The role of culture in health care provision to people living with HIV (PLHIV) in uMkhanyakude District, North of KwaZulu-Natal: A Nursing Communication Perspective

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Declaration

I hereby declare that the study entitled “The role of culture in health care provision to people living with HIV (PLHIV) in uMkhanyakude District, North of KwaZulu-Natal: Nursing Communication perspective” submitted to the Centre for Communication, Media and Society (CCMS) in the College of Humanities, is a record of original work done by me under the guidance of Professor Lauren Dyll. It is submitted in fulfilment of the requirements for the award of the Master of Social Science. The results embodied in this dissertation have not been submitted to any other University or Institution for the award of any degree or diploma.

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Abstract

Background: There is a sparse literature documenting the health-seeking behaviours of people living with HIV (PLHIV) who seek modern and traditional medicine and the cultural competence of nurses who provide healthcare services to them. The cultural practices of PLHIV who live in rural South Africa have an implication on their clinical outcomes. This study was conducted in order to explore ways in which nurses may / may not practice cultural competence in negotiating traditional and modern treatments for PLHIV and their communication, their practice of cultural sensitivity in their provision of care to PLHIV and to identify and analyse the benefits of cultural competence in nursing associated with PLHIV.

Methodology and Theory: The study adopted a qualitative methodology using a phenomenological design which facilitated the collection of data through open-ended in-depth interviews with six nurses in uMkhanyakude district. The data was analysed thematically and interpreted using the culture-centred approach jointly with the cultural competence model.

Results: The results showed that although all the nurses interviewed have been trained in Nursing Initiated Management of Antiretroviral Therapies (NIMART), but there was a lack of cultural competence. Their cultural awareness level differed and were low due to diverse barriers to cultural competence including the cultural imposition, the negative attitudes towards traditional medicine, lack of trust as an impediment to dialogic communication and the lack of cultural knowledge.

Conclusion: Nurses need to learn cultural competency concerning the PLHIV they work with, in order to be able to learn to appreciate diversity, avoid prejudice and provide culturally sensitive care to PLHIV. It is also important for nurses to recognise and respect PLHIV cultural values in order to render culturally competent care and to prevent cultural imposition. Nurses should be aware and cognisant of the Campinha-Bacote's five cultural constructs.

Keywords

Culture, Healthcare Services, HIV, KwaZulu-Natal, Nursing communication, PLHIV, Traditional Medicine

List of Acronyms

AHRI: Africa Health Research Institute

AIDS: Acquired Immunodeficiency Syndrome

ARVs: Antiretroviral

HIV: Human Immunodeficiency Virus

HSRC: Human Science Research Council

HST: Health Systems Trust

NDOH: National Department of Health

NIMART: Nursing Initiated Management of Antiretroviral Therapies

NSDA: Negotiated Service Delivery Agreement

PLHIV: People Living with HIV

SANC: South African National Aids Council

TasP: Treatment-as-Prevention

THPs: Traditional Health Practitioners

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Problem statement and background to the study

South Africa is faced with a burden of diseases, one of them being HIV/AIDS. The rural areas of KwaZulu-Natal in South Africa are the most affected by the epidemic (Gengiah, Yende-Zuma, Padayatch, Barker, Nunn, Subrayen and Karim, 2017; National Department of Health, 2017; Tenser *et al*., 2017; Zuma *et al*., 2017) and is the study location. The province of KwaZulu-Natal remains the highest hit by HIV and AIDS and this province has the highest incidence compared to other provinces with 26% of people living with the virus (KZN PAC, 2017). According to the Human Sciences Research Council (HSRC) in South Africa, the HIV prevalence has risen to 12,6% in South Africa (Simbayi *et al.*, 2019) and the province of KwaZulu-Natal contributes the highest percentage. uMkhanyakude district is this study's research location and is largely rural and was rated as the second most socio-economically deprived district in South Africa out of 52 health districts (Health Systems Trust [HST] 2007). More recently the district has been rated as being in the poorest quintile of South African districts (District Health Barometer 2016/17). There are 19 Traditional Councils, four Local Municipalities and one District Council, with high unemployment and limited access to piped water. Being a frontier district poses challenges to health care provision through cross border patient flow, and exposure to epidemics such as malaria (uMkhanyakude District Plan 2018-2019).

The HSRC published a report in 2019 using data collected in 2017 which suggests that approximately 7.9 million people of all ages (0+ years) were living with HIV (PLHIV) in South Africa in 2017 (Simbayi *et al*. 2019). HIV prevalence among adults aged 15 to 49 years in South Africa is 20.6 percent; 26.3 percent among females and 14.8 percent among males. HIV prevalence among Black Africans is 16.6 percent; followed by Coloureds (5.3 percent); Whites (1.1 percent); and Indian/Asian (0.8 percent). HIV annual incidence among adults aged 15 to 49 years in South Africa is 0.79 percent; 0.93 percent among females and 0.69 percent among males. This

corresponds to approximately 199,700 people newly infected with HIV aged 15 to 49 years in 2017 (Simbayi *et al.,* 2019). Annual incidence in children aged 2 to 14 years is 0.13 (95% CI: 0.03-0.23). Viral load suppression (VLS) prevalence among People Living with HIV (PLHIV) aged 15 to 49 years in South Africa is 61.0 percent: 66.7 percent among females and 50.8 percent among males (Simbayi, Zuma, Zungu *et al*, 2019). The South African National Aids Council (SANAC, 2019) shows that the number of infected individuals is extremely high by 236 000, which is 68% of new infections among women than men as they are standing at 38%. It is also estimated that 5700 new HIV infections occur daily, with 66% of these in Sub-Sahara Africa[1]. This depicts the disproportionate spread of the epidemic in regions around the world. In South Africa, KwaZulu-Natal has the highest burden of HIV prevalence, particularly in rural communities where nurses deal with PLHIV and who have first consulted with traditional healers and with modern medicine at the same time (Burman, 2018). Hence, this study is conducted in rural communities where PLHIV concurrently use both traditional and western medicine as a form of HIV treatment.

The Treatment-as-Prevention (TasP) is one of the studies conducted in uMkhanyakude District to fight HIV (Iwuji et al, 2013). The primary outcome of TasP was to reduce HIV incidence at population level preventing further infection, secondary outcomes included community perceptions and experiences of the universal test and treat approach (Iwuji et al., 2013, Orne-Gliemann et al., 2015). Studies such as TasP have focused on the treatment of HIV and AIDS and overlooked the role that culture plays in the health seeking and provision of healthcare services to PLHIV. Fatti, Bock, Grimwood and Eley (2010) explain that most paediatric Antiretroviral Treatment (ART) studies in South Africa have included only urban children with no direct comparisons between outcomes in rural and urban children. More than 40% of South Africa's population however, live in rural areas. The prevalence of HIV in children and adults are as high in rural as in urban areas, and certain rural districts have reported extremely high infection rates, particularly among women (Geubbels & Bowie, 2006). Moreover, a number of biomedical health interventions and treatment campaigns have been put in place to combat the spread of HIV and AIDS in South Africa but only a few

[1] Defined here as including eight countries: Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe.

of them have been successfully implemented (Campbell & Mzaidume, 2002; Campbell, 2003; DOH, 2016; Mohapi & Pitsoane, 2017; Williams, Gupta, Wollmers & Granich, 2017). The role of communication has therefore become central in health promotion. Zuma, Wight, Rochat and Moshabela (2017:4) explain that "given the emphasis placed on HIV/AIDS prevention and care, mostly because of the absence of cure or a vaccination against the disease, employing effective communication strategies becomes pivotal in controlling the pandemic''.

Consequently, evaluating and redefining approaches to communicating relevant messages to different populations and the public at large has become a critical aspect of HIV/AIDS prevention and care (Zuma *et al*., 2017). Based on this, an exploration of the cultural competency for the nurses who interact with clients who have sought traditional medicine is crucial. Traditional medicine is a large field that writers define differently. It refers to the antique and culture bound medical practice that existed in human societies before modern science was applied to health (Abdullahi, 2009). The way this kind of medicine is used differs extensively, considering the societal and cultural legacy of different communities of a country. This implies that each human community addresses the challenge of preserving health and treating diseases by developing a medical system that is helpful. Traditional medicine has been fashionable in all the cultures of the world. The cultural aspect of this medicine confirms that its practice is built on conventional usage and individual knowledge of each traditional healer. The value of traditional medicine still needs to be completely confirmed by means of modern scientific methods (Mothibe and Sibanda, 2019). General accounts of application and practices from generation to generation offer some indication of the usefulness and success of traditional medicine. Nevertheless, scientific studies are required to give evidence of further proof of its safety and success. This will be further discussed in the literature review chapter.

The role of cultural contexts in the successful implementation of programs is often omitted, even though evidence abounds that culture is a central feature in health behaviors and decisions particularly in the context of behaviors that may predispose people to HIV/AIDS (Crawford, 1994, Michal-Johnson & Bowen, 1992; Seidel, 1993). Mohan Dutta (2007) emphasises that cultural sensitivity is essential in creating effective health messages that are responsive to the values and beliefs of a particular

culture. For the nurses to become culturally competent, they must be culturally sensitive to PLHIV who may exhibit different treatment seeking behaviours, which may depend on the culture to which the person belongs. The advocacy for cultural sensitivity in health communication is based on the notion that communication about health ought to adapt to the characteristics of a culture in order to be most effective (Sue & Sue, 1999, Ulrey & Amason, 2001). Cultural sensitivity in health messages is important for this study because it drives the focus on nurses to create health messages that are responsive to the values and beliefs of the patient's culture, which is most predominantly Zulu in this study.

1.2 Study Location

This study is conducted in the district of uMkhanyakude, northern KwaZulu-Natal province. The district is largely rural and Mtubatuba is the only substantial town. The total population is estimated at over 610 000. The population is exceptionally young, with 70% being below 18 years of age. It is reported that 46% of the population have never been in school and only 66,4% have qualifications between grade 12 (Matric) and bachelor's degrees (uMkhanyakude district report 2016). The district is home to five district hospitals and 52 provincial clinics (DOH, 2017), which cater for the above-mentioned population who seek healthcare services. The number of traditional healers is unknown but reports from the local municipality suggests that 80% of the population in the area rely on traditional medicine (DOH, 2017).

In uMkhanyakude District, the population is culturally conservative, which means that there is a strong adherence to traditional customs, beliefs and practices, and this influences their health seeking behaviours. It affects the communication about health seeking behaviours of People Living with HIV (PLHIV). The uMkhanyakude District population predominantly adheres to the Zulu culture which holds strong beliefs and values in traditional medicine for treating chronic conditions including HIV/AIDS (Moshabela et al, 2011; Zuma et al, 2017). The uMkhanyakude population may be considered indigenous based on Davy's (2016) definition that indigenous populations are communities that live within, or are attached to, or ancestral territories, and who identify themselves as being part of a distinct cultural group, descended from groups present in the area before modern states were created and current borders defined.

Based on the assumption that nurses share the same culture as the participants; the nurses' indigenous knowledge can help them to meet the effective health care provision to PLHIV in this district because they can conserve the environment while its protection encourages the maintenance of traditional practices and lifestyles. This study focusses on the nurse's cultural competence since they deliver health care services to people who are culturally conservative. For the health care providers to such a population, being culturally competent could promote health communications that would be accepted by the patients/clients.

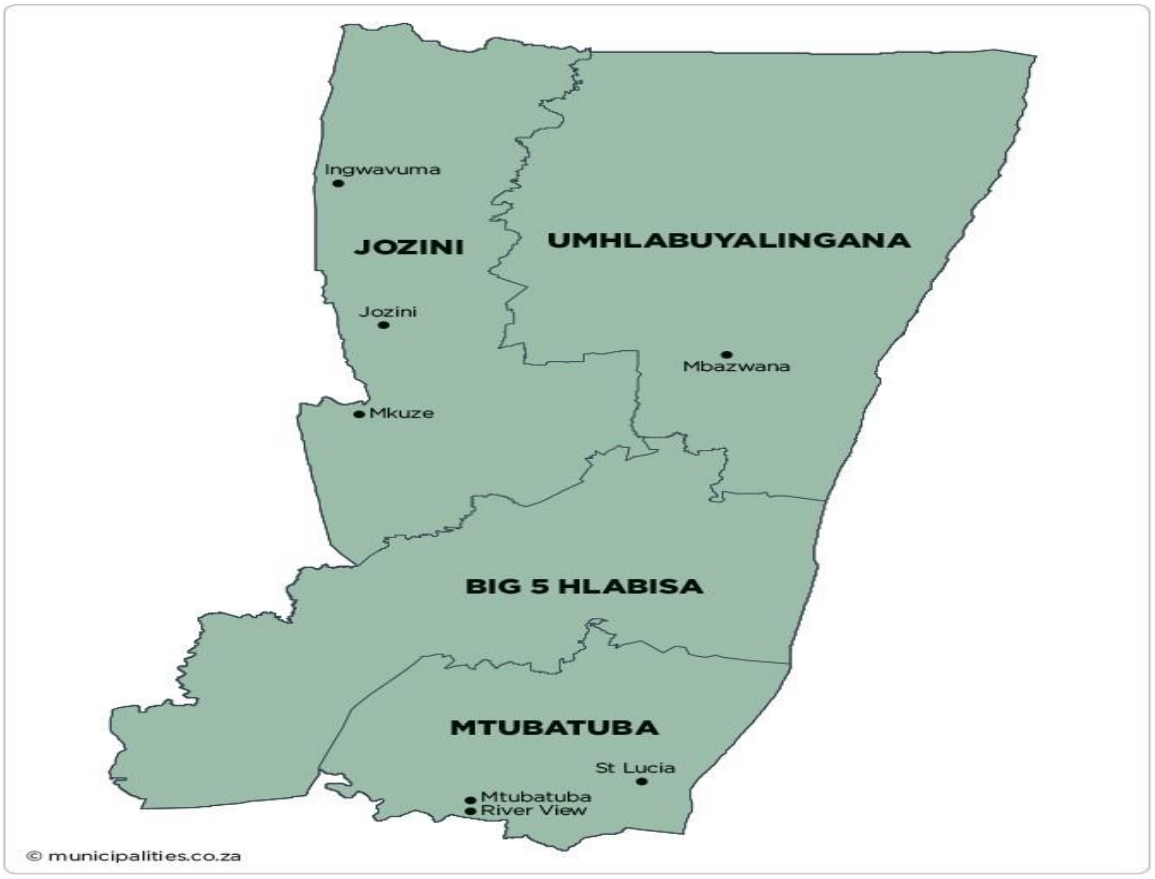

Figure 1.1: Map of uMkhanyakude District
Source: https://municipalities.co.za/map/121/umkhanyakude- uMkhanyakude District

1.2 Study Objectives

The objectives of this study are guided by the models of cultural competence, and particularly that of Josepha Campinha-Bacote (2009). Her model is useful to this study in that it is a practice model that illustrates the way in which the integration of cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters

are essential in the development of cultural competence. It, therefore, provides an applied perspective. In order to contextualise the relevance of this cultural competence model in South Africa, the study is also influenced by Thokozani Patrick Mhlongo (2016) and his application of these five characteristics of cultural competence, or what he also terms cultural sensitivity, in the South African nursing system. In this present study, the role of communication in the nurse's interaction with PLHIV will also be investigated as it is central in establishing understanding between service provider and patient.

The study further adopts a cultural competency approach as described by Dutta, (2008) who uses the Afrocentrism perspective to fit the model in studies related to African health seeking behaviours and to explain how culture plays a role in shaping our lives. Cultural competency has been defined differently by different researchers and authors. Some scholars defined it as the ability to understand and appropriately apply cultural values and practices that underpin peoples' world views and perspectives on health (Tiatia, 2005), and "a set of academic, experiential and interpersonal skills that allow individuals and systems to increase their understanding and appreciation of cultural differences and similarities within, among and between groups" (Jansen & Sorrensen, 2002:306). For the purpose of this study, the definition by Cross et al. (1989) is adopted according to which, cultural competence is a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations.

Camphina-Bacote (2009) does not directly speak to the issues of nurses in the context of South Africa but adds value to the general aspects of cultural competence in delivering services to PLHIV. This validates Mhlongo's (2016) relevance to this study as it directly addresses nurses in the South African context. Since this study's objectives are to explore the provision of health care services to a culturally conservative population in the treatment of HIV/AIDS it is applicable. Mhlongo (2016) presents the argument that nurse educators need to consider cultural competency theoretical models, to promote effective and safe nursing care. Culturally competent nurses have knowledge and are skilled in identifying cultural patterns so that an individualised care plan is formulated that will help meet the established healthcare

goals for that patient (Gustafson, 2005). According to Yuen and Yau (1999), understanding influences on health beliefs and behaviors of cultural groups leads to a better understanding of how clients perceive and take action around their illness, and improves clinical judgements.

1.3.1 The role of culture in health communication

The practice of traditional medicine is dominant in Africa and its influence on the treatment of illnesses by modern medicine cannot be ignored. Furthermore, the role that culture plays in shaping the health seeking behaviors of the population and the traditional beliefs regarding HIV are complex. There is an urgent need to develop cultural competency (Campinha-Bacote, 1999; Dutta, 2008; Gyasi, Asante, Abass, Yeboah, Adu-Gyamfi and Amoah, 2016; Mhlongo, 2016) amongst nurses and other care workers if they are to meet the needs of the diverse populations they serve. Professionals need to become more skillful in dealing with multicultural issues (Falvo & Parker, 2000, Remy, 1998, Steiner, 1997). This study thus focuses on the nurse's perspectives in the treatment of HIV/AIDS to the patients who also seek help from traditional healers in order to explore the way in which they may or may not demonstrate cultural competency in their practice.

Culture is one of the motives that drives clients to seek help from traditional healers (Moshabela, 2017; Zuma, 2016; White, 2015). Therefore, for nurses to be empathetic to this they must be aware of the client's culture and develop the desire to help them regardless of whether they have sought help from traditional healers or not. Campinha-Bacote (2008) noted in this regard that the process of cultural competence in the delivery of healthcare services is a practice model of cultural competence as the ongoing process in which the nurse continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient (Campinha-Bacote, 2007). Mhlongo, (2016) explained that according to Campinha-Bacote Model the development of culturally sensitive nurses includes five components, which are: cultural desire, cultural awareness, cultural skills, cultural encounters, and cultural knowledge.

Cultural desire is understood in this context as the motivation of the healthcare professionals to *want to*, rather than *have to*, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters (de Beer & Chipps, 2014). Cultural desire involves the concept of caring. It has been said that people do not care how much you know, until they first know how much you care (Campinha-Bacote, 1999). Cultural desire includes a genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants. This type of learning is a lifelong process that has been referred to as "cultural humility" (Tervalon & Murray-Garcia, 1998). It is therefore important that this study explores what motivates nurses *to want to know* about what is important to the patient in terms of their cultural beliefs, and if/how they ensure that they take this background into consideration in their communication with patients [My emphasis].

Cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional background. In this study, the nurses are prompted to explore the cultural construction of their values and normal behaviors and to reflect on how PLHIV's values and normal behaviors develop similarly. Without being aware of the influence of one's own cultural or professional values, there is a risk that the health care provider may engage in cultural imposition. Leiner (1978), described cultural imposition as the tendency of an individual to impose their beliefs, values, and patterns of behavior on another culture. For the nurses to provide effective services to PLHIV, they must understand the client's health related beliefs and values, which involves understanding their worldview. Lavizzo-Mourey (1996:27) mentioned that ''in obtaining **cultural knowledge**, the health care provider must focus on the integration of three specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy''. PLHIV present their health problems to nurses during their consultation. If nurses have no ability to collect the relevant cultural data as well as accurately performing a culturally physical assessment their work could be ineffective. Leininger (1978:12) defined a cultural assessment as a "systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the context of the people being served". Since nurses perform a physical assessment on ethnically diverse clients, they require **cultural skill**.

In this study, **cultural encounters** can encourage the nurses to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds. PLHIV are from different backgrounds. In the context of this study, the Zulu culture is dominant. Nurses need to be aware that the sporadic interaction with a few members of a specific ethnic group will not make them an expert on that cultural group. Those individuals may or may not represent the stated beliefs, values, or practices of the specific cultural group encountered by the nurses. Part of this study's objective is to investigate the aspects of cultural encounters, to document the ways in which (if any) nurses try to engage in cross-cultural interactions in terms of health and HIV prevention and treatment.

Emerging approaches to culture-centered health communication present alternative perspectives in which culture, rather than being seen as a barrier, is instead central to effective health communication. Culture-centered approaches provide "an avenue for opening up the dominant framework for health communication to communities and contexts that have so far been ignored, rendered silent and treated simple as subjects of health communication interventions" (Dutta 2008:14). It is, therefore, inevitable that the integration of knowledge about the importance of communication strategies and of culture in health behaviour has become a critical component of HIV/AIDS prevention and care in the new millennium. As such, past research has investigated people's beliefs around health issues (Yoder, 1997). This study adds to that body of knowledge, but from the perspective of health care workers.

The study objectives can be summarised as:

1. To explore the ways in which nurses may/may not practice cultural competence in negotiating traditional and modern treatments for people living with HIV (PLHIV) and their communication thereof.
2. To explore the ways in which nurses may / may not practice cultural sensitivity (cultural awareness, knowledge, desire, encounter and skills) in their provision of care to people living with HIV (PLHIV).
3. To identify and analyse the benefits of cultural competency in nursing association with PLHIV.

1.4 Rationale for the study and significance

The study was conducted in a setting that is reportedly the most affected with the HIV epidemic (Iwuji et al., 2013; Tenser et al., 2017; Zuma et al., 2017). The National Health Promotion Policy and Strategy (2015-2019) is grounded in four outputs of the Negotiated Service Delivery Agreement (NSDA) for outcome two which is; a Long and Healthy Life for all South Africans: The four outputs are: Improving life expectancy, reducing maternal and child mortality rate, combating HIV and AIDS, and TB & improving health system effectiveness. The 2019 ART Clinical Guidelines for Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates play a huge role in instructing nurses who deals with PLHIV and managing them. Keleher (2001) asserts that to make primary health care readily accessible and acceptable in the local communities, community participation is essential. Participation also contributes to the existing literature in the field and uncovers new knowledge through the participant's contributions and in addition to existing literature regarding this study. Nurses must possess a variety of health promotion skills, of these, communication skills are considered to be one of the most important (Jerden et al., 2006). Therefore, this study aims to explore the nurse's cultural competence as they interact with PLHIV on daily basis as for them being practicing those skills to PLHIV could improve the health care specifically for those who use both treatment for HIV. Nurses play pivotal roles in HIV care (Dimutru, Irwin, & Tailor, 2017, Tunnicliff, Piercy, Bowman, Hughes, & Goyder, 2013). ART management is one of the core competencies for nurses' practice in HIV, as documented in international best practice guidelines (Canadian Association of Nurses in HIV/AIDS Care, 2013a, 2013b, Dumitru *et al*., 2017, Relf *et al*., 2011). This study adds evidence from a nursing perspective as it records and analyses their difficulties and challenges, they encounter in the context of ART adherence on their everyday communication with PLHIV.

With regards to HIV, life in rural sub-Saharan Africa is usually characterised by unique challenges that include but are not limited to poor uptake of HIV prevention programmes (Warren *et al.*, 2018), stigma and discrimination (Airhihenbuwa, Ford & Iwelunmor, 2014), as well as cultural and traditional practices and beliefs (Zuma, Wight, Rochat and Moshabela, 2017). Studies have been conducted on the role of

service providers in KZN in the treatment of HIV/AIDS (Peltzer and Mngqundaniso, 2008; Mottiar and Lodge, 2018).

Health promotion interventions and studies conducted in the UMkhanyakude District have focused on the health of children, women and young people (AHRI, 2017; Chimbindi and Colleagues, 2016; Zuma et al. 2017). This study extends the scholarship on service providers but focuses on a topic that is under-explored but deemed necessary by some authors and researchers (Moshabela, 2016; Nemutandani, Hendricks and Mulaudzi, 2018; Zuma et al., 2017). Typically, indigenous or traditional health care is viewed as a threat to western medicine (Nemutandani, Hendricks, Mulaudzi, 2018). Traditional herbal medicine plays a significant role in remedial, prevention and of life-threatening diseases such as malaria, tuberculosis and HIV and AIDS in most developing countries, though no adequate scientific evidence has been documented about the safety, quality and efficacy of the medicine (MRC, 2008). The researcher argues that comparing the characteristics of western medicine and traditional herbal medicine is problematic because it positions the later as being inferior.

