in the treatment of HIV/AIDS is influenced by the social environment in which they live. Consequently, Lerclec- Madlala et al. (2009) assert that the relevance of cultural nuances, which vary according to different contexts within which HIV/AIDS occurs, need to be recognised. Thus, the culture and social setting of the participants in this research reflected on their understanding of the phenomenon under study.

Swartz, De la Rey, Duncan and Townsend (2011) advance the view that the sociocultural theory highlights the role played by indigenous knowledge systems in people’s lives. Moreover, this theory recognizes the role played by culture in the evaluation of human behaviour. Subsequently, Armenakis and Keifer (2007) posit that the advantages of the sociocultural perspective include the continuation of the connection between individuals and their surroundings, leading to people learning to understand their own wellness.

Austin et al. (2012) assert that different contexts within which illnesses arise are caused by an assortment of diverse pressures on the individual from his or her surroundings and how individuals respond to such pressures. Thus the fact that
people described their experiences using their own nuanced understanding of HIV/AIDS indicates that one cannot ignore the context within which the disease occurs. Furthermore, rich descriptions of the participant’s experiences, which are particularly unique to different individuals, were brought to the fore. Hence, Ordonez and Marconi (2012) assert that culture and ethnicity, the different gender roles and poverty have had an influence over the spread of the HIV/AIDS pandemic recently and have also worsened the high risk behaviour among individuals. However, Bourgeois and Perkin (2003) advance the view that socio-cultural approaches have been condemned for disregarding well-known scientific philosophy.

The relevance of this approach to this research cannot be undermined because it is through this perspective that the research got access into new insights regarding the approaches of traditional healers in the treatment of HIV/AIDS. Furthermore, Venter (2011) posits that culture provides people with different ways of interpreting their daily lives. Therefore, through their cultural interpretation, the participants in this research provided rich descriptions of their daily experiences regarding the approaches of traditional healers in the treatment of HIV/AIDS.

3.3. Social support theory

Seawell, Cutrona and Russell (2014) posit that, historically, social support theory was utilized in the early 1980s to establish the impact of social support in mitigating the severe effects of stress on individuals in such situations. Hence, Kang’ethe (2015) asserts that social support theory reflects the social interface between people in which
individuals derive a readily available resource of psychological, emotional and physical support which is critical among those infected and affected by HIV/AIDS. Consequently, Kang’ethe (2015) further asserts that social support theory advocates tapping into already existing reservoirs of support, especially in communities afflicted by HIV/AIDS and can act as a defence against the discrimination directed at those infected. Therefore, the theory demonstrates a state of interconnectedness among people in which support is offered to those in need, which are, in terms of this research, HIV/AIDS survivors.

Ellera et al. (2013) proclaims that people living with HIV/AIDS suffer from depression and other symptoms of stress which do not often receive the necessary attention upon diagnosis. Consequently, the use of the social support theory in this research is critical in terms of bringing to the fore the role played by the participants in trying to mitigate the severe impact of HIV/AIDS in their daily lives and the lives of others.

The relevance of this theory to this research is demonstrated through the involvement of some participants (caregivers) in providing care to those living with HIV/AIDS in Tsengiwe village, Eastern Cape. Furthermore, the use of this theory resonates with the efforts of the HIV/AIDS support group members reflected in their emotional support of each other as they grapple with the reality of HIV/AIDS in their everyday lives. Therefore, social support theory is an applicable theoretical framework in this research of the approaches of traditional healers in the treatment of HIV/AIDS in Tsengiwe village.
Thus, practically this theory demonstrates through available literature, the support that traditional healers and caregivers provide to those infected with HIV/AIDS. Furthermore, the use of the HIV/AIDS support group as one of the participants in this research reflects the significance of this theory. Consequently, Mufamadi (2009) asserts that due to the warm relations characterized by trust and cultural ties that traditional healers enjoy in their communities, they can be a vital source of support for those needing care for HIV/AIDS.
3.4. The Health Belief Model

Another theory that the researcher utilised is the health belief model which is deemed relevant to this chapter because of its basic principles. According to Strecher and Rosenstock (1997), the health belief model was developed in the 1950s as a way to clarify why the screening, particularly, of tuberculosis by the United States Health Service did not produce the desired results. Taylor et al. (2007) assert that some of the fundamental values of the health belief model involve the individual’s expected benefits in embarking on a certain health seeking action so as to counter the perceived severe effects of the threat to the person’s wellbeing.

The significance of this theory to the phenomenon under study is to demonstrate the participants’ perceptions regarding HIV/AIDS and how they understand and approach it. Therefore, through this theory, the lived experiences of the participants concerning the approaches of the traditional healers in the treatment of HIV/AIDS came to the fore. Bayat et al. (2013) further posit that the health belief model brings forth the individual’s perceived effectiveness of the actions he or she embarks upon regarding an illness.

Traditional healers, through this theory explained the impact of their approaches in the treatment of HIV/AIDS based on their daily experiences. Moreover, the HIV/AIDS support group members, through the health belief model, were able to articulate their lived experiences concerning the phenomenon under study. However,
some of the criticisms levelled against the health belief model include its ambiguity which negatively affects the legitimacy of the model (Rawlet, 2011).

3.5. The PEN3 Model

According to Cowdery, Parker and Thompson (2010), the PEN3 Model was historically developed as a strategy to promote health and disease prevention in African countries, with culture being central to such strategies. Consequently, the cultural nuances in this research cannot be ignored, especially since traditional healers are normally people rooted in their cultural practices. Furthermore, Iwelunmor, Newsome and Airhihenbuwa (2013) assert that, historically, the PEN3 model was developed in 1989 by Airhihenbuwa and is based on the belief that culture is important in the understanding of disease and the subsequent implementation of relevant interventions.

Webster (2005) asserts that the PEN3 model's values include the notion that it is central in developing culturally acceptable health interventions. Therefore, what this means specifically for the phenomenon under study is that the involvement of traditional healers in the management of HIV/AIDS should be a practical reality as individuals, especially indigenous communities, cannot be separated from culture. Simbayi (2009) warns against ignoring culture in strategies to fight the scourge of HIV/AIDS. Moreover, what this means is that a one size fits all approach to interventions in the management of HIV/AIDS must be abandoned as South Africa is a diverse country with many different cultures. As the study is conducted in a rural setting, it is fitting that the researcher does not ignore some of the cultural
interpretations of the phenomenon under study. Nevertheless, Iwelunmor et al. (2013) assert that the criticism against the PEN-3 model include the fact that quantitatively its reliability and validity cannot be tested together with its transferability to other contexts. What this means is that it would be challenging applying this model using quantitative research methods.

3.6. The Bio-psychosocial Model

Another theory that the researcher deemed relevant to the study is the bio-psychosocial model. Borrell-Carrio, Suchman and Epstein (2004) state that one of the principles of the bio-psychosocial model by George Engel is to provide a holistic approach to medicine as opposed to the dominant biomedicine of the 1920’s. Moreover, Engel (1981) advances the view that an individual’s social surroundings have an impact on his or her wellbeing and his or her illness should be approached as such. As a result, the relevance of this theory to the research is reflected through the experiences of traditional healers in dealing with HIV/AIDS which includes other aspects of the individual’s life such as rituals that needed to be performed on behalf of the patient.

Therefore, afflictions such as bad luck are a social construct emanating from the beliefs existing in the community. Yet, Green and Johnson (2013) assert that some of the criticism levelled against the bio psychosocial model is its susceptibility to inaccuracies because of its all-encompassing outlook making it difficult to prioritize its three components. Therefore, what this means is that the holistic nature of this
theory makes it difficult for biomedical practitioners and researchers to focus completely on individual parts making up the theory.

3.7. Conclusion

The relevant theoretical frameworks that have been utilised in this research have assisted the researcher in understanding the participants’ experiences regarding the approaches of traditional healers in the treatment of HIV/AIDS. Through the sociocultural perspective, the experiences of the participants were described in a manner that highlights the context within which these experiences occur. This, they did through using their own language and interpretation of the phenomenon under study. The social support theory sought to demonstrate how the support system provided in the environment, in this case traditional healers, and helps people living with HIV to cope with the stress of the illness.

Thereafter, the health belief model was used to assist the traditional healers to articulate how they perceive their role in the treatment of HIV/AIDS. The PEN3 model demonstrated how cultural practices of the participants were critical in the management of HIV/AIDS and its symptoms. Moreover, the bio-psychosocial model reflected on how factors in the environment have an impact on one’s wellbeing and health outcomes. Lastly, all these theories brought to the fore the view that a single rigid approach to HIV/AIDS treatment is not practical. Therefore, following chapter provides details on how the research was conducted and the methodology that was used.
CHAPTER FOUR
RESEARCH METHODOLOGY

4.1. Introduction

The preceding chapter dealt with the relevant theoretical frameworks that were used by the researcher in order to get a broader understanding of the participant’s experiences regarding the phenomenon under study. Therefore, theories such as the sociocultural perspective, the social support theory, the health belief model, the PEN3 model and the bio-psychosocial model were utilized. Subsequently, this chapter provides a comprehensive outline of what the researcher has done throughout the research period.

4.2. Research design

Maree (2007) asserts that a research design is a plan which evolves from theoretical assumptions to specifying how the participants are selected, data collection and analysis techniques to be used. For the purposes of this research, a qualitative research design was used. Thus, the researcher opted for the qualitative research design believing it can best articulate the experiences of the participants regarding the phenomenon under study. Babbie and Mouton (2001) argue that qualitative research mainly focuses on understanding human behaviour from an insider’s perspective.
The reason the researcher preferred this research design is that it enabled the participants to articulate their own understanding of how they experience HIV/AIDS within the context of their everyday lives. Therefore, the researcher explored how the participants, in their own words and language, experience the approaches of traditional healers in the treatment of HIV/AIDS in Tsengiwe village. Furthermore, the lived experiences of the participants regarding the approaches of traditional healers in the treatment of HIV/AIDS came to the fore.

4.2.1. Explorative research

Babbie (2012) posits that an exploratory qualitative research is designed to mirror on the diverse ways in which a phenomenon is demonstrated and on underlying processes. This research explored the context within which traditional healers approach HIV/AIDS. Through the gaps in available literature, new perspectives regarding the phenomenon under study were uncovered.

