

**Exploring the Role of Traditional Medicinal Practitioners in the use of
Indigenous Knowledge Methods for the Treatment and Management of
HIV/AIDS-related Symptoms: A Case Study of Keates the Drift
Community in the Province of KwaZulu-Natal**

by

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Declaration

I hereby certify that this is my original study, conducted as part of my Master's Degree in Community Work at the University of Zululand's Department of Social Work. The dissertation has not previously been submitted for consideration for any other degree or examination at this or any other university. All data in this publication were gathered and presented in conformity with academic standards, ethical processes, and standards of conduct. Additionally, I have adequately cited/referenced all texts and outcomes in this work that are not entirely my own.

Celimpilo Mkhize

Signature :

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Dedication

I dedicate this work to my mother, who has stood by me since my father passed on when I was five (5) years old. My mother has supported me up to this point, and I am indebted to her. I will always be in awe of her.

Abstract

It is widely accepted that Africa consumes over 80% of indigenous knowledge (IK) for medical purposes, including the treatment and management of diseases and other illnesses. Due to its accessibility and affordability, Africans continue to rely on and use traditional medicine. This study defined traditional medicinal knowledge as the use of local knowledge in medicine to diagnose, prevent, or eliminate physical and mental problems that community members suffer from to ensure that their conditions are treated and managed.

The purpose of this study was to investigate the role of traditional medicinal practitioners in KwaZulu-Natal Province in the use of indigenous knowledge methods for the treatment and management of HIV/AIDS-related symptoms. Four (4) research objectives guided the study, which examined the sorts of traditional medicinal practitioners, the indigenous knowledge of medicinal plants used to treat and manage illnesses such as HIV/AIDS, and the obstacles faced by traditional medicinal practitioners in treating and managing HIV/AIDS.

This study was guided by Asante's Afrocentric model (1998). This hypothesis was used because it recognises and values indigenous knowledge's use of medicinal plants to cure and manage ailments. The interpretive paradigm guided the study procedure. The study employed a qualitative methodology and a case study approach. The data were gathered using a combination of semi-structured interviews and content analysis. To estimate the sample size and frame of traditional medical practitioners from the Keates Drift Community in the province of KwaZulu-Natal, nonprobability sampling approaches such as purposive and snowball sampling were used. A total of 12 traditional medicine practitioners in the Keates Drift Community in the province of KwaZulu-Natal were interviewed.

The study's findings indicated that traditional medicinal practitioners reside in the Keates Drift Community, where they display their abilities in, and knowledge of, traditional medicine. Additionally, the findings indicated that traditional medicinal practitioners enjoy widespread respect in the community and are regarded as community physicians. The findings also indicated that diviners (Izangoma) and herbalists are the two categories of traditional medical practitioners found in the Keates Drift Community (Izinyanga). Additionally, traditional herbalists and diviners used medicinal herbs to treat and manage HIV/AIDS-related illnesses. Notably, the findings indicated that plant parts such as leaves, barks, stems, and roots were used to treat HIV/AIDS-related illnesses. It was determined that traditional medicinal practitioners did not use human or animal parts to treat illnesses, but instead relied on plants, as the use of human or animal parts is prohibited.

Concerning the difficulties experienced by traditional medicinal practitioners, the findings indicated that there is no collaboration between them and modern physicians, and that traditional medicinal practitioners are not treated similarly to modern physicians. The study concluded that it is critical to treat traditional healers with respect and to provide them with adequate space to treat and manage HIV/AIDS-related illnesses.

Keywords: traditional medicine, indigenous knowledge, indigenous plants, Afrocentric theory, HIV/AIDS

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LIST OF ABBREVIATIONS

HIV	:	Human Immunodeficiency Virus
IK	:	Indigenous knowledge
TM	:	Traditional medicine
TMP	:	Traditional medicinal practitioners
TMP	:	Traditional medicinal plants
IKTM	:	Indigenous knowledge traditional medicine
KZN	:	KwaZulu-Natal
WHO	:	World Health Organisation
TH	:	Traditional healers
SA	:	South Africa
SABC	;	South African Broadcast Corporation
WM	:	Western medicine
MD	:	Modern doctors
CM	:	Community doctors
TD	:	Traditional doctors
WHOTMS	:	World Health Organisation on Traditional Medicine Strategy
RC	:	Rural community
IC	:	Indigenous communities
AT	:	Afrocentric theory
DH	:	Department of Health
KD	:	Knowledge dissemination
UZIR	:	University of Zululand Institutional Repository
IR	:	Institutional Repository
UZ	:	University of Zululand
TF	:	Theoretical framework
APP	:	African philosophical perspective
IKS	:	Indigenous knowledge systems
THPB	:	Traditional Health Practitioners Bill
SATHPC	:	South African Traditional Health Practitioners Council
TBA	:	Traditional birth attendants
HPC	:	Health Professional Council

NRFCATM : National Reference Centre for African Traditional Medicine

Chapter 1. Introduction

1.1. Introduction

Africa continues to play a significant role in the management of human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) using indigenous knowledge methods (Zuma, Wight, Rochat & Moshabela, 2017). Important to note is that HIV is not AIDS but if not treated, it leads to AIDS. Hence the application of traditional medicinal knowledge to treat and manage the symptoms of HIV is crucial and this is the focus of the study. Since the colonial era, there has been a huge disparity between modern science and indigenous knowledge systems (Ideland, 2018). Additionally, modern science has prospered, while indigenous knowledge systems have been labelled primitive, outdated and witchcraft (Chinsembu, Shimwooshili-Shaimemanya, Kasanda & Zealand, 2011). However, the overpriced cost of modern healthcare systems and technology established in developing countries led to a national healthcare system approach, which gave traditional health practitioners the opportunity to be recognised in modern healthcare in rural communities (Helwig, 2010:30). Additionally, Masoga and Shokane (2020:1) also posited that traditional healers consider local healing highly essential for African people as it involves a quest for a quality of life and provides access to support healthcare. This means that African traditional medicine is very important to African people as it is very cheap and affordable to them.

During the colonial era in Africa, contemporary healthcare was used and promoted among Africans to the extent that modern science came to dominate over indigenous knowledge (Hillenbrand, 2006; Kayombo, 2007). Africans, however, continued to use traditional medicine, due to its accessibility and affordability. The support of the World Health Organisation (2002) in the integration of indigenous healing in modern science led to a rise in active indigenous healers in South Africa to approximately 200 000, with an estimated 80% of Africans consulting traditional healers on a daily basis (Mahomoodally, 2013). The traditional healers do so not only because it is a longstanding part of traditional culture, but also due to the lower cost of traditional medicine.

Indigenous knowledge medicinal practitioners use an amalgamation of management methods, which include pricking the skin with needles to alleviate pain and disease; predicting the future or coming troubles; massaging the feet for relaxation and improved circulation; and healing disease, both emotionally and physically (Viriri & Mungwini, 2009; Zuma, Wight, Rochat & Moshabela, 2017). Noticeably, it can be said that throughout Africa

and South Africa in particular, rural people and even some that live in urban areas, they consult traditional healers (izinyanga), herbalists (inyanga), diviners (sangomas), spiritualists and prophets to advise them when they are afflicted with sickness, whether the cause of their troubles is due to the displeasure of their ancestors and whether an individual is meant to become a sangoma (traditional healer). Then, after thorough consultation with these ancestors, the patient is expected to go through initiation (thwasa). Additionally, the iSiZulu speaking people in KwaZulu-Natal, South Africa, Shona in Zimbabwe, SiSwati people in Swaziland etc. believe that disease within society is the result of disturbed social relations and misfortune (Viriri & Mungwini, 2009; De Lange, 2017).

The prophets treat the natural causes of diseases by means of water and visions. Upon pinpointing the causes of the medical condition, the diviner prescribes medicine to the patient. Should it fail to minimise the symptoms of the condition, the patient is then referred to an herbalist/innyanga (traditional healer who manages or treat the illness by means of herbs and amathambo/bones) or a *sangoma* (who performs similar functions to the *inyanga*). The diviner may recommend a Western medicine regimen if the condition persists (Westerlund, 2006; Singh, Baijnath & Street, 2020).

The World Health Organisation (WHO) (2008:11) defined African traditional medicine (ATM) as ‘the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illnesses.’ African traditional medicine is deeply entrenched in indigenous life across the continent, since indigenous communities favour such treatment over Western medicine (Bussmann, 2010; World Health Organisation (WHO) (2008)). Indigenous medicine is also more accessible and affordable to many indigenous people around the world. It is a broad concept that includes a diverse range of practices, such as acupuncture, Ayurveda, Islamic medicine, traditional Vietnamese medicine and African traditional medicine (Wangchuk, 2008). Hakim and Chishti (2010) stated that the media often cast African traditional health practitioners in a negative light; for example, reports on the number of healers claiming to have found the cure for HIV/AIDS and the unethical treatment of patients. These reports have tarnished the image of traditional healing in South Africa. One such news item, by the South African Broadcast Corporation (SABC) on 5 October 2013, featured Bishop Nala, who claimed to have found a remedy for HIV. He alleged that drinking holy water had cured a number of HIV-positive people of the virus, a claim that elicited great criticism from the

Treatment Action Campaign and Government, since no proven cure had yet been found for HIV/AIDS.

Western society continues to be dismissive of traditional healing, and distrustful of any treatment that has not undergone extensive testing. One example of this comes from an article in the South African Medical Journal (Mahomoodally, 2013) that stated: A study conducted by the Department of Pharmacology of the University of Cape Town (UCT) showed that herbs used by traditional health practitioners are effective for treating malaria but remain unused in the public sector. The curative properties of herbs are scientifically sound, but none are close to mainstream medical adoption. Traditional medicine is, furthermore, experiencing an upward trend in developing countries, due to complementary and alternative medicine that applies natural science or formal science to develop knowledge or forms of medicine. The World Health Organisation on Traditional Medicine Strategy (2005) called for traditional medicine to be tested and evaluated for safety and efficacy, before it could be accepted into society/national healthcare policies.

Semenya, Martin and Potgieter (2014) explained that indigenous healers are the first to be consulted when calamity strikes a rural community because people trust and believe in their ability to treat, diagnose and cure ailments. They are considered as doctors of the community because of the amount of knowledge they have towards ailments and other unfamiliar conditions regarding sicknesses. It may be easy to be dismissive of traditional medicine, but its cultural values and healthcare practices are inherent to traditional society and pertinent to issues around HIV/AIDS (Munk, 1997:10). Indigenous communities will continue to opt for traditional health practitioners over Western medicine, a choice justified by the problems encountered in accessing antiretroviral medication, the negative attitude of healthcare professionals and the toxicity of drugs.

A study conducted in South Africa by the World Health Organisation (2013) reported that the majority of South Africans consult traditional healers (*inyangas*) and diviners (*sangomas*) for relief from symptoms related to HIV and AIDS. As such, the World Health Organisation (2013) recommended the collaboration between Western doctors and traditional health practitioners to find a cure for HIV/AIDS in southern Africa. A possible initiative could be to incorporate the expertise and skills possessed by traditional health practitioners in treating secondary or opportunistic infections. Furthermore, *sangomas* are able to spiritually connect with ancestral spirits for assistance in diagnosing and curing physical and spiritual ailments; while *inyangas* are primarily herbalists, who specifically employ the medicinal properties of

indigenous flora toward patient treatments and cures. Most traditional healers consult with ancestral spirits to locate plant material, using plant material vultures and rare animal species to make concoctions (muti). The word concoction (muti) means a mixture of herbs that are used by different traditional healers to treat and manage ailments associated with HIV/AIDS.

It is a belief of African people that the fortunes of life such as "health, disease, success or misfortune" are in the hands of the ancestors and it is thus necessary to seek the assistance of a traditional healer, who is guided by "prayer, dreams and visions" to gather the relevant herbs and apply the knowledge and skills acquired during training (Zuma, Wight, Rochat, & Moshabela, 2016:9). As such, a large number of South Africans consult traditional healers, diviners, herbalists and spiritualists for the relief of symptoms stemming from HIV/AIDS. Cultural values and healthcare are inherent to traditional society and within the context of HIV/AIDS treatment in Africa. This cultural bond to a particular indigenous community is the reason for the preference of traditional medicine over western medicine (Zuma, Wight, Rochat, & Moshabela, 2016). It is in that regard that the focus of the study was to uncover the different indigenous knowledge management methods used by traditional healers, diviners, herbalists and spiritualists in dealing with HIV/AIDS. Noticeably, studies of this nature are not common, yet indigenous knowledge medicinal practitioners are reported to be doing excellent work in Africa.

1.2. The concept of indigenous knowledge

There is no single definition of indigenous knowledge (IK) but it provides multiple definitions of the concept. According to Ngulube and Onyancha (2011), despite the recognition of the importance of the knowledge of traditional and indigenous communities, there is limited agreement on its definition and conceptualisation. The two authors stated that there are competing ways of defining IK and various ways of labelling it. Nevertheless, the various definitions also have some common traits. For example, the World Bank Group (2004) defined indigenous knowledge (IK) as the knowledge for local decision-making in agriculture, health, natural resource management and other activities. It is viewed to be used at local level by communities in developing countries as the basis for decision-making pertaining to food security, human and animal health, education, natural resource management, and other vital activities. Indigenous knowledge includes the experimental, locality-specific knowledge and practices of medicine, as well as healing, hunting, fishing,

gathering, agriculture, combat, education and environmental conservation developed by indigenous people over many years (Masoga, 2017).

1.3. Problem statement

Despite the fact that 80 percent of IK is used for medical purposes in Africa (Mahomoodally, 2013; World Health Organization (WHO), 2003), many organisations still regard IK as marginalised (Ocholla, 2007). Marginality, according to Ocholla (2007), is defined as exclusion. It refers to a feeling of being left out or not paying enough attention to anything - in this case, IK. According to Ocholla (2007), terms like "primitive," "backward," "archaic," "outdated," "pagan," and "barbaric" were frequently used to refer to IK in a derogatory or dismissive manner. However, the rising use of IK in alternative medicine has raised awareness of the necessity of adopting IK healing methods in HIV/AIDS in hospitals, communities, societies, countries, and business sectors. Traditional healers, sometimes known as herbalists, diviners, faith healers and spiritualists, or those (the vast majority of healers) are vital to the development of South Africa's health system and the strengthening and support of the country's HIV/AIDS response (Masoga & Shokane, 2020). In South Africa, there are reported to be between 150 000 and 200 000 traditional healers, with a healer/population ratio of 1:200 (Mbatha, 2010).

A variety of factors have been blamed for the escalation of South Africa's HIV/AIDS epidemic, and debate has raged over whether the traditional medicinal practitioners are involved in the treatment and management of HIV/AIDS-related symptoms. In that light, the purpose of this study is to present the roles of traditional medicinal practitioners (traditional healers, diviners, herbalists, spiritualists, and so on) in HIV/AIDS treatment and management in the Keates Drift Community in the province of KwaZulu-Natal.

1.4. Aim of study

The study's aim was to examine the role of traditional medicinal practitioners in KwaZulu-Natal province, in the usage of indigenous knowledge methods in treating and managing HIV/AIDS-related symptoms.

1.5. Objectives of study

In order to fulfil the aim of the study, the following objectives were formulated:

- To identify the types of traditional medicinal practitioners found in the Keates Drift Community in the Province of KwaZulu-Natal.
- To determine the types of indigenous knowledge medicinal plants used to treat and manage illnesses such as HIV/AIDS.
- To establish whether traditional medicinal practitioners are well informed in HIV/AIDS in KwaZulu-Natal.
- To identify challenges faced by traditional medicinal practitioners in treating and managing the spread of HIV/AIDS.

1.6. Research questions

In order to address the specific objectives of the study, the following research questions would be answered:

- What types of traditional medicinal practitioners are found in rural communities?
- What indigenous knowledge traditional medicinal plants do they use to treat and manage HIV/AIDS related symptoms?
- How well-informed are traditional medicinal practitioners in treating and managing HIV/AIDS related symptoms?
- What challenges faced by traditional medicinal practitioners in treating and managing HIV/AIDS relate symptoms?

1.7. Literature review

Journals, conference papers, research publications, official government publications, and books were used to gather and review current material. The majority of the information was acquired from the internet, which is a repository of recent articles. The sources discussed the different types of traditional medicinal practitioners, the different types of traditional

medicinal plants used to treat and manage HIV/AIDS-related symptoms, how well-informed traditional medicinal practitioners are in the treatment and management of HIV/AIDS-related symptoms, and the challenges that traditional medicinal knowledge practitioners face when dealing with the treatment and management of HIV/AIDS-related symptoms.

1.8 Theoretical framework

The Afrocentric Theory of Asante was used as the theoretical basis for this research (1998).

1.9 Research methodology

This section contains a synopsis of research methods, which are covered in greater depth in Chapter 3. The research objectives were investigated using a qualitative research method in this study. A naturalistic qualitative research method is one that focuses on the natural setting where interaction occurs by viewing social life in terms of processes rather than in static terms (Neuman, 2014). One of the distinguishing features of qualitative research is that it focuses on the human environment and how people interact with it through symbols, rituals, social structures, and social roles, among other things. This method examines and analyses data using words rather than numbers; it is subjective, and the researcher relies on the opinions of data gathering participants.

A case study approach was chosen as the research method. This used a case study because it is an in-depth investigation of a person, or a group of persons, with an intention of generalising across multiple units. A case study, according to Creswell (2014), is a qualitative design in which the researcher investigates a programme, event, activity, process, or one or more individuals in more depth. Traditional medicinal practitioners, such as diviners (izangoma) and herbalists (izinyanga), made up the study's population. The study used non-probability sampling, more specifically snowball sampling, the reason being that the researcher lacked any knowledge of traditional healers who were registered by the Department of Health to deal with HIV/AIDS in rural areas, and those who were using the traditional medicinal herbs. As such, snowball sampling was crucial for referral purposes. The study intended to get to know all traditional doctors who are recognised in rural regions and those who are registered by the Department of Health to deal with HIV/AIDS in rural

areas, in addition to identifying the traditional medicinal herbs used. Semi-structured interviews were employed to obtain data for this research. The study analysed the collected data using thematic analysis. Thematic analysis is a qualitative method for identifying, analysing, and reporting patterns and themes in data. It aids in the organisation and description of data sets in more depth (see Chapter 3 for a detailed discussion).

1.10 Definition of terms

The following main key terms used are explained:

1.10.1 Traditional medicinal knowledge

Traditional medicinal knowledge, according to Maluleka (2017), is defined as “the total sum of all knowledge and practices, whether explainable or not, used in diagnosing, preventing, or eliminating a physical, mental, or social disequilibrium and which rely exclusively on past experience and observation handed down verbally or in writing from generation to generation” and “health practices, approaches, and methods”. Traditional medicinal knowledge is defined in this study as the type of inborn and community knowledge used by traditional practitioners to treat and manage HIV/AIDS symptoms.

1.10.2 Traditional medicinal practitioners

Traditional medicine practitioners use herbs, medicinal plants, and other techniques that have been used in the community to treat mental and physical illnesses and are believed to cure and heal by assisting or stimulating nature, as well as provide advice on how to maintain or improve health and well-being (World Health Organisation, 2013). Traditional medicinal practitioners, who include diviners (sangomas) and herbalists (izinyanga), are the owners of the knowledge in this study. They are regarded as community traditional doctors who provide traditional medicine for the community's well-being. Traditional botanicals are typically used to treat and manage HIV/AIDS-related disorders.

1.10.3 Indigenous knowledge

Indigenous knowledge is inextricably linked to a community's culture, which has evolved over the course of its entire history (Chisenga, 2002; Ngulube, 2002). Indigenous knowledge, according to Eyong (2007), refers to what indigenous people know and do, as well as what they have learned and done for generations in a practice that has grown through

trial and error and has shown to be adaptable to change. It can also refer to local knowledge held by the community elders of a certain community for their survival.

1.10.3 Afrocentric

According to Asante (1998), the term "Afrocentric" refers to the practice of centring any study of African culture and behaviour on African principles. In other words, the term "Afrocentric" denotes to the actual placement of African values at the heart of any study of African culture and behaviour.

1.11 Ethical considerations of the study

It is widely acknowledged that when researchers embark on a research project, they normally think about the importance of ethical considerations before proceeding with the study. A study cannot, for example, impinge on the rights of the target population. An ethical clearance is always necessary in this situation (Hammond & Wellington, 2013: 60). In this regard, the researcher normally collected data while keeping in mind the rights of the target community. The researcher usually considered the respondents' rights, such as informed permission, confidentiality, and protection from disclosure of information (Corbin & Strauss, 2015).

