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**A Model to Facilitate the Integration of Indigenous  
Knowledge Systems in the Management of HIV &  
AIDS within a Primary Health Care Context in  
Limpopo Province, South Africa**

*by*

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*Thesis Submitted in Fulfillment of the Requirements for the Degree:*

**Doctor of Philosophy (PhD) in Nursing**

**Department of Nursing Science**

**Faculty of Agriculture, Science and Technology**

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# DECLARATION

I, **Julia Elisa Bereda**, declare that the thesis “**A Model to Facilitate the Integration of Indigenous Knowledge Systems in the Management of HIV & AIDS Within a Primary Health Care Context in Limpopo Province, South Africa**” hereby submitted to the North-West University for the degree **Doctor of Philosophy (PhD) in Nursing** has not been previously presented by me for the degree at this or any other university or institution, that it is my own work in design and in execution and that all the sources I have used and quoted have been indicated and acknowledged by means of complete references.

**J.E. Bereda**

:  .....

**Date Signed**

: 20/04/2015 .....

# DEDICATION

I dedicate this work to my whole family: both, my late parents, my in-laws, my loving husband, Prof. D.R. Thakhathi, all our children, siblings and all my relatives, for the support they have given me throughout the entire study.

# ACKNOWLEDGEMENTS

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# ABSTRACT

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Indigenous health practices have been in existence since the dawn of civilization, and the inception of western medical practices has created a divide between these health systems. This study focused on the development of a model that could facilitate the integration of Indigenous Knowledge Systems (IKS) in managing HIV & AIDS within a primary healthcare (PHC) context. The researcher affirms Capers (1992:19) notion that indigenous and western healthcare knowledge systems will continually be in existence and will always move parallel to one another until the two systems converge to collaborate on knowledge sharing for the benefit of both consumers of health and health practitioners. The purpose of this study was to develop a model to facilitate the integration of IKS in the management of HIV & AIDS within the PHC context in Limpopo Province, South Africa.

The objectives of this study were to:

- ✧ Explore and describe views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS, in the Limpopo Province, South Africa.
- ✧ Conceptualize a framework related to current dialogue about the integration of IKS in the management of HIV & AIDS within the PHC setting.
- ✧ Develop a model to facilitate the integration of IKS in the management of HIV & AIDS within the PHC context in South Africa.

In this study, an explorative, descriptive and contextual qualitative design was used in order for the researcher to gather more information that would be appropriate and necessary to support the development of the model which will facilitate the integration of IKS in the management of HIV & AIDS within a PHC context in the Vhembe District of the Limpopo Province. The population includes stakeholders (IKS practitioners, and healthcare professionals) who embody deeper concerns regarding the integrative approach to health and illness behaviour.

Purposive and snowballing sampling methods were used in this study. The snowballing technique has been utilized to further identify potential IKS participants not known to the researcher. Data collected were guided by the central question, “How can we integrate IKS in the management of HIV & AIDS within the PHC context in Limpopo Province?” All participants responded to the same question and the researcher used her probing and listening skills to gather more information. Data were collected until saturation was reached and data analysis was done using Tsech’s eight-step open-coding method (Creswell, 2009:186). Themes, categories and sub-categories emerged from the data analysis and were fully discussed and became fundamental units for development of the conceptual framework as well as the model.

Three themes were identified:

- ✎ IKS stakeholders expressed challenges experienced in dealing with marginalization and being looked down upon by their western health professional (WHPs) counterparts.
- ✎ IKS stakeholders reflected a need for WHPs to develop an understanding with regard to the differences in diagnosing and healing strategies of IKS.
- ✎ IKS stakeholders expressed that a number of issues need to be dealt with to ensure effective integration of IKS for quality management of HIV & AIDS.

In conclusion, IKS will remain the point of departure surrounding responses of individuals, families and communities to illness behaviours in any given human context of existence. A huge literature supports the construct that indigenous cultural practices have been in existence since time immemorial and will continue to influence health and social welfare in the global context. A great need exists to integrate the two systems, i.e., IKS and WHPs, towards a mutual understanding and respect for quality and efficacious healthcare.

**Keywords:** model, integration, IKS stakeholders (traditional healers, herbalists, pastors and IKS knowledge experts), HIV & AIDS, western health professional

# LIST OF ACRONYMS

<b>AFSA</b>	Antiretroviral Therapy/AIDS Foundation of South Africa
<b>ANC</b>	African National Congress
<b>ART/ARV</b>	Antiretroviral Therapy/Antiretroviral
<b>AHPC</b>	Allied Health Professions Council
<b>ASSA</b>	Actuarial Society of Southern Africa
<b>CAM</b>	Complementary and Alternative Medicine
<b>DENOSA</b>	Democratic Nursing Organization of South Africa
<b>DoH</b>	Department of Health
<b>DOT</b>	Directly Observed Therapy
<b>DST</b>	Department of Science and Technology
<b>FAO</b>	Food and Agricultural Organization
<b>FAST</b>	Faculty of Agriculture, Science and Technology
<b>GMRDC</b>	Govan Mbeki Research Development Centre
<b>HST</b>	Health Systems Strengthening Trust
<b>HIV</b>	Human Immunodeficiency Virus
<b>HPCSA</b>	Health Professions Council of South Africa
<b>IHS</b>	Indigenous Health System(s)
<b>IK</b>	Indigenous Knowledge
<b>ILO</b>	International Labour Organization
<b>IKP</b>	Indigenous Knowledge Practitioners
<b>IKS</b>	Indigenous Knowledge System(s)
<b>IPR</b>	Intellectual Property Rights
<b>MDC</b>	Medical and Dental Council
<b>MDG</b>	Millennium Development Goals
<b>NCM</b>	Non-Conventional Medicines
<b>MHAPP</b>	Mental Health and Poverty Project

<b>NHP</b>	National Health Plan
<b>NQF</b>	National Qualifications Framework
<b>NSDA</b>	Negotiated Service Delivery Agreement
<b>NDoH</b>	National Department of Health
<b>NSP</b>	National Strategic Plan
<b>NSTF</b>	National Science and Technology Forum
<b>PHC</b>	Primary Health Care
<b>PLWHA</b>	People Living with HIV & AIDS
<b>PRA</b>	Participatory Rural Appraisal
<b>QA</b>	Qualification Authority
<b>SA</b>	South Africa
<b>SABSSM</b>	South Africa Population-Based HIV & AIDS Behavioural Risks, Sero-Status and Mass Media Impact Survey
<b>SACAR</b>	South African Chapter of the African Renaissance
<b>SANAC</b>	The South African National AIDS Council
<b>SANC</b>	South African Nursing Council
<b>SAPC</b>	South African Pharmacy Council
<b>SAQA</b>	South African Qualifications Authority
<b>STI</b>	Sexually Transmitted Infections
<b>SWOT</b>	Strength Weaknesses, Opportunities and Threats
<b>TB</b>	Tuberculosis
<b>TH</b>	Traditional Healer
<b>TM</b>	Traditional Medicine
<b>UNAIDS</b>	Joint United Nations Programme on HIV & AIDS
<b>WHO</b>	World Health Organization
<b>WHPS</b>	Western Health Practitioners/Professionals
<b>WHS</b>	Western Health System
<b>YRS</b>	Years

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# CHAPTER 1

## OVERVIEW OF THE STUDY

### 1.1 Introduction

Currently, various philosophies and dialogues abound what Indigenous Knowledge Systems (IKS) entail, which forms the basis within which Indigenous Health Systems (IHS) originate. Several definitions are now found in the literature of which few will be discussed in the context of this study. A paper titled “The IKS Agenda in South Africa (SA)” explicates IKS as a human experience, organized and ordered into accumulated knowledge with the objective to utilize it to achieve quality of life and to create a liveable environment for both human and other forms of life (Serote, 2005:7). On the other hand, Green (1994:20) defines IKS as, “that body of accumulated wisdom that has evolved from years of experience, trial and error as well as problem solving by groups of people working to meet the challenges they face in their local environments, drawing upon the resources they have at hand.”

Unlike science and technology, indigenous knowledge (IK) is not invented, but inherent in people’s lives and how they see and do things. Tjale and De Villiers (2004:1) argue that prior to the arrival of European settlers in Southern Africa; people were treating diseases and illnesses in accordance with their cultural belief systems. It is therefore important to integrate cultural practices of Africans in the management of HIV & AIDS within the Primary Health Care (PHC) context. De Haan (2009:27) regards traditional healers as one of the health care teams in South Africa. An indication is made that they live and work within their communities, which gives them an opportunity to have close ties with their people. This, on its own, creates a supposition that we cannot isolate their efforts in disease management.

The inherent syndromic management of HIV & AIDS so far, together with the initiation of antiretrovirals (ARVs), including the ABC prevention strategies of Abstain, Be faithful, use Condoms, exclude the greatest influential part—which is about the IKS (Mulaudzi, 2007:31-32). Indigenous knowledge practices have been in use since the inception of man across different cultural groups and backgrounds, inherent within the society and societies that will always seek interventions from such health practices (Mulaudzi, 2007:32). Gausset (2001:152) cited in Mulaudzi (2007:32) argues that the ABC model overlooked the issue of indigenous cultural practices, sexual behaviours, knowledge and attitudes of the society. Up to this point, only biomedical approaches or models of cure seem to be the only acceptable mantras in the management of HIV & AIDS (Mulaudzi, 2007: 32).

According to the Traditional Health Practitioners Act, No. 22 of 2007, Chapter 1, section 6, previously traditional African families were hiding their inherent nature of transferring their indigenous knowledge perceptions and skills from generation to generation, and it is well stipulated and accepted. Nevertheless, IHS is still highly compromised practically by the infiltration of other new knowledge systems, for example, the Western Health System (WHS) (Tjale and De Villiers, 2004:1). In Africa, IHS co-existed with WHS which were referred to as scientific and therefore more credible, subjecting healthcare consumers to a plethora of systems relevant to their needs as well as their belief and value systems (Tjale and De Villiers, 2004:1).

Mpinga, Kandolo, Verloo, Bukonda, Kandala and Chastonay (2013:44) indicated a progressive uptake of unconventional medicines that received international recognition during the 1970s under the International Drug Monitoring Program of the World Health Organization (WHO), with various developments. In 2002, WHO adopted a world strategy to facilitate the integration of traditional medicine into health systems (Mpinga et al, 2013:44). This initiative was followed by political mobilization through new training programs in faculties of medicine, centres of research, and international meetings, with Africa

establishing an annual Africa day dedicated to these forms of medicine (Mpinga et al, 2013:44). The developments are happening in a global health context marked by new health challenges that call for more effective organization in the health sector, and prominent among these challenges are the HIV pandemic, non-contagious diseases and malnutrition (Mpinga et al, 2013:45).

Schrijvers (1993), in Sanderson and Kindon (2004:116), argue that development of knowledge is rooted in a belief in the supremacy of the western health system (WHS). Tucker (1999), in Sanderson and Kindon (2004:116), states that ‘development of knowledge has been accorded the status of natural law with the consequences of dismissing and devaluing alternative indigenous health practices’ as a result of Africans being looked down upon and their cultural practices were viewed as ‘barbaric’. Moreover, Turker (1999), in Sanderson and Kindon (2004:116), locates and explains this devaluing process in power/knowledge as a way of developing discourse, emphasizing the unequal power relations in the generation of knowledge.

Escobar (1997), in Sanderson and Kindon (2004:116), explains that this development of discourse has created a space in which only certain things could be said or imagined due to the restrictions of alternative conceptions and forms of knowledge that exist within it. One consequence is the lack of presentation of IKS in any health care setting (Sanderson and Kindon, 2004:116-117).

Due to non-declining of the burden of diseases in South Africa, as part of the overall government strategy “ Long and Healthy Life for All South Africans” the Minister of Health committed himself and the Members of the Executive Council (MECs) for all nine provinces to embark on four outputs through the implementation of PHC Re-engineering in South Africa. Four outputs were tabled; (i) Increase Life Expectancy, (ii) Decreased Maternal and Child mortality, (iii) Combating HIV and AIDS and decreasing the burden of disease from

Tuberculosis and (v) Strengthening Health System Effectiveness. Through benchmarking that was done by the Minister in Brazil in 2010 the Minister came up with this strategy. Looking at the proposed model of PHC re-engineering which had its control through the District/sub-district Management Team. The researcher still identifies a crucial omission with regard to the constitution of Ward based PHC outreach teams which excluded the crucial role that can be played by traditional healers to their people within the communities. This is still indicative of paper acknowledgement (Traditional Health practitioners Act, 22 of 2007) of Traditional health system but not functionally recognized. This is the category that is well received by its people and operates within their communities.

In the study that was conducted within the Department of Medicine in Korea regarding the National Health Insurance and Reforming Access to Medicines, an indicative feature was that the country started acknowledging the two different kinds of medicine, western and traditional (Cho and Kim, 2002:11). Colleges were developed in Korea for traditional medicine with a board for traditional doctors (Cho and Kim, 2002:11).

Most African communities utilize indigenous health systems secretly, for fear of being labeled and, in this regard, one realizes the continuous restrictions on the alternative conceptions and forms of indigenous knowledge existing within a given society due to the privileging of a particular type of knowledge in particular, the western-based knowledge (De Haan, 1996:12). People are deprived from relying upon their inherent indigenous knowledge when faced with health and illness behavioural changes at any given setting (De Haan, 1996:13). According to Sillitoe (1998:229), scientific development agencies seem to identify problems by turning to science and technology for theory and ways forward without the integration of IKS. There is a serious need for connection between scientists and indigenous people to establish an open platform for positive impact in the generation and development of new knowledge system (Sillitoe, 1998: 230). It is with this new knowledge system that nurse

educators can prepare student nurses to look at indigenous content as an integral component of professional nursing practice (Sillitoe, 1998:229-230).

Capers (1992:19), also affirms that indigenous and western health care knowledge systems will continually be in existence and always move parallel to one another until the two systems are made to collaborate to allow knowledge sharing for the benefit of both consumers of health and health practitioners. A holistic approach to patient care facilitates bringing both WHS and IHS together for the patient's benefit. Cathie Guzzetta (1998), in O'Brien (1999:4), describes holistic concepts as incorporating 'a sensitive balance between art and science, analytic and intuitive skills, and the knowledge to choose from a wide variety of treatment modalities to promote balance and interconnectedness of body, mind and spirit'. Thus, in the holistic teaching model, clients' spiritual or belief system needs have to be brought into equal focus with cognitive and physiological needs (O'Brien, 1999:4).

Disease in western medicine is termed the malfunctioning or maladaptation of biological and physiological processes in the individual, while illness represents personal, interpersonal and cultural reactions to disease or discomfort. This explanation ensured that western medical practitioners were taught to believe that there is a scientific basis for disease, diagnosis and treatment. If one's physical parameters like temperature, pulse, height, weight and blood pressure are within acceptable normal ranges, the individual is regarded as healthy, even if s/he could be experiencing problems from other forces which are not scientifically based (Tjale and De Villiers, 2004:2). An example of this is that there is a great misinterpretation of what HIV & AIDS is because different cultures have different ways of interpreting the concepts. HIV & AIDS is mostly looked at medically with regard to its cause, manifestations and management; doctors often ignore, however, the impact of the stigma attached to it. Traditionally, illness behaviour has cultural connotations or is deemed to occur in association with evilness that has been inflicted by someone (Tjale and De Villiers, 2004:3).

Capers (1992:19) indicated that of all health care professionals, nurses have the greatest contact with clients and through this contact, nurses see similarities and differences across and within groups, and become acutely aware of the influence of indigenous knowledge on healthcare practices. This influence forces healthcare professionals to strategically plan to incorporate indigenous knowledge factors into the healthcare delivery system, but there is a great need for health practitioners to have indigenous health knowledge (Capers, 1992:20). This knowledge gap has thus far resulted in failure to integrate the two knowledge systems (i.e., WHS and IHS) (Capers 1992:20).

*The researcher's earlier consultation with indigenous knowledge experts for the sake of model development led her to one focus area which is the management of HIV & AIDS. Because indigenous health systems cover a broad range of patient conditions, it became arduous to address all of them. This model, in particular, sampled one disease, but the model can be adapted to the management of other diseases associated with important sociocultural and psychological contexts.*

Haslwimmer (1994:1) alludes to the fact that HIV & AIDS erodes the asset base of rural households, depletes their labour force, reduces their range of knowledge and skills, restricts their ability to earn cash from farming and non-farming activities, and undermines their ability to feed themselves and maintain adequate levels of nutrition as well as reduces the amount of money available to affected households. At the national level, HIV & AIDS requires budgeting for health and for health education programmes for awareness building and information campaigns needs that require increasing governmental support. The epidemic is seriously undermining efforts to reduce poverty and, in some countries, is reversing the development gains made during recent decades. At present, the scale of the problem is most severe in sub-Saharan Africa: 70% of people with HIV & AIDS at present live in Africa and it is likely that at least one quarter of economically productive adults in Southern Africa will die within the next five to ten years Haslwimmer (1994:2-3). However,

the worst impact of the epidemic is still expected to come so far, few countries have taken measures sufficient to see a decrease in their national infection rates (Haslwimmer, 1994:4).

The South African Department of Health (DoH, 2011:1), based on a study conducted in 2009 of 32,861 women attending 1,447 antenatal clinics across all nine provinces, estimated 29.4% of pregnant women (age range 15-49) as living with HIV in 2009. In 1998, South Africa had one of the fastest expanding epidemics globally though the rate of HIV prevalence among pregnant women had remained stable since 2006 (Haslwimmer, 1994:1). Though there is a slight decrease of HIV prevalence among women aged between 15 and 19 years, the increase infection rate among women between 30 and 34 years of age is worrying. Based on all surveys of the overall national estimates, UNAIDS approximates that of the total SA population around 5.6 million were living with HIV at the end of 2009, including 300,000 children under 15 years old (DoH, 2011:7). The report of the same study by (DoH, 2011:5), indicated boldly that:

*Social stigma associated with HIV & AIDS, tacitly perpetuated by the Government's reluctance to bring the crisis into the open and face it head on, prevents many from speaking out about the causes of illness and deaths of loved ones and leads doctors to record uncontroversial diagnosis on death. The South African Government needs to stop being defensive and show backbone and courage to acknowledge and seriously tackle the HIV & AIDS crisis of its people.*

The researcher aimed at pitching her expectations high for the same Government of South Africa and Department of Health, in particular, to acknowledge the need to bridge the inherent divide between WHS and TKS and to bring about a mutual platform that will enable healthcare consumers to utilize both systems effectively and openly.

The Actuarial Society of South Africa (ASSA) (2011:1-2) media release by Peter Doyle, the Society's President, indicates that the new ASSA 2008 model estimated that 10.9% of the

South African population was infected with HIV, and that 5.5 million would be living with HIV in 2010, which was marginally lower than 5.8 million estimated by the ASSA 2003 model. A study conducted by Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wyk, Mbele, Van Zyl, Parker, Zungu, Pezi and the South Africa Population-Based HIV & AIDS Behavioural Risks, Sero-Status and Mass Media Impact Survey (SABSSM) III Implementation Team (2009:30), indicates that the HIV prevalence rate for 2008 was at 10.6%, which suggests that out of the total population, 5.2 million people were HIV-positive. With the exclusion of children less than 2 years of age, the estimate tends to 10.9%, and the worrying factor has been that the trend among adults showed an increase of 1.3% in adults who were 25 years and above between 2002 - 2008 and this is the group that could opt for alternative means of interventions to deal with their health seeking behaviours (Shisana et al, 2009:31).

Apart from the continuous loss of the indigenous practices, loss of indigenous knowledge too is a serious issue within the cultural context of human existence. The societies we are living in still utilize these knowledge and skills, but under serious confinement. If nothing is done, this knowledge will disappear with the senior citizens when they die. To avoid this loss, institutions of higher learning should integrate indigenous health knowledge into the curriculum of the training of student nurses and also develop disease management models that integrate IKS in the care and management of diseases (De Haan, 1996:12-13; Stanhope and Lancaster, 2000:233; ANC, 1994a:20).

Airhihenbuwa and De Witt Webster (2004:5) demonstrated that culture has both positive and negative influences on health behaviours, but culture also played a role in the prevention and promotion of health throughout without formal documentation of the inherent indigenous methods and practices. Even before the discovery of HIV & AIDS as a disease impacting the body's immune system, indigenous people prevented unnecessary lowered body resistance by using indigenous health preventive practices. Furthermore, Airhihenbuwa and De Witt

Webster (2004:6) argued that there is a vast inherent limitation as far as knowledge generation is concerned due to the biased western models of knowledge generation that continue to marginalize the African way of knowing as the appropriate anchor for a cultural model for understanding Africa and its people.

Culture always remains the central feature of understanding health behaviours amongst African people (Airhihenbuwa and De Witt Webster, 2004: 5). The researcher acknowledged the need for the revitalization of the eroded positive traditional responses to disease prevention within the African cultural care model that will promote a better understanding of Africa and its people (Airhihenbuwa and De Witt Webster, 2004:5). The erosion of the African ways of taking care of its sick amongst the community was that of caring for its own people from a family and community way of life. The African care model could have avoided the drawbacks Africa is facing today, that of 'stigma' due to the isolation of the sick from the knowledge of their families and friends in the light of legal rights (Airhihenbuwa and De Witt Webster, 2004: 5).

The protection of those who tested positive from family and friends who are later summoned to actively participate in rendering home-based care to the infected individuals created another challenge. In an African context, secrecy in relation to health and illness behaviour is something that is not common as families continue to be only institutions that embrace any sickness of their loved ones as their area of greatest concern (Airhihenbuwa and De Witt Webster, 2004:6). Phillips (2003: 75-76) outlines the distinctive features of HIV in South Africa in four categories:

1. The biology of HIV disease.
2. The relatively gradual advance of HIV, that is, its slow progress within the human body and the fact that its course is not yet reversible like other communicable diseases, and its long and debilitating duration that burdens society with increased

deaths of parents with resultant high number of orphans and child families, its negative impact on the economy and the increased number of people to be cared for within health institutions.

3. The biomedical approach within the country through the introduction of antiretroviral therapy (ART) which makes it seem that it is the only approach to HIV & AIDS while marginalizing all other means of dealing with the epidemiological aspects of the disease.
4. The immediate international seeking of aid by the government of South Africa drawing on overseas medical expertise was quite different from the way it was done with other diseases, leaving the local expertise which could have collaboratively joined forces in combating the epidemic.

The features described above continue to create dissonance between the biomedical intervention strategies and the African context of dealing with disease and illness behaviours, for example, the idea of teaching women how to use a male condom when the husband still holds the deciding powers regarding sexual matters (Phillips, 2003:76).

In the light of a cultural comprehensive health approach, our grandmothers embarked on many ways of improving and preventing occurrence of diseases by encouraging the intake of a well-balanced diet to children and young adults in order to boost their immune system, e.g., green vegetables with nuts; preparing a lot of traditional food rich in protein and carbohydrates and many other herbal drinks that are said to be immune boosters, hence the primary level of disease prevention. Furthermore, people from different cultural persuasions have their own way of giving health education on different topics, health safety and protection, e.g., traditional immunizations practices. The following are some of the indigenous inherent 'immunization' or protection measures that are commonly practised

amongst the Vha-Venda, Ba-Pedi and the Va-Tsonga tribes to ensure health promotion and disease prevention in our black communities:

- ✧ When one is to leave home for school or work or marriage, a healer will be called to sanctify the candidate against evil forces that might cause diseases or curses using traditional ritual performances. In the case of Christians, a pastor is summoned to pray for the candidate before leaving home in order to create a divine protection from God against all evil plan of the evil one (The New Scofield Study Bible 1989:686-687, Psalm 91:vv 1-13).
- ✧ When a woman gives birth to a baby, grannies will sleep by the mother and forbid the husband to enter the room until the mother receives her first post-delivery menstruations. This on its own prevented another pregnancy (child spacing), thus allowing the mother to return to her pre-gravid state, total child care, mother-child bonding and successful breastfeeding.
- ✧ A mother who miscarried is never allowed to get intimate/sleep with husband until she is cleansed by a traditional healer or to avoid killing the man ('u luma' in Tshivenda) or her husband, which was a way of preventing sexually transmitted infections (STIs) or clearing of any secondary infection that could be transmitted to the husband.
- ✧ If a mother accidentally falls pregnant when the baby is still on the breast, the baby is immediately removed from the breast to avoid malnutrition in the feeding baby. Breast milk will then be substituted with goat's milk or by the process of breast initiation to the non-breast-feeding mother for the purpose of the baby to feed and develop normally (De Haan, 1996:12).

- ✧ A baby is not to be carried by everybody who comes to the family while still small for fear of cross infection. The mother is also not allowed to go amongst crowds of people whilst the baby is not yet released by the traditional healer after a special protection ceremony ('Muthuso' in Tshivenda) is done.
  
- ✧ From the Christian perspective, if a child is born, the pastor or any spiritual leader prays for the child to ensure protection from childhood diseases and other evil projections as well as ensuring good health, normal development and blessing from God the Creator (The New Scofield Study Bible, 1989:1218, Luke 2:27-35).
  
- ✧ A child infected with measles is kept in isolation from other children until the rash disappears, and not allowed in the sun for fear of damaging the eyes, and is given a lot of fluids to prevent dehydration. This was a wiser way of preventing the spread of infection as well as giving the child serious attention for speedy recovery and prevention of complications. This is the time that forced feeding is done to ensure good nutrients to the baby to promote speedy recovery (De Haan, 1996:12-13).

Health professionals face the challenge of preventing the great loss of indigenous practices grounded in tradition that might contribute to the body of knowledge in Primary Health Care (PHC) programmes and practices. PHC systems promote the inclusion of other health facilities like traditional healers in its goal of 'health for all by the year 2000'. Looking holistically at the definition of PHC as defined in the Declaration of Alma Ata (1978:3), it is an 'essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination' (ANC, 1994a:20).

The National Health Plan (NHP) for South Africa of 1994 (ANC, 1994a:55) stipulated that there must be utilization of all health resources in the community, including traditional practitioners. In the analysis of the existing healthcare delivery, indigenous healing practices will become an integral and recognized part of healthcare in South Africa. Consumers are allowed to choose whom to consult for their healthcare, and legislation will be changed to facilitate controlled use of traditional practitioners. The NHP of South African of 1994 further indicates principal tenets with regard to utilization of traditional health practitioners, which include the following:

- ✧ People have the right of access to traditional practitioners as part of their cultural heritage and belief system.
- ✧ There are numerous advantages in cooperation and liaison between allopathic and traditional practitioners and interaction will thus be fostered.
- ✧ Traditional practitioners will have greater accessibility and acceptability than the health sector and this will be used to promote good health for all.
- ✧ Mutual education between the two health systems will take place so that all practitioners can be enriched in their health practices (ANC, 1994a:55-56).

These tenets indicate the importance of indigenous health knowledge utilization in dealing with illnesses and diseases. The NHP also emphasized the possible mechanisms through which the above tenets could be achieved, namely:

- ✧ Negotiations will be entered into with traditional practitioners so that the policy acceptable to all practitioners can be reached.
- ✧ Legislation to change the position and status of traditional practitioners will be enacted.

- ✧ Interaction between providers of allopathic and traditional medicine will be actively encouraged, especially at local level.
  
- ✧ Training programmes to promote good health care will be initiated
  
- ✧ A regulatory body for traditional medicine will be established (ANC, 1994a:56).

By contrast, Makgoba (1997:3) indicates that current university training and education systems in a way continue to fail to serve the needs of their local people and the aspirations of the African people in general. University education at present is discordant with African society in many ways. The non-accomplishment of previous attempts at renaissance lies in the failure of universities to address the problems of the rural communities. According to Makgoba (1997:3), universities must define, engage and respond to societal challenges and, therefore, place people at the centre of all institutional endeavours. The former education system in South Africa was used to legitimize an unequal social, economic and political power relation and to produce Africans who would remain subservient and subordinate to white and western interests. This led to undermining of traditional practices and cultures (Makgoba, 1997:3-4). Likewise, Mulaudzi (2001:18) underscores the need to include traditional healing as a field of medicine to be taught in institutions of higher learning as a way to promote students of the 21st century to have the rights to know their roots, as well as finding ways to choose between indigenous knowledge and modern medicine, or both.

Airhihenbuwa and De Witt Webster (2004:6) quoted Frantz Fanon (1986) from the book titled 'Black Skin, White Masks' that there is an impoverished yet strangulated methods and contents of school curricula which are developed for colonial education in African countries with the aim to turn an African into a 'white man' through the education system which today is in the process of metamorphosis. For example, most South African universities hardly have neither structured IKS programmes nor integrated any into the mainstream of their curricula that prepares the nurse and other health professionals who will in the end manage

patients and clients with different illnesses and in particular HIV & AIDS within culturally-context PHC settings. Sillitoe (1998:230) argues against the assumption that academics can record and document indigenous knowledge and it is 'passed up' to interested parties as technological packages in order for it to be 'passed down' to beneficiaries. 'Passing up' means collecting indigenous knowledge and passing it up to the so-called specialists for scrutiny. After serious scrutiny, the finalized information is then 'passed down' to the beneficiaries 'lower' in the intellectual hierarchy as highly compromised learning packages (Sillitoe, 1998:230).

Furthermore, Mulaudzi (2001:18) argues that current university curricula promote a distance between those who are trained in western medicine and the traditionally trained. She refers to the concept 'power play' which encourages a struggle for power over knowledge; thus creating a distance between the indigenous and western healing systems. This makes sharing of information and methods of healing amongst the two health care knowledge systems unattainable (Mulaudzi, 2001:18). An indication has been made of 'labelling' and 'secrecy' as problematic in this regard. 'Labelling', according to Good (1987:xii), cited in Mulaudzi (2001:18), refers to an indigenous African medical expert who experiences prejudice from his/her African counterparts in medical schools and hospitals, as well as from his/her own people who have dubbed traditional healers as witch doctors. 'Secrecy', on the other hand, denotes knowledge of indigenous medicine that is not formally documented anywhere. As a result, proper research and scrutiny for efficacy is virtually impossible. Westerners, in turn, guard their methods through registration or induction. This description highlights the anticipated difficulty to bridge the gap between the two healing systems (Mulaudzi, 2001:18).

The National Qualifications Framework (NQF) of South Africa (SAQA, 1998:7-8) developed and implemented basic tenets which address the IKS curriculum as follows:

✎ Knowledge relevant for the current world should be created through partnerships amongst varied groupings in society. These include academics and researchers, business people, workers, professional experts from government and community organizations, learners, professors and IK experts. Knowledge creation is therefore no longer the preserve of narrowly-defined groups of 'experts'. This study was aimed at opening a platform through collaborative research and knowledge sharing by both practitioner categories for quality service delivery (SAQA, 1998:7).

✎ The national system of education must balance the need for quality education for all its citizens. It has to be flexible enough to cater for the wide-ranging circumstances faced by learners. The education system should provide a learner with wide-ranging options for what constitutes relevant education and qualifications, i.e., balance between society's needs and the needs of the individual. The researcher sought a way of providing institutions of higher learning as well as health service providers with a model that will improve integrative care to the consumers which will demand training of healthcare learners to be developed in such a manner that they can respond to the needs of their clients using the culturally-based approach (SAQA, 1998:8).

The tenets of NQF in SAQA document of 1998 open up opportunities for indigenous people to be consulted so that knowledge generation is not confined to the minority group of the narrowly-defined 'experts'. The other reason for the incorporation of this knowledge is to make sure that the national system of education is able to balance the need for quality education and the relevance of its outcomes or qualification to the needs of the societies, families and the individuals. There should be serious transformation of every learning that takes place to ensure that it is community needs-based and that learning is competency- as well as outcomes-based (SAQA, 1998:8). Masoga and Musyoki (2001: iii) affirms the above tenets by indicating that:

- ✎ Indigenous knowledge, technologies, practices and wisdom must be translated into tangible (material and non-material) gain for communities.
  
- ✎ Academics must grapple purposively with the pervasive African problems of societal disintegration, ill-health, poverty, marginalization, and exploitation in all its forms and manifestations (Masoga and Musyoki, 2001: iii).

Agrawal (1995:1-6) highlights that distinctions have to be made regarding the fact that indigenous and western health systems are two different entities that need to be equally examined and integrated to prevent problems for those who believe in the significance of IK for development and life sustainability. The author delineates some of the differences between IK and western knowledge as follows:

❖ **Substantive Differences**

There are differences between indigenous and western knowledge with respect to their subject matter and historical background as well as their distinctive characteristics. For example, IK focuses more on people's concrete and immediate necessities for their daily livelihoods and does not contain an overall conceptual framework or deductive logic that it advances on the basis of new experiences, while western knowledge attempts to construct general explanations and is one step removed from the daily lives of people (Agrawal, 1995:2).

❖ **Methodological and Epistemological Differences**

It is true that the two forms of knowledge will employ different method to investigate realities because of their substantive grounds of existence (Agrawal, 995:3).

**❖ Contextual Differences**

Indigenous knowledge is more rooted in the environment and exists in a local context, anchored to a particular social group in a particular setting at a particular time. Western knowledge, on the other hand, has been divorced from an epistemic framework in its search for universal validity (Agrawal, 1995:3). In order to successfully build new epistemic foundations, accounts of innovation and experimentation must bridge the indigenous/western divide. Looking at specific forms of investigation and knowledge creation in different countries and different groups of people, there should be an allowance of the existence of diversity within what is commonly seen as Western or as Indigenous.

These distinctions can then allow the discovery of a common link on the way in which IKS practitioners and western practitioners create knowledge, rather than trying to conflate all non-western knowledge into a category termed 'indigenous', and all western into another category called 'western'. The researcher sought a way of finding a common ground of management of HIV & AIDS in a manner that the needs of healthcare consumers can be met in a holistic manner (<http://www.nuffic.nl/ciran/ikdm/3-3/articles/agrawal.html>).

The South African Chapter of the African Renaissance (SACAR) stated that IKS is one of the specific vehicles in the present situation for building a social movement of African people towards sustainable development (Maloka, 2001:3-4). Every community has a wealth of useful IK and practices to shape their ways to perceive and/or deal with illness and other health related issues. Community health as a recognized health science has its focus on health promotion and illness prevention, assessment, and targeting community needs and awareness of environmental and social factors in disease prevention and management (Maloka, 2001:3-4). This initiative could form a framework for the development of an HIV & AIDS management model which will be used by the community and for the community.

## 1.2 Problem Statement

Research has demonstrated that in a traditional medical encounter, be it at a clinic, hospital or a private practice with clients, the story told by the client is redefined and recast into the scientific and cognitive structure of western medicine, thereby depersonalizing the patient and preventing the nurse from seeing the client holistically (Roter and Hall, 1992:39-40). The client's story is usually altered to conform to the nurse's assessment structures and consequently ending up not representing the actual concern or the lived reality of that person.

According to Finkelman and Kenner (2010:308), nurses view patients through their personal experiences with culture and their personal histories, which may lead to problems, such as misinterpretation of communication and behaviour, which poses limitations for planning and implementing patient-centered care. Finkelman and Kenner (2010:308), further indicate that culture and language may influence many aspects of the quality service delivery, for example:

- ✧ Health, healing, and wellness belief system,
- ✧ Patients/consumers' perceptions of causes of illness and disease,
- ✧ Patients/consumers' behaviours and their attitudes towards health care providers, and
- ✧ Providers' perceptions and values.

From the above description of how culture can influence health and healing, the researcher looked at the healthcare processes that continue to succumb to and perpetuate greater disparities. The disparities of healthcare could be defined as 'racial or ethnic differences in the quality of health care that are due to access-related factors or clinical needs, preferences, and appropriateness of intervention' (Finkelman and Kenner, 2010:309). A greater challenge now is to generate facilitator methods/models which can combine the two knowledge systems for dealing with health and illness behaviour, particularly the management of HIV &

AIDS within a PHC context. There is a dire need for a genuine reciprocal flow of ideas and information between the two knowledge systems, Indigenous and Western (Sillitoe, 1998:231).

Furthermore Nursing Education departments, like other departments, continue to train and produce students without reshaping curricula to address and incorporate indigenous health systems in the management of HIV & AIDS, particularly those embedded in people's culture. The challenge in this regard therefore has to do with redefining what knowledge is and the relationship of such knowledge with its context, re-discovering indigenous ways of knowing, patterns of knowing and means of knowing and finding ways to integrate indigenous knowledge within conventional education systems Makgoba (1997:3-5). In this study, the researcher needed responses to the following central question as a point of departure for model development:

*How can we integrate IKS in the management of HIV & AIDS within the PHC context in Limpopo Province?*

### **1.3 Purpose of the Study**

The purpose of the study was to develop a model to facilitate the integration of IKS in the management of HIV & AIDS within the PHC context in Limpopo Province, South Africa.

### **1.4 Objectives of the Study**

The objectives of this study encompassed three phases:

#### **✧ Phase I**

To explore and describe views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS, Limpopo Province, South Africa.

**‡ Phase II**

To develop a conceptual framework related to current dialogue about the integration of IKS in the management of HIV & AIDS within the PHC context.

**‡ Phase III**

To develop a model to facilitate the integration of IKS in the management of HIV & AIDS within the PHC context in South Africa.