4.2.2. Qualitative research

Maree (2007) contends that qualitative research seeks to get a context based understanding of the phenomenon being researched. Furthermore, this approach allows participants to give detailed descriptions of their unique experiences regarding a phenomenon that is under study. Therefore, Creswell (2009) advances the view that the attachment of the meaning by the participants regarding the phenomenon under study is important in qualitative research.
Consequently, De Vos et al. (2011) argue that qualitative research affords the researcher a great deal of flexibility when conducting the research as it is not a fixed plan or blueprint. Hence, in this study, participants were not limited by the questions in the interview guide when relating their experiences regarding the approaches of traditional healers in the treatment of HIV/AIDS

4.2.2.1. Advantages of the qualitative research method

The qualitative approach, which has been the preferred method of conducting this particular study, has got advantages as well as disadvantages. Babbie and Mouton (2012) state that this approach seeks to get an understanding of the participant’s views or actions through his own belief system and history. Therefore, in this research, the participants were given a chance to describe their unique experiences regarding the approaches of traditional healers in the treatment of HIV/AIDS in Tsengiwe village. This has helped the researcher in terms of gaining a contextual understanding of how participants view the treatment of HIV/AIDS based on their own understanding of the disease. Hennink, Hutter and Bailey (2011) argue that qualitative research relies on the meanings that participants attach to phenomena. In terms of this research, the respondents’ use of their own language, which is isiXhosa, helped to simplify some issues that cannot just be explained using the scientific language often used when talking about HIV/AIDS, which is mostly in English. Therefore, the unrestricted nature of the qualitative research design helped the researcher to get as much detail as possible in terms of getting the participants
to explain their experiences. Thus, Leedy and Ormrod (2005) contend that the subjective nature of qualitative research may lead to researcher bias. Nonetheless, the interpretive nature of qualitative research is an important part of understanding social phenomenon

4.2.2.2. The disadvantages of qualitative research

Hennink et al. (2011) posit that one of the shortcomings of this research design is that it is time-consuming. As a result, the researcher had to spend a lot of time doing fieldwork due to the detailed nature of the participants’ experiences regarding the phenomenon under study. Furthermore, this had implications in terms of the costs that the researcher incurred.

4.3. Population

According to De Vos et al. (2011), a population consists of all the subjects a researcher wishes to study. The population of the research were members of the HIV/AIDS support group from the Tsengiwe Development One Stop Centre in Cala, traditional healers from Tsengiwe village and caregivers from the One Stop Development Centre were interviewed. The reason for the selection of traditional healers is that they live within the community and they get consulted for a range of illnesses including HIV/AIDS. The researcher was interested in how traditional healers specifically treat HIV/AIDS. The caregivers and people living with HIV/AIDS were selected in order to verify the information emanating from the traditional healers.
Moreover, the researcher wanted a broader perspective regarding the phenomenon in question in this research.

4.4. Sample and Sampling

Durrheim (2006) states that sampling is a process of selecting cases to study and involves the selection of the participants from the research population. Furthermore, Giddens (2009) posits that a sample is a small proportion of the overall group whose results, if correctly chosen, can be generalized to the entire population. The type of non-probability sampling selected was the purposive sample. De Vos et al. (2011) argue that in this type of sampling, the researcher selects the participants that best reflect an understanding of the research problem of the study. Furthermore, Leedy and Ormorod (2005) posit that purposeful sampling involves choosing participants that will produce adequate information regarding the phenomenon under study.

In this research, 16 participants were selected as the sample of the study, comprising of 5 people living with HIV/AIDS belonging to the Tsengiwe One Stop Development Centre Support Group as well as 5 caregivers from the centre. The gender of the participants (HIV/AIDS support group members) consisted of 1 male and 4 females and the age of the members of the support group ranged from 30 to 50. Six traditional healers were selected with the gender consisting of 1 male and 5 females. The ages of the traditional healers ranged from 35 to 70. The reason for having a bigger number of female traditional healers and their ages was dictated by
the reality on the ground. Five caregivers from the Tsengiwe One Stop Development Centre were interviewed and they were all females with their ages ranging from 35 to 55. The educational level and occupation of the participants was deemed irrelevant by the researcher.

4.5. Research instrument

Annum (2016) defines research instruments as tools for data collection and these include, for example, questionnaires, interviews etcetera. For this research, the researcher used an in-depth one-on-one interview guide for traditional healers as a suitable instrument for the research. Thus, the reason for choosing this instrument was to allow the participants to freely express themselves without any restrictions arising from the structure of the questions. As a result, this assisted the researcher as this enabled the participants to explain further their experiences regarding the research topic.

4.6. In-depth-interviews

Hennink et al. (2011) assert that an in-depth interview is a one to one method of data collection between an interviewer and interviewee discussing particular topics in-depth. Turner (2010) points out that an in-depth interview involves probing by the researcher which provides a window to the lived experiences of the subject. During the course of the research, a semi-structured interview guide administered in isiXhosa, which is the local language, was used with open-ended questions after consent was
sought and the consent forms signed. Therefore, the researcher translated the English version of the interview guide to isiXhosa so as to accommodate the participants.

This was done with the rationale of enabling the participants to fully articulate themselves without being limited by the structure of the questions or the language. Furthermore, incorporated in the interview schedule were the age, gender and language of the participants. Consequently, four open-ended questions were included in the interview schedule. However, for the purpose of interviewing the focus groups made up of the caregivers and the HIV/AIDS support group members, the researcher used a focus group guide.

4.6.1. **Advantages of in-depth –interviews**

De Vos et al. (2011) posit that the in-depth interview helps the interviewee in bringing to therefore what their experiences mean to them. Moreover, an individual’s perceptions regarding the subject matter of the research and opinions are clearly stated. Therefore, the use of isiXhosa to accommodate the research participants assisted in terms of ensuring there were no barriers emanating from the language of the interviewer and the interviewees.

4.6.1.1. **The disadvantages of in-depth- interviews**

Hennink et al. (2011) point out that some of the disadvantages of using an in-depth interview include, among others, the need for a lot of
transcription and more flexibility to change the order of the topic to accommodate the participant’s narrative. However, as De Vos et al. (2012) assert, one of the disadvantages of in-depth interviews includes participants providing responses that do not produce the required information.

4.7. Focus group discussions

Guest, Namey and Mitchell (2013) define focus groups as carefully planned discussions, with a small number of people on a focused topic, sharing experiences and perceptions. The researcher conducted lively discussions on the approaches of traditional healers in the treatment of HIV/AIDS with two focus groups, made up of caregivers and members of an HIV/AIDS support group. Liamputtong (2011) asserts that information emerging from focus group discussions tends to reveal the cultural context within which individual beliefs and attitudes emanate. During the course of these discussions, the participants made their feelings and views regarding the phenomenon under study very clear.

4.7.1. Advantages of focus groups

Guest et al. (2013) further state that the advantages of using smaller focus groups include simpler logistics and the psychological wellbeing of participants, especially for controversial topics. Consequently, the researcher did not struggle in managing the discussions among the participants due to the number that participated and everyone had a chance to air their views. Furthermore,
Evans and Rooney (2014) posit that focus group discussions enable the participants to produce ideas from one another. Participants in this research tended to agree on most of the issues that arose through the discussion.

4.7.2. Disadvantages of focus groups

Creswell (2014) argues that one of the limitations of focus group discussions is that the presence of the researcher might lead to the answers of the participants being subjective. This means that sometimes participants tend to provide responses that they deemed acceptable to the researcher. Furthermore, De Vos et al. (2012) advance the view that focus group discussions are characterized by exorbitant costs. In this regard, the researcher incurred some costs in organizing the logistics for the focus group discussions. For example, numerous phone calls had to be made in order to ensure that some participants made it to the venue of the focus group discussions so as to avoid endless postponements.

4.8. Data collection procedure

For the purpose of data collection, the researcher sought permission from the department of Psychology at the Alice campus to conduct the study. Thereafter, an ethical clearance form was obtained from the research committee of the faculty of Social Sciences and Humanities. To gain access to the research participants, a letter was sent to the chief of the Tsengiwe village at Cala in the Chris Hani District
Municipality and the chairperson of the Tsengiwe One Stop Centre for Development. However, before the researcher went to the field, he obtained invaluable advice from an Educational Psychologist who was a post-doctoral fellow attached to the HIV/AIDS unit at Fort Hare Alice campus regarding how to conduct the focus group discussions with HIV/AIDS support group members.

The researcher conducted in-depth one on one interviews with six traditional healers in their residences that are known in the area of the research; using a tape recorder and writing down notes to record the interviews after asking for permission from the participants to use their responses, with the researcher observing the participants’ reactions to questions. The researcher met two of the traditional healers at the Tsengiwe One Stop Centre for Development. Thereafter, two separate focus group discussions were held with five HIV/AIDS support group members and five caregivers from the Tsengiwe One Stop Centre for Development with the researcher writing down notes and simultaneously recording the discussions after asking for permission to write down notes and record the discussions. The researcher was a facilitator of both focus group discussions and observed the participants’ reactions to questions under discussion. The researcher was also probing and encouraging the participants to discuss openly and freely, emphasizing that there were no wrong or right answers.

This took place after the researcher explained in simple language what the research was about. This was done in the participants’ language of choice which is isiXhosa and the researcher adhered to the ethical principles of the avoidance of
harm, confidentiality and informed consent. The participants were informed by the researcher that they could withdraw from the interview at any stage if they so wished or if they felt uncomfortable with the discussions. The researcher was assisted by an HIV/AIDS lay counsellor concerning (HIV/AIDS support group members) in this regard.

4.9. Data analysis

During this process, the data that had been collected was sorted and arranged and minimized into manageable categories which helped in the identification and emergence of relevant themes. The raw data that was in the form of notes recorded and written down were analysed and grouped into themes. For this reason, categories of participants, consisting of HIV positive clients from Tsengiwe One Stop Development Centre, traditional healers and caregivers, were grouped to make the process of analysing data easier.

Three types of coding were identified, namely, open, axial and selective coding, to do the necessary data analysis. According to Creswell (2002), coding is the marking of the segments of data with symbols, words or categories. For De Vos et al. (2011) coding is seen as involving the reduction of data into work that is manageable. During this process, the researcher gets an opportunity to manage the data that has been collected. Therefore, Creswell (2002) states that there are two types of coding, which are open coding, which involves attaching labels to words and phrases in the transcript. Then, there is axial coding which involves the creation of themes by
grouping the labels that have been attached to the words and phrases. Moreover, De Vos et al. (2011) states that after analysing the data, the researcher reads the data that has been transcribed sentence by sentence and divides it into meaningful analytical units or themes.

In the current study, having come back from the field, the researcher went through the raw notes that were scribbled from the field interviews and listened to the recordings of the participants' interviews, starting with those from the traditional healers. Having repeated this process several times so as to minimize the possibility of errors, the researcher began typing verbatim the utterances of the participants. Thereafter, the transcripts were translated into English. Subsequently, the researcher went through the same process regarding the focus group discussions with the caregivers and the HIV/AIDS support group. Through this process, the researcher identified commonalities sifting through the raw data. Consequently, the most relevant parts of the common responses were coded using markers with different colours so as to group these as categories.