In a letter to the chief (induna), the researcher requested permission to collect data from traditional medicinal practitioners in the community of Keates Drift in Msinga. The researcher applied to the University of Zululand for ethical clearance. A letter was sent to the chief of the Keates Drift community, requesting permission to speak with owners of traditional medicinal knowledge, who are considered community doctors.

1.12 Intended contribution

The theory and practice of traditional medicinal knowledge have both benefited from this research. To begin with, the study was able to use a theoretical framework that encouraged the use and reliance on African knowledge, specifically traditional medicinal knowledge. Through its selected approach, the study revealed that traditional medicinal knowledge is vital for African people, particularly in the treatment and management of HIV/AIDS symptoms. In other words, the study found that Afrocentric theory supports the idea that Africans may rely on their own abilities and knowledge to combat HIV/AIDS-related illnesses and disorders.

The study was able to generate literature based on the sources of information it used. It was discovered in the study's literature review and analysis that there are many sorts of traditional medicinal knowledge practitioners in rural areas. Traditional medicinal practitioners are well versed in traditional medicine, as evidenced by the study's analysis of the literature, and they are referred to as community traditional doctors. The study's literature also revealed that there are plants that can be combined to treat and manage HIV/AIDS-related illnesses. The study provided additional light on the application of indigenous knowledge healing approaches in the treatment and management of HIV/AIDS and presented new research findings. Furthermore, the study has benefited indigenous knowledge practitioners, the Department of Health, academic institutions, the community, and the government at large in the utilisation of indigenous knowledge as a treatment and management of HIV/AIDS related symptoms.

Thirdly, the study findings were critical because they revealed a strong similarity with the literature review as well as the theoretical framework. The study's findings supported Afrocentric theory by demonstrating the importance of traditional medicine in the treatment and management of HIV/AIDS related symptoms. The findings demonstrated that Africans, particularly traditional medical practitioners, are well-equipped to deal with health-related issues without relying on western knowledge.

Finally, the research has given the researcher research skills, particularly in the application of traditional medicinal plants. The researcher's knowledge of the varieties of medicinal plants that are blended to treat and control HIV/AIDS symptoms has grown as a result of the research endeavour. The research has elevated the researcher to the status of an expert in the field of health and traditional medicinal knowledge.

1.13 Limitations of the study

The goal of the study was to look into the role of traditional medicinal practitioners in the treatment and management of HIV/AIDS related symptoms. The study was limited to the Keates Drift settlement in the KwaZulu-Natal province. Traditional medical practitioners, such as diviners (Izangoma) and herbalists (Izinyanga), were key informants to the study. Due to budgetary limits and time constraints, the investigation concentrated solely on this region, as the researcher was studying part-time, and the study was for a Master's degree that had to be completed within two years of registration.

1.14 Structure of the mini-dissertation

The outline of the mini-dissertation is outlined as follows:

Preambles: Title page, declaration, acknowledgements, dedication, abstract, table of contents, list of tables/ figures, abbreviations and acronyms, and list of appendices

Chapter 1: Introduction and background to the study

The study's conceptual and contextual settings are described in Chapter 1, as well as the problem statement, aim, objectives, and research questions, significance, literature review, theoretical framework, ethical considerations, definition of terms, limitations of the study, and conclusion.

Chapter 2: Theoretical framework and literature review

In this chapter, the Afrocentric Theory is discussed, as well as how it applies to the use of indigenous knowledge and traditional medicinal herbs in the treatment and management of HIV/AIDS symptoms. The chapter also includes literature reviews on the various types of traditional medicinal plants used to treat and manage HIV/AIDS-related symptoms, how well-informed traditional medicinal practitioners are in the treatment and management of HIV/AIDS-related symptoms, and the challenges that traditional medicinal knowledge practitioners face when dealing with the treatment and management of HIV/AIDS-related symptoms.

Chapter 3: Research Methodology

The research methods and study design are discussed in this chapter. The research paradigms, research design and technique, qualitative and quantitative approaches used, study population, sampling strategies, and data collection tools are all described in this chapter. Procedures for data gathering and analysis are also discussed.

Chapter 4: Data presentation, Analysis and Discussions

The outcomes of each study topic are presented in Chapter 4. The findings are provided in this chapter in the form of tables and narratives. The crucial findings are also clarified in light of the research aims and questions in this chapter, which is blended with the literature review and theoretical framework.

Chapter 5: Summary of Results, Conclusion and Recommendations

This chapter summarises the findings as they relate to the study's aims, conclusions, and suggestions for the field. It also makes recommendations for future research.

References

This section shows a list of references, namely books, journals, articles and online resource material used in developing this research project.

Appendices

These are supportive materials placed at the end of the thesis and include data collection instruments and letters to subjects.

1.15 Conclusion

This chapter focused on the introduction, which revealed how indigenous knowledge medicinal plants are widely used to treat HIV/AIDS symptoms. The chapter also demonstrated the importance of traditional medicinal knowledge in ensuring that rural people are equipped to combat any hazardous diseases that may arise. The study's problem statement, goal and objectives, as well as the research questions, were also discussed in this chapter. The significance of the study and the research methods used are also explained in the chapter. There is also a discussion of the study's key topics and following that, an outline of the study's layout was provided. The theoretical framework and literature review are discussed in the following chapter.

Chapter 2. Literature Review

2.1. Introduction

The study's introduction and context were described in the previous chapter. This chapter covers the literature evaluation as well as the theoretical framework that lays out the procedures and guidelines for using traditional medicinal herbs to treat and manage HIV/AIDS symptoms. This chapter explains who qualifies to be a rural community doctor and how they can use their local knowledge to treat and manage HIV/AIDS. Furthermore, in rural regions, the principle of Ubuntu - *Umuntu ngumuntu ngabantu/motho ke motho ka batho/* - which states that a human being is a human being through other human beings, is not forgotten. The chapter is driven by four research objectives which are looking at the types of traditional medicinal practitioners found in rural communities, the various types of traditional medicinal plants used to treat and manage HIV/AIDS-related symptoms, how well-informed traditional medicinal practitioners are in the treatment and management of HIV/AIDS-related symptoms, and the challenges that traditional medicinal knowledge practitioners face when dealing with the treatment and management of HIV/AIDS-related symptoms. It is important to note that this chapter begins with a discussion of the theoretical framework that was used.

2.2. Theoretical framework

A theoretical framework is commonly used to help a researcher in a broad field of expertise in their investigation by elaborating on an underlying principle, rationale, or basis in relation to the research issue (Neuman, 2014). A theoretical framework is a diagram that indicates how the variables in the study take into account how they should relate to one another (Awang, 2011). A theoretical framework, according to Ocholla and Le Roux (2011), is objectively focused towards improving research clarity, appropriateness and efficacy. They further defined a theoretical framework as the section of a research proposal or study that outlines the research topic (hypothesis), as well as the course of investigation and methods employed to address it. A theoretical framework relates to a study approach's agenda, outline, and theoretical construct, and it usually comes before the literature review. Concepts and constructs are thus employed on a theoretical level, whilst variables are used as explanations or interventions on an empirical one. Theories are broad statements regarding

variables and their relationships. This study is underpinned by the Afrocentric theory by Asante (1998). The theoretical framework is discussed in the following section.

2.2.1. Afrocentric theory

As previously stated, this research was guided by an African philosophical perspective. According to Mwansa (2010), Africa should produce what is hers rather than relying on western knowledge. In other words, rather than employing models that suit western knowledge, Africa needs to use Afrocentric models based on local knowledge systems. In this regard, Asante's Afrocentric model was applied in this study (1998). According to Asante (1998:2), the term "Afrocentric" refers to the actual placement of African values at the heart of any study of African culture and behaviour.

According to Afrocentricity, any phenomenon is perceived completely through the perspective of an African (Asante, 1991:171). As a result, Africans have the potential to study their own indigenous knowledge because it is theirs. It simply implies that all Africans, even traditional medicinal practitioners, have a responsibility to study the world and its people, ideas, and history through the lens of Africa. Since its formal birth, Afrocentricity has had huge effects on education, different social and civic institutions, and cultural life in Africa and the African diaspora (Asante, 1991). It is the responsibility of Africans, according to Asante (1991), to delve deeply into their own knowledge and recognise the benefits and downsides of their knowledge. African wisdom should be taught and known by Africans, according to Asante (1991), and studying their inborn knowledge should not be considered barbarian. In higher education institutions across the United States, Afrocentricity is now obviously dominant in the discipline of African studies.

According to Asante (1998), Eurocentricity rejects all depictions of Africans' history and culture. Masoga and Shokane (2018) praised the usage of African philosophy over western paradigms in their study. The Afrocentric paradigm, for example, places indigenous knowledge at the centre of all that Africans do, according to the two writers. In other words, the two authors emphasised the importance of relying on African culture rather than western knowledge. Masoga (2017) also praised Asante's work, stating that the theory's purpose is to enhance local knowledge. Asante's (1998) work, according to Masoga (2017), is creating awareness among African people to start relying on their own knowledge, which is African traditional knowledge, rather than appreciating western theories that push indigenous

knowledge deeper into darkness. In this study, Asante's model proved to be very useful in promoting the use of traditional medicinal plants to treat and control HIV/AIDS symptoms.

2.2.2 Relevance of the theory to the study

The research aim, which was to examine the role of traditional medicinal practitioners in KwaZulu-Natal province in the use of indigenous knowledge methods in treating and managing HIV/AIDS-related symptoms. The Afrocentric paradigm is a radical shift in thought, offered as a response to black disorientation and powerlessness. "What would African people do if there were no white people?" asks the Afrocentrist. (Asante, 1991:172.). In other words, what natural responses would occur in African people's relationships, education, attitudes toward the environment, types of religion, and historical points if colonisation or enslavement had not intervened? Asante (1991:172) continued, "Afrocentricity responds to this challenge by affirming the central position of the African person within the context of African history, thus displacing Europe from the centre of the African reality." According to Minishi-Majanja (2012), failing to comprehend the indigenous knowledge background of your working environment results in a lack of understanding of the setting in which you operate. This study found the Afrocentricity theory extremely relevant in addressing all four objectives of the study, namely to identify the types of traditional medicinal practitioners found in the Keates Drift Community in the province of KwaZulu-Natal; determine the types of indigenous knowledge medicinal plants used to treat and manage illnesses like HIV/AIDS; establish whether traditional medicinal practitioners are well informed of HIV/AIDS in KwaZulu-Natal; and identify challenges faced by traditional medicinal practitioners in treating and managing the spread of HIV/AIDS.

The Afrocentric theory was employed in this study because it has been widely used in other similar studies to popularise African traditional knowledge in tertiary institutions, information centres, and health-related centres. Owusu-Ansah (2013), for example, used Afrocentricity to raise awareness about the importance of incorporating IK into the design and implementation of education and research. Schiele (2017) and Fairfax (2016) published papers in the social sciences and humanities fields that highlighted the need of recognising Africa's cultural values and practices. Mkabela (2005) found that an Afrocentric model is necessary and most appropriate for promoting indigenous African culture. Afrocentricity as a theory seeks to aid in the development of motivated individuals who are dedicated and committed to the betterment of black communities and the African world. This study used

an Afrocentric model to shed light on the possibility of using traditional medicinal plants to treat and manage HIV/AIDS-related symptoms.

This theory was chosen for the study because it satisfied the expectations of the research objectives and issue description, as well as the study's goal. The notion placed a premium on indigenous knowledge, which was previously marginalised. African communities are encouraged to rely on African knowledge rather than western information, according to the ideology. To put it another way, it is critical for African communities to value IK over what they do not know. It is important to note that IK includes assets and capabilities that can be used to improve people's lives. Since indigenous people will be (and are) impacted by global challenges, such as climate change, their demands and interests must be considered at the local, national and international levels (Masoga & Shokane, 2019).

The relevance of the theory is wide enough to contribute to the profession of social work as it demonstrates that African knowledge is relevant in dealing with cases of HIV/AIDS. This means that even the professionals of social work can tap into their local knowledge to deal with cases of HIV/AIDS that rural people normally face. Asente (1991) in his model demonstrated that Africa needs to rely on her own knowledge to solve African problems. Hence, social work professionals need to believe in their local knowledge to solve mental problems of African people associated with HIV/AIDS.

2.3 Reviewing literature

This section examines the literature in light of the study's goals. It is critical to understand that the importance of a literature review cannot be overstated. Neuman (2011), for example, characterised a literature review as "based on the notion that knowledge accumulates and that people learn from and build on the work of others." One of the benefits of a literature review, according to Hammond and Wellington (2013:99), is that it provides an overview of what has been written about a certain field or issue. In other words, it discloses what has been said, who has said it, and establishes the field's current beliefs and approaches (Hammond & Wellington, 2013:99). As a result, it is assumed that the knowledge accumulated assists us in learning and building on what others have done. Neuman (2011) added that the scope and depth of literature reviews vary, but they all strive to achieve one of the following objectives:

- To establish credibility in the use of traditional medicinal knowledge by demonstrating acquaintance with a body of knowledge. In other words, it has provided this study with information regarding other findings that have been relayed to the current study; and
- The literature has aided the study by demonstrating the path of previous research and how earlier investigations have been carried out and linked to the current one. It also displays the progression of knowledge and outlines the path of study on a question.

2.4 Types of local health practitioners considered in rural communities

This section examines the many types of local traditional practitioners who are considered by the traditional medical community. It's worth noting that, like western doctors, the Traditional Health Practitioners Bill of 2003 allowed traditional doctors (traditional health practitioners) to prescribe medication and sick leave to patients. Charlatans (fraudulent healers who utilise human body parts to manufacture concoctions (muti) and claim to cure a variety of maladies) are not allowed to practise under the licence. The Traditional Health Practitioners Act (22 of 2007) was passed by the government to ensure that traditional doctors have the same rights as other healthcare practitioners in South Africa, as well as that all healthcare practitioners are operating legally and meeting all Department of Health standards. Parliament passed the Traditional Health Practitioner Bill (2003) in 2003. The Bill's goal was to recognise South Africa's traditional healthcare system, as well as to create a framework for assuring the efficacy and quality of traditional healthcare services, and to offer patients remedies in cases of malpractice (Sagan, 2013; Masoga & Shokane, 2020).

The Bill (2003) also established the South African Traditional Health Practitioners Council, which was only temporary. The Council is in charge of developing a regulatory framework for the regulator to protect the productivity, well-being, and excellence of traditional healthcare facilities, as well as detailing the recording, preparation, expansion, and behaviour of specialists, and defining the traditional medicine profession's classes.

The Traditional Health Practitioners Bill (2003) was never fully implemented, but it was examined by the late Ms. Manto Tshabalala Msimang, who emphasised the importance of recognising and respecting traditional medicine so that it might be used in the public sector with dignity. In a seminar held on September 15, 2004, traditional health practitioners were defined. The late Ms Manto Tshabalala Msimang stated that the Bill would bring traditional healers, such as diviners (sangomas), herbalists (izinyangas), traditional birth attendants

(iingcibi), and traditional surgeons (iingcibi), closer to the primary healthcare system, and that the Bill would benefit over 200 000 traditional health practitioners (Matomela, 2013).

It is crucial to remember that traditional medical practitioners are respected all around the world. As a result, in 2002 a meeting in Geneva was held to propose the integration of traditional health practitioners in the primary healthcare system, particularly in developing nations with national healthcare policies. Traditional health practitioners and traditional medicine in developing countries must be protected, according to the World Health Organization. Intellectual property rights and policies must be put in place to protect traditional health practitioners and traditional medicine in developing countries (WHO, 2010; Hakim & Chishti, 2010).

The Traditional Health Practitioners Bill (2003) in South Africa emphasised the importance of registering traditional health practitioners. According to the Traditional Health Practitioners Act 22 of 2007, all traditional health practitioners in South Africa are required to register with the Health Professional Council. The Act also established the Board of Traditional Health Practitioners as a legal framework. The Council's mission is to promote traditional health practitioners while also identifying those who financially exploit the public (Tshehla, 2015).

The Council's mission is to:

- promote health awareness to protect the quality of traditional health services;
- encourage and preserve moral and proficient health standards required of traditional health practitioners;
- increase interest in and encourage research and training;
- set and preserve the code of conduct; and
- ensure that traditional medical practice adheres to universal health-care guidelines.

2.4.1 Indigenous health practitioners

Indigenous knowledge, according to authors such as Adeniyi and Subair (2013), includes culture, religion, myths, economy, governance, medicine, and agriculture, as well as taboos, poetry, art, and crafts. As a result, IK is shared and communicated orally, and is a society's changed cultural inheritance. Masoga (2017:3) stressed that IK systems emanate from the human spirit and life experiences organised and ordered into accumulated knowledge with the objective of utilising it for quality of life and to create a liveable environment for both

human and other forms of life. Indigenous people, including farmers, landless labourers, women, rural artisans, cattle rearers and tribes, traditional healers, diviners, and herbalists, are considered custodians of indigenous knowledge systems, (Akullo, Kanzikwera, & Barwogeza, 2007; Anyira, Onoriode & Nwabueze, 2010; Naidu & Darong, 2015). The guardians of local knowledge, according to Rajasekaran (1993), are highly knowledgeable about their own problems, resources, what works and what doesn't, and how one change affects other aspects of their system. Traditional knowledge (TK) (or other co-terminous phrases such as indigenous knowledge and local knowledge) refers to the long-standing information, wisdom, traditions, and practices of specific indigenous peoples or local communities (Kothari, 2007; Masoga & Shokane, 2020). Singh, Baijnath and Street (2020), Hunter (2005) affirmed that IK contains potentially patentable knowledge concerning traditional medicines, foods, farm operations, building and construction, handicrafts, artwork, and folk music in this regard. Details on the various traditional health practitioners follow,

According to a study completed at the NWU in 2013, there are four types of traditional healers, including herbalists (inyanga), diviners (sangoma), faith healers (umthandazi), traditional surgeons, and traditional birth attendants. A traditional doctor specialises in the use of herbs to treat illnesses. The dingaka (Sotho) or isangoma (Zulu) is usually a man or woman (90 percent) who acts as a medium to the ancestral shades/spirits in a traditional religious supernatural framework. Only those who have been summoned by the gods can become diviners. The faith healer, also known as *umprofethi* or *umthandazi*, combines conventional practices with supernatural rites (Naidu & Darong, 2015).

2.5 Types of indigenous knowledge medicinal plants used to treat and manage illnesses like HIV/AIDS

It is widely known that for therapeutic purposes, 80 percent of the world's population relies on indigenous knowledge (Nyumba, 2006). This expertise has aided the provision of a wide range of services, including healthcare, agricultural production, and the construction of houses and roads, among others. However, the focus of this research was on the application of indigenous wisdom to situations of healing, particularly HIV/AIDS. Interestingly, different African countries utilise approximately fifty percent (50%) of the knowledge. Malaria, diabetes, cancer, and HIV/AIDS are among the disorders for which there is greater understanding (Nyumba, 2006). There are numerous sub forms in which indigenous

knowledge sources are employed to cope with sickness and diseases in rural regions (Dixit & Goyal, 2011; Makinde & Shorunke, 2013; Chicho, Chanda & Musisi-Nkambwe, 2020).

2.5.1 Beliefs

Indigenous people from remote places have a strong belief system that demonstrates their traditional wisdom (Ilo 2012; Sobiecki 2014). The belief that the elders who have passed on in life stand between the living and God is best illustrated through honouring ancestors. According to Ilo (2012)'s research, rural elders strongly think that ancestors can convene a message with an individual, among family members, on how to deal with a specific illness, casting out evil spirits. According to Dixit and Goyal (2011), ancestral worship lies at the heart of African indigenous religions. As a result, the worship of ancestor spirits reflects the beliefs of many groups. In this regard, IIRR (1996) contended that people's beliefs have a critical role in their livelihood, as well as their health and environment. Elderly people in Lesotho, for example, are the stewards of indigenous knowledge, living according to their culture and traditional practices (Magara, 2002:43).

Traditional healers and community elders are consulted anytime a dark cloud descends on a village (UNEP, 2008). To them, a dark cloud is sickness, which they mistake for an evil spirit. Traditional healers and community elders are strongly believed by the community to be able to pave a path and connect with ancestors, as well as give prayers, whenever they wish to seek the face of their gods (UNEP, 2008).