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**1.5 Significance of the Study**

The study has provided an opportunity for academics and Indigenous Knowledge Practitioners (IKPs) and Western Health Professionals (WHPs) to find solutions to issues related to the integration of the two knowledge systems with a particular focus on contemporary community health problems such as the management of HIV & AIDS for quality health service delivery and health systems strengthening. Furthermore, the model has facilitated reviews of all health science curricula, including PHC curriculum to ensure their relevance and responsiveness to the needs of healthcare consumers, health science students as well as the health service delivery planners and policy makers.

**1.6 Paradigmatic Perspective**

The paradigms from which the researcher departed are described as being a) meta-theoretical—the beliefs of the researcher; b) theoretical—the thinking based on what is written already, and c) the methodological assumption—based on the researcher's assumption of appropriate methodologies (Holloway, 2005:294). This provided the researcher with a set of beliefs about the world that guided the research process, in other words a paradigm is a world view or ideology about a phenomenon (Holloway, 2005:294). It implies the standards or criteria for assigning value or worth to both the processes and the procedures of the discipline (Chinn and Kramer, 1999:53).

### 1.6.1 Meta-Theoretical Assumptions

These assumptions are not open to testing, but deal with the researcher's viewpoints regarding the need for the incorporation of IKS into the management of HIV & AIDS within the PHC context, as well as the perceptions of different stakeholders (e.g., traditional healers, IKS experts, lecturers, WHPs, etc.). The researcher's points of departure have been that:

- ⌘ Health disease management models in PHC delivery settings should be developed by the people for the people.
- ⌘ Any model or health delivery framework that does not take into consideration the social, economic, cultural and political philosophy of the people is not valid and cannot be feasible to the people it is meant to help.
- ⌘ Disease management models should start from the people's philosophy and practice as well as what is inherent within their space.
- ⌘ IK infuses a sense of identity into our African health professionals as well as the recipients of the healthcare practices within a PHC setting.
- ⌘ IKS is an interwoven and integral component of people, i.e., it provides the basis for human societies to exist and to adapt to ever-changing environments. It shapes what is viewed as appropriate and inappropriate to its custodians (O'Brien, 1999:4).

The researcher is of the opinion that at any level of a person's existence, individually, in the family or in the community, in one way or another; inherent IK will continually be in operation in and around human nature of existence (O'Brien, 1999:4).

### 1.6.2 Theoretical Assumptions

During the course of this study, the researcher scrutinized various models to gain insight

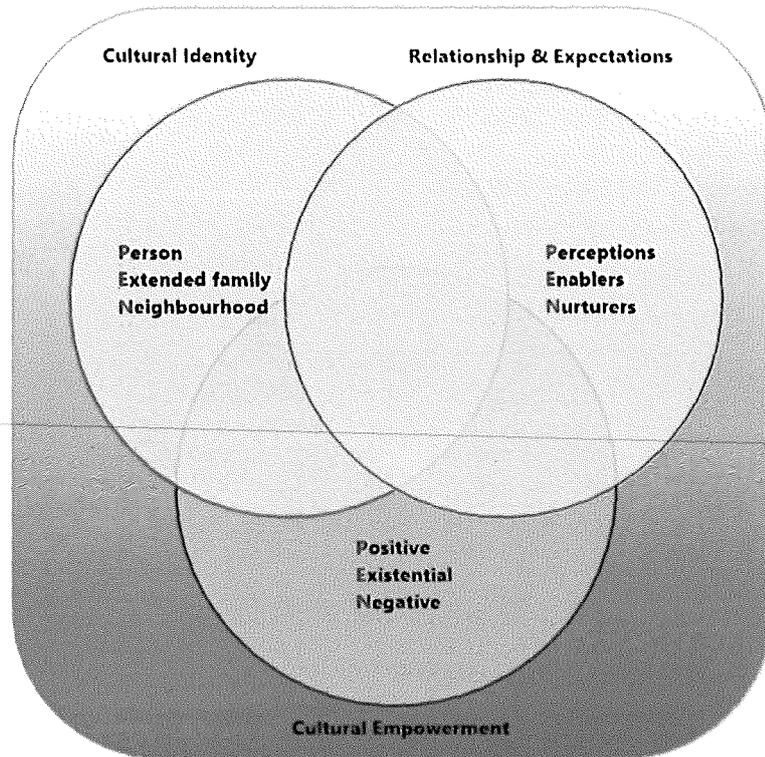
regarding model development and the matrix behind the process which includes the consideration of the purpose and the objectives of the study. The researcher focused on specific models that could possibly have a profound influence on the development of a functional model for the management of HIV & AIDS within a PHC context of the Vhembe District in the Limpopo Province of South Africa. These models are discussed in turn:

### **1.6.2.1 The PEN-3 Model**

Some models of care were developed in the past decades, e.g., Airhihenbuwa and De Witt Webster (2004:6) developed the PEN-3 model of care in 1989 to guide a cultural approach to HIV & AIDS in Africa. This model has been used by many researchers, including by Webster (2003) who evaluated cultural interpretations and meanings of the use of female condoms to reduce HIV & AIDS in South Africa. Furthermore, the researcher of the present study, in a way, went on to analyze Airhihenbuwa and De Witt Webster (2004:7) as they described the model's interconnectedness into **three** domains (Figure 1.1) because of the impact it made on the development of the model.

#### **❖ Cultural Identity Domain**

In this domain focus is made with regard to the point of intervention entry after group consensus is reached regarding all critical issues pertaining to the area of concern. Then an agreement is made regarding the nature of focus and reasons of the particular agreed intervention based on the cultural identity domain.



**Figure 1.1:** The PEN-3 model

The healthcare consumers as well as healthcare practitioners (traditional and western) are also faced with double consciousness where they belong to a certain set of rules, but within their cultural context of their daily existence (Airhihenbuwa and De Witt Webster, 2004:8). Religion also plays another role by shaping one's decision-making to seek medical interventions within certain cultural settings. In the development of the model, the researcher took the cultural domain as the co-context of the community where families and their cultural beliefs play a greater influence in the dialogue that the stakeholders will have as it constitutes the bases of decision making.

#### ❖ **Person**

An individual is the only person who should find a way of dealing with the double consciousness/mindedness on how cultural context defines and values the two health systems and the need for his/her health-seeking behaviour. For example, in this study, some WHPs

viewed traditional health as an acceptable method of disease intervention depending on their knowledge/belief system, though even after advising the patient secretly they still allowed the decision to be from the client (Airhihenbuwa and De Witt Webster, (2004:9).

#### ❖ **Extended Family**

Most interventions regarding illness behaviour are centred around the kinship structure of the family, for example, some key family members play a greater role in determining what decision is to be taken regarding illness behaviour of patterns of living. In an African cultural family the elders do have a leading role when it comes to how the family should respond to illness and health behaviours. The mother-in-law plays a greater role in what is to be done when a child is sick within a family structure and that could also determine the type of health interventions that will be taken, either western or traditional. Within the cultural context of families in the Vhembe District, extended family still plays a greater role in the health-seeking behaviour though the increase in nuclear families is, in a way, shaking the status quo (Airhihenbuwa and De Witt Webster, 2004:9).

#### ❖ **Neighbourhood**

This usually depends on the community's knowledge capacity to decide on the best method of integrating the two health systems and the political buy-in of the government that will forge the way towards model implementation in the management of communicable diseases that are increasingly burdening the ministry of health today. In this study, the model development process needed to solicit a point of departure by gathering views and perceptions of IKS stakeholders in order that a consensus could be reached regarding the development of a model which will be by the people and for the people (Airhihenbuwa and De Witt Webster, 2004:9).

**❖ Relationships and Expectations Domain**

For any model of human behaviour to realistically develop, a need to consider perceptions, resources and human influence is necessary. The PEN-3 model focuses on how culture defines the roles of persons and their expectations in family and community relationships. This was indicative of the point that personal actions could only be given a valid meaning if examined within the functionalistic view of the broader socio-cultural context (Airhihenbuwa and De Witt Webster, 2004:7). This domain was further categorized into:

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**❖ Perception**

In this study, comprehensive views and perceptions of IKS stakeholders and health professionals regarding the collaborative decision of the integration of traditional and western health systems revealed the need for a functional model to be developed for health system strengthening (Airhihenbuwa and De Witt Webster, 2004:7).

**❖ Enablers**

In this study, the enabling factors for the integrative model have been the buying-in of stakeholders (traditional healers and WHPs), based on the availability of health resources and/or services from both systems through which healthcare consumers could have access to without any form of marginalization or prejudice (Airhihenbuwa and De Witt Webster, 2004:7).

**❖ Nurturers**

The nurturers in this study were the home-based care approach that the government has embarked on to promote PHC services as well as the upcoming Re-Engineering of PHC to reduce hospital-based care with the aim of reaching all through mass coverage healthcare services. In the past the mere approach of PHC resulted in a massive resource depreciation and economic decline due to the approach being too depended on the provisions of the

government without the use of naturally available resources, including self-help activities. The only negative discouraging influence was the perceptions and bias found among some of the Christians and western health professionals, who degraded traditional practices as sinful yet the society, is continually utilizing the service without looking deeper at the benefits of herbs and other indigenous medicines (Airhihenbuwa and De Witt Webster, 2004:7).

### ❖ Cultural Empowerment

Culture plays a greater role in the empowerment of people though cognizance has to be made regarding only the positive influences to health of individuals around their health continuum (Airhihenbuwa and De Witt Webster, 2004:7). In this study, culture acts as the context within which the integration of all functional health systems will take place. According to the PEN-3 model, cultural influences should be supported in any empowerment process if only carrying the good in mind through identification of positive cultural behaviours and the process could take place under the three categories enumerated below:

#### 1. Positive

Only values and relationships that promote the health behaviour of interest is taken into cognizance. In this study, traditional health system practices with their unique ways of dealing with HIV & AIDS were embraced by participants (Airhihenbuwa and De Witt Webster, 2004:8).

## **2. Existential**

This category deals with values and beliefs that are practised within a cultural setting which poses no threat to health. Unlike Western medicine that contended for global identity and uniformity and lost its flexibility, traditional practices though intertwined within the Africa societies, still is rooted to the context of its existence and practice allowing people of similar locality to interpret illness behaviours differently. In this study, existential quality has been demonstrated with the realism that the extended family and kinship structures always agree and support the communal ways of traditional interventions regarding individual health and illness seeking behaviours (Airhihenbuwa and De Witt Webster, 2004:8).

## **3. Negative**

There are certain cultural determinants that focus on marginalization of certain individuals within the society that could be detrimental to health-seeking behaviours. For example, the five chapters of the Traditional Health Practitioners Act, No. 22 of 2007 are indicative of basically the legal registration and code of conduct with disciplinary procedures; little has been done so far to strengthen the functioning of this system in terms of its inclusion within the healthcare system of service delivery. This is creating a greater divide between the two systems to a point where only the Client/Family becomes the deciding factor on WHERE to go and WHEN in terms of health service needs as there is no formal collaboration between the two systems (Airhihenbuwa and De Witt Webster, 2004:8).

### **1.6.2.2 Leininger's Culture Care Theory**

The other theory is the Leininger's Culture Care Theory (1997:341-347), which was developed after the realization of a missing phenomenon in nursing that of combining care and culture, hence the birth of Transcultural Nursing. The theory was again developed due to the need to work with people from a broader divergent cultural atmosphere as this is the most

common existence within societies and the world today. It has come to a point that these differing people with their diverse culture and sub-cultures are more sensitive to the preservations of their cultural heritage and customs. Transcultural nursing was later incorporated into nursing curricula as well as in clinical practice (Leininger, 1991, 1995a, 1995b, 1997). According to this theory, caring always occurs in a cultural context and culture is viewed as a framework used by people to solve their human problems and culture is universal. Leininger further defines the dimensions of the Culture Care Theory by developing the Sunrise Model which depicts a total view on modes of cultural care preservation, maintenance cultural care negotiation and cultural care restructuring:

❖ **Cultural Care Preservation**

In this model, cultural care preservation or maintenance refers to nursing care activities that help people of particular cultures to retain and use core cultural care values related to healthcare concerns or conditions (Leininger, 1997:342-344).

❖ **Cultural Care Negotiation**

Cultural care accommodation and negotiation refer to creative nursing actions that help people of a particular culture adapt to or negotiate with others in the healthcare community in an effort to attain the shared goal of an optimal health outcome for client(s) of a designated culture (Leininger, 1997:345).

❖ **Cultural Care Restructuring**

Cultural re-patterning or restructuring refers to therapeutic actions taken by culturally competent nurse(s) or family (Leininger, 1997:346). These actions enable or assist a client to modify personal health behaviours towards beneficial outcomes while respecting the client cultural values (Leininger, 1997:347). So far there is no known model that can be used exclusively by the researcher to integrate IKS in the management of HIV & AIDS within a

PHC setting or its integration within the PHC training programmes for management of chronic conditions. Reference was made to the models of health promotion that are available in order to draw meaning to the need for an integrative model. Different models have been designed; amongst others is the KwaZulu-Natal Health Promotion Model which is based on:

- ✎ Empowering people through a systemic, planned, needs driven curriculum;
  - ✎ Empowering people through the interactive method of teaching;
- 
- ✎ Promoting behavioural change through small group support; and empowering people through linking with external sources (Uys, Majumdor and Gwele, 2004:3).

In this study, the researcher was also surfacing the need for learning that would be able to produce students who could holistically and comprehensively render relevant and quality services to their communities with acknowledgement of their inherent indigenous healthcare practices (Airhihenbuwa and De Witt Webster, 2004:7). This model will not only address the integration of the two health knowledge systems, but also will come up with a doctrine that could influence integration to impel effective and holistic management of HIV & AIDS and other ramifications of the burden of disease which pose serious global, national, provincial and local challenges for Ministries of Health. The two theories extensively discussed above will be incorporated in detail in Chapter 5. Furthermore the model can be adapted in different areas where integration is envisaged including in clinical settings.

### **1.6.3 Methodological Assumptions**

The researcher adopted a functionalist perspective or philosophy to conduct the research that will be useful to the body of knowledge and to practice (Munhall, 2007:105). This study will generate knowledge that will influence health systems development and strengthening. Functionalism promotes systems interactivity that produces the usefulness of a phenomenon in any given practical reality for social solidarity and smooth societal functioning. This

perspective, if well approached, can produce smooth social cohesion, which could necessarily bridge the divide between the two systems and foster an effective health systems collaborative approach to health service delivery (Munhall, 2007:105).

## **1.7 Definitions of Concepts**

The following concepts have been used throughout the study:

### **1.7.1 Indigenous Knowledge**

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Indigenous knowledge has been defined by the International Labour Organisation (ILO) in IKS Annotated Biography of South Africa as ‘that knowledge that is held and used by a people who identify themselves as indigenous of a place based on a combination of cultural distinctiveness and prior territorial occupancy relative to a more recently arrived population with own distinct and subsequently dominant culture’ (IKS, Annotated Biography SA, 2001:7).

Indigenous knowledge can also be defined as ‘A body of knowledge built up by a group of people through generations of living in close contact with nature’; such knowledge evolves in the local environment so that it is specifically adapted to the requirements of local people and conditions. It is also creative and experimental, constantly incorporating outside influences and inside innovations to meet new conditions by its inclusion of the social, political, economic and spiritual aspects of a local way of life (Johnson, 1992:3-4). In this study, both definitions align well with the direction which the study had undertaken.

### **1.7.2 Primary Health Care**

Primary healthcare based on scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination forms an

integral part of the country's health system, making it to be the central function and main focus of the overall social and economic development of the community (Hattingh, Dreyer and Roos, 2006:61). It is the first level of contact of individuals, the family and the community with the national healthcare system, bringing healthcare as close as possible to where people live and work and constitutes the first element of continuing healthcare processes (WHO, 1978:3). This definition is relevant to this study because of its abrasiveness as it aligns well with accessibility and acceptability to the individual, family and the community which form the point of departure for the research undertaken.

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### **1.7.3 Indigenous Health Practitioners**

In this study, indigenous health practitioners refer to all traditional healers who are recognized by the community as such. Van Rensburg, Fourie and Pretorious (1992:328) categorized them as follows:

#### **1.7.3.1 Diviner, Nanga (Venda)/Ngaka (Sesotho)/Inyanga (Zulu)**

Diviners concentrate on the diagnosis of mysteries. They analyze the cause of special events and interpret the messages of the ancestral spirits. They use divination objects or explain the unknown by the special powers of prophecy. Their function is that of divination, but they often also provide the medicaments for specific cases diagnosed by them (Van Rensburg et al, 1992:328).

#### **1.7.3.2 Herbalists**

Herbalists "mean a person who engages in traditional health practice and is registered a herbalist under this Act. (Traditional Health Practitioners Act, No. 22, 2007; Chapter 1:2). Herbalist can also mean 'ordinary people who have acquired an extensive knowledge of marginal technique and who do not, typically, possess occult powers'. Herbalists diagnose and prescribe medication for ordinary ailments and alleviate misfortune and disaster, to provide protection against sorcery and misfortunes and to promote happiness (Van Rensburg

et al, 1992:329).

### **1.7.3.3 Faith Healers/Prophets**

Faith healers/prophets actually indicate syncretism, a reinterpretation of orthodox Christianity in such a way to be reconcilable with traditional culture. Strictly speaking, prophets are therefore not traditional healers, yet they have the following in common with a traditional healer:

- 
- ✧ A shared theory of disease and health;
  
  - ✧ A similar means of divination, although God or the Holy Spirit, rather than ancestral spirit aids him;
  
  - ✧ The treatment of various diseases, including the so-called culture-related syndrome (Van Rensburg et al, 1992:330).

### **1.7.4 Western Health and Healing**

Western health and healing refers to the non-traditional models of health and healing that come from the Western ideologies (Green, 1994:20). It is sometimes referred to as scientific medicine. It covers all areas of technology-based healing systems that are deemed valid and superior on the basis that they have been tried and tested (Green, 1994:20).

### **1.7.5 Traditional Health Practitioner**

The Traditional Health Practitioners, “means a person registered under this Act in one or more of the categories of traditional health practitioners; (Act, No. 22 (2007; Chapter 1:2).

This can be further defined according to functions:

#### **1.7.5.1 Traditional Health Practice**

Means “the performance of a function, activity, process or service based on a traditional

philosophy that includes the utilization of traditional medicine or traditional practice and which has its object on the:

- ✧ Maintenance or restoration of physical or mental health or function; or;
- ✧ Diagnosis, treatment or prevention of a physical or mental illness; or;
- ✧ Rehabilitation of a person to enable that person to resume normal functioning within the family or community; or
- ✧ Physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death.

### **1.7.5.2 Traditional Medicine**

Is regarded as an object or substance use in traditional health practice for:

- ✧ The diagnosis, treatment or prevention of a physical or mental illness; or
- ✧ Any curative or therapeutic purpose, including the maintenance or restoration of physical or mental or well-being in human beings.

### **1.7.5.3 Traditional Philosophy**

Embraces indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from the ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional practice. These three concepts alone offer a convergent foundation for disease management which cannot ostracize inherent practices in the development of effective disease management, especially HIV & AIDS ((Act, No. 22 (2007; Chapter 1:2).

### **1.7.6 IKS Practitioners**

In this study, IKS practitioners refer to all academics and intellectuals doing IKS-related work and/or are known as custodians of this knowledge.

### **1.7.7 Model**

According to Chinn and Kramer (1995: 53), a model is a symbolic representation of an empiric experience in the form of words, pictorial or graphic diagrams, mathematical notations, or physical material as a way of illustrating relationships between complex perceptual phenomena related to concepts systematically.

### **1.7.8 Integration**

This concept refers to a process of attaining close and seamless coordination between several departments, groups, organizations, and/or systems (<http://www.businessdictionary.com>).

## **1.8 Research Strategy**

The research strategy adopted in this study is outlined in Figure 1.2. The research process flow map highlights three phases, viz., Phase 1-Qualitative data collection and analysis; Phase 2-Development of the conceptual framework, and Phase 3-Development of the model to facilitate the integration of IKS into the management of HIIV/AIDS in a PHC context in the Limpopo Province of South Africa.

## **1.9 Research Design**

According to Grove, Burns and Gray (2013:195), a research design is the blueprint for conducting a study which maximizes control over factors that could interfere with the validity of the study findings. The design of this study was qualitative, explorative, descriptive and contextual in nature as described in detail in Chapter 2. These designs are briefly delineate in the subsections that follow:

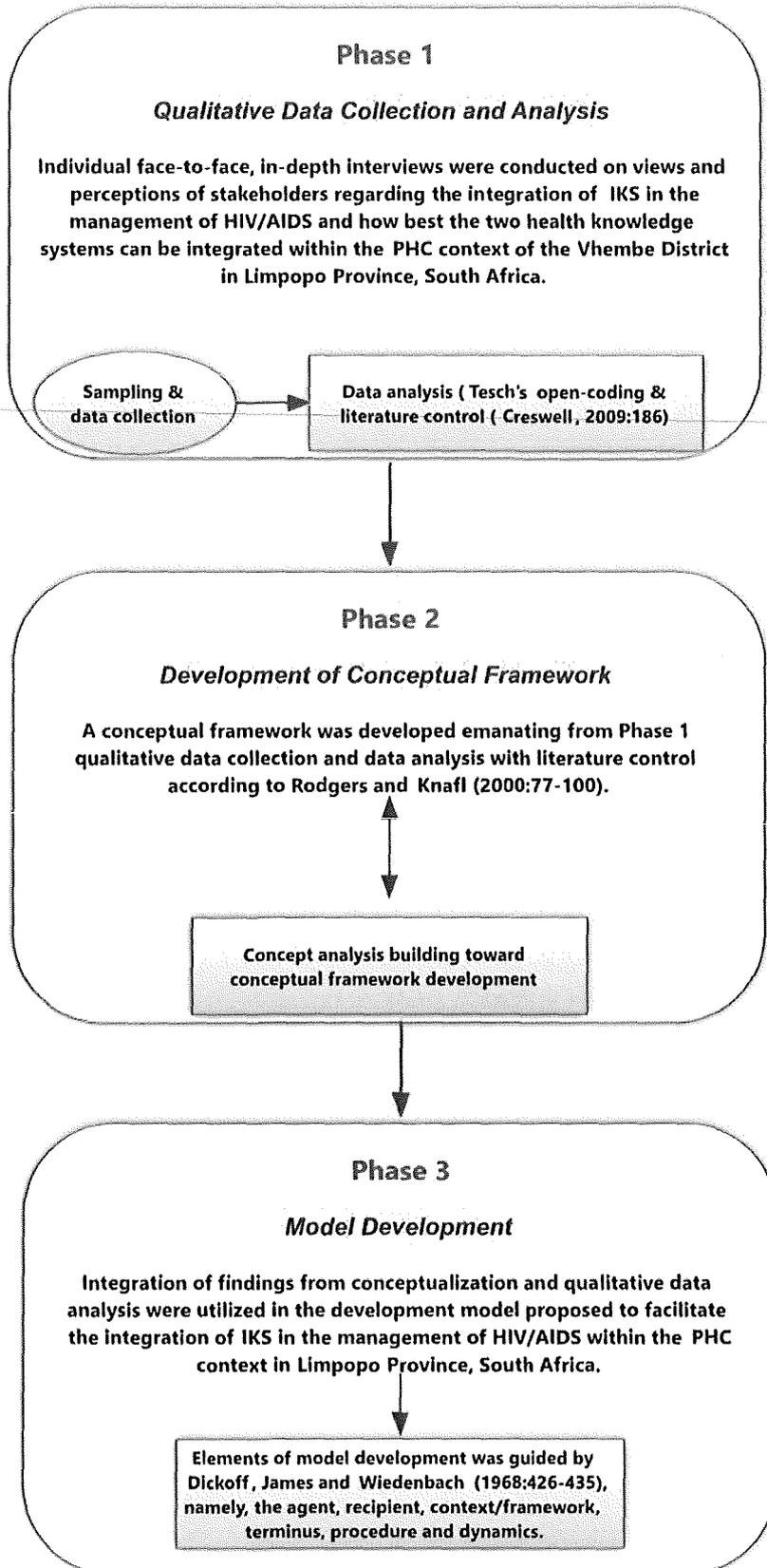


Figure 1.2: Research process flow map

### **1.9.1 Qualitative Design**

A qualitative design is a systematic, interactive, subjective approach used to describe life experiences and give them meaning (Burns and Grove, 2009:22). Grove et al (2013:57) view qualitative research as a scholarly approach to describe life experiences from the perspective of the persons involved, it is a way to give significance to the subjective human experience as well as to gain insight into and guide nursing practice. In qualitative research, variables are usually not controlled because the researcher wants to freely capture the natural development and representation.

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### **1.9.2 Exploratory Design**

An exploratory design aims to establish facts, to gather new data and to determine whether there are patterns in the data (Mouton, 1996:103). In this study the existing literature on IKS and other relevant attributes as well as the inherent knowledge of participants, namely IHP and IKS knowledge experts in disease management skills and knowledge have been explored.

### **1.9.3 Descriptive Design**

A descriptive study provides an accurate portrayal or account of the characteristics of a particular individual, event, or group in real life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorizing information (Burns and Grove, 2009:25). According to Streubert and Carpenter (2007:82-85), descriptive studies involve direct exploration, analysis and description of a particular phenomenon, as freely as possible from unexamined presuppositions, aiming at maximum intuitive presentation.

### **1.9.4 Contextual Design**

This study is contextual in nature because it has been conducted within the context of the IKS policy framework of South Africa, which is driven in large part by the need to interface with

other knowledge systems, for example, IK is used together with modern biotechnology in the pharmaceutical and other sectors to increase the rate of innovation (IKS Policy of the Republic of South Africa, 2004:9). Furthermore, it has also been conducted within the context of a PHC setting within a cultural context and the associated traditional health practitioners and custodians of IK (organic knowledge experts) who were accessible and willing to participate in the study.

## 1.10 Research Method

### 1.10.1 Population

The researcher's determination of the target population was guided by Mouton, (1998:83) and Leedy and Ormrod (2005:60) both indicated that the population is the sum total of all the people and their characteristics about which a conclusion is to be drawn. A sample of participants to some degree must share common language, culture and views, as suggested. In this study, the target population is outlined in Table 1.1.

**Table 1.1:** Stakeholder analysis

Population	Category	Method of Data Gathering
<b>IKS practitioners</b>	IKS academics experts, Pastors, Herbalist and Traditional Healers	Individual in-depth face-to-face interviews and naïve sketches
<b>Healthcare professionals (for triangulation purposes)</b>	Doctors and pharmacists	Individual in-depth interviews

The population of this study (Table 1.1) has been drawn from Limpopo Province stakeholders who embody deeper concerns regarding the integrative approach to health and illness behaviour that will be inclusive of IKS intervention approaches to health service delivery. The researcher preferred Limpopo Province due to the fact that there has been no language barrier as most of the traditional healers preferred their language in responding to the question. Furthermore, it became easier for the researcher to probe as she knows the three common languages that are utilized in Limpopo Province (Tshivenda, Sepedi and Xitsonga).

## **1.10.2 Sampling Methods**

According to Grove et al (2013:709), sampling is about selecting groups of people, events, behaviours, or other elements with which to conduct a study. Purposive and snowballing sampling methods have been used in this study, as applicable to each group as indicated in Table 1.2. The purposive sampling method is based on the judgment of the researcher regarding participants that are typical or representative of the study phenomenon, or who are especially knowledgeable about the question at hand (Brink, van der Walt and van Rensburg, 2012:141).

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The snowballing technique has been used to further identify potential participants not known to the researcher. Snowballing also known as network sampling which involves the assistance of the study subjects in obtaining other potential subjects by means of informed networking. The first ball is identified within the researcher's existing networks of IHS practitioners. Thereafter, participants were asked to indicate other people within their social networks who were fitting similar characteristics (Burns & Grove, 2009:356).

The researcher used the snowballing methodology for sampling traditional healers though the first group of traditional healers was those known to the researcher as she networked with them in the IKS curriculum development process in one university within the province. One traditional healer who is also a retired lecturer played a pivotal role in giving the researcher names of most traditional healers and their contact numbers for prior arrangements before the actual date of the interview. They then later directed the researcher to others whom they knew and trusted as genuine practitioners. The researcher's plan of stakeholder sampling has been categorical, as indicated in Table 1.2.

### **1.10.2.1 Sampling of IKS Practitioners**

The researcher used convenient purposive sampling to identify those known by the researcher and snowballing to further identify other IKS practitioners known by their

counterparts.

**Table 1.2:** Summary of sampling methods of stakeholders

Category of Stakeholders	Sampling Method	Reasons for Choosing the Participant
<b>IK academic experts</b>	Purposive	These were relevant to the study as they constituted the body of knowledge because of their involvement in IK generation, teaching and curricular development.
<b>Traditional healers</b>	Snowballing	Because the researcher did not know all traditional healers in the district.
<b>Herbalists</b>	Purposive and snowballing	One was known to the researcher and then directed the researcher to the other one. It was for the researcher to get a vast view of knowledge as she was using an inductive approach to deepen the data.
<b>Pastors</b>	Purposive	Only pastors from Charismatic and Apostolic Denominations who believed in the Divine Power of God and of the Holy Spirit through laying of hands in healing their sick.
<b>Doctor</b>	Purposive	The doctor was also practicing as a TH and had a deeper understanding of both health systems and the rate of utilization by clients
<b>Pharmacist</b>	Purposive	He was having using both systems, as a pharmacist as well as a TH and has I greater understanding of the two systems and how they are perceived and utilised by clients

### 1.10.2.2 Sampling of Healthcare Professionals

Purposive sampling was utilized in the selection of healthcare practitioners dealing with a plethora of diseases in hospital or PHC settings (healthcare centres) within the Limpopo Province fitting for data triangulation.

### 1.10.3 Sampling Criteria

The criteria for selection of IKS practitioners included traditional healers who participated in

traditional healers' training or those who got informal mentoring by family members, and are recognised or acknowledged by community members as traditional healers. The same criterion has been applied for IHP like faith healers, herbalists and others.

The IKS academics/experts included were those actively involved in IKS generation and curriculum development and demonstrated interested in IKS as a discipline. Amongst the groups some conducted research studies or related academic/intellectual work on IKS, and are actively involved in IKS issues. This also included other IK experts who are the custodians of IKS who might not necessarily be traditional healers (the organic knowledge experts).

#### **1.10.4 Sample Size**

The size of the study sample depended on data saturation per different stakeholder/participant categories. Data saturation occurs when no new or relevant data emerges, when all avenues or leads have been followed, and when the story or theory is complete or when relationships between categories are well-established and validated (Brink et al, 2012:141). In this study, the moment when no new information or additional explanation or views could come up from the incoming participants, the researcher concluded that data saturation has been reached and therefore the sample was deemed concluded.

#### **1.11 Data Collection: Qualitative Interviews**

According to Grove et al (2013:691), data collection is a precise, systemic gathering of information relevant to the research purpose or the specific objectives, questions or hypothesis of a study. This study took place in three phases, namely, a) Phase 1—the qualitative data collection (interview) analysis; b) Phase 2—development of the conceptual framework; and c) Phase 3—model development. In-depth individual face-to-face qualitative interviews were conducted at a most convenient time at a private or neutral place which was negotiated with participants. All interviews departed from a central question namely:

*How can we integrate IKS in the management of HIV & AIDS within the PHC context in Limpopo Province?*

Participants were allowed to deal with the question from their own perspectives. The researcher used interview facilitation skills such as probing, paraphrasing, summarizing, and listening and clarification to fully engage participants until information saturation was observed from their responses. A tape recorder was used to save the interviews that were to be transcribed verbatim (George & Cristiani, 1995:156). The researcher as an instrument for data collection ensured bracketing of the inherent information she had and allowed openness in order to avoid bias and being judgmental. The researcher also proceeded inductively to observe multiple instances and then combined them into a coherent whole or logical system (Chinn and Kramer, 1999:79).

### **1.12 Data Analysis and Literature Control**

Qualitative data analysis has been conducted and categories developed according to Tsech's eight steps as summarized by Creswell (2009:186). The data that was gathered using a tape recorder was first transcribed verbatim and thereafter translated into English to avoid losing the primary trends of the data. A Literature Control or extensive review has been conducted for data verification. Steps of creating a conceptual meaning have been followed according to Chin and Kramer (1999:57-74). These are summarized as follows:

- ✧ Identifying core concepts that are utilized in existing literature and dialogues on IKS and WHS;
- ✧ Defining the purpose of the review;
- ✧ Determining the related attributes in the literature pertaining to WHS and IKS; and
- ✧ Creating conceptual meanings and generating theoretical definitions.

## **1.13 Measures to Ensure Trustworthiness**

Trustworthiness is a method of establishing rigor in qualitative research without sacrificing relevance in order to ascertain whether the outcomes of a study can be reproducible or trusted (Lincoln & Guba, 1985:216-217). The four criteria to measure trustworthiness, according to Lincoln and Guba (1985:318), were used, namely, truth value, applicability, consistency and neutrality. These are briefly described below:

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### **1.13.1 Truth Value**

Truth value asks whether the researcher has established confidence in the truth of the findings for the participants with regard to the context in which the study was undertaken, research design and informants. This can further be achieved through ‘credibility’ which can be demonstrated by participants when they accept that the findings are a true reflection of their experiences (Lincoln & Guba, 1985:318).

### **1.13.2 Applicability**

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups. This includes the ability to generalize from the findings to larger populations. It can be further achieved through transferability, which explains the probability that the research findings have meaning to other similar situations (Krefting, 1991:45).

### **1.13.3 Consistency**

Consistency assesses whether the findings would be consistent if the inquiry were replicated with the same subjects in a similar context (Krefting, 1991:45). Consistency is described in terms of dependability due to the uniqueness of human nature (Krefting, 1991:45).

### **1.13.4 Neutrality**

Neutrality involves freedom from bias in the procedures and results rather than the

investigator. It is further defined through confirmability, which is the criterion of neutrality (Lincoln & Guba, 1985:217).

### **1.13.5 Authenticity**

Authenticity refers to the researcher's ability to represent multiple realities of those being studied with an emic perspective been accurately portrayed. (Polit & Beck, 2004:437-438). In this study the researcher ensured authenticity during individual in-depth interview because of the opportunity to observe participants in their real practice settings and also has a prolonged engagement with the participants because she went more than once to the field doing mender checking. Furthermore data was recoded and transcribed verbatim during data collection.

### **1.14 Ethical Considerations**

Ethical considerations were the core principles in this study. The approval to conduct the study was secured through a formal, written request to the appropriate authorities. The ethical considerations has been in accordance with ethical standards and principles espoused by DENOSA (1998:2.3.2-2.3.4) and Polit and Beck (2004:143-150), namely:

#### **1.14.1 Permission to Conduct the Study**

The researcher obtained written ethical clearance and permissions from the following institutions and stakeholders:

✧ **Annexure A: North West University Ethics Committee**

The researcher conducted formal presentations to the Department of Nursing Science and then to the Faculty of Science and Agriculture Research Committee and ethical clearance was thus granted.

‡ **Annexure B: Limpopo Province Department of Health Research Ethics Committee**

Approval to conduct the study was later obtained from the Limpopo Province, Department of Health Research Ethics Committee after submitting a letter of request to the research Directorate accompanied by the ethical clearance granted by the North-West University and attaching the proposal for the study.

‡ **Annexure C: His Majesty, King ‘Vho-Thovhele’ Toni Mphephu-Ramabulana**

The researcher further made a brief presentation to His Majesty, King ‘Vho-Thovhele’ Toni Mphephu-Ramabulana after a letter of request was submitted with the proposal and aforementioned approvals attached.

### **1.14.2 Adherence to Ethical Principles**

Ethical principles were also adhered to in this study as described below:

#### **1.14.2.1 Informed Consent**

Informed consent relates to the participants’ rights to adequate and relevant information before the commencement of the study. The researcher gave an opportunity to all the participants to make an informed decision regarding participation in the study. The researcher explained the purpose of the study and the procedures involved, potential risks/benefits, how confidentiality is to be maintained and the right to withdraw from participation. All explanations were done at the level of the participants’ understanding. Informed consent was then requested from participants who were over the age of 18 and the consent was in a written form, but narrated to participants who could not read nor write in clear terms before they made a cross of agreement (Annexure D).

#### **1.14.2.2 Right to Privacy**

In this study, all participants were granted the right as individuals to determine the time, extent and general circumstances under which the information will be shared with or

withheld from others. Private information of participants would not be shared without the individual's knowledge or against his/her will. The researcher ensured that participants were not losing their dignity, friendship, employment, and that they never in any way experienced embarrassment or shame. The technical equipment like an audiotape that was used as a means for data collection was explained to each participant prior the commencement of the process. Each participant was shown how to operate the tape in case s/he would like to stop it when giving the information that s/he does not want recorded for sensitive information privacy rule (Burns & Grove, 2009:194-196; Polit & Hungler, 1995:125).

### **1.14.2.3 The Right to Self-Determination and Justice**

The research study has been planned and executed in a way which fosters justice and beneficence, excluding any harm or exploitation of participants in accordance with freedom to conduct their lives as they wish. All participants were informed by the researcher about the proposed study and were allowed to choose voluntarily to participate in the study or not and even withdraw at any time.