Simon Nemutandani, Stephen Hendricks and Mavis Mulaudzi (2018) found that the two health systems render services to the same HIV and AIDS communities, but that a lack of communication creates confusion. They, therefore, highlight the need for collaboration between the two systems and a change in mindsets, attitudes and practices among practitioners with an acknowledgement that neither health system is better than the other, but the two should be complementary, recognising that the culture and beliefs of patients influence their health-seeking behaviour. Nyang's (1980) description of cultural issues within educational system shows that the system is not sufficiently sensitive to the African student's vulnerability. Historical background is critical and should be considered among racial groups. He further declares that "Africa was, and still is rich in cosmological ideas though diverse. Behind this diversity lies shared beliefs which spread across continent" (Nyang, 1980: 28). This study addresses this call as it explores the ways in which nurses may or may not practice cultural competence in their communication and provision of care to people living with HIV (PLHIV) who seek both traditional and western treatment. It is believed that a culturally competent health care provider can improve health outcomes of PLHIV

(Salminen *et al.,* 2010). In South Africa, cultural competence remains a challenge, for 'conventional science' nurses who are not necessarily aligned with the various indigenous knowledge systems (Corsiglia & Snively, 2001; Odora-Hoppers, 2002, Ogunniyi, 2004). This study therefore also seeks to establish the benefits of cultural competency in nursing in relation to PLHIV, based on the experiences of nurses and PLHIV in the UMkhanyakude District.

1.5 Key research questions

The study is guided by three main questions.

1.In what ways (if any) do nurses in the UMkhanyakude District practice cultural competence in negotiating traditional and modern treatments for people living with HIV (PLHIV)?
2.In what ways (if any) do nurses in the UMkhanyakude District practice cultural sensitivity (cultural awareness, knowledge, desire, encounter and skills) in their provision of care to people living with HIV (PLHIV)?
3.What are the benefits of cultural competency in nursing association with PLHIV?

1.6 Framing the Study: Theory

1.6.1 Culture-centred approach

The culture-centred approach proposes that traditional values are essential to the process in which the patient conceptualizes the disease they have and the solutions the healer may suggest in addressing the illness (Dutta, 2008). In this way, it is reasonable that the values of a culture are not only knotted with health issues, but equally with the forms of explanations that are anticipated to address these problems. Airhihenbuwa (1995) advocates that health communication should consider health and culture as overlapping; they are constitutive and help each other by echoing how people from different cultures can reflect on health and disease in their areas. The creation of a genuinely communicative space for dialogue between the healer and the patient opens the door to any approach based on the culture. The culture-centred approach is built upon dialogical engagement between the healer and the patient, which explores how traditional medical staff listens to their patients of HIV/AIDS in their

society (Bukenya et al., 2017). When the health care providers interconnect well with their PLHIV, the latter feel their cultural beliefs and ethics are taken into consideration (Dutta, 2008).

1.6.2 Culture competence model

‘’Cultural competence is a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations’’ (Cross et al. 1989). Cultural competency models propose principles that can be applied to sustain this practice (Campinha-Bacote, 1999; Mhlongo, 2016). Since this study’s objectives include an exploration of health communication and care services to a culturally conservative population in the treatment of HIV/AIDS, it chose as its participants the nurses who engage with this population. This choice is validated in that nursing education in recent times is the effort to develop more culturally sensitive graduates (Salminem et al. 2010). Mhlongo (2016) presented the argument that nurse educators need to consider cultural competency theoretical models, to promote effective and safe nursing care. This study includes interviews with clinic nurses who are the key informants in the study, as it is believed that culturally competent nurses have culturally sensitive knowledge and skills in identifying cultural patterns in an individualised care plan that will help meet the established healthcare goals for that patient (Gustafson, 2005). Understanding influences on health beliefs and behaviours of cultural groups leads to a better understanding of how clients perceive and take action around their illness, and improves clinical judgements (Yuen & Yau, 1999).

Community care and support strategies within a continuum of care can have a positive impact on mitigating and decreasing the spread of HIV/AIDS (Schneider, 2000). This is because community-based services are more accessible to clients and their families, compared to services based privately and far from community dwellings. Evidence from South Africa correlates to previous literature and suggests that patients that are being taken care of by traditional healers may live longer; experience a better quality of life and an improved health status (Ndingi, 2008 cited in Zuma et al., 2017). This may reduce the burden on clinics and hospitals as people learn to cope with minor symptoms and address them before they become complicated. In this study, the

researcher aims to explore the health communication by health care providers to PLHIV considering their cultural values, beliefs, and norms. As nurses need to understand that they should be culturally competent to provide effective health care services to PLHIV who have strong values,

The creation of good relationships between nurses and PLHIV represented a foundation for nursing interventions. It is essential to build trust with patients and establish a solid foundation for open and honest communication encompassed active, respectful, and non-judgemental listening, being open to patients' experiences, and important of being centered on PLHIV needs. This study, therefore, explores the ways in which nurses may/may not practice cultural competence in negotiating traditional and modern treatment for PLHIV and their communication thereof.

Both western and traditional medicines are used concurrently by PLHIV with the aim of treating HIV (Moshabela, 2016; Mothibe and Sibande, 2019; Zuma et al, 2017). The uMkhanyakude district is within the demographic surveillance areas of the Africa Health Research Institute, a setting that is reportedly the most affected with the epidemic (Iwuji et al., 2013; Tenser et al., 2017; Zuma et al., 2017). Conducting a study that examines the intersection between modern and traditional medicine in the provision of HIV/AIDS services in this area is thus crucial in a number of ways. Firstly, the study seeks to identify best practices and challenges in local nurses' negotiation of both traditional and western treatment in rural areas. It therefore aims to contribute to the growing body of knowledge of nursing communication and cultural competence role in the treatment of HIV in South Africa and Africa at large In doing so it is hoped that it provides a better understanding of the nuances of this negotiation that may aid health services and inform the successful implementation of new models of communication to PLHIV by public health care workers. The biggest problem that is currently encountered in nursing education is the effort to develop graduates who are culturally sensitive (Salminen, et al, 2010), yet it is believed that a culturally competent health care system can improve health outcomes of PLHIV. In South Africa, cultural competence remains a challenge for 'conventional science' nurses who are not necessarily aligned with the various indigenous knowledge systems (Corsiglia & Snively, 2001, Odora-Hoppers, 2002, Ogunniyi, 2004). This might be due to the nurses' scope of practice which has changed following their training in Nursing Initiated

Management of Antiretroviral Therapies (NIMART). Upon being trained and qualifying as a NIMART nurse, the Department of Health (DoH) wanted it all in one policy to signal a formal and structural recognition of the need for nurses to be people-centred. This more inclusive scope of work is a response to the WHO's advocacy for more people-centered holistic care (WHO, 2008), including but not limited to their traditional beliefs and cultural practices. The Kwazulu-Natal department of health has a robust engagement with Traditional Health Practitioners, which has been ongoing for a couple of years. This engagement involves cross-referrals between clinics and THPs, and in some clinics, include THPs as part of the Advisory Council (DOH, 2010; Hlabano, 2013; Zuma et al., 2019). This will be further elaborated in the literature review chapter.

Rural health has gained scholarly attention in South Africa (Gaede, 2016; Tomaselli, 2016; Moshabela 2017; McGregor, Ross and Zihindula, 2019). This study adds to this growing body of knowledge by exploring the potentiality of cultural sensitivity in health messages from nurses who treat Zulu patients, primarily in rural areas.

Cultural sensitivity refers to one's regard for a victim/survivor's beliefs, values and practices within a cultural context, and awareness of how their own cultural background may influence practice (Lister, 1999). The aim of this study is to explore the cultural sensitivity from nurses when they render health care service to PLHIV. This study seeks to explore the role of culture in the provision of health care services to PLHIV as residents of uMkhanyakude district, a rural area. This will be explored from a nursing communication perspective since nurses speak to patients who also consult traditional healers (Mnggundaniso & Pelter, 2008; Nemutandani, Hendricks, Mulaudzi, 2018). As such they know the ways in which people negotiate the uptake of Western medicine, alongside seeking traditional healing (Campbell-Hall et al. 2010; Moshabela, Pronyk, Williams, Schneider, Lurie, 2011; Pouane, Hughes, Uwimana, Johnson and Folk, 2012). The study seeks to establish the challenges as well as the best practices in negotiating the intersection of western and traditional medicine from a cultural competency perspective (Mhlongo, 2016; Nemutandani et al, 2019; White, 2015).

Although cultural competency models are typically used in the fields of psychology, social work and nursing (Alexander, 2008; Mhlongo, 2016) the approach is relevant to

the field of health communication as cultural competence refers to “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system to work effectively” (Cross, 1989: 4). More simply, cultural competency speaks to public health interventions taking into cognizance the dynamic contexts situated amid localised and cultural experiences of key populations. The objective of this study is to explore health care services rendered by health care workers to PLHIV considering PLHIV’s cultural diversity in their health seeking behaviors. Since the concurrent of traditional medicine and western medicine is not well understood for PLHIV in the era of antiretroviral therapy (ART). This study will explore the nurse’s experiences and perceptions in providing health care services to PLHIV, who are driven by culture in their health care seeking behaviors.

1.7 Research Methodology

1.7.1 Research paradigm

A paradigm is a way of describing a world view that is informed by philosophical assumptions about the nature of social reality (ontology), ways of knowing (epistemology), and ethics and value systems (axiology) (Patton, 2002). The paradigm in which this study is located guides the researcher to ask certain questions and use appropriate approaches to systematic inquiry that is ultimately known as methodology. This study is situated in the interpretive paradigm that accommodates a case study design in a qualitative study (Crotty, 2009). This research study follows appropriate methods that allow the researcher to collect analyse and present data in a scientific manner. This paradigm is thus an important part of this research methodology, which is based on a set of assumptions, concepts, practices, and values (Johnson & Christensen, 2005). This study is embedded in the interpretive paradigm because it is guided by the idea that the knowledge produced in this study is socially constructed through the interaction between the nurses as the expert interviewees, and the researcher who frames the interview questions and interprets the data based on a culture centred perspective (Willis *et al*., 2007).

1.7.2 Research approach

The study adopts a qualitative research method as it produces thick and detailed descriptions of the nurses' feelings, opinions, and experiences; and interprets the meanings of their actions (Denzin, 1989). A qualitative approach is necessary for interpretivist research as aims to understand the human experience in specific setting, (Denzin and Lincoln, 2002). For this research, the qualitative methods of face-to-face interviews and observation were used. This study adopted a qualitative approach because the researcher aimed to explore the nurses understanding of culture as they interact with PLHIV on daily basis. These nurses shared their experiences when they render health care services to people who concurrently use both medicine: traditional and western medicine as a form of HIV treatment

1.7.3 Research design

This study follows an exploratory research design that aims to provide an in-depth documentation of the experience of nurses who interact with PLHIV who seek both modern traditional healers' encounter with patients seeking HIV treatment and cure. This research study therefore adopted a case study design (Starman, 2013) as it allows the researcher to analyse, describe a group of people, a community or a problem, process, phenomenon, or event (Simons, 2009). This case study adopted an exploratory research design which explores the situation in which the nurse's intervention on the treatment of HIV/AIDS in uMkhanyakude District is being evaluated and has no clear outcome as describe by Yin (2003).

1.7.4 Data Collection

Data was collected using semi-structured individual face-to-face interviews with Nursing Initiated Management of Antiretroviral Therapies (NIMART) trained nurses between August 2018 and November 2019. The inclusion of trained nurses in the study was done based on their additional knowledge specifically to NIMART training that they received, as the training provided nurses with more insight on managing PLHIV. The researcher administered the interviews during which responses were

recorded with the permission of participants (see informed consent form as Appendix A1 and A2).

NIMART was introduced as a Task shifting strategy to delegate the ART management responsibilities from doctors to include Professional Nurses. From 2007, the burden was too high for the hospital system and for the patients who had to travel long distances to hospitals. Strategies had to change for the health system to cope with these changes hence the introduction on NIMART in 2010. The objectives of NIMART is: to improve access to ART services , to scale up ART services, to increase the number of patients on ART, to address the healthcare worker shortages , to capacitate nurses who work at HIV service point and to provide evidence based systems improvement (The KZN Success Story presented to the Provincial Council on AIDS, 2016).

A total of six healthcare facilities were visited for data collection with the nurses from different clinics within uMkhanyakude District. The names of the clinics that were visited during data collection cannot be mentioned due to the fact that the researcher respects the participant's anonymity and confidentiality as stated on the informed consent form (Appendix A1 and A2). Semi-structured interviews are a suitable data collection method for this study as it ensures that the specific research questions were addressed, but still allowed the nurses the freedom to express their views in their own terms which adds texture to the study (Fontana and Frey, 2003). They are well suited for this study because they explored the perceptions and opinions of nurses regarding their communication on the provision of health services to PLHIV. They allowed the researcher to probe for more information and clarification. For this study, it was necessary to standardise the questions asked of the participants so that the researcher can be sure that any differences in answers are due to differences among respondents rather than in the question asked.

The study adopted purposive sampling using geographic selection to identify and select individuals to represent the area and who were knowledgeable about or experienced with dealing with people who have sought traditional healing services prior to or after their seeking modern medicine (Creswell & Clark, 2011). This will be discussed further in the methodology chapter. The researcher works at the Africa

Health Research Institute (AHRI), which is the biggest employer in the uMkhanyakude district and one of the biggest populations, health and clinical research institute in South Africa. This work experience assisted the research as a list of clinics that have NIMART-trained nurses was provided by the nursing manager. In addition, the experience that the researcher has in conducting research for the institute provided the interview skills needed to get rich data from the Department of Health (DoH) nurses. Working for the institute that researches and provides community care within the uMkhanyakude district piqued the researcher's interest in this dissertation topic. However, it is important to note that this current study is specific to the researcher's Masters' degree and in no way is it part of or affected by the AHRI.

Of the 52 provincial clinics and five hospitals in the district, AHRI has presence in 11 clinics and one hospital. All these eleven clinics were targeted for inclusion in the study. Nurses who are working in the HIV unit and who have been trained in NIMART and specialise in treating people living with HIV were interviewed in this study. These NIMART nurses were selected based on their knowledge of the issues being explored and their day-to-day contact with the clients. To take part in this study, important criteria was established prior to the recruitment phase, as will be elaborated on in the Methodology chapter.

1.7.5 Data Analysis

Theoretical thematic analysis by Braun and Clarke (2006) is used to organise and analyse the transcribed data. The first step in analysing the data for this study involved familiarising and immersing oneself with the data to be analysed. Patterns of all common themes were identified (Ulin et al., 2002). The second step involved the identification of themes that shared the same words, styles and terms used by the NIMART nurses at public healthcare facilities. These themes were used to set up connections guided by the culture-centred approach (Dutta, 2008) and cultural competency model (Campinha-Bacote, 1999; Mhlongo, 2016) that informed the key research questions. Themes that emerged from the text were used; displayed in detail then reduced to essential points under major themes stated in the objectives. The third step in this study's data analysis phase was coding. The data were marked according to themes using the research questions as a guide. Step four involved the breaking

down and coding of the data into themes. Different concepts expressed by the participants in several ways were grouped together under a single theme. Each theme was elaborated in more detail. The final step consisted of putting together the interpretation of data, and checking it (Terre Blanche et al., 2006). Data is analysed and interpreted using the theoretical framework of the culture-centred approach (Dutta, 2008) and more specifically (Mhlongo (2016) and Campinha-Bacote, 1999) cultural competency model/s.

1.8 Structure of the Dissertation

Chapter 1 presents an overview of this dissertation. It provides the problem statement, research questions and study objectives based on the changes in nursing protocols that call for a human-centered approach (Holeman and Kane, 2019). Part of this new approach foregrounds how important it is that nurses in rural areas are culturally sensitive and that they exhibit the skills to be able to bridge the gap between western biomedical treatments and traditional treatment (Moshabela et al, 2017; Nemutandani et al, 2018). The study's location, uMkhanyakude district, is largely rural is also presented herein jointly with the rational and significance of the study. The first chapter also comprises of a glance to the theory framing the research study which is cultural competence as this study aims to address the benefit of cultural competence in nurses treating PLHIV. The chapter ends by delineating the study methodology that is framed within an interpretive paradigm and collects data via face-to-face semi structured interviews with clinic nurses.

Chapter 2 as a literature review, starts with a global perspective of cultural competency in nursing service delivery to PLHIV. Both locally and internationally published works were consulted for this study and covers the following topics: a global overview of the nursing knowledge of cultural sensitivity, the modern and traditional medicine approach, challenges to delivery of health care services to PLHIV in a culturally sensitive society and the role of nurses and their required level of competencies in dealing with such challenges.

Chapter 3 explains the theoretical framework that guides the study, the relevance to the study, as well as the critiques. The theoretical framework provides the key

concepts that thematise and assist in interpreting the data from a cultural-centered approach to health communication, with particular emphasis on cultural competency models (Dutta, 2008, Mhlongo, 2016).

Chapter 4 delineates the qualitative methodological approach of the study with an explanation as to why the chosen techniques are suitable for this study. It provides details on the exploratory research design, sampling, data collection, sampling and strategies and the form of thematic analysis to be adopted in the following chapter in which findings are analysed. The limitations of the researcher's field experience are also outlined in this chapter.

Chapter 5 presents and analyses the findings from the in-depth open-ended interviews. It follows a theoretical / deductive thematic analysis in order to address the research questions that explore the cultural competence (or lack thereof) in rendering health care services to PLHIV in a rural-based public health facilities. Interpretation is aided by previously discussed literature and theory.

Chapter 6 summarises and synthesises the overall conclusions emanating from the study. It also identifies areas for related further research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews the literature on the use of modern and traditional medicine in South Africa's rural areas and how these can be connected to the treatment of HIV and AIDS with the focus on cultural practices and beliefs. This literature review helps to integrate the results of previous studies on this topic under study (Terre Blanche and Durrheim, 1999). South Africans consult both modern and traditional (medical) practitioners. Reviewing literature on these systems is important as it orients the existing study with the various contexts through which these two systems are being used in the villages throughout South Africa (Tomaselli, 2011).

The context in which people choose traditional medicine speaks to the role of culture in rural villages when seeking medical support (Brumann, 1999). In the past traditional medicine was perceived, by policy and patients in rural setting, as the antithesis of modern medicine (Oyebode, Kandala, Chilton, Lilford, 2016). However, more recently efforts have been made to bridge the gap between these two systems (Moshabela, Zuma and Gaede, 2016). Importance is placed on culture by rural people and more recently international organisations such as the World Health Organisation (2018), the South African Health System Trust (2019) and the Department of Health (2010). The chapter reviews health reform in South Africa, particularly with regards to rural health, the practice of nursing (Maphumulo & Bhengu, 2019), and in relation to people living with HIV (PLHIV). The chapter thus concretises how important it is that cultural competences are mobilised to empower a health care provider dealing with people living with HIV (PLHIV). Finally, it includes a discussion on how nurses cope with culturally-influenced people in seeking HIV treatment.

2.2 HIV and AIDS: The importance of treatment

The literature review starts with a brief section that reminds the reader of the severity of HIV and AIDS in order illuminate the necessity for the uptake of comprehensive and consistent treatment by PLHIV. The Human Sciences and Research Council (Simbayi

et al., 2019) reveals that 7.9 million people within South Africa are living with HIV. The South African Department of Health (DoH) found that HIV and AIDS in South Africa is increasing daily due to the forever increasing prevalence of the epidemic in the sub-Saharan Africa region and in South Africa specifically (DOH 2018).

HIV, if not treated can develop into AIDS that weakens a person's system in combating opportunistic infections. As such life-expectancy without any treatment is unlikely to extend beyond 12 months (Anderson, 2012). HIV has no effective cure, but with proper medical care and antiretrovirals (ARVs) it can be managed and dramatically prolong the lives of many people infected with HIV, keep them healthy, and greatly lower their chance of infecting others (DoH, 2004).

The treatment of HIV and AIDS is important as the treatment limits the abilities of HIV to replicate itself in the body and mitigate the consequent immune system damage (Fauci and Folkers, 2009). Unfortunately, the antiretroviral therapies remain the only effective treatment of HIV which PLHIV should be encouraged to take (combining with traditional medicine- for those willing). It is worth noting though, that increasing resistance would mean that the war against HIV is being lost (Hughes, 2018).

It is also important to access treatment for HIV/AIDS and adhere to the treatment before the infection becomes resistant to the ARTs. Furthermore, the treatment allows PLIHV to prevent pre-mature deaths, which altogether result in a threatened country's economies and specifically in countries like those in sub-Saharan Africa. Studies have shown that HIV/AIDS destroys the health of individuals and wellbeing of families and communities at large (USAID, 2018; WHO, 2019), making the call urgent to get treatment.

In South Africa links have also been made between an individual's socio-economic background and the likelihood they will test for HIV. Those who have taken an HIV test and know their status are more likely to have a higher level of education, be employed, have accurate HIV knowledge and a higher perception of risk (Peltzer, 2009). This rigorous development followed the unpopular health minister Manto Tshababala Msimang who gained notoriety for her promotion of lemons, garlic and olive oil among other natural herbs and remedies to treat HIV and AIDS. The researcher argues that

her views reflected mistrust in traditional African societies of "western" remedies and earned her loyal supporters.

Although rates of HIV testing are similar across provinces -ranging from 82% in Gauteng to 88.3% in KwaZulu-Natal – those living in rural areas are as much as two times less likely to have tested for HIV than those in urban areas (Johnson, Dorrington and Moola,2017). The National Strategic Plan has identified closing these gaps as a key priority and plans on decentralising testing, so that more workplaces and community settings are able to provide HIV tests (SANAC, 2017)

Given the above and that treatment of others can reduce the risk of HIV, it is of paramount importance that PLHIV receive comprehensive treatment by health practitioners (that may include a mix of traditional medicine and ARV), as PLHIV need to be consistent in taking ARVs. One of the aims of this study is to examine how nurses communicate this comprehensive treatment.

2.3 Nursing Policy and Protocol in South Africa

The 2019 Antiretroviral Therapy (ART) Clinical Guidelines for Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates play a huge role in instructing and managing nurses who deal with PLHIV. The National Health Promotion Policy and Strategy (2015-2019) is grounded in four outputs of the Negotiated Service Delivery Agreement (NSDA). The four outputs are: Improving life expectancy, reducing maternal and child mortality rate, combating HIV and AIDS, and TB and improving health system effectiveness. The ways in which nurses interact with their patients impact on whether these outputs can be successfully met or not.

2.3.1 Health Reform in South Africa

During apartheid in South Africa there was criticism related to health care inequalities and access (Maphumulo and Bhengu, 2019). The current South African government seeks to design changes that address these inequalities. One of these changes is in the form of the health legislation, and of particular relevance to this study is the Nursing Amendment Act, 1997 which created a single South African Nursing Council which is inclusive of all racial groups. Others included the nationalisation of health laboratory

services, regulation of health care professionals, compensation for occupational injuries and diseases, and health promotion.

In developing an equitable national health care system, legislation was revised to meet the goal of improving access to quality health care services in a non-discriminatory approach. South African government has provided access to health care to approximately 45 million people in order to improve health status of its citizens (Maphumulo and Bhengu, 2019). However, there are still barriers especially in the area of resource shortages, financing and administration of the health care services. This has a direct negative impact on the functioning of clinics and implementation of the district health system (Benatar, 2004). According to the National Development Agency in South Africa, resources have been shifted from certain provinces (NDA, 2014), to KwaZulu-Natal and Eastern Cape as these were identified as more disadvantaged provinces (Romeo, Hall, Cluver and Steinert, 2018). This national redistribution of services seeks to provide primary and community-based care instead of tertiary care which would be financially reasonable and equitable.