It is critical to understand that traditional medicine is one of the key areas in which indigenous knowledge is abundant in African communities. Because African populations rely significantly on traditional medicine, indigenous knowledge is strong and rich in this field. Several studies (e.g. Coleman, 2013; Eyong, 2007; National Reference Centre for African Traditional Medicine (NRCATM), 2010) found that around "60%-80% of the world's population relies on indigenous healthcare based on medicinal plants" nowadays. According to Sraku-Latey (2014), the application of traditional medicine remedies in satisfying global health requirements is attracting a lot of interest on a global scale. In this light, Ilo, (2012); Nakapipi, Shalyefu, and Mushaandjan (2011) recognised that medicinal plants collected in the wild are important sources of medicine for indigenous people. The authors also revealed that some common plants are used in the body to treat a variety of ailments. For example, the African potato (leraka) is a beneficial root for strengthening the immune system and lowering blood pressure (Magara, 2002:40). Aloe (sekgokgopha), on the other hand, is used

to cleanse the body of pollutants and free radicals (Magara, 2002:40). Traditional herbs are employed as crucial medicinal treatments and are available to indigenous people, according to Kaniki and Mphahlele (2002) and the National Reference Centre for African Traditional Medicine (NRCATM) (2010). Herbs are also utilised as a preventative medicine, according to some. For example, the bark of a certain tree is gathered and chewed in several African cultures to clean teeth and protect them from dental disorders. The Dwarf Sage, on the other hand, has a long history of use as a medicinal therapeutic plant for external application exclusively (Nakapipi, Shalyefu & Mushaandjan, 2011).

According to the National Reference Centre for African Traditional Medicine (NRCATM), humans rely largely on plants to treat a wide range of illnesses, from simple ailments such as coughs and colds to life-threatening diseases such as tuberculosis and malaria. When there is a sick patient in an African community, indigenous people contact a witchdoctor, shaman, soothsayer or traditional healer for diagnosis and cure. Thus, indigenous healers have profited directly and indirectly from plants such as the iboga, as it is known in Cameroon and Gabon, in the treatment of cancer, obesity, drug addiction, diabetes, and other diseases (Eyong, 2007). Indigenous peoples in Central Africa have a vast knowledge of plants and animals that can be used for a variety of purposes on a local, national and international scale (Eyong, 2007). Because diseases are managed traditionally, African communities are thought to be exceedingly wise and cautious while dealing with symptoms. Makinde and Shorunke (2013), for example, contended that a human being is both a physical and a spiritual person, and that disease can be caused by supernatural factors such as ancestor or bad spirits' wrath, witchcraft or the introduction of an object into the body. It is possible to say that not only the disease's symptoms are considered, but also the patient's psychological and societal variables.

According to a study by Magara (2002:40), taking a patient to a health centre is something that a Mosotho or a Basotho does only after all traditional methods of assisting the patient have failed. It is claimed that the Basotho examine the patient's conduct before prescribing a drug that is appropriate for him or her. They locate remedies from outside the house or right there in the village to prepare for the patient in the case of minor ailments like headaches, flus, and stomach-aches, for example. After it has been boiled, the patient drinks it. To treat a headache, the bark of a peach tree is peeled and burned, and the patient is forced to inhale the smoke produced by this peel (Magara, 2002:40). Similarly, Gumede (1990:38) claimed that, unlike Westerners who were familiar with germ theories such as bacteriology, parasitology, and pathology, the Zulu people have a different knowledge of

disease origins and cures. Instead of recognising that diseases are created by natural laws that might lead to the spread of germs, bacteria, viruses, parasites, and other diseases, they believed that diseases were caused by witches and wizards who wanted to destroy the family. The family would then be cleansed of any harm by a traditional healer. The conclusion is that African communities have an abundance of traditional medicinal plants, which they use as a source of medicine (Anani et al., 2000; Eyong 2007; Hutchings et al., 1996; Van Wyk (2011). Despite the fact that the study's goal was not to measure and identify traditional African plants, citing a few instances of plants was critical. The table below shows African traditional plants that are used to treat a variety of ailments.

Table 2.1: Commonly used traditional plants and their indigenous use(s) in African communities

Common Name (local name)	Part of plant used	Medicinal uses
Pterocarpus soyauxi (padouk, or camwood)	Ground stem	Child birth, marriages
Milicia excelsa (Iroko)	Most sacred tree species	Sacrifices to appease gods
Nauclea diderrichii (bilinga)	Bark, root, and wood or trunk	Fevers, stomach problem
Canarium schweinfurthii (aiele)	Fruits, popular in local market	Resin is burnt as incense start fires or as "bush candle"
Lophira alata (azobé or ironwood)	Trunk	Medicine for back pain, toothache
Costus afer	Stem and juice	Coughs, sore throats, eye infection
Emilia coccinea	Entire plant	Anti-poison, jaundice, snakebite
Eremomastax speciosa	Leaves	Purify and strengthen blood
Aframomum spp	Leaves	Spice for food, coughs, magnifiers in medicinal mixtures
Piper guineensis	Leaves	Spice for food, treat hangovers, stomach problems, build strength
(Garcinia kola) Bitter Kola	Seeds	Digestive agent, poison antidote, protects microsomal enzymes against phalloidin
Bush Pepper	Seeds	Mix with others to treat cough, chest pain spleen for children
Araceae (Ihlukwe)	Leaves and rhizomes	Leaves used for wounds, sores and boils. Ground leaves applied to parts affected
Bombacaceae (Isimuku)	Bark	Asthma and skin disorders
Celastraceae (Umhlawazizi, umhlwazi)	Leaves	Coughs, asthma and other respiratory conditions, relief sleeplessness
Geraniaceae	Roots	Gonorrhoea, diarrhoea, dysentery, colds and lung infections

Lamiaceae	Leaves	Colds, influenza, liver problems and piles
Velloziaceae (Isiphemba, isiqumama)	Root, whole plant and bark	Dried leaves are smoked to stop nose bleeding
Zingiberaceae (Isiphepheto, indungulo)	Rhizomes	Asthma and dysmenorrhea
African potato (leraka)	Root	Treatment of patients with symptoms of HIV/AIDS

(Source Anani et al, 2000; Eyong, 2007; Hutchings, et al., 1996; Van Wyk, 2011)

As shown in the table above, indigenous plants are widely utilised to treat a wide range of illnesses that can harm the community. The table demonstrates that the indigenous people have their own herbs that are used in the community to treat specific illnesses. Indigenous knowledge is claimed to be widely used to treat a variety of illnesses for the well-being of community members.

Further examples of traditional medicine are as follows:

- Diarrhoea (*letshollo*) is treated with a mixture of heated water and mosokelo tree roots, which must be consumed three times a day.
- A patient suffering from stomach aches would be given hot water combined with the roots of the sekatapohwana tree. Warm water and the barks of the *leshogwa* tree can also be combined by a traditional health practitioner.
- To alleviate heartburn and vomiting, a diviner employs holy water and dried chicken breast. A woman who has given birth will be given *makwati a mosetlha* and *phate ya ngaka* to clean the womb.

2.6 Traditional medicinal practitioners' roles in rural communities and their well-versed knowledge in treating and managing symptoms related to HIV/AIDS

2.6.1 Traditional healer and herbalist (inyanga)

A herbalist and traditional healer are largely known in rural communities as traditional health practitioners. They are known as inyanga in Zulu (Van Rensburg, Fourie & Pretorius, 1992:328; Masoga & Shokane, 2020). Traditional healers are trained to treat sexually-transmitted diseases and children's illnesses (*tlhogwana*, *letshollo le khujwana le amangwe*), whereas faith healers specialise in substance misuse, chronic illnesses, and societal issues. Most traditional health practitioners would be willing to help the government

treat ailments caused by HIV/AIDS, but they would have to work out of the public eye in order to avoid upsetting the ancestors (Quaye & Kimpada, 2003). Plants are, among others, mostly used as traditional medicine, which is focused at keeping Africans well. The high expense of western drugs and the inaccessibility of western services contribute to the preference for traditional healing, making traditional health practitioners the only source of medical treatment for many Africans. According to a traditional healer and qualified dentist in Uganda, traditional healers provide considerable experience as well as inexpensive and successful therapy (even for HIV/AIDS) (Mapara, 2009).

The efficacy and efficiency of herbal medicines have recently piqued western society's interest, and more research is being conducted into the components (such as aloe, buchu, and devil's claw) used in traditional healers' medicine. Traditional health practitioners play an important role in the treatment of diseases such as HIV/AIDS, diarrhoea, and pneumonia, which are major causes of death in rural communities (especially in children). Traditional health practitioners in Africa have continued to help in the fight against HIV/AIDS (Mapara, 2009; Moshabela et al., 2016).

Herbalists have a broad understanding of magical tactics. They also use empirical knowledge to diagnose ailments and prescribe the appropriate medicinal herbs, as well as to avoid tragedy within a village, give protection against bewitchment and suffering, and bring riches and contentment. Traditional medicine, such as crocodile skin for fever, is used by traditional health practitioners to treat a number of illnesses. To become a herbalist, one must undergo seven years of rigorous training under the supervision of a competent herbalist, following which the learner is evaluated on his or her knowledge of herbal medicines during a ceremonial ritual (Mulungwa et al., 2018). A pharmacist who administers medicine manufactured from natural components such as tree bark, roots, leaves, animal skin, blood or parts of animals, herbs, and seawater is known as a herbalist (inyanga). Prediction is not one of their offerings (Natako, 2006; Latif, 2010; Mulungwa et al., 2018).

"A person who engages in traditional health practice and is registered as a herbalist under this Act is referred to as a herbalist" (Traditional Health Practitioners Act, No. 22, 2007). A herbalist can also refer to "ordinary persons who have gained a thorough understanding of the practice but do not, in most cases, possess occult powers." Herbalists diagnose and prescribe medication for common ailments, as well as to alleviate misfortune and disaster,

as well as to provide protection from sorcery and tragedies, and to encourage happiness” (Van Rensburg, 2011; Masoga & Shokane, 2020).

2.6.2 Diviner, Nanga (Venda)/Ngaka (Sesotho)/ Isangoma (Zulu)

Diviners must participate in a spirit-possession ritual that includes music, dance, community interaction, and dream interpretation, according to Kayombo (2007). Diviners are generally women who act as a link between humanity and their forefathers or the supernatural. It is a calling, not a choice, to follow this old tradition. A person may be called to this profession after experiencing visions, prophecies, or dreams, or after becoming ill for a period of time and learning about the calling after consulting a traditional healer (Masoga & Shokane, 2020).

In the case of an inexplicable disease, diviners diagnose by listening, observation, and experience, as well as with the help of the ancestors, who express their message through bone throwing. Prediction, which is used to determine the influence of illness and curative rites or mechanics, is another method a diviner utilizes to communicate with badimo (ancestors). This ritual includes palm reading, water, and mirrors, as well as dancing, trance, throwing bones or shells, and praying (Hakim, 2010).

There are several ways to train as a traditional healer. When witchdoctors are treated in this way, they become aware of their abilities and resolve to become healers once they recover (mental disarray might be a sign of spiritual calling). Other circumstances may involve a spiritual vocation, in which case the diagnosis and treatment will be supernatural in nature. Another method is to have a close family member, such as a father or uncle, or even a mother or aunt, pass on information and skills informally (in the case of midwives). It is a type of apprenticeship in which a typical healthcare provider passes on his or her skills and expertise to the following generation (Ramokgopa, 2013; De Wet, Nzama, & Van Vuuren, 2012).

2.6.3 Faith healers/prophets

Faith healers/prophets are a form of syncretism, a reinterpretation of orthodox Christianity in order to be reconcilable with traditional culture. So, while prophets are not strictly speaking traditional healers, they do share the following characteristics with them: Faith healers use

prayer, candlelight, or water to diagnose and treat disease. Patients who have been healed usually join the church at which the healer is a member (Masoga & Shokane, 2020).

2.7 Challenges faced by indigenous knowledge practitioners in preventing the spread of HIV/AIDS

The study's major goal was to explain, examine, and evaluate the current obstacles that traditional healers confront in treating HIV/AIDS patients in South Africa. Traditional healers face challenges regarding their credibility as healers, according to a study by Kang'ethe (2008). The lack or absence of reliable methods of evaluating the treatment provided by traditional healers undermines their credibility and calls into question their trustworthiness as professionals.

Many traditional healers in African countries, according to Homsy et al. (2004), are not adequately supported to maintain acceptable standards of care or to allow their patients to benefit from the efficacy of their herbal therapies in the management of opportunistic infections. Traditional healers in Uganda, for example, are said to lack the knowledge needed to follow antiretroviral medication regimens, interact with the contemporary health care system, and keep HIV/AIDS patients in long-term care (Homsy et al., 2004). Another viewpoint was offered by Mbatha et al. (2012) in a study of legislative frameworks controlling traditional health practitioners (THPs) and the issuing of sick notes, according to which the problem for THPs is to establish a council to manage and regulate their practices. Traditional health practitioners now lack formal recognition and the authority to provide medical certificates to their patients, and they are also ineligible to seek financing for traditional medicine research or legal protection for their operations.

When discussing the challenges and opportunities of integrating traditional healing into counselling and psychotherapy, Bojowoye (2010) argued that the process is hampered for traditional healers by the following factors:

- (i) A lack of constructive and open-ended communication among practitioners of traditional healing and modern medicine.
- (ii) Traditional healers do not have access to modern medicine.

In his study on increasing the capacity of traditional health practitioners in Kwazulu-Natal, South Africa, to treat HIV/AIDS and tuberculosis, Ndhlalambi (2009) identified the following stumbling obstacles that hinder traditional healers' potential in this endeavour:

- (1) Operational issues, such as the inability to manage the referral and patient record system;
- (2)) Issues negotiating a working partnership between traditional health practitioners and mainstream medical services; and
- (3) a lack of funding.

According to Ndhlalambi (2009), traditional healers in Kwazulu-Natal also face difficulties in obtaining government support for their work, as well as a lack of skills in securing funding, a handicap resulting from a historical lack of access to resources due to literacy and language difficulties among traditional health practitioners.

Traditional healers have challenges when attempting to collaborate with healthcare practitioners to prevent the transmission of HIV/AIDS, according to Mboera et al. (2009). On the one hand, they complain that healthcare workers do not refer patients to them, and on the other, they are perceived as lacking training, not being sufficiently aware of the safety measures that must be observed while treating patients or the standards of hygiene that must be maintained by people with backgrounds in modern medicine. Traditional healers have the disadvantage of not having surgical kits and not knowing the importance of maintaining accurate medical records. Traditional healers are also vulnerable to criticism from healthcare workers, according to Mboera et al. (2009), because their practices are not recognised by the current legal system, and THs have no way of obtaining the information needed to bring their practices in line with the hygiene standards maintained and observed by mainstream medicine.

Chipfakacha (2010) did another study on traditional healers' knowledge of STDs and HIV/AIDS in Botswana, finding that traditional healers (THs) lack adequate information about HIV/AIDS, and that most of the information they do obtain comes from the radio or from acquaintances. Traditional healers who treat HIV/AIDS patients are at a danger of becoming infected as a result of their lack of knowledge. Although many traditional healers in Botswana have been advised to advise their patients to use condoms as a means of having safe sex, most are unable to provide their patients with condoms or to distribute them from their consulting rooms (Pelzer & Petros, 2006; Zimba & Tanga, 2014). Zimba and Tanga (2014)

went on to say that traditional healers needed more understanding on how HIV/AIDS are transmitted, and that the possibility of infection from HIV-infected mothers' blood put traditional birth attendants in grave danger. According to Bareda (2002), traditional healers in nations such as Nigeria and Ghana confront the following issues:

- Traditional healers lack skills such as business administration and financial management;
- Traditional healers do not have the same reimbursement opportunities as health professionals, such as the ability to claim tariffs from medical aid programmes; and
- Traditional healers are unable to attract people to their organisation who could help them transform traditional medicine in African culture into modern medicine

Traditional healers face problems in treating persons living with HIV/AIDS in their practices, according to Abdullahi (2010), and their efforts are harmed further by criticism of their practices and therapies. Many of the criticisms levelled towards traditional healers' activities come from people who have a gloomy perspective of their work and argue that:

- Traditional healers lack the expertise required to correctly diagnose major diseases such as HIV/AIDS,
- Traditional medication lacks conventional dosages and has not been scientifically validated; and
- Traditional healers lack the necessary instruments to undertake patient physical examinations.

2.8 Conclusion

According to Ndingi (2006), traditional healers treating people living with HIV/AIDS, have trouble ensuring that their patients continue to use condoms, which leads to patients contracting STIs. Traditional healers have challenges, according to Mboera et al. (2009), when attempting to collaborate with healthcare personnel to prevent the transmission of HIV/AIDS. On the one hand, they complain that healthcare workers do not refer patients to them, and on the other, they are perceived as lacking training, not being sufficiently aware of the safety measures that must be observed while treating patients or the standards of hygiene that must be maintained by people with backgrounds in modern medicine. Traditional healers suffer from the lack of surgical equipment and a lack of understanding for the need to keep proper medical records. Traditional healers are also vulnerable to

criticism from healthcare workers, according to Mboera et al. (2009), because their practices are not recognised by the current legal system, and THs have no way of obtaining the information needed to bring their practices in line with the hygiene standards maintained and observed by mainstream medicine.

Traditional healers, diviners, and herbalists, according to the literature reviewed, have a real and significant role to play in their communities in treating and caring for persons living with HIV/AIDS, and other illnesses. Traditional doctors are treating HIV/AIDS patients with a variety of traditional herbs and animal parts, according to the literature. Traditional medicinal practitioners that employ human body parts for the treatment of local people in their communities are not recognised to be true traditional doctors. As a result, they are not even permitted to practise as community doctors. Despite being recognised as community doctors, traditional medical practitioners encounter a variety of problems. They face roadblocks and issues while treating HIV/AIDS patients. The methodological framework of the investigation will be outlined in the following chapter, as well as how the study was carried out.

Chapter 3. Research Design and Methodology

3.1 Introduction

The theoretical framework and literature review were discussed in the previous chapter. This chapter delves into the data collection process employed by the study. The first section of this chapter introduces the concept of research methodology. When collecting data, researchers use research methodology to create a plan of action. One of the benefits of research methodology is that it aids in the evaluation of the procedure that must be followed when conducting research. A research methodology aids in the resolution of research questions that a study seeks to address. In a nutshell, a research methodology aids researchers in focusing on the entire data collection process as well as the methods used to collect that data.

The tools that are relevant to be employed to collect data are identified by research methodology. As such, research methodology is concerned with ways for comprehending and giving meaning to an environment. In Msinga, KwaZulu-Natal, it was envisaged that this study would attempt to analyse the meaning that participants connected to the employment of indigenous knowledge healing methods to treat symptoms related to HIV/AIDS. The research paradigms, research design, study population, sample processes, instrumentation, data collection methods, data analysis procedures, and ethical issues are all covered in this chapter under research methodology. The research was of a qualitative character. The following research objectives were the focus of this study:

- To identify the types of traditional medicinal practitioners found in the Keates Drift Community in the Province of KwaZulu-Natal.
- To determine the types of indigenous knowledge medicinal plants used to treat and manage illnesses such as HIV/AIDS.
- To establish whether traditional medicinal practitioners are well informed of HIV/AIDS in KwaZulu-Natal.
- To identify challenges faced by traditional medicinal practitioners in treating and managing the spread of HIV/AIDS.

3.2 Research paradigm

A research paradigm, according to Ryan (2018), is a pattern by which scientists examine the subject of their research within the discipline of their interest. Researchers utilise paradigms as key outlines to organise their observations and reasoning (Babbie, 2010). These paradigms are said to be the way scientists view and make sense of the world (Johnson & Christensen, 2012). Ontology, whether realist or objectivist, and constructionist, impacts paradigms (Fraser, 2014; Sarantakos, 2013). A paradigm also includes an external or internal perspective of reality (ontology), a related understanding of the types of knowledge that can be acquired and the standards for justifying it (epistemology), and a disciplined way to obtaining that knowledge (methodology) (Babbie, 2010). Research paradigms orient the researcher towards acceptable research procedures and methodologies, depending on the nature of the phenomenon being researched, and create the foundation for the practice of science (Creswell, 2014). Positivism, interpretivism/constructivism, and post-positivism are the three major research paradigms (Pickard, 2013). However, just one research paradigm, interpretivism, was applied in the study. The interpretivism paradigm is discussed in this chapter.

3.2.1 Positivism

The social world, according to this paradigm, can be investigated in the same way as the natural world (Ryan, 2018). In this way, scientists are seen as observers of social reality by researchers (Corbin & Strauss, 2015). It is claimed that the social world can be researched using a value-free data collection strategy (Akhtar, 2016). According to Oakley (2000), positivist research is considered expert because it views objectivity to be the truth, and subjectivity to be the lie. Positivism is a commonly used and well-established research paradigm in institutions all around the world. It aims to examine, confirm, and anticipate law-like patterns of behaviour; it is widely employed in natural sciences, physical science, and, to a lesser extent, social sciences, particularly when large sample sizes are involved. In a word, the objectivity of the research process is the focus of this research paradigm (Creswell, 2014).