### **1.14.2.4 The Right to Anonymity and Confidentiality**

Based on the principle of privacy, the research participants have the right to anonymity and the right to assume that the data will be kept confidential. Complete anonymity could not exist due to the fact that the researcher had a prolonged interaction with the participants in a manner that some information could be linked to certain individuals for the purpose of member checking. However, confidentiality has been maintained throughout in terms of data collected. Confidentiality is related to the researcher's management of private information shared by the participant. The researcher refrained from sharing the information without the authorization of the participants. No one had access to the raw data of the study without authorization, be it a health professional of a family member (Burns & Grove, 2009:196-198).

### **1.15 Model Development**

Walker and Avant (1995:28) identify three basic approaches to theory building. The researcher followed these approaches during the organization of the model, namely, analysis, synthesis and derivation. The researcher moved back and forth between these approaches in the process of model development. During the literature study, a conceptual framework was developed by means of derivation to form the basis for the development of a model. Derivation implies the shifting and redefining of concepts from a body of data and theory or empirical statements about the development and reconstruction of models in another discipline (Dickoff et al, 1968:422).

Results of qualitative interviews were synthesized, analyzed, and integrated within the framework developed during literature review (Dickoff et al, 1968:426). Derivations are made to develop models and descriptors. Dickoff et al, (1968:422) and Stevens Barnums (1990:11) elements of a practice theory were adapted to organize the model, namely, the agent and recipients, the context, dynamics, outcomes and processes.

### **1.16 Plan of the Study**

**Chapter 1:** Background and Overview of the Study

**Chapter 2:** Research Design and Methodology

**Chapter 3:** Presentation of the Findings and Literature Control

**Chapter 4:** Concept Analysis

**Chapter 5:** Theoretical Framework for the Development of the Model to Integrate IKS in the Management of HIV & AIDS in a PHC Context

**Chapter 6:** Guidelines to Operationalize the Model, Justification, Limitations, Recommendations and Conclusions

**1.17 Summary**

In this chapter, an overview of the study is given; the background and rationale of the study as well as the problem statement were discussed. The research question and objectives were developed, followed by the paradigmatic perspectives that guided the study. Lastly an outline of the study was given as a framework on which the study was built.

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# CHAPTER 2

## RESEARCH DESIGN AND METHODOLOGY

### 2.1 Introduction and Rationale

In Chapter 1 the research design and the method was outlined briefly. This chapter aims at describing and justifying the research design and methods that have been used, including the three phases of the research study. This chapter thus brings forth the justification of the research method. The study involves developing a model that will facilitate the integration of IKS in the management of HIV & AIDS within the PHC setting in South Africa based on qualitative, descriptive, explorative and contextual research methods. This undertaking led to the development of a collaborative framework or model aimed at facilitating the integration of the two health systems, IKS and WHS. The whole process will unfold in three phases: namely:

#### 2.1.1 Phase 1

Phase 1 constituted qualitative data gathering and subsequent analysis thereof. The researcher involved stakeholders (IK experts, traditional healers as well as healthcare professionals and practitioners) in order to:

*Explore and describe the views and perceptions that different stakeholders have regarding the use of IKS in the management of HIV & AIDS within the PHC context of the Limpopo Province, South Africa.*

This phase demanded extensive engagement with the relevant stakeholders in the field through proper community, traditional health practice environments, IKS and academic expert entry processes. Through this phase data was collected and analyzed for use in the development of the conceptual framework that aided the final development of the model of integration in phase 3. It is in this phase where a need arose for the integration of the two

health knowledge systems regarding the best ways to implement disease intervention strategies. This integration resulted in a new phase of health service delivery that will cater for all South Africans regardless of their diverse cultural backgrounds, values and belief systems.

As much as individuals, communities and societies at large recognize the existence of WHS as a practice that provides them with a valuable and essential service for maintenance of their health across their life span, the society in turn looks at it as a social entity that is expected to carry social responsibility with the society holding certain expectations from it. Some of the expectations relate to the fact that healthcare consumers should not to be dictated to on what to do and what not to do regarding ways of dealing with their illness behaviours. This makes the society to operate with a continuous usage of IHP in isolation (Searle and Pera, 1995:115).

### **2.1.2 Phase 2**

This phase focused on a conceptual framework which facilitated the development of the model from relevant indigenous health knowledge gathered in order to bridge the divide between the two knowledge systems and their resultant influence on health management of patients with HIV & AIDS in particular. This exercise emanated from the emerged themes, categories and sub-categories from qualitative data analysis with rigorous literature verification processes. Literature verification again enabled the researcher to articulate recommendations from other previous research studies to justify the need for the study as well as the addition of knowledge into the greater scientific body of knowledge (Tjale and De Villiers, 2004:1; Makgoba, 1997:3; ANC, 1994a:55-56; Agrawal, 1995:1-9; Capers, 1992:19; Sillitoe, 1998:230; Masoga and Musyoki, 2001: iii; Mulaudzi, 2001:18).

### **2.1.3 Phase 3**

This phase involved the integration of findings from qualitative interviews and the conceptualized framework which were then used as building blocks for model development. The model has been tailored to facilitate the integration of IKS into the management of

HIV & AIDS within the PHC setting. Furthermore, the development of this model could be playing a pivotal role in dealing with other chronic diseases within the same context of care. Finally, the model was then tested for its clarity, simplicity and feasibility by IKS experts.

## **2.2 The Purpose and Objectives of the Study**

The purpose of the study was to develop a model to facilitate the integration of IKS in the management of HIV & AIDS within the PHC context in South Africa. In order to achieve this overall purpose, the researcher further indicated the objectives according to the three phases of the study:

### **2.2.1 Objectives for Phase 1**

The objective for this phase was to interview stakeholders (IKS experts academics, religious people, traditional healers as well as healthcare professionals and practitioners) regarding:

*Explore and describe the views and perceptions that different stakeholders have regarding the use of IKS in the management of HIV & AIDS within the PHC context of the Limpopo Province, South Africa.*

### **2.2.2 Objectives for Phase 2**

The objectives for this phase cover the development of the conceptual framework. After careful analysis of the data gathered in phase 1 and extensive literature verification, the researcher then came to a conclusion that the following needed to be done:

- ✎ Develop a conceptual framework incorporating views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS within a PHC context.
  
- ✎ Incorporate literature and dialogues in relation to IKS disease management control verify the concepts.

### 2.2.3 Objectives for Phase 3

Following the conceptual framework that has been developed in phase 2, the researcher then embarked on the process to:

- ✧ Develop a functional model that will be able to facilitate the integration of IHS knowledge and practices with regard to management of HIV & AIDS within a PHC context in South Africa.
  
- ✧ Evaluate the model for its accessibility and feasibility within a PHC context.

### 2.3 Research Question

The main research question in this study was:

*How can we integrate IKS in the management of HIV & AIDS within the PHC context in Limpopo Province?*

All other questions were derived from the information obtained from participants in response to this question and the researcher used probing skills to gain more information.

### 2.4 Research Design and Methods

#### 2.4.1 Qualitative Research Design

The researcher, being informed by the research purpose and objectives, utilized a qualitative design which was descriptive, explorative and contextual in nature. Though the researcher was using multiple research approaches the greater part of the study has been contextual in nature with the use of others approaches in specific phases of the research (Burns & Grove, 2009:22). The researcher needed to develop a model of integration of IKS in the management of HIV & AIDS within a PHC context following inductive qualitative approaches in data collection which was then analyzed deductively to ensure validity of model outcome.

Qualitative research is a systematic, interactive, subjective approach used to describe and promote deeper understanding of human life experiences and give them meaning from the perspective of the people (Burns & Grove, 2009:717). Furthermore, a qualitative design is in a way naturalistic because the research takes place in real world settings and the researcher cannot manipulate the phenomenon under study. According to Henning (2004:1), qualitative studies aim for depth rather than 'quantity of understanding' and such studies are conducted in settings that are bound by the theme of inquiry. In this study, people have been interviewed in their own operational setting in order to discover the inherent indigenous health knowledge and practices used for addressing health and illness behavioural challenges with emphasis on the management of HIV & AIDS.

For the reason that little is known regarding IHP surrounding health and illness management within the society, the researcher was obliged to use the inductive model of logic by aiming and developing concepts, insights and understanding the logic of patterns in the data to avoid assessing data to give meaning to preconceived models, theories or hypothesis inherent within the body of knowledge (Bryman, 1995:61). The researcher needed to accumulate participants' perspectives as experiences by way of penetrating into their inherent meanings, knowledge and perceptions regarding the phenomenon underpinning the study (Henning, 2004:1-2). The researcher comes from the same province within which the study was undertaken and has a working knowledge of languages and most cultural practices which may impact study outcomes (Bryman, 1995:61).

The researcher was fully aware that generalization of the study could not be done, but the model of integration of IKS in the management of HIV & AIDS that has been developed could be utilized in another setting of similar cultural context as well as inform PHC curriculum development and review towards training and development of nurses that are professionally and culturally relevant to the inherent health needs within their community settings.

## 2.4.2 Exploratory Research Design

An exploratory research design begins with a phenomenon of interest, but rather than simple observing and describing, it investigates the full nature of the phenomenon, the manner in which it is manifested and the other factors to which it is related (Polit & Beck, 2004:20). According to Mouton (1996:103), an exploratory design aims to establish facts, to gather new data and to determine whether there are patterns in the data. The researcher needed this design as the first step of approach in this study for the development of new knowledge that became the building blocks of the model of integration through:

*Synthesis of existing views and perceptions of IKS experts regarding the integration of IKS in the management of HIV & AIDS within a PHC setting, relevant literature and other attributes that have been explored, conceptualized and then utilized in the process of model development.*

Due to minimal literature regarding the subject matter and the perceptions behind IKS and practices by WHS practitioners, the researcher saw a need to use the exploratory approach in seeking new knowledge that would serve as baseline for the development of the model of integration of the two health systems for quality and effective service delivery to the clients. The use of this design was considered necessary for the researcher to be able to achieve the objectives of the study and to be as open as possible in order to explore new unknown terrain of the problem under investigation and to validate the development of the model.

Due to minimal literature regarding the subject matter and the perceptions behind IKS and practices by WHS practitioners, the researcher saw a need to use the exploratory approach in seeking new knowledge that would serve as baseline for the development of the model of integration of the two health systems for quality and effective service delivery to the clients. The use of this design was considered necessary for the researcher to be able to achieve the objectives of the study and to be as open as possible in order to explore new unknown terrain of the problem under investigation and to validate the development of the model.

### **2.4.3 Descriptive Design**

A descriptive study design provides an accurate portrayal or account of characteristics of a particular individual, event, or group in real life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorizing information through observation, analysis, description and classification (Burns & Grove, 2009:696; Strauss & Corbin, 1999:16). A descriptive study may be used to develop a theory, identify problems with current practice, justify current practice, make judgments, or determine what others in similar situations are doing (Burns and Grove, 2009:237).

IKS, concepts and related attributes identified from data analysis and the literature control have been described, and finally the model to facilitate integration of IHS into the management of HIV & AIDS in a PHC context was developed. The researcher further suspended her beliefs, preconceived information and expectations about the importance of IHS by bracketing as well as by following the three-step process of describing the phenomenon according to Streubert and Carpenter (2007:82-86), which are:

#### **2.4.3.1 Intuiting**

The researcher with her inherent knowledge was obliged to avoid being influential to the information given, by reserving comments, opinions or criticisms that could mislead the participants in order to get realistic data (Streubert & Carpenter, 2007:79). The researcher had to review and understand description of the data as transcribed from the raw data until a common understanding about the phenomenon emerged (Streubert & Carpenter, 2007:85).

#### **2.4.3.2 Analyzing**

The researcher had to identify the essence and the contextual meaning of the views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS based on non-tampered data. The researcher fully immersed herself in the data analysis

for a prolonged period of time in order to attain an in-depth description of the phenomenon under study. These resulted in the emergence of themes, categories and sub-categories as elements or constituents of data started to relate and connect into a meaningful phenomenon (Streubert & Carpenter, 2007:85-86).

### **2.4.3.3 Describing**

The researcher had to fully describe and communicate back the information to the body of knowledge, all verbal and written critical elements about the ways through which IKS can be integrated into the management of HIV & AIDS in a PHC context within the Limpopo Province (Streubert & Carpenter, 2007:86). This step allowed the researcher to fully engage in the process of classification or grouping all critical elements or essences that were common to the experiences of the stakeholders regarding their views and perception towards the integration of IKS into the management of HIV & AIDS within the PHC context in the Limpopo Provinces.

Furthermore, this step also aided the researcher to avoid premature data analysis which usually occurs due to minimal engagement with the data before analysis could take place (Carpenter, 2007:86). The knowledge of the researcher was bracketed throughout the process when views and perceptions of all participants were transcribed verbatim (Grove et al, 2013:60). Theory generation was achieved through conceptualization of the constructs using the steps in Rodgers and Knafl (1993:78) and the framework was developed to clarify the guiding concepts and thus a base for model development was created (Dickoff et al, 1968:426).

### **2.4.4 Objectives for Phase 1**

The objective for this phase was to interview stakeholders (IKS experts academics, religious people, traditional healers as well as healthcare professionals and practitioners) regarding:

*Explore and describe the views and perceptions that different stakeholders have regarding the use of IKS in the management of HIV & AIDS within the PHC context of the Limpopo Province, South Africa.*

### **2.4.5 Objectives for Phase 2**

The objectives for this phase cover the development of the conceptual framework. After careful analysis of the data gathered in phase 1 and extensive literature verification, the researcher then came to a conclusion that the following needed to be done:

- ✧ Develop a conceptual framework incorporating views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS within a PHC context.
- ✧ Incorporate literature and dialogues in relation to IKS disease management and control to verify the concepts.

### **2.4.6 Objectives for Phase 3**

Following the conceptual framework that has been developed in phase 2, the researcher then embarked on the process to:

- ✧ Develop a functional model that will be able to facilitate the integration of IKS knowledge and practices with regard to management of HIV & AIDS within a PHC context in South Africa.
- ✧ Evaluate the model for its accessibility and feasibility within a PHC context.

## **2.5 Research Question**

The main research question in this study was:

*How can we integrate IKS in the management of HIV & AIDS within the PHC context in Limpopo Province?*

All other questions were derived from the information obtained from participants in response to this question and the researcher used probing skills to gain more information.

## **2.6 Research Design and Methods**

### **2.6.1 Qualitative Research Design**

The researcher, being informed by the research purpose and objectives, utilized a qualitative design which was descriptive, explorative and contextual in nature. Though the researcher was using multiple research approaches the greater part of the study has been contextual in nature with the use of others approaches in specific phases of the research (Burns & Grove, 2009:22). The researcher needed to develop a model of integration of IKS in the management of HIV & AIDS within a PHC context following inductive qualitative approaches in data collection which was then analyzed deductively to ensure validity of model outcome.

Qualitative research is a systematic, interactive, subjective approach used to describe and promote deeper understanding of human life experiences and give them meaning from the perspective of the people (Burns and Grove, 2009:717). Furthermore, a qualitative design is in a way naturalistic because the research takes place in real world settings and the researcher cannot manipulate the phenomenon under study. According to Henning (2004:1), qualitative studies aim for depth rather than 'quantity of understanding' and such studies are conducted in settings that are bound by the theme of inquiry. In this study, people have been interviewed in their own operational setting in order to discover the inherent indigenous health knowledge and practices used for addressing health and illness behavioural challenges with emphasis on the management of HIV & AIDS.

For the reason that little is known regarding IHP surrounding health and illness management within the society, the researcher was obliged to use the inductive model of logic by aiming

and developing concepts, insights and understanding the logic of patterns in the data to avoid assessing data to give meaning to preconceived models, theories or hypothesis inherent within the body of knowledge (Bryman, 1995:61). The researcher needed to accumulate participants' perspectives as experiences by way of penetrating into their inherent meanings, knowledge and perceptions regarding the phenomenon underpinning the study (Henning, 2004:1-2). The researcher comes from the same province within which the study was undertaken and has a working knowledge of languages and most cultural practices which may impact study outcomes (Bryman, 1995:61).

The researcher was fully aware that generalization of the study could not be done, but the model of integration of IKS in the management of HIV & AIDS that has been developed could be utilized in another setting of similar cultural context as well as inform PHC curriculum development and review towards training and development of nurses that are professionally and culturally relevant to the inherent health needs within their community settings.

## **2.6.2 Exploratory Research Design**

An exploratory research design begins with a phenomenon of interest, but rather than simple observing and describing, it investigates the full nature of the phenomenon, the manner in which it is manifested and the other factors to which it is related (Polit & Beck, 2004:20).

According to Mouton (1996:103), an exploratory design aims to establish facts, to gather new data and to determine whether there are patterns in the data. The researcher needed this design as the first step of approach in this study for the development of new knowledge that became the building blocks of the model of integration through:

*Synthesis of existing views and perceptions of IKS experts regarding the integration of IKS in the management of HIV & AIDS within a PHC setting, relevant literature and other attributes that have been explored, conceptualized and then utilized in the process of model development.*

Due to minimal literature regarding the subject matter and the perceptions behind IKS and practices by WHS practitioners, the researcher saw a need to use the exploratory approach in seeking new knowledge that would serve as baseline for the development of the model of integration of the two health systems for quality and effective service delivery to the clients. The use of this design was considered necessary for the researcher to be able to achieve the objectives of the study and to be as open as possible in order to explore new unknown terrain of the problem under investigation and to validate the development of the model.

### **2.6.3 Descriptive Design**

A descriptive study design provides an accurate portrayal or account of characteristics of a particular individual, event, or group in real life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorizing information through observation, analysis, description and classification (Burns and Grove, 2009:696; Strauss and Corbin, 1999:16). A descriptive study may be used to develop a theory, identify problems with current practice, justify current practice, make judgments, or determine what others in similar situations are doing (Burns and Grove, 2009:237). IKS, concepts and related attributes identified from data analysis and the literature control have been described, and finally the model to facilitate integration of IHS into the management of HIV & AIDS in a PHC context was developed. The researcher further suspended her beliefs, preconceived information and expectations about the importance of IHS by bracketing as well as by following the three-step process of describing the phenomenon according to Streubert and Carpenter (2007:82-86), which are:

#### **2.6.3.1 Intuiting**

The researcher with her inherent knowledge was obliged to avoid being influential to the information given, by reserving comments, opinions or criticisms that could mislead the participants in order to get realistic data (Streubert & Carpenter, 2007:79). The researcher

had to review and understand description of the data as transcribed from the raw data until a common understanding about the phenomenon emerged (Streubert & Carpenter, 2007:85).

### **2.6.3.2 Analyzing**

The researcher had to identify the essence and the contextual meaning of the views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS based on non-tampered data. The researcher fully immersed herself in the data analysis for a prolonged period of time in order to attain an in-depth description of the phenomenon under study. These resulted in the emergence of themes, categories and sub-categories as elements or constituents of data started to relate and connect into a meaningful phenomenon (Streubert and Carpenter, 2007:85-86).

### **2.6.3.3 Describing**

The researcher had to fully describe and communicate back the information to the body of knowledge, all verbal and written critical elements about the ways through which IKS can be integrated into the management of HIV & AIDS in a PHC context within the Limpopo Province (Streubert & Carpenter, 2007:86). This step allowed the researcher to fully engage in the process of classification or grouping all critical elements or essences that were common to the experiences of the stakeholders regarding their views and perception towards the integration of IKS into the management of HIV & AIDS within the PHC context in the Limpopo Provinces. Furthermore, this step also aided the researcher to avoid premature data analysis which usually occurs due to minimal engagement with the data before analysis could take place (Carpenter, 2007:86). The knowledge of the researcher was bracketed throughout the process when views and perceptions of all participants were transcribed verbatim (Grove et al, 2013:60). Theory generation was achieved through conceptualization of the constructs using the steps in Rodgers and Knafl (1993:78) and the framework was developed to clarify the guiding concepts and thus a base for model development was created (Dickoff et al, 1968:426).

## **2.6.4 Contextual Design**

The researcher conducted the interviews within the environment of the participants to avoid the disturbance of the natural context of the practice of IHP because in the first place most of the traditional healers preferred to be addressed in their practice designated place. Traditional healers indicated a strong connection with their powers of divinity which connected them to their source of power in whatever they do (Streubert & Carpenter, 2007:22). The researcher visited each participant within their residing villages, and then indicated the fact that the study was undertaken in complete rural settings of the Vhembe District in Limpopo Province. Finally, the study was conducted in respect of *The Constitution of the Republic of South Africa—Bill of Rights, Chapter 2, Section 7, Subsections 1 and 2* that stipulate that the state must enshrine the rights of all people in our country and affirm the democratic values of human dignity, equality and freedom, as well as respecting, protecting, promoting and fulfill the rights in the *Bill of Rights*.

## **2.7 Research Methods**

The study was conducted in three phases as discussed in Chapter 1 as well as in the purpose and objectives above. Phase 1 involved the exploration and description of the views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS in a PHC context in the Limpopo Province of South Africa as well as ways through which integration of the two health systems can be forged for better and quality service delivery for clients. Phase 2 entailed the development of the theoretical framework following data analysis of the qualitative data gathered in phase 1 and extensive literature verification.

### **2.7.1 Phase 1**

#### **2.7.1.1 Data Collection**

In this study, data collection took place in phase 1, with the aim of building a conceptual framework in phase 2 which later became the building block for model development. During phase 1,

the researcher embarked on the process of data gathering and analysis using a qualitative approach with explorative, descriptive and contextual designs as explained in detail above. The researcher used in-depth face-to-face interviews after bracketing her inherent knowledge and possible bias, and embarked on orderly and effective data gathering and recording of data as presented by the participants. Field notes were also carefully recorded in the field notebook to capture all that the tape recorder could not register like personal behaviours and emphasis of emotions by the participants. The overall reason for the researcher to capture everything was to ensure accurate and reliable data retrieval that will depict the real voices of participants.

### **2.7.1.2 Data Collection Overview**

The researcher gathered data from the participants in their respective places which included their homes, places of practice or work and three participants were telephonically interviewed as they were not in the province during the time of data collection. Individual in-depth face-to-face interviews were conducted departing from two central questions, namely:

**QUESTION 1:** *What are your views and perceptions with regard to the integration of IKS in the management of HIV & AIDS within a PHC setting in the Limpopo Province?*

**QUESTION 2:** *How best can the two systems work together or be integrated?*

### **2.7.2 Population**

The researcher's determination of the population was guided by Mouton (1998:83) as well as Leedy and Ormrod (2005:60) who indicated that the population is the sum total of all the people and their characteristics about which a conclusion is to be drawn. A sample of participants, to some degree, must share common language, culture and views, as suggested. On the other hand, Brink et al (2012:131) define population as the entire group of persons or objects that meets the criteria of interest for the researcher's study.

The population of this study was drawn from the Vhembe District in Limpopo Province, in South Africa. **Vhembe** is one of the 5 districts of Limpopo Province. It is the northern most district of the country and shares its northern border with Beitbridge district in Matabeleland South, Zimbabwe. Vhembe consist of all territories that were part of the former Venda Bantustan, however, two large densely populated districts of the former Tsonga homeland of Gazankulu, in particular, Hlanganani and Malamulele were also incorporated into Vhembe, hence the ethnic diversity of the District. The five districts are namely, Mopani, Waterberg, Capricorn, Sekhukhune and Vhembe. The study was conducted in the Vhembe District. Vhembe District is further operating in four Municipalities/ sub-district namely, Musina, Mutale, Thulamela and Makhado.

The province is mainly populated by Vendas and Shangaans, and is mostly rural with 800 000 Venda speaking, 400 000 Tsonga speaking and 27 000 Northern Sotho speaking citizens (Statistics South Africa. Census 2011). The target population included all stakeholders as indicated in Chapter 1, the IKS stakeholders as well as the WHPs who are practising within the Vhembe District, and who embody deeper concerns and understanding of the need regarding the integrative approach to health and illness behaviour that will be inclusive of IKS intervention approaches to health service delivery. The researcher's predisposition to the Limpopo Province was guided by the fact that there was no language barrier as most of the traditional healers preferred their own language in responding to the questions. Furthermore, it became easier for the researcher to probe as she is fluent in the three common languages that are utilized in Limpopo Province (Tshivenda, Sepedi and Xitsonga).

### **2.7.3 Sampling and Sampling Criteria**

The researcher used both purposive and snowballing techniques in recruiting the participants with the advantage that she worked with most of them in IKS curriculum development for one of the universities within the province. A purposive sampling method is based on the judgment of the researcher regarding participants or objects that are typical or

representative of the study phenomenon, or who are especially knowledgeable about question at hand (Brink et al, 2012:141). The snowballing technique has been utilized to further identify potential participants not known to the researcher. Snowballing is also known as network sampling and involves the assistance of the study subjects in obtaining other potential subjects by means of informed networking.

The first ball is identified within the researcher's existing networks of IHS practitioners. Thereafter, participants were asked to indicate other people within their social networks who were fitting the similar characteristics (Burns & Grove, 2009:356). De Vos, Strydom, Fouché and Delpont (2011:393), further indicate that snowball sampling has particular application value in qualitative research since it is directed at the identification of hard-to-reach individuals. Participants were selected on the bases of the following set of criteria:

- ✎ The criteria for selection of traditional healers included those who had undergone traditional healers' training by a traditional healer or those who received informal mentoring by family members who also are traditional healers, and lastly are recognized or acknowledged by community members as traditional healers, including all other indigenous health practitioners like faith healers, herbalists, traditional birth attendants, homeopaths, and others.
- ✎ For the sampling of IKS practitioners/experts, these are knowledge experts who are the custodians of IHP who might not necessarily be traditional healers.
- ✎ For pastors, the researcher used ordained pastors who are serving in well-known and succeeding churches that have been in operation for more than 3 years.
- ✎ For IK academic participants, selection included those who are actively involved in IK teaching and curriculum development and have a greater passion in an IKS

discipline. Amongst the groups some might have done research or related academic/intellectual work on IKS and are actively involved in IKS issues.

- ✎ For health care professionals, selection has been for those who were available during the time of data triangulation for data verification purposes.

### **2.7.3.1 Description of the Sample**

The sample included:

1. 10 Traditional healers
2. 2 Herbalists
3. 2 IKS organic experts
4. 2 IKS academics teaching IKS programmes and one of them being a practicing traditional healer who spoke at national and international IKS conferences
5. 1 Pharmacist who is also a qualified traditional healer
6. 1 Medical doctor who is also a qualified traditional healer
7. 2 Ordained pastors

The sample comprised nine (9) females and twelve (11) males within the age range of 35-75 years. As indicated by Grove et al, (2013:709), a sample refers to a subset of the population that is selected for a study and sampling includes selecting groups of people, events, behaviours, or other elements with which to conduct a study.

### **2.7.3.2 Sample Size**

Data saturation in qualitative research occurs when additional sampling provides no new information, only redundancy of previous collected data (Grove et al, 2013:691). The sample size of this study depended on data saturation which occurred when no new or relevant data emerged, when all avenues or leads have been followed, and when the story or theory was complete or when relationships between categories were well-established and validated (Brink

et al, 2012:141). The researcher continued identifying participants and collected data until there was repetition of previously collected information and data was saturated after 20 participants were interviewed.

### **2.7.4 Process of Individual In-Depth Interviews**

The researcher followed all ethical considerations necessary before embarking on the real process of data collection. Data collection was done on two different occasions—the first data was collected after the pilot study as the researcher had two weeks in August 2012 and the process was continued in 2013 as data was far from saturation point. The researcher called one well-known traditional healer within the district for the first interview and thereafter he directed the researcher to others known to him. Some traditional healers had telephone numbers and were consulted before the real visit could take place. Those who did not give their contact numbers, preferred to be visited unannounced before the real visit could take place. Most of the traditional healers were visited unannounced because in traditional healing a healer does not get offended when people enter his or her house as that is how their patients visit. No prior appointment was made. All the researcher's visits were warmly welcomed by each traditional healer who, in turn, referred the researcher to the next well-known and best traditional healer in the next village or similar village. On arrival, the researcher followed protocol of waiting at the gate until a messenger from the house could come out to greet and ask the reason for the visit then went to report to the traditional healer, who would then ask if the visit is for consultation or any other purpose. After clearly explaining to the messenger the reason for the visit, the researcher was welcomed and then directed by the traditional healer to the place where the conversation could take place. The settings differed among traditional healers; some preferred their consulting rooms and others insisted on a neutral place as the researcher was not coming for consultation.

The researcher made it a point that participants be calm and comfortable with the process. They were greeted with respect and the researcher followed all the instructions they gave her.

For example, most traditional healers preferred to be interviewed in their operation room or a rondavel for them not to anger their ancestors and some asked permission from their ancestors by pouring 'snuff' on the floor before they could communicate with the researcher and participate in any discussion. The researcher tried to allow the participants to flow without interruption as per questions posed. The tendency with most traditional healers was that they mostly flow with information to a point where the researcher needed to be a good listener in order to probe where necessary in a manner that will not make the participants close up the flow of information.

The researcher conducted all interviews at the homes of the traditional healers who were found in 13 villages of the Vhembe District in the Limpopo Province. The researcher and the participants preferred a comfortable space within the traditional healers' naturalistic settings to ensure comfort and privacy during the process of the interviews. Due to the vast distance, the researcher spent nine days gathering data from all the participants with each interview lasting from 30 minutes to 1 hour. With the consent from all participants, a tape recorder was used during the interviews and field notes captured for nonverbal cues that were observed during the process of data collection by the researcher. Participants were allowed to deal with the question from their perspective. The researcher used interview facilitation skills such as listening, summarizing, and clarification to fully engage participants to gain a deeper understanding of the information gathered. Furthermore, the researcher utilized probing and paraphrasing to generate more information from the participants until data saturation was reached. The following techniques were utilized to gather a deeper sense of information:

#### **2.7.4.1 Probing**

The researcher as an instrument for data collection in qualitative research was obliged to utilize this technique. De Vos et al, (2011:345) describe the purpose of probing as a way to deepen the response to a question, to increase the richness of the data being obtained, and to

give cues to the participants about the level of response that is desired. This is the technique that qualitative researchers use to obtain more information in a specific area of the interview (Burns & Grove, 2009:405). The researcher at times repeated questions or the comments from the participants in order to get clarity of what the participants actually meant without putting them under cross examination (Burns and Grove, 2009:405)

#### **2.7.4.2 Clarifying and Summarizing**

The researcher had a responsibility to ask for clarity from participants in case the statements were not clear so that a lucid meaning could be arrived at (Streubert & Carpenter, 2007:95). The researcher had to repeat what the participant has said in order to be sure if she got the message correctly which also assisted her when transcribing as all things were clarified whilst in the field. Phrases like ‘zwiamba uri vhakhouri’ . . . ‘arali ndo vhapha zwavhudi’ (it means *is this is what you said, if I heard you correctly?*) (Streubert & Carpenter, 2007:95).

#### **2.7.4.3 Data Capturing**

Data were collected with the use of an audio tape and all field notes captured during the interviews were documented in the field notebook. These were also incorporated in the transcription of the data to give a dense picture of what actually transpired (Streubert & Carpenter, 2007:94).

#### **2.7.4.4 Field Notes**

Field notes are notes that were captured by the researcher and which were often missed by the recorder like nodding, opening eyes in amazement including the observable cues and features like the state of the participant, the area where interview was done, the cleanliness of both the participant and the environment (Polit & Beck, 2004:718, 726). According to De Vos et al, (2011:359), field notes are a written account of the things the researcher hears, sees experiences and thinks about in the course of interviewing. The researcher kept a reflexive diary to capture all relevant information that could not be achieved by audiotaping.

#### **2.7.4.5 Observational Notes**

Observations included the *what, who, when, where* and *how* of human activity, regarding facial expressions in relation to certain experiences like when traditional healers were indicating how they are stigmatized and marginalized as a system by WHPSs, the researcher observed sadness in most of them but with a sense of contentment in what they are doing (De Vos et al, 2011:409).

#### **2.7.4.6 Theoretical Notes**

Theoretical notes are self-conscious, systemic attempts by the researcher to critically reflect on what took place, what he or she thought and experiences and also the reflections on the dimensions and deeper meanings of concepts by the researcher in order to derive meaning from the observational notes and to make own interpretations to strengthen the conceptual meaning, that is the process involving identification of repeatedly found patterns that the researcher need to explain the particular phenomenon under study within the relevant literature (De Vos et al, 2011:408-409).

#### **2.7.4.7 Methodological Notes**

Methodological notes are detailed notes on circumstances relevant to understanding the data, what happened, and what was heard, seen and experienced (De Vos et al, 2011:409). These instructions are to the researcher, critiques of one's tactics that act as reminders to the researcher regarding the methodological approaches that may be fruitful, this makes the researcher to be fully focused on the core components to be studied (De Vos et al, 2011:408-410).

#### **2.7.4.8 Personal Notes**

These notes surrounds the researcher's perceptions and experiences regarding the researcher's own feelings as well as the behavioural changes that came up during the process of data collection, like most traditional healer participants took their time in settling

down for the interview, and the researcher resorted to having a general conversations with other family members to avoid a vacuum during the waiting period (Polit & Beck, 2004:727).

### **2.7.5 Data Analysis**

Tsech's eight steps of data analysis were followed in this study (Creswell, 2009:186). The researcher as an instrument for data collection ensured bracketing and openness to avoid bias and being judgmental as she had worked with some of the IKS experts within the field of IK curriculum development and in her previous Masters study (Grove et al, 2013:60). Data were analyzed immediately after few participants were interviewed and transcribed verbatim with the continuous inclusion of field notes. The researcher observed a trend on most of the traditional healers or IKS knowledge experts that they all appear differently as compared to other individuals, regarding their dress code. And again they appeared very disturbed when it comes to the idea of them being looked down upon by WHPs. The researcher proceeded inductively to observe multiple instances and then combined them into a larger whole or another logical system (Chinn & Kramer, 1999:79).

Meaning from the collected data was elicited in a systemic, comprehensive and rigorous manner, through proper organizing, reduction and describing of data. It is this process of data analysis that themes, categories and sub-categories emerged and inductive reasoning, bracketing, intuition and synthesis were utilized to sift and match the data to deduce relationships of common concepts, categories and sub-categories inherent in the data. The researcher managed to relate the data outcomes with the objectives of the study in order for the purpose of the study to be realized. The researcher was guided by Tsech's eight steps to analyze and describe the textual data that were collected, that is, the researcher managed to:

- ✧ Carefully read through all typed transcripts and writing down ideas as they came in order to make sense of them;

- ✧ Identify the most interesting transcript which was also short, asking herself questions reflecting on what actually transpired in the field to come to the actual meaning and then document it on the sides of the transcript;
- ✧ Write down a list of topics with all the information, clustered together similar topics and arranged them into columns under major topics, unique topics and leftover topics;
- ✧ Take the list reflecting back to the data, abbreviating the topics as codes and writing the codes next to the appropriate segments of information from the text, assess the preliminary organizing scheme to see whether new categories and codes are emerging;
- ✧ Turn the most descriptive wording for topics into categories, grouped together the topics which were related to one another, drew lines between categories to show interrelationships;
- ✧ Make a final decision about the abbreviation for each category and alphabetized the code;
- ✧ Assemble the data material belonging to each category in one place and performed a preliminary analysis; and
- ✧ Record the existing data according to the need pattern using Tsech's method and then data was supported by relevant literature (Creswell, 2009:186).

### **2.7.6 Measures to Ensure Trustworthiness**

Four criteria to measure trustworthiness (Table 2.1; Lincoln & Guba, 1985:161) were used.

### 2.7.6.1 Truth Value (Credibility)

Truth value asks whether the researcher has established confidence in the truth of the findings from the participants with regard to context in which the study is undertaken, research design and informants. The researcher did a study prior to this research regarding *Traditional Health as a Health Care System in a Trans-Cultural Society* and also participated in IKS curriculum development within the institution of higher learning.



**Table 2.1:** Criteria to ensure trustworthiness

Measures	Strategies	Criteria	Applications
Truth value	Credibility	<i>Triangulation</i>	The researcher recruited different IKPs, WHPs, pastors, IK experts, researchers and lecturers, as well as IKS organic knowledge experts for vast information gathering. Preliminary results presented in three international seminars.
		<i>Member checking</i>	Follow-up interviews were conducted regarding the same topic and members verified accuracy.
		<i>Reflexivity</i>	Information was gathered using multiple strategies, e.g., interviewing, field notes, personal notes, theoretical notes and observation notes, including literature control.
Applicability	Transparency	<i>Deep description</i>	Clear description of methodology used, use of audiotape, transcription of raw data verbatim as well as utilization of literature to control the findings. Model could be utilized in similar contexts.
		<i>Sample type recruited</i>	Data was collected from the relevant participants who embodies a deeper understanding of IKS matters and who are practising.
Consistency	Dependability	<i>Deep description</i>	Deeper and continuous description of data, using the same qualitative steps of data analysis; was maintained throughout the process.
		<i>Triangulation</i>	Health professionals were also interviewed as a way of verifying data or information obtained from IKS stakeholders and acquiring other views of data from IKS.
Neutrality	Confirmability	<i>Reflexivity</i>	Member checking done for the confirmation of the preliminary analysis. Transcribed raw data available. Central concept to model development analyzed fully. Bracketing was done by the researcher as she embodies some knowledge regarding IKS gathered during IKS curriculum development studying Transcultural Health Care in her M Cur, using the same province.
Authenticity	Credibility	<i>Member checking</i>	Prolonged engagements were done to deepen the data and for member checking. Data was recoded clearly. Multiple modes of data collection.