4.10. Trustworthiness

For Guba and Lincoln, as cited in Leedy and Ormond (2005), qualitative research can be assessed using the four criteria to ensure its validity and reliability. These are as follow:
4.10.1. **Credibility**

De Vos et al. (2011) refer to credibility as the accuracy of the data reflecting reality. The research provided information that is clear, honest and believable. Therefore, the veracity of the participant’s description of their experiences cannot be doubted. To ensure this, the researcher interviewed different categories of participants concerning the research topic.

4.10.2. **Dependability**

De Vos, Strydom, Fouche and Delport (2005) stat that the researcher is accountable for the changes in the situation in which the phenomenon takes place and an understanding of the environment which is being constructed. The research provided descriptions of the phenomenon that can be repeated.

4.10.3. **Transferability**

De Vos et al. (2011) state that this is about the researcher asking about whether the findings of the study can be transferred from one specific case to another. This research proved in the end that its findings can be transferred and applied to other cases or situations.
4.10.4. Confirmability

Leedy and Ormorod (2005) state that this is the extent to which other researchers can confirm the research results. Other researchers could come to similar conclusions based on the findings in this study.

4.11. Ethical considerations

The researcher adhered to the following ethical considerations:

4.11.1. No harm to the participants

According to Babbie (2010), participants should under no circumstances experience harm caused by the researchers at any stage of the research. The research did not harm the participants physically, emotionally and psychologically. The researcher procured the services of an HIV/AIDS lay counsellor to provide pre- and post- counselling to those participants who are living with HIV/AIDS in the focus group discussions. The researcher did not pursue any line of questioning that might have resulted in emotional, physical and psychological distress to the participants. Throughout the interviewing process the researcher was guided by the advice of the counsellor regarding the probing of the issues that were not clear so as to minimize the possibility of emotional and psychological distress on the participants.
4.11.2. **Informed consent**

According to Bless, Higson-Smith and Kagee (2006), research participants have a right to know everything about the study and how it will affect them in terms of the potential risks and benefits to them participating voluntarily. Moreover, Bless et al. (2006) assert that participants must be informed that they may withdraw from participating in the research at any time if they so wish. The researcher provided information about the research in the language that the participants understood which isiXhosa is. Thus, researcher took great care in explaining to the participants in the isiXhosa language what the research was about and what the researcher was going to do with the information provided by the participants.
4.11.3. Confidentiality

According to de Vos et al. (2011), the principle of confidentiality places a strong responsibility on the part of the researcher to treat sensitively the information that has been confided in them. The researcher treated the information provided by the participants with a heightened degree of confidence at all times. The researcher recognized the right of the participants not to reveal any information to the researcher that they deemed too sensitive to share and they were allowed to use their sole discretion in this regard. The real identities of the participants were concealed through the use of pseudo names so as to protect them from any harm that might be caused by the research.

4.12. Conclusion

This chapter sought to provide an explanation, in a simple but detailed manner, of the steps that the researcher took in conducting the research from the first stage right to its conclusion. Therefore, the researcher outlined the research design that was used together with the methodology. The data collection procedure was outlined in detail with the population, sample and the technique and instruments of data collection clearly stated. Furthermore, due to the sensitive nature of the research topic, the researcher adhered to strict ethical conduct by ensuring informed consent, anonymity and the confidentiality of the information provided by the participants. Participants were also informed that they had the right to withdraw at any stage of the research if they so desired. The following chapter will focus on the analysis, interpretation and discussion of the research findings.
CHAPTER FIVE
DATA PRESENTATION, ANALYSIS AND INTERPRETATION

5.1. Introduction

This chapter is mostly focused on analysing, interpreting and presenting the empirical findings of the results that were drawn from the qualitative investigations of the approaches of traditional healers in the treatment of HIV/AIDS in Tsengiwe village, Chris Hani District Municipality, Cala, Eastern Cape. Wisker (2009) asserts that the main purpose of data analysis is the understanding of the themes emerging from the data that the researcher has collected. This research utilised the thematic content data analysis through various processes such as coding, categorization and organization to analyse, interpret and present the participants’ experiences regarding the topic under study. In this research, the sample consisted of six (6) traditional healers with whom the researcher interacted using in-depth interviews complemented by focus group members made up of five (5) caregivers and five (5) HIV/AIDS support group members from the Tsengiwe One Stop Development Centre. The biographical details of the participants are indicated on the table below:

5.2. The biographical profile of the participants

The biographical profile of the participants was organized according to their pseudonyms, age and gender. However, other aspects of the demographic profile of the participants such the level of education, marital status and socioeconomic status were
deemed irrelevant in terms of the objectives of the study. Traditional healers, caregivers and HIV/AIDS support group members participated in this research.

The real identities of the participants were hidden by using pseudonyms so as to protect their real identities. This was done to uphold the ethical principle of anonymity. Therefore, all the biographical information of the participants is reflected in table 2 and the illustrations below.

Table 1.

<table>
<thead>
<tr>
<th>Pseudonym of Participants</th>
<th>Age</th>
<th>Gender</th>
<th>Participant category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zaziwe</td>
<td>44</td>
<td>Female</td>
<td>Traditional healers</td>
</tr>
<tr>
<td>Nozesazi</td>
<td>54</td>
<td>Female</td>
<td>Traditional healers</td>
</tr>
<tr>
<td>Zanemvula</td>
<td>40</td>
<td>Male</td>
<td>Traditional healers</td>
</tr>
<tr>
<td>Nodebelele</td>
<td>61</td>
<td>Female</td>
<td>Traditional healers</td>
</tr>
<tr>
<td>Nomendu</td>
<td>73</td>
<td>Female</td>
<td>Traditional healers</td>
</tr>
<tr>
<td>Notaka</td>
<td>50</td>
<td>Female</td>
<td>Traditional healers</td>
</tr>
<tr>
<td>Gonondo</td>
<td>41</td>
<td>Male</td>
<td>HIV/AIDS Support Group Members</td>
</tr>
<tr>
<td>Nono</td>
<td>47</td>
<td>Female</td>
<td>HIV/AIDS Support Group Members</td>
</tr>
<tr>
<td>Noma</td>
<td>51</td>
<td>Female</td>
<td>HIV/AIDS Support Group Members</td>
</tr>
<tr>
<td>Ntshontsho</td>
<td>44</td>
<td>Female</td>
<td>HIV/AIDS Support Group Members</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Gender</td>
<td>Role</td>
</tr>
<tr>
<td>----------</td>
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<td>--------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Nomeva</td>
<td>33</td>
<td>Female</td>
<td>HIV/AIDS Support Group Members</td>
</tr>
<tr>
<td>Norooi</td>
<td>57</td>
<td>Female</td>
<td>Caregiver</td>
</tr>
<tr>
<td>NoAmen</td>
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<td>Caregiver</td>
</tr>
<tr>
<td>Norose</td>
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<tr>
<td>Nondidi</td>
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<tr>
<td>Ntyatyi</td>
<td>32</td>
<td>Female</td>
<td>Caregiver</td>
</tr>
<tr>
<td>Ntyatyi</td>
<td>32</td>
<td>Female</td>
<td>Caregiver</td>
</tr>
</tbody>
</table>
Figure 1. Age of traditional healers

The research findings in table 2 and age graphic representation in figure 1.1 indicated that the youngest traditional healers were between the ages of 40-50 while the oldest ranged in age from 61 and above.

Figure 1.1 Gender of the traditional healers
In terms of the gender of the participants, traditional healing also reflects the lopsided gender dynamics because of the dominance of women in terms of numbers, which is the phenomenon that seems to be common in many African societies.

Figure 1.2 Age of support group members

The research findings in table 2 and age graphic representation in figure 1.3 indicated that the youngest support group member was 33 years while the oldest was 51 years old. However, the majority of support group members were between the age ranges of 36 to 50.
Gender of the support group members

Figure 1.3

In this research, it was discovered the gender of the HIV/AIDS support group members is predominantly female with only one male as a member of the support group. Therefore, this could mean that males have relinquished their duties when it comes to dealing with campaigns on HIV/AIDS.
Figure 1.4 Age of caregiver
The age of caregivers illustrates a variation of 30 to above 55 years in the village of Tsengiwe, Chris Hani District Municipality Eastern Cape.

**Gender of the caregivers Figure 1.5**

5.3. **Themes that emerged from the collection and analysis of data**

In the section below, five (5) broad themes that emerged from the thematic content analysis and their sub-themes which stemmed from the in-depth interviews with traditional healers and focus group discussions with both caregivers and HIV/AIDS support group members are discussed. The five broad themes are:

- HIV/AIDS is incurable and understood by symptoms
Belief system entrenched in traditional healing;

Biomedical practitioners viewed as

an alternative;

Cleansing rituals and alternative interventions;

Strengthening relations between stakeholders

5.3.1. **HIV/AIDS is incurable and understood by symptoms**

As narrated by the research participants, this perception arose as their common knowledge and understanding of the HIV/AIDS pandemic. Accordingly, the majority of the traditional healers and members of both focus group discussions that took part in this research expressed the understanding that HIV/AIDS does not have a cure and has reached endemic levels. Furthermore, the participants understand HIV/AIDS based on the observable physical symptoms of an individual. In addition, they displayed a fairly accurate description of how HIV/AIDS is transmitted. These findings resonate with the sentiments expressed by the some of the participants (traditional healers):

“Xa utreata ubaright.....sisifo esinobungozi kakhulu, umntu

angacadli kutya, ukuphela angabinamandla”
(When you treat you become alright...It is a disease that is very dangerous….a person loses appetite and experiences loss of strength)

[The participant is displaying a sad facial expression]

“Ubhityile, abenezilonda, intloko engapheliyo”

(He or she becomes thin, develop sores and a constant headache)…

[The participant’s tone of voice is very low.]

“Ndiphawula ukuthanda nokubila, nebala lijike, aphume amathumba aphalaze, agcwale umsindo”

(I notice the tendency to sweat, developing blisters and vomiting, the person is full of anger)… [The participant is using gestures to emphasize her point].