3.2.2 Post-positivism

This research paradigm refers to post-positivist thought, which questions the traditional notion of absolute knowledge truth. It recognizes that while analysing human behaviour and

activities, it is impossible to be "positive" about their claims of knowing (Ryan, 2018). In research, the post-positivism paradigm acknowledges the impact of values and theories. It promotes the use of strict qualitative data collection and analysis procedures (Creswell, 2014).

3.2.3 Interpretivist paradigm

According to Mason (2002), scholars consider interpretivism as individuals and the meaning they attribute to the world, as well as their perceptions as fundamental data sources. The interpretivist regards that entities pursue understanding the universe in which they reside. It is done in order to understand the historic and traditional locations of the people targeted (Creswell, 2014). In other words, interpretivism seeks to understand the entire context, at the macro and micro environment level. Additionally, interpretivism is seen as a philosophical notion that people bring meanings to situations and use these meanings to understand their world and influence their behaviour (Creswell, 2014). Creswell (2014) further stated that the interpretivist pursues comprehending the whole framework at the macro and micro environment level. Lastly, one of the advantages of the interpretivist is the philosophical way of making people comprehend connotations to conditions and applies those connotations to understand their area and influence their behaviour.

The purpose of this study was to discover, narrate, and analyse the connotation of different involvements of the role played by traditional health practitioners in using indigenous knowledge medicinal plants in healing and preventing symptoms related to HIV/AIDS: how each participant detects it, judges it, recalls it, makes sense of it, and so on (Braun & Clarke, 2013). According to Maree (2016), interpretation focuses on people's subjective experiences, how they share meaning to form the social environment, and how they interact with or relate to one another. The fundamental notion is that by placing people in their social situations, it will be easier to grasp their judgments of their own actions. Understanding and interpreting the meaning generated requires an understanding of the situation's uniqueness. Maree (2016) continued by claiming that the human mind is the purposive genesis of meaning. We can begin to build a feeling of understanding of the meaning imparted by individuals to phenomena and their social environment by exploring the richness, depth, and complexity of phenomena.

Maree (2016) went on to say that any effort associated with a study project that aims to comprehend participants' thoughts and ideas is heavily reliant on qualitative research

methods. The interpretivism paradigm was used in this study because it is beneficial in analysing everyday experiences of traditional health practitioners when dealing with HIV/AIDS cases (Neuman, 2014). Traditional health practitioners were identified as key informants, and the study provided them with the opportunity to describe their daily experiences using their own vocabularies, ensuring high-quality and relevant data. Finally, the interpretivism paradigm allowed the researcher to learn more about how traditional health practitioners felt about employing indigenous knowledge medicinal plants to treat HIV/AIDS symptoms in their patients.

3.3 Research design

A research design can be characterised as a strategy framework for action that directs the organisation of conditions for data collection and analysis in such a manner that there is a mix of research questions and research implementation (De Vos, 2005; Creswell, 2014). It is a plan that explains how the study was carried out in such a way that the research questions were answered. It may also entail a number of judgments about how data was collected and analysed. It also guarantees that the final report responds to the research questions posed at the start of the project (Akhtar, 2016). Hence, exploratory and descriptive research designs were used in this study. One of the reasons for using the two research designs is because the study made direct quotations as explained by the key informants. The key informants described in detailed their experiences of treating and managing the symptoms related to HIV/AIDS in their communities.

In nature, this study is a qualitative research method. Kumar (2014) described qualitative research as an interpretive, multi-method approach to studying individuals in their natural habitat. This study used a qualitative approach in order to narrate, depict, and understand the sentiments and experiences of traditional health practitioners dealing with HIV/AIDS cases using indigenous knowledge medicinal plants. The study used a qualitative research approach to explore traditional health practitioners' experiences and indigenous knowledge practices for treating HIV/AIDS symptoms in their patients.

3.3.1 Justification of the use of the research methods chosen

The study used the qualitative research method, as stated in the preceding section. The researcher felt it was critical to clarify the rationale for using qualitative research methods in

depth. Because the study was exploratory in nature, it used a qualitative research approach. Semi-structured interviews with traditional health practitioners were conducted using open-ended questions about indigenous knowledge medicinal approaches used to treat HIV/AIDS symptoms. The study intended to know all traditional doctors who are recognised in rural regions and those who are registered by the Department of Health to deal with HIV/AIDS in rural areas, in addition to identifying the traditional medicinal herbs used. The semi-structured interviews were also employed in the study to gather rich and useful information about the challenges that traditional health practitioners encounter when treating HIV/AIDS. The researchers wanted traditional health practitioners to express their views and opinions, as well as the experiences they had treating clients with contaminated HIV/AIDS.

3.4 Population

The collection of all units of analysis about which the researcher sought to draw specific conclusions is referred to as the study population (Hammond & Wellington, 2013). Neuman (2011), on the other hand, defined a population as the procedure through which a researcher identifies the unit that will be studied, the geographical place where the study will be done, and the population's sequential bounds. This research was carried out in the uMsinga Municipality, where the researcher grew up and became familiar with the area's traditional health practitioners.

The population in this study referred to all traditional health practitioners, often known as traditional healers. Traditional healers were divided into three categories in the study: diviners (sangomas), herbalists (izinyangas), and traditional birth attendants. The study chose traditional health practitioners because they represent a group of people who can provide the study with the detailed information it requires. A targeted population, according to Neuman (2014), is a group of people who have a wealth of information that may be used to make accurate judgments and recommendations. Traditional medicinal practitioners have a wealth of reliable information that the study needed to reach a conclusion and make recommendations. The study chose traditional healers because they have wealth information and considered custodians of traditional medicinal knowledge in rural communities. As such, the criteria for choosing them was based on the knowledge they possessed on traditional medicinal knowledge.

3.5 Sampling

In every research project, sampling is crucial. The entire number of units or objects considered for inquiry purposes in a study is referred to as a sample (Neuman, 2011). In this light, researchers employ a sampling technique to select a subset of people or social phenomena to be researched from the greater universe to which they belong in one of various ways, in order to be either non-representative or representative (Neuman, 2011). One of the benefits of sampling is that it allows researchers to select the population for participation in a study in a methodical manner. It can also be used to choose volunteers for a study (Kumar) (2014). According to Kumar (2014), the primary goal of sampling is to acquire a representative selection of sampling units within the population, and the sample must be free of bias. Thus, in order for sampling to be effective, a manageable number of participants or respondents must be chosen, but it must also be reliable in order to offer appropriate information that can be kept, altered, and statistically evaluated (Kumar, 2014:382; Moule & Goodman, 2014:291).

The researcher was able to pick a manageable number of respondents with the use of sampling in this investigation. Not only did this study's successful sampling strategy save the researcher a lot of money, but it also saved him time. Furthermore, in this study, good sampling technique enabled the study to be representative and bias-free, allowing the results to be comparable to other potential data sets gathered from the same population at the same time. In other words, the research's outcome is trustworthy.

3.5.1 Types of sampling

Sampling can be classified into two types, namely probability sampling and non-probability sampling. Probability sampling refers to whether or not each unit in the population has an equal chance of being included in the sample (Romm & Ngulube, 2015). This means that every item in the sampling frame has an equal chance of being included in the sample as probability sampling. Probability sampling can be classified into several types, including simple random sampling, systematical sampling, stratified sampling, cluster sampling, multi-stage sampling, area sampling, and multi-phase sampling (Pascoe, 2014). Non-probability sampling is used when it is very difficult to determine who the entire population is or when it is difficult to gain access to the entire population (Pascoe, 2014). Pascoe (2014) listed

various types of non-probability to include accidental sampling, purposive sampling, quota sampling, and snowball sampling.

Non-probability sampling, specifically snowball sampling, was used in this investigation. Non-probability sampling is employed in studies where the population is difficult to estimate, particularly in terms of size (Creswell, 2014). The researcher was unsure about the number of traditional health practitioners in the area in this example. As a result, the study used snowball sampling. Snowball sampling, for example, entails the study participants assisting in the recruitment of other potential participants, especially when access to the population is challenging for the researcher. There are several stages that make up this form of sampling. To begin, the researcher has to find a small number of people who possess the necessary criteria. They then assist him in identifying other people who share the necessary criteria, and they are included in the next round (Neuman, 2011). The procedure is repeated until the researcher is satisfied that the sample is large enough (Neuman, 2011). As a result, the researcher employed snowball sampling procedures to identify a small number of traditional health practitioners. The researcher utilised the snowball sampling technique to create a sample of a certain demographic by asking an initial group of informants for names of other people who could be included in the sample.

It is widely acknowledged that estimates determine the sample size in qualitative sampling (Moser & Korsjens, 2018). In that light, between 25 and 50 people are needed in ethnographic research, with four to six focus groups; less than ten interviews are required in phenomenology; between 20 and 30 interviews are required in grounded theory; and between 15 and 20 interviews are required in content analysis. This research study collected data from accessible key informants who volunteered to participate in the study until the number reached the minimum requirements for a mini-dissertation. This means that the study interviewed only those key informants who were accessible and willing to participate in the study.

The study initially intended to interview 15 to 20 key informants who were considered traditional medicinal practitioners. A sample was used as a subset of a population in this investigation. Although it was hard to include all traditional medicinal practitioners in the study, the researcher chose those who were working and regarded as community doctors. These included diviners (izangoma) and herbalists (izinyanga), for example, were separated into tiny groups (izinyanga). For the purposes of the study, the researcher managed to find and interview twelve traditional medicinal practitioners, who were very scarce to find. These included six diviners (izangoma) and six herbalists (izinyanga) who had a more indigenous

understanding of medicinal plants to treat HIV/AIDS symptoms. However, the initial plan was presented on Table 3.1 below:

Table 3.1: Representation of traditional health practitioners in villages

Villages	Diviner (Isangoma)		Herbalist (Inyanga)	
	Male	Female	Male	Female
Baso	0	0	1	1
Bomvu	2	1	1	0
Chunu	0	2	1	1
Mthembu	1	0	2	0
Ngubane	1	1	1	1
Qamu	1	1	1	0
Total				

The researcher chose people who would provide plenty of data in order to arrive at conclusions and recommendations. Purposive sampling was also used in the study. Purposive sampling, according to Richards (2015), allows a researcher to select persons who would best enable him or her to answer study questions and accomplish objectives. In this light, Neuman (2011) agreed with the previous author that when the research is informative, and the sample size is modest, purposeful sampling is also used. In order to acquire maximum variation sampling, which allows a researcher to collect data to define and explain the important themes, the study needed to use a heterogeneous population. Traditional medicinal practitioners who were involved in treating HIV/AIDS cases in the community were used as participants in this study. Purposive sampling was utilised because the study's sample was made up of elements that had the most characteristic, representative, or typical characteristics of the population, and which best served the study's goal (De Vos et al, 2011).

3.6 Data collection instruments

Data collecting instruments, according to Hammond and Wellington (2013), are tools used by researchers to collect information needed to answer the study's objectives. Data collecting is vital in research, according to Johnson and Christensen (2011:161), since it answers questions that researchers have in mind in order to achieve the desired goal. The data for this study was gathered by content analysis, using a literature review of published and unpublished sources of information to address the study's objectives and make conclusions on the application of indigenous knowledge medicinal plants to treat HIV/AIDS symptoms (Neuman, 2011). To find e-databases and electronic journals related to the study's topic, the researcher visited libraries at the University of Zululand.

As this is a qualitative study, there are additional strategies for gathering data besides the literature review that the study used. In actuality, qualitative research employs structured interviews, in-depth structured interviews, focus group discussions, and semi structured interviews to gather information (Neuman, 2014). The four primary types of data collecting interviews are briefly described as follows:

- **Structured interviews**

In structured interviews, researchers ask questions and listen carefully as participants respond. While researchers are listening, they also intervene by providing more explanation to clarify questions where participants may be having difficulty in order to obtain more rich information (probing) (Johnson & Christensen, 2011: 161).

- **In-depth interview**

In-depth interviews are also used by researchers to acquire data from participants. In-depth interviews are less formal and less structured than standard interviews, with the terminology and questions not predetermined. This sort of interview is better for gathering complex information with a higher percentage of opinion-based data (Creswell, 2014).

- **Focus group discussion**

Focus-group discussions are another form of data collection instrument utilised by academics. It is defined as a structured conversation among a group of people with the goal of provoking discussion about a specific topic. Specifically, during a focus-group discussion, the data collector would ask questions while those selected to participate shared their

thoughts and feelings on the topic under investigation. During the focus-group method, the researcher pays close attention to the dialog as participants give their responses, and at that point, the researcher examines and evaluates all of the participants' points of view to see if they are similar or different. Participants in a focus-group discussion are more open to the researcher who is asking questions, which leads to more trustworthy and relevant information being shared, which may be utilised to draw conclusions and make recommendations (Kumar, 2014).

- **Semi-structured interviews**

A researcher includes a number of predefined questions in semi-structured interviews, but the interviewer has more leeway to change the language and order of the questions. Because follow-up questions are asked, semi-structured interviews capture detailed information from participants (Johnson & Christensen, 2011: 161).

3.6.1 Advantages and disadvantages of using Interviews

It is critical to discuss the benefits and drawbacks of interviews. The following are the points that will be discussed:

3.6.1.1 Advantages

- In gathering information from those who cannot read, interviews are more useful than questionnaires.
- Interviews allow researchers to clarify answers and follow up on particularly intriguing responses.
- Interviews lead to the gathering of entire data with a better understanding.
- Interviews allow one greater control over the sequence and flow of questions.
- Because interviews are flexible, they are likely to produce information that the researcher did not intend to obtain due to follow-up questions (Fraser, 2014).

3.6.5.2 Disadvantages

- Interviewing a big group of people might be exhausting.

- Interviews are also costly (both financially and in terms of time), and there is the possibility of interviewer bias.
- Due to tiredness and becoming overly concerned with applicants, there is a considerable risk of bias (Johnson & Christensen, 2011: 161).
- Interviews are difficult to plan.
- A language barrier may prevent the interviewer from asking questions that elicit extensive narratives from participants.
- The presence of a researcher may prejudice responses, resulting in individuals who are not as articulate and perceptive (Leedy & Ormrod, 2011:137).

3.7 Semi-structured interviews

The data collecting tool that was utilised to collect data from traditional health practitioners in the Msinga Municipality is discussed in this section. The data on the use of indigenous knowledge medicinal plants to treat symptoms associated with HIV/AIDS was obtained through semi-structured interviews with traditional health practitioners. Furthermore, interviews were used in this study because they allow researchers to take detailed notes of corroboration in order to improve other data collection procedures that assist researchers to obtain insight into events (Cohen, Manion & Morrison, 2011).

According to Braun and Clarke (2013), interviews are skilful performances. Interviewing individuals is a more natural way of connecting with them than having them fill out questionnaires, take an exam, or participate in some kind of research project. According to Terre Blanche et al. (2006), an interview allows researchers to become closer to and familiarise themselves with participants, allowing them to better understand how they think and feel.

Interpretive techniques regard an interview as a means to an end, ensuring that the participant is at ease and accurately expresses himself. An interview, according to Maree (2016), is a two-way dialogue in which the interviewer asks the participants questions in order to collect data and learn about the participants' ideas, beliefs, perspectives, opinions, and behaviours. Interviews try to perceive the world through the participants' eyes, and they can be a great source of information as well (Maree, 2016).

The goal is to collect rich, descriptive data that will aid the researcher in understanding how the participants create knowledge and social reality. Conducting interviews allowed the interviewer to interact with the participants and learn exactly how they felt, what they disliked, and what their thoughts and attitudes were when it came to using indigenous knowledge medicinal plants to treat HIV/AIDS symptoms.

Semi-structured interviews were included in the study since they are often used by researchers in research projects to corroborate data from other data sources (Johnson & Christensen, 2004: 161). Semi-structured interviews typically require participants to respond to a set of pre-set questions while also allowing the researcher to probe and explain questions in order to obtain rich replies. According to Cohen, Manion, and Morrison (2011), probes allow the interviewer to ask respondents to expound, add to, explain, or qualify their responses, addressing richness, depth of answer, comprehensiveness and honesty, which are all hallmarks of successful interviewing.

In semi-structured interviews, researchers would generally pay attention to the participants' responses to the questions asked during the interview process. This is done so that participants can freely provide information while the researcher identifies fresh emergent lines of inquiry and asks follow-up questions as needed. The researcher also employed semi-structured interviews in this study to examine and clarify the responses of the participants. This helped participants return to the interview's main topic (Neuman, 2011).

3.8 Data analysis

The process of organising data into categories based on themes is known as data analysis in qualitative research (Stake, 2005). To put it another way, data analysis is the process of putting order, structure, and meaning to the information gathered (Maree, 2016). In this situation, the researcher read through all of the written questions and listened to the recorded data in order to supplement the written data. This was done to verify that the researcher completely comprehended the information gathered.

Braun and Clark (2013) used theme analysis to qualitatively analyse the collected material. According to Braun and Clark (2013), thematic analysis is a qualitative method for identifying, analysing, and reporting patterns and themes in data. It aids in the organisation

and description of data sets in more depth. The data for this study was gathered via semi-structured interview questions, which were then organised into topics.

Bertram (2003) also included data organisation and development processes. The same processes were used to organise the data collected in this investigation, as per the following steps:

Step 1: To obtain a feel of what's going on, the researcher starts by documenting the entire data set (interview transcripts, field notes). As he or she reads, the researcher jots down any thoughts that spring to mind.

Step 2: The researcher looks for emerging themes in the data. The subject content of a piece of text is referred to as a theme. In the margin, the researcher jots down the themes.

Step 3: The researcher compiles a list of issues that have arisen from the various data sets and compares them to determine if there are any overlaps. He or she now has a set of subjects with which to classify or categorise live data. The term "classification" refers to the grouping of related characteristics.

Step 4: The researcher uses this interim categorisation technique to classify all of the data sets. Next to the suitable piece of data, he or she may abbreviate the topic to a code (Bertram, 2003).

The researcher viewed and transcribed the data acquired in the first stage to gain an understanding of what happens when traditional health practitioners treat individuals with HIV/AIDS symptoms. This was done so that the researcher could become familiar with the data and see what themes could emerge from it (Maree, 2016).

The researcher created codes in order to gain a better understanding of the data gathered. This assisted the researcher in assessing and making sense of the data acquired. In this study, coding was utilised to classify and organise the qualitative data collected, as well as to identify different themes and their linkages. Themes that arose from data acquired during the interviews were categorised in this procedure, with similarities and differences removed. After that, the researcher created narrations to show that he understood the findings.

The researcher considered the third phase, which was to produce or seek themes. The transcribed data was used to look for emergent themes by the researcher. This was accomplished by detecting patterns among the data and then developing themes. The topics were more closely tied to the issues posed therefore codes were created, and themes were assigned to them (Braun & Clark, 2013).

The researcher ensured that themes and correct representations of the data were drawn in step four. The researcher had to go back to the data collection he had gathered and compare his findings to it. This was done to guarantee that no important information is overlooked (Braun & Clark, 2013). During this step, the researcher double-checked that all of the themes are present in the data and, if necessary, makes changes. The developed topics are subjects about which the participants were particularly passionate and stressed.

The definition and naming of themes is the sixth phase. The final stage, according to Maree (2016), is to name and catalogue the themes that have been developed after they have been created. This process entails defining themes, outlining exactly what each theme entails, and determining how each topic aids the researcher in comprehending the data obtained. The process of naming themes entails coming up with a short, easy-to-understand name for each subject so that it does not divert from the researcher's intended conclusion and recommendation.

The writing up process is the final step in producing a final report. The process of analysing and interpreting the data collected is known as writing up. The researcher merged the research questions, objectives, and literature review to evaluate whether there were any gaps in the information (Braun & Clark, 2013). The literature that was utilised to answer the study's objectives was also used to see if what the participants had said agreed or differed from the views of the participants. In the results or findings section, each theme is normally handled one at a time. Finally, the researcher concluded by describing the key insights and demonstrating how the analysis addressed the study issue. Recommendations were also made based on themes that emerged from the participants' comments.

3.9 Ethical consideration

It is widely acknowledged that when researchers embark on a research project, they normally think about the importance of ethical considerations before proceeding with the study. A study cannot, for example, impinge on the rights of the target population. An ethical clearance is always necessary in this situation (Hammond & Wellington, 2013: 60). In this regard, the researcher normally collects data while keeping in mind the rights of the target community. The researcher usually takes into account the respondent's rights, such as informed permission, confidentiality, and protection from disclosure of information (Corbin & Strauss, 2015).