It was very crucial for the researcher to establish how confident she was with the truth of the research findings based on the research design, informants and the context (Krefting, 1991:215). Truth value also could be ensured through credibility which is about the truth as known, experiences or deeply felt by participants under study and how data were interpreted from findings of co-participants' evidence as in its 'real world' or the truth in realities, meaning, its subjectivity, inter-subjectivity and objectivity of the realities (Krefting, 1991:216). Furthermore, credibility was achieved through paraphrasing the participants' responses for affirmation of data by the participant and the use of a tape recorder that captured the data as was.

The researcher also continued further and do member checking to ensure accuracy of the final reporting of the study outcomes. The audio data and transcripts are available for scrutiny at any given time, including the duty of the independent coder was instituted (Lincoln & Guba, 1985:161). Continuous consultations were done for credibility with the supervisor who stands at a position of an expert in both the research methodology as well as data analysis quality checking, looking at all emerged themes, categories as well as the sub-categories for credibility of the outcomes of the findings (Krefting, 1991:219).

### **2.7.6.2 Applicability (Transferability)**

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups. This can be further achieved through meaningful transferability of the research findings into another setting, (Krefting, 1991:216). This study designed a model for integration of IKS in the management of HIV & AIDS in a PHC setting which can in future be utilized by other health care providers within the context of PHC in South Africa and/or elsewhere in the continent. Human beings as well as their behaviours are governed by many factors, that is, their environment, interactive exposure as well as their belief systems. It is not always possible to repeat the findings of this type of research in another setting as human perceptions and attitudes are uniquely made. Nevertheless, a model that has been designed to

integrate IKS can be transferred and utilized in another setting that depicts similar contextual evidence (Lincoln & Guba, 1985:215).

### **2.7.6.3 Consistency (Dependability)**

Consistency assesses whether the findings would be consistent if the inquiry were replicated with the same subjects in a similar context (Krefting, 1991:217). Consistency is described in terms of dependability due to the uniqueness of human nature. The study outcome may reflect the same meaning if repeated within the same contextual research setting. Multiple participants were interviewed in this study, including traditional healers, doctors, a pharmacist, pastors, IKS experts, organic custodians of IK and herbalists, which ensured participant triangulation and dependability of the findings. An independent coder served as an agent to ensure data consistency, dependability and validity.

### **2.7.6.4 Neutrality (Confirmability)**

Neutrality involves freedom from bias in the procedures and results rather than the investigator. It is further defined through confirmability, which is the criterion of neutrality (Lincoln & Guba, 1985:216). Confirmability could further be described as ways of obtaining evidence from participants about findings or interpretations of the researcher through member checking, which the researcher embarked on. According to Krefting (1991:217), confirmability is the capability to capture the traditional concept of objectivity to balance bias as indicated above. In this study, every participant enjoyed the same status of participation in the research without any influence from the researcher as the researcher used bracketing to avoid such influences. The independent coder's duty increased the neutrality of the research outcomes.

### **2.7.6.5 Authenticity**

Authenticity refers to the researcher's ability to represent multiple realities of those being studied with an emic perspective been accurately portrayed. (Polit & Beck, 2004:437-438).

In this study the researcher ensured authenticity during individual in-depth interview because of the opportunity to observe participants in their real practice settings and also has a prolonged engagement with the participants because she went more than once to the field doing member checking. Furthermore data was recoded and transcribed verbatim during data collection. The researcher interviewed multiple participants and all data was audiotaped and transcribed verbatim for authenticity purposes. Member checking was done to verify if the information is the accurate portrayal of what came up from data collection.

## **2.8 Ethical Considerations**

Ethical considerations were the core principles in this study. The approval to conduct the study was secured by a written request to the appropriate authorities. As described fully in Chapter 1, ethical considerations applied in this study have been in accordance with ethical standards and principles as espoused by DENOSA (1998:2.3.2-2.3.4); Polit and Beck (2004:143-150).

### **2.7.2 Phase 2: Conceptual Framework: Identification of the Concept of Interest**

A conceptual framework involves the process of clarification and analysis of lay concepts that emerged in the study supported by the body of relevant literature around the topic under study, and it is also a framework to guide the entire study. This is the process that goes on in one's mind or thought process in trying to create meaning, perceptions, identifying similarities, putting them together to make up a concrete thought which expresses the meaning of the similarities and then give them a name (Mouton, 1996:119). Using the steps of concept analysis by Rodgers and Knafl (2000:83-100), the concept was then interpreted and its analytic outcomes then formed the bases of model development, namely:

- ✧ Identification and selection of the appropriate settings and sample of data collection;
- ✧ Collection of data regarding the attributes of the concept along with surrogate terms,

references, antecedents and consequences;

- ✎ Identification of related concepts of interest;
- ✎ Identification of a model case;
- ✎ Conducting interdisciplinary or temporal comparison, and
- ✎ Identification of hypotheses and implications for further development (Walker and Avant, 1995:39; Rodgers, 2000:83-100).

## **2.7.3 Phase 3: Model Development**

### **2.7.3.1 Introduction**

Following the conceptual framework development, model development came into being and concepts were classified according to elements of model development as described by Dickoff et al, (1968:426), which are as follows: agent, recipient, context/framework, terminus, procedure and dynamics. These are outlined below:

#### **❖ Agent**

According to Dickoff et al, (1968:426), an agent is a person or persons or objects whose activities have a direct contribution towards the realization of the actual outcome. In this case different people or persons can perform different activities or roles with a similar goal in mind to achieve.

#### **❖ Recipients**

Recipients are persons or (things/objects) whose activity contributes to the realization of the expected goal (Dickoff et al, 1968:426).

#### **❖ Context**

According to Dickoff et al, (1968:426), the context is a framework viewed from the aspect of the matrix of activity that is ability to see it from its relationship with other things meaning

people or other activities. One can look at the context from the systems perspective where you look at things according to relationship or interaction towards to whole or unity or its totality.

❖ **Terminus/Purpose**

The terminus or purpose of the model is about viewing the activity from the perspective of the endpoint or accomplishment of the activity (Dickoff et al, 1968:426).

❖ **Dynamics**

Dynamics are forces or energy sources for the activity to take place, which could be either, chemical, physical, biological or psychological for any person or thing to be able to function as an agent, recipient or part of the framework towards the realization of the expected goal as indicated in full in Chapter 5 (Dickoff et al, 1968:426).

### **2.7.3.2 Model Development**

According to Chinn and Kramer (1999:51), a model is a symbolic description of reality. It depicts the schematic representation of relationships among phenomena and uses symbols or a diagram to represent an idea. It gives a structural or symbolic structure through which situations, events and groups of people can be viewed. In this study, model development encompassed the following:

❖ **Formulation of Criteria for Concepts**

Criteria for concept analysis played a major role as the researcher obtained the skill and experience for the identification, differentiation from other similar concepts, definition and describing the concepts as they emerged from data analysis and literature control for the purpose of model development according to (Chinn & Kramer, 1999:69).

**❖ Structure and Contextualization the Model**

This is a process by which the researcher establishes systemic linkages between and among concepts resulting in formal construction of a theoretical structure. The whole process depends on the type and purpose of the model that is to be developed. These include what the researcher knew (from life experiences or literature) or assumed to be true, according to the researcher's underlying philosophical ideas in relation to the body of knowledge as well as the outcomes of the analyzed data working towards the development of the model from a structural point of view (Chinn & Kramer, 1999:73).

**❖ Identification and Definition of the Concepts**

The researcher embarked on identifying the concepts that became the building blocks for model development. The researcher identified these concepts as they emerged from the analysis of the data and also from the literature control. After identification of relevant concepts, the researcher determined their relationships, but with greater reference to other models developed in the past, previous research done, and philosophical ideas and personal experiences to form the bases of model development (Chinn & Kramer, 1999:84).

**❖ Identification of Assumptions as Part of the Model**

Assumptions are underlying issues that are presumed to be true. They are not intended to be empirically tested for soundness, but they can be challenged philosophically and may be investigated empirically (Chinn & Kramer, 1999:76).

**❖ Clarification of the Context**

According to Chinn and Kramer (1999:77), clarification of context means putting relationships among concepts within the context of the study. In this study, the context is the community cultural context, the WHS context as well as the legislative context.

### ❖ Design of the Relationship Statement

This involves the description of the relationship statements, explaining or predicting the nature of the interaction between the concepts of the model (Chinn & Kramer, 1999:77). This process will be explained in detail in the chapter that outlines concept analysis.

### 2.7.3.3 Model Description

Model description has something to do with answering the following leading questions (Chinn & Kramer 1999:84):

**Question 1:** What is the purpose of the model?

**Question 2:** How are the concepts defined?

**Question 3:** What is the nature of the relationship?

**Question 4:** On what assumptions is the model built?

**Question 5:** What is the structure of the model?

**Question 6:** What is the procedure of the model?

### ❖ Model Overview

At this stage, emanating from the systemic representation of the model, the researcher needed to highlight all elements and relational statements concerning the process that could aid the development of the integrative model that would ensure IKS inclusion in the management of HIV & AIDS within a PHC context of the Vhembe District in Limpopo Province, South Africa (Chinn & Kramer, 1999:77).

## 2.8 Summary

This chapter embarked on outlining and detailing the research methods and processes as they occurred in the field in order to achieve the purpose and the objectives of the study. The design used was qualitative, explorative, descriptive and contextual in nature with the aim of model development later in the ensuing chapters. Ethical considerations and principles were

strictly adhered to in order to ensure validity and credibility of the study. Trustworthiness was also fully discussed and its application in this study explicated.

# CHAPTER 3

## PRESENTATION OF THE FINDINGS AND LITERATURE CONTROL

### 3.1 Introduction

The previous chapters focused on the background of the study and the research methodology, respectively. In this chapter, findings from qualitative individual in-depth face-to-face interviews of IKS and WHS stakeholders done in phase 1 are discussed and presented in relation to views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS within a PHC context in the Limpopo Province. Different participants and methods of data capturing were used to ensure triangulation for validity. The data collection process was carefully guided by the central broad question:

*How can we integrate IKS in the management HIV & AIDS within the PHC context in the Limpopo Province?*

The researcher incorporated the reflection of field notes and individual cues within the discussions to reflect the true picture of the lived experiences of all participants about their views and perceptions regarding the integration of IKS in the management of HIV & AIDS as well as finding ways through which this integration could be realized within a PHC context in the Limpopo Province. The flow of the discussion was governed by the outcomes from the data analysis exercise.

### 3.2 An Overview of the Interviews

Participants who met the criteria described in Chapter 2 were allowed to participate in the research. Participants were heterogonous in nature and included both males and females, educated and uneducated. Marital status was of no significance in this study as it had no

direct effect on the quality of the data that was collected. The researcher followed Tesch's eight steps of data analysis in order to come to the final conclusion of the findings (Creswell, 2009:186). Table 3.1 provides a summary of the profile of the participants.

### **3.3 Discussion of the Findings**

Three main themes emerged from data analysis process, namely:

**Theme 1:** *IKS stakeholders expressed challenges experienced in dealing with marginalization and being looked down upon by their counterparts (WHPs).*

**Theme 2:** *IKS stakeholders reflected a need for WHPs to have an understanding regarding the differing diagnosing and healing strategies of IKS.*

**Theme 3:** *Stakeholders expressed issues to be dealt with to ensure effective integration of IKS for quality management of HIV & AIDS.*

The summary of the themes that emerged as well as categories and sub-categories with accompanying extracts from the data in relation to the participants' perceptions regarding the integration of IKS in the management of HIV & AIDS within a PHC context in the Limpopo Province are discussed as summarized in Table 3.2. Each theme is discussed in the context of its categories and sub-categories, with emphasis or inclusions of the participants' sentiments coupled with relevant literature control.

#### **3.3.1 Theme 1: IKS Stakeholders Expressed Challenges Experienced in Dealing with Marginalization and Being Looked Down Upon by Their Counterparts (WHPs)**

The general perception regarding IKS was that most participants strongly indicated that there is a scientific lens that is used to validate WHS and its practising professionals using qualifications and specializations which are termed scientifically based and technically grounded.

**Table 3.1:** Profile of the participants

No.	Age	Gender	Qualification	Type of Practice	Years of Practice	Ethnicity
1	51	Female	Honours in African Languages	Lecturer / IKS	13	Northern Sotho
2	66	Male	Masters in African Languages	Retired lecturer / traditional healer	15	Venda
3	60	Male	National Diploma in Agriculture & Forestry, herbalist	Agriculturist and herbalist, part-time practicing	>20	Venda
4	55	Male	Traditional healer	Traditional healer	20	Venda
5	50	Female	Traditional healer	Traditional healer	10	Tsonga
6	35	Female	Traditional healer	Traditional healer	3	Venda
7	40	Female	Traditional healer	Traditional healer	4	Venda
8	45	Female	Traditional healer	Traditional healer	7	Venda
9	45	Female	Traditional healer	Traditional healer	15	Venda
10	66	Male	Masters in African Languages	Chair of Vhembe Traditional Healers' Forum, Traditional healer	15	Venda
11	51	Female	Masters in African Languages, LLB	Acting HoD, IKS Unit & Lecturer, Anthropology & IKS curriculum developer	13	Venda
12	65	Male	Traditional healer	Traditional healer	?30	Venda
13	75	Male	Traditional healer	Traditional healer	25	Venda
14	70	Male	Traditional healer	Traditional healer	40	Venda
15	51	Male	Traditional healer	Traditional healer	4	Venda
16	56	Male	Medical Doctor & Traditional healer	Practicing both professions	23	Venda
17	51	Male	Pharmacist & Traditional healer	Practicing both	22	Venda
18	30	Female	Medical Doctor	Practicing GP	5	Venda
19	45	Female	Pastor	Lead pastor	6	Venda
20	55	Male	Pastor	Lead pastor	17	Venda

Table 3.2: Themes, categories and sub-categories that emerged from the data analysis

Themes	Categories	Sub-Categories
1. IKS stakeholders expressed challenges experienced in dealing with marginalization and being looked down upon by their counterparts (WHPs)	1.1 IKS practices marginalized	1.1.1 Disregard for IKS practices
		1.1.2 Bias towards WHS
	1.2 IKS practitioners highly stigmatized	1.2.1 IKS cognitive injustice
		1.2.2 Miss-identification of traditional healers
2. IKS stakeholders reflected a need for WHPs to have an understanding regarding the differing diagnosing and healing strategies of IKS	2.1 Acknowledgement of ancestral powers in healing	2.1.1 Ancestral healing powers and languages
		2.1.2 Indigenous healing space is highly contextual
	2.2 Acknowledgement of healing powers from God	2.2.1 Power of faith and prayers as a method of healing

Continued/...

Table 3.2: Themes, categories and sub-categories that emerged from the data analysis (continued)

Themes	Categories	Sub-Categories
3. Stakeholders expressed issues to be dealt with to ensure effective integration of IKS for quality management of HIV & AIDS	3.1 A need for a multi-disciplinary approach to HIV & AIDS management	3.1.1 HIV & AIDS is a global challenge
		3.1.2 Mutual respect and understanding
		3.1.3 Collaboration through referral system
		3.1.4 Collaboration through research
	3.2 Training needs on IKS matters	3.2.1 Training on IKS medication
		3.2.2 Training on self-medication
3.2.3 Proper and formal packaging of IKS knowledge		

This precept contributed to the marginalization and stigmatization of IKS and its practitioners and created a serious bias towards and disregard for IKS practices and practitioners. The whole scenario tempered with the open access and utilization of IKS by their clientele/consumers. Emanating from the WHO definition of non-conventional medicines (NCM), in Mpinga, Kandolo, Verloo, Bukonda, Kandala and Chastonay (2013: 45), NCM refers to ‘different practices, methods, knowledge and beliefs in health which imply the utilization for medical purposes of plants, animal parts and minerals, spiritual therapies, techniques and manual exercises, applied either individually or in a combination to look at, to diagnose and to prevent the diseases or to protect the health’.

There is a clear indication of differing methods of practice and cures compared to WHS practices, hence a deeper understanding of both systems is needed. Mpinga et al, (2013:45-46) outlines the fact that in developing countries where there is little access to the services and programs of modern medicines, NCM constitute the only most available and accessible health services for people in need of care. IKS stakeholders expressed challenges experienced in dealing with marginalization and being looked down by WHPs and two categories emerged:

- ✦ IKS Practices marginalized
  
- ✦ IKS practitioners highly stigmatized

### **3.3.1.1 Category 1.1: IKS Practices Marginalized**

Participants indicated a great concern about the way they are regarded by WHPs and they had the following to say regarding marginalization. One renounced traditional healer who is also an academic indicated:

*“The problem started when western medicine came to South Africa, traditional medicine was stigmatized, not acknowledged and highly*

*marginalized this makes us to work from different platforms. It is time for us to work together from common or equal grounds to avoid the clients from visiting us in the night or travel to a different or far area for help which makes it difficult due to transport logistics as a result of fear of victimization. They call you names such as heathen when they discover that you visit Inyanga/Nanga”*

With a smile and nodding of his head, he further said:

*“This is the only way we can go, herbs are part of us—why are they regarding them as evil, why do we say it’s practising witchcraft, why are we not respected as professionals who have knowledge on herbs and how to use them? According to my understanding I think doctors must also acknowledge and accept that THs exist and will continue to serve their people with all their strength”*

According to Ocholla (2007:3), marginalization of IK refers to ‘exclusion a state of being left out or insufficient attention to something for example IK’. This is conclusively what most participants indicated in terms of their practice being marginalized and looked down upon by WHPS. The findings are in agreement with Richter (2003:26) who indicates that for decades of colonialism, cultural imperialism and the power of the multinational pharmaceutical industry, both TH and TM have been severely marginalized and their value to their communities also seriously underplayed.

Sub-categories that emanated from this category were:

- ✧ Disregard for IKS practices
  
- ✧ Bias towards WHS

### 3.3.1.1.1 Sub-Category 1.1.1: Disregard for IKS Practices

Participants indicated the way their practice is disregarded and hated by WHPSs without even considering the fact that patients are now forced to consult THs secretly.

Traditional healers explained:

*“The problem is that herbal medication or traditional healing in South Africa is not taken seriously and side-lined so badly and hated highly by western practitioners, especially by medical doctors because they think we will take their clients”*

*“Yeeeeeeeees it’s all about fighting for customers, but this will not help them. The only solution is for them (doctors) is that they themselves are from the same background of traditional medical help if they are true Africans. Their mothers used herbs to feed, protect and treat them when they were still young. People do not know that people with HIV & AIDS trust us more than their families; most of them come to me, maybe because I am young and I look very thin maybe they think I have the disease. It is very true that we need to work together because doctors think we know nothing and our medications are dangerous. I know what to give a child and what to give an adult. I think if we start appreciating one another it will be better, because what I know doctors hate us and I don’t hate them because when I got my child I went to the hospital and not to the TH, because we THs are no longer delivering babies we also prefer the hospital because after delivery there are some injections that are to be given to the child and the card to be opened”*

*“You will be amazed some patients come to me because some nurses whisper to them to seek us THs in case they see that the illness is not getting any better through the use of western medicine, but they tell patients to ask for discharge and not to mention them (nurses) that they are the ones that advised them”*

Ganyi and Ogar (2012:31) affirm that herbal cures or practice of medicine in traditional societies is often viewed with mixed feelings, yet it has its own history of achievements in bone setting, exorcism as well as its therapeutic cures. Ganyi and Ogar (2012:31) further indicate that in most traditional African societies the practice of any medicinal cures outside orthodox medicine is often associated with witchcraft, necromancy or other derogatory associations that are worthless to mention in so-called civilized society. This shows how far IKS has been mislabeled and disregarded.

Mbatha, Street, Ngcobo and Gqaleni (2012:1) substantiate that THPs play a very significant role in South African health care, however; the *Basic Condition of Employment Act* (75 of 1997, section 23 sub-section 2) does not consider sick notes issued by THPs to be valid. This is a clear indication that a lot still needs to be done to ensure recognition of THPs role within the health care system regarding choice of health care by clients and patients whose right are said to be protected by the *Constitution of the Republic of South Africa Act* (108 of 1996, Chapter 2).

### **3.3.1.1.2 Sub-Category 1.1.2: Bias towards WHS**

Most participants indicated that WHPs are biased in terms of their ways of looking at THPs and its effect, to a point where one renowned IKS scholar and a practising TH indicated that:

*“We are usually not acknowledged by western medical practitioners because they say our things are not scientifically based. We are so undermined that this attitude will make us drift apart and will affect the client at the end of the day . . . I am saying the problem is the differing in criteria or yardstick, like for example, those of us who are fully qualified are not allowed to openly treat the patients (our patients) or even visit them in the hospitals because they are not certified, I mean they do not have qualification certification. The only problem is when nurses and doctors tell our patients not to visit us and not to take our medicines saying they*

*are poisonous, hey .... I don't understand, because, they were born using these medicines, but now they pretend they do not know that ... It's amazing"*

Another concern expressed by IKS stakeholders was that many people regard WHS as the best option for dealing with HIV & AIDS as indicated by some participants:

*"There is a wrong belief that when a person visits a doctor, that is the only way that the person will be cured there are herbs that can be used which can be of good remedy to the sick person, herbs like 'Moringa' can be used . . . mhhhhhhh . . . I mean using herbs it's ok, there is nothing wrong with that I am also using 'Moringa' and I am not ashamed of that"*

*"Yes, it's very obvious because, western health system appears to be more re- garded as the best option. They belief that when a person visits a doctor, that is the only way that the person will be cured, and we know that diseases like epilepsy and mental illness western doctors will never heal them completely that is why people come to us with diseases that are said to be of no cure, like HIV & AIDS"*

Finkelman and Kenner (2010:309) define bias as a predisposed point of view. Ocholla (2007:3) indicates that during periods of domination by colonialism and apartheid, IK was a subject referred to in a negative or derivative manner, termed *primitive, backward, archaic, outdated, pagan, and barbaric*, and this demeaning reference did not create space for IKS integration with other forms of knowledge commonly referred to as scientific, western or modern knowledge.

### **3.3.1.2 Category 1.2: IKS Practitioners Highly Stigmatized**

There is a serious stigmatization of IKS because participants indicated that there are still issues that need to be dealt with before a mutual integration could be realized. The fact that the two systems are still continually running parallel to each other are clear indications that in most

instances IKS stakeholders and THPs are still experiencing issues which from the data analysis can be grouped into the following sub-categories:

- ✧ IKS Cognitive Injustice
- ✧ Miss-Identification of Traditional Healers

### **3.3.1.2.1 Sub-Category 1.2.1: IKS Cognitive Injustice**

Traditional health practitioners expressed their perceptions regarding how they are recognized by WHPs as follows:

*“People call us “witch doctors” instead of calling us traditional healers who use herbs or other means of healing processes and our clients are discouraged from coming to visit us, but they usually visit us secretly in the night for fear of stigma”*

*“The first thing that we need to deal with is the hatred that medical doctors and pastors have on us THs, they always talk bad about us that we cannot heal people and we do not have powers to heal. To my surprise, pastors also cannot heal all diseases and some of the members do visit us though they come in the night for consultation”*

*“Hey! you are bringing a difficult topic now. . . mmmmm, we are usually not acknowledged by western medical practitioners because they say our things are not scientifically based. We are so undermined that this attitude will make us drift apart and will affect the client at the end of the day. I mean our patients, our profession is highly stigmatized because from the western side they will say they were trained and from our side we hear a calling from the ancestral and we also work with extra powers from the ancestors, which is not believable by many people, but to my surprise people believe that there are powers from God or Jesus or someone”*

*One pharmacist who is also a practicing TH indicated that:*

*“Doctors and pharmacists like me should stop criticizing traditional medicine because that does not stop people from consulting, but promote them to consult in secret, hence makes it difficult to solicit previous medication used prior consultation”*

*“Usually when the clients have used the treatments from the hospital and are not getting any better they come back to us and when we ask how they used the medicines we gave them in the first visit, they usually look down and say they were forced to throw them away as these medications are poisonous and will damage their livers”*

*“Yes, I think is better to open to one another because even some Christians and pastors come to me when they are sick, but they usually tell me not to tell anyone that they visited me”*

According to Ganyi and Ogar (2012:1), an indication has been made that in most of our traditional African societies, the practice of medicine or medicinal cures outside orthodox medicine is often associated with witchcraft, necromancy or other derogatory associations that are not worthy of mention in so-called civilized society. The predominance of western medicine and the prevalence of literacy in most traditional societies have also tended to eradicate traditional medical practitioners (Ganyi & Ogar (2012:1). The authors further indicate that a holistic view to health or any form of ailment cannot be seen conceived of except in the context of inter-human and human-spirit relationship (Ganyi & Ogar (2012:1).

A community or persons who are recognized to be utilizing IK more often were supposedly inferior to those that practised the opposite, that is, they become stigmatized in simple terms (Ocholla, 2007:3). Furthermore, in order for an individual/community to be admitted into the so called ‘civilized’ or modern society, that individual/community had to abandon practising and using IK (Ocholla, 2007:3).

In a study conducted by AFSA (2010:10) within the Kwazulu-Natal Province, an example was given to the fact that WHPs become reluctant to help a patient if they found out that s/he has been in the care of THs before opting for biomedical help, and will keep questioning why the person went to the traditional healer and will eventually discourage the client from taking their traditional herbs or denied access to biomedical care. This clearly indicated the disrespect, discrimination and stigmatization of IKS by WHPs which is still inherent today. Furthermore, an indication was made to the fact that many Christians or 'professionals' because of the attached stigma consult THPs secretly, by consulting at night or sending people to collect the staff because they do not want to be seen entering the house of a THs (AFSA, 2010:10). In this study, the same accolade was made by one participant that pastors and Christians do consult THs, but secretly.

### **3.3.1.2.2 Sub-Category 1.2.2: Miss-Identification of Traditional Healers**

Most participants, as borne out by the quotations that follow, indicated that it is a common practice amongst health professionals not to recognize traditional healers as health care practitioners contributing to disease management:

*“Fully qualified traditional healers are not accepted due to the fact that they have to meet the criteria set by the other health experts, like, certification qualification which is western-based.”*

*“We get it from our clients when they go to the hospitals they are asked if they visited us (THs) and if they make a mistake and agree they will be shouted at and be told if they want to die they must visit those witches, I think this is not good, we are not witches, but healers and we know what we are doing, the we also want to help not to kill . . . this is not fair to us (shaking her head in disbelief).”*

*“People call us witch doctors instead of calling us healers who use herbs or other means of healing processes, and clients are discouraged from coming to visit us, but they usually visit us secretly in the night for fear of stigma”*

Stafford (2010:66) quoted Dr. Zhang, who has been a leader of the WHO Traditional Medicine (TM) programme for 20 years for continually maintaining her belief in TM and the importance of an integrative relationship between TM and Western medicine when she said ‘I was a barefooted doctor in a rural area for 5 years. I used herbs and acupuncture of the patients and I’ve seen it work. I have big hopes for traditional medicine because the people need it and it works. We need to do more research on its safety, efficacy and quality to ensure that the patient benefit’ (Stafford, 2010:66).

The researcher then concluded that challenges of marginalization and stigmatization of IKS as a practice, have created a greater gap between IKPs and WHPs to a point that a greater need has been realized from this study that calls for a renewed or better understanding regarding the different practices that are in co-existence within African societies to avoid them from competing or destroying each other.

A greater tension was identified amongst most THs during face-to-face interviews; hence the following theme is seeking to bridge the divide between IKPs and WHPs. Therefore, it is mandatory that all players in a health care delivery system begin to understand the differing in diagnosis and healing strategies of IKP in order for integration to be realized.

### **3.3.2 Theme 2: IKS Stakeholders Reflected a Need for WHPs to have an Understanding Regarding the Differing in Diagnosing and Healing Strategies of IKS**

Ganyi and Ogar (2012:31) further state that ‘the word’ in the healing process is seen as an appeal to a supernatural being who is summoned to the aid of the patient. The supernatural

force may be the supreme God or the traditional deities believed to be in control of human existence, for example, chants, invocations, incantation and exhortations (Ganyi & Ogar, 2012:31).

Regardless of the recognition of IKS and its practices by South Africa's release of the *Traditional Health Practitioners Act*, No. 35 of 2004, there are still a variety of obstacles that deny the greater use of traditional medicines and their roles which then limit their impact on global health as indicated (Mpinga et al, 2013:47). Grace, cited in Mpinga et al (2013:47) noted that the increasing endorsement of Complementary and Alternative Medicine (CAM) stands in contrast to the negative attitude towards CAM workforce by some members of the medical and other health professions, and by government policy makers.

Participants indicated a great concern regarding the fact that IKS practices are disregarded and also indicated that there is bias from people towards WHS as if it is the only system that provides authentic health care services. The researcher deduced from the views and experiences of IKS stakeholders that there is a necessity for integration of IKS to be fulfilled in that WHPs need to strive for a better understanding that IKS as a system that possesses differing ways and means to respond to human health and illness behaviours. The following two categories emerged from the data analysis:

- ✎ Acknowledgement of Ancestral Powers to Healing
  
- ✎ Acknowledgement of Healing Powers from God

### **3.3.2.1 Category 2.1: Acknowledgement of Ancestral Powers to Healing**

The researcher established that THs use powers from their ancestors following a certain pattern of operation, including the use of unique sacred language and actions during the

*“I am comfortable with working as a team with other healers because as a person i cannot heal all sicknesses and... mhhhhhh... the other thing that I think could help both of us to help our clients is to know what one can treat and what one cannot treat and then refer the client as early as possible to avoid unnecessary death”*

According to a study conducted by the AIDS Foundation of South Africa (AFSA) released in 2010 in relation to healing strategies, mention was made that THPs differ in their healing methods and it is evident that within the general population there is no shared understanding that can lead to distinguishing one type of practitioner from another, but only THPs seem to have adequate understanding to differentiate one practice to from the other. This is what is needed for WHPs to also start understanding this differing in the healing practice (AFSA, 2010:6).

The researcher deduced from the views and experiences of THs that most of them made emphasis that according to their calling and training there are certain things that matter regarding how diseases are handled for there are patterns of doing things, ascertaining meanings on the outcomes of the diagnostic processes as well as the use of certain utterances or languages in order to allow the ancestral involvement in the healing process. This brings us to the fact that indigenous healing and its spaces will continually be contextual in nature as expressed by most participants.

### **3.3.2.1.2 Sub-Category 2.1.2: Indigenous Healing is Space Highly Contextual**

One participant who is an anthropologist and IK specialist reflected the following:

*“Traditional healers provide a client-based personalized health care, that is culturally appropriate and tailor made to meet the needs and expectations of patients. In other words, the patient is warmly embraced and the approach is welcoming because the approach is mostly related to the*

*natural surrounding like, weather, harvest and rain or the sun as a way of greeting which is done in a relaxed manner and thus creates a conducive environment for healing to take place”*

*“By looking at the two approaches to ill health, IKS looks at the totality of the problems of its client because part from the symptoms that are seen it goes deeper into looking and the spiritual influence and the social influence to the disease like if there is hatred or witchcraft related to the sickness and protect the client; whereas western medicine only operates from a shallow base and fails to get into the deeper base of originality of the person in seeking solutions to holistic cure”*

*“The clients are surrounded by people they know (full family support) starting from the family members choosing a TH and then accompanying him or her to the traditional healer who operates from a contextual environment of a home,.....Mostly they are accompanied by their parents especially grannies”*

The contextual nature of IKS practices has been also affirmed by Mpinga et al (2013:46), when distinguishing the three theories regarding the extent at which NCM are utilized within our societies showing as well its uniqueness as a system as indicated by:

- ⌘ Dissatisfaction of patients who have experienced the downside of conventional medicines, finding them sometimes ineffective, impersonal, overly high-tech and expensive;
- ⌘ Personal control by patients who resort to alternative medicines because they find them less authoritarian and more participative;
- ⌘ Philosophic congruency, that is, alternative medicines are attractive because of their compatibility with the spiritual of philosophic world’s representation of health and disease (Mpinga et al, 2013:46).

It has been indicated in the study conducted by AFSA (2010:10) that THPs provide a holistic approach by looking at the whole person when making treatment judgment within the whole family unit, in contrast to the individualistic symptomatic approach employed within the biomedical field.

### **3.3.2.2 Category 2.2: Acknowledgement of Healing Powers from God**

The Merriam-Webster Online dictionary (<http://www.merriam-webster.com/dictionary/prayer>) elaborates that prayer is an act of communication with God it is speaking and listening to God, in other words, a conversation with God and is a temporary break from material pursuits to engage in personal introspection. Participants expressed the fact that for a person to be healed, healing powers and exercise of faith should be acknowledged as a method of disease intervention. One sub-category emerged from this category through data analysis.

#### **3.3.2.2.1 Sub-Category 2.2.1: Power of Faith and Prayers as a Method of Healing**

The following are examples of responses from pastors in this regard:

*“Prayer is very important. I feel like the church is not doing enough, I feel that if the pastors and churches can hold hands as it is stated in the bible, if I am not mistaken that... ‘If my people, who are called by my name, will humble themselves and pray and seek my face and turn from their wicked ways, then I will hear from heaven, and I will forgive their sin and will heal their land.’ [2 Chronicles 7:14, <http://biblehub.com/2chronicles/7-14.htm>]. If the land is healed, even our bodies are healed just one day fasting prayer according to provinces”*

*“In most of my services, praying for the sick is one of the five-fold ministries of Jesus Christ that we most pastors do in most of our Sunday services and miracle services”*

*“Most of the HIV-positive members disclosed to me and I give them special prayers when they are in need of it. With the matter of integration this is a good idea as long as doctors could acknowledge that they are also given the wisdom by the same God to heal the sick—the only difference is that they use medicines and operations and we use the healing power from the stripes of Jesus through prayer and exercising faith”*

*“When my members are admitted or sick at home we have a team that goes to offer prayers and they get healed through prayers”*

According to Baldacchino (2010:23-25), spirituality refers to the part of man which seeks to worship someone or something (God) outside his/her own powers. Again, spirituality is a dynamic creative force that keeps a person growing and changing as well as finding meaning, purpose, fulfillment in life, suffering and death and foster hope regarding one’s will to live. Baldacchino (2010:27) further describes the characteristics of spirituality and divine healing in four dimensions, which are highly related to the power of believing God for healing during times of illnesses and diseases, especially conditions like HIV & AIDS for which there is not yet a cure in the medical health systems. The four spiritual dimensions (Baldacchino, 2010:27) referred to above are:

1. **Unifying life force:** here the spiritual dimension is described as the dynamic, unifying, integrative and creative force instilling hope, inspiration and motivation towards change.
2. **Wholeness:** the spiritual dimension unifies all aspects of the human being, namely, the bio-psychosocial component, making a holistic person.
3. **Connectedness:** a relationship with self, others, higher power/God and the environment may lead to a harmonious life in times of distress.
4. **Self-transcendence:** in this dimension an individual goes beyond the self in search for some higher powers/God for divine intervention. Looking at these dimensions of

spirituality and faith many HIV & AIDS clients/patients are sustained and acquired hope to life and healing through the supernatural power of God.

Again in the book of Matthew, Chapter 4:23, the bible says: “And Jesus went about all Galilee, teaching in their synagogues, preaching the gospel of the kingdom and healing all kinds of sickness and all kinds of diseases amongst the people.” This theme focused on paving a way for IKS stakeholders and WHPs to create a working platform through which they will be able to understand their differences, but have pivotal roles in rendering quality care to their clients in response to health and illness behaviours. From perceptions of IKS stakeholders, it was clearly discernible that there are still many issues that need to be dealt with to ensure effective integration of the two health systems.

### **3.3.3 Theme 3: Stakeholders Expressed Issues to be Dealt with to Ensure Effective Integration of IKS for Quality Management of HIV & AIDS**

It is of paramount importance that Ministries of Health, globally and in South Africa, in particular, with its players in health service delivery, begin to embrace the transformative process of acknowledging the presence of IKS as a health system that is forming part of health care delivery systems. In November 2008, participants of the first-ever *World Health Organization Congress on Traditional Medicine (TM)* adopted the *Beijing Declaration* which promotes safe and effective use of TM, while guiding and supporting its integration into the national health care systems around the world (Stafford, 2010:64). The declaration suggested that all governments of WHO member states, South Africa included should:

- ✎ Respect, preserve, promote and communicate widely knowledge of TM, treatment and practices;
- ✎ Be responsible for the health of their people, formulate national policies, regulations,

and standards within the national health system to ensure appropriate, safe and effective use of TM;

- ✧ Integrate TM into national health systems;
- ✧ Further develop TM, based on research and innovation in line with the ‘Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property,’ adopted at the 61st World Health Assembly in 2008; and
- ✧ Establish systems for the qualification, accreditation or licensing of TM practitioners;
- ✧ Strengthen communication between conventional and TM providers and establish training programmes for health professionals, medical students and relevant researchers.

There is a clear indication that a need exists for IKS and WHS to be integrated as indicated by many participants. The following categories support this theme:

- ✧ A need for a multi-disciplinary approach to HIV & AIDS management
- ✧ Training needs on IKS matters

A detailed discussion on these categories follow.