“Ayinyangeki iyagquba ebantwini abamnyama…weight-loss TB dityaniswa ne

HIV/AIDS, weight-loss, ekutyeni akayi kakhulu”

(It is incurable and is prevalent among the black population. Weight-loss is associated with TB and HIV/AIDS, weight-loss, with food he or she is very
limited)… [Voice very low and subdued]

“Alahle isiqu sakhe, abhitye, avomithe”

(One loses body weight, gets thin and is prone to vomit) [The participant is speaking in a low tone of voice]

“Uyacikideka mos, omnye abile, agodole kakhulu”

(One wastes away, some experience sweat and gets extremely cold)

[Serious tone of voice]

The above-mentioned findings indicate that the majority of people who took part in this study possess an elementary understanding of HIV/AIDS which is informed by how HIV/AIDS was initially introduced to most communities in Africa and South Africa with images of death and terminal illness. Therefore, for these participants (traditional healers), HIV/AIDS is synonymous with the above-mentioned symptoms. Furthermore, the above research outcomes could be demonstrating the rampant nature of HIV/AIDS, especially in indigenous communities. Others (caregivers and HIV/AIDS support group members) expressed their views as follows:
“Mna ndayiqaphela ngeenyawo ndabanento ethanda ukuba nengqaqambo
apha phantsi kwenyawo nalapha ezandleni”

(I started noticing it by having pain underneath my feet and
hands)[Participant’s voice is calm and measured]

“Komnye ivele okungathi yi T-B but ibe ngawulayo”

(From someone else it appears as T-B but it is HIV/AIDS)…. [Participant’s
voice and demeanour is serious]

“Nochuku lubakhona, umntu abenchuku nomsindo
nasebantwini”

(Irritability develops, a person becomes irritable and angry towards
others)

[Participant is smiling] “Ubanochuku”

(You become irritable) [The participant is interjecting and laughing]

“Nenkenkqe, uvele ubenalamaphupha ubenemibono, ekuhambeni

kwethuba

kanti ikwayiyo loonto
leyo”
(Mental and emotional disturbances, suddenly experiencing dreams and visions, after sometime discovering that it is this thing)...[The participant's voice is high] Caregivers

"Into endiyaziyo nge HIV yinto yokuba iyabulala...asinyangeki, amachiza akhoyo ayathomalalisa"

(The thing I know about HIV is that it kills...it is incurable, the available medicine alleviates the effects of the disease) [Emotional with voice shaking]

"Ubonakala ngeshingle, omnye amadyungudyungu, ifever engapheliyo, ukuhlakomzimba"

(One can tell by the shingles, another by blisters, constantly being feverish, weight loss)....[The participant's demeanour is calm]

"Ngamanye amaxesha uyadumba or amathumba"

(Sometimes one experiences swelling or boils)...[The participant speaks with authority]
There are various related sub-themes discussed below:

5.3.1.1 Exposure to contaminated blood and bodily fluids

Virtually all the participants in this research believed that the exposure to contaminated blood and bodily fluids can lead to transmission of HIV/AIDS. These points to the evidence from diverse literature sources confirming burgeoning new infections associated with exposure to contaminated blood and bodily fluids. Thus, such findings find support from the following participants’ comments:

“Udibane nomntu onesisifo nilale ningafakanga condom, nangengozi unceda umntu enegazi unganxibanga zikhuselo zezandla”

(You meet a person with this disease and sleep [with him or her] without putting on a condom, with an accident helping someone with blood without hand protection) [The participant displays a serious facial expression]

“Siva ukuba sifumaneka ngesondo, nangokuba umntu onesisifo uthe wafumana esisifo wena udibane negazi lakhe”
(We hear that it is contracted through sex, and when a person who has this disease you come into contact with his or her blood)… *The participant talks in an animated fashion using gestures*.

“Uyakwazi ukosuleleka ngaso ngokwesondo, ifana nento nthi nibay2 nilale without condom”

(You can get infected with it through sex, it is like when two people sleep without a condom)…. *The participant is smiling*.

“Nakwingozi, xa kuthe kwakho ingoz, kwawa imoto kwadibana amagazi abantu. Yindlela abosuleleka ngayo abantu.

(Even in an accident, when there is an accident, a car rolls over and blood gets mixed up. It is the way people get infected)…. *using gestures to drive the point home*

The above findings seem to show that participants highlight contaminated blood and unprotected sex as the leading causes of transmission of HIV/AIDS. Furthermore, unprotected sex was also mentioned as one of the leading causes of the transmission of HIV/AIDS from one person to another. However, the researcher is of the firm view that there
is so much that still needs to be done to educate and inform the participants about HIV/AIDS transmission. This is because there are many ways that the transmission occurs but the participants’ understanding seems to be confined to a few ways.
5.3.2. Belief system entrenched in traditional healing

Findings from the participants belonging to the focus group discussions, HIV survivors and the in-depth interviews with traditional healers indicate that the belief systems entrenched in traditional healing have a bearing on the reasons why HIV/AIDS survivors consult traditional healers. This could be because most African communities have been consulting traditional healers for a number of their ailments for a long time. It does not come as a surprise, therefore, that such statements elicited the following remarks:

“Uzakundivumela xa ndisithi yinkolo okanye yinkolelo yokuba xa ndiye kwelaggirha ndiya kuba ndisiva ukuba liyanyanga”

(You will allow me to say it is a religion or a belief that when I consult a traditional healer I do so because I hear that he or she heals)…… [The participant’s voice is forceful].

“Abanye bathi banamadliso, abanye bathi bayathwasa”

(Some say they have ingested poison, with some claiming to be answering the call of the ancestors to be a traditional healer)…… [The participant makes animated gestures to drive his point home].
Omnye suba engaziqondi ukuba unaso onqene ukubheka e clinic
angayicingeli ukuba yile

(Another person may not realize that he or she has it and be reluctant to go
to the clinic not thinking that it is this)…. [The participant is smiling]

“Mhlawundi ebeye kwagqirha wava ukuba uneHIV into nayo akakholelwa
ukuba unayo”

(Maybe he or she went to the doctor and heard that he or she is HIV
positive and he or she did not believe he or she has it)…… [The participant
raises her voice]. “Kaloku xa ethe wanethongo asetyenzwe
ligqirha…amathumba,igqirha lisebenze amathumba”

(If the person had a vision he or she is worked on by the traditional
healer... with blisters, the traditional healer works on the blisters)…. [Voice
very low]. “Omnye ngokubona omnye ukuba uncedakele”

(By seeing that someone has been assisted)…. [Smiling]

The above answers seem to indicate that most of the reasons expressed
by the majority of the participants for the consultation of traditional healers
are based on the cultural beliefs of those who consult them. Similarly, other
participants in the focus group discussions mentioned the same reasons as
to why people living with HIV/AIDS consult traditional healers. Hence, their 
support group members' views elicited the following responses:

“Yinkolelo”

(It is a belief)…. [Laughing]

“Omnye kuba engazazi ukuba unalentsholongwane so ke ngoku azixelele 
ukuba ndinesifo esithile makhe ndiye egqirheni elithile so ayofuna uncedo 
kulo”

(Because someone does not know that she is suffering from this virus so he or she tells himself that I have a certain disease I must go to a certain traditional healer to get help)…. [Participant is gesticulating wildly to explain]

“Kube ekholelwa mhlambi ingathi angancedwa bhetele”

(It is because of the belief that he or she can be helped better)…. [voice is high pitched].

“Yimveli manditsho, umzekelo umhlaza manditsho mos yi cancer, so ke ngoku thina maXhosa sibenenkolelo ethi lincedwa lelayeza lesiXhosa”
(It is nature I must say, for example I must say if it is cancer, so with us Xhosas we will have a belief that says it is helped by the Xhosa traditional medicine)...[the participant is gesturing wildly to emphasize her point].

“Mhlawumbi abe engakholelwa ziipilisi”

(Maybe he or she does not believe in pills)...[demeanour is calm and serious].

“Ngelinye ixesha siye sithi ngoku sesisitya itreatment uve kusithiwa likhona igqirha mhlawumbi liyisibenza lento, yeka le treatment uhambe uye pha kwelagqirha liyokunceda sikholelwe ke thina kulonont”

(Sometimes while we are on treatment you hear that there is a traditional healer maybe who works on this thing, stop the treatment and go to the traditional healer for help, then we tend to believe in that)...[The participant’s manner is very serious].

The views articulated by the participants seem to concur with the others that individuals’ beliefs play an important role in their decision as to whether
they are going to consult traditional healers or not. However, other participants (caregivers) expressed disparaging remarks about the reasons as to why people living with HIV/AIDS consult traditional healers. Furthermore, these participants were scathing in their criticism, and their views elicited the following responses:

“Bat’i abantu bayathwasa, udlisiwe uba nemibono”

(They say people are being called upon by the ancestors to heal, have been poisoned and have visions). . . . [The participant is angry]

“Ixesha eliniz’i bayazifihla abantu ukuba banalento inje, bathanda ukuthi banamadliso, abanye bathi bayathwasa, umntu abheke emagqirheni angabheki ekliniki”

(Most of the time people tend to hide the fact that they have something like this, they tend to say they have poison, some like to say they are being called by the ancestors, a person would go to traditional healers instead of going to the clinic). . . . [sounding agitated]

“Axhelelwe ibhokwe”
(A goat would be slaughtered for him or her)...*[sarcastic]*

“Iqirha lingathi ambotester, lithi uyathwasa”

(A traditional healer would not say go and test, he or she will say you suffer from the calling by the ancestors)....*[The participant is a bit angry]*

“Abanye limane lisithi uphuphile umntu unemibono”

(Some would say a person has dreams and visions)...*[Shaking her head in disapproval]*

These remarks indicate that some of the participants hold a contemptuous view of the reasons as to why people living with HIV/AIDS consult traditional healers. Perhaps this could be because of the fact that in their line of work as caregivers they would prefer that individuals go to the clinic as soon as possible.

5.3.2.1. Biomedical practitioners viewed as an alternative

The participants in this study were in agreement on the alternative to consulting traditional healers for HIV/AIDS as being
that of the biomedical practitioners such as clinics and hospitals. Therefore, when asked as to what other treatment options were available to people living HIV/AIDS besides traditional healers, the majority of the participants in this research were unanimous in their agreement:

“Kukubheka esibhedlela, kugqirha nasekliniki”

(It is to go to the hospital, doctor and the clinic)…(participant’s manner is calm) “Baya eklinski”

(They go to the clinic)…[emphatic]

“Kunyanzelekile xa eneentlunlu aye kwagqirha”

(It is vital that when he or she feels pain to go to the doctor) … [The participant’s demeanour is forceful]

In this research, the majority of the participants expressed the view that the alternative choice besides consulting traditional healers is the hospitals, clinic or medical doctors. This could be an acknowledgement,
especially on the part of traditional healers, of their limitations pertaining
to the treatment of HIV/AIDS, especially in this era of antiretroviral
medication.
5.3.3. Cleansing rituals and traditional medicinal remedies

On the strategies used by traditional healers in the treatment of HIV/AIDS, the participants in this research expressed diametrically opposing views, with traditional healers mentioning indigenous medicinal remedies, rituals and referrals as a form of intervention in treating HIV/AIDS. However, some participants (caregivers and support group members) expressed scepticism as to the involvement of traditional healers in the treatment of HIV/AIDS. The majority of the participants' (traditional healers') views found resonance in the following remarks:

“Ukusebenzisa inongwe, uyathomalala nje kancinci..ubakhona umahlukwana kodwa ungabimkhulu”

(Using African potato, he or she experiences a slight relief...there is a change but not that big)....[smiling]

“Uzawthi kuqala kalok sisisu,ndikhande ke elayeza lesisu ndimnike, mhlawumbi athi ndiyahambisa nje ,nento yonqamla ndimnike...mhlawumbi ukuty akuhlali, yabona ke ngoku ayikho enye indlela ngaphandle kokumphalazisa nokumcima..xa enengqele ukha

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amayeza afuthe, lento kaloku ingena okwe fever futhi ingena ngongathi
umntu unengqele, uthathe namayeza umfuthise”

(He or she will first say it is a stomach-ache, then I will mix the medicine for the stomach-ache and give it to him or her maybe he or she is not retaining food, you see now there is no other way but to induce vomiting and purging. When he or she has a cold you harvest medicine and make the person inhale the steam from the medicine while it is boiling hot, this thing comes as a fever and comes across as a cold, then you take the medicine and make him inhale the steam from the medicine while it is boiling hot)...