Despite the move to improve health care services in the above provinces there remains a challenge for poor patients without medical aid. Additionally, there is the challenge of a shortage of skilled / specialised personnel which frustrates the delivery of services. There is also a shortage of basic medicines and treatment at the primary / community level. In terms of those that are assigned to provide the service, health care professionals have reported that they feel isolated and dissatisfied with available resources including but not limited to human resource capacity in public health facilities (Benatar, 2004)

The issue of the HIV and AIDS epidemic worsens the scenario as most financial resources must be utilised for this epidemic. The focus and energy on preventing HIV comes after the initial denial by the South African Former President Thabo Mbheki that HIV and AIDS are linked (Fassin and Schneider, 2003) which resulted in the failure to initiate a comprehensive prevention campaign for over a decade (see Mulwo et al., 2012). Ineffective treatments have contributed to sustained denial of the existence of the HIV pandemic in different parts of the globe and specifically for people in rural

areas of South Africa (Bertozi, Padian, Wegbreit, DeMaria et al., 2008). Stigma has also been exacerbated due to this denial (Wirawan, 2019).

With the health care reform in South Africa there have been significant changes in nursing. The South African Nursing Council (SANC), which is a body regulating roles, functions and responsibilities of nurses and the nursing education system underwent major changes in that legal discrimination of black nurses was eradicated. However, black nurses are still concentrated in overcrowded government hospitals and clinics (Jewkes *et al.* 1998). These black nurses are the majority who are living in rural societies where traditional medicine is practised. Van Der Merwe (1999) states that black nurses before 1994 were discriminated regarding their roles and responsibilities with SANC. They were misused to provide low skilled health care services. They also had to function in poorly equipped and segregated health and nursing education facilities until the genesis of the new SANC. No current literature has explained clearly the role that SANC has played especially in getting the issue solved or facilitating the process of bridging the gap between the two types of medicine. However, other entities in government have been active and addressing the issue and the following section shows the relevance of their involvement and the progress to date.

The South Africa DoH at large and the Kwazulu-Natal Provincial Department of health in particular have ongoing programmes and robust engagement with THPs for over a decade. The DOH (2010) report acknowledges the role of THPs in addressing HIV and AIDS, TB and mental health if they work in collaboration with the modern medicine practitioners. Other studies have provided scientific evidence on the benefits of the collaborations between the two providers to the patients (Hlabano, 2013; Nompumelelo et al., 2019; Zuma et al., 2019). For example, the African Medical and Research Foundation (AMREF) initiated a project with the THPs between 2005-2006 which sought to increase their recognition and build their capacity in the understanding of basic HIV and AIDS, and TB epidemiological processes (Hlabano, 2013), and to establish effective collaboration and patient referral mechanisms between 82 THPs and four public health facilities in uMkhanyakude district in Kwazulu-Natal province (AMREF, 2007). Upon completion of the project, an evaluation was carried out to verify if the project's objectives were met, amongst which THPs should be able to refer patients suspected of having HIV or TB to nurses in public health facilities, whom in

turn would take them through voluntary counselling and testing (VCT), and TB screening, to offer palliative care services (home based care), DOTS and ARV adherence counselling (DOH, 2010; Hlabano, 2013).

According to the AMREF Evaluation report (2007:11), participants reported that they had been taught to recognise signs and symptoms that are suggestive of TB and HIV/AIDS and that this led to improved understanding in the management of these cases. The THs reported having learnt to distinguish between *idliso* (herbal inducement of chronic cough for vindictive or witchcraft purposes) and Tuberculosis (TB). Most black Africans and THs believe that vindictive people or enemies can be be- witched/poisoned by certain herbs that induce chronic cough that has the same fatal consequences as TB if left untreated. THs in the HIV/AIDS and TB program said that they had learnt that it is more beneficial to first refer clients who presented with weight loss, coughing and night sweats for sputum tests to their local clinics before making conclusions that they had *idliso*. Only when TB had been excluded would they then proceed with their own traditional healing treatment for *idliso*. Similarly, when someone came to them indicating that they were suspecting being be-witched and yet they were presenting with symptoms suggestive of HIV infection, the THs will first refer them for VCT in order to exclude HIV/AIDS. This change in knowledge and practice was seen as particularly important because the presentation of *idliso*, TB and HIV/AIDS can be confusing as all have common symptoms like weight loss and coughing. This means that the trained healers had learnt how to avoid confusing TB and HIV/AIDS with other illnesses brought about by witchcraft and evil spirits. This was a positive sign of improved management of HIV/AIDS and TB patients (AMREF 2009).

The evaluation report revealed that the DOH and the THPs were satisfied with the results and acknowledged their role to play in the fight against HIV and AIDS and TB or any other diseases (AMREF, 2009). These results are supported by Mbatha, Street, Ngcobo and Gqaleni (2012) in their quoting of the DOH's white paper for transforming the health system in South Africa and recommend the recognition of the important role of the THPs in primary healthcare.

2.4 Bridging the gap between biomedical and traditional medicine

Some countries have managed to bridge the gap between biomedicine and traditional medicine. Countries like India and Bangladesh are said to have successfully bridged this gap (Chako, 2003; Verotta, Macchi, Venkatasubramanian, 2015). In South Africa, a study exploring the progress of bridging the gap between traditional and modern medicine conducted by Moshabela and colleagues (2016) verifies that the process of getting policies, infrastructure and methodologies implementation is in progress and that related relevant government entities have started discussions on this subject.

2.4.1 Traditional Medicine and Modern Medicine in South Africa

Traditional medicine is a large field with varying descriptions. A concise definition is that it refers to the antique and culture bound medical practice that existed in human societies before modern science was applied to health (Abdullahi, 2009).

Traditional medicine is performed/practiced by traditional healers who can be defined as any individual who is recognised by the community where he or she lives as someone competent to provide health care by using plant, animal and mineral substances and other methods based on social, cultural and religious practices (Pretorious, 1999). In traditional medicine, traditional practitioners use strategies that are often known as alternative or even complementary medicine, which is a form of medicine that has evolved recently as a reaction to high technology medicine (Nangalama, 2016). Abdullahi (2009) supports this idea as he details that traditional medicine denotes health approaches, beliefs, knowledge and practices that combine spiritual therapies, animals and mineral-based medicines, manual techniques and trainings.

Similarly, the World Health Organization's (WHO, 2002) definition also stresses the indigenous knowledge involved in traditional medicine and they further highlight its competence: "a traditional health practitioner is any individual who is known by the community where they live as a person who is competent to provide health care by

using plants, animals and substance minerals and other methods based on social, cultural and religious practices". Further highlighting this skill Moshabela et al. (2017) assert that, traditional medicine practitioners are also known as specialists on community attitudes and beliefs connected to physical, mental and social health. However, it can be argued that the terminology used to refer to traditional medicine such as alternative medicine or alternative approaches to health serves to perpetuate the inferiority of traditional modes of healing.

Building on the above definition, Abdullahi (2009) and WHO (2011) argue that all over the world, traditional medicine is the oldest system of health care that is used to prevent and treat physical and mental sicknesses and is surely considered as complementary or alternative medicine. As not all rural people can afford access to modern medicine, this has been one of the great reasons why they massively turn to traditional medicine to restore their health. Furthermore, WHO (2011) confirms that traditional medicine is a health care system that the majority rural South Africans hugely value because it restores their physical, mental health or their welfare.

In a South African context, modern and traditional medicine are solely combined in order to diagnose, prevent or treat a given illness or else simply maintain a person's health (Gumede, 1990). The process of treatment is often transmitted from parent to child, and no documentation can be traced to scientific use. Yet, this can still be refined over time after the source person has passed away. According to Pretorious (1999), traditional medicine and HIV/AIDS can also be defined by looking at its accessibility in comparison with clinically tested antiretrovirals. It is known that antiretroviral drugs that are clinically tested with the main purpose of restoring immunity function in the people who are sick with HIV/AIDS. Mokgobi (2012) ascertains that this has been motivating the patients to take the way to traditional medicine that seems affordable. It is also confirmed that even in the situation where some of the treatments are cheap or accessible at no cost, rural communities are still located far from the cities (Cook, 2009). This distant isolation of villages means that reaching a health care center where a patient can collect modern drugs remains another obstacle toward seeking modern medicine. In line with Mokgobi (2012), in most cases, Africans in general and South Africans do not have good understanding about HIV/AIDS. This has led most PLHIV to trust traditional medicine and healers to cure them of their disease. Even those

patients who have been tested in clinics and hospitals can still seek healers for treatment (Gqaleni et al., 2007). The villages' remoteness and patient's poverty and trust in traditional medicine have stopped PLHIV from seeking modern medicine (Flint, 2013). For such patients, the perception appears to be that relief will come from the traditional healer, and not medical doctors.

The practice of traditional medicine is used differently from country to country, based on its cultural legacy and societal structures. This implies that communities create local ways in which to preserve health and treat diseases. The cultural aspect of this medicine confirms that its practice is basically built on conventional usage and individual knowledge of each traditional healer (Moshabela, Zuma, Gaede, 2017; Sindayigaya, 2016). General accounts of application and practices from generation to generation offer some indication of the usefulness and success of traditional medicine. As of 2019, the DoH (2019) estimated that there are over 200,000 practicing traditional health practitioners in South Africa, and they are consulted by almost 60% of the South Africa population, mostly in conjunction with modern medicine. The efficacy of traditional medicine still needs to be completely confirmed by means of modern scientific methods as many researchers argue in the previous sections of this chapter. However, the popularity of traditional medicine in preserving health in rural communities cannot be overlooked (Ozioma and Chinwe, 2019).

Further research continues to reveal that South Africans, both in urban and rural areas, still believe in traditional medicine more than they do in modern medicine. For example, the WHO (2018) released statistics that confirm that approximately 80% of South Africans seek treatment from traditional medicine. Ross (2010) found that 8 out of 10 black South Africans believe in THPs and can consult them in case of need, along with western medicine. Statistics South Africa mentions that about 70% of South African black people trust THPs in one way or another (SSA, 2013). All in all, the vast majority of South Africans admit that traditional medicine is imperative since it is common, cheap and easily accessible compared to modern medicine. Considering the South African Traditional Health Practitioners Act, people frequent traditional healers because of their connection of health with patients' social and cultural beliefs (Flint, 2015). Furthermore, traditional healers are on the rise because the majority of the patients, as well as other people, recurrently visit them. It is therefore promising that

recently there have been policies that acknowledge the ways in which traditional medicine can be coordinated with modern medicine (Moshabela, Zuma and Gaede, 2016). Some policies on collaborations between the two practitioners are being developed by relevant governmental departments and there are task teams in place to coordinate this process. Examples are the Standards Operating Plans, the National, Provincial and Districts strategic plans, as well as guiding materials in terms of joint practice (ART Clinical Guidelines, 2019). As the process takes shape, the assumption is that closing the gap will see many diseases treated / healed as patients' cultural spiritual beliefs play a big role in their healing process.

Moshabela, Zuma and Gaede (2016) state that THPs in South Africa are being formally acknowledged as essential health care providers. The DoH is taking solid steps towards formal regulation of THP. This initiative comes along with some important challenges like gaps in scientific evidence for traditional medicine and practice as well as mistrust on the part of biomedical practitioners. These practitioners are reluctant to approve traditional medicine due to complications and their belief in unmeasurable doses and toxicity (Moshabela, Zuma and Gaede, 2016). While traditional medicine is being formally acknowledged, there remains tensions between modern and traditional health services providers as noted (Moshabela et al., 2016). This study is, therefore, necessary in that it aims to demonstrate the cultural competency in treating PLHIV within a select group of nurses. The results are aimed at contributing to exploring ways in which it may be possible to bridge the gap between modern and traditional health practitioners in South Africa.

There is currently a move towards reconciliation from looking at THPs as witchdoctors to acknowledging them as having a pivotal role to play in traditional medicine and practice. Statistics South Africa sustains that there were roughly between 150 000 and 200 000 of traditional healers throughout South Africa (SSA, 2013). Narrowing in on this study's research location Gqaleni (2007:12) discloses that there were "25 000 healers in the Province of KwaZulu-Natal and that only 7000 were registered with their interim professional body". To Ross (2010), "the ratio of THPs to medical doctors were about 250 000 and 400 000 THPs and 28 000 medical doctors in the entire country of South Africa".

Peltzer et al. (2008) explain that the South African THPs who are recorded under the "Traditional Health Practitioners Act include herbalists (izinyanga or Amaxhwele), diviners (izangoma, umthandazi or amagqirha), traditional surgeons (iingcibi) who mainly do circumcision and help in traditional births as attendants (ababelethisi or abazalisi)". Based on this diversity, Gqaleni et al. (2007) confirm that it is hard to be precise about the exact number of all the traditional healers in South Africa since many of them have never been registered.

The South African government decided to formally integrate traditional health into its public health system after 1994 (Hunt *et al.,* 2000). Accordingly, research shows that the use of THPs has been a long-standing component of health care practice in the country and this has contributed a lot to the South African needs in health care (Campbell-Hall, Petersen and Bhana, 2010). Up to now, there have been attempts to accredit THPs in the system of public health in South Africa, but in vain. Summerton (2006) supports this by pointing out the absence of proof for the diagnostic procedures, approaches and training for THPs (Summerton, 2006). With these challenges, it is difficult to gather precise and relevant data regarding qualitative and quantitative methods regarding TM in South Africa (Moshabela et al., 2016).

Research reports that the knowledge applied by different types of healers is a product of and is dependent on, the different disciplines of traditional healing to suit different aims and functions. However, evidence documenting how THPs roles are related to their categories is scant (Semenya, Protgieter and Bapedi, 2014). Existing evidence focuses primarily on how THPs are initiated into the role of healing, their socio-cultural profile and traditional healing practices and methods. However, further research is needed to understand the cultural specificity of THP types, how they vary, and how they are related to their roles.

Hlabano (2013) admits that both positive and negative criticisms have repeatedly been made toward the roles played by THP in Sub-Saharan Africa. Consequently, he also ascertains that THPs in South Africa must fight for recognition by different quarters of society, as well as all departments regarding health. In addition, not all parts concerning traditional medicine have been considered. In fact, excluding some of what

traditional healers deal with, such as spiritual heightening, shows a general ignorance of the positive role they could play in health care (Cook, 2009).

While this study does not directly engage with traditional healers, it may illuminate some of the ways in which traditional medicine is best incorporated with modern medicine, according to nurses who treat PLHIV. Modern medicine is a structure of care that builds on the information based on a scientific logical process (Lee et al., 2017). Modern medicine developed very fast and made key contributions to sickness control in the past century. This, however, becomes difficult to prove as anecdotal evidence suggest that traditional medicine is also claimed to treat and cure, sometimes even faster than modern medicine. Anderson (2012) quotes the Orthodox Medicine Model (OMM) to explain that modern medicine has the power and the knowledge that can heal an innate human system by interfering in its ordinary homeostasis by means of strong chemicals that man has made.

Atman (2011) confirms that regardless of a quick progress in information and methods in modern medicine, the end of the last century also saw an amplified awareness in traditional medicine. As shown above, the growing public request for its use has culminated into substantial advantage among policymakers, health administrators and medical doctors on the possibilities of bringing traditional and modern medicine together (Anderson, 2012).

Anderson (2012) foregrounds the commonality between modern medicine and traditional medicine: both have the goal of restoring and maintaining the physical health of the patients who approach them, though they use different strategies to do so. However, one of its major difference is that the scientific medical practitioners of this era treat the body of an individual by checking its various components separately (Anderson 2012). On the other hand, traditional medicine's approach is more holistic as culture is commonly recognised as an aspect that is connected to health, behaviour and body (Rathore and Krunholz, 2011).

On the other hand, patients treated by modern medicine practitioners do come with their cultural beliefs and this has also to be taken in consideration when treating them. In connection to this research, Brumann (1999) explains that culture and patient

treatments go hand in hand. He states that culture is a set of complex traditional behaviours that have been developed by humans of a given area and that are successively inherited from generation to generation. This study examines cultural practices in connection with rural South Africans living with HIV/AIDS and the contexts in which they approach both modern and traditional medicines for curing their sickness without rejecting their cultural views. It is in this vein that Evian (2006) views culture as an organization of consistent principles sufficiently vigorous to inspire and condition perception, decision, communication, and behaviour among the people who belong to a given community. Additionally, Ntombana (2011) exposes the importance of both culture and society regarding healing sickness by equally stressing the role of language for a better understanding of sickness concepts. When rural patients consult their medical doctors for antiretroviral therapy (ART), Kinsler *et al*. (2007) confirm they have to express clearly what they are feeling to allow the doctor to find the real cause of the disease and thus, find appropriate medicine to prescribe them. However, Freeman and Motsei (1992) approve that in some instances, there are patients who combine both modern and traditional medicine (Sangoma); and the latter being part of South African's cultural life. Research shows that the majority of HIV/AIDS patients in rural areas of South Africa who have access to ART fail to communicate to their medical doctors they are also taking traditional medication (Campbell, 1998). Consequently, the main goal of this research is to examine the ways in which nurses may/may not be bridging the gap with rural South Africans with HIV/AIDS seeking modern and traditional health care.

2.4.1 Grounds for Leaning on Traditional Medicine

It is crucial that the reasons for which people seek traditional medicine are well understood (Flint 2015). Studies on health seeking behaviours of rurally based populations in the Third World have documented the cultural and traditional values rural people attach to traditional medicine as the main reasons for them to seek such health services (Mokgobi, 2016). For the purpose of this study, the focus is on the PLHIV and who seek healthcare services from traditional healers in combination to the modern healthcare services that they receive at their local clinics and free of charge in South Africa. This section will examine literature on the main reasons that motivate the people to turn to traditional medicine.

South Africans strongly cling to their healing traditions simply because traditional healers are integrated into every aspect of their lives. Since these healers can perform spiritual and medical roles, they play a crucial role in the community (Hlabano, 2013). This integrates them into traditions from religious celebrations to moral guidance. As such they gain trust from the local people compared to health care professionals who went to universities (Zuma *et al.*, 2016)

The popularity of traditional practitioners is that they often mix various unknown herbal concoctions to cure their patients (Gqaleni *et al*., 2007). Some anecdotal evidence suggests this as being connected to magic, which gives them a mystical position in their community. Consequently, Pretorius (1999) ascertains that herbal treatments differ largely as all traditional healers do not use the same herbs. This cannot be accepted in modern medicine because there is no clear explanation to it (Zuma et al., 2017). For most Africans, these traditional practitioners remain the sole source of treatment as healers are easily accessible as they communicate well with the patient because they speak the same language (Hahn, 1995). Additionally, the healers are trusted in rural areas since they are often the only healthcare possibilities for the patient and the latter does not cover huge distances before reaching the healer's hut (Sodi et al. 2011).

2.5 Traditional and modern medicine: further complicated in HIV treatment

The 'relationship' between traditional and modern medicine is further complicated in the context of HIV prevention and treatment. Traditional medicine has always been accused of obstructing the safe and effective HIV treatment and adherence to ART (USHHS, 2017). This reflection has never considered the context and motivators of traditional medicine and its relation to HIV/AIDS treatment and care (Peltzer et al., 2010). The interaction between antiretroviral drugs and traditional medication is not always predictable as an ingredient of traditional preparations since these two do not have common strategies of addressing the sickness. The process of identifying and encouraging sangomas or local healers to join the ART programme will help in both spreading the information and offer a joint service, and this may lead to finding the right solution to this issue (Rodney, 2010). Such a process is hoped to open a real

expression of a powerful communication in addressing the proliferation of the HIV/AIDS pandemic (Rodney, 2010). This study seeks to shed some light on the potentialities of this process through examining the nurse's knowledge of both traditional and modern treatments and the reasons for why PLHIV access both/either, and through exploring the nurse's communication approaches in negotiating traditional and modern treatments.

Cultural variances are one of the major influences in the communication between health care providers and PLHIV. Most health care professionals sustain that communication operates better if it directly addresses the patient's desires, preferences and ethics (Steward, 2001). On the other hand, any cultural misinterpretation between a patient and their health care providers will lead to poor quality care, and thus patient's dissatisfaction. The main objective of traditional medicine is to seek both the proximal and spiritual causes of a disease (see Prejean et al. 2010; Ryan, 2015), and this approach should be considered in any form of treatment, be it traditional or modern. Understanding proximal causes helps the traditional practitioner to ascertain the physical causes of that disease and in the ultimate cause, they look meticulously into the reasons why the disease exists. This implies that in some cases HIV and other STDs will be connected to a malicious force or sorcery that exists in the minds of most Africans as a result of jealousy or fury (Flint, 2015 and Hunt et al, 2000). However, the biomedical interventions focus on the proximal cause of the disease but neglect its ultimate cause that infers magic. Still, many traditional practitioners support the belief that only considering the proximal cause and overlooking the 'spiritual dimension' cannot effectively treat the HIV/AIDS patient (Lee *et al.,* 2017). This explains how different ethnicities value the role of their culture and their purpose in adopting behaviours. All in all, this reflects it is hard for people to abide to the use of ART as they do not strongly trust it could positively address HIV/AIDS (Moshabela *et al*., 2017). This belief supports the literature that foregrounds the importance of the incorporation of traditional healers into HIV care. This might be successful if the healers have been identified as endowed and culturally relevant HIV-support or ART-adherence counsellors (O' Conner, 1996; Pear, 2017 and Evian, 2006).

2.6 South African perceptions of sickness and traditional healing

There is a belief in South Africa which is slowly becoming more commonplace whereby any person who falls sick is believed to have been bewitched (Moshabela et al., 2017). It is erroneous to disconnect people from their cultural beliefs and practices, particularly because this connection depicts a deep knowledge of how Africans consider the world around them. Without it, it becomes hard to understand what the concepts of health and disease mean to some traditional African people (Karim *et al.* 1994).

Indeed, the way Africans consider the world remains a complex idea that incorporates the physical, metaphysical, as well as the sociological environments (Karim et al., 1994). As a matter of fact, Bukenya et al., 2017; Nangalama, 2016 and Cook, 2009) admit that this view refers to the existing continuity between family and community members (living humans) and the ancestors (deceased people); thus, agreeing with the metaphysical powers of the universe which is reffered to as African Cosmology as articulated by (Kanu, 2013). This way of seeing the world involves the family, the community, and the power the ancestral spirits have on us human beings who are alive and that is what mainly determines every African's wellbeing (Napier, 2014). In the same vein, the way Africans view the world conceptualises Africans as simultaneously embracing the body, mind and the spirit as one unit. This inseparability of these elements is fostered by the belief that they all depend on each other and none of them is autonomously dependent (Hatala, 2012). This interdependence implies that the state of one of them regulates that of the others at a given moment in time (Dubos, 1965). For example, Hucks and Tracy (2013) reveal that in the minds of some African groups, when a person becomes rich, that implies that their fortunes of health has created the equilibrium between them and their relationship with their social setting and the supernatural powers within his environment. In other words, when an individual presents good behaviour and persistent sacrifice to the ancestors 'spirits, this is often rewarded by good health and good fortunate (Hatala, 2012). However, the person will be sanctioned and so, they will become sickly and poor because of their sins, their indecent life and wrongs to family and community members (Hatala, 2012).

Punishment or sanction can be extended to family and community members depending on the position of the person who is concerned (Gumede, 1990).

Another way in which social behaviour is governed in African society is through the creation of taboos and myths. Taboos and myths together with other traditional customary laws are tools that are used to guarantee that there is perpetuation of the harmony between two worlds: the living and the invisible (Ngubane, 1977). Another study by Napier (2014:7) confirms that taboos are "a system of avoidance, which regulate human conduct in order to ensure a healthy whole – physically, spiritually and morally". He further explains that throughout Africa, taboos are non-written social laws that are kept by the society elders, from mouth to ear and are transmitted from generation to generation. The main goal of such rules is to impart to the new members of the community the codes that have been recognised as ways of conduct. This highlights the communitarianism that characterises many societies in Africa.

According to Ekpunobi et al. (1990), in the African traditional belief system, a person is never in isolation. The person feels complete when living in perfect communion with others, during the time of happiness or unhappiness. Thus, a person's comfort should not be exclusively reliant on only that individual; it also varies according to the relationship that person entertains with all the people around them in their home, in the village and in the community (Booth, 1990; Ikenga, 1981 and Parrinder, 1969). In the context of the Zulu culture the traditional belief is an imbalance between the well-being and the whole family who experience evil or scary forces in the environment (Ngubane,1977).