### **3.3.3.1 Category 3.1: A Need for a Multi-Disciplinary Approach to HIV & AIDS Management**

Participants expressed the need for a multidisciplinary approach to HIV & AIDS management.

One participant had this to say:



*“Basically let’s start by saying we are Africans born within the system of African tradition and cultural practices. For me this is who we are and that is why I do not see any problem for the two systems to work together, interchangeably, as long as the needs of the clients are met. If we look in other countries, for example, Ghana, Nigeria, Tanzania and Korea as well as China, all attempts are made to collaborate the two systems unlike what South Africa is doing. We pretend like indigenous health practice does not exist and that is a lie because even some of my clients prefer both of my interventions”*

The following sub-categories supported this category:

- ✎ HIV & AIDS is a Global Challenge
- ✎ Mutual Respect and Understanding
- ✎ Collaboration through Referral System
- ✎ Collaboration through Research

### **3.3.3.1.1 Sub-Category 3.1.1: HIV & AIDS is a Global Challenge**

When asked if integration is necessary in the management of HIV & AIDS, participants indicated a deeper understanding of IKS and HIV & AIDS management as a global challenge, as exemplified by the following quotations:

*“My views and perceptions regarding integration of IKS in the management of HIV & AIDS rest upon the fact that HIV has now become a human, social and economic disaster that has become the leading cause of death in Sub-Saharan Africa that is threatening to destroy the fabric of society”*

*“Yes, I think even the stigma that comes to people who use us will fade away because we will be regarded as part of the team that is working together in order to help our patients”*

*“The HIV pandemic is no longer an individual responsibility, but has become a national issue which needs to be tackled with utmost urgency. There has to be a move to integrate Western and traditional medicine to reach a common goal of finding a cure for HIV & AIDS”*

The researcher concluded that participants intimated that HIV & AIDS should not only be perceived as a local challenge, but should also be viewed from the global point of view. Mpinga et al, (2013:46) affirm that the use of NCM is now a global initiative, hence a need for benchmarking. The authors further indicate that in China, traditional preparations from plants represents 30-50% of the total medicine consumption, whereas in Ghana, Mali, Nigeria and Zambia, the initial treatment for 60% of children suffering from high fever due to malaria is the use of healing plants administered at home.

The WHO (2002-2005:9) also reported that 80% of the African population resorted to traditional medicines, with most countries still receiving care from traditional midwives who appear to be attending to most of their births. Furthermore, in Europe, North America, and other industrialized regions, more than 50% of the populations received help at least once from alternative medicine. In San Francisco, London and South Africa, 75% of people living with HIV & AIDS seek help from traditional, additional, or parallel medicines, while 70% of Canadians have sought help at least once from NCM at some point in their life (WHO, 2002-2005:9).

The Department of Science and Technology (DST) and the National Science and Technology Forum (NSTF) held a workshop on the 14th and 15th of July 2011, in Pretoria, and many IKS challenges, opportunities and the way forward were deliberated and recommendations

were made. The DST alluded that the IKS concept should not only be located within African traditional communities, but within the IKS of all the indigenous communities of the world, bringing an understanding that IKS is universal and not only an African issue and should be interpreted in terms of the modern physics and the bio-economy (DST, 2011:34). The researcher fully agrees with Richter (2003:23) who indicated that THs make a unique contribution that is complementary to other health care approaches and have been a point of entry for care in many African communities that made them to gain respect among the people they serve.

The researcher affirms the findings regarding bridging science and development together through news and analysis, that for the two systems to work together in harmony on a larger scale, we need a global effort to breakdown the legal, regulatory and conceptual barriers that support the promotion of modern medicine at the expense of traditional practices(<http://www.scidev.net/global/systems/editorials/the-imperatives-for-traditionalmedicine>). Also, wendeman et al, (2013:1324) gave an indication that studies of people living with HIV & AIDS (PLWHA) across cultures demonstrated diversity of needs and the importance of tailoring interventions to personal and cultural contexts.

### **3.3.3.1.2 Sub-Category 3.1.2: Mutual Respect and Understanding**

This study is indicative of the fact there has to be a move to integrate Western and traditional medicine to reach a common goal of finding a cure for HIV & AIDS and also for maintaining and sustaining health of the infected and affected. It is time for both health systems to depart from a mutual form of understanding and mutual respect in order to close the divide that exists between them. The researcher discovered that most IKPs and experts are very comfortable with WHPSs and do not have a problem with regard to their practice. On asking one well-known traditional healer about this aspect, he said:

*“I don’t have a problem with integration because according to me I take treatments and also use my herbs, I don’t have a problem because even now that I am still alive is because I am under doctors as well as under herbs of this world, the two do not fight with each other”*

*“I am talking about what I passed from, I once left here, and visited one of the hospitals here in Venda (without mentioning the name) because I was worried. Then I met one nurse and said I am here because I have some news, then I said I was asking if I can be given one patient especially one of the newly diagnosed with HIV, if it is possible so that I can be with the patient for the whole week treating them, and Sunday. . . Sunday they can come to be tested to see the progress then another week with me and then tested again on Sunday so that I could see if it is true that they do not heal with my herbs. . . then the nurse went inside where I do not know where, then she came back and said it is not possible because when the person comes here s/he cannot go to any other place again, then I realized that it is just pure jealousy then I said hey. . . let me go my way everyone will operate the way he wants whoever needs my help will come to me”*

*“For a very long time Western medicine has been trying to get a cure but in vain, therefore, the issue of including traditional medicine needs to be also explored. In other words, traditional healers’ role in the management of HIV & AIDS should be explored. It can be positively said that if contextualized properly both modern and traditional healing methods are valid and, as such, can complement each other”*

*“There is a great need to integrate the two systems because all are operational within and across our clients and instead of shooting each other it’s time to join hands and begin to forge ways towards getting a cure for the disease”*

Another TH indicated the need for mutual respect in this way:

*“I agree that some patients are dying in the house of TH even if death does not knock but if a person is getting serious anyone can see*

*it so I think even ambulances must be allowed to come anywhere including to the traditional healer's house to collect the patient to the clinic or to the hospital without the TH not fearing any victimization by the health personnel"*

*"I do not have a problem to work with doctors and nurses, because like for instance I do not help women to give birth though in our training we are taught how to deliver women 'musi nowa i tshiluma' (during labour pains), this is easier in the hospital, especially now that touching blood is a problem because of the fear of contracting HIV. Remember we THs do not use gloves as gloves are a sign of unkindness to the client and the client will not trust you"*

One TH when asked if she can cure HIV & AIDS, said:

*"Not really, but all my interventions supplement each other and so far just like the medical intervention we are all still seeking the complete cure of the disease. So far I have herbs that I use regarding increasing the immunity system and also give them strength and cure other opportunistic infections like diarrhoea, sores, body weakness and others"*

*"According to my understanding I think doctors must also acknowledge and accept that THs exists and will continue to serve their people with all their strength"*

*"The only other way is to start respecting the two systems as well as also allowing the clients to take their own decision in choosing which way do they want to solve their illnesses without prejudicing them or side-lining them"*

*"They are starting to come to me of late, but I usually tell them to continue their treatments that they got from the hospital together with my herbs."*

*"The only problem that is dividing us is that the so-called Western doctors do not appreciate our work, in fact let me be open, we are highly*

*undermined, but I am not worried because my patients are still coming to me nevertheless, but I wish one day we can see each other as doctors, but working differently due to our callings that are not the same”*

*I don't know why doctors tell our patients to throw away our medications when they are not even sure how bad they are.*

One participant who expressed a sense of discouragement regarding mutual understanding had this to say:

*“I am not sure whether that will work because we (THs) are hated and our clients are shouted at when they indicate that they are from us, and this makes them to lie that they do not visit us or use our medications. According to my knowledge all pills are coming from the herbs is just that they are now looking different”*

*“Yes. . . like I indicated, we need to love each other and we need to respect each other”*

One participant when asked about how she found out that doctors hate THs, said:

*“We get it from our clients when they go to the hospitals they are asked if they visited us (THs) and if they make a mistake and agree they will be shouted at and be told if they want to die they must visit those witches. I think this is not good, we are not witches, but healers and we know what we are doing, we also want to help not to kill . . . this is not fair to us (shaking her head in disbelief)”*

Mpinga et al, (2013:44) indicated that knowledge, products, and practices stemming from NCM began to receive some international recognition during the 1970s under the *WHO International Drug Monitoring Programme*. Interest in these medicines grew with various developments and, in 2002, WHO adopted a world strategy to facilitate the integration of traditional medicine into health systems. This initiative was followed by a strong political

mobilization with training programmes in faculties of medicine, centres of research, and international meetings to a point where Africa in particular declared an ‘annual day’ dedicated to these forms of medicine (Mpinga et al, 2013:44-45).

### **3.3.3.1.3 Sub-Category 3.1.3: Collaboration Through Referral System**

There is a general feeling that both systems need to consider working in collaboration with each other as this parallel existence is affecting the common client in need of care from either one or both of them concurrently or alternatively. Effective communication should be ensured for clear interactive lines between both practitioners to ensure effective referral processes, as expressed by most participants:

*“There must be a way where we THs can transfer our clients openly because when we send them to the hospital or clinic we tell them not to say they are coming from us because they can be victimized by both nurses and doctors”*

*“Of course I do send people to the hospital for HIV test because we THs do not have machines to test it but we hear from radios that people with sores must be tested”*

*“It is time that we share the client from equal grounds through referral where one refers the client to the other according to diseases that the client present with, let us not all claim we are jack-of-all-trades, we are all important to the client”*

*“I believe that all of us (THs and pastors) should agree that if a person does not have blood or water s/he cannot do anything, the only way we can help the client is to refer the client to the hospital to avoid unnecessary deaths. I don’t keep a person who does not have water in the body, I usually tell them to go to the clinic or hospital for a drip (intravenous infusion) then when they are strong they can come back for me to do my part. I usually refer them to the hospital if they are weak and showing*

*lack of blood. It's easy to see a person who is not having blood by looking at their eyes"*

*"People must stop hiding when coming to us (THs), doctors must accept us and start acknowledging that we can work together through referral and we will also do the same. We must work together as a team"*

*"These two systems can work together with ease, depending on the client if s/he can understand because like me when a person come to me I do ask them if they had gone to the doctor or hospital because at times the client could be lacking water or blood or maybe having either cancer of the bones or other things. I do that especially I also ask them if they checked for 'Dwadze lihulwane' (HIV in Tshivenda language) even though they may say they were checked and even when they are positive they will never agree that they are positive, even though they did test. And usually I insist for them to be checked because I usually see the symptoms that is related to HIV they usually say I have been checked and nothing was found, but later you will still see the client getting severe and worse to a point where some die, that is how I conduct my practice"*

*"This is what I am indicating that you can drink both treatments, remember herbal medication and pills do not fight it's us that are making them fight saying this is right this is not right. It is not right to say when you are using herbs you are not supposed to drink your tablets, let me give you an example if a person comes to me with high blood or sugar I will give them my medication and instruct them not to stop their medication"*

In most instances some doctors create their own lines of communication with individual THs in case they suggest another intervention or they secretly advise the family or the patient on seeking prayers from their pastors if the situation is getting unpredictable. Participants responded as follows:

*"It is time that we share the client from equal grounds through referral where one refers the client to the other according to diseases that the client*

*present with, let us not all claim we are jack-of-all-trades, we are all important to the client”*

*“After all we are serving similar clients, and most of the clients including health professionals usually visit us secretly especially in the night”*

*“There are diseases or symptoms that must not be ignored when we (THs) see our clients that we need to transfer to the hospital; when a person is having the signs of HIV as I know some of them, he must first go to the hospital then come back for me to do the necessary rituals if it’s necessary”*

One traditional healer when asked if it would be acceptable for him to receive patients that were transferred from the hospital, he nodded and said:

*“Of course, you just don’t know most of the people I am treating are coming from the hospital”*

*“People must stop hiding when coming to us (THs), doctors must accept us and start acknowledging that we can work together through referral and we will also do the same”*

Another traditional healer shared the same sentiment that he finds it very easy to refer to other powerful healers or a medical doctor, according to the nature of the ailment the patient present to him:

*“Oh yes. . . I am working with one young Venda medical doctor, who works very well with me; he is having a surgery in Mpumalanga. When I assess patients and I am told not to treat them I refer them to him and in case he sees people and think he cannot handle them he brings them to me and sit in the car while I am helping them and go with them when I am done, we have been working together for some time now”*

*“I also work hand in hand with three pastors, but one of them passed on. If I am told to send a patient for the pastor to pray for them I do so and the very pastors also do the same when they think I will best help the client. I think we as THs cannot heal all diseases. I also refer clients to other THs when the condition is not under my capabilities”*

*“At times even when a person has terrible sores and cannot eat well it’s better for the person to be referred to the hospital where they will give him a drip of water and also of food. . . mmmm they know how to do it”*

One IK academic expert eluded that:

*“The model that should be developed should include the influences that are governing the health behavioural systems of individuals who are affected and infected with HIV & AIDS which includes visiting a doctor, a THs as well as spiritual healers (pastors)”*

*“The referral part of the model should be governed by (i) the perfect skill of history taking of patients; (ii) total listening skills (avoidance of a tendency to practice selective listening, diluting the story to suit the medical parameters of disease assessment as well as portrayal of a non-judgmental attitude); (iii) cultural relativism (understanding client’s cultural context and believe system as it is presented); and (iv) individual free will or decision to further consult either a doctor, a TH or a pastor”*

*“There should be a guideline or a structure that is developed and formalized by government, which will allow free flow of clients to the area of their preference without fear of victimization by health professionals. There should be community engagement workshops where clients could be able to voice out their frustration regarding their disregarded and stigmatized choices to see us as they indicate to us when they consult. Communities must be taught about the common practices that could be done at home without even coming to consult any of the practitioners by just using nutritional herbs and common medicinal herbs”*

*“Like I indicated before, I think integration is needed only if we as THs are accepted because the only problem I am seeing is not with our clients it is basically with Western practitioners who continually poison the client saying we will kill them. This is pure undermining. . . I think we need to collaborate I mean work hand in hand”*

*“Traditional healers and Traditional practices or operation as far as I am concerned cannot be transferred to a common area like hospitals or clinics as our spirits do not prefer any space of operation, this mean that it will be difficult for us to operate in the same space with the Western Health practitioners”*

Some THs indicated difficulties in working from the same area with Western health practitioners saying:

*“I don’t see any problem as long as I am practising from my home, we THs cannot connect with our ancestors in any place like a hospital, hey no. . . no. . . no. . . no, it cannot work!”*

*“Yes. . . because I connect well to the ancestors when I am in my consulting room. The hospital and clinics are having smells that I cannot stand even when I am visiting my relatives I keep on belching continuously because of the smell that is why I say it will not be possible, but I will continue to refer patients to them (Western practitioners) when a need arise”*

Mulaudzi (2001:19) indicates that mutual referral could be a possibility if practitioners from both systems could start creating a climate that would allow respect for each other’s uniqueness and competency through proper training by institutions of higher learning. A referral system that involves communication between patients, traditional healers and medical practitioners is the best way to provide quality care based on future consensus and mutual understanding by all health practitioners, rather than continuous unilateral validation of WHS as eluded by Ben-Arye and Frenkel (2008:235-236).

Mpinga et al, (2013:48) indicate that collaboration between traditional medicine and WHS could facilitate and encourage a transfer of patients between the two systems. Mulaudzi (2001:19) pointed out that mutual referral could only be achieved in a climate whereby people respect each other's uniqueness and competency.

The researcher shares the same sentiments with most participants and researchers that the only difference in the referral process done by TH is that they use the word of mouth not a written referral like WHPS, this is affirmed by Ae-Ngibise, Cooper, Adii bokah, Akpalu, Lund, Doku and The MHAPP Research Programme Consortium (2010:564). Traditional healers and faith healers have a complex system of referral amongst themselves as they refer their clients through narrative means of communication which is to be taken into consideration in the integration of the two systems and *vice versa* as most THs cannot read or write.

#### **3.3.3.1.4 Sub-Category 3.1.4: Collaboration Through Research**

For indigenous knowledge generation, utilization and preservation, researchers and IK experts should embark on serious inherent knowledge documentation, taking into consideration the ethical and methodological issues associated in conducting research in local communities. The best method of doing research with communities is that of Participatory Rural Appraisal (PRA), which is highly relevant as it allows effective involvement of the local people in the research process (Freudenberger, 2013:8). This methodology applies traditional methods by which communities share information such as asset mapping. With this approach, researchers assist local people to record their own knowledge, using techniques which involve a minimum of outsider involvement in order for them to own their knowledge, identify with it and embrace it at all times. Researchers must always be sensitive to the issue of intellectual property rights during knowledge generation.

The researcher deduced a deeper concern with IK experts who participated in the study and who indicated a great concern that knowledge is being ‘stolen’ and used without their awareness or share in any economic benefits that may result from the development of related commercial products. This has been a worrying factor even during the time when the researcher conducted her Masters studies. Hence, it is of greater importance that consideration be given to a plan for protecting the knowledge that results from research initiatives. Participants expressed their views as follows:

*“If we want real collaboration, I think it is time we start working together, I mean recognizing each other’s capabilities, by sharing knowledge from all aspects by being transparent to one another, but I know with most of us (THs) this is a bit difficult as we must get permission from our ancestors first before we do anything, there should be promotion and protection of our Intellectual Property Rights (IPR) for all of us”*

*“I mean we (THs) are now adamant to give anyone our secrets and medicines because people are writing and using our things without acknowledging us at all. . . the other thing is unlike Western medicine, traditional healing skills can only run within families, that is one family and not from one family to the other”*

*“My advice will be for both systems to share ideas and embark on collaborative research to discover the cure and other ways of dealing with other communicable diseases. I believe, like I indicated, traditional healers know a lot of medicinal plants, it’s high time we do collaborative research with pharmaceutical companies, including THs who will also ask their ancestors and inquire further regarding the possible ways of dealing with HIV and TB, for example, so far I have herbs that I use regarding increasing the immunity system and also give them strength”*

Ocholla (2007:4) indicate steps that can be followed to ensure IKS generation as follows:

- ✧ IK has to be recognized, identified and selected from a multitude of other knowledges;
- ✧ IK has to be validated/affirmed by identifying its significance, relevance, reliability, functionality, effectiveness and transferability;
- ✧ IK should be recorded or documented and kept within a recordal system with high cognizance of Intellectual Property Rights (IPR) regarding IK access and use a database developed by the World Bank for South Africa, being an example to achieve and safeguard such knowledge (Ocholla, 2007:4).

### **3.3.3.2 Category 3.2: Training Needs on IKS Matters**

Participants indicated a possibility for THs to share knowledge regarding management of diseases, in particular HIV & AIDS, as borne out by the following quotations:

*“We must work together as a team. If they want to train us they must also be ready to be trained by us on the bases of how we operate and what we do so that we can treat our patients better”*

*“Ok, I mean we TH share our knowledge of some medicines that can be used for managing HIV & AIDS”*

Mpinga et al, (2013:48-49) indicated that valuing traditional health knowledge and practices remains a subject of interest of several national, regional or international authorities. The field of training regarding healing plants varies worldwide in 1998, 72% of United States Pharmacy schools offered instruction on healing plants, in South Korea a survey done between 2007 to 2010 showed 85% of their medical schools offered lessons on complementary or alternative medicines. In Europe 40% medical schools offered such teaching in 2006. In Africa, Akinola, cited in Mpinga et al, (2013:49) called for such instructions during basic medical training.

This category was corroborated by the following sub-categories:

- ✧ Training on IKS Medication
- ✧ Training on Self-Medication
- ✧ Proper and Formal Packaging of IKS Knowledge

### **3.3.3.2.1 Sub-Category 3.2.1: Training on IKS Medication**

Some IKP indicated that there is lack of knowledge regarding common herbs that could easily be accessed and used within communities:

*People should be informed about common useful herbs that can be used and they should be easily available in drug stores just like mmmmmm. . . for example, one can buy Panado or other drugs from the chemist for pain and headache because people have been taught that it works without visiting the doctor.*

*There is an international initiative which is not yet in South Africa which can also help in the management of minor illnesses, where a middle school can be started that is responsible for training of interested people on traditional or herbal medication and their use for treating some diseases, these are not traditional healers, but they could be called herbalists as they do not use spiritual powers to diagnose or treat their clients, they treat symptoms, I think these ones can operate anywhere in terms of space.*

### **3.3.3.2.2 Sub-Category 3.2.2: Training on Self-Medication**

Swendeman, Ingram and Rotheram-Borus (2013:1323) emphasize that chronic disease management requires that patients not only comply with physicians' instructions, but also assume an active role in decision-making, problem-solving, and implementation of a personalized treatment plan to become informed, activated patients in partnership with their

physicians. Swendeman et al, (2013:1326) further indicate that through the aforementioned cognitive processes, PLWHA will be able to monitor their physical functioning as well as make lifestyle adjustments like the use of condoms, avoiding shared injections and disclosing their status to their partners, and periodically receive feed-back of test results like CD4 counts from their physicians. The participants' responses in this regard are encapsulated below:

*“Communities must be taught about the common practices that could be done at home without even coming to consult any of the practitioners by just using nutritional herbs and common medicinal herbs”*

*“Yes, of course, some of these herbs we can even plant them at home so that when a child is sick with flu, you can get it from the back of the house”*

*“Western medicine they think they are the only ones who can tackle HIV, but it is not true, herbs are also part of the nutrients that boost immunity.”*

Swendeman et al, (2013:1321-1322) emphasize a need for PLWHA to shift from acute to chronic disease management with general emphasis on self-management by assuming the role of being a self-principal care giver, active and informed in managing own physical, psychological and social aspects of health in order to achieve improved health outcomes, which will also result in reduction of the burden on health system resources and capacities in hospitals.

### **3.3.3.2.3 Sub-Category 3.2.3: Proper and Formal Packaging of IKS Knowledge**

The researcher recognized that a gap still exists between the two health systems in question, due to lack of transparency. There is no clear communication amongst the two types of practitioners that is legally developed or stipulated to govern the terms and conditions of their interactions. One participant said:

*“Indigenous herbs should be easily available, e.g., can be planted around the house for easy use, drugs like ‘Moringa’ which is having many properties that can help an HIV & AIDS patient”*

The participant also indicated:

*“I also went to Google and searched for Moringa and found that it has many good nutritional as well as medicinal properties, and as I am speaking now I am using it and I am not ashamed of it”*

One herbalist, who has a vast knowledge about herbal medicine and also possesses a home garden for herbal plants, responded:

*“The society seems to have a fragmented knowledge about indigenous knowledge and processes that occur regarding disease causation and management”*

He indicated a need for this knowledge to be taught from individual homes, primary schools, secondary schools as well as in tertiary education level. When asked by the researcher how that will happen, he said:

*“IKS should be included in the health training curricula and parents should stop behaving like they are not real Africans, but something in between”*

*“The only best way for us to fully integrate is when we are fully recognized by our government, I mean not only on ‘paper’ (Act), but in partnership and practice. . . that is open. . . we need to also have a ‘voice’ as THs in policy making. The National Strategic Plan for illness (I think he is referring to the NSP for Health), is usually done excluding THs as stakeholders we are also dealing with things that need to be addressed by the plan”*

*“I mean we THs are now adamant to give anyone our secrets and medicines because people are writing and using our things without acknowledging us at all. The other thing is, unlike Western medicine, traditional healing skills can only run within families, that is one family and not from one family to the other”*

When asked if he could train a student in traditional healing if s/he is not family member, the respond was he responded:

*“No. . . I mean family traditional skills runs amongst the family that is from the father to the son or from the mother to the child, but only the chosen one”*

*“I think even us traditional healers we need to open up I mean to be open, I don't say we should tell people all that we do, but we need to start coming to the open and tell people that I am a traditional healer like a doctor or a pastor saying who they are openly. This will also remove the stigma that we have as traditional healers”*

Asked if he can share his IKS knowledge with other practitioners, one participant answered:

*“Hey. . . (with a serious look) I need to first ask my ancestors, but the challenge could be that with doctors their treatment is open to everyone yet with THs treatment is mostly a secret, one does not share easily with another healer neither can I trust the treatment advice that one healer tells me what about if he is lying and the treatment kills the client. Unless you are very close and have gone to a point of trusting each other. With us treatment is determined by our ancestors—they tell us what to use”*

*“Like THs of old they will be shown the treatment, but first eat it to see if it's not a dangerous one before giving the patient regardless of the number of people who are coming in that day every edible treatment given the TH will first lick it with his tongue to assure the patient and the family that it is not poisonous”*

Masoga and Musyoki (2001: iii) affirm that indigenous knowledge, technologies, practices and wisdom must be translated into tangible (material and non-material) gains for our communities. This will be a way to preserve the continuous unidentified loss of this body of knowledge. Ocholla (2007:9) also sustain the agenda of IK development and management through many strategies, for example:

- ✧ Through mapping and auditing IK capacity in Africa (e.g., health, agriculture and food, trade and tourism) and this should involve making people aware of IK policies, legislations and strategies, managing structures and existing IK programmes, including promoting research outputs.
- ✧ Legal and ethical issues in IK generation and management (IPR and policy legislation) to be taken into cognisance.
- ✧ Education and training issues (knowledge sharing seminars and workshops, short courses, IK market places, review of curricula for IK inclusion in all levels of student education.
- ✧ Protection of IK brain drain, that is, preserving IK from its organic custodians before they die, because one strong IK holder's death is the total disappearance of the community library that has no trace or through mere relocation of the individual for many reasons (Ocholla, 2007:9-10).

### **3.4 Summary**

This chapter aimed at providing deeper understanding of the outcomes of phase 1 of this study which included the outcomes of the qualitative data collection and analysis of the views and experiences of stakeholders regarding the integration of IKS in the management of HIV & AIDS within a PHC context in Limpopo Province, South Africa. Tesch's eight steps of data analysis were used and supported by quotations from the participants and pertinent

literature control. Findings were reported and discussed within the parameters of the views and perceptions of stakeholders who participated in the study in relation to the themes, categories and sub-categories that emerged from data analysis.

# CHAPTER 4

## CONCEPT ANALYSIS

### 4.1 Introduction

The previous chapter centred on the discussions of findings and literature control. The main focus of this chapter was to identify and define the concepts as they emerge from data analysis from stakeholders' views as well as the literature reviewed in relation to data analysis. The conceptual analysis outcomes are presented and discussed with a view to forming the foundation for model development. Furthermore, a concept analysis process has to do with dissecting the whole into different parts for better understanding. The central concept identified in this study is *Integration*.

### 4.2 Objectives of the Chapter

The objectives of this chapter were to:

- ✧ Define and analyze the concept “Integration”
  
- ✧ Present a graphic structure of the whole integration process, using the steps from Rodgers and Knafl (2000:45).

### 4.3 Method of Concept Analysis

According to Chin and Kramer (1995:74), concept analysis is defined as a ‘complex mental formulation of experience’ and a state that concepts are extracted from life experiences, clinical practice and/or research. Walker and Avant (1995:39) further describe concept analysis as a strategy to examine the attributes or characteristics of a concept through a rigorous process

of analysis. Ryle, cited in Rodgers and Knafl (2000:25, 83) define a concept as an abstracted feature of the world and is directly related to the ability to perform certain tasks. Ryle explains that a well-developed, clarified and elaborated concept can be viewed as the creation of improved ability and new ways to function effectively.

Looking at the outcomes of this study the driving wheel to the realization of an effective model is the manner in which integration will take place between WHPs and IKP which will bring about a meaningful integration to facilitate the management of HIV & AIDS within a PHC context of the Vhembe District of Limpopo Province in South Africa. The researcher used Rodgers and Knafl's (2000:77-100) eight steps as well as Walker and Avant's (1995:39) strategies for theory construction to analyze the concept. The following eight steps were used:

1. Identification of the concept of interest;
2. Identification and selection of an appropriate realm (settings/samples) of data collection;
3. Data collection of attributes of the concept along with surrogate terms, references, antecedents and consequences;
4. Identification of related concepts of interest;
5. Analysis of data regarding the above characteristics of the concept;
6. Conducting interdisciplinary or temporal comparison
7. Identification of a model case; and
8. Identification of hypothesis and implications for further development (Rodgers and Knafl, 2000:90; Walker and Avant, 1995:39).

For the purpose of this study, the researcher utilized only six steps out of the eight steps of concept analysis as listed by Rodgers and Knafl (2000:77-100) .

### **4.3.1 Identification of the Concept of Interest**

According to Walker and Avant (1995:40), identification of the concept reflects the topic or area of greatest interest. Furthermore, identification of the concept has to do with the researcher choosing the concept that actually describes the participants' experiences from data analysis or findings. The researcher's concept of interest was then selected as that which will facilitate the process of model development (Rodgers and Knafl, 2000:85-86). The researcher deduced from the data and was convinced that the common binding factor that will bridge the divide between WHS and IKS will be by creating a means towards integrating the two health systems in a way of bringing the current health system into a process of transformation to health systems development and strengthening. The researcher, therefore, was convinced that the term INTEGRATION is the relevant concept to this study. The researcher discovered that clarification of INTEGRATION was necessary in order to arrive at the conceptual framework to guide the development of the model.

### **4.3.2 Identification and Selection of the Appropriate Setting and Sample for Data Collection**

According to Rodgers and Knafl (2000:87-90) an appropriate setting refers to the time period to be examined and the disciplines or types of literature that have been included in the data analysis and discussions. The researcher's appropriate context that provided the space within which the study was conducted was the Vhembe District which is located within the Limpopo Province. Limpopo Province is composed of five Districts namely, Mopani, Waterberg, Capricorn, Sekhukhune and Vhembe. The Vhembe District occupies the northernmost part of the province closer to the Zimbabwe as described in Chapter 2. The

province is mainly populated by Venda and Tsongas and is mostly rural. The population included stakeholders as indicated in Chapter 1 of this study.

### **4.3.3 Data Collection of Attributes of the Concept along with Surrogate Terms, References, Antecedents and Consequences**

The researcher consulted a variety of literature material and discovered various definitions of the concept INTEGRATION from many schools of thoughts, including social sciences, education, business, information technology, health sciences and online search databases. This exercise was deemed necessary to obtain a deeper understanding of the concept in question. Throughout the definition and clarification process INTEGRATION came out distinctly, that is the stronger matrix in this study that will be able to promote the development of a functional integrative model that will enhance the integration of IKS in the management of HIV & AIDS within the PHC context in the Vhembe district of the Limpopo Province. Rodgers and Knafl (2000:9) describe this phase of concept analysis as the one that reflects all possible sources of concept clarification.

#### **4.3.3.1 Definition of the Concept Integration**

The researcher sought to further define and analyze the concept INTEGRATION as identified in Chapter 3 during data analysis and through literature control. Literature and other sources/materials were extensively researched in order to bring about the best understanding possible for concept clarity and its functionality in any given process. The researcher embarked on extensive definition of the concept INTEGRATION to clearly have a point of departure in concept analysis. Conceptual definition in this study created a roadmap towards the expected final outcome of an integrative model development that could be used in many sectors if contextualized appropriately. The researcher embarked on defining INTEGRATION as an identified concept that the study is revolving around from wider

world views. According to Business Dictionary (2014:n.p); there are three definitions for the concept INTEGRATION:

**1. General Definition**

The concept integration refers to a process of attaining close and seamless coordination between several department, groups, organizations and systems.

**2. Companies Definition**

Merger of two or more firms resulting in a new legal entity.

**3. Contracts Definition**

Amalgamation of two or more agreements into one contract that serves as a full expression of the intent of the contracting parties (Business Dictionary, 2014:n.p).

The process of definition of the concept INTEGRATION is further detailed in Annexure F. The annexure addresses the functional definition of the concept INTEGRATION and related issues. This discussion on the definition includes the following:

- ✧ The imperial definitions of INTEGRATION from different authors
- ✧ Point of views
- ✧ Social perspective
- ✧ Definition of INTEGRATION within the continuum of integrative care
- ✧ Elements that govern the process of INTEGRATION
- ✧ Types of INTEGRATION and
- ✧ Focus of INTEGRATION within the study

**4.3.3.2 Identification and Definition of Attributes of the Concept**

This is the second level of identifying attributes which are also key components of the identified concept, which consistently appear when the concept is defined and help clarify the main concept (Chinn and Kramer, 1999:95; Rodgers and Knafl, 2000:91). In this study,

the concept INTEGRATION describes attributes as a real definition, as opposed to a nominal or dictionary definition that merely substitutes one synonymous expression for another. The focus in exploring the contextual aspect of the concept is to gain an understanding of the situations in which the concept is used, its use in varying situations and its use by people with potential diverse perspectives (Zulkosky, 2009:93). Defining attributes assist in identifying the occurrence of a phenomenon in order to differentiate it from similar or related terms. The discussion that follows gives a description of attributes.

- **Integration Demands Mutual Respect and Appreciation**

From the expressions of IKS stakeholders, integration can only take place if there is mutual respect and appreciation among practitioners (IKP and WHPs). According to Fan (2004:6), appreciation is not only about art and beauty, but also of nature, a human feeling and experience. Increased human appreciation breeds interest on actualization of a phenomenon. Whitehead (1967), cited in Fan (2004:7), said: ‘there can be no mental development without interest. Interest is the sine qua non for attention and apprehension. You may endeavour to excite interest by means of birch rods, or you may coax it by the incitement of pleasurable activity. But without interest there will be no progress.’ Participants indicated:

*“The only problem that is dividing us is that the so-called Western doctors do not appreciate our work. In fact, let me be open, we are highly undermined, but I am not worried because my patients are still coming to me nevertheless, but I wish one day we can see each other as doctors, but working differently due to our callings that are not the same”*

*“For a very long time Western medicine has been trying to get a cure, but in vain. Therefore, the issue of including traditional medicine needs to be also explored. In other words traditional healers’ role in the management of HIV & AIDS should be explored. It can be positively said that if*

*contextualized properly both modern and traditional healing methods are valid, and as such can complement each other”*

*“There is a great need to integrate the two systems because all are operational within and across our clients and instead of shooting each other it’s time to join hands and begin to forge ways towards getting a cure for the disease.”*

- **Willingness to Engage**

Both practitioners should be willing to embark on a project of bringing their expertise together for the management of HIV & AIDS within a PHC environment. This was also indicated by Whitehead in Fan (2004:7), namely, *‘Interest gives people the initiative to do things. At best, people do things because they are willing and not pushed by others. This is the reason they can concentrate on what they do and can use every ability they have and every opportunity they have found to achieve it. Their creativity grows while they are doing things very actively and on their own initiative. This is an only way people can develop their creative potential. We must foster the creative initiative towards the maintenance of objective values. You will not obtain the apprehension without the initiative, or the initiative without the apprehension.’*

- **Integration Demands Mutual Understanding**

One participant who is a traditional healer and a renowned IKS scholar indicated:

*“For a very long time Western medicine has been trying to get a cure, but in vain. Therefore, the issue of including traditional medicine needs to be also explored. In other words traditional healers’ role in the management of HIV & AIDS should be explored. It can be positively said that if contextualized properly both modern and traditional healing methods are valid, and as such can complement each other”*

*“According to my understanding, I think doctors must also acknowledge and accept that THs exist and will continue to serve their people with all their*

*strength. The only other way is to start respecting the two systems as well as also allowing the clients to take their own decision in choosing which way do they want to solve their illnesses without prejudicing them or sidelining them”*

- **Effective Communication is Key to Integration**

Effective communication occurs when a desired effect is the result of intentional or unintentional information sharing, which is interpreted between multiple entities and acted upon in a desired way. The purpose of any effective communication could be to elicit change, generate action, create understanding, inform or communicate a certain idea or point of view (<http://en.wikipedia.org/wiki/Communication>). It is of paramount importance that IKS stakeholders and WHPs, one way or the other create a communication platform as they are sharing clients and try build an understanding as a point of departure towards an integration process. When asked which is the best way to link with WHPs, one participant responded:

*“There must be a way where we THs can transfer our clients openly because when we send them to the hospital or clinic we tell them not to say they are coming from us because they can be victimized by both nurses and doctors”*

- **Collaboration Leads to Integration**

The researcher discovered from the data analysis process that collaboration is the only way to integration only if the voice of stakeholders is taken into consideration. One participant stated:

*“Basically let’s start by saying we are Africans born within the system of African tradition and cultural practices. For me this is who we are and that is why I do not see any problem for the two systems to work together, interchangeably, as long as the needs of the clients are met. If we*

*look in other countries, for example, Ghana, Nigeria, Tanzania and Korea, as well as China, all attempts are made to collaborate the two systems unlike what South Africa is doing. We pretend like indigenous health practice does not exist and that is a lie because even some of my clients prefer both of my interventions”*

Another participant, when asked about the model that could ensure effective integration of IKS in the management of HIV & AIDS responded:

*“The model that should be developed should include the influences that governs health behavioural systems of individuals who are affected and infected with HIV & AIDS, and that includes visiting a doctor; a traditional healer as well as spiritual healers (pastors)”*

*“Like I indicated before, I think integration is needed only if we as THs are accepted because the only problem I am seeing is not with our clients it is basically with Western practitioners who continually poison the client saying we will kill them. This is pure undermining. . . I think we need to collaborate I mean work hand in hand”*

- **Role Clarification**

It was clearly demonstrated by IKS stakeholders that the roles and practices of both practitioners need to be clarified so that both can begin to function from an informed platform. Some participants indicated:

*“Traditional healers provide a client-based personalized health care, that is, culturally appropriate and tailor-made to meet the needs and expectations of patients. In other words, the patient is warmly embraced and the approach is welcoming because the approach is mostly related to the natural surrounding like, weather, harvest and rain or the sun as a way of greeting which is done in a relaxed manner and thus create a conducive environment for healing to take place”*

*“By looking at the two approaches to ill health, IKS looks at the totality of the problems of its client because part from the symptoms that are seen it goes deeper into looking and the spiritual influence and the social influence to the disease like if there is hatred or witchcraft related to the sickness and protect the client, whereas Western medicine only operates from a shallow base and fail to get into the deeper base of originality of the person in seeking solutions to holistic cure”*

One participant who is an academic and a traditional healer indicated:

*“People have a tendency of acknowledging only God as a source of power, whereas our ancestors are also powerful, they speak to us regarding diagnosis and cures. There are differences in the healing languages to be used in certain circumstances, for example, certain medications are only effective if they are identified according to a certain pattern of language from the ancestors”*

- **Need for Government Buy-In**

There is a great need for buy-in by government into the idea and revisit its policies, legislative rules that are governing the ministry of health and its service delivery processes. On serious scrutiny, *The implementation of PHC Re-engineering in South Africa* (Pillay and Barron, 2012:1) points out that the intent of the Minister of Health regarding the new approach to PHC transformation, namely, ‘As part of the health sector’s contribution to the overall government strategy of *A Long and Healthy Life for All South Africans*, the Minister of Health has a signed performance agreement (the Negotiated Service Delivery Agreement ? the NSDA) with the President where he has committed himself and the Members of the Executive Council (MECs) of the nine provinces to four main outputs. . . ’ The four outputs are as explained in Chapter 1 of this study (Pillay and Baron, 2012:13):

1. Increasing Life Expectancy
2. Decreasing Maternal and Child Mortality

3. Combating HIV & AIDS and Decreasing the Burden of Disease from Tuberculosis
4. Strengthening Health System Effectiveness

The model of re-engineering of PHC became the means for pulling forces in promoting integrative models of care for illnesses and diseases, in particular HIV & AIDS and TB, and part of the greater burden to the Ministry of Health and Economic Development of our country. It is for this reason that the researcher looked with a greater lens to the proposed PHC model of implementation and discovered that within the broader context there are three streams of PHC re-engineering of which the ward-based PHC outreach teams is a great off-site model of excluding IKP (traditional healers, herbalists, IK knowledge experts and pastors) who reside with their clients on a daily basis providing care acceptable to the their clients. This off-site framework is indicative of the non-functional *Traditional Health Act*, No. 35 of 2004, as well as the *Indigenous Knowledge System Policy* of 2004 that acknowledge inherent IKS knowledge and its utilization by its inhabitants—that is just on paper and on shelves of the drivers of our government structures.