[Participant is using gestures for emphasis]

“Uye unyange ezindawo zigulayo ngeyeza, unyange nomphufumo ngesiko. Umzekelo, ngelishwa ke omnye udibana ne AIDS (fullblown) engasakwazi uphakama ebhedini ehlanjwa iisymphoms zisithi AIDS, sixelele ifamily makenzelwe isiko lebhokhwe, kwaahluzwa utywala waziphumela endlini kwabe siwunyangile umphufumo...wangena emithini yesintu emva kwe veki waphakama.

(You treat the parts that are sick with medicine, and then you treat the emotions with cultural rituals. For example, unfortunately the other one I discovered had full-blown AIDS, we informed the family to conduct a
traditional ritual by slaughtering a goat, traditional beer was brewed after that she came out of the house on her own proving that we have healed the emotional aspect. Then after a week using traditional medicine she was up and about)... [Tone of voice is loud]

“Kukwenza isiwasho esi ehle, ndikunike nebhotile yosela inceda nayo incedisana nesiwasho esifukuthwayo, kufana nokusela igrandpa. Amanzi omthandazo, uyebla uphephepe, umzekelo olwakholokholo nalanto ivalayo ibangathi liphika iyehla.”

(It is to make cleansing traditional water to calm the person; I also give you the bottle to drink which works together with the cleansing traditional water which is taken raw which is like taking grandpa. Holy water alleviates the constant cough, for example the cough together with the out of breath sensation and palpitations begin to go down)...[The participant is calm]

“Kwidliso ndiyagabhisa ndicime, ukufutha kukhupha ingqe le kuhume ubumdaka” (In poisoning I induce vomiting, inhaling the steam from the traditional medicine while it is boiling hot alleviates the effects of the cold, and this purges the dirt)... [Using hands to demonstrate]
The findings in this research indicate that traditional healers, based on their client’s presenting symptoms do indeed administer some form of treatment for some of the many ailments associated with HIV/AIDS. Furthermore, these include herbal concoctions and the performing of traditional rituals to request the intervention of the ancestors to intercede on behalf of those afflicted by HIV/AIDS. Be that as it may, the traditional healers acknowledged that they did not have a cure for HIV/AIDS. As a result, a significant number of them encourage their clients to seek further assistance from biomedical professionals concerning HIV/AIDS.

5.3.3.1. Referrals

Most of the participants (traditional healers) were in agreement that it is prudent to refer those who are HIV positive to the biomedical professionals such as the clinics, doctors and the hospitals. The following statements capture the essence of their views:

“Ndimthumela eklini kuqala afumane uncedo, umzekelo uba uze ngentloko ndimthimise nje then aye eklini”
(I refer the person to a clinic first to get help, for example if she comes complaining of a headache, I induce sneezing and then refer him or her to the clinic)… [smiling]

“Mna specifically ndiyasebenzisana ne kliniki, if uggirha uyibonile unyanga isifo esi sbonakalayo”

(I specifically work hand in hand with the clinic, if the medical doctor has seen it then he or she treats the disease that can be seen)… [The participant is confident]

The participants (traditional healers) in this research expressed a willingness to allow their HIV positive clients to seek treatment for HIV/AIDS from the clinics. This shows that on their part, they acknowledge that they cannot on their own, successfully treat HIV/AIDS. Therefore, this contradicts the widely held view that traditional healers arrogantly think they can cure HIV/AIDS. Maybe this could lead to a new era of constructive engagement by all stakeholders involved in the treatment of HIV/AIDS so as to better understand the different approaches to its treatment.
Although traditional healers in this research did not have qualms about referring their HIV positive clients to the clinics and hospitals for further treatment, some of the participants (caregivers) were scathing in their rejection of the involvement of traditional healers and their approaches in the treatment of HIV/AIDS. Consequently, their (caregivers) views were compatible with the following statements:

“*Iqirha alikwazi ukulithomalalisa ulwamvila le HIV/AIDS, into eliyenzayo kukhandiyeza qha kanti iyeza lona into eliyenzayo lithi ndizakunyanga ngoku lingazukunyanga, akunike iyeza usele kanti iyeza eli leli lingekho right for umntu opositive*”

(A traditional healers does not know how to alleviate the severe effects of HIV, what he or she knows is to mix traditional medicine even though the medicine says it will cure you while that is not the case, he or she will give you traditional medicine to drink even if it is not right for a positive person)... [Participant is angry]

“*Iqirha lona limsa ekuthwaseni, akhonto elinceda ngayo kwi HIV/AIDS*”
(A traditional healer tends to make someone to answer the calling of the ancestors to be a traditional healer, there is nothing he or she can do to help on HIV/AIDS)... [Agitated]

“Enyinto bathi badlisiwe, ixesha elininzi ke ngoku ufumanise ukuba anesisu, igqirha lithanda ukunyanga isisu kanti umntu kungenelixeshaka limbulalayo ngoba kaloku lizamnika iyeza elihambisayo limtheza amandla, aphinde ehle eweightini. Akhonto incedayo emaggirheni”

(The other thing they say they have been poisoned, most of the time you will find that a person suffers from stomach ache, a traditional healer tends to treat the stomach ache resulting in death because he or she will give the person traditional medicine that induces diarrhoea which weakens someone’s strength resulting in weight loss. There is nothing that helps with traditional healers)... [Using animated gestures]

“Uyagajiswa kanti i HIV ayifuni u gabhe, ayifuni uhambise, aphethe esishiya ke ngoku simngcwabe”

(A person is made to vomit but HIV does not, does not want diarrhoea, this result in the person leaving us and we bury him or her)... [Participant’s voice is sombre]
“Ixesha elininzi bayasweleka abantu ababhaka emagqirheni xa bene HIV”
(Most of the time people who consult traditional healers when they have
HIV tend to die)… [Shaking her head]

The findings in this research seem to indicate that the participants
(caregivers) are united in their rejection of traditional healers and their
approaches to the treatment of HIV/AIDS. Therefore, it is possible that
such attitudes are a reflection of the current popular view that
antiretroviral medication is the best and only option in the treatment of
HIV/AIDS. Furthermore, the controversy surrounding HIV/AIDS in the
early 2000s which resulted in the government of the day being forced
through the courts to provide ARVs to people living with HIV/AIDS may
have influenced such negative attitudes to traditional healers.
Similarly, the other participants (HIV/AIDS support group members) expressed a less than enthusiastic view about consulting traditional healers, stating that they instead self-medicate through buying traditional medicine from people who sell traditional medicine from the stands and other sources. Furthermore, the participants did not admit that they consult traditional healers for HIV/AIDS, preferring, instead, to state that they boost their immune system through buying herbal concoctions from hawkers. Thus their (HIV/AIDS support group members) views were consistent with the following statements:

“Ndinya kwababantu bazithengiselayo, ababantu bathengisa amayeza, hayi andiyi emagqirheni”

(I go to those people who sell for themselves, the people who sell medicine, no I
do not go to traditional healers)...
[Smiling]

“Kaloku phaya ezitendini nhe kukho iibhotile, nawe uyawfika zimile, ngumxube kuthwa mhlawumbi ngoomahlabekufeni, ngelinye ixesha so kubekho iphepha lamaphepha siwanikwa ngababafana kuthwe kukho uggirha othile thile, uyawfika kukho ke ngoku imixube phayana, ungayazi
ke ngoku kudityaniswe ntoni nantoni ufike ke ngoku kwelaphepha zonke

ezizinto zibhaliwe pha ii HIV ne TB”
(In the stalls there are bottles, even you will find them standing, it is a mixture called maybe mahlabekufeni, sometimes there is a piece of paper; those papers that are given to us by young men saying there is a certain doctor, you will come across mixtures of medicine there and you don’t even know what the mixture is made up of and find that in those pamphlets all these things are written such as HIV and TB)... *The participants points with her hands to explain*

“Ngababantu bawa odayo bawathengise, siwafumana seyimixube thina”

(It is those people who order the medicine to sell, we get the medicine mixed already)... *Calm*

“Mna ngokokwam kwinto endakhe ndayisebenzisa nje ngale bendiyitsho, ndathi ndisawfumana l CD4 count yam isithi 800 ndatsho ndathi noko iyandizama”

(I myself in something that I had used like the one I was talking about (i.e. referring to something that looks like the African potato), when I later discovered my CD4 count measuring 800 I became convinced it works)...*Confident*

“Okoo ndasebenzisa iipilisi mna”
The findings in this research seem to indicate the participants (HIV/AIDS support group members) do not acknowledge that they consult traditional healers for the treatment of HIV related conditions. Furthermore, the researcher found that the majority of them prefer to self-medicate by buying the so called boosters from the hawkers who have stalls for such medicine. However, the participants did not seem willing to state that the people selling the traditional medicine are traditional healers, opting to say those people are just traders who order the medicine from somewhere. Maybe this could be because of the instruction from the biomedical practitioners to those on ARV’s not to mix the treatment with traditional medicine, as the majority of the participants indicated.

5.4. **Strengthening relations between stakeholders**

The majority of the participants (traditional healers) in this research expressed a desire to work with the other stakeholders, especially the biomedical professionals, in the treatment of HIV/AIDS. Moreover, traditional healers showed a willingness to refer their clients to medical doctors in the
treatments of HIV/AIDS. Their views found resonance in the following proclamations:

“Asikwazi ukulibona igazi,funeka ndimse kugqirha kuqala ndandule mna ukumsebenza”

(We cannot see blood, I have to take the person to the doctor first and then work on the person)… [The participant’s demeanour is calm]

“Intsebenziswanano  asiyichasanga kakhulu”

(We are not very much against cooperation)… [The participant is talking in a high pitched tone]

“Bona ke oorhulmente banceda ngeepilisi, thina kaloku sinceda ngeziwasho, kuyimfuneko ukumthumela ekliniki, kliniki ibaluleke kakhulu”

(The government helps with the pills, we help with cleansing water, there is a need to send the person to the clinic, the clinic is very important)… [The participant is calm]

“Baye kooggqirha”

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(They must go to the doctors)… [Emphatic]

“Kufanele umntu anyange umntu ophantsi
kwesihedlele”

(One must treat a person that is under the hospital)…. [The participant speaks with authority]

The above answers in this research point towards the fact that traditional healers seem to be more than willing to cooperate with the biomedical practitioners in the treatment of HIV/AIDS. This could be seen as attributable to their acknowledgement on their part of the fact that they cannot on their own treat HIV/AIDS. These findings, therefore, are in stark contrast to the image portrayed in the media of traditional healers as people who think they can cure HIV/AIDS.