For this study, the researcher requested permission to collect data from traditional medicinal practitioners in the community of Keates Drift in Msinga Municipality in a letter to the chief (induna). The researcher applied to the University of Zululand for ethical clearance. A letter was sent to the chief of the Keates Drift community, requesting permission to speak with owners of traditional medicinal knowledge who are considered community doctors. Permission to conduct research in rural communities was granted by the KwaZulu-Natal Traditional Authorities based in Msinga Municipality. It was also made clear to the participants that participation in the study was entirely voluntary, and that their privacy and confidentiality would be respected at all times. Informed consent for data collection was also obtained for the study.

- As confidentiality denotes a situation in which a researcher is aware of the identity of a research subject but takes precautions to keep that information private. Ensuring a signed consent of agreement was reached for the benefit of both parties. This study kept confidentiality in place to ensure that private information of participants was respected (Tolich, 2004). The researcher kept in mind that he was dealing with people and their information was only shared between him and the participants remained private. The following are the procedures taken by the researcher to ensure that data was protected:
- The researcher did not ask personal information family name and names, cellphone number and home address of the participants. Nevertheless, the researcher asked information like gender, age and marital status and this information was only used for this project.
- Lastly, the informed consent was also considered by this study and the researcher guaranteed that all parties involved were aware of the informed consent, which included telling the subject about his or her rights, the research's goal, procedures to be followed, and possible dangers and benefits of involvement in the study. The researcher informed participants that they are participating voluntarily and payment will be made.

3.10 Rigour

The research was planned and carried out in accordance with well-established research standards for selecting an effective research approach. To ensure the validity and reliability of the research findings, data generation instruments and data analysis were used

(Creswell, 2014; Cohen, Manion & Morrison, 2011). To establish the theoretical underpinning of the study and guarantee that the meaning linked to the concept was consistent, the researcher conducted a thorough review of literature. The literature review provided a rich backdrop for analysing and interpreting research findings. The findings were validated by the conclusions drawn from the research after evaluating semi-structured interviews.

3.11 Trustworthiness

In this investigation, trustworthiness was determined to be crucial since it allowed the study to produce steady and dependable data. In this light, Cohen et al. (2011:119) recommended that qualitative research may employ terms such as "credibility, trustworthiness, and transferability" to ensure that the study is trustworthy. Multiple realities and interpretations that hold dependability in the same context by many researchers were supplied by the interpretative paradigm. The study tool employed was able to provide the researcher with crucial information. The researcher made certain that the pilot study was completed so that the instruments could be evaluated for bias. The researcher's supervisor and another expert in social work double-checked the data from the pilot research to ensure the results were accurate. The supervisor and expert also assisted the researcher in ensuring that the questions posed were relevant to the study's goals.

3.12 Chapter summary

The design and methodology used in this investigation were discussed in this chapter. Given that the study was qualitative, a case study was the best option because it uses a small sample size and provides a thorough grasp of the phenomenon. The use of semi-structured interviews as a data collection strategy was considered. The chapter's conclusion addressed concerns of trustworthiness and ethical considerations. The data from semi-structured interviews is analysed in the following chapter.

Chapter 4

Data Presentation, Analysis and Interpretation as well as Discussions of Results: Traditional Medicinal Practitioners

4.1 Introduction

The purpose of this chapter was to report the results of the data analysis, which transformed the raw data, obtained from the traditional medicinal practitioners, into meaningful facts. This chapter is divided into two parts. Part one of the chapter presents the data that pertains to the characteristics of the key informants. Part two of the chapter analyses the data pertaining to the management of HIV/AIDS through traditional medicinal plants.

The chapter is organised as follows:

- 4.2 Demographic profile of respondents
- 4.3 Types of treatment management used for HIV/AIDS by IK medicinal practitioners
- 4.4 Kind of indigenous knowledge medicinal practitioners for the community
- 4.5 IK medicinal practitioners dealing with HIV/AIDS
- 4.6 Challenges faced by indigenous knowledge medicinal practitioners in the management of HIV/AIDS.

4.2 Part One: Demographic characteristics of key informants

The key informants were asked to answer structured questions about themselves, including their gender, age, marital status, and highest academic qualification. The goal of these structured questions was to see if there were any links between demographic variables and the purposes of treating and managing HIV/AIDS.

Table 4.1: Demographic characteristics of key informants

Variables of Biographic data		
Variables	Frequency	Percentage %
Gender		
Male	7	58.3%
Female	5	41.6%
TOTAL	12	100
Age group		
31-40 years	1	8.3%
41-60 years	7	58.3%
61-70 years	3	25%
Older than 70 years	1	8.3%
TOTAL	12	100
Marital status		
Married	9	75%
Single	3	25%
TOTAL	12	100

4.2.1 Classification of key informants according to gender

Table 4.1 shows that there were slightly more males (58.3 percent) than females (41.6 percent) among the key informants in the sample group. In the province of KwaZulu-Natal, both women and men are considered indigenous knowledge medicinal practitioners. It may be stated that men and women are equally represented in this survey.

4.2.2 Classification of key informants by age

The results in Table 4.1 showed that many of the key informants were between the ages of 41 and 60, with a score of (58.3 percent), while (25 percent) were between the ages of 61 and 70. Only one (8.3%) of the key informants was over the age of 70, and another (8.3%) was between the ages of 31 and 40. The study findings by age group indicated that the age groups were well represented, and indigenous knowledge medicinal practitioners can live to be more than 70 years old. Interestingly, one could argue that their ability to reach adulthood was aided by the use of African medicine and other related homemade foods.

4.2.3 Classification of key informant's marital status

According to the study's marital status findings, 75% of the key informants were married, while just 25% were single. The findings could indicate that traditional medicine practitioners value marriage as a highly essential aspect of life, and that it is a sign of excellent social standing.

4.3 Part Two: Management of HIV/AIDS through indigenous knowledge medicinal plants

This section highlights the use of indigenous knowledge medicinal plants to treat and manage the symptoms related to HIV/AIDS. It is worth noting that this section is mentioned under the study's four key research objectives. To find relevant results, the participants were asked the following questions:

4.3.1 Are you considered as the traditional medicinal practitioner in your community?

The first question from objective one of the study was to establish from the key informants if they were traditional medicinal practitioners in their communities. This question was asked in order to ensure that the key informants were the ones dealing with cases of HIV/AIDS as traditional doctors. The following table summarises the findings.

Table 2.2: Are you considered as the traditional medicinal practitioners in your community?

Practitioners	Response to the question
Traditional medicinal practitioner 1	Yes I am
Traditional medicinal practitioner 2	I am a traditional doctor
Traditional medicinal practitioner 3	Yes, I am
Traditional medicinal practitioner 4	I am one of them
Traditional medicinal practitioner 5	Yes I am
Traditional medicinal practitioner 6	Yes
Traditional medicinal practitioner 7	Yes I am
Traditional medicinal practitioner 8	Yes I am
Traditional medicinal practitioner 9	Yes
Traditional medicinal practitioner 10	Yes
Traditional medicinal practitioner 11	Yes
Traditional medicinal practitioner 12	Yes I am

Surprisingly, the study's findings in Table 4.2 revealed that all of the key informants acknowledged that they were community traditional medicinal practitioners (traditional doctors). The findings from the key informants provided assurance to the study that rich information relevant to the study's objectives was acquired from appropriate sources of information. The findings from Table 4.2 above harmonised with previous findings that in rural communities there are traditional doctors responsible for treating illnesses that the community is faced with (Habtom, 2018). The findings of the study also agreed with those of Akullo, Kanzikwera, and Barwogeza (2007) and Anyira, Onoriode, and Nwabueze (2010), Masoga and Shokane (2020) who discovered that traditional healers, diviners, and herbalists are considered custodians and traditional doctors in rural communities.

4.3.2 Kind of traditional medicinal practitioner

The key informants were asked a follow-up question about their roles as traditional medicinal practitioners as part of the study. In order to get a clear picture of what each key informant had to say, their responses were narrated for the study. It is worth noting that the key informants were categorised as Traditional Medicinal Practitioners 1–12. The key informants identified only two (2) types of traditional medicinal practitioners as the most prevalent in their rural areas. Their responses were as follows:

Traditional medicinal practitioner 1: ... *“I am an herbalist (inyanga) (in my community)”*.

Traditional medicinal practitioner 2: ... *“In my village, I am known as a diviner (isangoma)”*.

Traditional medicinal practitioner: ... *“Sir, I am an herbalist (inyanga)”*.

Traditional medicinal practitioner 4: ... *“I am a diviner (isangoma)”*.

Traditional medicinal practitioner 5: ... *“I am an herbalist (inyanga)”*.

Traditional medicinal practitioner 6: ... *“I am a diviner (isangoma)”*.

Traditional medicinal practitioner 7: ... *“I am a diviner (isangoma)”*.

Traditional medicinal practitioner 8: ... *“I am an herbalist (inyanga)”*.

Traditional medicinal practitioner 9: ... *“I am a diviner (isangoma)”*.

Traditional medicinal practitioner 10: ... *“I am an herbalist (inyanga)”*.

Traditional medicinal practitioner 11: ... *“I am an herbalist (inyanga)”*.

Traditional medicinal practitioner 12: ... *“I am a diviner (isangoma)”*.

The study confirmed that the categories of traditional medicinal practitioners in Keates Drift in Msinga are diviners (isangoma) and herbalists (izinyanga). In rural communities, these traditional medicinal practitioners are valued because they hold a key position as community traditional doctors. Several studies by Matomela (2013), Akullo, Kanzikwera, and Barwogeza (2007), Anyira, Onoriode, and Nwabueze (2010) also confirmed that traditional doctors in rural communities include diviners (sangomas), herbalists (izinyangas), faith healers (abathandazi), and traditional birth attendants (ingcibi). Even though the study only found two (2) kinds of traditional practitioners in Keates Drift, they are related to those

addressed in the literature review. When compared to the study's findings, the literature contained a number of traditional medicinal practitioners. This could be due to the fact that the study was conducted in one rural area as opposed to literature with a worldwide perspective.

4.3.3 Opinions on whether traditional medicine practitioners used herbs to treat HIV/AIDS related symptoms

Key informants (traditional medical practitioners) were questioned if they used traditional medicinal plants or other herbs to treat and manage HIV/AIDS-related symptoms. The study intended to see if traditional medicinal practitioners were assisting community members who were unwell as traditional community doctors by asking this question. The key informants indicated that they were using many different traditional medicinal plants to treat and manage HIV/AIDS-related symptoms. In confirmation of interpretations, the research key informants made the following comments:

Traditional medicinal practitioner 1: ... *"Yes, I use plants from the forest to help my clients who are HIV/AIDS positive"*.

Traditional medicinal practitioner 2: ... *"I do use plants but first I consult the ancestors to tell me what to do"*.

Traditional medicinal practitioner 3: ... *"I only use plants to treat symptoms of HIV/AIDS"*.

Traditional medicinal practitioner 4: ... *"I utilise my bones to inform me what to do, and then I use plants once I have been given instructions."*

Traditional medicinal practitioner 5: ... *"I use plants"*.

Traditional medicinal practitioner 6: ... *"I consult my ancestors and then use plants"*.

Traditional medicinal practitioner 7: ... *"I consult my ancestors and apply plants to treat and manage HIV/AIDS"*.

Traditional medicinal practitioner 8: ... *"I use plants only"*.

Traditional medicinal practitioner 9 : ... *"I consult my ancestors and then use the plants as directed"*.

Traditional medicinal practitioner 10: ... *"I use plants"*.

Traditional medicinal practitioner 11: ... *"I always use plants especially roots and leaves"*.

Traditional medicinal practitioner 12: ... *"I use traditional plants after consulting my ancestors"*.

The findings presented above from the participants confirmed that traditional medicinal practitioners use plants such as leaves, roots, stems and barks for treatment and the management of symptoms related to HIV/AIDS. These findings from the traditional medicinal practitioners resonated with the research of Mushaandjan (2011) and Magara (2002:40) who revealed in their studies that traditional medicinal plants obtained in the wilderness are major sources of medicine for rural community members. According to Eyong (2007), indigenous healers use various plants to ensure that ailments among community members are treated and managed.

4.3.4 Types of traditional medicinal plants used to treat and manage HIV/AIDS-related symptoms

The researcher thought it was vital to ask the key informants what kinds of traditional medicinal herbs they used to treat and manage HIV/AIDS symptoms. This question was posed to determine how traditional doctors assisted community members in the management of HIV/AIDS. Surprisingly, the participants revealed that they employed a variety of traditional medicinal plants to treat and control HIV/AIDS-related illnesses. The following responses from the research participants backed up the interpretations:

Traditional medicinal practitioner 1: ... *"I use aloe (inhlaba) and African potato (ilabatheka)"*.

Traditional medicinal practitioner 2: ... *"I usually use aloe (inhlaba), and African potato (ilabatheka)"*.

Traditional medicinal practitioner 3: ... *"I use Celastraceae (umhlwazi) and African potato (ilabatheka)"*.

Traditional medicinal practitioner 4: ... *"I normally use Araceae (Ihlukwe) and aloe (Inhlaba)"*.

Traditional medicinal practitioner 5: ... *"I use Celastraceae (umhlwazi) and aloe (Inhlaba)"*.

Traditional medicinal practitioner 6: ... *"I use African potato (ilabatheka) to boost the immune system of my patients"*.

Traditional medicinal practitioner 7: ... *"I use African potato ((ilabatheka) and aloe (Inhlaba)"*.

Traditional medicinal practitioner 8: ... *"I normally use Araceae (Ihlukwe) and aloe (Inhlaba)"*.

Traditional medicinal practitioner 9: ... *"I use Celastraceae (umhlwazi)"*.

Traditional medicinal practitioner 10: ... *"I use normally a mixture of African potato ((ilabatheka), aloe (Inhlaba), and Araceae (Ihlukwe)"*.

Traditional medicinal practitioner 11t: ... *"African potato (ilabatheka) and aloe (inhlaba)"*.

Traditional medicinal practitioner 12: ... *"I use Celastraceae (umhlwazi) and aloe (inhlaba)"*.

The findings above have revealed that diviners (izangoma) and herbalists (izinyanga) use several plants to ensure that the symptoms related to HIV/AIDS are treated and managed. Noticeably, African potato (ilabatheka) and aloe (inhlaba) were the most used plants among traditional medicinal practitioners. It was also discovered that Celastraceae (umhlwazi) and Araceae (ihlukwe) were frequently used by traditional medicinal practitioners. These findings resonated with the research findings of Magara (2002:40) in that some common plants are used by traditional medicinal practitioners to treat a number of illnesses of the human body. The African potato (ilabatheka), for example, is a good root for boosting immunity and decreasing blood pressure to patients with HIV/AIDS (Magara, 2002:40). Aloe (inhlaba) or (sekgokgopha), on the other hand, is used to cleanse the body of toxins and free radicals (Magara, 2002:40). Other authors, including Anani et al. (2000), Eyong (2007), Hutchings et al. (1996), and Van Wyk (2011), agreed with the findings of traditional medicinal practitioners that Araceae (ihlukwe), African potato (leraka), and Celastraceae (mmhlawazizi, umhlwazi) are the most commonly used plants to treat and manage HIV/AIDS symptoms.

4.3.5 Traditional medicine practitioners' perspectives on how patients respond to the traditional medicine plants given to manage HIV/AIDS symptoms

The researcher thought it was vital to question the key informants if their patients responded well after being prescribed and given a typical traditional medication. This inquiry was designed to observe and offer proof that traditional medical practitioners were truly assisting in rural communities, and that their assistance was crucial in the lives of patients suffering from HIV/AIDS related symptoms. Surprisingly, the key informants (traditional medicinal practitioners) stated that they always receive feedback from their patients that their HIV/AIDS symptoms are lessening as a result of the medication's effectiveness. The narratives of the key informants were as follows:

Traditional medicinal practitioner 1: ... *"Oh yes sir, my clients or patients respond positively all the time"*.

Traditional medicinal practitioner 2: ... *"I am pleased to tell you that I always receive positive response from my patients"*.

Traditional medicinal practitioner 3y: ... *"They respond extremely well to treatment, especially if they arrive in the early stages of the illness"*.

Traditional medicinal practitioner 4: ... *"Some people respond favourably as they grow better, whereas others do not respond positively because they arrive late"*.

Traditional medicinal practitioner 5: ... *"They respond positively but only if they came early"*.

Traditional medicinal practitioner 6: ... *"Those who come early respond positively but those who come late it becomes very difficult and they normally pass on"*.

Traditional medicinal practitioner 7: ... *"Some of my patients respond well to treatment, while others find it harder to respond because their immune systems have weakened"*.

Traditional medicinal practitioner 8: ... *"Some respond well, and some get minor problems"*.

Traditional medicinal practitioner 9: ... *"They normally get well once they get my medicine"*.

Traditional medicinal practitioner 10: ... *"They do cope after using my medicine"*.

Traditional medicinal practitioner 11: ... *"They respond positively but only if they came a bit earlier"*.

Traditional medicinal practitioner 12: ... *"My medicine is always helping all community members but those who come in the early stages of HIV/AIDS"*.

The above research findings are consistent with the findings of the Reference Centre for African Traditional Medicine (RCATM) (2010), which stated that "60%-80% of the world's population relies on traditional medicine for illness and disease treatment".

4.3.6 Key informants' perspectives on how they know their patients have reacted effectively to HIV/AIDS treatment and care

The key informants (traditional medicinal practitioners) were asked how they knew their patients (clients) were responding effectively to HIV/AIDS symptoms' therapy and management. The question was posed to elicit information from important informants on how their patients reacted to the treatment they received. This question elicited a wide range of responses from the key informants. The following is a summary of their responses:

Traditional medicinal practitioner 1: ... *"They always return to thank me because they do not go to modern hospitals"*.

Traditional medicinal practitioner 2: ... *"Those who came sick improved after taking my prescription and returned to tell me that they were no longer in pain. They also refer a lot of clients to me as proof that what I do is effective"*.

Traditional medicinal practitioner 3: ... *"Others respond well and come back and even tell others that my traditional medicine is always spot on"*.

Traditional medicinal practitioner 4: ... *"Patients tell others if your diagnosis and medicine are helpful"*.

Traditional medicinal practitioner 5: ... *"When patients visit modern hospitals for check-ups, they receive positive responses, and many of them are referred to me"*.

Traditional medicinal practitioner 6: ... *"After using my medicine, they live a normal life like anyone else and they refer many to me"*.

Traditional medicinal practitioner 7: ... *"Doctors who check them always give them a good report and this is proof that traditional medicine works. Many patients are referred to me for treatment"*.

Traditional medicinal practitioner 8: ... *"They respond well, and they normally come back for check-ups only to find that they are well and feeling better"*.

Traditional medicinal practitioner 9: ... *"I am always busy as those I help refer others to me"*.

Traditional medicinal practitioner 10: ... *"Most of them cope from our treatment and refer many to us"*.

Traditional medicinal practitioner 11: ... *"They become normal and always mention my name to others who going through the same sickness"*.

Traditional medicinal practitioner 12: ... *"My medicine is always helping all community members and even people who are not from my community always come looking for me to help them"*.

4.3.7. How traditional medicinal plants are used to treat and manage HIV/AIDS symptoms

It was critical for this study to learn how traditional medicinal herbs are used to treat and manage HIV/AIDS symptoms from traditional medicinal practitioners. This subject sparked a lively discussion among the key informants. According to the key informants, they use a combination of plants to ensure that all HIV/AIDS-related symptoms are effectively treated and managed. The following is a summary of their responses:

Traditional medicinal practitioner 1: ... *"Normally, I combine plants and roots and then boil the mixture. Once my mixture has cooled, I give it to my patients and have them drink it every 3 hours until they improve"*.

Traditional medicinal practitioner 2: ... *"I bring plants and roots down from the mountain and boil them until they are ready to use. After that, I instruct my patients to consume one litre of water every day for seven days"*.

Traditional medicinal practitioner 3: ... *"I boil the crushed leaves and roots for two hours before giving them to my patients"*.

Traditional medicinal practitioner 4: ... *"I usually combine umadlozane with insibhinya, boil it, and then give it to my patients"*.

Traditional medicinal practitioner 5: ... *"I cook one African potato with noGobho for two hours before giving it to my patients to drink for a few days"*.

Traditional medicinal practitioner 6: ... *"I boil isinwazi and isibhinya for two hours"*.

Traditional medicinal practitioner 7: ... *"I mix and boil aloe, African potato and isibhinya for my patients to drink for seven days"*.

Traditional medicinal practitioner 8: ... *"I boil isinwazi"*.

Traditional medicinal practitioner 9: ... *"I boil Araceae (Ihlukwe) and African potato and allow my clients to drink for ten days"*.

Traditional medicinal practitioner 10: ... *"I use the stem and juice for Costus afer and allow my patients to use it for few days and get well"*.