#### **4.3.3.3 Identification of Surrogate Terms**

A ‘surrogate’ is a philosophical position that a concept may be expressed in different ways, but helps to impart significance to the concept of interest (Rogers and Knafl, 1993:83). Surrogate terms/concepts constitute the remaining data to be collected, in other words, they are a means of expressing the concept other than the word or expression selected by the researcher to focus the study (Rogers and Knafl, 2000:92). The surrogate terms that emerged during the process of data analysis were *sharing client base* through which both IKPs and WHPSs could openly work together and share ideas about the patient situations and care given for continuity of care through open communication, cooperation mutual respect and knowledge sharing. Both practitioners need to appreciate and accept one another with their differing

ways/roles in disease interventions. There should be fluid interactive relations that promote two-way referral processes.

#### **4.3.3.4 Identification of References**

According to Rodgers and Knafl (1993:83), references are actual situations to which the concept INTEGRATION is applied, as listed below:

- **Value Clarification**

Both parties need to bracket the self and engage with great openness and respect.

- **Role Identification**

Stakeholders (TH, WHPS, pastors and IK experts) need to clarify their roles to each other in order to create a better understanding.

- **Effective Communication**

Interpersonal relations and listening skills will be needed to ensure fruitful and healthy discussions.

- **Platform for Effective Interaction**

Working paces to be respected and ways of collaboration to be created.

#### **4.3.3.5 Identification of Antecedents**

Antecedents are aspects that normally precede the concept. In this study, these are some words, events or incidents that occur or precede the concept (Walker and Avant, 1993:83; Walker and Avant, 1995:73; Rodgers and Knafl, 2000:111). These events or incidents could facilitate the integrative process that has to take place for the management of HIV & AIDS in a PHC context. In this study, the following antecedents were identified:

- **Willingness**
- **Appreciation**
- **Understanding**
- **Readiness**
- **Mutual Trust**
- **Openness**
- **Mutual Respect**
- **Role Clarification**
- **Moral Values**
- **Accountability**
- **Responsibility**

Fan (2004:7) suggested factors that need consideration because they impact the integration process. These are discussed below:

- **No Appreciation, No Creativity**

This is indicative of the fact that in the process of one appreciating something, for example, *nature*, it involves feelings, experiences and interest (Fan, 2004:7). It is very difficult for stakeholders to understand the need for IKS integration into the management of HIV & AIDS if they cannot develop a keen interest in the phenomenon. Interest stimulates people to do things, because of their own free will and willingness and not because they are forced to do it. This spirit makes them concentrate on what they are doing and find every reason to achieve the expected end, hence ‘no appreciation, no creativity’.

- **No Appreciation, No Integration**

Coordination of body systems functioning could be a very good example—they are different but function in unison to achieve the well-being of the whole/total being. For example, the heart cannot function like the liver to work better for sustaining the homeostatic nature of the body. If stakeholders lack appreciation of the two health systems, integration will be difficult to attain. If one’s reasoning wants to do and the will and emotions or even one’s body do

not want to, how can one do it, or enjoy doing it? There is a reason for mutual willingness amongst the stakeholders to join hands when dealing with the HIV & AIDS pandemic that is wiping our loved ones out by each passing day (Fan, 2004:7).

- **No Appreciation, No Wisdom**

Wisdom is the way in which knowledge is held, that is, how people handle knowledge. It is the selection for the determination of relevant issues, its employment in order to add value to our immediate experience, hence initiation of freedom (Fan, 2004:8). It is of importance that IKS stakeholders with their accumulated knowledge come to the party and employ their expertise from a common ground to deal with health-related issues of clients. The importance of knowledge lies in its use, that is, what people do with that which they claim to know. Apostle John endorsed the importance of wisdom as a form of knowledge were Jesus said to those Jews who believed in Him, 'If you abide in My word, you are My disciples indeed. And you shall know the truth, and the truth shall make you free' (The New Scofield Study Bible, 1989:1282 in John 8:31-32, New King James Version (NKJV)).

#### **4.3.3.6 Identification of Consequences**

Walker and Avant (1995:73) describe consequences as those events or incidents that occur as a result of the presence of the concept, which becomes the expected outcomes of the concept of interest. In this study, possible consequences of integration will be the following:

- **Open communications**
- **Mutual trust and respect amongst both health systems**
- **Patients receiving care freely from the two health practitioners, open consultation**
- **Recognition of IKS health practices**

- **Respecting patients' choices regarding health/illness-seeking behaviour**
- **Knowledge generation and preservation for future use**
- **Joint research**
- **End of stigma and marginalization of IKS practices**

#### **4.3.4 Identification of the Related Concepts of Interest**

The following concept emerged during data analysis as expressed by participants and was then used interchangeably with the term/concept INTEGRATION. This could be expressed closer to surrogates or a term that bears a close relation with the concept of interest and in this case COLLABORATION became the related term as expressed by participants (Rodgers and Knafelz, 2000:113).

- **Collaboration**

According to WHO (2010:13), collaborative practice in health care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. This definition befits the expected outcomes of developing a model to integrate IKS in the management of HIV & AIDS within a PHC context. IKS should also be part of the providers of HIV & AIDS disease management and other conditions affecting humanity across the life continuum. Furthermore, the *Free Merriam Webster Dictionary* (2014:nd) elicits the fact that collaboration could mean the following:

- ⌘ To work jointly with others or together, especially in an intellectual endeavour;
- ⌘ To cooperate with or willingly assist an enemy of one's country and especially an occupying force; and/or

- ✧ To cooperate with an agency or instrument with which one is not immediately connected.

### **4.3.5 Analysis of Data on the Characteristics of the Concept 'Integration'**

Through conceptual analysis of the concept INTEGRATION with the use of extensive literature, meaningful outcomes were clustered according to their similarities as well as their differences. The researcher, governed by the concept INTEGRATION and the means to the expected out- come, clustered similarities and coded them according to their common attributes, meanings, categories and sub-categories that were developed, defined and described in the process of integration (Table 4.1 and Figure 4.1).

### **4.3.6 Conceptual Framework of Integrative Levels to Ensure Development of the Model of Integration of IKS in the Management of HIV & AIDS within a PHC Context**

#### **4.3.6.1 The Process of Integration**

The process of integration is described according to its phases, linkages and flow as illustrated in Table 4.1 and Figure 4.1.

#### **4.3.6.2 Phases of Integration**

- **Phase 1: Initiation (Ice-Breaking Session)**

Stakeholders come to a common ground of understanding through:

- ✧ Role identification clarification by distinguishing the different roles regarding disease interventions by both health practitioners in order for them to have a clear understanding of one another and in a way drawing common grounds.
- ✧ Mutual agreements, respect and trust makes the corner stones for the process of integration to be realized.

**Table 4.1:** Conceptual analysis framework

Categories	Sub-Categories	List of Descriptions
<b>Meaningful Integration</b> <b>PHASE 4</b> <i>Quality Assurance and Sustainability</i>	Collaborative care	Adaptation Transformation and health system strengthening & policy review QA combined committee periodic review and reporting
<b>PHASE 3</b> <i>Dynamics</i>	Process towards meaningful integration	Willingness to engage Mutual trust & respect Acceptance of others Effective communication Openness accountability Active participation Resources / funding Appreciation & responsiveness
<b>PHASE 2</b> <i>Implementation</i>	Logistical preparedness by stakeholders	Workshop Vision and mission Needs analysis Develop objectives Legislation & policy analysis
<b>PHASE 1</b> <i>Initiation &amp; Ice-Breaking</i>	Role clarification and lobbying	Lobbying government buy-in Mutual interaction and trust Committee formulation of stakeholders Mutual agreements, respect Role clarification Drawing common ground

- ✦ For the whole process to start and have influence on policy development and review, stakeholders should begin to lobby for government buy-in. Committees should also be formulated for strategic direction as well as role allocations.

In this phase, the initiation process begins upon a closer look into the antecedents as these are the driving forces before the actual integration takes place. These antecedents are lobbying government buy-in, mutual interaction and trust, committee formulation of stakeholders, mutual agreements, respect, role clarification and drawing common ground. Stakeholders

need to embark on clarifying the above antecedents so that they can enter into an agreeable common ground of operation.

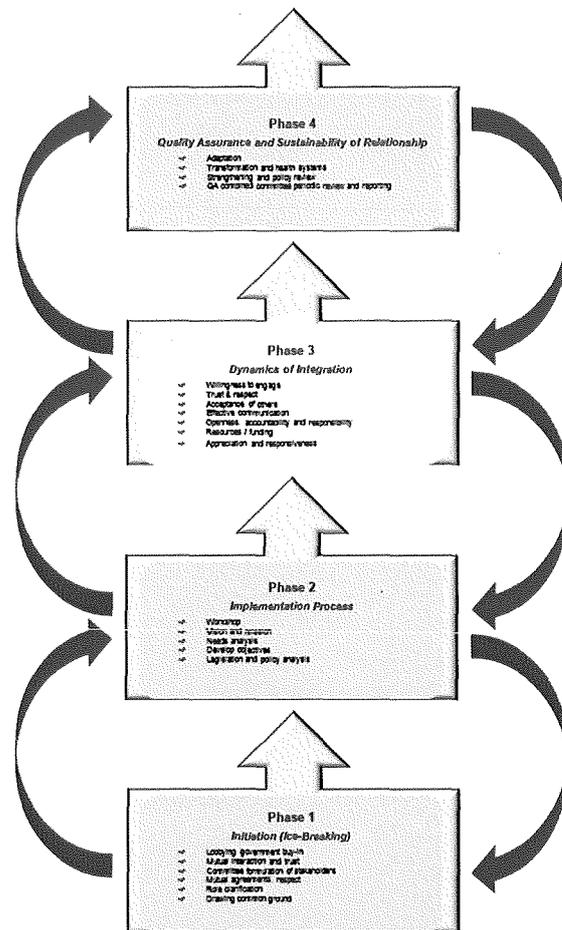


Figure 4.1: Integration levels: upward and downward flow structure

Health, Wise Romero and Reynolds (2013:3) clearly indicate that ‘until there is a way to reliably categorize integration implementation, meaningful comparisons of implementations or associated health outcomes cannot occur’. The authors further explained that ‘knowing what features of integrated health care implementations lead to the most favourable and stable health outcomes will be an important contribution to the health field’, which is what the researcher has aimed to achieve.

The framework illustrates several enhancements that enable it to be comprehensive enough to serve as a national standard for future discussions about integrated health care. The framework also allows organizations implementing integration to gauge their degree of integration against acknowledged benchmarking, and serve as a foundation for comparison for campaigning health care outcomes between integration levels or phases (Health et al, 2013:5).

- **Phase 2: Implementation Process**

Stakeholders need to come up with a strategic plan after careful SWOT (Strength, Weaknesses, Opportunities and Threats) analysis of the present fragmented health system and its delivery processes. The process of implementation included the following attributes to facilitate the implementation during the workshop:

- ✧ Needs analysis
- ✧ Development of vision and mission, leading to
- ✧ Development of objectives

The whole process should be able to influence legislation and policy formulation. Phase 2 occurs after meaningful description and ice-breaking for a purposeful common ground of understanding. Stakeholders need to engage at various levels of activities that are necessary for meaningful integration to take place as illustrated in Table 4.1 and Figure 4.1. Organizing a workshop for designing a strategic way forward, drawing an operational vision and mission, doing a needs analysis, developing operational objectives and analyzing all relevant legislations and policies that govern the two health systems to conceptualize the parameters of operations, necessitate broad terms of reference, including:

- ✧ Traditional Health Practitioners Act 22 of 2007

- ✎ Constitution of the Republic of South Africa, Act 108 of 1996
- ✎ SANAC-The National Strategic Plan (NSP), 2012-2016
- ✎ Pharmacy Act 53 of 1974, as amended
- ✎ South African Medical and Dental Council Rules and Regulations
- ✎ National Health Act 61 of 2003, as amended

- **Phase 3: Dynamics**

For effective integration, stakeholders need to deal with all relevant dynamics related to the process of integration, such as willingness to engage, execution of trust, respect and acceptance of others. Effective communication, openness, responsibility, appreciation and responsiveness form the bases of the integration process that will later lead to a two-way referral system of care. In this phase, there is a clear indication that in any interaction there are possible dynamics that need to be dealt with such as having to willingly accept views of others, exercise mutual trust and respect to gain full cooperation of all parties, practice effective communication and inter- personal skills, ensure openness, accountability and ensure generation of resources both material and human for the implementation of the project.

- **Phase 4: Quality Assurance (QA) and Sustainability**

It is the 'Ahaa' moment when a two-way of the degree at which integration could amicably take place. It is at this stage that the government can advocate health for all, a two-way glass mirror that will be able to monitor and evaluate all health systems within its country and communities they are serving, through periodic review and reporting, as well as transformation and health system strengthening and policy review by a combined QA committee. Phase 4 is where there is adaptation, transformation and effective collaboration which then lead to meaningful integrative care that allow a fluid flow of activities amongst different stakeholders for the benefit of both the clients and the practitioners.

### 4.3.6.3 Degree of Integration

According to Leutz (1999), cited in (Kodner 2009:15), perhaps the most well-known framework for health-related service integration encompasses at least three different configurations as listed below:

- **Linkage**

This is the least-change approach which entails providers working together on an *ad hoc* basis within major system constraints.

- **Coordination**

This is a structured inter-organizational response involving defined mechanisms to facilitate communication, information-sharing and collaboration while retaining separate eligibility criteria, service responsibilities and funding.

- **Full Integration**

This is the most transformative combination; it refers to a ‘new’ entity that consolidates responsibilities, resources and financing in a single organization or system in order.

In this study, the researcher envisaged the possibilities of the first two degrees of integration in relation to the integration of IKS in the management of HIV & AIDS, because the working environment of most TH is highly contextual as indicated by some participants:

*“Traditional healers and traditional practices or operation, as far as I am concerned, that I cannot be transferred to a common area like hospitals or clinics as our spirits do not prefer any space of operation, this mean that it will be difficult for us to operate in the same space with the WHPs”*

*“I can only help my clients here in the house . . . the only problem is that I cannot work in any other environment other that my small room because that is where I was ordained into by my trainer”*

#### 4.3.6.4 Identification of a Model Case for Integration of IKS

During information gathering, some essential or non-essential features emerged which are described by Chinn and Kramer (1993:62) as a model case, as that which enables the researcher to identify or distinguish essential from non-essentials, either from the literature of any other context within which the concept is symbolized. In this study, this was symbolically demonstrated by the contextuality of the phenomenon under study as it was naturally occurring and experienced in a real life setting.

##### ❖ Model Case in Support of the Need for Integration of IKS

The following responses from participants exemplify support for a model case:

*“Basically let’s start by saying we are Africans born within the system of African tradition and cultural practices. For me this is who we are and that is why I do not see any problem for the two systems to work together interchangeably, as long as the needs of the clients are met. If we look in other countries, for example, Ghana, Nigeria, Tanzania and Korea as well as China, all attempts are made to collaborate the two systems, unlike what South Africa is doing. We pretend like indigenous health practice does not exist and that is a lie because even some of my clients prefer both of my interventions”*

*“The model that should be developed should include the influences that are governing the health behavioural systems of individuals who are affected and infected with HIV & AIDS which includes visiting a doctor, a TH as well as spiritual healers (pastors)”*

##### ❖ Contrary Case against the Need for Integration of IKS

Examples of sentiments expressed by participants in this regard are:

*“The Western medicine thing that when one goes to the doctor one will be healed there are still herbs that can be used which were used before, but I*

*am not talking about herbs that are coming from a traditional healer's point of view"*

*"Not agreeable of that lineage my mother being a traditional healer. We the ancestors, but I never saw her making any progress (shaking her head)"*

When asked to explain if she considers collaboration to be good, but only if it does not have an ancestral connection, she said:

*"Yes, because from my Christian point of view there are no way the ancestors can communicate healing. God created these herbs for us to use, but the problem is when Christians associate herbs with traditional healers. . . it is not a sin to use a herb, but it is not nice if one is consulting traditional healers"*

#### **4.4 Summary**

This chapter described the conceptual framework that became the building block for the development of the model which will be described in detail the next chapter. One concept of interest was identified from data analysis, namely, INTEGRATION which emanated as central to the realization of the expected outcome. Model development in the next chapter will be guided essentially as described by Dickoff et al (1986:423, 434-435).

# CHAPTER 5

## THEORETICAL FRAMEWORK FOR THE DEVELOPMENT OF THE MODEL TO INTEGRATE IKS IN THE MANAGEMENT OF HIV & AIDS IN A PHC CONTEXT

### 5.1 Introduction

This chapter focuses on the description of the theoretical framework for the development of the model that will promote integration of IKS in the management of HIV & AIDS within a PHC context of care. The researcher was guided by the six elements of practice theory as outlined by Dickoff et al (1968:415-435). The model was developed on the premise of the outcomes from data analysis, concept analysis as well as from relevant literature on the views and perceptions of stakeholders regarding the possibilities of integration of IKS in the management of HIV & AIDS. According to Murphy, Williams and Pridmore (2010:18), a model can be thought of as a way of representing reality, and can also represent abstract and complex situations such as the economy, health beliefs, or a grief and bereavement.

### 5.2 Objectives of the Chapter

The objectives of this chapter were to:

- ✎ Classify and describe activities according to the six elements of the survey list according to Dickoff et al (1968:434-435), and then,
- ✎ Develop a theoretical framework for the model that will facilitate the integration of IKS in the management of HIV & AIDS within a PHC setting.

### 5.3 The Six Elements of Practice Theory

The survey list according to Dickoff et al, (1968:435) is summarized in Table 5.1 and will be described briefly.

**Table 5.1:** Summary of the components for model development

Agents	Description	Components
<b>Context/ Framework</b>	This is the environment within which activities are taking place	The process of integration will take place within the cultural and Western contexts, including the family as a sub-structure that cuts across both contexts.
<b>Agent</b>	Who is responsible for the activity to take place?	<ul style="list-style-type: none"> <li>↖ IKS stakeholders</li> <li>↖ Western health practitioners</li> </ul>
<b>Recipient</b>	Who are the beneficiaries of the activities?	Patients (HIV and AIDS patients/clients)
<b>Dynamics</b>	What is the energy source for the activity to take place?	Willingness, trust and respect, acceptance of others, effective communication among practitioners, openness accountability and responsibility, resources / funding, appreciation and responsiveness, two-way referral system
<b>Procedure</b>	What are the procedures, techniques or protocol that will ensure realization of the activity?	Initiation workshop, role and value clarification, integration needs analysis, develop vision and mission, develop objectives of integration, analysis and review of current state of legislation and analysis and review of operational policies and guidelines
<b>Purpose of the Model</b>	What is the expected end goal or outcomes of the activity?	Meaningful integration, effective management of HIV/AIDS, mutual understanding and responsiveness, two-way referrals, patient advocacy by both types of practitioners

Dickoff et al (1968:434-435) use six survey list questions to identify the practical activities that guide the description of the theory framework:

#### 1. Context: In what context is the activity performed?

The context embodies any specific environment within which integration will take place in an amicable manner (Dickoff et al, 1968:434). Emanating from the **Pen-3 Model** described in chapter 1 the **Cultural Identity Domain** became the point of entry after certain group

consensus are met regarding any critical area of concern, of which in this model integration could only take place after the parties reach a workable agreement through lobbying and role clarification. Of course the researcher is looking at possible dynamics that could also influence the process like, respect, good communication and mutual understanding amongst others Airhihenbuwa and De Witt Webster (2004:8). In this study the contexts were:

#### ✧ **Community Cultural Context**

This includes the setting or environment within which traditional healers, herbalists, pastors and indigenous knowledge and the *family structure*, as a sub-context, operate. **Again the Pen-3 Model has a bearing in the cultural context of model development in the fact that it outlined the role of the family** as that that plays a role in determine the type of health interventions that will be taken, either western or traditional. Mostly in extended family there is still a greater role in the health-seeking behaviour though the increase in nuclear families is, in a way, shaking the status quo (Airhihenbuwa and De Witt Webster, 2004:9).

#### ✧ **Western Health System Context**

This is the operational environment of doctors and pharmacists. Within the WHS environment there is also a sub-structure which is the health legislative framework that governs health service delivery processes. This includes the South African Medical and Dental Council (SAMDC), South African Pharmacy Council (SAPC), Health Professional Council of South Africa (HPCSA), Department of Health (DOH), South African Nursing Council (SANC) and Allied Health Professional Council (AHPC), responsible for the legal conducts of their professionals as well as the legal parameters governing their different professions.

**2. Agent: Who or what performs the activity?**

An agent is a person or persons who are involved in the achievement of the goal (Dickoff et al, 1968:434). In this study the goal is the integration of IKS in the management of HIV & AIDS within a PHC context in Vhembe District in Limpopo Province, South Africa. The agents in this study were IKS stakeholders (traditional healers, herbalists, IK experts and pastors) as well as WHPs (doctors and a pharmacist) who acted as the driving force behind the realization of the expected outcome.

**3. Recipients: Who or what is the recipient of the activity?**

In this study, patients are the potential beneficiaries of the activity (Dickoff et al, 1968:434). In this study, the recipients were HIV & AIDS patients, in particular, who were receiving health care services within a PHC context in Vhembe District, Limpopo Province.

**4. Dynamics: What is the energy source of the activity or underlying dynamics?**

According to Dickoff et al, (1968:434), dynamics is the source underlying the process. In this study, the indicators of dynamism were willingness to integrate, trust and respect, acceptance of others, effective communication, openness accountability and responsibility, resources / funding, appreciation and responsiveness.

**5. Procedure: What is the guiding procedure or process?**

Procedure specifies the path, steps and pattern according to which the activity is performed (Dickoff et al, 1968:434). The procedure in this study centres around initiating the process of integration, role clarification, lobbying and logistical preparedness by stakeholders through the following procedures that will build up to meaningful integrative care, workshop for initiating the process, role clarification, needs analysis, development of vision and mission, advancement towards objectives as well as legislation and policy analysis.

#### **6. Purpose: What is the endpoint of the activity?**

This is the final expected outcome of any activity done (Dickoff et al, 1968:435), that is, in this study, the development of an effective, sustainable and meaningful integration of IKS in the management of HIV & AIDS within a PHC setting.

### **5.3.1 Context**

The context specifies the environment within which the activity will take place allowing the activity to be viewed in relation with other things (Dickoff et al, 1968:434). For smooth integration to take place, the researcher took into cognizance the importance of the contexts within which the process will be taking place. The following contexts are hereby described.

#### **5.3.1.1 Community Cultural Context**

Community cultural setting provided a conducive context within which IKS stakeholders (traditional healers, herbalists, pastors and IK experts) interact with their different clients and patients. Salimbene (1999), cited in (Finkelman & Kenner, 2010:308), note that culture is generally defined as a shared system of values, beliefs, traditions, behaviour, and verbal and non-verbal patterns of communication that hold a group of people together and distinguishes them from other groups. It is within this environment that families reside hosting the different clientele who are in need of care at any given point in time of their life and disease challenges, hence the emergence of another sub-context that plays a vital role in management of HIV & AIDS and influences decision making regarding the choices to be made between IKS and WHS interventions for its members during illness behaviour.

#### **5.3.1.2 The Western Health System Context**

The second context of this study is the WHS. This context becomes the operational setting or environment for doctors and pharmacists to execute their practices within the health care delivery setting. It is in this environment that all WHPs are provided with an operational ground

for care of their patients/clients at any given point of life and disease continuum. The National Department of Health (NDoH) in conjunction with the provincial and local government is the basis within which all health practitioners and professionals operate, be it private or public practices. All practitioners are guided by the National Strategic Plan (NSP) that is developed in response to the health needs of the country and burden of diseases for a particular time frame.

#### ❖ **The Health Legislative Framework Sub-Structure**

The third context of this study is the health legislative framework. This framework plays a significant role in shaping and controlling health systems quality service delivery within all four levels of health care; national, provincial and district as well as local level of health system management and care. It is within the district and local levels of care where PHC services are rendered as a point of contact or entry to the health care delivery system. It is also at these levels where IKS practices are rooted and contextual in nature, yet fragmented. The health legislative framework governs health service delivery processes through Acts, legislative policy, regulations and Bills. The following are regulatory bodies and Acts that govern or shapes the delivery of services to recipients to ensure patient safety and prevention of potential harm: The South African Medical and Dental Council (SAMDC), South African Pharmacy Council (SAPC) and Allied Health Professions Council (AHPC). Furthermore, these statutory bodies and regulations are responsible for the legal conduct of their professionals as well as the legal parameters governing their different profession, through licensing, registration for legal practice and periodic monitoring and evaluation of all services. Also, the NDoH with its NSP for health, guidelines and protocols continues to direct the execution of the strategic goals through different indicators for quality service delivery.

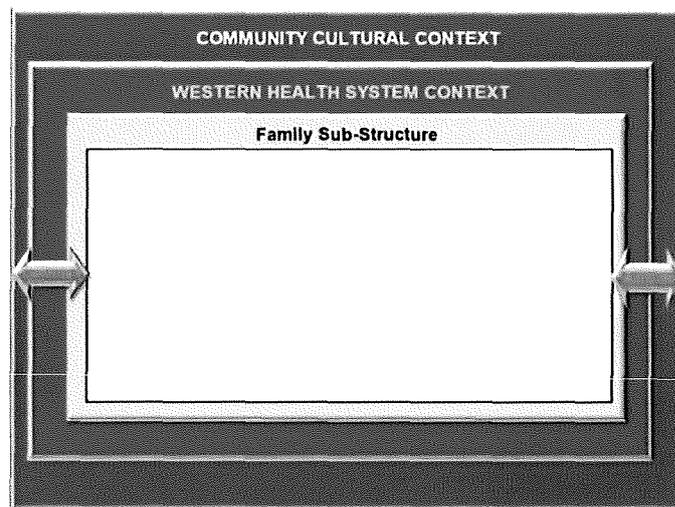
### **5.3.1.3 The Family Sub-Structure**

It is within the family sub-structure of both the community cultural context as well as the Western health context which possess the inherent practices and influences that have an impact on patients' diseases and illness seeking behaviour. The cultural values, customs and belief systems within the community, as well as the family, play a pivotal role in shaping most vital activities within a socio-cultural setting. According to Finkelman and Kenner (2010:223), a functional family is considered healthy where there is a state of bio/psycho/cultural/spiritual well-being, and can provide autonomy and is responsive to individual members within the family. It is within both the community cultural context and the Western health context that patients draw energy from regarding the acceptable and inherent belief systems that form the bases of one's response to health and illness behaviour.

The family structure is a component within the community that provides the clients/patients infected and affected by HIV & AIDS with support and care, including a joint decision regarding when to visit a doctor or an IKP or a pastor for interventions and/or advice. The role of the family is that of creating a homely environment governed by the inherent cultural setting in seeking help or any cure when its member is confronted by illnesses or health-related challenges. It is within this sub-context of the community as well as the WHS that the affected and infected are finally residing after any intervention has taken place. Most importantly, family members are role players with regard to continuous care after any prescription is given and have all the opportunity to disqualify or uphold the intervention depending on the patient's response and prognosis.

It is also within this family sub-structure, where individual families may have their own different views and perceptions regarding causes of disease, intervention strategies as well as decision regarding where to go when such a need arises. The family structure could

further be governed by unique believe systems like cultural orientation, religious orientation and beliefs systems or scientific WHS understanding of disease causation, which also plays a part in their health seeking behaviour and orientation to the concept health across human existence. The two small arrows in Figure 5.1 are indicative of the family sub-structure as the base of influence in both the WHS and community cultural contexts within which these health systems come into contact with individual and their family.



**Figure 5.1:** Context for health systems integration

### 5.3.2 Agent

An agent is a person or persons responsible for executing or facilitating the performance of activities so that an expected goal can be achieved (Dickoff et al, 1968:435). In this study, agents are persons who facilitate the process of integration of IKS in the management of HIV & AIDS within a PHC context of Vhembe District in Limpopo Province, South Africa. The agents in this study were IKS stakeholders (traditional healers, herbalists, IK experts and pastors) as well as WHPSs (doctors and a pharmacist) who acting as drivers for the realization of the goal. These agents are the ones that should drive the process of integration in a manner that health care consumers could freely utilize both health systems without any form of

prejudice or marginalization. It is through constructive communication, role clarification, mutual respect and mutual understanding of both parties that this model could become a reality. The agents should make it a point that they forge integration without any form of undermining one another and without forcing the other to succumb to the other without clear understanding and role clarification. This will demand both parties to be empathetic with a deep sense of humour in order to allow fluid movement of the integrative process to take place. This kind of action has to be started as the shared clientele is continuing to utilize both health systems in dealing with their health and illness behaviour. The agents in this study as indicated in the first paragraph of this section can be further divided into:

### **5.3.2.1 IKS Stakeholders**

IKS stakeholders (traditional healers, herbalists, IK experts and pastors) have a responsibility of opening up their horizon of operation and begin to interact with WHPS in order to close the practice divide that has existed since the inception of WHS. The researcher has already eluded to the fact that traditional practices have been in existence since the origin of man and cannot be overlooked—neither can the practice be wished away. Patients and clients are still exercising their will power to utilize both systems simultaneously or alternatively without open indication of fear of victimisation. There is a critical need for IKP to talk about the hidden challenges that they experienced throughout the years in order that they can debunk such beliefs and start operating from a platform of mutual understanding. Patience, good interpersonal relations and maturity in dealing with this matter will be a priority to avoid unnecessary tensions that can adversely affect the fluid movements of the intended outcome.

Building trust will be the corner stone for effective integration and responsiveness by responsible parties. It the responsibility of IKP and IK experts and pastors to indicate possible logistical arrangements and protocols that should be put into place to ensure a good

environment within which the process of integration could take place, for example, communicating with their ancestors regarding their intended contributions and also making sure they are available when dialogues are happening in order to take and informed decisions. On the other hand, pastors too, should share their views in forging the way forward because they are also active members in dealing with all kinds of sicknesses affecting man in their life experiences. They too are not legally recognized as a force that is participating in the healing process though they indicate that their clients are acceptable by all other agents if they mention that they visited them for prayers.

### **5.3.2.2 Western Health Practitioners**

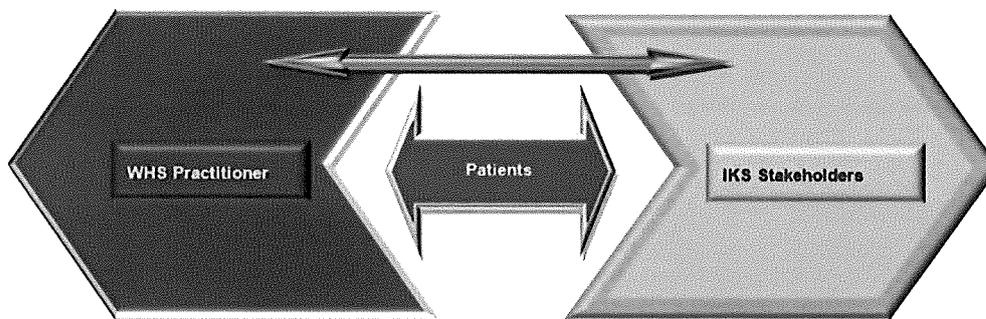
Doctors and pharmacists are part of the agents that should equally drive the process of integrating IKS in the management of illnesses and diseases, in particular HIV & AIDS within a PHC context in Limpopo Province. These categories were selected because they participated in the study, but there are many more other health professionals who could also come on board for corporate discussions, like allied health professionals (physiotherapists, occupational therapists, speech and hearing therapists and audiology specialists) and nurses. As a result of their unique perceptions about integration, WHPS should also embrace and appreciate other health professionals in order that they can work hand in hand.

This process is necessary because out of the qualitative analysis, there is an indication that WHPS should start understanding that IKS is also a health practice in its own right and needs some form of acknowledgement as both are serving the same clientele. With their scientific understanding, they should also facilitate how best the two systems can integrate for the benefit of the patient/client without trying to reorganize the system to suit the scientific measuring standards as IKS also possesses its indigenous ways of qualifying the practice. As practitioners, this integrative proposition does not mean WHPS should practise outside

their legal parameters, but should strive to find a way that could allow both to operate from a common understanding without them changing their character (Fan, 2004:1-10).

### 5.3.3 Recipient

The recipients of the integrative model of HIV & AIDS management are the HIV & AIDS patients and clients, who find themselves juggling between the different health systems (IKS and WH service delivery) with or without the permission of the other. With reference to Figure 5.2 there is a clear indication that the recipient has been for quite a while now been receiving care from the two health systems disjointedly without informing the other system's practitioners openly. The big arrow is indicative of the collaborative force that, when realized, integration of IKS and WHS will be possible and be openly utilized complementing each other, rather than competing.



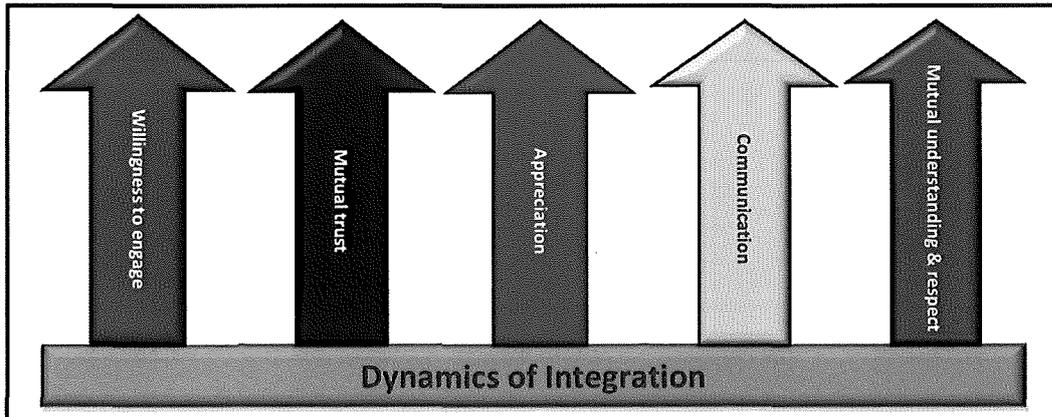
**Figure 5.2:** The fragmented interaction of agents and recipients

### 5.3.4 Dynamics

Dynamics are the power sources for the activity which can either be chemical, physical, biological or psychological for a person or thing functioning as agent, patient or part of the framework in realizing the goal (Dickoff et al, 1968:434-435). Dynamics of this study were willingness to engage, open communication, trust and respect, acceptance and responsiveness, appreciation, understanding and respect (Figure 5.3).