Although traditional healers expressed willingness on their part to work with the biomedical practitioners, others (caregivers) were not that keen, preferring rather for HIV/AIDS to be dealt with by the biomedical practitioners. Moreover, most expressed disparaging remarks about the involvement of
traditional healers in the treatment of HIV/AIDS. Their sentiments were expressed through the following utterances:

“Kodwa ke bayalahlekisa, amgqirha bayabalalekisa”

(But they are misleading, traditional healers are misleading them)… [The participant is angry]

“Bayabalalekisa ngoba abakwazi ubanceda”

(They are misleading them because they cannot help them)… [Voice loud] “Amgqirha mababayeku abantu abapostive ngoba bayababulala”

(Traditional healers must leave people who are HIV positive alone because they are killing them)… [Agitated]

“Iqgirha lesintu bekunyaenzelekile ukuba lidibane nogqirha kuzoboniswana ngalomuntu uguayo”

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(A traditional healer must be forced to meet with the medical doctor in order for them to discuss the person that is sick). [The participant’s voice is calm and measured]

“Ingathi intetho inye ithi igqirha xa lizawnyanga umntu kunyanzelekele ukuba liqale lithi yiza nephepha lisithi ndithestile, akubonwanganto kungonje ndizawnyanga lento uthi unayo, andikwazi ukunyanga ungakhange uye ekliniki, makuze iphepha emagqirheni”

(It seems like the view is the same and it says before a traditional healer treats someone he or she must first the person must bring a piece of paper stating I have tested, nothing has been seen and I will treat what you are sick of, I cannot treat you without you going to the clinic, the piece of paper must be given to the traditional healers). [The participant’s voice is loud]

The above inferences are a reflection of negative attitudes towards the involvement of traditional healers and their approaches in the treatment of HIV/AIDS. Perhaps this could be because of a lack of communication between the biomedical sector and traditional healers in the treatment of HIV/AIDS. This reflects the current prevalent view captured in the media.
that antiretroviral drugs are the only medication needed in the treatment of HIV/AIDS. Similarly, the members of the HIV/AIDS support group expressed a less than keen interest in the involvement of traditional healers in the treatment of HIV/AIDS. Therefore, the majority of the participants' views found meaning in the following declarations:

“Lyandixaka ngoba kaloku kwakungathiwanga na ekliniki xa sowusebenzise iipilisi sukumixer neyeza lesiXhosa?”

(It confuses me because was it not said at the clinic that when you have used the pills you must not mix with Xhosa medicine?)…. [Participant speaks in a high tone of voice]

“Mna ndirhalela ingaske amagqirha angalisebenzisi kakhulu elayeza lopeyta nelophalaza”

(I wish that traditional healers do not use too much of the medicine for purging and vomiting)…. [Participant looks serious]

“Makamthumele ekliniki”(He or she must send the person to the clinic)…. [Participant speaks in a high pitched tone of voice]
“Makamthumele ekiniki coz ayizonceda lanto yokuba amnike elayeza coz xa emnika iyeza umsa ekufeni”

(He or she must refer the person to the clinic because giving the person that medicine is not going to help because when she or he gives the person the medicine she or he is sending the person to his or her death)…[Participant’s demeanour is agitated]

“Into yoya emagqirheni iya ngokwenkolelo yakho”

(Going to traditional healers depends on your beliefs)… [Participant is calm]

It was found that the participants (HIV/AIDS support group members) would be more than happy if traditional healers would refer their HIV positive clients to the biomedical practitioners such as doctors in clinics and hospitals. Therefore, based on the above findings, the majority of the participants did not see any role for traditional healers in the treatment of HIV/AIDS. Some participants alluded to the fact that some of the health care professionals at the local ARV site warned them not to mix their medication with traditional medicine. This could be the reflection of the current prevailing sentiments in the popular media regarding traditional healing and medicine in the treatment
of HIV/AIDS; with people advocating an alternative to ARV treatment being given labels such as “dissidents”, “quacks” and other derogatory terms.

5.5. Conclusion

In this chapter, the researcher engaged in the analysis and interpretation of the experiences of the participants regarding the approaches of traditional healers in the treatment of HIV/AIDS in Tsengiwe village, Chris Hani District Municipality, Eastern Cape. Against this background, the following chapter will provide a detailed discussion of the research findings and the recommendations of the research.
CHAPTER SIX
DISCUSSION OF THE STUDY FINDINGS

6.1. Introduction

The previous chapter dealt extensively with the analysis and the interpretation of the research findings. Therefore, the researcher provided the interpretation of what the research participants articulated on the approaches of traditional healers in the treatment of HIV/AIDS. Thus, in this chapter, the researcher will engage with the discussion of the research findings together with the recommendations as well as the limitations of the research. Subsequently, the significance of the research pertaining to the on-going efforts to fight the scourge of HIV/AIDS in South Africa will be clearly articulated.

6.2. Biographical profile of the research participants

The researcher deliberated on the biographical details of all the research participants made up of traditional healers, HIV/AIDS support group members from Tsengiwe One Stop Centre for Development and Caregivers from the abovementioned centre. The researcher must emphasize that the marital and socio-economic status of the research participants was deemed irrelevant to the research. Therefore, this is how the discussion ensued:
6.2.1. Age

The demographic profile of the traditional healers pertaining to age reflected a range of 40 to above 70 years, with caregivers revealing a range of 30 to above 55. Furthermore, the age of the HIV/AIDS support group members varied from 30 to slightly above 50 years. Mbatha (2012), in his study on the contribution of traditional healers to halting the spread of HIV/AIDS in Tshwane, Soshanguve township in South Africa, discovered that the age of traditional healers ranged from 40 to above 50 years. Probably, this might be the reflection of the status and role of traditional healers in indigenous African communities in which they are mostly seen as providers of guidance and wisdom. Therefore, what this means is that a traditional healer in a community occupies the status of an elder. As Audet et al. (2012) have pointed out therefore traditional healers are usually older and provide traditionally significant services to communities.

6.2.2. Gender

In this research, the gender of the participants reflected a dominance of the females in all categories. Consequently, traditional healers consisted of five females and one male with five caregivers being female. Thus, Ogunmefun, Gilbert and Schatz (2011) assert that the gender of caregivers in South Africa is made up of mostly adult females. Moreover, the HIV/AIDS support group members had four females and one male. Therefore, this is in congruence with
what Kang’ethe (2010) found, namely, that programmes that involve the prevention and care of HIV/AIDS are dominated by females. It is this researcher’s considered argument that men in general have been found wanting in terms of leading efforts to fight HIV/AIDS; with even the number of HIV activists in South Africa being female with the exception of a few from NGO’s such as the TAC (Treatment Action Campaign) Sonke Gender Network etc.

Perhaps this could be because females carry the burden of care and nurturing in households, hence the lack of enthusiasm from their male counterparts. Additionally, this corroborates what Mavhunga (2009) alluded to, that males in general, tend to display an aversion to testing for HIV while women have to be tested when pregnant so as to get them on treatment when HIV positive to prevent their babies from being infected. Moreover, this echoes what Hackle, Somlai, Kelly and Kalichnan (1997) found; that the majority of women living with HIV/AIDS often express the need for psychosocial support through support group programmes. Thus within the South African context, this could mean that initiatives such as Brothers for life which are geared towards sensitizing males to society’s ills such as HIV/AIDS prevention and care still have a long way to go in achieving their noble task.
McFarlane (2015) asserts that, within the African context, the majority of diviners tend to be female. This corroborates what Mathibela, Egan, Du Plessis and Potgieter (2015) found; that in the Blouberg Municipality the number of female traditional healers compared to their male counterparts is 80%. Consequently, the majority of traditional healers in this research are women. However, the researcher could not construe any meaningful reason as to why in this particular context the majority of traditional healers were female. Maybe this could be attributed to the geographical realities on the ground.

6.3. HIV/AIDS is incurable and is understood by symptoms

The findings in this research seem to indicate that the majority of the participants’ understanding of HIV/AIDS is based on the person’s physical symptoms. These findings were based on what the participants could observe from the physical appearance of the person, with weight loss being the most common symptom. Such findings resonate with what Semenya and Potgieter (2014) found that traditional healer’s diagnosis of a patient’s illness is often based on the patient’s presenting physical symptoms and the performance of certain cultural rituals. Moreover, the participant’s understanding of HIV/AIDS is that of something that is rampant, leading to certain death. Therefore, such sentiments seem to substantiate what Gilbert and Walker (2010) found; that
the advent of ARV treatment brought a shift in terms of understanding HIV/AIDS from being a deadly phenomenon to a condition that can be survived.

These findings echo Armenakis and Keifer’s (2007) assertions that the sociocultural perspective enhances people’s understanding of their wellness based on the context within which diseases take place. Possibly this could be because initially HIV/AIDS prevention campaigns were characterised by images of people emaciated and ravaged by HIV/AIDS, hence the perception of it being deadly. This researcher is firmly of the view that HIV/AIDS, like any other condition, should have been introduced as a manageable disease instead of something leading to certain death. Furthermore, the wide consultation of all stakeholders on strategies to fight HIV/AIDS is critically important, instead of a top down approach whereby ready-made solutions are brought to communities.

This view validates Airhihenbuwa and Webster’s (2004) argument that the PEN-3 model on HIV/AIDS prevention entails, among other things involving local communities in the strategies to educate and inform people about the virus. Thus, in the South African context, NGO’s such as the TAC (Treatment Action Campaign) and the department of health have a
responsibility to collaborate with local communities when planning and implementing strategies in the fight against HIV/AIDS.
6.4. Exposure to contaminated blood and bodily fluids

Research findings seem to indicate that the majority of the participants understand the transmission of HIV/AIDS as being caused by unprotected sexual intercourse with an HIV positive person and being exposed through open wounds with an infected individual’s blood. Such, conclusions are in congruence with the findings by Ndabula (2008) indicating that in South Africa the most common way of HIV/AIDS transmission is having sex without any protection. This situation would seem to indicate that despite the humongous efforts and strides that have been taken to educate people about HIV/AIDS, safe sex remains a challenge. Consequently, this argument substantiates what Visser and Moleko (2012) found in their study which is that some South African communities perceive unsafe sexual practices as normal.