Traditional medicinal practitioner 11: ... *"I use the leaves of Celastraceae (Umhlawazizi, umhlwazi) and mix it with African potato"*.

Traditional medicinal practitioner 12: ... *"I use the roots of Geraniaceae to treat cough and diarrhoea to dehydrated patients"*.

The findings showed that mixing different types of traditional medicinal plants is what helps ensure that all symptoms related to HIV/AIDS are treated and managed. The traditional medicinal practitioners indicated that they normally combine leaves, roots, barks, just to mention a few, to be taken by patients as treatment. The findings of the study concurred with Magara (2002) who also found that traditional healers use a mixture of different plants like barks, leaves and roots to treat their patients.

These findings were consistent with Kaniki and Mphahlele (2002) and the National Reference Centre for African Traditional Medicine (NRCATM) (2010) in that the African potato (ilabatheka) and aloe (inhlaba) are mixed with other traditional herbs as crucial medicinal treatments for patients with symptoms related to HIV/AIDS.

4.3.8. Opinions on whether or not it is appropriate to utilise human and animal parts to treat the symptoms of HIV/AIDS or any other disease

The key informants in the study were asked if human and animal parts were suitable for treating symptoms of HIV/AIDS or any other condition. This question was posed to determine what is permissible for traditional medical practitioners to utilise in the treatment and management of any illness or virus that affects their patients. Amazingly, the twelve (12) traditional medicinal practitioners indicated that human and animal body parts are not

authorised to be employed for treating and managing any illness or ailment in their patients. Their remarks were categorised as follows:

Traditional medicinal practitioner 1: ... *"It is not allowed sir"*.

Traditional medicinal practitioner 2: ... *"I do not use that and it is not allowed"*.

Traditional medicinal practitioner 3: ... *"Not allowed in our field"*.

Traditional medicinal practitioner 4: ... *"We do not use human or animal parts"*.

Traditional medicinal practitioner 5: ... *"Not allowed"*.

Traditional medicinal practitioner 6: ... *"Only a witch can use that"*.

Traditional medicinal practitioner 7: ... *"I do not use that thing"*.

Traditional medicinal practitioner 8: ... *"It is not allowed"*.

Traditional medicinal practitioner 9: ... *"I do not know but as for me, I do not use it"*.

Traditional medicinal practitioner 10: ... *"No sir, we do not use it"*.

Traditional medicinal practitioner 11: ... *"I do not use that sir"*.

Traditional medicinal practitioner 12: ... *"It is not acceptable"*.

The overall findings in this theme showed that the use of human and animal parts are prohibited from being used by traditional medicinal practitioners. This is consistent with other findings that charlatans (fraudulent healers who utilise human body parts to manufacture medicine and claim to cure a variety of maladies) are not allowed to practise under the licence (Sagan, 2013). This means that any traditional medicinal practitioner that uses human or animal body parts may not ever be allowed to operate as a traditional healthcare advisor nor treat or manage any case of illness.

4.3.9 Reasons why using human or animal components is not acceptable

It was critical to do a follow-up inquiry on the reasons why human or animal parts cannot be used to cure or manage HIV/AIDS or any disease. This question was intended to determine whether they have a policy or regulation that requires them to solely utilise plants, or whether it is their custom not to. The key informants are barred from using human and animal body parts, thus they did not utilise them to treat or manage HIV/AIDS-related symptoms, according to the findings. They expressed the following in this regard:

Traditional medicinal practitioner 1: ... *"We are not allowed to use human and animal parts. We are registered as traditional practitioners"*.

Traditional medicinal practitioner 2: ... *"Our ancestors are against the use of human and animal parts. The South African constitution of traditional medicinal practitioners is against this thing"*.

Traditional medicinal practitioner 3: ... *"I never got a training on that. It is a dirty thing to use human or animal parts. The constitution is against such practices"*.

Traditional medicinal practitioner 4: ... *"Traditional medicinal practitioners were told not to use human or animal parts"*.

Traditional medicinal practitioner 5: ... *"It is evil to do that. We have a policy that states we should not use human and animal parts"*.

Traditional medicinal practitioner 6: ... *"My ancestors do not allow that"*.

Traditional medicinal practitioner 7: ... *"We as traditional healers are not allowed to use that. We are registered in South African constitution for traditional healers"*.

Traditional medicinal practitioner 8: ... *"Our policy states it clear that no human and animal parts should be used"*.

Traditional medicinal practitioner 9: ... *"we are prohibited by government to use human and animal parts"*.

Traditional medicinal practitioner 10: ... *"Generally, it is evil"*.

Traditional medicinal practitioner 11: ... *"It is satanic and against our law"*.

Traditional medicinal practitioner 12: ... *"It is not acceptable by my ancestors"*.

The study's findings revealed that traditional medicinal practitioners are not permitted to use human or animal body parts, according to the policy. This is in line with prior research findings that charlatans (false healers who produce medicine from human body parts and claim to cure a range of ailments) are not permitted to practise under the licence (Sagan, 2013). The government passed the Traditional Health Practitioners Act (22 of 2007) to ensure that traditional doctors in South Africa have the same rights as other healthcare practitioners, and that all healthcare practitioners are working lawfully and fulfilling all Department of Health criteria (Sagan, 2013).

4.3.10. Are you well informed regarding treating and managing the symptoms related to HIV/AIDS using traditional medicinal plants?

The key informants were questioned if they were adequately educated about the use of traditional medicinal plants to treat and manage HIV/AIDS symptoms. This question was intended to determine whether traditional medical practitioners are knowledgeable of HIV/AIDS symptoms. The participants indicated that they have well and advanced skills and knowledge in treating and managing symptoms related to HIV/AIDS. In-line with the aforesaid statement, the following responses emanated from them:

Traditional medicinal practitioner 1: ... *"I was trained to deal with any sickness including HIV/AIDS"*.

Traditional medicinal practitioner 2: ... *"I am fully informed on this"*.

Traditional medicinal practitioner 3: ... *"This is my area to deal with such sicknesses even covid-19"*.

Traditional medicinal practitioner 4: ... *"I went for a training which took me five years"*.

Traditional medicinal practitioner 5: ... *"I am extremely knowledgeable"*.

Traditional medicinal practitioner 6: ... *"I got trained and even at night I have visions"*.

Traditional medicinal practitioner 7: ... *"Well informed"*.

Traditional medicinal practitioner 8: ... *"I was trained and I know what I am doing"*.

Traditional medicinal practitioner 9: ... *"I am fully trained"*.

Traditional medicinal practitioner 10: ... *"I am trained and have full knowledge"*.

Traditional medicinal practitioner 11: ... *"Well trained and skilled"*.

Traditional medicinal practitioner 12: ... *"I am fully informed and even today we treat and manage cases of Covid-19"*.

According to the findings above, traditional medicinal practitioners are well-versed in the treatment and management of HIV/AIDS symptoms using medicinal plants. The findings supported the late Ms Manto Tshabalala Msimang's statement in the Bill that traditional healers such as diviners (sangomas), herbalists (izinyangas), traditional birth attendants (iingcibi), and traditional surgeons (iingcibi) are well advanced in traditional medicine and should be respected and recognised (Matomela, 2013). In this context, the Geneva summit

endorsed the acknowledgment and promotion of traditional medicine, particularly where traditional healers are involved (WHO, 2010; Hakim & Chishti, 2010).

The above findings are consistent with Sagan's (2013) research, which found that, like western doctors, traditional doctors can prescribe medication and sick-leave to patients under the Traditional Medicinal Practitioners Bill of 2003. This indicated that traditional medical practitioners are aware of their duties and responsibilities in society.

4.3.11 Methods for learning to be a traditional medicinal practitioner

The researcher felt it was crucial to hear from key informants about how they learned to treat and manage HIV/AIDS as traditional medicine practitioners. This topic produced a lot of debate among the key informants, and their comments were extremely useful in achieving the study's goals. The findings revealed that the main informants obtained traditional medicinal plant skills and knowledge from a variety of sources. The following are their responses in detail:

Traditional medicinal practitioner 1: ... *"I learned the skills from my ancestors, but I also had dreams and interacted with other herbalists (izinyanga)".*

Traditional medicinal practitioner 2: ... *"I was taught by an elderly herbalist (inyanga), but it is largely a legacy from my forefathers."*

Traditional medicinal practitioner 3: ... *"I used to help a herbalist, and while doing so, I learned how to combine various plants to treat a variety of ailments. My ancestors also gave me a gift".*

Traditional medicinal practitioner 4: ... *"From my forefathers and a wise old man (sangoma)".*

Traditional medicinal practitioner 5: ... *"I believe this was a divine gift because I had visions about those medicinal herbs".*

Traditional medicinal practitioner 6: ... *"Our elders teach us how to be diviners (ilzangoma)".*

Traditional medicinal practitioner 7: ... *"We are taught as herbalists (izinyanga) by highly experienced herbalists (izinyanga) who are well-versed in dealing with ailments".*

Traditional medicinal practitioner 8: ... *"I received training when I was very young".*

Traditional medicinal practitioner 9: ... *"I was trained by another diviner (isangoma)".*

Traditional medicinal practitioner 10: ... *"I was taught by village elders who were well-versed in the practice of traditional medicine".*

Traditional medicinal practitioner 11: ... *"I learned from my father, who was also endowed with the ability by his forefathers".*

Traditional medicinal practitioner 12: ... *"It is a unique gift from my forefathers".*

These findings revealed that traditional medicinal practitioners must be trained by an advanced elder in the field they wished to learn in order to be equipped in traditional medicine. As a result, the research revealed that traditional medical practitioners learned their abilities and expertise from seasoned traditional healers and forefathers. This is in line with Adeniyi and Subair (2013), who found that traditional knowledge is passed down and communicated orally, and that it is a society's cultural inheritance.

The findings resonated with the research findings of Ilo (2012) in that rural elders strongly believe that ancestors can convey a message with an individual, among family members, on how to deal with a specific illness, casting out evil spirits.

4.4 Views whether traditional medicinal practitioners encounter problems when treating and managing patients with symptoms of HIV/AIDS

The final objective of the study was for key informants to respond to whether they were having difficulties treating and managing patients with HIV/AIDS symptoms. The purpose of this inquiry was to identify the key informants who were having difficulties. The following table contains the following information:

Table 4.4: Views on whether or not traditional medical practitioners have difficulty treating and managing HIV/AIDS

Practitioners	Response to the question
Traditional medicinal practitioner 1	No problem encountered
Traditional medicinal practitioner 2	No
Traditional medicinal practitioner 3	Yes, I do
Traditional medicinal practitioner 4	No

Traditional medicinal practitioner 5	Yes I experience problems
Traditional medicinal practitioner 6	No
Traditional medicinal practitioner 7	Yes I do
Traditional medicinal practitioner 8	No
	No
Traditional medicinal practitioner 9	No
Traditional medicinal practitioner 10	Yes I do
Traditional medicinal practitioner 11	No
Traditional medicinal practitioner 12	Sometimes I do

Table 4.4 shows that only a small percentage of traditional medicine practitioners have difficulty treating and controlling HIV/AIDS symptoms, while a much greater percentage do not. These findings implied that traditional medical practitioners are well-informed about the services they provide to the general public. It is crucial to remember that traditional medical practitioners are respected all around the world. As a result, in 2002 a meeting in Geneva was held to propose the integration of traditional health practitioners in the primary healthcare system, particularly in developing nations with national healthcare policies. Traditional health practitioners and traditional medicine in developing countries must be protected, according to the World Health Organisation. Intellectual property rights and policies must be put in place to protect traditional health practitioners and traditional medicine in developing countries (WHO, 2010; Hakim & Chishti, 2010).

4.4.1 Challenges encountered

The key informants were asked to describe the problems they encountered when dealing with HIV/AIDS patients. This question was created to reveal the types of challenges that traditional medical practitioners experience when treating and managing HIV/AIDS patients. It's worth noting that only individuals who claimed to be struggling responded to this question. Only five (5) participants responded to this question as a consequence. They stated that there is no collaboration between traditional medicinal practitioners and modern doctors. The depths of their views are discussed as follows:

Traditional medicinal practitioner 3: ... *“There is a lack of collaboration between us and modern doctors. Secondly, I always have issues with patients who come to me*

late and my medicine is unable to help them. It pains me to see them die in front of my eyes. No condoms to support our patients whom we treat symptoms related to HIV/AIDS”.

Traditional medicinal practitioner 5: ... *“Some patients take a long time to recover, which leads to some of them speaking critically about me. Other clients are less likely to trust me as a result of this. We are not working hand-in-hand with western doctors”.*

Traditional medicinal practitioner 7: ... *“We do not have condoms to be given to our patients as we treat and manage symptoms related to HIV/AIDS. Some of my patients die while taking my medicine, but this is usually due to the fact that they arrive late”.*

Traditional medicinal practitioner 10: ... *“Modern doctors do not recognise us. Secondly, some patients take a long time to respond to treatment, leading them to doubt our abilities. However, when a person is infected with HIV/AIDS, their bodies do not respond to HIV/AIDS in the same way. They then have reservations about what we give them. The issue of giving out of condoms to our clients. We do not have them”.*

Traditional medicinal practitioner 12: ... *“No support and working together between us and modern doctors. Secondly, there are patients who die during the procedure not as a result of my medication, but because they arrived late”.*

The outcomes of the study corroborated prior research findings that traditional medicinal practitioners and mainstream medical services do not cooperate together (Ndhlalambi, 2009). Chipfakacha (2010) stated, "Traditional healers do not have condoms to distribute to their patients who are suffering from HIV/AIDS symptoms."

4.4.3 Strategies for minimising problems encountered

The key informants who encountered problems in treating and managing HIV/AIDS were asked to describe how they believe the issues could be reduced. Only those key informants who stated that they had concerns responded to this question. The respondents to this question raised a number of strategies that are required to ensure that they meet the expectations of their patients. The key informants indicated the following:

Traditional medicinal practitioner 3: ... *“We require funding to buy condom for free distribution. Secondly, if my patients and others in the community want to be treated and managed for HIV/AIDS symptoms, I encourage them to come to us early. When they are not knocked out by the sickness, this aids in their treatment”.*

Traditional medicinal practitioner 5: ... *“Government needs to fund us with condoms for free distribution. The other strategy I use is that I explain to the patients that their bodies may take some time to respond to the medication we give them, but they must remain patient. I also encourage them not to criticise our services because different people's bodies react differently to the medications they are taking. Give it some time”.*

Traditional medicinal practitioner 7: ... *“I occasionally enable my patient to remain with me until he or she has fully recovered. When you treat HIV/AIDS patients and they stick with you, it increases their trust in your service. Our government needs to fund us with condoms for free distribution”.*

Traditional medicinal practitioner 10: ... *“I let my patients stay with me for a few days until I notice that they are getting well, and then I release them to their family members. I also advise everyone in the neighbourhood to get tested for HIV/AIDS at a contemporary doctor as soon as possible. This aids in the early detection of the virus, allowing us to begin therapy as soon as possible”.*

Traditional medicinal practitioner 12: ... *“We need support from government, especially funding. I encourage people in the community to get tested by modern doctors, and if they test positive for HIV, we can begin treatment right away”.*

The findings revealed that traditional medicinal practitioners demand government assistance in the form of condoms for free distribution to their patients who are suffering from HIV/AIDS symptoms. Although traditional healers treat and manage HIV/AIDS-related illnesses, they also need to assist in the distribution of free condoms to their patients to ensure they practise safe sex, according to Chipfakacha's (2010) research findings.

4.5 Suggestions regarding treating and managing symptoms related to HIV/AIDS

It was crucial for this study to ask the key informants to make suggestions regarding treating and managing symptoms related to HIV/AIDS using traditional medicinal plants. This question was asked with an aim to establish solutions that could be implemented to resolve their challenges stated above. The key informants made a number of suggestions that they thought would be appropriate for effectively treating and managing HIV/AIDS symptoms. The following narrations are classified and presented as evidence:

Traditional medicinal practitioner 1: ... *"If we can be treated equally with modern doctors who use western medicine, and we need a consultation centre"*.

Traditional medicinal practitioner 2: ... *"We need to be allowed to work hand in hand with modern doctors because many of our African people get help from us whenever they come to us for treatment"*.

Traditional medicinal practitioner 3: ... *"Government should grant our traditional medicine to be used in hospitals because they need us. We are Africans and we know what works for us. We require a consultation centre where we can be officially consulted"*.

Traditional medicinal practitioner 4: ... *"We are now treating even Covid-19 and we have many patients both modern people and those from rural communities. Let us be allowed to work together with modern doctors and if government can build us a centre where we can be consulted"*.

Traditional medicinal practitioner 5: ... *"We as diviners (izangoma) should be given a chance to educate our African people about using traditional medicine rather than relying on western medicine alone. Government should intervene in this because these are the days of using natural herbs as they do not have side effects"*.

Traditional medicinal practitioner 6: ... *"Traditional medicine needs to be given a chance not to keep relying in western medicine. Why are supressing what belongs to us? We should be given an opportunity just like modern doctors. It helps in many different ways because where modern medicine fails, we can use our traditional medicine. We also need a centre where the public can consult us if they need traditional medicine"*.

Traditional medicinal practitioner 7: ... *"Let Africa rely heavily in traditional medicine than western medicine. We treat and manage many different kind of ailments even Covid-19. What we use works, and the problem is to undermine our skills"*.

Traditional medicinal practitioner 8: ... *"We should be given the opportunity to treat our people not to rely only in modern medicine. We will eliminate unnecessary death if we are allowed"*.

Traditional medicinal practitioner 9: ... *"Government should grant our traditional medicine to be used in hospitals especially where modern medicine has failed"*.

Traditional medicinal practitioner 10: ... *"Patients should be encouraged to come to us as early as they are diagnosed with HIV/AIDS symptoms"*.

Traditional medicinal practitioner 11: ... *"We need to have a consultation centre which allows all people to consult us"*.

Traditional medicinal practitioner 12: ... *"It is important that traditional medicinal practitioners have a centre where they are consulted for diagnoses and treatment as well as management of that particular illness"*.

According to the findings, traditional medicinal practitioners believe that African medicine, like western medicine, deserves a chance. The findings also revealed that African people should embrace their traditional medicine rather than dismissing it as savage. These findings resonate with Asante's (2000) assertion that Africans must rely on indigenous knowledge rather than western knowledge. In addition, the Afrocentric concept encourages the use of traditional treatment rather than western medicine. Furthermore, Mwansa's (2010) findings suggested that instead of relying on western knowledge, Africa should generate what is indigenous to her.

CHAPTER 5

Summary, Conclusion and Recommendations

5.1 Introduction

The previous chapter discussed the findings of the study based on the data that was collected from traditional medicinal practitioners. The data presented and interpreted in the previous chapter forms the basis for this chapter. It includes an overview of the study's important findings, consequences, conclusions, as well as recommendations for improving the treatment and management of HIV/AIDS-related symptoms. Based on the research objectives, a summary of the study's findings is offered (see Chapter 1, Section 1.5). In addition, the findings are based on the information offered in Chapter 4. The study set out to examine the role of traditional medicinal practitioners in KwaZulu-Natal Province, in the usage of indigenous knowledge methods in treating and managing HIV/AIDS-related symptoms. In order to achieve this aim, the following specific research objectives were formulated:

- To identify the types of traditional medicinal practitioners found in in the Keates Drift Community in the province of KwaZulu-Natal.
- To determine the types of indigenous knowledge medicinal plants used to treat and manage illnesses like HIV/AIDS.
- To establish whether traditional medicinal practitioners are well informed of HIV/AIDS in KwaZulu-Natal.
- To identify challenges faced by traditional medicinal practitioners in treating and managing the spread of HIV/AIDS.

5.2 Summary on research findings based on research objectives

This section summarises the study findings, which are organised according to the research objectives and research questions stated in Sections 1.5 and 1.6 of Chapter 1. Each of the research topics below has a set of objectives matched to it.

5.2.1 Types of traditional medicinal practitioners

The study's findings confirmed that the Keates Drift community has traditional medical practitioners who are known as community traditional doctors. The study was also able to identify the different types of traditional medical practitioners in the Keates Drift community. These are herbalists (izangoma) and diviners (izinyanga). The study indicated that traditional medical practitioners are appreciated in rural areas because they have an important position and ensure that community members with diseases and other symptoms associated with HIV/AIDS are treated and managed, according to the research.