### 5.3.4.1 Willingness to Engage

This is a very strong energy where all stakeholders need to be willing to engage in the process of transformation and change that will bring about better and open health care delivery to the clients under their care.



**Figure 5.3:** Dynamics of the integration process

### 5.3.4.2 Open Communication Among Practitioners

This is a strongest binding fibre in any endeavour—communication brings about understanding and trust. This is the only tool that can bridge the divide between stakeholders of health from all spheres of practice. There should be meaningful communication and openness in order for all parties to be on board and understand their progress forward. Effective communication is very vital for integration to take place. It is at this phase that a language clear to everyone should be used or interpretation could be of help where needed to promote active participation by stakeholders. Stakeholders should possess the following calibre: listening skills, emotional maturity, patience, sharing and exchange of information as well as interactive learning that comes when one is open to learn from another.

### **5.3.4.2 Mutual Trust**

Mutual trust among participants of any activity erodes any sense of suspicion, fear of prejudice and conservation of information needed for the achievement of the expected goal. This energy promotes interpersonal relation and effective participation. Stakeholders then engage in the process of deliberation with the aim of finding amicable solutions towards effective integration and smooth running of health services within the PHC context.

### **5.3.4.3 Appreciation and Responsiveness**

Stakeholders should begin to appreciate one another and learn to be responsive to the need of integrating IKS in the management of HIV & AIDS within any PHC setting. This process will demand both parties to understand the practice of the other as of importance to the clientele.

### **5.3.4.4 Mutual Understanding and Respect**

Where there is full understanding of the differences in roles and skills, mutual respect comes in automatically. Stakeholders should engage in value clarification for better understanding of each other's strength and weakness so as to be able to complement each other than compete. A proper clarification of roles and values will ensure a better identity, understanding as well as mutual respect for both parties.

### **5.3.5 Procedure**

The procedure can be described as rules, steps, protocols or techniques that guide the activity by directing the path and patterns that are to be followed to execute the activity (Dickoff et al, 1968:430). The aspect of the procedure does not stress the outcomes or terminus or particularize features of the activity, but emphasizes the path, steps or pattern according to which the activity is performed (Dickoff et al, 1968:430-431). These authors further indicate

that the function of the procedure is to try and provide sufficient details to enable an activity to be carried out, meaning to serve as a safeguard to agent or recipient of the activity or process. The procedure also helps safeguard the danger to both the agent and the recipient where the process could be compromised due to lack of a prescribed pattern of course. In this study, the procedure that was used to ensure parameters of successful integration included:

### **5.3.5.1 Initiation Workshop**

The role of the researcher at this stage is to facilitate a workshop with stakeholders to identify key figures comprized of IKS experts and practitioners, pastors, as well as WHPs. Policy makers and directors /managers within the Ministry of Health should be part of the process for political buy-in. Lobbying has to be done in order to gain support from relevant structures and Department of Science and Technology (DST) as they are also involved in identifying and preserving IK products and medicines.

### **5.3.5.2 Role and Value Clarification**

Looking at the background of the IKS stakeholders, most of them possess status from their cultural settings and communities of their operations. There are special ways on how they are addressed as well as their level of understanding. Similarly, doctors and pharmacists have their own status within their communities and work places. This might affect communication process if not clearly dealt with. For example, TH being called ‘witch doctors’, if not dealt with, can create tensions and disengagement of members on the bases of cognitive injustice as described in Chapters 1 and 3. Stakeholders should clearly indicate their values regarding their involvement in the process of forging forward an integrative approach to illness and disease patterns, in particular HIV & AIDS within a PHC context.

These values and roles should be clearly defined and then be set aside if they are seen as hindrances to effective interaction. A sense of effective and active participation and involvement should be the base of the project. Provincial Departments of Health should take an initiative as done by the Northwest Province where an announcement was made by the MEC for Health, Dr Magome Masike in the *African Medicine Celebration* themed *Collaboration between Practitioners of Traditional Medicine and Practitioners of Conventional Medicine?* where clarity was made regarding the roles of THPs in the health system, to convey to communities the right messages on the effective and efficient use of TM and enhance continuous participation in departmental activities aimed at promoting healthy lifestyles (Youth Today Newspaper, 2014, September 1-2).

### **5.3.5.3 Needs Analysis**

Needs analysis for possible integration should be done and clarified by all stakeholders in order for mutual understanding to be realized. The identified needs form the base and a driving force in the integrative process. All needs that are identified are to be prioritized according to their urgency and availability of resources to guide the implementation process to take place. Later, emanating from the analyzed needs and strategic goal plan, a proposal can then be developed by a stakeholders task team which is then submitted to relevant government structures for the appeal of health systems transformation for integrative quality service delivery. Furthermore, the committee should take it upon itself to look at all legislative frameworks that govern both systems and identify gaps so that proposals can be made to policy makers regarding reviews of such laws in order to accommodate the needs of both the agents and the recipients for effective health care service delivery. All policies, including the ones described under the context of the model, should be scrutinized and strengths and weaknesses identified.

### **5.3.5.4 Development Vision and Mission, Purpose and Objectives**

As a collective, stakeholders should develop a vision and a mission to direct their strategic move towards health systems integration and strengthening. These will provide a road map of the project and guide the process for the attainment of the goals and objectives of the project. Clear, achievable and measurable goal and objectives must be developed to guide the process and facilitate evaluation of the success of the project. The objectives will be the dissected parts of the whole that will make the process manageable and easy to follow—they also are indicators of success or failure as they act as parameters of monitoring and evaluation.

### **5.3.6 Terminus/Purpose**

The purpose or terminus is the end point or the final end of the activity (Dickoff et al, 1968:428), which for this study is the successful integration of IKS in the management of illnesses and diseases, in particular HIV & AIDS, within a PHC setting. This will bring about cohesiveness and interaction among TH, herbalists, pastors, doctors, pharmacists and other allied health professionals. This interaction will minimize or prevent chances of hiding patients or preventing them from seeking medical attention of their own choices. Meaningful integration also widens the horizon for mutual communication and referral of clients before they complicate or result in unnecessary loss of life.

From the outcomes of data analysis most participants expressed the need for integration of the two health systems because working in their own silos does not help either of the systems. They stressed that it is necessary because the client will then utilize traditional practices without any fear of judgement, prejudice or stigmatization by WHPS. Dickoff et al (1968:430) emphasize the importance of a well-defined outcome in order for it to be easily communicated or utilized further. Both the agent and the recipient should be

comfortable with their expected end as there is a very clear link with how dynamics have been dealt with for a smooth integration to take place. In the end, the researcher has to make a point that the model designed is as practicable as possible to produce the expected outcomes.

Within the society, communities, families, and individuals exist within the cultural contexts that determine and shape their belief system and decision making regarding how to respond to illness and diseases. The health and illness related belief structure is culturally inclined. Regardless of the inclination, both systems of health be it WHS or IHS will continue to have a greater influence on people's health seeking behaviours. The question is whether the influence is positive or negative in nature, hence the need for meaningful integration of the two systems. Since witchcraft has been inherent in various cultures through the ages, a strong trend continued from generations to generations that those afflictions cannot be resolved by means of Western health interventions. This trend has kept indigenous people with an inherent belief system that made them continue resorting to other means of cures like traditional healing practices, sorcerers, and diviners and/or religious means of intervention where prayers are sought from pastors and Prophets of God. This is because indigenous belief systems acknowledge that there is also another world of the supernatural and the ancestral side which is believed to have a hand in disease causation and prevention.

It is from this understanding that the researcher sought to drive the development of the model that will incorporate all facets of life and human existence. Man does not live in a vacuum, but is influenced by many forces and energies—hence the need for a multi-faceted approach to health interventions in human lives and their daily existence and functionality. Through effective engagement in the process of interaction as described by Dickoff et al (1968:426), using the six elements of survey list, a plausible model was designed in order to promote effective PHC, that is, a multi-sectoral health service delivery for the people by the people.

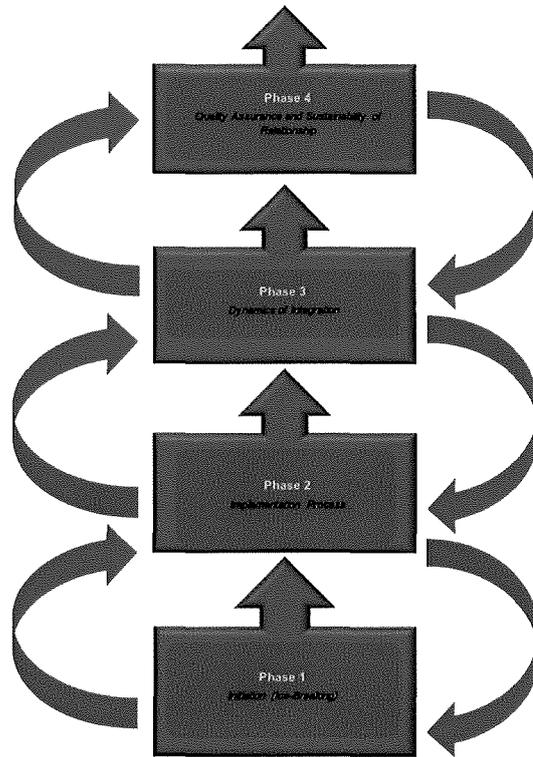
The researcher outlined this in depth in Chapter 1 in the paradigmatic perspectives under meta-theoretical assumptions.

## **5.4 Model Development**

This model as indicated above was developed guided by the six elements of survey list according to Dickoff et al (1968:426), but fully informed by the findings from the qualitative data analysis as well as the theoretical framework as supported by the literature control that was done. The foundational context of the model remained the community cultural context with the family as the centre of the context, as well as the WHS context with its legislative framework as the driving force to health service delivery by its practitioners. Furthermore, the model will be described essentially according to Chinn and Kramer (1999:84-97) in the sub-headings that follow.

### **5.4.1 Overview of the Integrative Process of the Model**

A brief description of model development will now be discussed. The description will outline how integration could be developed and how best it can be promoted between IHS and WHS for the benefit of the patient/client, particularly those living with HIV & AIDS within a PHC context. The whole process occurred in a spiral configuration (Figure 5.4), that is, following phases denoting the process that could take place for the realization of a meaningful integration (Figure 5.5) as fully described in Chapter 4 of this study.



**Figure 5.4:** Spiral flow process of integration indicating the upward and downward interactive flow



**Figure 5.5:** The final purpose of integration process

### **5.4.1.1 Phase 1: Initiation (Ice-Breaking)**

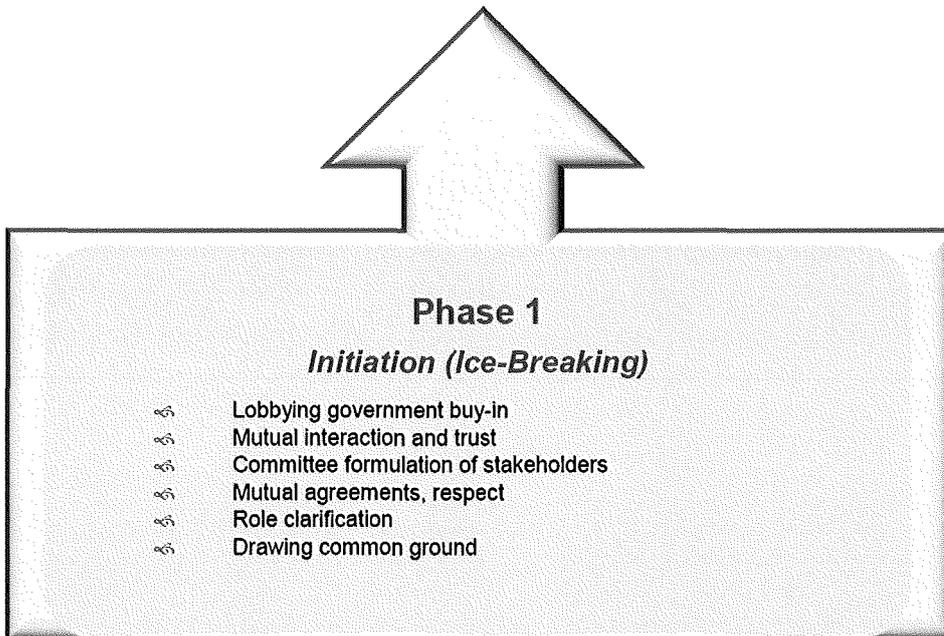
This is the foundation or the beginning of the interactive phase between the agents responsible for the process of integration. The researcher defines this phase as an ‘icebreaking’ phase where agents enter into an initiation process (Figure 5.6).

#### **❖ Ice-Breaking**

The process begins with the facilitation embarking on awareness of the move to be taken towards integration process—this could be done through engagement of agents interacting with each other to build a relationship of trust. IK stakeholders thus begin to engage in a dialogue with the WHPs to unfold the aim of the integrative purpose and to gain a better understanding and respect of one another before identifying the needs.

#### **❖ Role and Value Clarification**

In this exercise, the stakeholders take a closer look into the possible energies that could drive or retard the process, for example, stakeholders should be allowed an opening session to describe who they are, what their roles in the project are and how they would prefer to be identified through the sessions. This process allows for the creation of a conducive environment for participants to openly and effectively contribute to the needs of the integration process, which is drawing a common ground.



**Figure 5.6:** Initiation or ice breaking

❖ **Mutual Interaction and Trust**

An activity has to be put in place that will allow acknowledgement of all stakeholders to realize the interactive needs of both parties. This can be achieved by allowing group sessions where stakeholders are seat together in homogenous groups and indicate aims of the need for both health systems to begin working together with mutual understanding and trust, then return to the plenary session for discussion of the outcomes for inputs and dialogue.

❖ **Committee Formulation of Stakeholders**

Stakeholders should now formulate a heterogeneous committee to ensure representation of different stakeholders to assume roles and facilitate the process of integration further in a formal process through:

- ⌘ Lobbying with relevant directorates like government and DoH

- ✧ Seeking funding to run the project
  
- ✧ Benchmarking with countries in Africa and others that have already begun integrating the systems, such as Korea, Malaysia, Nigeria and Ghana.

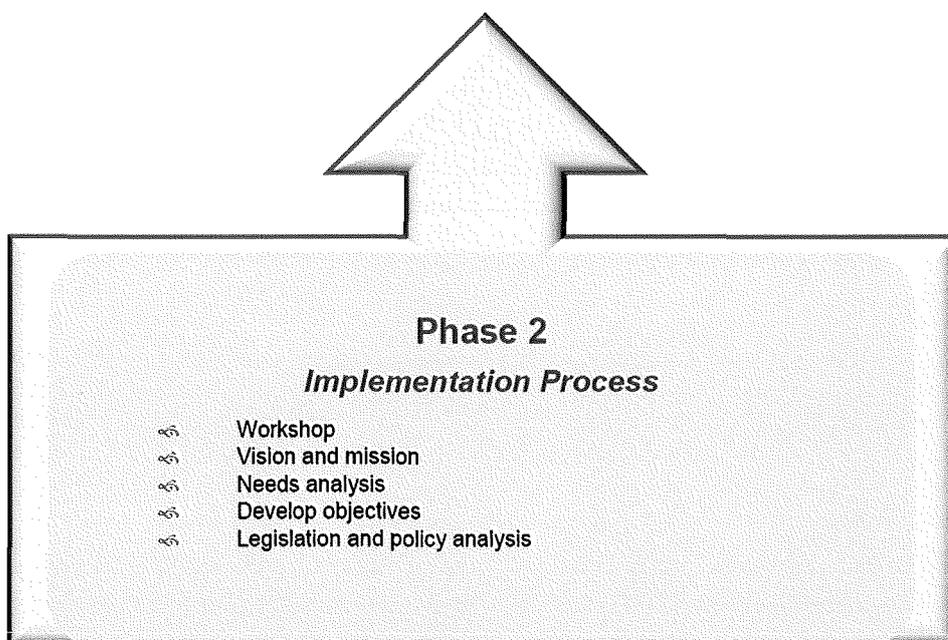
Stakeholders need to embark on clarifying the antecedents so that they can enter into an agreeable common ground of operation. Health et al (2013:3) clearly indicate that ‘until there is a way to reliably categorize integration implementation, meaningful comparisons of implementations or associated health outcomes cannot occur’. They also underscored ‘knowing what features of integrated health care implementations lead to favourable and stable health outcomes which becomes an important contribution to the health field’.

#### **5.4.1.2 Phase 2: Implementation (Logistical Preparedness of Stakeholders)**

This phase marks the logical preparedness of stakeholders and does not close the flow of interaction with the first phase if gaps are identified, phase 1 antecedents are again attended to, hence the spiral type of the process of interaction to and from the phases. After the initial ice breaking for a meaningful common ground of understanding, stakeholders need to engage on various levels of activities that are necessary for meaningful integration to take place as indicated in phase 2 (Figure 5.7).

The researcher should take a lead in organizing a workshop for the development of the strategic plan and way forward, draw an operational vision and mission, do needs analysis, develop operational objectives and analyze all relevant legislations and policies that govern IHS and WHS practices in order to draw closer all parameters of operations. For example, looking at all legislations under the following indicators (this exercise can be done by the committee), that is, how best does they serve the system(s), what are their terms of reference, what roles does they play in health and profession strengthening, what are the strength and

weaknesses, how best can they be reviewed to respond to the identified agents and recipients' needs.



**Figure 5.7:** Implementation process

Conceptualization of the parameters of operations, necessitate broad terms of reference, including:

- ✦ Traditional Health Act 35 of 2004
- ✦ Constitution of the Republic of South Africa, Act 108 of 1996
- ✦ SANAC-The National Strategic Plan (NSP), 2012-2016
- ✦ Pharmacy Act 53 of 1974, as amended
- ✦ South African Medical and Dental Council Rules and Regulations
- ✦ National Health Act 61 of 2003, as amended

### 5.4.1.3 Phase 3: Dynamics

In this phase there is a clear indication that in any interaction there are possible dynamics that need to be dealt with, including to willingly accept views of others, exercise mutual trust and respect to gain full cooperation of all parties (Figure 5.8). Stakeholders need to begin to engage into effective communication ensuring interpersonal skills, openness, responsibility and accountability, generation of resources—both material and human—for the implementation of the project. If this process is done well both parties will then reach consensus, agreements and design a workable scenario of patient care without compromising human lives.

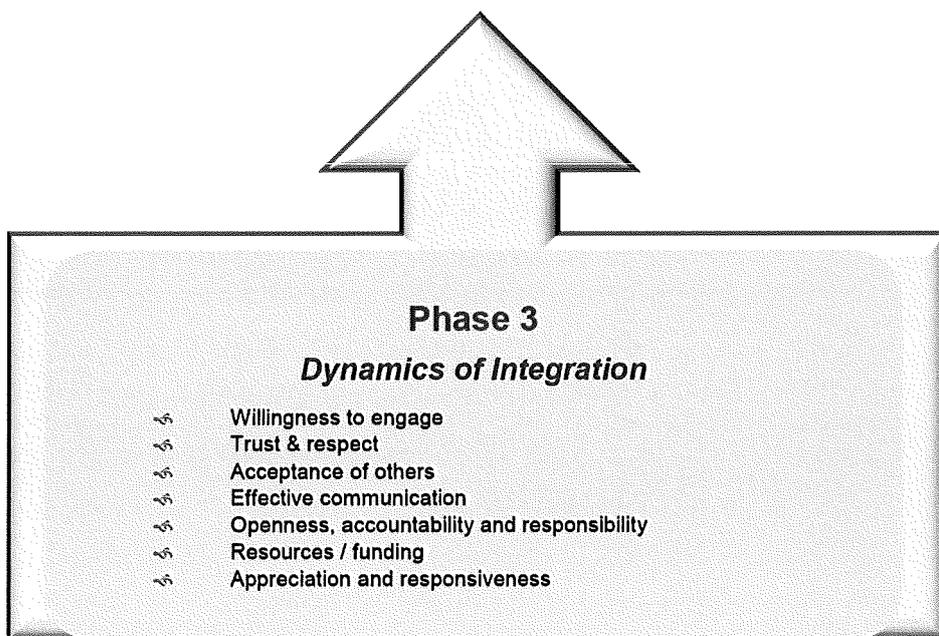
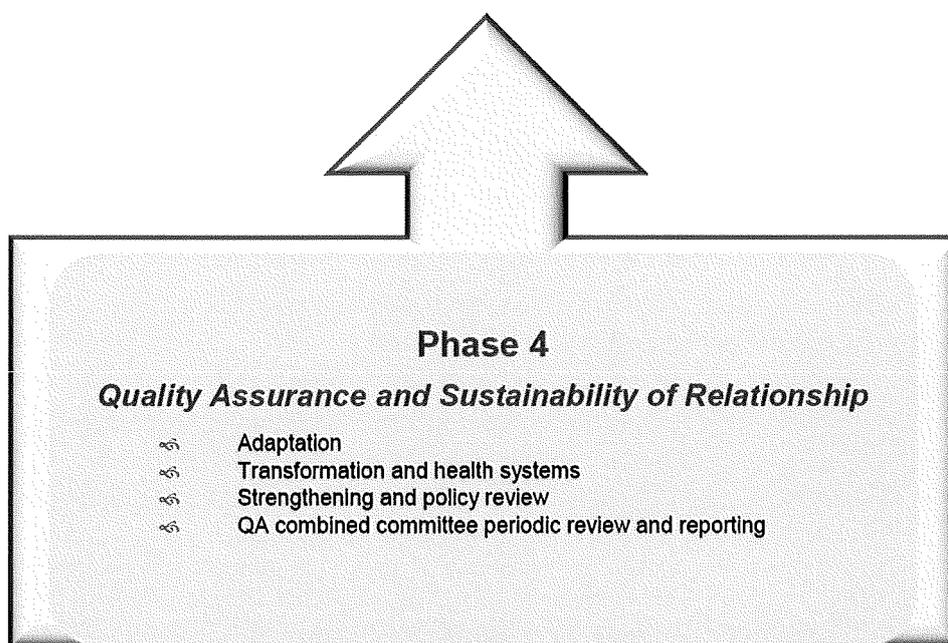


Figure 5.8: Dynamics of integration

### 5.4.1.4 Phase 4: Quality Assurance and Sustainability of Meaningful Integration

In this phase there is a great need for both agents to have an effective adaptation, transformation and effective collaboration which then can lead to meaningful integrative care

that allow a fluid flow of activities amongst different stakeholders (Figure 5.9). This phase should promote the implementation of an integrative health care system that will benefit both the clients (recipients) as well as the practitioners (agents). The following concepts should be attended to: adaptation to the new scenario of working environment, transformation and health system strengthening and policy review, QA combined committee periodic review and reporting to be done for awareness purposes to all beneficiaries of the model.



**Figure 5.9:** Quality assurance and sustainability of meaningful integration

### **5.4.2 Purpose and Structure of the Model**

The ultimate purpose of this model is to facilitate the integration of IKS in the management of HIV & AIDS within a PHC context. This integration is to follow a spiral process that has to take place between the agents (IKS stakeholders and WHPs) who are the main drivers of the process for the realization of a meaningful integration. This integrative care model will benefit both the agents as well as the recipients of the health care delivery process which will

now be holistically in nature and finally contribute to health systems strengthening (Figure 5.10).

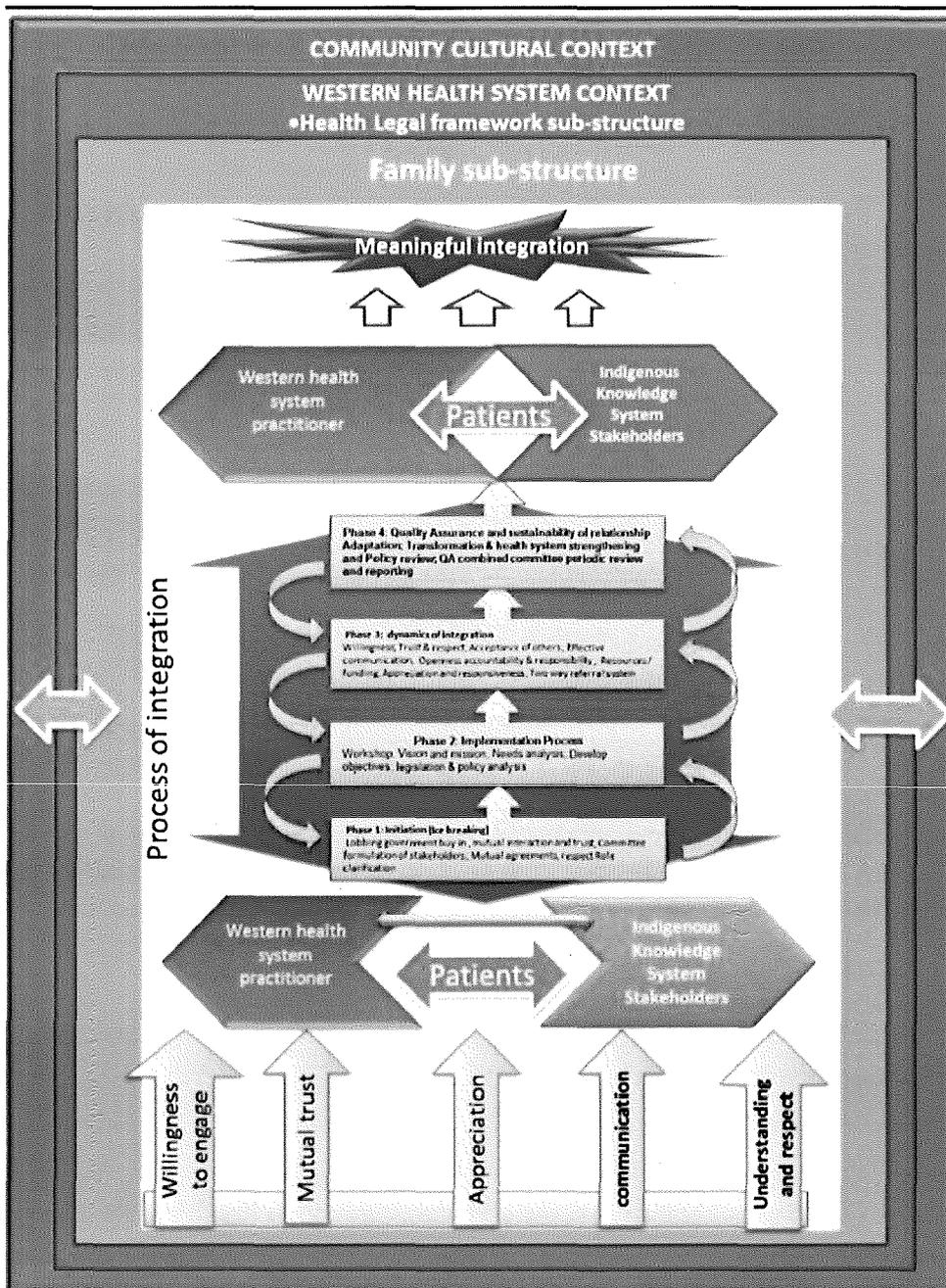


Figure 5.10: Model to facilitate IKS integration in HIV & AIDS management within a PHC context

Furthermore, the model could also be used within the body of knowledge where, if adopted well, can be applied by many disciplines to promote integration. The integration process allows a fluid flow of processes that has to take place in phases, to and from, if need be, until

the final outcome is achieved. The model creates opportunities for quality assurance and sustainability of the outcomes of the meaningful integration to avoid relapse or redundancy.

The researcher can now affirm that the whole structure of this model was designed and guided by context, agents, recipients, dynamics, integrative processes/procedures, as well as the final expected outcome.

### **5.4.3 Discussion of the Model**

The community cultural context though culture evolves with time, will always have influences on views and perceptions of life, health sicknesses and diseases at any given point in the lives of the inhabitants of a particular locality. The WHS context is shaped by and grounded in scientific beliefs and influenced by legislations, policies and guidelines that are in place at a given time. Regardless of legislations as a given parameter, it is always necessary that they be contextualized to serve within the continuum of human existence (culture, values, norms and beliefs), taking into consideration all external forces that affect the client and agents it serves.

The nature or schematic structure of the model is summarized in Figure 5.10 and is symbolically indicative of the interactive process and structures involved towards the whole. The Agents (IKPs and WHPs) are people who are in a way expected to maintain a certain status quo, and that was visible where one individual was playing double characters in careering, that is as a TH and doctor or a TH and a pharmacist. The participation of these agents and their regarding integration could be fluid in nature as they fully understand the systems in place. Moreover, each agent in any interaction will continuously be influenced by his/her personal belief system as well as the professional ethical influence to determine the degree of participation in the integration process.

The recipients (HIV clients/patients) can freely move between the systems if a meaningful integration can be promoted without any fear of prejudice. The process and dynamics are driving forces that determine the course. In any human interaction, internal and external influences impact the action of individuals and those antecedents or dynamics need to be dealt with for the process to take place for any outcome to be achieved (Dickoff et al, 1968:434-435).

The integration process will always be influenced by how best one understands the other and what benefits each participant will gain after the achieved outcome. The researcher can conclude that a meaningful integration of the health systems that are in place within a given locality will enhance access by the consumers and will promote integrative participation of the providers towards quality health service delivery.

### **5.5 Summary**

This chapter provided a clear description of the conceptualization of the theoretical framework which resulted in the development of the model using the six elements of practice theory as described by Dickoff et al (1968:415-435), namely, context, agent, recipient, dynamics, procedure and purpose. The model provides the structural process ensuring how a meaningful integration could be realized. The discussions included all concepts from the survey list which are context, agents, recipients, procedure, dynamics and terminus, using a schematic diagram of the model for better navigation and understanding of the model structure. The next chapter will focus mainly of the guidelines to operationalize the model, its justification, limitations, recommendations and conclusions of the study.

# CHAPTER 6

## GUIDELINES TO OPERATIONALIZE THE MODEL, JUSTIFICATION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

### 6.1 Introduction

This chapter describes the guidelines to operationalize the model within a PHC context in Vhembe District in Limpopo Province, South Africa. This follows the development process described in Chapter 5. Pursuant to extensive discussions and application of the model structure, the researcher embarked on ensuring that the purpose of the study was realized, including its justification as a true reflection of what transpired in the field and whether the results/outcomes can contribute to health system strengthening as well as adding to the existing body of knowledge. This chapter also incorporates a discussion of the limitations, conclusions and recommendations in relation to the study aims.

### 6.2 Rationale of the Study

The researcher's point of departure centred around the fact that regardless of the marginalization, cognitive injustice and prejudice that some people have experienced regarding IKS practices in dealing with illnesses, people still continue to utilize the service, either in parallel or alternatively in quest for seeking solutions to their illnesses.

This premise is also with reference to HIV & AIDS because of its status as a worst case scenario and a disease for which a cure has yet to be found. IKS continues to be another avenue that has been in practice since the inception of man across different cultural groups

and backgrounds, and people continue to utilize these practices when seeking health and lifestyle interventions (Mulaudzi, 2007:32). The PHC re-engineering strategy which is rolling out in all the provinces excluded this alternative health system, the IKS, regardless of its massive user base. This is indicative that the study model is of great importance if the political mandate from the Ministry of Health given to the teams of re-engineering of PHC is that of transformation of health systems with the emphasis on system strengthening. This is so because the model is aimed at creating an integrative care that will promote the use of all other health systems—hence system strengthening.

The study sought to develop or find a way through which an integrative model of care could be developed looking at ways that could promote the integration of IKS into the management of HIV & AIDS within a PHC context. It is in this study that ways and means were designed to find a way of bringing the two systems together and creating a platform of operation that will foster mutual understanding and respect of each other. In the final analysis of the impact that the model will bring, it is now clear that IKS stakeholder and WHPS can now engage each other and share information regarding the care they provide to their common clients.

With the release of the Indigenous Knowledge System Policy by the DST, as adopted by the National Cabinet of South Africa, in 2004, and the Traditional Health Practitioners Act, No. 35 of 2004, it became evident during this study that regardless of the mandates from these policies, the divide has never been bridged as the two health systems continue to operate separately and uniquely. The client has a right to choose any health care service when responding to illness behaviours without any prejudice or discrimination by another system practitioner. Cultural beliefs, values and norms persist to have a strong influence on its members, defining their behavioural patterns, perceptions and views regarding health and illness which inform their decision making at any given point and time.

### **6.3 Purpose of the Study**

The purpose of the study was to develop a model to facilitate the integration of IKS in the management of HIV & AIDS within the PHC context. To arrive at this purpose, the researcher explored and described views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS within a PHC context. Data were analyzed guided by Tesch's eight steps of qualitative data analysis and verified through extensive literature control. The principles formulated by Rodgers and Knafl (2000:77-100) as well as Walker and Avant (1995:39) were used in the identification of the concept of interest as well as in the conceptualization process that led to the development of the model.

### **6.4 Research Objectives**

The objectives of this study were described in Chapters 1 and 2 and will be evaluated independently below:

#### **OBJECTIVE 1**

*Views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS, Limpopo Province, South Africa.*

This objective was fully attended to in phase 1 of the study as illustrated in Figure 2.1 of Chapter 2. Phase 1 involved the exploration and description of the views and perceptions of stakeholders regarding the integration of IKS in the management of HIV & AIDS in the Limpopo Province of South Africa, indicating factors to be considered so that a meaningful integration of IKS and WHS can be realized towards better and quality service delivery. Data was collected using in-depth face-to-face interviews with multidisciplinary stakeholders.

The central question was:

*What are your views and perceptions with regard to the integration of IKS in the management of HIV & AIDS within a PHC context in the Limpopo Province? How best can the two systems work together?*

Data was then analyzed guided by Tech's eight steps of open-coding as described by Creswell (2009:186). All views and experiences as expressed by participants were described and discussed extensively in relation to a relevant literature control for verification of the findings. The focal point within the findings was that even though the two systems continue to exist and be utilized by clients, they are confounded by the great divide that exists between them. The majority of IKS practitioners still are reflecting on them still being marginalized, hated, ignored, judged, wrongly identified and excluded by the WHPS and the WHS as a whole. IKP are continuously being regarded as 'witch doctors' instead as 'doctors' who use herbs, as indicated by some participants. Out of these data a conceptual framework and model was developed as the findings formed the building blocks for the researcher to construct the model.

#### **OBJECTIVE 2**

*To develop a conceptual framework related to current dialogue about the integration of IKS in the management of HIV & AIDS within the PHC setting.*

The central concept was INTEGRATION which became the concept of interest to the researcher. During data analysis the outcomes or findings yielded the driving force for the realization of an effective model, including the manner in which integration could take place between WHPS and IKP. In Chapter 4, the concept was described fully in terms of all attributes, surrogates, antecedents and consequences using supporting literature and findings from data analysis to obtain a deeper understanding of the concept before the model was developed.

**OBJECTIVE 3**

*To develop a model to facilitate the integration of IKS in the management of HIV & AIDS within the PHC context in South Africa.*

The main source for model development was derived from the findings from qualitative data analysis, literature control as well as conceptual analysis which provided guidelines and building blocks for the model to be realized. The construction of the model was guided by six elements of practice theory as described by Dickoff et al (1968:415-435).

**6.5 Guidelines to Operationalize the Model**

According to Chinn and Kramer (1999:96-98), the last or final step in model development is the application of the model which is indicative of the process or guidelines on the best way that the model can be operationalized. Community context will always be the point of departure for integration to take place and will continually shape the views and perceptions of stakeholders regarding any interaction towards a meaningful integration of services. The following guidelines should be adhered to:

- ✎ Guidelines pertaining to the context of the model
  
- ✎ The participating agents
  
- ✎ The recipients
  
- ✎ The procedure or process followed
  
- ✎ The dynamics
  
- ✎ The final outcome/ purpose

### **6.5.1 Guidelines on the Context of Integration**

Following data analysis, literature control and concept analysis and the entire process of the development of the model aimed at facilitating the meaningful integration of IKS in the management of HIV & AIDS, the following guiding factors are relevant:

#### **6.5.1.1 Guidelines on Community Cultural Context**

- ✎ Proper channels need to be followed for community entry in order to be well received, accepted and acknowledged by community stakeholders, leaders and members. This will prevent possibilities of rejection and humiliation.
  
- ✎ Workshops and road shows are to be organized within communities to promote awareness of what is going on and promoting effective participation in any envisaged change or project.
  
- ✎ It is of importance that human beings be viewed in terms of their origin, their values and beliefs systems, norms and values shaping their activities as well as factors that constitute their value systems.
  
- ✎ Interpersonal relations, communication skills and emotional maturity should be infused in any training or community development, though it has to be culturally oriented.
  
- ✎ It is therefore important to engage individuals from a point of family and community setting to be able to identify variables that could be beneficial or detrimental to health to human existence.
  
- ✎ Effective needs analysis, lobbying and buy-in of other community structures,

including traditional leaders, religious leaders, radio stations, ward councillors and the Department of Social Development could be key to community participation and involvement for meaningful integration.

### **6.5.1.2 Guidelines on Family Sub-Structure**

- ✎ Greater recognition of a family as a sub-structure of the community system has to be engendered as it has a great influence on its members collectively or individually in health seeking behaviour at any given point of human existence.
  
- ✎ Families should be fully empowered regarding all processes that take place within community structures for them to make informed decisions in their responses to illness behaviour as well as expectations regarding home-based care of their loved ones when infected with HIV.
  