This argument is consistent with what Rosenberg and Strecher’s (1997) theory in explaining perceived vulnerability found using the health belief model, when they argue that people’s perception of their risk to contracting HIV/AIDS depends on whether they believe their unsafe sexual practices will lead to them contracting the disease or not. Maybe, such sentiments indicate that attempts aimed at sensitizing people to the dangers of unprotected sex have not yet yielded the desired results, especially considering the endemic nature of HIV/AIDS in South Africa. Hence, Shisana et al. (2014) state that in the South African National
HIV prevalence, incidental and behaviour survey 2012, approximately 12.2% of the population was infected with HIV/AIDS, reflecting a 1.2 million upsurge than previously recorded.

This is attuned with Albright’s (2007) submission that, despite efforts to educate the public about HIV/AIDS, many sub-Saharan countries continue to experience new HIV infections on a daily basis. This researcher argues that this state of affairs is disheartening, especially considering the huge amount of resources, human and material that have been put together in an attempt to turn the tide against the disturbing impact of HIV/AIDS.

6.5. Belief system entrenched in traditional healing

The researcher found that an overwhelming number of the participants in this research came to the conclusion that the reasons people living with HIV/AIDS would access traditional healers is largely based on the individual’s beliefs about the illness and the perceived efficacy of the healer’s methods of healing. Such findings are consistent with Bayat et al. (2013) claims that the health belief model tends to highlight the person’s views regarding the usefulness of the strategies he or she makes regarding an illness. Thus, such conclusions echo with Moodley and Sutherland’s (2010) proclamations that one of the most popular reasons for the consultation of traditional healers is
their client’s unwavering trust in the effectiveness of the healer’s abilities to treat their illness.

In addition, some people’s cultural beliefs dictate that in times of crisis and illness they seek the services of the traditional healer first. Therefore, the researcher learnt that some of the reasons people living with HIV/AIDS consult traditional healers are based on their beliefs that it is witchcraft, poison (idliso) or ukuthwasa (the call by the ancestors to become a traditional healer). Such views resonate with Ashford’s (2002) findings that there is still a significant section of South African society that attributes HIV/AIDS related deaths to witchcraft and poison.

This finds resonance with Lerclec-Mdlala et al. (2009) claims that relevant cultural distinctions must be acknowledged in efforts to manage HIV/AIDS. Hence, traditional healers tend to enjoy veneration and a close kinship with their community members because of shared cultural values which have existed for centuries (Kang’ethe; 2008). On the other hand, the findings in this research revealed that some stakeholders in the fight against HIV/AIDS seem to have misgivings about people living with HIV/AIDS seeking the services of traditional healers. In the same way, Wreford and Esser (2008) found that a significant number of biomedical professionals tend to display a
negative outlook towards the involvement of traditional healers with people living with HIV/AIDS.

The researcher discovered that some participants expressed frustration with traditional healers’ treatment of HIV/AIDS survivors, preferring that they should desist from doing so. Be that as it may, it is this researcher’s contention that, had there been a clear process of engagement with all the stakeholders’ formally through regulation and informally involved in the fight against HIV/AIDS, such tensions would be minimal. Such sentiments find resonance with, Liverpool et al. (2004) argument that a collaborative process of engagement between the biomedical professionals and traditional healers to alleviate such tensions is crucial in efforts to fight HIV/AIDS.

6.6. Biomedical practitioners viewed as an alternative

The researcher discovered that virtually all the participants were in unison in terms of acknowledging the biomedical practitioners, for example, doctors and nurses as a credible alternative in the treatment of HIV/AIDS. Hence, such proclamations corroborate what Wreford and Esser (2008) discovered that traditional healers generally accept that they cannot cure HIV/AIDS and the intervention of western trained medical professionals is critical in this regard. Consequently, even in this research, traditional healers
readily accepted their limitations in treating HIV/AIDS, preferring to refer their clients to clinics and hospitals instead. This goes against the popular narrative available in the mainstream media that traditional healers generally claim to cure HIV/AIDS with often disastrous consequences. Therefore, this researcher argues that the implementation of policy guidelines pertaining to the involvement of traditional healers in the management of HIV/AIDS is of critical importance.

6.7. Cleansing rituals and traditional medicinal remedies

The findings in this research point to the fact that traditional healers assess their client’s state of health based on the presenting physical symptoms and administer some form of treatment, mainly herbal medicine, with some even performing rituals in an effort to appease the individual’s ancestors. Therefore, this finds support in Mbatha’s (2012) argument that traditional healers mostly treat a number of ailments associated with HIV/AIDS. Hence, Borrell-Carrio et al. (2003) assert that one of the cornerstones of the biopsychosocial model is its holistic approach to healing as opposed to the individualized western medicine. Moreover, traditional healers seem to be more than willing to refer their HIV positive clients to hospitals and clinics for further treatment.
Iwelunmo, Newsome and Airhihenbuwa (2013) contend that it is critical to observe the cultural milieu within which a disease takes place in order to come up with culturally relevant intervention strategies. Consequently, this researcher submits that this is an illustration of the various approaches of the traditional healer in the treatment of HIV/AIDS. However, not all the participants shared the traditional healer’s eagerness to participate in the management of HIV/AIDS related symptoms.

Additionally, these participants were scathing in their criticism of the traditional healer’s approaches in the treatment of HIV/AIDS, urging them not to get involved with people living with HIV/AIDS. Their sentiments were compatible with Liverpool et al. (2004) that several biomedical professionals continue treating traditional healers with contempt. This researcher argues that, perhaps the extreme popularity of antiretroviral medication among those surviving HIV/AIDS with support from the mainstream media has diluted the relevance of traditional healers in the treatment of HIV/AIDS.

6.8. Referrals
The findings in this research clearly demonstrated the majority of the participants’ emphatic view that people afflicted by HIV/AIDS must be referred to the clinics and hospitals for further treatment. Therefore, such
conclusions concur with Gqaleni et al.’s (2011) findings that a significant number of traditional healers tend to express an enthusiasm to refer their HIV positive clients to hospitals and clinics for ARV treatment. Thus, during the course of this research, the researcher never encountered a traditional healer claiming to have a cure for HIV/AIDS. Be that as it may, some participants displayed a contemptuous attitude towards traditional healers and their involvement in the treatment of HIV/AIDS. Moreover, they expressed an extreme level of contempt regarding traditional healers’ approaches to the treatment of HIV/AIDS.

Such negative attitudes find resonance with Murguia, Peterson and Zea’s (2003) contention that many biomedical practitioners display an aversion to accepting indigenous healing practices for many illnesses. Therefore, in the context of this research, those providing care to people afflicted by HIV/AIDS rejected traditional healers’ approaches in the treatment of HIV/AIDS. Furthermore, they expressed strong criticism regarding traditional medicinal remedies provided by traditional healers in the treatment of HIV/AIDS.

Hence Dahab et al. (2008) found that several biomedical professionals regard indigenous medicine as a hindrance to a patient’s compliance with antiretroviral medicine treatment. Perhaps this could assist in shedding light
on the reasons for such disparaging remarks emanating from other stakeholders against the approaches of traditional healers in the treatment of HIV/AIDS in Tsengiwe village, Eastern Cape. However, having denied that they consult traditional healers for the treatment of HIV/AIDS symptoms, the researcher was found that some participants mentioned self-medication as a preferred option through buying medicinal remedies at hawker’s stands.

Such findings are compatible with Mathibela et al.’s (2015) assertions that, recently, there has been a mushrooming of traders in traditional medicine with some even opening shops to sell their wares, which means that people do not necessarily have to consult a traditional healer for the treatment of a physical as well as social ailment. Nevertheless, it is this researcher’s considered view that the denials expressed by those living with HIV/AIDS concerning the consultation of traditional healers may be due to the prevailing sentiments and advice from nurses and doctors against such practices regarding the treatment of HIV/AIDS.

Hence, Campbell and Gibbs (2008) assert that HIV/AIDS has been rigorously portrayed by the media as a crisis requiring only the biomedical sector’s intervention. Possibly this is because of the dim view demonstrated by those western educated medical practitioners, such as nurses, concerning the involvement of traditional healers in the treatment of HIV/AIDS.
Therefore, this is consistent with what Mall’s (2008) finding that biomedical practitioners discourage those living with HIV/AIDS from consulting traditional healers due to the methods used by the healers in the treatment of HIV/AIDS, such as inducing vomiting and diarrhea in their clients.
6.9. **Strengthening relations between stakeholders**

The findings in this research indicated an unconditional willingness on the part of traditional healers to collaborate with the biomedical professionals in the treatment of HIV/AIDS. Furthermore, they did not put any preconditions on such an arrangement, going as far as admitting that they refer their clients to the local clinic and hospital for further treatment of HIV/AIDS. Thus, such conclusions reinforce what Mufamadi (2009) found; that a significant number of traditional healers tend to display a willingness to work closely with the biomedical professionals in the treatment of HIV/AIDS. However, some stakeholders in this research did not express any inclination to work with traditional healers, preferring that traditional healers do not get involved with HIV/AIDS treatment at all. In this respect, their views are consistent with Summerton’s (2006) assertions that traditional healers are not needed in the treatment of HIV/AIDS as they are peddlers of false cures and only cause unnecessary delay in the antiretroviral treatment of HIV/AIDS. In a similar vein, Bourgeois and Perkin (2003) found that one of the criticisms against the sociocultural perspective is its disregard for proven scientific findings.

Such criticism tallies with what Belisle et al.’s (2015) assertion that biomedical professionals generally did not encourage traditional healers’ involvement in the treatment of HIV/AIDS citing them as a cause of non-
adherence to antiretroviral treatment. This researcher found it strange that the participant’s (HIV/AIDS support group members) despite their denials concerning going traditional healers did not establish the identity of those selling medicine to them as herbalist can be referred to as traditional healers.

6.10. Research conclusion

The main focus of the research was the approaches of traditional healers in the treatment of HIV/AIDS in Tsengiwe village, Cala, Eastern Cape. Therefore, in this regard, traditional healers in this research indicated that after observing their clients’ physical symptoms they administer some form of assistance such as herbal mixtures to mitigate the severity of the symptoms. Moreover, the findings in this research indicated that traditional healers unanimously agreed that referring HIV positive clients to the biomedical professionals was the best option. However, some of the participants, namely caregivers and HIV/AIDS support group members were not keen on any involvement by traditional healers in the treatment of HIV/AIDS. Furthermore, what emerged that, those living with HIV/AIDS preferred self-medicating through buying medicinal remedies from the traders who have stalls around their area denying that they consult traditional healers for HIV/AIDS related ailments.
CHAPTER SEVEN
RESEARCH CONCLUSIONS SUMMARY AND RECOMMENDATIONS

7.1. Introduction

The previous chapters brought to the fore the introduction to the research, detailed review of related literature to the research and the relevant theoretical framework. Furthermore, the methodology, analysis and interpretation of research findings and the discussion and the conclusion of the findings was extensively engaged with. Lastly, the researcher brought to the fore the research summary and recommendations.