The above discussion explains how many African people view their world in a traditional way, and how they interpret the concept of health. This idea directly connects with the WHO's definition of health "as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (cited in Bannerman et al., 1983:56). Respecting this definition as a global concept and as old as it is, many researchers and theorists subsequently advocated for the adoption of a working, practical, and operational definition of health. This definition is: the ability to conduct a socially and economically productive life. This definition was maintained and remained part of the 1977 adoption of the WHO's global strategy called "Health for All

by Year 2000". Within the last few decades, the WHO definition of health has been increasingly amended and supplemented by the fourth dimension – spiritual health. Generally speaking, spiritual health involves a sense of fulfilment and satisfaction with our own lives, system of values, self-confidence and self-esteem, self-awareness and presence, peacefulness and tranquillity with dynamic emotional balance, both internal and toward the environment, morality and truthfulness, selflessness, positive emotions, compassion and willingness to help and support others, responsibility and contribution to the common good, and successful management of everyday life problems and demands as well as social stress (Donev, 2014). For a person to be in good health and enjoy welfare, they have to live a peaceful and good relationship with themselves and the surrounding, have positive social relations and the social environment. Therefore Karim *et al*. (1994) and adapted by WHO (2017) state that disease is viewed as a danger to human comfort and good health; it is a human harmony's disturber.

Studies conducted in Africa have revealed different results regarding health and diseases perceptions by African populations. For example, it is reported that many traditional African healers examine the different causes of a disease in two angles; some are natural while others remain supernatural (Freeman and Motsei 1992). A disease is natural in cases where its causes are definite, identifiable, and foreseeable. It is supernatural if it connects to culture and it is hard for humans to explain it by accepted norms (etiology). Finally, a supernatural disease will have diagnosis and treatment that remain all inseparable from the way Africans view the world (WHO, 1978). Thus, the origins of a supernatural sickness are directly related to the culture and the traditions in the society.

For illnesses associated with cancer, HIV and diabetes (that are considered as natural incidences) traditional or modern medicine can be applied for healing. In case the disease does not respond positively to herbs or drugs, this means the situation is malignant (Dubos, 1965). In this way, the idea of thinking of a natural disease evaporates from the mind and people look for other explanations for the sickness. The role of biomedicine is to look for causes of the disease and understand how the patient got sick (Karim et al., 1994). However, the researcher argues that traditional medical system will always seek to understand *who* caused the patient to be sick, and what is

the reason that person used to break the harmony of this patient. To find an appropriate answer to these two questions, Ozioma and Chinwe (2019) assert that Africans will consult their ancestors in their roles. This will also help to know if the patient has never broken any social taboos. The main reason behind this is to understand the root cause of the disease and to know if the disease or misfortune did not come as punishment to this patient's ill behaviours (Gumede, 1990). These ill behaviours can affect a family member, either the patient who committed it, or someone in their family or community caused the ancestors to be angry (Twumasi, 1988). It is believed that ancestors do not protect people triggering social contentions that include, for instance, clash between members of a family, breaching some customs and norms, which ultimately will cause ancestors to give up protecting the family or the person (Ekpunobi et al., 1990). Ngubane (1977) describes causes of illnesses as sorcery and believes that they have a relationship to the ancestors. From this perspective, the researcher argues that many Africans believe that illness is a result of supernatural powers or an outcome of irritated ancestral spirits and other spirits that have been infuriated due to people's social or family misconduct. However, in contemporary South Africa Zulu people have been integrated into modern industrial societies and live in scattered tribal locations with an influence of modern western ways of healing thereby distorting the Afrocentric ways of healing.

In view of the above discussion, an individual will be vulnerable to sickness if they have annoyed or disrespected the supernatural forces, represented by ancestors. Again, to Freeman and Motsei (1992), illness may be sent to destabilise an individual or a family and even a community because of their state of impurity or uncleanliness like menarche, childbirth, miscarriage and death that are also considered as reasons that generate supernatural sickness. Alternatively, Parrinder (1969) and (Booth, 1990) confirm that many Africans can develop jealousy against their neighbours so that they use witchcraft and sorcery to endanger their lives; they send them sickness, such as stroke. Stroke is believed to be a sickness that is created and sent by wizards and witches.

As for the categories of diseases and illnesses under the African traditional medical system, the THP looks at these extensive varieties of diseases from both natural and supernatural roots (Hatala, 2012). THPs treat a variety of illnesses such as diabetes,

the effects of strokes, asthma, and even personal emotional problems. They are also able to consult with people on different economic and social issues such as employment questions and bad luck in relationship (Campbell, 1998). A study by Hatala (2012) adds that some practitioners treat epileptic seizures, suicidal tendencies, nightmares, infertility, and other economic calamities. Regarding AIDS, there exist many healers who are confident that they can lengthen and improve the quality of life of an AIDS patient via some food regime (Pear, 2017 and Freeman and Motsei, 1992). A lack of current research in exploring the South African perception of diseases and healing, leads to the researcher to use the old references that could only be found during the literature search.

2.6.1 The processes of healing: similarities and differences

The healing process in western tradition differs from the process of healing in the African context, and this is based on many factors and stages of healing. For example, African traditional healing processes follow a particular methodological course. The first stage is crucial as it identifies the source of the disease because the causation factor is well known and so an idea of what to use can come to the mind of the healer. Then the second step can be strategies to use in order to fully remove that cause, and this may require some rituals or sacrifices in order to cool down the angry spirit of the ancestors (Freeman and Motsei ,1992). By doing so, the healer makes sure he is neutralising the ailment that would have been sent to harm the person who is sick now or he can think of the kind of herbs to use accordingly.

According to Zuma *et al.* (2017), modern medicine follows almost the same process, though the methodologies differ; it first detects the main cause of the sickness through a laboratory analysis or by the symptoms that the patient presents. However, the traditional healer will discover the cause of the illness substantially, which is different from what modern medicine does (Karim et al., 1994) were there is no room for supernatural and rituals or sacrifice in modern medical way of healing. According to existing literature, most traditional healers all over the world, and in Africa precisely, will think modern medicine is inefficient for the only reason that it cannot address the sickness by removing what is supposed to be its root cause as does traditional healing (Batisai, 2016; Mothibe and Sibanda, 2019).

In some situations, traditional healers prescribe medical drugs to their patients but still, they always must reinforce with witchcraft and supernatural basics (Karim et al. 1994) These include, among others, chants and rituals whose aim is make the evil spirits fly off, and this makes the patient trust the healer, which can play on his psyche and so restores his body and mental equilibrium (Hucks and Tracy, 2013; Hatala, 2012).

Most traditional healers perform their practices in their compound. It is in the healer's medical hut that the entire traditional healing process takes place, and it is there that the person who is mentally and physically ill will be living with the healing community (Karim et al., 1994). With modernity, there exist some variations to this statement, if we consider modern day traditional healers who reside in cities. Thus, in most urban centres, the majority of TMPs have their place of work that sometimes either distant from or near their home (Booth, 1990). In such situations, the traditional healing process will thus occur outside the traditional healer's compound. Based on this point, Napier (2014) confirms that any healing that is performed in the traditional medical system that often happens in the healer's compound remains oriented to a group. As this happens, then the concept of the family looks like an extended family environment for the person seeking healing (Ekpunobi et al., 1990). In fact, this shows a clear difference since the patient's isolation from their community can affect their healing process, which modern medicine often does to the patient as well (Karim et al., 1994).

However, there exists other contexts in which some traditional healers decide to take their patient far away from their family and the community (Ikenga, 1981). Parrinder (1969) mentions the case of leprosy persons, or any other person whose sickness is thought to be an ancestral sanction due to stubbornness or taboo inobservance. When such people are hit by such sicknesses, they are automatically driven far away from the village, to the community's outskirts. In the mind of Twumasi (1988), healers do this because they do not want all the society to be contaminated from such ailments that have been placed on a person. However, there exist some communities throughout Africa where members believe that when a person is inhabited by evil spirits, the person possessed will present some strange behaviours that may also end turning into health issues (Mbiti, 1969). According to Mbiti (1969), epileptic people should also be taken to the peripheries of their village, which becomes an unusual

settlement for them to heal. It is therefore feasible to argue that both traditional healing and modern medical practices can quarantine a patient for suitable treatment in case there is fear they might contaminate the members of their usual family or community. Likely to PLHIV this is not the case and there is no literature that has shown that they also set-aside or far from the community. The understanding is potentially that HIV cannot be contracted just by living within society unless the PLHIV decides to practice unsafe sex, or co-uses sharp instruments like a razor, needle or so on.

Traditional healing includes the strategy of reassuring the patient that their concern is gone and their tension with family or community members is removed. In this way, Mbiti (1969) and (Ikenga, 1981) reveal that the patient can understand that internal peace with himself and harmony with family and community members have been normalised. So, social harmony and order have won over unfriendly attitudes that have been nurturing fire among people in the family and the community. To Bannerman et al. (1983), such a community congruence is achieved thanks to some special ritual ceremonies the healer had performed during the healing process that re-valued the community's cultural beliefs and ethics.

Similarly, Moshabela et al. (2017) explain that the whole process has included rituals to reassure the patient that the consequences that would devastate their entire life and relations are banned. The comfort the patient regains revives their hope. Most traditional healing practices are not conducted for protecting cultural institutions, but rather generally for allowing people to live in harmony with other members within the same clan, family, village and tribe, as well as their own inner self (Freeman and Motsei, 1992).

This traditional therapy is arguably like the social approach to treatment recommended by WHO (2018), whose main objective is to eloquently describe the disease by considering the socio-cultural perspective of the patient. African traditional healing is a holistic process through which the healer can promote people's well-being and maintain their continuity of the way in which society functions (Booth, 1990; Mbiti, 1969). A deeper understanding of this thought allows a full appreciation of the reasons why the treatment given without explanation in modern biomedical practice may cause confusion in the mind of the patient who is seeking cure (WHO, 2018).

Additionally, this may make the same patient develop the insight that the therapy they got is less effective or sometimes even improper. This idea is supported by Twumasi (1988); such a situation also depicts the main reasons why an African patient will seek a dual healing process; with a modern medical practitioner for symptoms relief and with a traditional healer to determine the origin of the sickness. The issue with this method is that the patient may not know who exactly helped them to heal.

Folk medicine and religious beliefs are often integrative parts of faith in traditional therapeutic processes (Levin, 2009). An innovative therapeutic domain in the traditional healing structure, which is faith oriented, has been shaped with the advent and the incorporation of imported and foreign religious beliefs and the traditional African healing structure (Atman, 2011 and Kinsler *et al*., 2007). In developing countries all over the world, and mostly in Africa, the role of faith in healing in this modern period has been strongly recognised (Campbell, 1998).

Most of these faith healers build on churches. This said, these healers are often visited by patients with infirmity as they seek healing. The importance of these faith healers has often been considered as non-scientific as they mostly deal with religious beliefs. According to Moshabela (2017), there still exists different notional perceptions together with the psychology that support the role and effects of faith in healing patients. For a better explanation of the connection between faith and healing, Moshabela (2017) describes the theoretical meaning of both faith and healing. In line with Hucks and Tracy (2013), the theoretical connotation of both concepts is vital for the instigation of their notional bases.

Although different religions have different faiths, there is still a certain cohesion on the way they view faith no matter their religious beliefs (Moshabela, 2017). This cohesion builds on human cognitive, mental, and emotional elements that are primarily founded in action. Considering faith as a belief channel through which an individual can express their affection and behaviours, it becomes clearer that this is an important component for getting healed (Napier, 2014; Ikenga, 1981). Moreover, when belief and trust are put into action, they create a sense of hope in an individual, which leads to optimism that makes the patient's faith grow. According to Hatala, (2012), people who work in

the healing industry have different opinions regarding the concept of healing, making the concept polysomic; the way biomedical healers see it diverges from the clinical psychological perspective. As an illustration, biomedical convention considers it as the adhesion and granulation of a local lesion, such as a dermal wound (Moshabela, 2017). On the other hand, the clinical psychology standpoint on healing is that it is an outcome, recovery, remission and cure from any health problem. Healing is considered as either a focal, systemic or something in between just to limit it to the only comprehension of traditional biomedical.

Faith can heal a patient in two ways. There exists a possibility of healing a patient by suggestion. In this way, the healer can involve the patient into some readings, discussions, recitations, mediations and concentration with the aim of impeding any impact of the sickness in the mind or body of the patient (Ekpunobi et al., 1990). Furthermore, there is a hypnosis effect. This is a healing strategy the healer applies to alter the patient's state of consciousness (Ikenga, 1981). Here, with courage, the healer will use his powers to the patient by activating his faith in order to empower him toward developing a personal psychological mechanism in order to soothe himself, and so to improve the way he copes with his pain and alleviates the symptoms caused by his sickness (Mbiti, 1969).

These intricacies of, and similarities and differences between traditional and modern medicine are negotiated by nurses when treating PLHIV, particularly in rural areas. This study will, therefore, examine these negotiations and perceptions, particularly in terms of the role of culture in health care provision to people living with HIV (PLHIV) by nurses in uMkhanyakude District, North of KwaZulu-Natal.

2.7 Culture in tradition and modern medicine

This section discusses relevant literature about modern and traditional medicines in connection with culture. Available literature describes the advantages of modern medicine because it is precise and fast when treating a given disease (Zuma et al., 2017). One of its negative sides is that over time diseases adapt to and resist drugs (Nangalama, 2016). On the other hand, traditional healing seems good because it shares the worldview and belief system of its users. This means that traditional healing

is a substitute to what its users often consider as apparent, and as an ineffective care system in the eyes of the west (Babb et al., 2007; Flint & Payne, 2013; Flint, 2015). Within the research conducted on traditional healing, many agree that it is characterised the system's confidentiality and absence of time limitations per consultation, treating patients psychologically, and scientifically unexplained physiological liberation of the symptoms of précised diseases (Summerton, 2006).

Traditional belief and culture influences people's healthcare seeking behaviour. According to Lewis and Lewis (2015:12), "culture is a decisive thought that helps humans realise the habits in which they cooperate and interrelate among themselves at family and community levels". Limited concepts of culture have reinforced most health communication, with reference to shared opinions and practices of a specific ethnicity, religion, and marginalized groups (Summerton, 2006). This is how such understandings are finally used to support practitioners and researchers to better participate with cultural groups, to overcome cultural walls with the objective of altering and adapting the actions and messages of health and patients accordingly (Dutta, 2008 and Corcoran, 2007). This study aims to understand the use of modern and traditional medicine in South Africa's rural areas and how these can be connected to the treatment of HIV/AIDS. Based on this, it then becomes crucial for the healer or the medical doctor to recognise their patients' beliefs. Such an appreciation indicates that the patient's opinions are incorporated into the treatment process, which expands the patient's satisfaction and raise their trust toward the practitioner. To this end, Zuma et al. (2017) argue that to maintain an even more ethnically and racially miscellaneous population, edifying cultural competence must be protected. This is a collaborative progression that builds on facilitating health staff's information about and gratitude of cultural differences, as well as the effect this can produce on health care system and those who are involved.

Further research shows that there is a link between health education and promotion. Yoder (1997) and Lewis (2015) confirm that media and cultural education should be framed to the comprehension of health education and promotion. The boundaries of earlier mass media tactics to health communication and the progress towards socio-ecological models (Kincaid *et al.,* 2007; Sallis *et al.* 2002) can equally support complex modern health promotion and educational movements in traditional ways (Lee *et al.,*

2017). This said, some professional health care providers who have been trained in the modern medicine seem to take for granted established systems of values that are often not common to their patients. This explains the reasons why a patient with HIV will feel frustrated, destabilised in their morality and sometimes not well communicative as they feel marginalised (Darnell, 2002). Ignoring the culture of an HIV patient will often lead the modern health care provider to impose their culture to the patient (Dutta, 2008). This is a cultural imposition, and it may lead to hindering the whole process of healing. Imposing one's culture to a patient means to impose one's beliefs and patterns of behaviour on another person who has different culture (Leininger, 1978). Consequently, the encouragement for cultural understanding in health communication is founded on the concept that communication about health should adjust to the features of a culture for its effectivity (Matthew et al., 2004). The goals of this study connect with the above as they intend to find out how modern and traditional medicine in UMkhanyakude district operates. South Africa can be connected to HIV/AIDS treatment. In brief, for the treatment to be effective, there must be good communication between the patient and the healer. Communication is part of culture; both the curer and the patient need to consider these factors.

The implementation of this concept in this research assists in understanding the ways in which the attitudes, behaviours, beliefs, knowledge, and capacity to convey health education to patients of HIV/AIDS may / may not influence how PLHIV access their medical care (Bukenya et al*.,* 2017). Based on the ideas of the different scholars presented above, it is evident that there exist some similarities between modern biomedicine and traditional medicine and that the patient's culture and beliefs should be considered. This is because, most of scholars on traditional and modern medicines have demonstrated that despite slight differences between both ways of healing, there are still many common bases among these remedies; they aim at alienating or healing a patient's ailment that causes him/her suffering.

2.8 Role of culture in health care provision to PLHIV

The role of culture in health care delivery to PLHIV is a tool that the medical care provider should use with the aim of better understanding how to satisfy the patient's aspirations regarding his sickness. Culture and health care provision overlap; they are

usually pertinent to public health because they both do help to vigorously address the patient's problem because poor health can occur in case a patient is not willing to seek preventive care or mind the nurse's recommendations regarding the disease. In line with this and recently, the United Nations General Assembly called for policies to reduce the weight of global disease weight of communicable diseases like HIV/AIDS, which necessitates a re-examination of patients-based methods used by nurses in dealing with culture and care provision (UNGA, 2011). Similarly, Orr (2006) confirms that care provision should be very much focused on culture for great success, which can often reach a meaningful and sustainable healing for the patient and giving him hope of positive health outcomes. In order to effectively use culture in health care provision, Spector (2011) supports the opinion that the health care provider must shun the culture related negative thoughts that abound in the patient's mind. By doing so, the WHO admits that the health care provider should first recognise and encourage the patient to maintain the positive points of the culture that can favour the health care provision to become more successful or effective (WHO, 2011). Indeed, sustaining the constructive sides of the culture during health care provision can create change in the minds of the patient, which certainly requires patient's personal efforts to move toward an effective culturally stranded tactic to various interventions in the sector of public health (Muula and Mfusto-Bengo, 2005). Any influence from the patient's mind of not being open or not being willing to seek appropriate medical care might hinder care provision on both sides of the health care provider and the patient themselves.

Patients should collaborate openly when they need healing; and mostly people with HIV should hurry to seek care at a medical institution (Hunt, 2000). However, most cultures will discourage patients from seeking support from a medical institution because they believe sickness can be caused by cultural factors, such as breaking taboos and not necessarily microbes. On a daily basis, many patients can only resort to seeking medical care in the last stage. Hunt (2000) states that they first keep quiet and think twice about what is going on, and then they seek advice from friends, relatives and then they meet a traditional healer for advice. According to Spector (2016), once this one fails, a PLHIV may then decide to go to a medical institution. The reason why they do not hurry to hospitals is that they think some symptoms are self-cured, and some diseases come and go on their own (Kinsler et al., 2007). Such beliefs build on culture and the latter has a great role on the minds of a patient.

Accordingly, Kleinman and Hall (2009) argue that for the medical health care provider to treat such patients effectively and efficiently, he has to appreciate the role that their culture has on them and their health care. Since culture is considered as a set that summarises the social principles, morals, and attitudes commonly shared among all the members of a given community, this encourages Hunt (2000) to support the complexity of both the role and the power of culture in health care provision. He argues that complexity resides in that culture is a whole that equally includes joint language, mores, customs, and norms that have to be acquired basically from families and communities in society. During medical provision for a PLHIV, each of these components has to be looked at meticulously and find its role in the healing process of the patient (Kinsler *et al*., 2007 and Orr, 2006).

A study with PLHIV in South Africa underlines the importance of communication in local language when dealing with this pandemic and the abilities of eased communication to reduce the burden of work while ultimately drawing the patient closer to the health care providers (Lubombo and Dyll, 2018). For example, patients know most of the herbs in their local language, but modern medicine is explained in another language which is not well-known by the majority of patients especially those in rural areas of South Africa.

2.9 Conclusion

This chapter has reviewed the literature regarding the use of modern and traditional medicine in South Africa's rural areas and how these can be connected to the treatment of HIV/AIDS. It discussed research on traditional medicine and defined some key terms. It also highlighted how traditional and modern medicine are being used to address the pandemic of HIV both globally and in South Africa. The reasons why the majority of rural South Africans seek health care from traditional healers instead of going to hospitals was also explained. One main reason is access and the other reasons centre on the role of culture and belief. The chapter examined the strong influence that culture has on the patient before and during the moment they decide to seek medical care about HIV. The points regarding the context in which traditional and modern medicine can be combined to effectively address HIV were also discussed, this included the role of religious and faith-based beliefs. Finally, the chapter

investigated the similarities and the differences between traditional and modern medicine. Both treatment approaches overlap and should complement each other in order to help patients with HIV/AIDS. The aim of reviewing this literature was to discover the connectivity between the use of both modern and traditional medicine in South Africa's rural areas and how these can apply in addressing the pandemic of HIV/AIDS. This said, the literature has shown how PLHIV generally first seek traditional healing, then turn to modern medical care because they have failed traditionally. Nonetheless, the literature review has presented some skills that are required for medical health care providers. These skills should be compulsory since they help them to support well their patients. These skills are a good tool to cope with the culture of the patient. The chapter closes with a discussion on the role culture plays in health care provision, specifically to PLHIV. This was necessary because the impact culture has on the patient and the care provider's communication can highlight how the patient can easily explain his ailment and on the other hand, the nurse to know how to address the questions of the patient. In the same vein, it was also discussed how nurses cope with their patients in case the latter are more influenced by their cultural behaviours. This implies that health care worker's (both traditional healers and biomedical) cultural competency can facilitate the process of bridging the gap between the modern and traditional medicine, and also render successful clinical outcome for patients.

This chapter has explored some of the global and local problems, as well as some of the efforts, in the negotiation of traditional and modern medicine in rural areas. The next chapter discusses how certain theoretical approaches and models have attempted to resolve these problems. This is in order to establish a theoretical foundation on which to analyse how nurses may/may not practice cultural competency in their communication with PLHIV in rural areas.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 Introduction

Local tradition and culture affect the ways in which rural South African community members seek health assistance for HIV and AIDS (Golooba-Mutebi and Tollman, 2007; Moshabela, 2016; Zuma et al., 2017). This study is therefore guided by a culture-centred approach (Dutta, 2008) that, in the context of this study assists in theorising an Afrocentric perspective in connection to African health-seeking. Culture-centred health proposes a way of recognising and correctly applying people's cultural values and practices with the sole aim of fortifying their way of seeing the world and viewpoints about health (McLaughlin & Braun 1998).

The study further adopts the model of cultural competence, and particularly that of Josepha Campinha-Bacote (2009). Her model is useful to this study in that it is a practice model that illustrates how the integration of cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters are essential in the development of cultural competence. It, therefore, provides an applied perspective in addressing some of the problems in the negotiation of traditional and modern medicine, and the communication thereof, in rural areas discussed in Chapter Two. In order to contextualise the relevance of this cultural competency model in South Africa, the study is also influenced by Thokozani Patrick Mhlongo (2016) and his application of the five characteristics of cultural competence, or what he also terms cultural sensitivity, in the South African nursing system. In this present study, the role of communication in the nurse's interaction with People Living with HIV (PLHIV) will also be investigated as it is central in establishing understanding between a health care provider and patient.

3.2 Responses to behaviour change theory

A brief explanation on the ways in which behaviour change theorists treated culture helps to present the value of culture in the more contemporary health communication.

Behaviour change theory is characterised by different models, but for the purpose of this study only two models are considered to illustrate some of this approach's main tenets, namely the Health Belief Model [HBM] (Rosenstock, 1974) and the Theory of Reasoned Action (TRA) (Fischbein, 1995). The use of HBM focuses solely on measurements and analysis of susceptibility, severity, benefit and barrier perception component (Rosenstock et al., 1994) and leaves out the influence of culture and its power in influencing health seeking behaviours of individuals. This has led to the criticism that the HBM has a weak predictive power in most areas of health-related behaviour (Tyler et al., 2006). A critical comparative meta-analysis of models of preventive health behaviour conducted by Zimmerman and Verberg (1994) reveals that the TRA has a substantially better predictor of health behaviours than the HBM (Fischbein, 1995; Fischbein and Ajzen, 2005). However, the TRA was also shown to ignore culture as an influential component of the model. Its focus was on the individual, thus overlooking the influence of cultural context. More specifically, it is based on an individual's attitudes towards certain behaviours and their motivation to undertake an action.