- ✎ Families should participate as a partner with any health practitioner, be it IKS or WHS, in the management process of their family member and take an advisory role where need be.
  
- ✎ Families should also act as an open sanctuary for information during the period of frailness of the patient in informing both practitioners regarding the history of the illness and the interventions taken thus far to ensure openness and drive further implementation plans.

### **6.5.1.3 Guidelines on the Western Health System**

- ✎ It is time that the system acknowledges the existence of other health system practices to forge a way forward towards integrative health services and care that will be responsive to the needs of the clients/patients in totality.

- ✧ WHPs should widen their horizons through interactive participation with other practitioners, with the client in mind that they both serve.

- ✧ WHPs need to begin looking at disease causation, not only from the scientific point of view, but also start embracing the cultural point of disease causality so that they can increase their understanding from the point of view of their patients.
- ✧ Whilst operating within their professional legislations and guidelines, WHPs need to still understand that integration does not necessarily mean losing your professionalism and ethical standards but has to do with awareness of other health care systems operating with similar aims of curing and eliminating occurrence of diseases to human kind.
- ✧ WHPs should also participate in cultural dialogues that have an influence on health and illness behaviour and share their expertise regarding collaborative care to their communities, families and individuals under their care.
- ✧ WHPs should develop a better way of understanding the background of the patient's condition, even if it is tapping from the cultural point of view, rather than to change the story by discarding some culturally related information and create a skewed scenario that will suit their scientific base of understanding.
- ✧ WHPs should also embrace the spiritual point of view of patients, especially with diseases that are not curable like HIV & AIDS. If the client makes statements like 'I know God can heal me. Nothing is impossible for God to perform.'
- ✧ WHPs should begin to work within these spiritual parameters and promote both the belief system and combine it with continued prescribed treatment, rather than discouraging the client, which that can lead to poor compliance even to the treatment that is prescribed.

### **6.5.1.4 Guidelines on the Legislative Framework Sub-Structure**

- ✎ A policy framework to guide service delivery should be developed after a careful needs analysis.
- ✎ Review of policies should be done periodically as health and life are not static but continuous with human existence and development.
- ✎ Acts that are developed should be as contextual and relevant to the needs of the people, for example, the Traditional Health Practitioners Act No. 35 of 2004 which concentrated on the formulation of Traditional Health Practice Council to promote and regulate a liaison between traditional health practitioners and other health professionals registered under the law. There is nothing known to the researcher that has been developed so far to promote further integration of these systems in disease management and care.
- ✎ Policies and regulations pertaining to IKS issues should be reviewed and guidelines formulated to implement and support of IKS practices in South Africa as a way of promoting the diversified health care inherent within our societies. So far the Eastern Cape Province managed to respond to the need of acknowledging traditional circumcisions by developing an Act that guides all traditional circumcision initiation schools, the Traditional Circumcision Act No. 66 of 2001, which is now in place to regulate the service. The Traditional Circumcision Act was also developed in response to high mortality rates among youth undergoing such initiations.

### **6.5.1.5 Guidelines on Agents**

- ✎ The terms of reference governing the partnership and the working relations between the WHPs and IKP should be encapsulated within a memorandum of understanding

(MOU) to cover the widest possible scope to respond to the needs of recipients/clients.

- ✧ IKS stakeholders as agents (traditional healers, herbalists, IK experts and pastors) should understand their roles to ensure meaningful integration. Knowledge generation and documentation with Intellectual Property Rights (IPR) should be done through collaborative research by both practitioners.
- ✧ WHPs as agents (doctors and a pharmacist) should also be part of the process to drive realization of integration of health systems for holistic care. They need to willingly appreciate the existence of IKS for better understanding which will lead to them working together in serving their clientele.
- ✧ Both agents should be responsible in driving the process of integration in a manner that health care consumers could freely utilize both health systems without any form of prejudice or marginalization.
- ✧ Constructive and effective communication, mutual respect and understanding of both parties should be the key towards realization of mutual integration for model practicality.
- ✧ Health departments and institutions of training and education should develop curricula with the community/recipient/family in mind, that is, any learning and education process should be community-based and culturally-oriented in order to serve and meet the needs of the intended society.
- ✧ Willingness to participate in knowledge generation and preservation will be possible through collaborative research with due IPR consideration from the side of the IKS

stakeholders to stem prevailing exploitation without recognition practices.

### **6.5.1.6 Guidelines on Recipients**

- ✎ Health care consumers should also play an active role in dialogues, road shows as well as workshops that will be conducted in the community setting.
- ✎ Openness about the need for integration of these systems should be clearly indicated during discussions or the time of needs analysis.
- ✎ Patients should be willing to cooperate in situations where information about previous interventions is needed by either of the health system practitioners.
- ✎ Client/patients should participate actively during treatment and be informed about their prognosis in order for them to take informed decisions regarding their health interventions.
- ✎ Information about the integration is to be shared.

### **6.5.2 Guidelines Related to Model Outcome**

It very crucial that all steps be implemented with determination and passion because that is the only way the purpose or outcome of the model could be fully realized. In this study, the outcome of the implementation of the model structure will be to facilitate the integration of IKS in the management of HIV & AIDS within a PHC context in Limpopo Province. During the entire process of stakeholders' active engagement in the realization of the outcome, new meaning, skills, and a deeper understanding were evident, for example:

- ✎ Free visitation of clients by their traditional healers and pastors during their period of hospitalization.

- ✧ Two-way referral system could be possible when all stakeholders know the expertise of the other practitioner in relation to the ailment the client is suffering from.
- ✧ Open and increase of utilization of IKS practices as a way of PHC system strengthening towards attainment of re-engineering of PHC goals that the country is embarking on.
- ✧ Clinical trials through scientific research on traditional medicinal plants could be done with ease to ascertain the medicinal properties. This can be possible if IKP are willing to share their medicinal plants for laboratory investigations.
- ✧ Basic training on medicinal plants could be organized where traditional healers and herbalists could take a leading role in teaching health care consumers to promote self-help with free access of herbal medication in the market places like in the rest of the African countries.
- ✧ Health-related curricula will then be reviewed and include IKS in the education and training of their students and guest lecturing by IK experts could be instituted to ensure collaboration. If this is done properly, graduates from institutions of higher learning will be able to respond to the actual needs of their communities, families and individuals from a cultural point of view.

### **6.6 Justification of the Study**

Views and perceptions expressed by stakeholders regarding the integration of IKS in management of HIV & AIDS within a PHC context became the evidence of realities as experienced by participants and that brings the study to its contextuality and relevant to the objectives and outcomes set initially. The preliminary results of this study has been presented

nationally and internationally (in FAST Research conference within the Faculty of Science and Agriculture, Northwest University-Mafikeng (2012), in the 6th SA-AIDS Conference in Durban (2013) and Berlin, Germany (2013) and received greater support and expert inputs which were guiding factors in the development of the model.

The researcher stands to indicate the authenticity of the study as an original contribution to strengthen both health systems as well as an addition to the body of knowledge. Justification was also achieved through the guidelines developed. This model could be of value in health system strengthening within the country in settings similar to that where the study was developed and, more importantly, within the Limpopo Province. South Africa, as a country, is embarking on implementation of the PHC Re-Engineering Model. The model demands development of Ward-Based PHC Outreach Teams, including only WHPs who are trained and employed by the DoH. These teams are operating within community-ward structures and IKPs are excluded as players in this initiative. The teams aim at strengthening and improving accessibility of PHC services by all citizens of the country. These outreach teams are presently composed of six community health workers, professional nurses, environmental health and health promotion practitioners who are to provide health services to ensure, healthy communities, healthy families, healthy individuals and a healthy environment.

However, the cultural aspect is never included, regardless if its influence on health and illness issues among community members. In other words, the PHC Re-Engineering Model (Pillay and Barron, 2012:1) does not include IKP as part of the role players in service delivery within the PHC setting where they are also rendering service to the same clients, hence the importance of the model developed in this study for integration of IHS and WHS. The study results and the model will play a pivotal role as a reference in shaping further research and clinical service delivery across health professionals and other disciplines. Articles and further presentation will still be published in both national and international

journals for scholarly access by professionals and researchers.

### **6.7 Limitations of the Study**

The following are limitations of the study:

- ✧ The research was qualitative in nature and could limit the generalization of the findings, but the designed model could be of value to other similar contexts and settings.
- ✧ Traditional healing is regarded as ‘sacred’ since most traditional healers indicated that they needed a go ahead from their ancestors this the researcher feels could be a limitation in case if information is needed and there is no agreement to do so by the traditional healer from the ancestors.

### **6.8 Recommendations and Implications**

The researcher deemed it appropriate that in the light of the findings and expressions from the participants regarding the study that the following general recommendations be made:

#### **6.8.1 General Recommendations**

- ✧ There should be a revisit of the proposed Re-Engineering PHC Model by Pillay and Barron (2012:1) that IKS be included under the contracted private provider as they operate within the community health sector. This cadre could join the health service official mandated for community services and household PHC outreach teams.
- ✧ IKPs and IK experts should form part of NHP deliberations, needs analysis, planning and design for them to bring their expertise on board.
- ✧ Workshops and seminars should be open to all health care practitioners like IKPs,

and others for comprehensive knowledge generation.

- ✧ Benchmarking is to be implemented for best practices that will benefit clients and patients for quality service delivery.

### **6.8.2 Implications for Western Health Practitioners**

- ✧ Openness and willingness to embrace IKS practices is needed in order for the horizon of health practitioners to be extended within the PHC sector of care.
- ✧ For more effective community- and home-based care, traditional healers, herbalists, pastors, etc. should form part of health system strengthening, for example as antiretroviral treatment (ART) supporters, directly-observed treatment (DOT) TB supporters, as well as community health care committee forum members.

### **6.8.3 Implications for Legislation and Policy Making**

- ✧ Based on the findings of this study, the literature control and the available legislations governing the practice within our country, policy makers and health care service planners should have an inclusive mentality during the process of policy development and begin to involve all stakeholders, for example, IKPs and IK experts who provide care to clients/patients, to ensure integration of services in PHC settings and health system strengthening.
- ✧ Funding must be budgeted and legitimized towards strengthening IK generation and practice if the government has any intention of regulating the practice to safeguard patient care.
- ✧ The Traditional Health Practice Act No. 35 of 2004 needs to be amended to include

IKS practices in the health care system.

- ✧ Traditional healers who could share facilities with WHPs should be legally accommodated within clinics, health care and community centres to provide consultative care where needed.
- ✧ An open policy framework needs to be designed that will allow traditional healers, herbalists and pastors to refer their clients to WHPs without fear of intimidation or prejudice.
- ✧ Inclusion of IKS stakeholders into policy making forums is imperative for them to contribute effectively in the legislative framework of the country they serve.

#### **6.8.4 Implications for Education and Training of Health Care Professionals**

- ✧ A serious shift in mindset regarding the training and practice of doctors, nurses, pharmacists and other health professionals is critical for IKS to be integrated within the training curricula to produce relevant and community needs-based responsive cadres of professionals who will be able to sufficiently care for their patients.
- ✧ Training institutions should begin to invite the real knowledge experts and organic knowledge custodians as guest lecturers to debate issues regarding IKS that pertain to the programmes students are doing.

#### **6.8.5 Recommendations for Further Research**

- ✧ Collaborative clinical trials of traditional medicines/herbs need to be done.
- ✧ Explorative studies regarding verification and accreditation of IKPs by their own IK experts are required to ensure authenticity of practitioners.

- ✧ Further research can be conducted amongst doctors and nurses around IKS issues for deeper understanding.

## 6.9 Conclusions

Western paradigms of development does not always accommodate the community's realities and survival strategies. Few consultations were done to ensure relevance of planned development interventions, hence the lack of sustainability and community ownership (Luka, 2005:2). The integration of service and learning into health professions education is an increasingly important agenda as trends in health care service delivery shift from acute to community-based settings. This brings a challenge to institutions of higher learning to find appropriate strategies to involve Western and indigenous health practices in the development and training of student nurses and other health professionals. A joint venture is needed for the integration of IKS health practices with WH practices in knowledge generation and transferability to the student nurses in institutions of higher learning.

In their production of future health professionals, these institutions must be responsive to both student-learning objectives (which include Western- and indigenous-based outcomes) as well as community service objectives (which include culturally-based outcomes) for competency generation which is relevant to the consumers' health (Luka. 2005:6-8). With the current burden of HIV & AIDS and TB infections that South Africa is facing, together with poor access to public health facilities in most of the rural communities, traditional healing practices will continue to be the first option in response to health and illness behaviours. Traditional and faith healing stood the test of time, specifically the erosion due to colonialism and invasion of science and technological means as well as pharmaceutical clinical trials. The current scenario in dealing with health and illness behaviour is for both practitioners (IKPs and WHPs) to avoid scepticisms and paradigmatic dysfunctions associated with different treat modalities and begin working together within this given context of their existentialism,

rather than maintaining their indifferent and suspicious distance which debase and compromise efficacious health services to their shared clientele (Ae-Ngibise et al, (2010:566).

Service delivery is governed not only by high expertise within the health care sector, but also by the cultural beliefs, values and norms surrounding the recipients of the service in a given locality. This study was conducted from a cultural context of health care delivery and facilitated by both Western and traditional health care practitioners, including pastoral care. This scenario led the researcher to conclude that parallel service delivery is detrimental to total and holistic care of clients/patients as this continues to promote the divide between the health systems. Finally, the quest for integrating modern and traditional medicine will require the breakdown of legal and regulatory barriers that disadvantage the poor (<http://www.Scidev.net/global/systems/editorials/the-imperatives-for-traditionalmedicine>, accessed 2104/09/08, 1-3).

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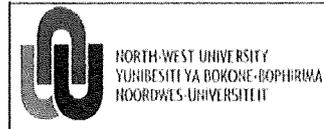
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# ANNEXURE A

## ETHICAL CLEARANCE FROM NORTH-WEST UNIVERSITY (MAFIKENG CAMPUS)



Private Bag X6001  
Potchefstroom  
South Africa  
2520  
Tel: (018)299-4900  
Fax: (018)299-4910  
Web: <http://www.nwu.ac.za>

### ETHICS APPROVAL OF PROJECT

#### Ethics Committee

Tel: +27 18 2994850

Fax: +27 18 293 5329

Email: [ethics@nwu.ac.za](mailto:ethics@nwu.ac.za)

This is to certify that the next project was approved by the NWU Ethics Committee:

**Project Title:** A model to facilitate integration of indigenous Knowledge Systems in the management of HIV and AIDS within the Primary Health Care (PHC) context in Limpopo Province, South Africa.

**Ethics number:** NWU-00009-12-A9

Status: S-Submission, R-Re-Submission, P-Preparational

**Expiry date:** 2017/03/07

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance. The formal Ethics approval certificate will be sent to you as soon as possible.

Yours sincerely



Me. Marietjie Halgryn

NWU Ethics Secretariat

# ANNEXURE B

## APPROVAL LETTER FROM DEPARTMENT OF HEALTH, LIMPOPO PROVINCE

 **LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

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**DEPARTMENT OF HEALTH**

Enquiries: Selamolela Donald Ref:4272

Bereda J  
North-West University  
Potchefstroom  
2520

Dear Ms Bereda

**Re: Permission to conduct the study titled: A model to facilitate integration of indigenous knowledge systems in the management of HIV and AIDS within the primary health care context in Limpopo Province, South Africa.**

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:
  - Further arrangement should be made with the targeted institutions.
  - In the course of your study there should be no action that disrupts the services.
  - After completion of the study, a copy should be submitted to the Department to serve as a resource.
  - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

  
General Manager, Strategic Planning, Policy and Monitoring  
Date 20/09/2017

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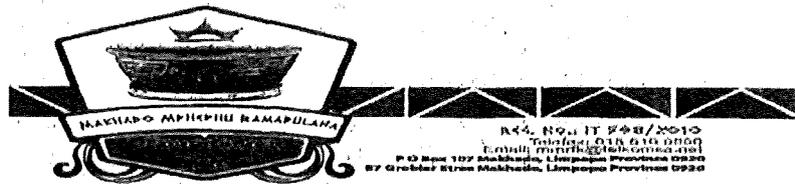
15 College Street, Polokwane, 2700 Private Bag 9002, POLOKWANE, 2700  
Tel: (014) 293 8000, Fax: (014) 293 4311/20 Website: <http://health.limpopo.gov.za>

**The heartland of Southern Africa - development is about people**

Z. 094 01/2017 21 01/17 01/17 01/17

# ANNEXURE C

## APPROVAL LETTER FROM HIS MAJESTY, THE KING



To: Julia Bereda

### PERMISSION TO CONDUCT RESEARCH IN THE INTEGRATION OF IKS IN HIV/AIDS MANAGEMENT WITHIN THE PRIMARY HEALTH CARE CONTEXT

1. Your letter concerning the matter above refers:
2. It is a pleasure to inform you that permission has been granted by His Majesty King Toni Mphahlele Ramapulana for you to conduct research on IKS in the traditional areas of the King.
3. The view of the King is that HIV/AIDS is a monster that must be confronted with all the energy and enthusiasm that we can muster as a people; in this regard IKS can play an important role. Also, this research will assist in deepening an understanding amongst our people, especially the youth that traditional societies have always been caring about the health status of the people. Further, efforts were always made to encourage behavior enhancing good health among the people.
4. You are also advised that wherever people will be consulted for the purpose of this research, traditional leaders in that area should be consulted and the purpose of the research explained. To this end, this letter will serve to introduce the researcher to that community and its leadership.
5. It is hoped that you will find this to be in order.

Secretary

Date

27/12/2012

# ANNEXURE D

## PARTICIPANT INFORMED CONSENT FORM

### CONSENT FORM FOR PARTICIPANTS

**A model to facilitate the integration of Indigenous knowledge Systems in the management of HIV and AIDS within a Primary Health Care context; Limpopo Province, South Africa.**

**CANDIDATE: MS J.E. BEREDA**

**PROMOTER: PROFESSOR M. DAVHANA-MASELESELE**

The purpose of this study is to develop a model that will facilitate the integration of indigenous knowledge systems within the management of HIV and AIDS as a way of creating relevant knowledge and skills that talks to the needs of the community in a holistic manner. During the interview you will be asked about the need of integrating indigenous knowledge systems into the management of HIV and AIDS in a Primary Health care setting and your contribution will serve as building blocks for Model development. Furthermore information will be gathered concerning indigenous health practices that can contribute to the management of HIV and AIDS pandemic worldwide. Information will be recorded but it will be treated confidentially. The researcher will also make notes of some information during interviews to supplement the tape recorded information. The final report containing anonymous quotations will be available to all at the end of the study. Intellectual property right shall be highly considered during the process of this study

**THIS IS TO CERTIFY I.....**

**(PRINT NAME)**

Hereby consent to be interviewed in this research with the understanding that;

There will be no harm to me resulting from my participation in the research. This interview will be tape recorded, and at the end of the research, the information will be published with anonymity. No reimbursement will be made by the researcher for information given or for my participation in this study. I may refrain from answering some of the questions if not comfortable with them. When I sign this agreement I undertake to give honest answers to reasonable question and not to mislead the researcher. I may withdraw from participating in the interview without any prejudice and the information that I gave before can be used by the researcher.

Signatures:

Participant: ..... Date: .....

Researcher: ..... Date: .....

# ANNEXURE E

## TRANSCRIPT OF INTERVIEW 13

### Participant Profile

✕ Gender: Male

✕ Qualification: Traditional Healer (TH)

✕ Age: 75 years

✕ Has been operating since 1987 when he was guided in a dream to follow the path that lead him to his trainer, where he was trained for 12 months and then came back home to start his own practice from then till now, amazingly he is now blind but he is treating his clients with ease and he is even saying his skills are not affected as he is instructed by his bones what the client is suffering from and he knows his herbs by touch and by smell.

✕ 25 years as a TH

Researcher= R

Participant= P

Two main questions were addressed:

1. *What are your views and perceptions regarding the integration of IKS in the management of HIV & AIDS in the Vhembe District within the Limpopo Province?*

2. *How do you think we can best integrate IKS in the management of HIV & AIDS?*

**R:** Good morning! I am here doing a study regarding the integration of IKS in the management of HIV & AIDS. Is there a way that the two systems could work together... I don't know if I am clear enough... I mean could you kindly tell me your views regarding the integration of IKS in the management of HIV & AIDS for the benefit of our patients?

**P:** Yes I am hearing you, but according to me I don't look down upon anyone because I know what I am and I believe everyone knows who they are.

**R:** Mmm... Ok!

**P:** (Continues) I don't have a problem with integration because according to me I take treatments and also use my herbs, I don't have a problem because even now that I am still alive is because I am under doctors as well as under herbs of this world, the two do not fight with each other.

**R:** Now when a client comes to you how do you go about it?

**P:** If a patient comes to me I treat what I see in the *bones*, not what I am thinking, if you come to me I don't ask you what you are feeling my *bones* tell me what you are suffering from and also how I should treat you

**R:** Ok let's say I come to you and you see what I am suffering from and then you treat me... is there a way where you can see whether there is a need for me to be referred to the hospital?

**P:** Mmm...

**R:** When is that?

**P:** Is when I am seeing that you are lacking blood.

**R:** OK...

**P:** ... and in the mist of my assessment and I discovered that you do not have either water or blood I will then send you to the hospital for you to get the water or blood.

**R:** So, then after that I can come back if need be?

**P:** Of course, the fact that you got the blood or water does not mean you are completely healed you will still need to be treated for that which was supposed to have been treated before you went for the blood or water.

**R:** So, if I come back with medication from the hospital then what?

- P:** This is what I am indicating that you can drink both treatments. . . remember herbal medication and pills do not fight—it's us that are making them fight saying this is right this is not right. It is not right to say when you are using herbs you are not supposed to drink your tablets. Let me give you an example. . . if a person comes to me with high blood or sugar I will give them my medication and instruct them not to stop their medication.
- R:** This is very clear, but let me ask you something. . . as a traditional healer you are busy helping your people and the doctor is also doing the same. . . if I may ask, can it be possible for you to move out here to a neutral built area where you can operate together with doctors?
- P:** It cannot be possible because with me my operation comes in dreams while I am asleep or by the use of *bones* using the process called *u tungula* (which means searching for information using the bones), whereas doctors start by asking patients what they are suffering from and then give them treatment. . . so I do not ask them what I can only ask is who is consulting is it you or the other one, then I do what I need to do then know the condition using the *bones* (*thangu* in Tshivenda). . . they do not speculate they speak exactly what one is suffering from and even give a directive on which medication to treat that person with.
- R:** Mmm. . .
- P:** If one is well trained in the interpretation of the bones in and out one cannot go wrong. The medications do not come from the book or the laboratory, they come from the bush.
- R:** Hey! *mukalaha* (an elderly person) you are moving yoh! I am enjoying this (the wife and son giggling on the side saying *hey* he is so much straightforward and the wife saying it is also influenced by the interviewer).
- R:** So you indicated that you will prefer working from home when doctors operate from the hospital. . . so tell me have you ever heard about HIV & AIDS or come across a client that said s/he has the disease?
- P:** In Tshivenda (in his culture) this disease is not there (meaning it does not have a specific name), but I got one lady that came to me saying she is HIV-positive, being told by those who told her.
- R:** Mmm. . .

**P:** She was coming from far, but was born here and married far, she went to the hospital and she had a sister that came saying she has the disease told by those that are saying it and she came to me and I treated her and she got healed. Personally, this name called AIDS I don't know it, but I treated her of what she had and she got healed.

**R:** Mmm...

**P:** ... and she had a sister who was taken to the same hospital with the same disease as they say. Then she went and visited her in the hospital and came here to ask from the *bones* if she can be helped and if it is possible, as I was also diagnosed the same and I was helped here, she indicated that her sister was due to be transferred to Garankuwa Hospital in three weeks' time. So I said to her as I indicated this sickness called AIDS, I don't know it, but what she can do is to go to the hospital and ask for her sister to be released and bring her here, then I will assess with my *bones*. Indeed, she went and ask for her sister and on the third day she came with her.

So I assessed using the bones and found the sickness that I found and said I will give her medications that she should use, but she must not hurry to go to the doctor as she is still having some time before going to Garankuwa Hospital. Then she came and I gave her my medications and told her to use them and come back before she goes to Garankuwa. Indeed, she came in the last week and I asked her not to go to the hospital but to continue with my treatment, and the I said now you can go to the hospital and take the file as if you are just consulting. Is in it that in the file it has this information that she is positive, then she went and she took the file saw the doctor and the doctor she found, I do not know him whether it was the one she saw before or a new one. Then after the patient saw what was in the file and that which is found in the patient, he said what is written about her is not true that you have HIV, but what I am seeing is the fact that you had sores in the wound and that is getting better, I think you understand that!

**R:** Mmm... I know!

**P:** Now the doctor discharged her and told her to finish the treatment she was eating, but she is healed.

**R:** So the client never went to Garankuwa Hospital?

**P:** How will she go? Because she is healed, so she was discharged. Now one day I was going to a village called Ngovhela. . . I met her at the bridge and she greeted me and I responded to this well-dressed and beautiful lady, and I could not recognize her, then she stopped at a distance and said Mr. . . why are you passing me like u don't know me? And I said how because I greeted you and you greeted me, then she said you don't know me, then she said I am that patient from. . . whom you treated and I said eee! I could not recognize you, but I am happy you are healed. Even today she is still alive and healed no problem.

**R:** Mmm. . . that is good, this is very clear now!

**P:** I am talking about what I passed from, I once lived here, and visited one of the hospitals here in Venda because I was worried. Then I met one nurse and said I am here because I have some news. Then I said I was asking if it I can be given one patient, especially one of the newly diagnosed with HIV, if it is possible so that I can be with the patient for the whole week treating them, and Sunday. . . Sunday they can come to be tested to see the progress then another week with me and then tested again on Sunday so that I could see if it's true that they do not heal by my herbs.

**R:** Mmm. . .

**P:** Then the nurse went inside where I do not know where, then she came back and said it is not possible because when the person comes here cannot go to any other place again. Then I realized that it is just pure jealousy then I said hey! let me go my way everyone will operate the way he wants, whoever needs my help will come to me.

**R:** Hey! this is the reason why you see me here. . . this would be the only way that you could have worked together as a team.

**P:** Because if I was allowed I would have treated the person and they would have done the testing to check the progress and if that one gets healed they would then give me another one to treat, I went there to help. . . I was not sick, but I was told when one gets in the hospital cannot come out and go somewhere, so what can one do?

**R:** Thank you very much my dad!

**P:** I am also thankful, I wishing you well on your studies. . . let's hope this will help people in the future.

**R:** Of course, this study will come up with a way the these healing systems could have a way of working together in the future for the benefit of both, including the patient in particular.

# ANNEXURE F

## FUNCTIONAL DEFINITION OF THE CONCEPT 'INTEGRATION'

### A. The Empirical Definitions of 'Integration' from Different Authors' Points of View

1. According to Rodgers and Knaff (2000:9), concepts are the *building blocks of theory*, and are *symbolic* representations of the things or events of which phenomena are composed of.
2. Fawcett (2005:4) defines a concept as a *word or phrase that summarizes ideas, observations and experiences*. They are *tools* that provide *mental images that can facilitate communication about and understanding of a phenomenon*.
3. Kodner (2009:1) summarizes the main *building blocks* of integrated care and suggests a way to address its various complexities and unknowns from real-world views and indicated that the need for health system integration to meet changing patient needs and community expectations is widely recognized and ways explored regarding methods found in health-system and service integration.

South Africa, in particular also needs a collectively capturing and sharing of the key learning from healthcare leaders and practitioners directly involved in the delivery of quality health services to our clients and not only focusing of the advancement of organisational knowledge about *what works* and *what doesn't work* in a *unilateral manner* (Kodner, 2009:1). He indicates that *new learnings could help in breaking down the integration silos* that often result from taking on much targeted quality improvement initiatives, thereby preventing missed opportunities for a broader spread of proven methods and innovative solutions.

**B. Definition of 'Integration' from the Social Perspective**

According to Rubin (2012:22-28), integration from the social perspective is said to be *the set of arrangements adopted by the society and the group to accept a new member amongst them and facilitate their acceptance process.* This has to do with people's beliefs, values and norms that make up a *collective consciousness, a shared way of understanding each other and the world we live in.* From data analysis regarding the views and perceptions of IK stakeholders it was evident that there is minimal or no integration of IKS in the main stream of health and that evoked many challenges that are needing solutions as IKP expressed a deeper feeling of being marginalized, side-lined and not supported at all in what they are doing, even though they have been in existence within their cultural context for as long as man lived. The participants's responses affirm the marginalization experiences by stakeholders that interfere with the definition of social integration:

*Hey! you are bringing a difficult topic now. Mmm. . . we are usually not acknowledged by Western medical practitioners because they say our things are not scientifically based. We are so undermined that this attitude will make us drift apart and will affect the client at the end of the day. I mean our patients, our profession is highly stigmatized because from the Western side they will say they were trained and from our side we hear a calling from the ancestor and we also work with extra powers from the ancestors, which is not believable by many people, but to my surprise people believe that there are powers from God or Jesus, or someone.*

*The problem is that herbal medication or traditional healing in South Africa, is stigmatized, not taken serious, side-lined so badly and hated highly by Western practitioners, especially by medical doctors because they think we will take their clients. Yeeeeeeeees it's all about fighting for customers, but this will not help them. The only solution for them (doctors) is that they themselves are from the same background of traditional medical help if they are true Africans. Their mothers used herbs to feed, protect and treat them when they were still young.*

### C. Definition of 'Integration' within the Continuum of Integrative Care

1. Kodner (2002), cited in Kodner (2009:7), defines integration as the glue that bonds the entity together, thus enabling it to achieve common goals and optimal results. Kodner (2009:7) further delimit integrated care in terms of the original terms, authors and definitions as tabulated below.

Original term and Author	Definition
Integrated Care (Vrevelt, 1998)	Methods and type of organization that will provide the most cost-effective preventative and caring services to those with the greatest health needs and that will ensure continuity of care and co-ordination between different services.
Integration (Leutz, 1999)	The search to connect the health care system (acute, primary medical and skilled) with other human service systems (e.g., long-term care, education and vocational and housing services) to improve outcomes (clinical, satisfaction and efficiency).
Integrated Care (Gröne and Garcia-Barbero, 2001)	A concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion...[as] a means to improve the services in relation to access, quality, user satisfaction and efficiency.
Integrated Care (Kodner and Spreuwenberg, 2002)	A coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the care and care sectors...[to] enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex problems cutting across multiple services, providers and settings.

The tabled definitions are indicative of a comprehensive approach to disease management to the level of client satisfaction. According to the author, INTEGRATION is designed to create *coherence and synergy between various parts of the health care enterprise* in order to enhance system efficiency, quality of care, quality of life and consumer satisfaction, especially for complex and multi-problem patients or clients. In essence, integrated care can be seen as a *demand-driven response* to what generally ails modern-day health care: access concerns, *fragmented services, disjointed care*, less than-optimal quality, system inefficiencies and difficult-to-control costs. The researcher concurs with all these definitions as described in the table above because in a PHC context clients have the liberty to choose any health care system in order to

deal with their health and illness behaviour, from indigenous system, power of prayer for divine healing, Western medicine hypnosis and other that are available.

2. Kordner (2009:10) further shows that disease management is a systematic, *population-based approach* involving the identification of people at risk of a particular disease, intervention throughout the condition's life cycle, and the packaging and management of treatments and services across the entire care and disease spectrum in order to achieve better and more cost-effective health outcomes.
3. According to WHO (2008:5), INTEGRATION as the *organization and management of health services* so that people *get the care they need, when they need it*, in ways that are user-friendly, achieve the desired results and provide *value for money*.
4. The Change Foundation in England (2008:3-5), expounds different views of *Integrated Care* as follows:

✦ **Patients/Users**

- For the patient, integration means *easy access and navigation and seamless care*.
- For the user, integration means health care that is *seamless and easy to navigate*.
- Well-integrated health systems are *patient focused*, and is characterized by internal organizational processes that that *consider the needs of patients and their families, easy navigation for patients and families across transition points, integrated processes, and patient choices*.

✦ **Providers**

- For the patient, integration means *interdisciplinary teamwork*; coordination of tasks, services and care across professional and institutional boundaries.
- From the WHO perspective, integration means that separate technical services, and their management support systems, are provided, managed, financed and evaluated either together, or in a coordinated way.
- Provider performances are documented and posted on the NHS website for patients to make an informed decision on who should treat them.

❖ **Managers**

- ❖ Oversight of combined funding streams; coordination of joint performance targets; supervision of enlarged and professionally diverse staff; management of complex organizational structures and inter-agency relationships; building and maintenance of shared culture.
- ❖ Bringing together different technical programmes, but also *considering the whole network of public, private and voluntary health services*, rather than looking at the public sector in isolation.
- ❖ England General Medical Council still remains the regulator of the medical profession in the United Kingdom, just like in South Africa.

❖ **Policymakers**

- ❖ Design of *integration-friendly policies*, regulations and financing arrangements; evaluation of systems/programs on a holistic basis.
- ❖ Integration happens when decisions on policies, financing, regulation or delivery are not inappropriately compartmentalized.
- ❖ The *Integrated Health Care* in England regarding policy is aimed at reforming the *National Health Strategy* (NHS) of England in order to be able to *provide patients with a stronger voice and more choice* through branding of the NHS to be *choices: your health, your choice*. They made patients to decide how they should be treated and where they should be treated (Kodner, 2009:14).

**D. Elements Governing the Process of Integration**

Fan (2004:1-10) defines integration from the Chinese perspective as literally meaning *putting different cultures together, based on positive moral concepts*. The article indicates that for cultures to become integrated they must *know each other*, they should *appreciate and respect each other* without necessarily *giving up their own characters*, nor *focus on their differences*, that will then be termed *proper or meaningful integration* governed by the deeper meaning of the following elements (Fan (2004:7-8).

The researcher amongst all the definitions found has a greater interest on the definition of INTEGRATION as indicated by Fan (2004:7-8), because it encapsulates the real meaning of the expected outcomes of the study, IKP and WHP could only arrive at a meaningful integration of their services and expertise if they take into consideration the elements of this definition:

- **Knowing** each other first;
- **Appreciating** each other as a system of health service delivery;
- **Respecting** each other without any prejudice;
- **Not giving up** their characteristics,
- **Not focusing** on their differences.

#### **E. Types of Integration**

Integration also was discovered to be the means to the end, that is it will be the connecting factor that will make the two health systems to:

- i. Know each other better;
- ii. Appreciate each other;
- iii. Respect each other; as well as
- iv. Embracing each other's differing in roles, that is, role clarification as fully described in chapter 4 of the study.

Realization of proper or meaningful integration will be possible when all analyses depart from the cultural and WHS contexts of human existence where the process of integration has to take place. Definitions and observations of types of integration can present in different modalities as tabulated below (PAHO, 2011:30):

Type	Definition	Observations / Examples
<b>Horizontal Integration</b>	Refers to the coordination of activities across operating units that are at the same stage in the process of delivering services.	Integration is about consolidations, mergers, and shared services within a single level of care.
<b>Vertical Integration</b>	Refers to the coordination of services among operating units that are at different stages of the process of delivering services.	Integration is about the linkages between hospitals and medical groups, outpatient surgery centres and home-based care agencies. There is forward vertical integration, which is toward the patient or user, and backward vertical integration, which is toward the supply side such as medical equipment and supply companies. Furthermore, there is the possibility of vertical integration with the health insurer.
<b>Real Integration</b>	Refers to integration through control and direct ownership of all of the parts of the system (Unified ownership of assets).	
<b>Virtual Integration</b>	Refers to integration through relationships and not asset ownership as a means for collaboration among system components.	Modality that uses contracts, agreements, strategic partnerships, affiliations or franchises, which "simulate" the benefits of asset ownership. This type of integration can coexist with asset ownership.

Source: Shortell, Anderson, Gillies, Mitchell & Morgan (1993:20-6)

#### F. Focus of Integration within the Study

According to Kodner (2008), In (Kodner, 2009: 15), integration efforts can focus on:

- i. Entire communities or enrolled/rostered populations irrespective of health status;
- ii. Vulnerable client sub-groups (e.g., the frail elderly and persons with disabilities); or
- iii. Patients with complex illnesses (e.g., chronic conditions, some cancers).

Vulnerable and complex patients need to benefit to the highest degree from integrated care. In this study, the focus of the INTEGRATION concerns the integrated efforts affecting a group within the community (IK experts/practitioners and WHP). The vulnerable complex clients sub-group are patients with HIV & AIDS at any point of their disease continuum.

# ANNEXURE G

## MAP OF THE REPUBLIC OF SOUTH AFRICA



Red arrow indicates the administrative capital of the Limpopo Province.

# ANNEXURE H

## CONFIRMATION BY LANGUAGE EDITOR

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12 March 2015

To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the PhD thesis by **Julia Elisa Bereda**, titled: **“A Model to Facilitate the Integration of Indigenous Knowledge Systems in the Management of HIV & AIDS Within a Primary Health Care Context in Limpopo Province, South Africa.”** The manuscript was also professionally typeset by me.

Sincerely Yours

A handwritten signature in black ink, appearing to be 'D. Hiss'.

Dip. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD

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