7.2. Summary of the findings

Since the research was about the approaches of traditional healers in the treatment of HIV/AIDS in the village of Tsengiwe in Chris Hani District Municipality, Cala, Eastern Cape, therefore, the first objective was to assess the participant’s understanding of HIV/AIDS. In this regard, the findings indicated that participants demonstrated a basic symptom based knowledge about HIV/AIDS. Secondly, the researcher sought to assess the reasons people living with HIV/AIDS consult traditional healers. Consequently, the findings reflected various reasons from cultural beliefs as well the denial of one’s HIV/AIDS status.

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Thirdly, the treatment strategies of Tsengiwe village traditional healers in the treatment of HIV/AIDS were another objective. Where this is concerned, the findings indicated a minimalist intervention role in treating the observable symptoms of HIV/AIDS, with the referral of their clients to the local clinic and hospital a pivotal aspect of their intervention.

The fourth objective was to establish how traditional healers view their role in the treatment of HIV/AIDS. In this regard, the researcher found that there was entirely opposing outlooks, with traditional healers expressing an enthusiasm to cooperate with biomedical professionals. However, other stakeholders were unequivocal in their disapproval concerning the involvement of traditional healers in the treatment of HIV/AIDS symptoms. Thus this researcher contends that the main objective of this research, which was to investigate the approaches of traditional healers in the treatment of HIV/AIDS, was answered successfully. Furthermore, there seem to be a dichotomy of view between traditional healers and other stakeholders in terms of the involvement of traditional healers in the treatment of HIV/AIDS.

7.3. Limitations of the research

One major constraint concerning the research was the limited amount of time available to collect the data, with some participants postponing appointments numerous times. Another constraint that the researcher
encountered is the limited resources, for example, budgetary restrictions, resulting in delays in data collection. The fact that the study is confined to a small rural area means that it cannot be generalized to other contexts.
7.4. **Recommendations for further study**

During the course of this research, the researcher discovered that there was no coordination between what the traditional healers were doing in treating HIV/AIDS and the efforts of the biomedical practitioners in this regard. Furthermore, no formal collaboration exists practically on the ground between the two aforementioned sectors. Therefore, the researcher recommends the following:

- The dissemination of proper and relevant information concerning the recent developments and UN guidelines on the treatment of HIV/AIDS.
- The involvement or co-option of traditional healers in all efforts in the fight against HIV/AIDS.
- The strengthening of the traditional healers’ organisations and associations at grassroots level and their registration so as to deal with those bringing traditional healers into disrepute.
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APPENDIX A:
SOUTH AFRICAN MAP ILLUSTRATING THE RESEARCH AREA
APPENDIX B:

INTERVIEW GUIDE TSENGWE VILLAGE TRADITIONAL HEALERS

<table>
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<th>Place.................................</th>
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<table>
<thead>
<tr>
<th>Usuku</th>
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1. How do traditional healers and people living with HIV/AIDS in Tsengiwe village understand HIV/AIDS?

   Ingaba amagqirha nabantu abaphila nentsholongwane ka gawulayo apha kwilali yaku Tsengiwe basiqonda njani isifo sika gawulayo?

   - What do you know about HIV/AIDS?
     Wazi ntoni ngesifo sika gawulayo?
   - What are the symptoms of HIV/AIDS?
     Ngeziphi iimpawu zika gawulayo
   - How does someone get infected with HIV/AIDS? WoSuleleka njani umntu sisifo sika gawulayo?

2. What are the reasons for the consultation of traditional healers by people living with HIV/AIDS in Tsengiwe village?

   Ngezi phi izizathu ezi bangela ukuba abantu abaphila nentsholongwane ka gawulayo baye emagqirheni apha kwilali yaku Tsengiwe?

3. What are the treatment strategies used by Tsengiwe village traditional healers to treat HIV/AIDS?

   Ngawaphi amacebo asetyenziswa ngamagqirha alapha kuTsengiwe ukunyanga isifo sika gawulayo?

   - How do traditional healers help HIV/AIDS survivors?
     Amagqirha abanceda njani abo baphila nentsholongwane ka gawulayo?

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• What do traditional healers give HIV positive clients to treat HIV/AIDS and why?
  Abanika ntoni amagqirha abo baphila nentsholongwane ka gawulayo ukubanyanga, ngabuni?

• Describe the experiences of people living with HIV/AIDS before and after consulting a traditional healer?
  Khawucacise ngamava abantu abaphila nentsholongwane kagawulawo phambi nasemva kokuba beye kwigqirha?

4. How do traditional healers view their role in the treatment of HIV/AIDS in Tsengiwe village?
  Amagqirha ayibona njani inxaxheb a yawo kunyango luka gawulayo kwilali yakuTsengiwe?

• What do you see as the duty of traditional healers in treating someone with HIV/AIDS and why?
  Uwubona ingowuphi umsebenzi wamagqirha ekunyangeni isifo sika gawulayo, ngabuni?

• Why is it important for traditional healers to be involved in the treatment of HIV/AIDS?
  Kutheni kubalulekile ukuba amagqirha abenenxaxheba ayithathayo kunyango luka gawulayo?
FOCUS GROUP DISCUSSION GUIDE
TSENGIWE HIV/AIDS SUPPORT GROUP/CAREGIVERS

Place........................................ Date........................................ Indawo
Usuku
Gender........................................ Age...................................... Isini
Iminyaka

1. How do traditional healers and people living with HIV/AIDS in Tsengiwe understand HIV/AIDS?
   Ingaba amagqirha nabantu abaphila nentsholongwane ka gawulayo apha kwilali yaku Tsengiwe basiqonda njani isifo sika gawulayo?
   • What do you know about HIV/AIDS?
   Wazi ntoni ngesifo sika gawulayo?
   • What are the symptoms of HIV/AIDS? Ngezipheli iimpawu zika gawulayo
   • How does someone get infected with HIV/AIDS? Wosuleleka njani umntu sisifo sika gawulayo?

2. What are the reasons for the consultation of traditional healers by the people living with HIV/AIDS in Tsengiwe?
   Ngezipheli izizathu ezi bangela ukuba abantu abaphi la nentsholongwane ka gawulayo baye emagqirheni apha kwilali yaku Tsengiwe?
   • What do people living with HIV/AIDS look for in a traditional healer and why?
   Ngeyiphili into abantu abaphila nentsholongwane ka gawuloyo abayikhangelayo emagqirheni ngabuni?
   • If someone living with HIV/AIDS is not using a traditional healer, then, what is he/she using and why?
   Ukuba ubani ophila nentsholongwane ka gawulayo akayi emagqirheni, ingaba usebenzisa ntoni ngabuni?

3. What are the treatment strategies used by Tsengiwe village traditional healers in the treatment of HIV/AIDS?
   Ngawaphi amacebo asetyenziswa ngamagqirha alapha kuTsengiwe ukunyanga isifo sika gawulayo?
   How do traditional healers help HIV/AIDS survivors?
   Amagqirha abanceda njani abo baphila nentsholongwane ka gawulayo?
• What do traditional healers give HIV positive clients to treat HIV/AIDS and why?
  Abanika ntoni amagqirha abo baphila nentsholongwane ka gawulayo ukubanyanga, ngabuni?
• Describe the experiences of people living with HIV/AIDS before and after consulting a traditional healer.
  Khawucacise ngamava abantu abaphila nentsholongwane kagawulawo phambi nasemva kokuba beye kwigqirha?

4. How do traditional healers view their role in the treatment of HIV/AIDS in Tsengiwe village?
  Amagqirha ayibona njani inxaxheba yawo kunyango luka gawulayo kwilali yaku Tsengiwe?
• What do you see as the duty of traditional healers in treating someone with HIV/AIDS and why?
  Uwubona ingowuphi umsebenzi wamagqirha ekunyangeni isifo sika gawulayo, ngabuni?
• Why is it important for traditional healers to be involved in the treatment of HIV/AIDS?
  Kutheni kubalulekile ukuba amagqirha abenexaxheba ayithathayo kunyango luka gawulayo?
CONSENT FORM

I hereby agree to participate in the research regarding the approaches of traditional healers in the treatment of HIV/AIDS. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can leave the focus group discussion at any point should I not want to continue and that this decision will not in any way affect me negatively. I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this focus group discussion.

I understand that this consent form will not be linked to the focus group discussion and that my response will remain confidential.

I understand that, if at all possible, feedback on the results of the completed research will be provided to my community.

Signature of the participant ___________________________ Date __________

I hereby agree to the tape recording of my participation in the study

Signature of the participant ___________________________ Date __________
ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number: SAN101SMAT01


Nature of Project: Masters

Principal Researcher: Similo Mati

Supervisor: Mrs NS Sandiana
Co-supervisor: Dr LN Misa

On behalf of the University of Fort Hare’s Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research
Dear Mr Mati

This serves to confirm that Tsengiwe Development One Stop Centre have duly granted permission to Mr Similo Mati to collect data at One Stop Centre support group and Care givers. The research is focuses on the approaches of traditional healers in the treatment of HIV/AIDS.

Chairperson

Signature: [Signature]
Date: [Signature Date]

APPENDIX E:
APPENDIX F:

Finanace Administrative and
Casa
Samhorne Local Municipality
30 June 2015

Miss Sandzana (Psychology Department)
Fort Hare

Sir/Madam

This serves to confirm that I, B.N. Makamula (Tongque A/A Headman), have duly granted permission to Mr. Similo Mani and Miss Ukulima Sonni (identity number 301066697 and 95104438 respectively) to collect data at Tongque Administrative Area. The research is focused on the approaches used by traditional healers in the treatment of HIV/AIDS.

Yours faithfully

[Signature]

21/06/2015
APPENDIX G:

18 May 2015.

To Whom It May Concern

Dear Sir/Madam

REQUEST FOR PERMISSION TO COLLECT DATA

This letter serves as request for permission for Mr Simlito Mati (student number- 201006697), a registered second year master’s student in the Department of Psychology, at the University of Fort Hare, Alice Campus to collect data at Tsengiwe village. He is currently collecting data to enable him to complete the research project which is required for the fulfilment of his degree. His focus is on the approaches used by traditional healers in the treatment of HIV/AIDS.

Your assistance in this endeavour will be highly appreciated. Please be assured that the data collected is strictly meant for academic purposes.

Thanking you in advance.

Yours faithfully,

N.S. Sandlana (Mrs)(Supervisor)