There are three researchers in particular that characterise the response to the inadequacies of behaviour change theories by addressing behaviour change to integrate culture. Airhihenbuwa (1995) developed the PEN-3 Cultural model which described a process for ensuring culture primarily through an educational diagnosis of health behaviours via survey, interview and community input. The second group of researchers include Kreuter, Lukwago, Bucholtz and Sanders (2003) who focused on the practical issues related to the identification and use of cultural variables in health communication and interventions, using five basic strategies to organise their approach. These include the constituent involving, evidential, linguistic, peripheral, and sociocultural factors (Kreuter et al., 2003). The third one is Dutta (2008) who developed a culture-centred approach to offer a more comprehensive effort to articulate a process for integrating culture into the research and intervention process. Regardless of the fact that all the three approaches are interconnected, this study is guided by Dutta (2008) as it encourages the consideration of culture in every process of health promotion interventions and treatment as well as in communication with patients.

Besides the role of culture in influencing the behaviours of people seeking care in particular (Smedly et al., 2003), culture can also influence those not seeking care and this could result in a death that could have been prevented or delayed (Nabieva and Souares, 2019). Since this research focuses on the use of modern and traditional medicine in addressing HIV/AIDS in rural South Africa, both practitioners should demonstrate cultural aptitude in their exercise. It then makes sense that culture is one of the main reasons that push patients to seek medical help from traditional healers in rural South Africa (Mokgobi, 2014; Moshabela et al., 2018; Zuma et al., 2017; White, 2015).

The practice of traditional medicine is dominant in Africa (Abdullahi, 2011; Mahomoodally, 2013; Mothib and Sibanda, 2019; Ozioma and Chinwe, 2019), and its influence on the treatment of illnesses by modern medicine should not be ignored. Furthermore, the role that culture plays in shaping the health-seeking behaviours of the population and the traditional beliefs regarding HIV is complex. The most dominant complexities are the myths and denial about the existence of the pandemic (Moyo and Muller, 2011), the belief that traditional medicine is a better treatment than modern medicine, while also ignoring the side-effects of the later (Zuma et al., 2017). Another challenge is the taboo that surrounds disclosing one's positive status, especially in a patriarchal society like South Africa, and specifically in a Zulu-culture dominated society.

3.3 The value of culture in contemporary health communication

Communication and culture are interlinked when patients express themselves regarding their ailments. In other words, Beach et al. (2006) ascertain that culture remains a significant factor that can quickly boost the patient to communicate effectively in the presence of a health care provider. Hence, culture can affect communication both positively and negatively, and it has power to influence the satisfactions of both the patient and the nurse.

Traditional medicine builds on culture, and when a patient must explain his suffering, culture intervenes. In this vein, we cannot understand how traditional and modern medicine are used to address HIV/AIDS and ignore how health communication and

culture are used in the process. Anderson and Dedrick (1990) disclose that modern medicine should assess the practice of traditional medicine thoroughly in rural areas regarding healers' claims of its impact on the treatment of HIV/AIDS.

There is, therefore, an urgent need to develop cultural competency amongst nurses and other care workers if they are to meet the needs of the diverse populations they serve (Dutta, 2008; Gyasi, Asante, Abass, Yeboah, Adu-Gyamfi, and Amoah, 2016). Professionals need to become more skilful in dealing with multicultural issues (Falvo & Parker, 2000; Remy, 1998, Steiner, 1997). Since this study focuses on the nurse's perspectives in HIV/AIDS treatment for the patients who also seek help from traditional healers, they should ideally demonstrate cultural competency in their practice.

Culture is one of the motives that drive clients to seek help from traditional healers (Mokgobi, 2014; White, 2015). Therefore, for nurses to be empathetic to this, they should be aware of the client's culture and develop the desire to help them regardless of whether they have sought help from traditional healers or not. Campinha-Bacote (2007) notes in this regard that the process of cultural competence in the delivery of healthcare services is a practice model of cultural competence, that it involves an ongoing process in which the nurse continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient (Campinha-Bacote, 2007).

3.4 Culture-centred approach

Central to a culture-centred approach is the understanding that communicating about health involves the negotiation of shared meanings embedded in socially constructed identities, relationships, social norms, and structures (Dutta, 2008:55). These identities, relationships, social norms, and structures are mutually interdependent. Dutta explains that the concept of culture that drives the culture centred approach foregrounds the active participation of community members in the construction of shared meanings and experiences. Culture is constituted through this act of participation and is actively constructed by its members. It is through this active participation that they create shared meanings, values, and practices. These meanings, values, and practices, in turn, constitute the culture of the community.

Cultural competency may be considered as part of the broader call for culture-centred approaches to health communication as it centralises the importance of culture (Campinha-Bacote, 2007).

Based on the above, it is evident that the culture-centred approach is appropriate to frame this study that explores how modern and traditional medicine can be used together in the villages of South Africa and how to connect them with the treatment of HIV/AIDS. The most significant matter facing modern and traditional medicine in addressing HIV/AIDS is the effort to help nurses and THPs to be more culturally sensitive when they are dealing with their patients (Evian, 2006). According to Airhihenbuwa and Webster (2012), the behaviour of individuals in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV/AIDS prevention and control efforts. Both authors support the patient-centred cultural sensitivity approach and advise that a culture-centred approach to prevention, care and support remains a critical strategy to addressing the continually unabated HIV/AIDS pandemic (Airhihenbuwa and Webster, 2012).

Scientific evidence continues to loom in presenting potential strategies to improve the patient-centred cultural sensitivity in Africa and globally. Tucker et al. (2011: 1-2) provide specific characteristics of patient-centred cultural sensitivity. “Firstly, it emphasises displaying patient-desired, modifiable provider and staff behaviours and attitudes, implementing health care centred policies, and displaying physical healthcare centred environment characteristics and policies that are culturally diverse patients’ identity as indicators of respect for their culture and that enables these patients to feel comfortable with trusting of, and respected by their health care providers and office staff. Secondly, it conceptualises the patient-provider relationship as a partnership that emerges from patient-centeredness. Thirdly, it is patient empowerment-oriented. Since this research explores how traditional and modern medicine are used in addressing HIV/AIDS, it becomes important to discuss how the disease is addressed in a culturally sensitive manner” (Tucker et al., 2011:1-2). This leads the researcher to identify available cultural forms that can help improve the way patients are cared for. Ryan (2015) and Summerton (2006) agree that the consideration of the effects of traditions and customs on the process of healing a patient cannot be overlooked. Healers/ care providers ought to understand how PLHIV

view and act according to their pathology, as this can help in improving the clinical outcome and healing strategies.

Several studies have shown that some aspects of culture can favour the spread of HIV and AIDS, as well as its healing (Joubert-Wallis, 2008; Leclerc-Madlala, Simbayi, Cloete, 2010; Pear, 2017). Some ways in which cultural practices can promote the spread of HIV are through practices involving blood and other fluids (Sovran, 2013). For example, traditional surgical practices like male circumcision and genital tattooing are potential sources of infection with serial use of unsterilized equipment and performed on groups (Feldman, 1990). Another cultural practice is the African normalisation of sexual practices. According to Gausset, (2001), the perceived sexual promiscuity of Africans comparing to the western, has been blamed for rapidly spreading the virus. This because Africans are sometimes labelled as culturally tolerant of sexual indulgence, multiple partnership and prostitution (Coetzee, Gray, Jewkes, 2017). Early marriage and coital debut have also been mentioned as a cultural practice that favours the spread of HIV/AIDS (Sovran, 2013). Similarly, widow inheritance and sexual cleansing rituals also facilitate the spread of HIV. For example, widow inheritance has been implicated in the spread of HIV/AIDS because it encourages the formation of extended sexual networks (Nyindo, 2005). The considerable chance that the death of a young husband was caused by AIDS means that widows may also be more likely to be infected (Ayikukwei, Ngare, Sidle, Ayuku, Baliddawa and Greene 2008). Gender relation and norms, as well as female genital mutilation or cutting (FGC), are cited as practices that confer vulnerability to HIV (Sovran, 2013). Some of the cultural practices cited as protective from contracting the virus are male circumcision and religion and religiosity (Sovran, 2013). The reason for this is that cultural factors are connected to most of the services HIV/AIDS patients are accessible to in the community. From rural South Africa, anecdotal evidence suggests that there exists untrustworthy claims that are linked that patients of HIV under traditional medication/healing may live longer, live a better quality of life, and upgraded health status (Zuma et al., 2017). If this belief becomes normalised, it could soon be perceived as a cultural norm and could influence the health seeking behaviours of PLHIV in one way or the other.

Hence, for modern nurses to be empathetic to this end, they must be attentive to their patient's culture and so grow the wish to assist them irrespective of whether they have received assistance from traditional healers or not. Cultural competence in the transfer of healthcare services refers to an exercise model of cultural ability as the standardised procedure through which the modern care provider uninterruptedly endeavours to accomplish the skill and convenience to work successfully within the cultural context of the patient (Goode et al., 2006). A study by Mhlongo (2016: 136) defines culture as how people do and view things in their groups or society. Within the health care context, cultural competence is seen as the process where health care personnel continuously strive to achieve the ability to work effectively within the cultural context of a client, individual, family, or community.

The researcher is aware of the three crucial pillars of Dutta's (2008) culture-centred approach as culture, agency and structure. While aspects of each are evident in the study, they will not be used as an analytical guide. The culture-centred approach is the broader theoretical guide to this study. More specifically, the cultural competence model by Campinha-Bacote (2007) that is situated in the same paradigm, offers an analytical lens to the data. Mhlongo (2016) is an important inclusion in the theoretical framework as he applies the cultural competence model to a South African nursing context.

However, the other two pillars remain relevant in that they help to understand the benefits of cultural competency in nursing associated with PLHIV for this study, and the opportunities as well as challenges in communicating culturally sensitive advice. Taking the above in consideration will ultimately help to achieve the aim of this study on documenting the ways in which negotiations between nurses and official health messages with patient's culture and beliefs does take place.

3.5 Cultural Competency Model

Campinha-Bacote (2007) developed a cultural competency model in the delivery of health care services and state that this process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.

The culture competency model proposes that traditional values are essential to the process in which the patient conceptualises the disease they have and the solutions the healer may suggest in addressing the illness (Dutta, 2008). In this way, it is reasonable that the values of a culture are not only knotted with health issues, but equally with the forms of explanations that are anticipated to address these problems. Airhihenbuwa (1995) advocates that an approach built on culture and health considers both health and culture as overlapping; they are constitutive and help each other. It echoes how people from different cultures can reflect on health and disease in their areas. The creation of a genuinely communicative space for dialogue between the healer and the patient widely opens the door to any approach based on the culture. The culture-centred method is built upon dialogical engagement between the healer and the patient, which explores how traditional medical staff listens to their patients of HIV/AIDS in their society (Bukenya *et al*., 2017). When the health care providers interconnect well with their PLHIV, the latter feel their cultural beliefs and ethics are taken into consideration (Dutta, 2008).

Cultural desire is the motivation of those healthcare professionals who want to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful, and familiar with cultural encounters (Betancourt, 2005). Regarding this research, cultural desire implies the notion of caring about how to respond to the patient's needs of seeking medical health. To Davis *et al*. (2005), communicating with a patient about his health includes a sincere cultural passion for being open and flexible and for accepting the differences in order to build on likenesses and to show goodwill of learning from them as cultural information providers. This way of learning is a long-lasting process that wants the health care provider to be humble as they aim to understand the meaning of the patient's beliefs and customs (Doorenbos et al., 2005). Health communication and culture requires some skills that a medical care provider needs to have. It could also open the door to effective communication of understanding the seeking behaviours that lead PLHIV to access help in one or both service providers, which are traditional healing and modern healing (Prejean *et al*., 2010). In order to develop culturally sensitive health care providers who can better understand the needs of villagers contaminated with HIV/AIDS, students in health care education should deal with a curriculum that details five components: cultural awareness, knowledge, desire, encounter, and skills (Jahng et al., 2004). In this study, all these

components will be discussed with the health care providers in order to explore if and/or how they may or may not be applied.

Cultural awareness is the introspection and thorough examination of one's own cultural and professional background. In this vein, this study includes interviews with nurses to explore if and how they apply them effectively. Cultural encounters can inspire health care providers to be directly involved in cross-cultural exchanges with health care seekers from various cultures (Betancourt, 2005). However, the health care provider needs to understand that interacting with some of his patients will not make them become an expert on that cultural group (Goode *et al*. 2006). Those individuals may or may not represent the stated beliefs, values, or practices of the specific cultural group encountered by the health care provider.

Cultural desire is understood in this context as the motivation of the healthcare professionals to want to (rather than have to) engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful, and familiar with cultural encounters (de Beer & Chipps, 2014). Cultural desire involves the concept of caring. It has been said that people do not care how much the person knows until they first know how much he cares (Campinha-Bacote, 1999). Cultural desire includes a genuine passion for being open and flexible with others, for accepting differences and building on similarities, and for being willing to learn from others as cultural informants. This type of learning is a lifelong process that has been referred to as "cultural humility" (Tervalon & Murray-Garcia, 1998). The cultural competence model frames this study which argues that cultural competency needs to be adopted by nurses in that it will assist communication between nurse and client and their understandings of and reasons for seeking both traditional and modern healing. Campinha-Bacote's (2007) model explains that to develop culturally sensitive nursing university graduates, the curriculum should include five components, which are cultural awareness, knowledge, desire, encounter, and skills. In this study, these principles guided the formulation of the interview questions that were asked of the nurses who participated in this study, particularly around the application of these concepts in their practice.

Cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional background. In this study, the nurses, as they are key

informants in the study, should be prompted to explore and reflect on the cultural construction of their values and health behaviours in order to sensitively approach the PLHIV's health values. Without being aware of the influence of one's own cultural or professional values, there are risks that the health care provider may engage in cultural imposition described as the tendency of an individual to impose their beliefs, values, and patterns of behaviour on another culture (Leiner, 1978). For the nurses to provide effective services to PLHIV, they must understand the reasons for the client's health-related beliefs and values. Lavizzo-Mourey (1996) supports this view, explaining that healthcare providers must focus on the integration of three specific issues in order to obtain cultural knowledge. These issues are the health-related beliefs and cultural values, disease incidence and prevalence as well as the treatment efficacy. PLHIV present their health problems to nurses during their consultation. If nurses cannot collect the relevant cultural data, as well as accurately perform a culturally physical assessment, their work could be ineffective. Leininger (1978:86) defined a cultural assessment as a systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the context of the people being served. Since nurses perform a physical assessment of ethnically diverse clients, they require cultural skills.

In this study, cultural encounters can encourage nurses to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds. A qualitative meta-analysis study conducted by Murcia and Lopez (2016) explored the experiences of nurses in care for culturally diverse families and found that experiences of nurses in care delivery to culturally diverse families was demanding and challenging because it imprints a constant tension among barriers, cultural manifestations and the ethical responsibility of care, incipiently revealing elements of cultural competency. As a group, all PLHIV are from different backgrounds, but the nurses need to be aware that interaction with three or four members of a specific ethnic group will not make them an expert on that cultural group. Those individuals may or may not represent the stated beliefs, values, or practices of the specific cultural group encountered by the nurses. In terms of the Zulu culture, many people are still different in terms of education, religious beliefs, up-bringing, as well as their social ranking in terms of economic income (Bowen, Govender, Edwards, Cattell, 2014).

Culture should be central to health communication. Emerging approaches to culture-centred health communication present alternative perspectives in which culture, rather than being seen as a barrier, is instead central to effective health communication. Culture-centred approaches provide "an avenue for opening up the dominant framework for health communication to communities and contexts that have so far been ignored, rendered silent and treated simply as subjects of health communication interventions" (Dutta 2008:14). It is, therefore, inevitable that the integration of knowledge about the importance of communication strategies and culture in health behaviour has become a critical component of HIV and AIDS prevention and care in the new millennium as such past research has investigated people's beliefs around health issues (Yoder, 1997). This study adds to that body of knowledge but from the perspective of nurses.

The five characteristics of cultural competence by Mhlongo (2016) listed in the previous chapter are also key to developing an appropriate concept that takes culture into consideration. For example, Mhlongo indicates in his study that the interaction between nurses and patients should not ignore their cultural background as this is central in establishing understanding between the two. This current research lies at the intersection between the work of Mhlongo (2016) and Campinha-Bacote (2007). The most appealing part for this study is the classification of culture as a key determinant of health seeking behaviours and satisfactory aspect for the receivers of care if the providers are culturally-competent. This concept is of interest to the current study as it investigates issues related to HIV and AIDS which remain more sensitive and stigmatising to rural communities (Li, Morano, Khoshnood, Hsieh, Sheng, 2018), ultimately leading them to seek care from traditional healers where they pay a fee and reject the free public health services.

3.6 Conclusion

The value of culture in contemporary health communication, via the culture-centred approach (Dutta, 2008) and the cultural competency models (Campinah-Bacote, 2007; Mhlongo, 2016), were explained, and included important principles and concepts that support and inform this study. Setting up a discussion with close reference to the key

theorists broadened the understanding of the role that culture plays in the provision of healthcare services to PLHIV and who reside in a rural setting where culture bounds people and influences their actions and decisions on a daily basis. Focusing on the context of a South African rural setting and on a Zulu culture; the theories help to understand the positive and negative effects of culture on HIV transmission and treatment, and the value added to this practice if both modern and traditional healthcare practitioners are culturally-aware and adopt a patient-centred approach in the delivery of care. The analysis and discussion chapters will provide clear evidence and understanding of this as the interpretation of data will be mobilised from this culture-centred perspective.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Introduction

This chapter delineates the qualitative methodological approach of the study with an explanation as to why the chosen techniques are suitable for the investigation into the ways in which culturally competent nurses can contribute to the treatment of HIV in a rural setting. It provides details on the qualitative research approach, phenomenological design, in-depth interviews (including sampling strategies) and the thematic analysis (Braun and Clark, 2006), that is presented in the following chapter in which findings are interpreted using the culture-centred approach (Dutta, 2008) and cultural competency models (Campinha-Bacote, 2009; Mhlongo, 2016). The researcher's fieldwork experiences are also recorded in this chapter.

4.2 Research paradigm: Interpretivism

Research paradigms are ways of describing a world view that is informed by philosophical assumptions about the nature of social reality (ontology), ways of knowing (epistemology), and ethics and value systems (axiology) (Patton, 2002). The paradigm in which this study is located led the researcher to ask certain questions and use appropriate approaches to conduct a systematic inquiry that is ultimately known as methodology. In other words, methods are informed by how a researcher thinks about knowledge (epistemology), and this is based on how a researcher constructs a vision of reality and their own being (ontology). Method then becomes the answer to the question, "how can we come to know it?" (Pickard, 2013).

The way in which the researcher came to *know* about nurses' experiences in treating peoples who seek out both traditional and modern medicine is through the interpretivist paradigm that is underpinned by observation and interpretation. To observe is to collect information about events, while to interpret is to make meaning of that information by drawing inferences or by judging the match between the information and some abstract pattern (Pickard, 2013). Studies within the interpretive paradigm aim to understand phenomena through the meanings that people assign to them

(Deetz, 1996). Nurses in this study shared the meaning that they attach to the phenomenon of people seeking healthcare services from two different service providers. The interpretivist paradigm stresses the need to put analysis in context and is concerned with understanding the world as it is from subjective experiences of individuals (Reeves and Hedberg, 2003:32). Researchers working within this paradigm use meaning (versus measurement) oriented methodologies, such as interviewing or participant observation, that rely on a subjective relationship between the researcher and subjects. Interpretive research does not predefine dependent and independent variables but focuses on the full complexity of human sense making as the situation emerges (Pickard, 2013). This interpretive approach therefore orients this study that aims to explain the subjective reasons and meanings that lie behind nurses' levels of cultural competency in treating PLHIV who combine both traditional and modern medicine use.

FEATURE	DESCRIPTION
Purpose	This study seeks to establish the benefits of cultural competency in nursing in relation to PLHIV, based on the experiences of nurses and PLHIV in the UMkhanyakude District.
Ontology	This study subscribes to the humanist ontological view as the nurses' values, experiences and interpretations predominate (as opposed to a deterministic ontology that gives great power to institutions and assigns less power to the role of people within these institutions). Linking to the interpretive paradigm there are multiple realities that can be explored and constructed through human interactions and meaningful actions. For this study, this interaction exists at two levels – between the nurse and patient (within the structure/institution of the health care sector and rural realities) and on another level between the nurses and the researcher.

Epistemology	This study subscribes to the subjective epistemological view. Nurses in this research process socially constructed knowledge by experiencing the real life and understood through mental processes of (subjective) interpretation.
Axiology	Research is value bond, the researcher is part of what is being researched, cannot be separated and so will be subjective. Given that this study deals with PLHIV who hail from the same cultural context with the researcher it is the researchers mandate to be conscious of this to ensure that it does not influence the views of the participants.
Methodology	Data is collected by semi-structured face-to-face interviews and reflective sessions.

Table 4.1: Summary of interpretivism characteristics in this study.

4.3 Research approach: Qualitative

The study adopted a qualitative research method as it produces thick and detailed descriptions of participants' feelings, opinions, and experiences; and interprets the meanings of their actions (Denzin, 1989). This approach is suited to my study as it aims to understand the human experience in specific settings. Qualitative researchers generally aim to answer research questions which are more concerned with meanings attributed to events and experiences as described by the participants (Barbour, 2000; Willig, 2008), which in this case are nurses who treat PLHIV seeking both traditional and modern medicine in UMkhanyakude district. Qualitative research encompasses a wide range of epistemological viewpoints, research methods, and interpretive techniques of understanding human experiences (Denzin and Lincoln, 2002). Qualitative researchers utilise specific types of data collection that allow for rich data to emerge that can be used to understand a particular phenomenon (see Cohen *et al.* 2011). In this case the phenomenon is the mixing of traditional and modern health seeking behaviours of PLHIV living in a rural area and how nurses communicate with them (from a nursing perspective). The qualitative techniques employed in this study were semi-structured interviews and direct observation.

This study adopted a qualitative approach because the researcher aimed to explore the understanding of the role of culture in health communication by nurses as they communicate with PLHIV on a daily basis. These nurses shared their experiences when they render health care services to people who concurrently use both traditional and western medicine as a form of HIV treatment. The nurses shared their thoughts and opinions about the HIV treatment that they suggested for their clients. They stated the reasons about what they think is the cause for different behaviors reflected by their patients and how they deal with them. This qualitative study therefore also aimed to document the ways in which the nurses negotiated official health messages with the patients' culture and beliefs.

4.4 Research design: Phenomenological

This study is phenomenological in nature and most of its aspects are underpinned by the principles of phenomenology which focuses on discovering and expressing essential characteristics of a certain phenomenon. In this case, the phenomenon under study is the delivery of care to PLHIV who consult with both traditional healers and modern care. Cresswell (1998:51) contends that a phenomenological study describes the meaning of the lived experiences for several individuals about a concept or the phenomenon. In the human sphere, this normally translates into gathering deep information and perceptions through inductive qualitative research methods such as interviews and observation, representing this information and these perceptions from the perspective of the research participants (Lester, 1999). Observation and interviews are the key data collection methods within phenomenological designs (Aspers, 2004). Phenomenological strategies are particularly effective at bringing to the fore the experiences and perceptions of individuals from their own perspectives, and therefore challenging structural or normative assumptions (Lester, 1999).

4.5 Data Collection: Semi-structured face-to-face interviews

Data was collected using individual semi-structured face-to-face interviews with six Nursing Initiated Management of Antiretroviral Therapies (NIMART)-trained nurses, who are the key informants for this study. All interviews were audio-recorded,

transcribed verbatim and translated from IsiZulu to English, coded and thematically analysed (Braun & Clarke, 2006).

4.5.1 Interviews

Interviews are defined as “face-to-face encounters between the researcher and the informants directed toward understanding informant’s perspective on their lives, experiences or situations as expressed in their own words” (Taylor and Bogdan 1998: 77). This approach allowed the researcher to observe facial expressions and body language which gave a better understanding of responses. Semi-structured in-depth interviews were used as they allow researchers to explore interviewee thoughts and feelings on a particular research topic (Davis, 2007). Interviews with the nurses allowed the researcher to explore their day-to-day experiences on working with PLWHIV who seek both traditional and modern medicine and if and / or how cultural competency level assists them in navigating through the care provision process and the communication approach association with this care.