5.2.2 Types of indigenous knowledge medicinal plants used to treat and manage illnesses like HIV/AIDS

Concerning the types of indigenous knowledge medicinal plants used to treat and manage HIV/AIDS-related symptoms, the study's findings confirmed that traditional medicinal practitioners use a variety of medicinal plants to treat and manage HIV/AIDS-related symptoms. Furthermore, the findings demonstrated that the use of traditional plants such as leaves, roots, stems, and barks is critical in the treatment and management of HIV/AIDS symptoms. The findings confirmed that diviners (izangoma) and herbalists (izinyanga) use a variety of plants to treat and manage HIV/AIDS symptoms, including African potato (ilabatheka), aloe (inhlaba), Celastraceae (umhlwazi), and Araceae (ihlukwe).

The study's findings also confirmed that community members who are patients of traditional medicinal practitioners generally provide feedback to their community traditional doctors on how they respond to HIV/AIDS-related symptoms' therapy. Interestingly, the research revealed that community members consistently compliment traditional medicinal practitioners on how well their medicine works, with the majority of patients responding favourably. Many people who are suffering from symptoms connected to HIV/AIDS are referred to traditional doctors by community members who have received aid, according to the data, demonstrating how patients respect and value traditional medicine offered by traditional healers.

5.2.3 Traditional medicinal practitioners and their knowledge of HIV/AIDS symptoms

The findings confirmed that traditional medicinal practitioners are well informed in using medicinal plant to treat and manage HIV/AIDS-related symptoms. The key informants further demonstrated their understanding of using medicinal plants by indicating that they normally make a mixture of different medicinal plants to ensure that it treats and manages all HIV/AIDS-related symptoms. The findings revealed that a mixture of leaves, roots, barks, and stems, to name a few, are boiled and given to patients to drink for a period of time as a manner of treating and controlling HIV/AIDS-related symptoms. Additionally, the findings confirmed that animal and human body parts are never allowed to be utilised in proving the safety of practising traditional medicine because they are considered demonic and diabolical. The key informants also reported that they are listed on a database of traditional healers that restricts the use of human and animal body parts to treat HIV/AIDS symptoms and other maladies or illnesses.

It was concluded from the findings that the key informants learned traditional medicine skills and knowledge from a range of sources. Traditional medicine practitioners gained their powers and experience from seasoned traditional healers, community elders, and ancestors through dreams, according to the findings. It was established that traditional medicinal practitioners received three (3) years of training from an advanced elder in the field they wished to master in order to be equipped in traditional medicine.

5.2.4 Challenges faced by traditional medicinal practitioners in treating and managing HIV/AIDS related symptoms

The outcomes of the study revealed that five (5) of the key informants were having difficulty treating and managing HIV/AIDS-related illnesses. However, the findings demonstrated that seven (7) of the key informants did not face any difficulties in treating and managing HIV/AIDS-related symptoms. The data revealed that traditional medicinal practitioners face a variety of obstacles that are all similar. The findings revealed issues such as a lack of collaboration between traditional medicinal practitioners and modern doctors, patients arriving too late for treatment when medicine is unable to help, a lack of government involvement and support, and a lack of condoms available for free distribution to patients.

The key informants used the study's findings to come up with a solution to the issues they faced in ensuring that patients' medical requirements were met efficiently. The key informants who were facing difficulties revealed that they needed the government's help with funds or condoms to distribute to their patients, community members should get tested for HIV/AIDS early to avoid relapse, patients should visit traditional healers early to begin treatment, and that allowing a patient to stay with their traditional doctors for some time would be beneficial.

5.3 Limitations of the study

This section discusses the study's complications or limitations. It is important to note that when it came to data collection, this study, like any other research effort or study, encountered a number of challenges.

- The researcher was not able to move at his own pace as he was working and studying same time. However, because of the nature of the study, the researcher was aware of the scenario and allowed it to evolve naturally.
- Since the subjects spoke Zulu, the researcher had to translate the research questions from English to IsiZulu. The research questions were translated because traditional medical practitioners were not literate in English. To minimise misunderstandings between himself and the participants, the researcher translated the research questions into Zulu.
- More participants reported that the research questions were long and tedious, which jeopardised the research process. The participants began to lose interest in answering the questions, and some of them agreed to let the researcher interview them over two days since they were fatigued.
- The researcher had no idea that traditional medical practitioners would charge him money to answer his study queries. The participants requested money, claiming that the study would benefit the researcher rather than them. The participants even stated that it would be the researcher, not them, who would be recognised at the end of the day. In that regard, the researcher had little choice but to buy them bread and sugar as a sign of his gratitude because he was unwilling to pay for the feedback.

- The Covid-19 problem had a significant impact on the study's development. The researcher was required to follow the protocols of Covid-19 since he was supposed to interview the individuals. The researcher was required to adhere to the levels set by the President and to follow the rules. This slowed down the data collection procedure because the researcher had to wait weeks or months for the data to be collected. Even though the researcher was wearing a face mask and used hand sanitizers, the subjects were terrified of getting too close to him. The participants were sceptical of the face masks handed to them, believing that the virus could be contained within the masks. The researcher was successful in persuading the individuals to settle down and cooperate.
- The researcher believes that other researchers should employ an Induna (chief) when collecting data from rural areas to explain that the data would be used for educational purposes because rural people want to benefit from it right away.

5.4 Recommendations of the study

The current study discussed the findings based on data gathered from traditional medical practitioners. The study's findings revealed some recommendations that must be considered because they provide guidance on what needs to be done and how it should be done. In that light, the following recommendations are made:

5.4.1 Treating traditional doctors equal with modern doctors

Traditional medicine practitioners are community traditional doctors who use herbs, medicinal plants, and other techniques that have been used in the community to treat mental and physical illnesses and are believed to cure and heal by assisting or stimulating nature, as well as provide advice on how to maintain or improve health and well-being (World Health Organisation, 2014). The following recommendations should be considered:

- There is an urgent need to treat traditional doctors the same way that modern doctors are treated in South Africa.

- Traditional doctors should be provided with a centre where patients of diverse problems can be treated and managed. This is where government should play a crucial role by ensuring that the provision of accommodation is attended to.

5.4.2 Recognition of traditional medicine

Traditional medicinal knowledge, according to Maluleka (2017), is defined as “the total sum of all knowledge and practices, whether explainable or not, used in diagnosing, preventing, or eliminating a physical, mental, or social disequilibrium and which rely exclusively on past experience and observation handed down verbally or in writing from generation to generation” and “health practices, approaches, and methods”. The study has made the following recommendations:

- Traditional medicine needs to be given a chance to not keep relying on western medicine. It means traditional medicine needs to be recognised and given an opportunity just like western medicine.
- Since traditional medicine is used by 60%-80% of the world’s population, it is imperative that it should be applauded and allowed to treat and manage all other ailments, just like western medicine.

5.4.3 Collaboration between traditional doctors and modern doctors

Collaboration is defined as a working practice in which individuals are allowed to work together for a common goal in order to obtain a business gain. Collaboration allows people to work together to achieve a specific and shared corporate goal. In supporting the above statements, the following recommendations should be considered:

- Traditional medicinal doctors should be allowed to work hand-in-hand with modern doctors when treating and managing patients with HIV/AIDS-related symptoms.
- Traditional doctors should be consulted by modern healthcare practitioners should modern medicine and knowledge fail.

5.4.4 Recommendations for social work practice

Social work as a profession is very important in the society in improving the lives of all citizens who are traumatised psychologically and mentally. Moreover, the principles of social work are that all citizens should enjoy an equal right and have access to all resources that

are crucial for mental health and physical body (Healy, 2005). The Afrocentric model by Asante (1991) is commended for social work practice as it demonstrates that local citizens should have full access in their local resources and in this case traditional medicine.

5.4.5 Recommendations for policy

Legalising traditional medicine is believed to be crucial as it promotes indigenous knowledge in one or the other. The following recommendations could be made in terms of traditional healers:

- There is an urgent need for traditional healers to be registered in one database in order for their traditional medicinal services to be recognised and utilised by the public.
- There is a need to prohibit traditional healers from using body parts of animals and humans and this can be successfully curbed by registering and having a constitution for traditional healers.

5.5 Concluding remarks

This section of the chapter gives the reader an overview of the study, as well as critical reflections, limitations, conclusions, and recommendations. The study's research objectives revealed whether the study's goals were proven or refused. It is worth noting that the findings and literature evaluation backed up all of the research objectives. The theoretical framework that the study used in conjunction with the research findings are the focus of this section of the chapter.

The research aim has led to the usage of the Afrocentric paradigm as the study's backbone. The study focused on the Afrocentric approach, which emphasises the significance of depending on African traditional medicinal knowledge rather than western medicine. The findings of the study also corroborate Asante's (1991) theory that Africa should employ what is brewed and natured in Africa, rather than relying on what Africans do not know. Traditional medicinal practitioners are available to demonstrate their abilities and knowledge in traditional medicine, according to the study, but they are not provided with a sufficient platform to do so. According to the study, traditional medical practitioners have advanced knowledge and skills in diagnosing and treating HIV/AIDS symptoms. In this light, it was concluded that community members recognise and take advantage of the opportunity to be treated by traditional doctors rather than modern doctors. This reinforced the Afrocentric

model, just as Asante (1998) posed the question, "What would Africans do if there was no western help?"

According to the findings, Africa has a wealth of indigenous knowledge that does not require the assistance of modern or European expertise. "Afrocentricity reacts to this issue by confirming the central place of the African person within the context of African history, therefore displacing Europe from the centre of the African reality," wrote Asante (1991:172). According to the findings of this study, the Afrocentricity theory is particularly significant when it comes to the usage of traditional medicinal herbs to treat and manage HIV/AIDS-related illnesses. This has been shown by the fact that traditional medicine practitioners treat and manage HIV/AIDS patients, and their lives improve as a result of the treatment.

The Afrocentric model was used for this investigation since it satisfied and validated the research goals. The study's findings showed that indigenous knowledge is valued and respected far more than it is ignored. The study showed and concluded that African communities are the pillars of traditional medicinal knowledge's effectiveness only if they recognise it. To put it another way, African communities must prioritise IKS over what they do not know. It is worth noting that IKS has assets and capabilities that can help individuals live better lives.

5.6 Recommendations for further research

The current study discussed how traditional healers treat and manage the symptoms related to HIV/AIDS. As Asante's (1991) Afrocentric theory states that Africa should employ what is brewed and natured in Africa, rather than relying only on foreign knowledge. The study demonstrated that traditional medicinal practitioners are available to demonstrate their abilities and knowledge in traditional medicine, however, they are not provided with a sufficient platform to do so. Hence, the following needs to be considered:

- Government should adopt traditional healers' database and legalise their practices;
- There is a need to conduct a study of this nature in KwaZulu-Natal as this province is very rich with indigenous medicinal knowledge; and
- A study of this nature should be conducted at PhD level where a student can have enough time to do an in-depth study.

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Appendix A

SECTION ONE: PERSONAL INFORMATION

1. Gender
2. Marital status
3. Area where you stay
4. What is your age group

SECTION B: INDIGENOUS KNOWLEDGE AND HIV/AIDS

1. What types of indigenous knowledge practices are you familiar with in rural communities?
2. Are there indigenous knowledge medicinal plants used to treat symptoms related to HIV/AIDS?
3. If you agree that there are indigenous knowledge medicinal plants, what are those plants used?
4. How are those indigenous knowledge medicinal plants used?
5. Do patients respond to the treatment you always give to them?
6. Are you allowed to use human and animal parts to treat the symptoms of HIV/AIDS?
7. If you are allowed, what parts do you use?
8. If not allowed, what is the reason?
9. In overall, how the results after treating a patient who is HIV/AIDS either by traditional medicinal plants or human parts?
10. Who are traditional health practitioners in rural areas?
11. From those you have mentioned, are they all regarded as rural community doctors?
12. Are traditional health practitioners recognised in your province as rural community doctors?
13. What licence do you have for treating patients with HIV/AIDS?
14. As traditional health practitioners, do you encounter problems regarding treating patients with symptoms of HIV/AIDS?
15. What challenges do you normally encounter when dealing with cases related to symptoms of HIV/AIDS?
16. How do you ensure that problems encountered are minimised?
17. What comments would you like to make regarding treating patients with symptoms related to HIV/AIDS?

Appendixes B

Chapter 1. PARTICIPATION

CONSENT DECLARATION

INFORMED CONSENT DECLARATION

(Participation)

Exploring indigenous knowledge management methods in HIV/AIDS: A case study of Keates Drift community in the province

I Mkhize Celimpilo from the **Department of Social Work; University of Zululand** has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project, and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the research project is only for academic purposes
2. The University of Zululand has given ethical clearance to this research project and I have seen/may request to see the clearance certificate.
3. By participating in this research project I will be contributing towards helping raise awareness in the community.
4. I will participate in the project by agreeing to be interviewed
5. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences
6. I will not be compensated for participating in the research
7. There may be risks associated with my participation in the project. I am aware that:
 - A.** The following risks are with my participation: Expressing my views on the matter may elicit feelings of discomfort
 - B.** The following steps have been taken to prevent the risks: The researcher will allow a moment of debriefing after the interview; where I will talk about how I felt expressing my views on the subject matter
 - C.** There is a 10 % chance of the risk materialising
8. The researcher intends publishing the research results in the form of articles in journals however, confidentially and anonymity of records will be maintained and that

my name and identity will not be revealed to anyone who has not been involved in the conduct of the research.

9. I will receive feedback in the form of verbal feedback recorded on the tape recorder
Regarding the results obtained during the interview.
10. Any further questions that I might have concerning the research or my participation will be answered by the researcher.
11. By signing this informed consent declaration I am not waiving any legal claims, rights or remedies.
12. A copy of this informed consent declaration will be given to me, and the original will be kept on record.

I _____ have read the above information / confirm that the above informed has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

.....

Participant's signature

.....

Date

IFOMU YOKUZIBOPHEZELA

(Kobambe iqhaza)

**Isihloko: UKUHLOLWA KOLWAZI LWESINTU EKUDAMBISENI ISIFO SESANDULELA
NGCULAZI: INDATSHANA EBANDAKANYA UMPHAKATHI WASE MPOFANE
ESIFUNDAZWENI SAKWAZULU NATAL**

UMkhize Celimpilo ovela ku Mnyango wezenhlalakahle eNyuvesi yakwa Zulu, ube nesicelo semvume yokuzimbandakanya kulolucwaningo olulotshiwe ngenhla.

Imvelaphi kanye nenhloso yalolucwaningo, nalolu lwazi nophawu lokwamukela ukuzibophezela ngichazeliwe ngalo ngolimi lwami engilizwayo.

Ngityaqonda ukuthi:

1. Inhloso yalolucwaningo ukucwaninga ukuthi ngabe imifelandawonye iyalibamba yini iqhaza ekwehliseni izinga lobubha emiphakathini.
 2. Inyuvesi yakwaZulu inikeze ngemvume kubanzi balolu cwaningo ukuba benze loluhlelo futhi ngiyibonile leyomvume/ngingacela ukubona isitifiketi semvume.
 3. Ngokubamba iqhaza kulolucwaningo ngizonikezela iqhaza ngokuqwashisa umphakathi ngezindlela zokuzibandakanya nemifelandawonye ukuzilekelela ekulweni nobubha.
 4. Ngizobamba iqhaza kulolucwaningo ngokuvuma ukuba yingxenye yenhlolovo kanye nokungqubuza amakhanda ngaloludaba.
 5. Ekuzimbandakanyeni kwami angizukubheka mhlomulo futhi akukho lapho engizotholakala ngihoxa ocwaningweni, umakwenzeka ngeke kube nemiphumela emibi ocwaningweni.
 6. Mina angizikunxephezela ngokuzimbandakanya kwami kulolucwaningo, kodwa izindleko eziphume kwelami iphakethe zizokhokhelwa. (uma kukhona isinxephezelo nikeza imininingwane).
 7. Lolu cwaningo alunabo ubungozi futhi akukho lapho ozozizwa ungenakho ukukhululeka.
 8. Umphequlili uzoshicilela imiphumela yalolucwaningo ngihlelo lwamaathicle kumajenali.
- Nokho, ubhalomfihlo, nofihlo-gama lwemininingwane izobe igciniwe nokuthi igama lakho angeke kubonakaliswe kunoma yimuphi umuntu obengeyona inhlangothi yocwaningo.
9. Angeke ngiyamukele imiphumela/ngizoyamukela imiphumela engaloluhlelo lovukhuluma kwami ngiqoshiwe emayelana nemiphumela etholakale ngesikhathi sesifundo.

10. Eminye imibuzo ephathelene nalolucwaningo noma mayelana nokuzimbandakanya kwami ingaphendulwa ngu Mkhize Celimpilo (inombolo kamakhalekhukhwini; 079 019 8034)

11. Ngokusayina lamafomu angiqubuli ubuthi noma amalungele kwezomthetho

12. Ikhophi enolwazi oluphelele nophawu lokwamukela ukuzibophezela kwami ngizonikezwa, bese okungungqo kuyasayinwa.

Mina..... ngikufundile lokhu okubhalwe ngenhla/ngiyavuma ukuthi ngiyakuqonda

okuqukethwe nokubhaliwe. Ngiyibuzile yonke imibuzo engifuna ukuyibuza, futhi yaphendulwa ngendlela engenelisayo. Ngiyayoqonda kahle ukuba kulundelekile ini kimi kulolucwaningo.

Angiphoqwanga nakancane ukubamba iqhaza kulolicwaningo.

.....

Isishicilelo kobambe iqhaza

.....

Usuku



ETHICAL CLEARANCE CERTIFICATE

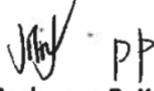
Certificate Number	UZREC 171110-030 PGM 2021/81						
Project Title	EXPLORING INDIGENOUS KNOWLEDGE MANAGEMENT METHODS IN HIV/AIDS: A CASE STUDY OF KEATES DRIFT COMMUNITY IN THE PROVINCE OF KWAZULU-NATAL						
Principal Researcher/ Investigator	C Mkhize						
Supervisor and Co-supervisor	Prof M.A Masoga				Prof A.L Shokane		
Department	Social Work						
Faculty	Arts						
Type of Risk	Medium Risk – Data collection from people						
Nature of Project	Honours/4 th Year		Master's	x	Doctoral		Departmental

The University of Zululand's Research Ethics Committee (UZREC) hereby gives ethical approval in respect of the undertakings contained in the above-mentioned project. The Researcher may therefore commence with data collection as from the date of this Certificate, using the certificate number indicated above.

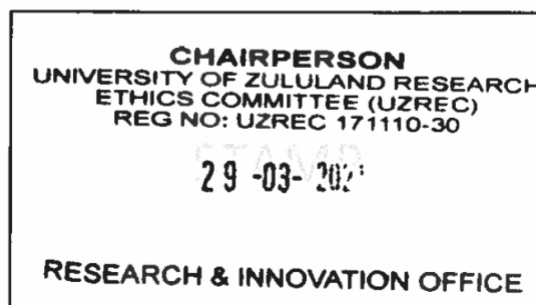
Special conditions:

- (1) This certificate is valid for 1 year from the date of issue.
- (2) Principal researcher must provide an annual report to the UZREC in the prescribed format [due date-29 March 2022]
- (3) Principal researcher must submit a report at the end of project in respect of ethical compliance.
- (4) The UZREC must be informed immediately of any material change in the conditions or undertakings mentioned in the documents that were presented to the meeting.

The UZREC wishes the researcher well in conducting research.


Professor Mashupye R. Kgaphola
 University Research Ethics Committee
 Deputy Vice-Chancellor: Research & Innovation

29 March 2021



APPENDIXES C: DATA TRANSCRIPT

SECTION ONE: PERSONAL INFORMATION

1. Gender/Ubulili

FEMALE

2. Marital status/Ushadile

MARRIED

3. Area where you stay/Indawo lapho ohlala kuyo

KONTOS DRIFT EFABENI

4. What is your age group/Iqoqo leminyaka yakho

53

SECTION B: INDIGENOUS KNOWLEDGE AND HIV/AIDS

1. Are you considered as the traditional medicinal practitioner in your community/ Ngabe uthathwa njengomelaphi wendabuko endaweni ?

YES

2. What kind of traditional medicinal practitioner are you in your community/Hloboluni lomelaphi wesintu ouilo emphakathini wakho ?

KANGOMA

3. What other traditional medicinal practitioners are you familiar with in your community/Ibaphi abanye abelaphi bendabuko obaziyo emphakathini wakho?

IZINYANGA

4. Do you use traditional medicinal plants to treat the symptoms related to HIV/AIDS/Ngabe uyazisebenzisa izihlahla zemvelo ukudambisa izimpawo ezihlobene nesandulelangculazi?

YES

5. If yes, what traditional medicinal plants do you use to treat and manage HIV/AIDS related symptoms/ Uma uvuma, iziphi izihlahla zesintu ozisebenzisayo ukudambisa isandulelangculazi?