A semi-structured interview guide written in IsiZulu was used to collect the qualitative data because in this method, the questions asked to the participants were opened-ended meaning that the questions are prompts that elicit responses that reflect the perspectives of each participant (Gall et al., 2003) (see appendix C). As the researcher is an isiZulu speaker and familiar with some of the issues being investigated in the study, she conducted all the interviews with the nurses individually until all six interviews were completed. During the interview, the researcher made use of an audio-recorder and field notes with the permission of each participants (as indicated in the consent form, appendix A1) for documentation of interview responses for data transcription and analysis. Fortunately, all participants had no problem of being recorded. They all spoke isiZulu which is the main language spoken and thus it was relatively easy to articulate words in their mother tongue.

As a Social Science Research Assistant at Africa Health Research Institute (AHRI) at Mtubatuba, which is the biggest employer in the uMkhanyakude District, my experience helped me to facilitate the data collection process in two ways. The interviews I conducted with community care givers and people living with long-term

chronic conditions including HIV/AIDS for a AHRI study, was an added advantage to my data collection for this research in that it provided me with interview experience. While in the field, the informed consent forms (appendix A1) were given to each participant before the commencement of the interview. All the six participants choose to be anonymous and hence I am here referring to them as P01-P06 (standing for participant number one until participant number 6 respectively),

4.5.2 Ethical considerations in data collection

Ethical considerations in research call for the researcher to engage with necessary documentation and permission letters without which the scientific values of the study can be jeopardised (see Tomaselli and Dyll, 2018). A gatekeeper permission letter was obtained from the Sub-District Office (appendix D1) and Health District Office (D2). Full approval was granted by Humanities and Social Sciences Research Ethics Committee (Protocol number: HSS/1973/018M) from the University of KwaZulu-Natal, Durban South Africa. These letters allowed me access to the clinics in the district of uMkhanyakude. Upon arrival to the facilities, I then presented the informed consent forms (appendices A1 and A2) which nurses read and those who accepted to participate signed them as a written acceptance to take part in the study. During the informed consent process, anonymity was requested and ensured, such that I am using the codes to refer to the nurses as explained in the section on sampling below.

4.6 Sampling and Recruitment

A total of six healthcare facilities were sampled for this study, one nurse from each facility was interviewed. The health facilities included three clinics and three hospitals within UMkhanyakude District. As stage one in the sampling strategy the study adopted purposive sampling to identify and select individuals that are especially knowledgeable about or experienced in dealing with people who have sought traditional healing services prior to or after their seeking modern medicine (Creswell & Clark, 2011). Stage two adopted convenience sampling which is clarified below in the discussion of the recruitment phase.

Table 4.2 below provides information on public health facilities that were visited for interviews and where nurses who participated in the study worked. Some details including the geographic location of each clinic, their headcounts, the distance between the researcher's place of work (AHRI) and the clinics, the number of professional nurses per clinic and the specific services offered are all provided in the table. Further details like participants gender, age, level of education and others, are provided in the next table found in the qualitative data analysis section.

Element	Somkhele Clinic	Machibini Clinic	Esiyembeni Clinic	Gunjaneni Clinic	Mtuba Clinic	KwaMsane Clinic
Geographical Location	Semi-Urban	Semi-urban	Rural	Rural	Urban	Urban
Catchment Area Population	17819	10 640	5 800	8219	24600	31 516
Headcount (April 2019)	4054	2 1050	860	1848	7187	4 500
On ART (April 2019)	2760	1 085	303	822	5727	4100
DoH Professional Nurses (PNs)	06	03	03	05	07	21
DoH PNs (Trained in NIMART)	06	03	03	02	06	18
Number of DoH Enrolled Nurses	02	03	01	01	06	08
Number of AHRI Professional Research Nurses	01	01	01	01	03	03
Distance from AHRI Offices to clinics	0kms	9kms	15kms	11kms	14kms	18kms
Sponsors (supporting ART Programme)	None	None	None	None	None	None
Operating Hours	10 hrs	10hrs	10hrs	10hrs	10hrs	24hrs

Open on weekends	Yes	No	For emergencies only	Yes	Yes	Yes
Issuing ART on weekends	No	No	Yes	Yes	No	No

Table 4.2: Description of sampled health care facilities

4.6.1 Recruitment and inclusion criteria

A list with clinics that have NIMART trained nurses was issued by the Africa Health Research Institute (AHRI) nursing manager. Out of the 52 provincial clinics and five hospitals in the district, AHRI has presence in 11 clinics and one hospital. All these eleven clinics were targeted for inclusion in the study. However, only six of them were included for data collection due to the availability of participants. Nurses needed to have experience or exposure to participants who previously consulted or used traditional medicine. Where the nurse was not available to be interviewed, the researcher skipped and moved to the next clinic to identify an available nurse. Since public healthcare facilities are often busy and report a shortage of clinical staff (DOH, 2016; Econex, 2015; Campbell, Ross and MacGregor, 2016), especially in remote rural areas, the recruitment was flexible and relied on convenience sampling. I called in the facilities to book an appointment with the clinic's operational managers, and upon approval of the appointment, I travelled for the meeting and presentation of the study to be conducted. The operational manager then presented a list of nurses who have completed the NIMART training and who are in the focal HIV service delivery position. Their names were compared with the list of NIMART trained nurses available at each clinic which I received from AHRI prior to conducting the study. All the names that were consistent and whose nurses were still active in their positions were then approached and introduced to the study and its purpose. After this stage, appointments were then booked with these particular nurses. Although most of them would be unavailable at the day of the interview simply due to their reported shortage of staff; the researcher moved to the next facility and flexibly shifted the appointment to the next availability of the participant.

The shortage of clinic staff and the resulting “flexible” approach resulted in time delays in data collection. Some clinics were visited several times to get access from the clinic operational manager of the clinic. In some cases when nurses agreed to the interviews, appointments were postponed several times until the researcher moved to another clinic for recruitment. P05 agreed to participate on the research study, however when the interview had to start, her busy schedule led her to ask me if she could respond to the questions while she packed treatment on the shelves. The interview continued since the participant was not too far for the recorder to capture her responses. However, I was a bit concerned about the possibility of the participant’s attention being distracted. However, the interview went well, and the nurse soon sat down as the interview was flowing.

I also observed that before the interview one of the participants asked for the permission from the patients to have an interview with the researcher. The patients agreed and waited patiently outside the consultation room. However, the participant agreed that she will use her lunch time to give the researcher time for an interview. Other participants requested their colleagues to take over with their work while they were busy in the interview. The operational managers of the clinics agreed that the research must be conducted at the clinic during work time. Also, the researcher observed that in most clinics that were visited during data collection, they were very busy since the clients were waiting in the queues.

In terms of the inclusion criteria, nurses who are working in the HIV unit within each clinic and who have been trained in NIMART and who specialises in treating people living with HIV were interviewed. Nurses who participated in this study are also aware of traditional medicine and they have knowledge about this issue. In order to take part in this research study, the participant nurses were therefore ensured that they are capable of speaking to the issues of traditional healing and that they have experience in treating patients who have previously sought traditional healing and who have also visited a public healthcare facility. This was done during the recruitment phase. The researcher clarified the objectives and aim of the study to every recruited nurse. One nurse was not eligible because he was the operating manager of the clinic. Therefore, he explained that he helps at ART department only if the nurse is not at work. Another clinic was visited, and the eligible nurse was on leave then the researcher moved to

recruit from other clinics. There were challenges on the recruitment strategy that was used in this study because some nurses were not available on the date of recruitment. That delays the data collection process.

4.7 Data analysis

Theoretical thematic analysis by Braun and Clarke (2006) was used to organise all the transcribed data. As such, concept-driven categories based on the cultural competency model directed the analysis. The first step in analysing the data for this study involved familiarising and immersing oneself with the data to be analysed. The second step involved the breaking down and coding of the data, then the patterns of all common themes were identified. The third step involved the identification of themes that shared the same words, styles and terms used by the NIMART nurses. These themes were used to set up connections guided by the culture-centred health communication approach (Braun and Clarke, 2006). Themes that emerged from the text were used, displayed in detail and then reduced to essential points under the major themes stated in the objectives. Different concepts expressed by the participants in several ways were grouped together under a single theme. Each theme was then elaborated on in more detail. The final step interpretated the thematised data through the lens of the theoretical frameworks adopted in this study (Terre Blanche et al., 2006). In other words, the culture-centred approach (Dutta, 2008) and the cultural competency model (Campinha-Bacote, 2009; Mhlongo, 2016) were mobilised in order to analyse the identified themes.

There are many reasons to adopt the use of thematic analysis in health and social aspects of health-related research. In this study, a thematic analysis of content is suitable for a descriptive presentation of qualitative data that is then analysed (Anderson 2007). The use of thematic analysis helped the researcher to organise and describe the data that she collected in a very detailed and plenteous way (Braun and Clarke, 2006).

4.8 Trustworthiness of the study

Research integrity and robustness are important in research. To ensure the trustworthiness of a study Lincoln and Guba (1981) identify four important criterions in qualitative research which are dependability, credibility, transferability and confirmability. It is important that the research remains ethical, intelligibly described and uses appropriate and rigorous methods, resulting in data that is trustworthy and acceptable. In this study, the credibility of collected data was established by way of ensuring honesty in informants when contributing data. In particular, each person who was approached was given the opportunity to volunteer participation so as to ensure that the data collection sessions involve only those who are genuinely willing to take part and prepared to offer data freely.

In addition, a transparent and explicit research procedure was maintained between researcher and participants so as to ensure consistency and dependability of results (Hammerberg and Kirkman, 2016). The responses from participants are provided verbatim as a way to demonstrate that the results were based solely on the data collected from nurses providing healthcare services to PLWHIV. Transferability according to Meriam (1998) is concerned with the extent to which the findings of one study can be applied to other situations. The researcher ensured that sufficient contextual information about the research site was provided to enable the reader to make such a transfer. The concept of confirmability is the qualitative investigator's comparable concern to objectivity. Here steps must be taken to help ensure as far as possible that the work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher (Shenton 2004) The researcher maintained an "audit trail", which documented the relevant steps taken in the process of collecting, processing and managing data.

I undertook to be impartial in the collection and reporting of data. Usefulness of the information was tested against whether it was able to provide sufficient information about the cultural sensitivity of nurses providing healthcare services to PLWHIV who seek both modern medicine and traditional medicine in rural settings. Additionally, the reliability of the study was enforced through clear explanations of the processes

undertaken to obtain data with detailed explanations about how the results were derived.

4.9 Conclusion

The chapter started by placing this qualitative study within the interpretive paradigm which is suitable for a study of this nature that is based on nurses' *experiences* of communicating with PLHIV who seek both traditional and modern treatment. It detailed the data collection process including sampling, recruitment and inclusion criteria, demonstrating that is set out with a clear vision on how to best collect data in response to the key research questions. It also explained the way in which the collected data will be analysed through theoretical (or deductive) thematic analysis in the following chapter.

CHAPTER FIVE

DATA PRESENTATION AND ANALYSIS

5.1 Introduction

This chapter presents the information collected from six nurses in six different clinics offering public health services to PLHIV who seek healthcare services from both modern and traditional health practitioners. All the nurses who participated in the study have been trained on Nursing Initiated Management of Antiretroviral Therapies (NIMART) and licensed to treat PLHIV. The study uses a nursing communication approach to explore and document the role of culture in health care provision to PLHIV in a rural setting of South Africa. The in-depth open-ended interviews produced rich data in response to the study's three key questions (that are explicated by the sub-questions presented directly under each):

1. In what ways (if any) do nurses in the UMkhanyakude District practice cultural competence in negotiating traditional and modern treatments for PLHIV[1]?
   - What is their knowledge of both traditional and modern treatments and the reasons for why PLHIV access both/either?
   - What communication approaches are used in communication about traditional and modern treatments, and what are their associated benefits and challenges?

2. In what ways (if any) do nurses in the UMkhanyakude District practice cultural sensitivity (cultural awareness, knowledge, desire, encounter and skills) in their provision of care to PLHIV?
   - In terms of *cultural awareness*, what is the role of the nurses' own personal health beliefs in her treatment of PLHIV?
   - In terms of *cultural knowledge*, in what ways (if any) do nurses assess health-related beliefs and communicate treatment efficacy?
   -In terms of *cultural desire*, what motivates nurses *to want to know* about what is important to the patient in terms of their cultural beliefs? And if there is no motivation to do so, why not?

- In terms of *cultural encounters*, what experience (if any) do nurses have in cross-cultural interactions and what does this play in their care provision?
- In terms of *cultural skills*, what communicative practices are employed by the nurses in consultations with PLHIV, and what does this communication aim to achieve?

3. What are the benefits of cultural competency in nursing association with PLHIV[3]?)
   - What are the opportunities and challenges in communicating culturally sensitive advice?

The recorded interviews from the participants were translated and transcribed into written form. Verbatim transcripts are considered both loyal and authentic, because they can be true to the intentions of the participant (Kvale 1996). Concept-driven categories based on the cultural competency model directed the theoretical thematic analysis where the researcher "identi[fied], analy[sed] and report[ed] patterns (themes) within data" (Braun and Clarke, 2006: 79). The prescribed themes to which the data speaks include: cultural competence; cultural awareness; cultural encounters; cultural knowledge; NIMART, cultural skills and communication approaches; and lastly there is a discussion on barriers to cultural competence.

5.2 Demographic characteristics

All the participants in the study were female nurses with extensive experience working with PLHIV, and they were in a position to provide insightful information on the role of culture and communication in the provision of health care services to people who are living with HIV (PLHIV). The average years of experience for nurses working with PLHIV was 11 years, with 14 years being the most experienced, while the least experienced had worked for nine years. The participants were drawn from different geographical areas within the UMkhanyakude district Municipality to give this study a diverse, comprehensive and holistic view on the topic under study.

Participants #	Age	Gender	Working experience with PLHIV	Geographical area
Participant 1	45	Female	14 years	Somkhele Area
Participant 2	49	Female	10 years	Mtuba Area
Participant 3	53	Female	10 years	Kwamsane Area
Participant 4	45	Female	9 years	Gunjaneni Area
Participant 5	59	Female	13 years	Esiyembeni Area
Participant 6	48	Female	11 years	Machibini Area

Table 5.1 Summary of research participant demographic information

5.3 Thematic Analysis and Discussion

This section presents and discusses each pre-determined theme identified above. These themes are analysed with evidence from interview excerpts and in relation to the research objectives, through the theoretical lens of the of the culture-centred approach to health communication (Dutta, 2008) and the cultural competency model (Campinha-Bacote, 2007; Mhlongo 2016) as well as in 'conversation' with the literature that was reviewed in Chapter Two.

5.3.2 Cultural competence

Nurses are primary caregivers and have a key role in providing care in a culturally diverse healthcare system, such as in South Africa (de Beer and Chips, 2014). Therefore, it is important for nurses working with PLHIV to understand the cultural background and social norms of their patients in order to intervene accordingly. Culture is an important component of meaning construction connected to health in a social context and also when constructing a personal understanding of health and illness. For nurses in South Africa, understanding culture helps them to gain the fullest understanding of PLHIV as social and cultural beings. Cultural competence refers to the knowledge and skills nurses should possess in order to care for patients from a

cultural background different from their own (Campinha-Bacote, 2002). Papadopoulos (2006) adds that cultural competence in nursing refers to the ability to take into account patients' cultural beliefs, behaviours and needs in order to provide efficient healthcare.

Five of the six nurses are Zulu, one of them hailed from a ….. background and so in terms of language and ethnic culture, those who were of Zulu origin shared the same background as many PLHIV in the area. The acquisition of cultural competency is referred to across different cultures. In this study the idea of "cultural background" is used quite liberally in that is also includes religious beliefs and other perspectives. For example, although part of the Zulu cultural group, a nurse may be from a 'different cultural background' as a rural Zulu PLHIV who seeks traditional medicine, as she operates from a modern medical orientation. Furthermore, being Zulu does not exclude the fact that some may have adopted the culture of other tribes where they grew up.

Some of the nurses in the current study demonstrated the importance of being culturally competent, and this generally entails the process in which they continuously strived to work effectively within the cultural context of PLHIV. Accordingly, one of the nurses indicated that:

> It helps you to know the patient's cultural beliefs because you cannot advise a person with something that he doesn't believe in you must advise him with something he believes in. you don't need to generalise so that you can be specific on your advice to him (Participant 5, interview, 09/09/2019).

Another nurse further reported that, "[y]ou tell him about the importance of taking his treatment obvious you cannot take him away from the traditional things (Participant 1, interview, 16/05/2019).

This is in line with de Beer and Chips' (2014) findings that cultural competence begins with an awareness of nurses own cultural beliefs and practices, with the recognition that patients from other cultures may not share these. Consequently, working within a cultural competency framework is important for nurses as it makes it possible for them to provide appropriate and holistic care for PLHIV with diverse values and beliefs. Nursing has always stressed the importance of rendering culturally conscious care that

respects individual differences and incorporates one's own values, beliefs and lifestyles and practices into the delivery of health care. In support, participant 2 reported that:

> I always try to find all about what the patient believes in and try to add our beliefs together and try to make them understand and show him the right way without making him feel bad or judging what he believes in and end up on the same page (interview, 20/08/2019).

Similarly, Vanderpool (2005) found that providing culturally competent care, nurses should be willing and able to provide family- and patient-centred care by adjusting their attitudes and behaviours to the needs of diverse patient groups. This means that nurses need to incorporate important values such as caring, empathy, truthfulness and respecting PLHIV choices that can ultimately promote their autonomy to make informed decisions. Thus, the process of becoming a culturally competent nurse must begin with a careful examination of ones' own beliefs, values and intentions. Nurses work with people in a variety of settings and frequently interact with groups and subgroups whose thinking, beliefs, values, habits, language are different from their own. Nurses, therefore, need to provide holistic, individualised nursing care to PLHIV in South Africa, taking into consideration their cultural and ethnic background. This ultimately makes their intervention not only effective but culturally-centred. Ultimately it is important for nurses to work towards achieving cultural competency in nursing patients of diverse cultures by referring to individual knowledge, skills, values and behaviours and organisational management and operational frameworks and practices (Munoz et al, 2009).

5.3.2.1 Complexity of Cultural Competence Negotiation

Some of the nurses practice cultural competence in negotiating with the traditional and modern treatments for PLHIV by working collaboratively with traditional healers as most of patients tend to consult these traditional healers:

> So, we have that challenge however, we are trying since we are working hand in hand with traditional healers because we know some of them do referrals of patients to clinics. Sometimes you find that a person has shingles and most of those people when

> coming to clinic they say that they have started consultation with traditional healers for *ukugcaba*[2](Participant 3, interview, 02/09/2019*).*

Caring for patients from diverse backgrounds is a daily reality for nurses who are expected to provide both clinically safe and culturally sensitive care (de Beers and Chips, 2014). Cultural competence in nursing refers to the ability to take into account people's cultural beliefs, behaviours and needs in order to provide efficient healthcare, and it is not simply a skill but a process. In essence, cultural competence for the nurses working with PLHIV begins with an awareness of their own cultural beliefs and practices, with the recognition that PLHIV from other cultures may not share these.

The nurses in the study report that they frequently use collaborative engagement with the PLHIV to communicate about the traditional and modern treatments and encourage PLHIV to seek support from family and friends:

> It happens that a person has received counselling but when you ask him about the time he will take treatment at. Then, you start noticing that the person is not ready for taking treatment then I have to start afresh giving him counselling. What I have discovered is that others have problems with taking treatment because they don't have people to trust at home. They have no one to tell, another person maybe has a problem with the partner or maybe at home they don't believe in traditional medicine. If the person opened up I usually encourage him/her to get someone who he/she will talk to at home so that person will help him/her (participant 4, interview, 04/09/2019)

According to Cang-Wong et al. (2009) communication is the central factor in providing cultural competent care to patients. Therefore, the nurses in the current study used collaborative engagement through counselling to communicate about traditional and modern treatment and the benefit of this was that it enabled the patients to open up about the traditional medicine that they were also using for HIV.

Campinha-Bacote's (2002:182) model of cultural competency is regarded as a process rather than an end point in which professional nurses continuously strive to achieve the ability to effectively work within the cultural context of an individual or community from a diverse or ethnic background. Cultural competency, as highlighted by the

[2] Translation: Cutting the skin to put some traditional medicine or muti in the human body.

nurses in the current study, is an ongoing process which must be continually monitored, reviewed and adapted to meet the specific cultural needs of PLHIV. Although the nurses did not provide a direct account on how they follow a process with PLHIV, that is ongoing, monitored and evaluated; they reported that their NIMART guideline provided details on steps to follow and that they have been adhering to it. Therefore, it is important that nurses should always strive to achieve competency when working with PLWHIV of diverse cultures by referring to individual knowledge, skills, values and behaviours and organisational management and operational frameworks and practices (Munoz et al., 2009:499).

5.3.3 Cultural awareness

Cultural awareness is the process of self-examination and exploration into ones cultural and professional background (Campinha-Bacote, 2002). Hence, it is essential for nurses working with PLWHIV to be aware of their own cultural orientation in order to be able to understand that it can have a significant influence on their patients' culture. The majority of nurses in the study indicated that it is important on their part to be culturally sensitive or aware of PLHIV cultural background as this is vital when working with them. Cultural sensitivity/awareness implies an awareness of nurses own cultural orientation as well as their alertness to the differences of perception, values and beliefs of their patients. Therefore, cultural sensitivity is part of the process towards cultural competence. The nurses demonstrated the aspect of cultural awareness by accepting some of the traditional medicine being used by PLHIV. One of the nurses indicated that:

> The patient didn't want to stop using his *Ndayela*[3] then I said you must take both. Just take the pill at its time and this *Ndayela* too then we will see what will happen. Because I was shocked since he was not failing for resistance test he didn't resist to any of the drugs so it means the problem was the compliance. So, I asked him to take the pills with that *Ndayela* tea (Participant 2, interview, 20/08/2019).

In the same vein, another participant further reported that:

> *Unwele* is a plant that most people used those herbs before ARVs. Others they talk about *izambane* (a potato) they say it's a tree with a husband, unfortunately, I never

[3] Translation: Traditional medicine made of herbs.

> see that tree. It is a sort of a root they call it *izambane*. It was also effective, but they are not talking much about them (Participant 5, interview, 09/09/2019).

This is in line with Nota's (2019) findings that gaining an understanding of patients' health-related beliefs and values should involve a consideration of their world views and the patient's world views will explain how they makes sense of illness (HIV) and how it guides their seeking for medical care. Consequently, on the part of the nurses working with PLHIV this essentially becomes important when giving diagnosis, explaining health-related issues, explaining illness and wellness to patients.

Therefore, the development of cultural awareness on the part of the nurses enhances the nurse-patient relationship and facilitates the caring process (Campinah-Bacote, 2002). In the nurse-patient relationship, the values of both the nurse and the patient come into play because both are members of cultural groups. Hence, some of the nurses in the current study respected, accepted and allowed PLHIV to subscribe and practice their traditional beliefs by using their traditional medicine to complement the ARVs. The cultural awareness on the part of nurses that ethnic groups have culturally prescribed beliefs and practices related to health is important. Health and illness are culturally defined the same as traditional practices that promote and prevent illness. Therefore, a culturally competent nurse should assess each patient individually and not make assumptions about a patient's beliefs and health practices (de Beer and Chips, 2014). The cultural awareness of the cultural beliefs of PLHIV, can influence nurses to integrate these beliefs so as to intervene holistically.

5.3.4 Cultural encounters

It is important to highlight that nurses have their own beliefs; however, they should ensure that these beliefs are not imposed on the patient. In support, participant 1 indicated that:

> Isn't the patient most important? I don't know how I can explain but my culture shouldn't interfere like if I am a Christian then I want someone to be a Christian too. As per our training we not allowed to make people change their beliefs and you must treat people equally (interview, 16/05/2019).

The above excerpt directly speaks to the issue of cultural encounters that is an integral part of the study and it illuminates an instance where there is a cross-cultural interaction and the nurses thought process in their care provision. Camphinha-Bacote (2002:182) highlighted that cultural encounters involve direct interaction with patients from diverse cultural groups.

Cultural encounters refer to the process where the healthcare provider deliberately engages in cross-cultural interactions with clients from diverse backgrounds (Kardong-Edgren and Campinha-Bacote, 2008). On the contrary, Nota, (2019) states that nurses should be conscious that interactions with two or three persons from a different cultural background does not make them an expert in that culture. It is always important for nurses working with PLHIV to see them as individuals with different cultural backgrounds and beliefs that are unique. Maier-Lorentz (2008:38) maintains that cross-cultural communication involves several aspects that should be understood in order to achieve cultural competency.

Cultural encounters show an intense cultural desire on the part of nurses to want to learn about the different cultures of their patients. Thus, it is also important to briefly focus on cultural desire which is the degree to which nurses seek to be culturally competent when working with PLHIV. Some of the participants demonstrated the need to know about what is important to PLHIV in terms of their cultural beliefs and their deliberate efforts to find out:

> It helps you to know the patient's cultural belief because you cannot advice a person with something that he doesn't believe in you must advise him with something he believes in. You don't need to generalise so that you can be specific on your advice to him (participant 5, interview, 09/09/2019).

> However, I am not quite sure, but I heard someone saying he is taking *Vukuhlale*, the medicine that is bought from people or from the chemist and another one is that drops that I forgot its name (participant 4, interview, 04/09/2019).

Consequently, the nurses' desire can influence their ability to work well with PLHIV who may hold different traditional practices or religious beliefs to themselves. Marcinkiw (2003:180) highlights that if nurses have a true aspiration to work with

culturally diverse patients, the patients will feel greater support and understanding if cultural aspects are included in the creation of health plans. Similarly, Tortumluoglu (2006:11) maintains that cultural desire is the spiritual pivotal construct of cultural competence that provides the energy source and foundation for one's journey towards culture competence. While, Campinha-Bacote (2011) indicates that cultural desire is the driving force for becoming educated, skilled, competent, and aware of culture; it also entails a willingness to have transcultural interactions. When nurses are culturally sensitive, they are willing to address PLHIV with respect and without assumptions. Some of the nurses in this study demonstrated a personal and deliberate willingness to explore and have an awareness of their patients' cultural beliefs.

5.3.5 Cultural knowledge

An important basic characteristic of cultural competence is cultural awareness, which entails the acceptance, respect and valuing of differences which can be gained by learning more about something (de Beers and Chips, 2014). The study revealed that a lack of cultural knowledge on the part of some of the nurses was detrimental in their capacity to learn and understand the importance of traditional medicine used by PLHIV. Some of the nurses in the current study did not know some of the traditional medicine that PLHIV were using, and they lacked the cultural desire to learn about them. The following excerpts demonstrate the lack of cultural knowledge by nurses:

> No, there is nothing I have ever suggested as much as I am working in the department of health. Even culturally, I have never used traditional medicine, so I have never told my patient to use traditional medicine because even myself I am not using it (Participant 3, interview, 02/09/2019).

> I do not know any traditional medicine; I would be lying and I do not speak about traditional healers because I do not know them (Participant 6, interview, 15/09/2019).

This was the reason that some nurses imposed ARVs on PLHIV as they were not knowledgeable of the effectiveness of traditional medicine that some PLHIV used. One participant indicated that "if you are HIV positive you must choose and forget the traditional beliefs and all the other stuff" (Participant 1, interview, 16/05/2019).

Lack of knowledge about other cultures, religions and perspectives, as well as generalisations based on limited experiences, negatively affect the quality of care provided to PLHIV in South Africa. This lack of knowledge could lead to an inability to provide culturally competent care that in turn can lead to conflict, increased levels of anxiety, and stress among nurses, patients and patients' relatives (de Beers and Chips, 2014).

Gaining this understanding of patients' health-related beliefs and values entails considering their world views as it links to how they make sense of illness and guides their expectations for medical care. The perception and aspects of African culture is grounded in the firm belief in traditional culture, hence it is not surprising that PLHIV in rural areas seek the services of traditional healers in HIV counselling, support and treatment (Peltzer, 2009). This becomes essential for nurses when giving a diagnosis, explaining health-related issues, explaining illness and wellness to patients.

Pinikahana, Manias and Happel's (2003:150) study found that it is important for nurses to have sound knowledge of cultural values, beliefs, practices and attitudes in order to respond effectively to the needs of patients. The value of their response is linked to their communication approach.

5.3.6 Cultural skills, NIMART and communication

In December 2009, the South African government set ambitious goals of testing 15 million people for HIV and expanding ART initiation to 2000 PHC facilities that previously could not offer this service. This required a drastic increase in the number of nurses trained in Nurse Initiated and Managed Antiretroviral Therapy (NIMART). Part of the initiative for NIMART was for nurses to be culturally competent and develop cultural skills when working with PLHIV. Some of these cultural skills included the respect of privacy and confidentiality of PLHIV, non- judgement attitude, being aware of their culture, values and biases and cultural-specific knowledge. This is indicated by the participants below.

> Mmm even though the training is not that much based on that topic, but they said that when a person comes to you and say that my culture goes like this you must not oppose him/her because at the end his/her word must be the last one. That's why when

> a person has tested positive we ask if he/she is ready or not to start taking pills and he/she must say when he/she is ready and if not ready you cannot force a person to take the pills if he/she is not ready yet he/she says that he needs time or if he is still using other things, there are such people (Participant 6, interview, 15/09/2020).

> Yes, it was very informative because you should take culture of the patient into consideration for him/her to gain focus. (Participant 3, interview, 02/09/2019)

> [W]hen they are training us, they say you must be in a person's shoes so that he couldn't say you are judgmental. I think the benefit is to know to respect another person by respecting and accepting him as a human (Participant 2, 20/08/2019).

NIMART was identified as a key strategy to decentralise HIV treatment to primary health care centres with the ultimate goal of universal access to HIV treatment (Smith, Matshikwe and Letsoalo, 2011). Erasmus (2013) indicates that in 2010, nurses began initiating ARVs to patients after they had received NIMART training, in order to bridge the gap between knowledge and practice.

Therefore, NIMART training was important for the nurses to understand that everyone has a culture, and for them to provide culturally appropriate care. In essence, nurses are compelled to understand their own culture and that of the nursing profession. Values such as caring, empathy, truthfulness, promoting health and autonomy, and respecting PLHIV choices influence how a nurse interacts with PLHIV. Caring for patients from diverse backgrounds is a daily reality for nurses who are expected to provide both clinically safe and culturally sensitive care. Consequently, NIMART training assisted nurses in providing culturally competent healthcare to PLHIV in South Africa.

This study found that some of the nurses adopted a dialogic communication approach when treating PLHIV:

> The communication is two way. The consulting room that we use keep the sound out without being heard outside. I wanted to maintain the confidentiality so no one can hear that the patient is infected (Participant 4, interview, 04/09/2019)

> There is nothing except communicating with a person and understanding his/her background, but you should also tell him/her about the importance of what you have. You must also listen what he/she is saying because I do not know some of the things in as much as I am a Zulu speaking person, but you must listen and then tell him/her about its disadvantages, you see that (Participant 3, interview, 02/09/2019).

Active listening and collaboration were used by the nurses in the current study as cultural skills to learn about the cultural beliefs of PLHIV. According to Manganyi (2013) nurses must listen and ask questions from patients in order to collect relevant data from the client. This is in line with the findings by Dogan, Tschudin, Hot and Ozkan (2009:690) study who found that nurses require cultural skills to explore the meaning of illness, determine patients' social and family contexts, and provide patient-centred and culturally competent care as an aspect of ethical responsibility. Campinha-Bacote (2002) indicated that doing a cultural assessment requires skills in order to obtain accurate information from the patient which ultimately helps in formulating a mutually acceptable and relevant treatment plan for each patient problem.

The intersection and interrelatedness of the culture-centred approaches' three concepts of agency, structure and culture creates space for diverse PLHIV to be heard, and their cultural beliefs to be integrated into mainstream structures that are mostly Eurocentric and in favour of the bio-medical methods of treatment. Cultural competence interventions need to focus on addressing structural barriers to ensure cultural appropriate health education materials, improving the medical referral process (Betancourt et al., 2002). There are many structural barriers facing PLHIV which has a negative impact on their help seeking behaviour and this include the design, and functioning of the healthcare system, including; the intake process, waiting period for appointments, referral methods, and continuity of care (Nota, 2019). The current study mainly focused on culture while being conscious and aware of the interrelationship of all the three concepts of culture centred approach.

Importantly before proceeding to the next section it is essential to outline the benefits and challenges of cultural competency in nursing association with PLHIV in rural areas in South Africa. Cultural competence assists professional nurses to understand patients' needs and to plan the nursing care considering the cultural differences of

patients. According to Barbee and Gibson (2001) there is need to recognise that talking and writing about cultural competence without forthrightly dealing with it in nursing education and practice are essentially empty exercises that would continue to perpetuate the status quo. Therefore, nursing should include cultural content within undergraduate training in South Africa in order to provide culturally appropriate care to patients (Zwane and Poggenpoel, 2000).

The next section focusses on the barriers and challenges of adopting cultural competency and efficient communication in rural settings where nurses negotiate tradition and modern medicine with PLHIV.

5.4 Barriers to cultural competence

There are many barriers to cultural competence that were evident from the interviews with the nurses. They include; cultural imposition, negative attitudes towards traditional medicine, lack of trust, lack of cultural desire. These themes are presented underneath.

5.4.1 Cultural imposition

Some of the nurses imposed their own beliefs on the PLHIV, which was primarily informed by their influence from the Eurocentric biomedical worldview. Even in the nursing profession, there is a tendency to lean towards ethnocentrism (Solomon, 2017). Ethnocentrism is the propensity of an individual or group to believe that ones' own culture is the most desirable, acceptable or best and act in a superior manner to the other cultural group (Solomon, 2017). This can prompt cultural imposition, that is, the inclination for nurses to impose their beliefs, values and patterns of behaviour upon PLHIV. “Cultural imposition is the tendency of an individual to impose their beliefs, values, and patterns of behaviour on another culture” (Campinha-Bacote, 2002:182).

Particular nurses in the current study felt that ARVs were the only effective medicine for PLHIV and in the process inadvertently labelled traditional medicine ineffective. As discussed above these nurses treat the PLHIV with low levels of knowledge of different cultures and belief in the superiority of their own ethnocentric culture that is biased

towards the nursing profession. One of the participants in the study indicated that "[they] tell them that ARVs works effectively if you are taking them alone not mixing with other things" (Participant 1, interview, 16/05/2019).

Other nurses reiterated that they:

> Usually discourage them from mixing treatment because if you further probe a person who has high viral load, the problem is that he mixed the treatment by using herbs and our treatment. Then, our treatment (ARVs) becomes ineffective then the person develops multi-organ failure and his liver and kidneys become damaged (interview, participant 2, 20/08/2020).

While another nurse revealed that:

> Yes, if he is not adhering, he will be in trouble because the more he takes more tablets it is adding many complications, so you make sure you take them accordingly. So, in other words it means I am discouraging the intake of other treatment indirectly that could have impact on the failure of ARVs (Participant 4, interview, 04/09/2019).

The findings are confirmed in a study done in Limpopo by Manganyi (2013), which found that some nurses imposed their beliefs on patients without being aware of the risk of engaging in cultural imposition.

The cultural imposition of beliefs, practices and values on PLHIV by some of the nurses, is because they believe that their ideas are superior and that they are experts. This cultural imposition has severe ethical and professional implications since the patient has both a human right and a cultural right to have his or her cultural values and way of life taken into consideration in nursing practice. Sealey, Burnett and Johnson (2006:131) indicate that nurses should provide care that is culturally competent; with emphasis on considering the cultural needs of the patients because the patients' compliance and response to treatment will be influenced by their culture. Some of the nurses in the study discouraged the use of traditional medicine because they felt that it was relatively ineffective as compared to ARVs. This is illustrated with:

> So, usually, we discourage them even though they believe in such things, but we make it clear that they shouldn't mix treatment. I was raised by my grandmother and she was a Christian and didn't believe in such a thing (Participant 2, interview, 20/08/2019).

The negative attitude held by the above nurse towards traditional medicine is apparent and the repeated use of the words '*such things'* clearly shows that traditional medicine is regarded as worthless. Likewise, another participant further condemned and discouraged the use of traditional medicine by PLHIV. She indicated that:

> Yes, even though its rare, we try to discourage it. We tell them that it is not good to use them concurrently because you can hear that they use ARVs and traditional treatment concurrently. Then, traditional medicine flushes ARVs in your blood and they become ineffective (Participant 3, interview, 02/09/2020).

A number of nurses in the current study are working with an assumption that traditional medicine is ineffective, and this leads to stereotypical behaviour. Stereotypical attitudes are not based on reality. Aspects of PLHIV beliefs that differ from the nurses can lead to negative stereotyping. If nurses base their nursing practice on stereotypes, the result can be ineffective care. There is not only a set of beliefs about others which are captured in stereotypes, but there is also a deeply felt set of feelings about what is good and bad, right or wrong, moral and immoral. It seems that some of the nurses' negative attitudes towards traditional treatment is underpinned by their strong adherence to modern medicine which is based on its perceived efficacy, as well as the complications brought on by the combination with traditional medicine. On the contrary, there seems to be an "increased popularity of traditional medicine which has created the need for patients to receive accurate information from professional nurses who work on the front lines of mainstream medicine" (Sibiya, Maharaj & Bhagwan 2017:18–19). Therefore, respect for the uniqueness of PLHIV is central to effective nursing care. Consequently, it is vital for the nurses to have an understanding of negative attitudes that hinder the provision of culturally competent nursing care for PLHIV.

This negative attitude towards traditional medicine by nurses in the current study might indicate the challenge of including traditional medicine in the health sector in South Africa. Another probable reason for the negative attitude by nurses towards traditional treatment for PLHIV is the lack of education and training on the effectiveness of the traditional medicine. This is supported by Hall and colleagues (2017:47) that "nurses' attitudes towards traditional medicines indicates that nurses have very limited education in this field and a lack of professional frameworks to assist them." Even after

education and training some scholars argue that nurse's negative attitudes and behaviours in the healthcare setting do not necessary change (Jonas et al., 2018, Mulaudzi et al., 2018, Lesedi et al., 2011).

PLHIV's decision not to follow biomedical oriented treatment (ARVs) was one of the reasons that PLHIV were labelled as noncompliant by some of the nurses in the current study. This can be considered an ethnocentric judgement on the part of the nurses, which is based on the assumption that biomedicine is superior compared to PLHIV health cultural values, beliefs and practices. Nursing diagnosis of non-compliance violates the concept of cultural competence and severely inhibits the ability of nurses to provide holistic and culturally sensitive care. Therefore, despite nurses being trained according to Eurocentric nursing care principles and practices, they can strive to become culturally competent when working with PLHIV of diverse cultures.

The findings suggest that the negative attitudes towards traditional medicine by some of the nurses was a significant barrier for them to work in a culturally competent manner that respected the cultural beliefs of PLHIV. Some researchers such as Müller et al. (2016) strongly support the strategy of educating and training of nurses in order to mediate their values and beliefs in the clinic setting.

5.4.2 Lack of trust as an impediment to dialogic communication

The discussion above on the nurses' communication approaches shows that many of the nurses believe in the value of dialogue with their patients. However, the findings also indicated that the nurses believe that the PLHIV do not trust them to share with them information on whether they use traditional medicine or not. This suggests that some patients would rather keep this information to themselves as nurses appear to judge. The minority of nurses in the current study revealed that:

> You not even aware because they don't tell you anything, they don't explain about their consultations with traditional healers. We don't discuss anything about traditional treatment because they hide from us (Participant 1, interview, 16/05/2019).

> Honestly, patients do confess and tell you that this is what I am using (Participant 6, interview, 05/09/2019).

PLHIV will not reveal much about themselves to a nurse whose communication shows bias, condescension or lack of respect. If the relationship was positive PLHIV would be able to share some of the traditional medicine they are using to complement the ARVs. In some instances, traditional medicine is blamed for the non-compliance to ARVs by the nurses. This is indicated by one of the participants in her explanation that they “reinforce the adherence however there are many cases of defaults as per my observations because of traditional medicine” (Participant 2, interview, 20/08/2019).

This means that there is a lack of collaboration between the nurses and PLHIV, and the nurses are not keen to discuss anything that has to do with traditional medicine. A study conducted in Switzerland revealed that the majority (70%) of nurses surveyed never asked patients about traditional medicine use, either because they did not feel it was relevant, or their responsibility (Jong et al., 2015:642). Healthcare professionals who lack cultural competence may be putting PLHIV at risk for delays in treatment, inappropriate diagnosis, non-compliance with healthcare regimens, and even death of patients. The fact that the PLHIV do not always disclose their use of traditional medicine further complicates this communication process as it negates the opportunity for dialogue that may allow for more cultural competency.

In healthcare, trust is imperative, and most of the time PLHIV are vulnerable and seeking answers. Trust is necessary in order to support them and provide the best care for the best outcomes possible. A positive relationship has a significant impact on PLHIV experience and sets the tone for overall satisfaction. Hence, nurses need to build trusting relationship with PLHIV as this enhances nurses understanding of their cultural beliefs and could importantly provide insight into traditional medicine.

5.5 Conclusion

In order to render culture-competent care to PLHIV in South Africa, nurses must be aware and cognisant of Campinha-Bacote’s five constructs comprising of cultural awareness; cultural knowledge; cultural encounters; cultural skill, and cultural desire. The findings in the current study demonstrated that nurses need to learn cultural competency concerning the PLHIV they work with, in order to be able to learn to appreciate diversity, avoid prejudice and provide culturally sensitive care to PLHIV.

The study further demonstrated that it is important for nurses to recognise and respect PLHIV cultural values in order to render culturally competent care and to prevent cultural imposition. However, patient also have the responsibility to speak openly with nurses. The next chapter elaborates on the study's overall findings.

CHAPTER SIX

CONCLUSION

6.1 Summary and synthesis of study findings

The value of cultural competence for nurses providing services to PLHIV cannot be over-emphasised. Since its outbreak, HIV/AIDS has affected South Africa negatively and rural areas are bearing the burden. Hence, finding possible solutions to respond to the challenges caused by HIV is crucial. The results of this study are summarised under three main points including: efforts in practising cultural sensitivity in the UMkhanyakude District for nurses providing care to PLHIV; the benefits and opportunities for cultural competency in nursing association with PLHIV; and challenges and barriers in communicating culturally sensitive advice.

6.1.1. Efforts in practising cultural sensitivity in the UMkhanyakude District for nurses providing care to PLHIV

Results in this study have shown that nurses caring for PLHIV in the district of UMkhanyakude do attempt to practise cultural sensitivity. However, many aspects were missing in their practice to ensure a complete, cultural sensitivity component including open attitudes, cultural self-awareness, cultural knowledge (which includes an understanding of the cultural language, values and non-verbal behaviour of PLHIV patients), cultural desire and barriers dialogic communication (most often based on the limited time they could spend with patients). In this study, some nurses were found making assumptions about their patient's cultural practices and beliefs, for others it was hard to build trust and rapport with their patients. However, nurses acknowledged the importance of being culturally aware and this was consistent with Nota's (2019) findings suggesting that in order to gain understanding on the health care seeking behaviour and beliefs of the patients, their views of the world and that of the patients should be considered in addition to the explanation of how they make sense of illness and how it guides their seeking for medical care. Campinah-Bacote (2002) concurs also that the development of cultural awareness on the part of the nurses enhances the nurse-patient relationship and facilitates the caring process just as it was encouraged in this study.

Some of the nurses believe that traditional medicine is part of their culture but they are not confident that it can respond to the medical need for PLHIV. The culture-centered approach gives room for the creation of processes and spaces where local marginalised voices can be heard and play an important role in the development of indigenous solutions that are specific to the community needs (Dutta and Thaker, 2016). An important process that nurses could take up is the use of cultural assessments that allows for agency to PLHIV to actively engage in the treatment process research so that they have a sense of ownership in the intervention and possibly come up with culturally specific health-related solutions to HIV within their communities, alongside the uptake of ARVs. However the nurses reported that they are not provided with the necessary cultural assessment tools.

In this study, some cultural competence was displayed by the nurses but one of the weaker components is cultural knowledge. This is consistent with a study in South Africa by van Rensburg, Razlog and Pellow (2020) which found that the majority (57%) of nurses reported having little to no knowledge of traditional medicine. The nurses fail to recognise the variations among cultures which is attributed to a lack of cultural knowledge, and it was evident that cultural differences exist between nurses and PLHIV. The results showed that nurses in uMkhanyakude district practice cultural competence in negotiating traditional and modern medicine for PLHIV through communication that lacks awareness and knowledge of the patients' culture. PLHIV access both traditional and modern treatment because they believe in their tradition more than modern world. The challenges associated with the acquiring cultural knowledge is the nurses the negligence in learn more about traditional medicine. The study revealed that a lack of cultural knowledge from the nurses which was detrimental in their capacity to learn and understand the importance of traditional medicine used by PLHIV. Some of the nurses did not know some of the traditional medicine that PLHIV were using, and they lacked the cultural desire to learn about them. This impacted negatively on benefits and opportunities for cultural competency in nursing associated with PLHIV, most of which would yield positive results from both providers and receivers of relevant healthcare services.

The study therefore concludes that the benefits of cultural competency in nursing associated with PLHIV should not be ignored. Nurses providing healthcare services to PLHIV should be trained and deemed culturally competent prior to them being service providers. According to the results in this study, cultural competence allows the nurses to communicate efficiently with the clients and drugs the client closer and ultimately willing to take up all services heartedly. Healthcare professionals who lack cultural competence may be putting PLHIV at risk for delays in treatment, inappropriate diagnosis, non-compliance with healthcare regimens, and even death of patients. The fact that the PLHIV do not always disclose their use of traditional medicine further complicates this communication process as it negates the opportunity for dialogue that may allow for more cultural competency.

6.1.2 Benefits and opportunities for cultural competency in nursing association with PLHIV

The findings are interesting in the context that the nurses and the patients are all Zulu people, yet some of the nurses displayed ethnocentrism in terms of identification with western or modern medicine. Professional nurses should understand patients' cultural background and needs when providing nursing care because a lack thereof could result in interpreting the patients as uncooperative, difficult or stubborn (Manganyi, 2013). The nurses' attitudes affect their success in gathering data on cultural competency for nurses. Consequently, nurses who lack cultural competence may place patients at risk for delays in treatment due to non-compliance with healthcare regimes as the patient feels imposed upon by modern medicine and as a reaction resists it (de Beers and Chips, 2014).

Findings from this study, however, showed that there are some benefits and opportunities for a good clinical outcome of PLIHV when nurses communicate efficiently and clearly with them. One of the great potential benefits is the rapport built between nurses and patients which allows the patient to open up and disclose the types of traditional medicine that they are taking jointly with the modern medicine being provided by the nurse. Hence, if nurses could communicate efficiently, change their attitudes toward PLHIV who seek both traditional and modern medicine, be willing to learn about their cultures and accommodate the patients views of the world, this opens

up an opportunity for satisfactory treatment and benefits to both clients and service providers. This further exacerbates the already existing challenges and barriers in communicating culturally sensitive advice by nurses to PLHIV in rural areas of UMkhanyakude district in South Africa.

6.1.3 Challenges and barriers in communicating culturally sensitive advice

A number of challenges are faced by nurses in their attempt to communicate culturally sensitive advice to patient and vice-versa. While studies show that language is a main barrier, this study revealed that the assumption by patients of the nurses' attitudes towards traditional medicine hinders the establishment of rapport. The nurses reported that they believe their patients are often not truthful about the traditional medicines they use. The reason for this may be the Eurocentric judgment that is assumed of the nurses, but that the nurses do at times display, as revealed in this study.

Some nurses explained that they do attempt to adopt a dialogic form of communication with their patients, but the barriers mentioned above is an impediment. Another challenge is the limited time that the nurses have in their consultations with PLHIV,

Other barriers include a limited application of full aspects of the cultural-centered approach and cultural competency model (Dutta, 2008). The analysis revealed that nurses did not apply all the five characteristics of cultural competence by Mhlongo (2016), reflected through a failure to display the practising of an integrated model (Campinha-Bacotte, 2009) of cultural awareness, cultural encounter, cultural desire and cultural knowledge which are all crucial in the development of cultural competency. Hence, these theories and approaches should be translated into practice and implemented for use by nurses who provide healthcare services to PLHIV who use both traditional and modern medicine jointly.

6.2 Suggestions for Further Research

Further studies using quantitative methodologies should be conducted in order to determine if these results are general to all NIMART nurses in the country or a specific case to uMkhanyakude district.