I use.....ISIBHANYA AND ISINWAZI.....
.....
.....

6. How do your patients respond to the traditional medicinal plants you give them to manage the symptoms of HIV/AIDS/ Baye bazizwa kanjani abaphathekile uma emva kokuthola amakhambi esintu ekudambiseni isandulelangculazi?

THEY RESPOND POSITIVE RESULT.....
.....
.....

7. How do you know that your patient has responded well in the treatment and management of HIV/AIDS symptoms/Uye wazi kanjani ukuthi isiguli sakho sisimama kahle kumshanguzo wokudambisa isandulelangculazi?

TO THOSE DO NOT RESPOND WELL THEY BECOME SICK, AND OTHERS RESPOND WELL.....
.....
.....

8. How are those traditional medicinal plants used to treat and manage symptoms of HIV/AIDS/Isebenza kanjani imishanguzo yesintu ukuvikela nokudambisa izimpawu zesandulelangculazi?

I FETCH IT FROM FOREST, THEN BOIL IT TILL IT IS READY FOR USE THEN A PATIENT TAKE A LITRE PER DAY.....
.....
.....

9. Are you allowed to use human and animal parts to treat the symptoms of HIV/AIDS/Ngabe uvumelekile ukusebenzisa izitho zabantu nezezilwane ukudambisa zesandulelangculazi?

NO.....
.....

10. If you are allowed, what parts do you use/Uma uvumelkile, iziphi izitho ozisebenzisayo?

NONE.....
.....
.....

11. If not allowed, what is the reason/Uma ungavumelikile, isisphi isizathu ?

I DON'T HAVE INFORMATION FOR THAT

12. Are you well informed regarding treating and managing the symptoms related to HIV/AIDS using traditional medicinal plants/Ngabe unolwazi olunzulu mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulelangculazi usebenzisa imishanguzo yesintu?

YES I WAS TRAINED

13. How did you acquire the skill of using traditional medicinal plants to treat and manage HIV/AIDS/Walutholaphi ulwazi lokusebenzisa imishanguzo yesintu ukuze ukudambisa isandulelangculazi?

I WAS GIVEN BY ANCESTORS THROUGH NIGHT DREAMS

14. As traditional health practitioners, do you encounter problems regarding treating patients with symptoms of HIV/AIDS/Njengomelaphi wendabuko, uke wahlangabezana nezinkinga ukudambisa iziguli ezinezimpawu zesandulelangculazi?

NO AT THE MOMENT

15. What challenges do you normally encounter when dealing with cases related to symptoms of HIV/AIDS/ Hloboluni lwezinsalelo eziwayelele ohlangabezana nazo uma usebenza ngezimpawu zesandulelangculazi?

NONE

16. How do you ensure that problems encountered are minimised/ Wenza kanjani ukuthi izinkinga ohlangabezana nazo ziyancipha?

NONE

17. What comments would you like to make regarding treating and managing symptoms related to HIV/AIDS using traditional medicinal plants/ikuphi ongathanda ukukubeka mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulela ngculazi usebenzisa amakhambi esintu?

WE AS SANGOMA SHOULD TRAIN MORE
PEOPLE ABOUT HIV AS WELL AS PREVENTION
TO AVOID CURING

SECTION ONE: PERSONAL INFORMATION

1. Gender/Ubulili

MALE

2. Marital status/Ushadile

MARRIED

3. Area where you stay/Indawo lapho ohlala kuyo

KEATS DRIFT

4. What is your age group/Iqoqo leminyaka yakho

65

SECTION B: INDIGENOUS KNOWLEDGE AND HIV/AIDS

1. Are you considered as the traditional medicinal practitioner in your community/ Ngabe uthathwa njengomelaphi wendabuko endaweni ?

YES

2. What kind of traditional medicinal practitioner are you in your community/Hloboluni lomelaphi wesintu ouilo emphakathini wakho ?

INYANGA

3. What other traditional medicinal practitioners are you familiar with in your community/Ibaphi abanye abelaphi bendabuko obaziyo emphakathini wakho?

IZANGOMA

4. Do you use traditional medicinal plants to treat the symptoms related to HIV/AIDS/Ngabe uyazisebenzisa izihlahla zemvelo ukudambisa izimpawo ezihlobene nesandulelangculazi?

YES

5. If yes, what traditional medicinal plants do you use to treat and manage HIV/AIDS related symptoms/ Uma uvuma, iziphi izihlahla zesintu ozisebenzisayo ukudambisa isandulelangculazi?

I USE ISINWAZI

6. How do your patients respond to the traditional medicinal plants you give them to manage the symptoms of HIV/AIDS/ Baye bazizwa kanjani abaphathekile uma emva kokuthola amakhambi esintu ekudambiseni isandulelangculazi?

THEY RESPOND VERY WELL AFTER THE TREATMENT ESPECIALLY IF THEY COME EARLY

7. How do you know that your patient has responded well in the treatment and management of HIV/AIDS symptoms/Uye wazi kanjani ukuthi isiguli sakho sisimama kahle kumshanguzo wokudambisa isandulelangculazi?

THEY COME BACK FOR CHECKUP THEY RESPOND WELL

8. How are those traditional medicinal plants used to treat and manage symptoms of HIV/AIDS/Isebenza kanjani imishanguzo yesintu ukuvikela nokudambisa izimpawu zesandulelangculazi?

I BOILED IT FOR 2 HOURS THEN GIVE TO PATIENT

9. Are you allowed to use human and animal parts to treat the symptoms of HIV/AIDS/Ngabe uvumelekile ukusebenzisa izitho zabantu nezezilwane ukudambisa zesandulelangculazi?

NO

10. If you are allowed, what parts do you use/Uma uvumelkile, iziphi izitho ozisebenzisayo?

NONE

11. If not allowed, what is the reason/Uma ungavumelikile, isisphi isizathu ?

I NEVER TOLD BY SGT

12. Are you well informed regarding treating and managing the symptoms related to HIV/AIDS using traditional medicinal plants/Ngabe unolwazi olunzulu mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulelangculazi usebenzisa imishanguzo yesintu?

YES ACCORDING TO MY KNOWLEDGE

13. How did you acquire the skill of using traditional medicinal plants to treat and manage HIV/AIDS/Walutholaphi ulwazi lokusebenzisa imishanguzo yesintu ukuze ukudambisa isandulelangculazi?

I WAS TRAINED BY OLD IZIMYANGA BUT THAT WAS GIFT FROM ANCESTORS

14. As traditional health practitioners, do you encounter problems regarding treating patients with symptoms of HIV/AIDS/Njengomelaphi wendabuko, uke wahlangabezana nezinkinga ukudambisa iziguli ezinezimpawu zesandulelangculazi?

YES

15. What challenges do you normally encounter when dealing with cases related to symptoms of HIV/AIDS/ Hloboluni lwezinsalelo ezijwayelekile ohlangabezana nazo uma usebenza ngezimpawu zesandulelangculazi?

SOME PATIENTS ONLY TO FIND MEDICINE DOES NOT CORRESPOND WITH THEIR BLOOD

16. How do you ensure that problems encountered are minimised/ Wenza kanjani ukuthi izinkinga ohlangabezana nazo ziyancipha?

THAT IS NOT AN EASY TASK BUT I WOULD TO ENCOURAGE PATIENTS TO BE PATIENT

17. What comments would you like to make regarding treating and managing symptoms related to HIV/AIDS using traditional medicinal plants/Ikuphi ongathanda ukukubeka mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulela ngculazi usebenzisa amakhambi esintu?

WESTERN PRACTITIONERS AND AFRICAN PRACTITIONERS
SHOULD WORK TOGETHER TO MANAGE HIV

SECTION ONE: PERSONAL INFORMATION

1. Gender/Ubulili

FEMALE

2. Marital status/Ushadile

NO

3. Area where you stay/Indawo lapho ohlala kuyo

40 KENTIS ARIT

4. What is your age group/Iqoqo leminyaka yakho

40

SECTION B: INDIGENOUS KNOWLEDGE AND HIV/AIDS

1. Are you considered as the traditional medicinal practitioner in your community/ Ngabe uthathwa njengomelaphi wendabuko endaweni ?

YES

2. What kind of traditional medicinal practitioner are you in your community/Hloboluni lomelaphi wesintu ouilo emphakathini wakho ?

ISANGOMA

3. What other traditional medicinal practitioners are you familiar with in your community/Ibaphi abanye abelaphi bendabuko obaziyo emphakathini wakho?

IZANUSI

IZIMYARGA

4. Do you use traditional medicinal plants to treat the symptoms related to HIV/AIDS/Ngabe uyazisebenzisa izihlahla zemvelo ukudambisa izimpawo ezihlobene nesandulelangculazi?

YES

5. If yes, what traditional medicinal plants do you use to treat and manage HIV/AIDS related symptoms/ Uma uvuma, iziphi izihlahla zesintu ozisebenzisayo ukudambisa isandulelangculazi?

UMADLOZANE (Kastolom) AND ISIBHANYA

6. How do your patients respond to the traditional medicinal plants you give them to manage the symptoms of HIV/AIDS/ Baye bazizwa kanjani abaphathekile uma emva kokuthola amakhambi esintu ekudambiseni isandulelangculazi?

SOME RESPOND POSITIVE BECAUSE THEY ARE HEALED

7. How do you know that your patient has responded well in the treatment and management of HIV/AIDS symptoms/Uye wazi kanjani ukuthi isiguli sakho sisimama kahle kumshanguzo wokudambisa isandulelangculazi?

THEY GET A GOOD RESPONSE FROM HOSPITAL W.T.K.P

8. How are those traditional medicinal plants used to treat and manage symptoms of HIV/AIDS/Isebenza kanjani imishanguzo yesintu ukuvikela nokudambisa izimpawu zesandulelangculazi?

WE NORMAL MIXED LIQUID: UMA DLOZANE AND ISIBHANYA THEN WE BOIL THEN PATIENT DRINK IT.

9. Are you allowed to use human and animal parts to treat the symptoms of HIV/AIDS/Ngabe uvumelekile ukusebenzisa izitho zabantu nezezilwane ukudambisa zesandulelangculazi?

NO

10. If you are allowed, what parts do you use/Uma uvumelkile, iziphi izitho ozisebenzisayo?

NONE

11. If not allowed, what is the reason/Uma ungavumelikile, isisphi isizathu?

I NEVER TRAINED TO USE THOSE THINGS.....

12. Are you well informed regarding treating and managing the symptoms related to HIV/AIDS using traditional medicinal plants/Ngabe unolwazi olunzulu mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulelangculazi usebenzisa imishanguzo yesintu?

YES POTENTIALLY

13. How did you acquire the skill of using traditional medicinal plants to treat and manage HIV/AIDS/Walutholaphi ulwazi lokusebenzisa imishanguzo yesintu ukuze ukudambisa isandulelangculazi?

FROM THE OLD ZANGOMA AS WELL AS OTHERS MEDICINE COME FROM OUR UNCLE WITH AMAPHUPHO.

14. As traditional health practitioners, do you encounter problems regarding treating patients with symptoms of HIV/AIDS/Njengomelaphi wendabuko, uke wahlangabezana nezinkinga ukudambisa iziguli ezinezimpawu zesandulelangculazi?

NOT YET

15. What challenges do you normally encounter when dealing with cases related to symptoms of HIV/AIDS/ Hloboluni lwezinsalelo ezijwayelekile ohlangabezana nazo uma usebenza ngezimpawu zesandulelangculazi?

none

16. How do you ensure that problems encountered are minimised/ Wenza kanjani ukuthi izinkinga ohlangabezana nazo ziyancipha?

none

17. What comments would you like to make regarding treating and managing symptoms related to HIV/AIDS using traditional medicinal plants/ikuphi ongathanda ukukubeka mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulela ngculazi usebenzisa amakhambi esintu?

TRADITIONAL PRACTITIONERS SHOULD BE
GIVEN A TASK TO PRACTISE THEIR OWN.

SECTION ONE: PERSONAL INFORMATION

1. Gender/Ubulili

MALE

2. Marital status/Ushadile

MARRIED

3. Area where you stay/Indawo lapho ohlala kuyo

JO KEATES DRIFT

4. What is your age group/Iqoqo leminyaka yakho

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SECTION B: INDIGENOUS KNOWLEDGE AND HIV/AIDS

1. Are you considered as the traditional medicinal practitioner in your community/ Ngabe uthathwa njengomelaphi wendabuko endaweni ?

YES

2. What kind of traditional medicinal practitioner are you in your community/Hloboluni lomelaphi wesintu ouilo emphakathini wakho ?

INYANGA

3. What other traditional medicinal practitioners are you familiar with in your community/Ibaphi abanye abelaphi bendabuko obaziyo emphakathini wakho?

IZANGOMA

4. Do you use traditional medicinal plants to treat the symptoms related to HIV/AIDS/Ngabe uyazisebenzisa izihlahla zemvelo ukudambisa izimpawo ezihlobene nesandulelangculazi.

YES

5. If yes, what traditional medicinal plants do you use to treat and manage HIV/AIDS related symptoms/ Uma uvuma, iziphi izihlahla zesintu ozisebenzisayo ukudambisa isandulelangculazi?

ISINWAZI UGOBOTO
.....
.....
.....

6. How do your patients respond to the traditional medicinal plants you give them to manage the symptoms of HIV/AIDS/ Baye bazizwa kanjani abaphathekile uma emva kokuthola amakhambi esintu ekudambiseni isandulelangculazi?

I BOIL ISINWAZI PLUS UGOBOTO
TOGETHER
.....
.....

7. How do you know that your patient has responded well in the treatment and management of HIV/AIDS symptoms/Uye wazi kanjani ukuthi isiguli sakho sisimama kahle kumshanguzo wokudambisa isandulelangculazi?

THEY LEAVE A NORMAL LIFE LIKE OTHER
PEOPLE
.....
.....

8. How are those traditional medicinal plants used to treat and manage symptoms of HIV/AIDS/Isebenza kanjani imishanguzo yesintu ukuvikela nokudambisa izimpawu zesandulelangculazi?

BOILED THEM TOGETHER FOR 2 HOURS
THEN PATIENT DRINK IT
.....
.....

9. Are you allowed to use human and animal parts to treat the symptoms of HIV/AIDS/Ngabe uvumelekile ukusebenzisa izitho zabantu nezezilwane ukudambisa zesandulelangculazi?

NO
.....

10. If you are allowed, what parts do you use/Uma uvumelkile, iziphi izitho ozisebenzisayo?

NONE
.....
.....
.....

11. If not allowed, what is the reason/Uma ungavumelikile, isisphi isizathu ?

NO PERMISSION

12. Are you well informed regarding treating and managing the symptoms related to HIV/AIDS using traditional medicinal plants/Ngabe unolwazi olunzulu mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulelangculazi usebenzisa imishanguzo yesintu?

Yes

13. How did you acquire the skill of using traditional medicinal plants to treat and manage HIV/AIDS/Walutholaphi ulwazi lokusebenzisa imishanguzo yesintu ukuze ukudambisa isandulelangculazi?

I THINK IT A GOD GIFT BECAUSE
I USED DREAM ABOUT THOSE
MEDICAL PLANTS.

14. As traditional health practitioners, do you encounter problems regarding treating patients with symptoms of HIV/AIDS/Njengomelaphi wendabuko, uke wahlangabezana nezinkinga ukudambisa iziguli ezinezimpawu zesandulelangculazi?

YES

15. What challenges do you normally encounter when dealing with cases related to symptoms of HIV/AIDS/ Hloboluni lwezinsalelo eziwayelelele ohlangabezana nazo uma usebenza ngezimpawu zesandulelangculazi?

AT FIRST WHEN PATIENT START TO
USE THOSE TRADITIONAL MEDICINE SOME
THEY BECAME TOO ILL

16. How do you ensure that problems encountered are minimised/ Wenza kanjani ukuthi izinkinga ohlangabezana nazo ziyancipha?

I TRY TO MANAGE THE ~~SCALE~~ SCALE
FROM LITTLE

17. What comments would you like to make regarding treating and managing symptoms related to HIV/AIDS using traditional medicinal plants/ikuphi ongathanda ukukubeka mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulela ngculazi usebenzisa amakhambi esintu?

Allowe Patient to Take TRADITIONAL
MEDICINAL, It Help

SECTION ONE: PERSONAL INFORMATION

1. Gender/Ubulili

MALE

2. Marital status/Ushadile

NOT MARRIED

3. Area where you stay/Indawo lapho ohlala kuyo

KEATE'S DAIRI KWALATHA

4. What is your age group/Iqoqo leminyaka yakho

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SECTION B: INDIGENOUS KNOWLEDGE AND HIV/AIDS

1. Are you considered as the traditional medicinal practitioner in your community/ Ngabe uthathwa njengomelaphi wendabuko endaweni ?

YES

2. What kind of traditional medicinal practitioner are you in your community/Hloboluni lomelaphi wesintu ouilo emphakathini wakho ?

ISAMGOMA

3. What other traditional medicinal practitioners are you familiar with in your community/Ibaphi abanye abelaphi bendabuko obaziyo emphakathini wakho?

IZARUSI

IZAMGOMA

4. Do you use traditional medicinal plants to treat the symptoms related to HIV/AIDS/Ngabe uyazisebenzisa izihlahla zemvelo ukudambisa izimpawo ezihlobene nesandulelangculazi?

YES

5. If yes, what traditional medicinal plants do you use to treat and manage HIV/AIDS related symptoms/ Uma uvuma, iziphi izihlahla zesintu ozisebenzisayo ukudambisa isandulelangculazi?

ISINWAZI AND ISIBHANYA

6. How do your patients respond to the traditional medicinal plants you give them to manage the symptoms of HIV/AIDS/ Baye bazizwa kanjani abaphathekile uma emva kokuthola amakhambi esintu ekudambiseni isandulelangculazi?

TO THOSE WHO CAME LATE I BECOME VERY DIFFICULT

7. How do you know that your patient has responded well in the treatment and management of HIV/AIDS symptoms/Uye wazi kanjani ukuthi isiguli sakho sisimama kahle kumshanguzo wokudambisa isandulelangculazi?

THEY GET A GOOD REPORT FROM HOSPITAL

8. How are those traditional medicinal plants used to treat and manage symptoms of HIV/AIDS/Isebenza kanjani imishanguzo yesintu ukuvikela nokudambisa izimpawu zesandulela ngculazi?

IT IS USED TO MANAGE HIV WE BOIL FOR ONLY 2 HOURS THEN DRINK BY PATIENT

9. Are you allowed to use human and animal parts to treat the symptoms of HIV/AIDS/Ngabe uvumelekile ukusebenzisa izitho zabantu nezezilwane ukudambisa zesandulelangculazi?

NO NOT AT ALL

10. If you are allowed, what parts do you use/Uma uvumelkile, iziphi izitho ozisebenzisayo?

NONE

11. If not allowed, what is the reason/Uma ungavumelikile, isisphi isizathu ?

NOT PERMITTED

12. Are you well informed regarding treating and managing the symptoms related to HIV/AIDS using traditional medicinal plants/Ngabe unolwazi olunzulu mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulelangculazi usebenzisa imishanguzo yesintu?

YES

13. How did you acquire the skill of using traditional medicinal plants to treat and manage HIV/AIDS/Walutholaphi ulwazi lokusebenzisa imishanguzo yesintu ukuze ukudambisa isandulelangculazi?

WE AS ZINYANGA TRAINED BY ZINYANGA WHO ARE WELL INFORMED

14. As traditional health practitioners, do you encounter problems regarding treating patients with symptoms of HIV/AIDS/Njengomelaphi wendabuko, uke wahlangabezana nezinkinga ukudambisa iziguli ezinezimpawu zesandulelangculazi?

YES

15. What challenges do you normally encounter when dealing with cases related to symptoms of HIV/AIDS/ Hloboluni lwezinsalelo eziwayelelele ohlangabezana nazo uma usebenza ngezimpawu zesandulelangculazi?

SOME PATIENT WE ARE THAT IT IS DIFFICULT WHEN THE TREATMENT IS NEW

16. How do you ensure that problems encountered are minimised/ Wenza kanjani ukuthi izinkinga ohlangabezana nazo ziyancipha?

I START TO DIAGNOSE THE PATIENT FIRST AND GIVE RELEVANT TREATMENT

17. What comments would you like to make regarding treating and managing symptoms related to HIV/AIDS using traditional medicinal plants/ikuphi ongathanda ukukubeka mayelana nokulwa nokudambisa izimpawu ezihlobene nesandulela ngculazi usebenzisa amakhambi esintu?

I MUST SAY IF WE WORK HARD IN HAND
WITH PROFESSIONAL PRACTITIONERS TO MOTIVATE
HIV TOGETHER