A study documenting traditional health practitioners' perceptions of nurses who provide healthcare services to PLHIV is needed to pave the way for a collaboration between both services providers. In order to avoid contradicting each other; nurses should collaborate with traditional health practitioners on possible ways to co-serve PLHIV in rural areas of South Africa.

Based on the findings in this study; nurses providing services to PLHIV in rural areas of South Africa should be trained in cultural competency for them to be efficient in their work and render services that are satisfactory. Results from this study encourage research involving participatory workshops that aim to establish best ways in which this can be done. For the purpose of this study, this means that nurses need to build trusting relationship with PLHIV as this enhances nurses understanding of their cultural beliefs and could provide insight into traditional medicine. Training to increase nurses' awareness of cultural features is crucial as it might facilitate the communication between health services providers and receivers which is ultimately an important component of quality healthcare. Hence, training opportunity for all nurses beyond that of NIMART is recommended.

7. References

Abdullahi, A.A. (2009). Trends and challenges of traditional medicine in Africa. *Afr. J. Tradit Complement Altern Med*, 8: 115–123.

Abdullahi, A.A. (2011). Trends and challenges of traditional medicine in Africa. *Afr. J. Tradit Complement Altern Med*, 8: 115–123.

Airhihenbuwa CO., Ford CL., Iwelunmor JL. (2014). Why culture matters in health interventions: Lessons from HIV/AIDS stigma and NCDs. *Health Education and Behaviour*, 41(1):78-84. [http://dx.doi.org/10.1177/1090198113487199]

Airhihenbuwa, C.O & Webster, J.D. (2012). Culture and African context of HIV/AIDS prevention, care and support. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*. 1(2004):4-13. https://doi.org/10.1080/17290376.2004.9724822

Airhihenbuwa, C.O. (1995). *Health and culture: Beyond the Western paradigm*. Thousand Oaks: Sage.

Alexander, G.R. (2008). Cultural competence models in nursing. *Critical care nursing clinic Northern America,* 20(4): 415-421

Altman K. (2011). Government plans random AIDS tests for 45,000 in U.S. *New York Times.* June 6, 2011. Available at: www.nytimes.com/1987/06/06/us/government-plans-random-aids-tests-for-45000-in-us.html. Accessed October 20, 2018.

AMREF. (2009). *Strengthening the capacity of traditional health practitioners to respond to HIV/AIDS and TB in Kwazulu-Natal, South Africa*. AMREF Case Studies Series, Volume 1, Nairobi.

AMREF. (2007). *Evaluation report on the Umkhanyakude traditional healers project*. Amref.org/download/51402d60a16c6. AMREF Nairobi.

Anderson J. (2012). Women and HIV: motherhood and more. *Current Opinion in Infectious Diseases. 25 (1): 58–65.*

Anderson, LA and Dedrick, RF. (1990). Development of the trust in physician scale: a measure to assess interpersonal trust in patient-physician relationships*. Psychological Reports*; 67:1091–1100. doi: 2466/PR0.67.7.1091-1100.

Anderson, R. (2007). *Thematic content analysis (TCA). Descriptive presentation of qualitative data*. Unpublished article. Retrieved from: http://rosemarieanderson.com/wp-content/uploads/2014/08/ThematicContentAnalysis.pdf

Ashforth, A (2002). An epidemic of witchcraft? Implications of AIDS for the post-apartheid state. *African Studies*, 61(1): 121-143

Aspers, P. (2004). Empirical Phenomenology: A qualitative Research Approach (The Cologne Seminars). *Indo-Pacific Journal of Phenomenology*, 9(2):1-12. doi: 10.1080/20797222.2009.11433992

AVERT (2018). *What are HIV/AIDS: Global information and education on HIV and AIDS*. Retrieved from https://www.avert.org/about-hiv-aids/what-hiv-aids

Ayikukwei R., Ngare D., Sidle J., Ayuku D., Baliddawa J., Greene J. (2008). HIV/AIDS and cultural practices in western Kenya: the impact of sexual cleansing rituals on sexual behaviours. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*.10(6):587–599

Babb DA, Pemba L, Seatlanyane P, Charalambous S, Churchyard GJ, Grant AD. (2007). Use of traditional medicine by HIV-infected individuals in South Africa in the era of antiretroviral therapy. *Psychol Health Med*. 12(3):314–320. https://doi.org/10.1080/13548500600621511

Bannerman, R. H. O., Burton, J., & Ch'en, W. C. (1983). *Traditional medicine and health care coverage: A Reader for health administrators and practitioners*. Geneva: World Health Organization.

Barbee, E.L & Gibson, S.E. (2001). Our dismal progress: The recruitment of non-whites into nursing. *Journal of Nursing Education,* 40(6), 243-244.

Batisai, K. (2016). Towards an integrated approach to health and medicine in Africa. *SAHARA Journal*. 13(1):113-122.

Beach, M.C., Saha, S., Cooper, L. (2006). *The role and Relationship of cultural competence and Patient-Centeredness in Healthcare Quality*. Commonwealth Fund; The Commonwealth Fund

Bertozzi, S., Padian, N.S., Wegbreit, J., DeMaria, M.L et al., (2006). *HIV/AIDS Prevention and Treatment: Disease Control Priorities in Developing Countries*. 2nd Edition. New York: Oxford University Press.

Betancourt, JR. (2005). Racial and ethnic disparities in health care: No one suspect, no one solution. Delaware Medical Journal. 77:333–334.

Betancourt, JR., Green, AR and Carrillo, EJ. (2002). *Cultural competence in health care: emerging frameworks and practical approaches*. New York: The commonwealth Fund.

Bink, M.C.A.M., Uimari, P., Sillanpää, M., Janss, L. and Jansen, R., (2002). Multiple QTL mapping in related plant populations via a pedigree-analysis approach. *Theoretical and Applied Genetics*, 104(5):751-762.

Bonder, Bette & Martin, L. & Miracle, A. (2001). Achieving cultural competence: The challenge for clients and healthcare workers in a multicultural society. Generations. 25. 35-42.

Booth, N. (1979). *African Religions New York*: NOK Publishers International pp: 6-1

Bowen, PA., Govender, R., Edwards, JP., Cattell, K. (2014). An integrated model of HIV/AIDS testing behaviour in the construction industry. *Construction Management and Economics* 32(11):1106-1129

Braun V & Clark, V (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3 (2):77-101.

Braun V & Clark, V (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*. Vol, 3 (2):77-101.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology,* 3**,** 77-101.

Brody, D., Miller, S., Lerman, C., Smith, D., Lazaro, C., & Blum, M. (1989). The Relationship between Patients' Satisfaction with Their Physicians and Perceptions about Interventions They Desired and Received. *Medical Care, 27*(11), 1027-1035. Retrieved June 15, 2020, from www.jstor.org/stable/3765522

Brumann, C. (1999). Writing for culture: Why a successful concept should not be discarded. *Current Anthropology*: 40.

Bukenya D, Wringe A, Moshabela M*, et al* (2017). Where are we now? A multi-country qualitative study to explore access to pre-antiretroviral care services: a precursor to antiretroviral therapy initiation Sex. *Transm Infect* 93: e052970.

Burman, C. (2018). An evaluation of the innovative potentials of a HIV pilot exploring medical pluralism in rural South Africa. SAHARA-J: *Journal of Social Aspects of HIV/AIDS*. 15: 164-178. 10.1080/17290376.2018.1536560.

Campbell-Hall V, Petersen I, Bhana A, Mjadu S, Hosegood V, Flisher AJ. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: Developing a workable partnership for community mental health services. *Transcult Psychiatry*. (4): 610–628. https://doi.org/10.1177/1363461510383459

Campbell, C & Mzaidume, Y. (2002). How can HIV be prevented in South Africa? A social perspective. *BMJ*, 324(7331):229-232

Campbell, C. (2003). Why HIV prevention programmes fail. Student *BMJ*. (11):437-480.

Campbell, L.M., Ross, J.A & MacGregor, R.G. (2016). The Umthombo Youth Development Foundation, South Africa: lessons towards community involvement in health professional education. *Afr J Health Professions Educ*, 8(1):50-55. DOI:10.7196/AJHPE. 2016.v8i1.559.

Campbell, T. (1998). Technology, multimedia and qualitative research in education. *Journal of Research on Computing in Education*: 30 (9): 122-133.

Campinha-Bacote, J. (2011). Delivering patient-centered care in the midst of a cultural conflict: the role of cultural competence. *Online Journal Issues Nursing*, 16: 5.

Campinha-Bacote, J. (2008). *The process of cultural competence in the delivery of healthcare services*. Retrieved from: http://transculturalcare.net/the-process-of-cultural-competence-in-the- delivery-of-healthcare-services/

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of transcultural nursing*, 13**,** 181-184.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, *38*(5): 204- 207.

Cang-Wong, C., Murphy, S.O & Adelman, T. (2009). Nursing responses to transcultural encounters: What nurses draw on when faced with a patient from another? *Perm J*, 13(3):31-36.

Chacko, E. (2003). Culture and therapy: Complementary strategies for the treatment of type-2 diabetes in an urban setting in Kerala, India. *Social Science & Medicine*, *56*:1087-1098.

Chalhoub-Deville, M., & Deville, C. (2008). Utilizing psychometric methods in assessment. In E. Shohamy, & N.H. Hornberger (Eds.), *Encyclopedia of language and education* (2nd ed., Vol 7:211-224). New York, NY: Springer Science + Business Media LLC.

Coetzee, J., Gray, E.G., Jewkes, R. (2017). Prevalence and patterns of victimisation and polyvictimisation among female sex workers in Soweto, a South African township: a cross-sectional, respondent-driven sampling study. *Global Health Action*, 10(1):1403815

Cohen, L., Manion, L., & Morrison, K. (2011). *Research methods in education* (7th ed.). London: Routledge

Collins O. Airhihenbuwa, RO. (2012). A Critical Assessment of Theories/Models Used in Health Communication for HIV/AIDS. *Journal of Health Communication,* 5(1): 5-15, DOI: 10.1080/10810730050019528

Cook, C. (2009). Sangomas: Problem or solution for South Africa's health care system. *Journal of the National Medical Association*: 101:261-265.
Corcoran, S. (2007). Achieving cultural appropriateness in health promotion programs: targeted and tailored approaches. *Health Educ. Behav*.30:133-46.
Craig P, Dieppe P, Macintyre S, *et al.* (2008) Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ*. 337:a1655.
Cresswell JW, Plano Clark VL. (2011). *Designing and conducting mixed method research*. 2nd Edition, Sage; Thousand Oaks, CA.
Creswell, J.W. (1998). Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks, CA: Sage.
Cross T.L., Barbara, J., Bazron, KW.,Mareasa, R.I (2009). Towards a culturally competent system of care. Washington: *National Institute of Mental Health, Child and Adolescent Service System Program*. 1989:13
Cross, N. and Roy, R. (1989) *Engineering design methods* (Vol. 4). New York: Wiley.
Darnell T. (2003). Multiple QTL mapping in related plant populations via a pedigree-analysis approach. *Theoretical and Applied Genetics*, 104(5):751-762.
Davies, M. B. (2007). *Doing a Successful Research Project*. New York: Palgrave Macmillan.
Davis, K., Schoenbaum, S.C. and Audet, A.-M. (2005), A 2020 Vision of Patient-Centered Primary Care. *Journal of General Internal Medicine*, 20: 953-957. doi:10.1111/j.1525-1497.2005.0178.x
Davy C, Harfield S, McArthur A, Munn Z, Brown A. (2016) Access to primary health care services for Indigenous peoples: A framework synthesis. *Int J Equity Health*. 15(1):163-171
Dayer-Bereson, L. (2010). *Cultural competencies for nurses: impact on health and illness*. Sadbury: Jones and Barlett.
De Beer, J & Chipps, J. (2014). A survey of cultural competence of critical care nurses in Kwazulu-Natal. *South Africa Journal of Critical Care* 30(2): 20-29. DOI:10.7196/SAJCC.188
De Beer, J. & Chipps, J. (2014). A survey of cultural competence of critical care nurses in KwaZulu-Natal. *South African Journal for Critical Care*, 30(2), 50-54.
Denzin, N. K. (1989). *Interpretive interactionism*. Newbury Park, CA: Sage.
Denzin, N. K., & Lincoln, Y. S. (2002). *The qualitative inquiry reader*. London: Sage Publications.
DOH. (2017). *UMkhanyakude health district report*. Retrieved from: http://www.kznhealth.gov.za/umkhanyakude.htm
DOH. (2016). *Health sector HIV prevention strategy 2016*. South Africa: National Department of Health.

DOH. (2010). *Operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa*. South Africa: National Department of Health.
Donev, D. (2014). Toward the fourth dimension of health – the spiritual health. *Vox Medici*. 23:318–21
Doorenbos, AZ., Schim, SM., Benkert, R., Borse, NN. (2005). Psychometric evaluation of the cultural competence assessment instrument among healthcare providers. *Nursing Research*. 54:324-331. Doi:10.1097/00006199-200509000-00006
Drimie, S. (2002). *The impact of HIV/AIDS on rural households and land issues in South Africa and Eastern Africa*. Pretoria: Human Sciences Research Council. Retrieved from http://www.fao.org/wairdocs/ad696e/ad696e00.HTM
Dubos, R. (1965). *Man adapting New Haven*: Yale University pp: 17-19

Dutta, M. (2008). *Community health: A culture-centred approach*. Cambridge. Polity Press
Dutta, M. & Thaker, J. (2016). Culture-centered method: The nuts and bolts of co-creating communication infrastructures of listening in communities.
Ekpunobi, E. et al. (1990). *Socio-philosophical perspective of African Traditional Religion*. Enugu: New Age publishers.
Erasmus, J. (2013). Biomedical interventions contributing to “getting to zero”, AfroAIDSinfo. Issue 13 no. 12, Science (Open access).
Evian, C., (2006). *Primary HIV/AIDS care: a practical guide for primary health care personnel in a clinical and supportive setting* (Updated 4th ed.). Houghton [South Africa]: Jacana. p. 29. ISBN 978-1-77009-198-6
Fassin, D., Schneider, H. (2003). The politics of AIDS in South Africa: beyond the controversies. *BMJ*. 326(7387):495-497.
Fatti, G, Bock, P, Grimwood, A, Eley, B. (2010). Increased vulnerability of rural children on antiretroviral therapy attending public health facilities in South Africa: a retrospective cohort study. *Journal of international AIDS Society*. 13:46. http://www.jisociety.org/contect/13/1/46
Fauci, S.A & Folkers, K.G. (2009). Investing to meet the scientific challenges of HV/AIDS. *Health Affairs*, 28(6) https://doi.org/10.1377/hlthaff.28.6.1629
Feldman, D.A. (1990). *Culture and AIDS*. New York: Praeger
Fishbein, M. (1995). Developing effective behavior change interventions: some lessons learned from behavioral research. *NIDA Research Monograph*, vol. 155, pp. 246-61
Fishbein, M. & Ajzen, I. (2005). Theory-based behavior change interventions: comments on Hobbis and Sutton. *Journal of Health Psychology*, vol. 10, no. 1, pp. 27-31
Flick, U. (2011). *Introducing research methodology: A beginner’s guide to doing a research projec*t. London: SAGE Publications Ltd.
Flint AG, Payne JR. (2013). Reconciling the irreconcilable? HIV/AIDS and the potential for middle ground between the traditional and biomedical healthcare sectors in South Africa. *Forum Develop Stud*. 47–68. https://doi.org/10.1080/08039410.2012.702681
Flint AG. (2015). Traditional healing, biomedicine and the treatment of HIV/AIDS: Contrasting South African and Native American Experiences. *J Environ Res Public Health*. 12(4):4321–4339. https://doi.org/10.3390/ijerph120404321.
Flint, K. (2013). *Healing traditions: African Medicine, cultural exchange, and competition in South Africa, 1820-1948*. Athens: Ohio University Press.
Freeman M. and Motsei, M. (1992). Planning health care in South Africa – is there a role for traditional healers? *Social Science and Medicine 34: 1183-1190*
Gaede, M.B. (2016). Doctors as street-level bureaucrats in a rural hospital in South Africa. rural Remote Health, 16(1),3461.
Gausset Q. (2001). AIDS and cultural practices in Africa: the case of the Tonga (Zambia). *Social Science & Medicine*. 52(4):509–518
Geubbels E, Bowie C. (2006). Epidemiology of HIV/AIDS in adults in Malawi. *Malawi Med J*. 18(3):111–133.
Golooba-Mutebi, F and Tollman, S. (2007). Confronting HIV/AIDS in a South African village: The impact of health-seeking behaviour. *Scandinavian journal OF public Health Supplement*. (69):175-180. Doi:10.1080/14034950701355437.
Goode, TD., Dunne, MC., Bronheim, SM. (2006). *The evidence base for cultural and linguistic competency in Health Care*. The commonwealth Fund.
Govender, E. (2010). How effective is HIV and AIDS communication in Africa. *African Communication Research*, 3(2):205-234
Govender, E. (2018). Methodology is the engine of your study. In Keyan, G. Tomaselli: *making sense of research*. South Africa: Van Schaik Publishers.

Gqaleni, N. et al. (2007). Traditional and complementary medicine: Health care delivery. *In S. Harrison, R. Bhana, & A. Ntuli (eds.), South African health review* (175-188). Durban: Health Systems Trust.

Grünkemeier, E. (2013). *Breaking the Silence: South African Representations of HIV/AIDS*. Woodbridge: Boydell and Brewer.

Guba, E.G., 1981. Criteria for assessing the trustworthiness of naturalistic inquiries. *Ectj*, *29*(2), pp.75-91.

Gumede, MV. (1990). *Traditional healers: a medical practitioner's perspective*. Braamfontain: Skotaville.

Gustafson, D.L. (2005). Transcultural nursing theory from a critical cultural perspective. *Advances in Nursing Science*, 28:2-16.

Gyasi, M.R., Asante,F., Abass, K., Yeboah, Y.J., Adu-Gyamfi, S & Amoah, A.P. (2016). Do health beliefs explain traditional medical therapies utilisation? Evidence from Ghana. *Cogent Social Sciences*, 2:1209995 http://dx.doi.org/10.1080/23311886.2016.1209995

Haile, K.T., Ayele, A.A., Mekuria, A.B., Demeke, C.A., Gebresillassie, B.M. and Erku, D.A. (2017). Traditional herbal medicine uses among people living with HIV/AIDS in Gondar, Ethiopia: Do their health care providers know? *Complementary therapies in medicine*, 35:14-19.

Hall, H. I., Song, R., Rhodes, P., Prejean, J., An, Q., Lee, L. M., Karon, J., Brookmeyer, R., Kaplan, E. H., McKenna, M. T., Janssen, R. S., & HIV Incidence Surveillance Group (2008). Estimation of HIV incidence in the United States. *JAMA*, *300*(5):520–529. https://doi.org/10.1001/jama.300.5.520

Hammarberg, K., Kirkman, M. and de Lacey, S. (2016). Qualitative research methods: when to use them and how to judge them. *Human reproduction*, 31(3): 498-501.

Harris, N.L., Jaffe, E.S., Diebold, J., Flandrin, G., Muller-Hermelink, H.K., Vardiman, J., Lister, T.A. and Bloomfield, C.D., (1999). The World Health Organization classification of neoplastic diseases of the hematopoietic and lymphoid tissues: report of the Clinical Advisory Committee meeting, Airlie House, Virginia, November 1997. *Annals of Oncology*, *10*(12):1419-1432.

Hatala, A. (2012). The status of the Biopsychosocial model in Health Psychology: towards an integrated Approach and critique of cultural conceptions. *Open Journal of Medical Psychology* pp: 51-62.

Holeman, I & Kane, D (2019): Human-centred design for global health equity, Information Technology for Development, DOI: 10.1080/02681102.2019.1667289

Hopa, M. et al. (1998). Perceptions on integration on traditional and western healing in the new South Africa. *South African Journal of Psychology*, 28 (1): 8-14.

Hucks, P. and Tracy, E. (2013). Habitations of the Sacred: African approaches to disease and healing complex disease. *Harvard Divinity Bulletin Autumn* Vol-41.

Hughes, Z. (2018). Antiretroviral therapy in the treatment of HIV and AIDS. *Ausmed*. Retrieved from https://www.ausmed.com/cpd/articles/antiretroviral-therapy

Hunt, LM. et al., (2000). Herbs, prayer and insulin: Use of medical and alternative treatments by a group of Mexican American Diabetes patients. *The Journal of Family Practice*; 49 (3): 216-223.

Ikenga-ME. (1981). *God and man in African Religion* London: Geoffrey Chapman.

Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press (US).

Jahng, K., Martin, L., Golin, C & DiMatteo, M. (2005). Preferences for medical collaboration: Patient-physician congruence and patient outcomes. *Patient education and counselling*. 57:308-314. DOI10.1016/j.pec.2004.08.006.

- Johnson, L.F., Dorrington, RE, Moolla, H, (2017) 'Progress towards the 2020 targets for HIV diagnosis and antiretroviral treatment in South Africa.', South African Journal of HIV Medicine, Volume 18, Issue 1, p.2078-6751.

Jonas, K., Crutzen, R., Krumeich, A., Roman, N., Van Den Borne, B. & Reddy, P. (2018). Healthcare workers' beliefs, motivations and behaviours affecting adequate provision of sexual and reproductive healthcare services to adolescents in Cape Town, South Africa: a qualitative study. *BMC health services research,* 18**,** 109.

Jong, M., Lundqvist, V. & Jong, M. (2015), 'A cross-sectional study on Swedish licensed nurses' use, practice, perception and knowledge about complementary and alternative medicine'. *Scandinavian Journal of Caring Sciences* 29(4), 642–650.

Joubert-Wallis, M. (2008). *The contribution of culture to the spread of HIV*. Unpublished Master of Science degree submitted at the University of South Africa (UNISA).

Kanu, I. A. (2013). The dimensions of African cosmology. *Filosofia Theoretica: Journal of African Philosophy, Culture and Religions*, *2*(2), 533-555.

Kardong-Edgren, S. & Campinha-Bacote, J. (2008). Cultural competency of graduating US Bachelor of Science nursing students. *Contemporary Nurse,* 28**,** 37- 44.

Karim, S. et al. (1994). HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response. *The Lancet*: 374: 921-933.

Kincaid, D.L., Figueroa, M.E., Storey, D. and Underwood, C. (2007). *A social ecology model of communication, behavior change, and behavior maintenance*. Working paper. Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.

Kinsler, J. J., et al. (2007). The effect of perceived stigma from a health care provider on access to care among a low-income HIV-positive population. *AIDS Patient Care STDS*, 21: 584-592.

Klaas, N. E. (2017). *The role of culture and gender in the spread of HIV and AIDS and strategies for the reduction of HIV and AIDS among farm workers in South Africa*. University of South Africa, Pretoria, http://hdl.handle.net/10500/23590

Kleinman, A., & Hall-Clifford, R. (2009). Stigma: A social, cultural and moral process. *Journal of Epidemiology and Community Health*, 63: 418-419.

Kreuter, M., Lukwago, S., Bucholtz, D., Clark, E., & Thompson Sanders, V. (2003). Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education & Behavior*, 30 (15):133-146

Kristina, H. Jahng, Leslie R, Martin, Carol E, Golin,M. Robin DiMatteo. (2004). Preferences for medical collaboration: Patient-physician congruence and patient outcomes. *Patient Education and Counselling*, 57:308–314. doi: 10.1016/j.pec.2004.08.006.

Kumanyika, S. K. (2003). Commentary: Cultural appropriateness: Working our way toward a practicable framework. *Health Education & Behavior*, 30, 147-15

Kunda, J., Tomaselli, K.G., Lagerwerf, L., Boer, H. and Wasserman, H. (2009). Social representations of HIV/AIDS in South Africa and Zambia: Lessons for health communication. Health communication in southern Africa: *Engaging with social and cultural diversity*, 11:93.

Kvale, S. A. (1996). *Interviews: An introduction to qualitative research interviewing*. Sage.

Leclerc-Madladla, S., Simbayi, L., Cloete, A. (2010). *The sociocultural aspects of HIV/AIDS in South Africa*. in book: HIV/AIDS in South Africa 25 Years On. Springer, Psychosocial Perspectives.

Lee, C.B., Bendixsen, C., Liebman, K.A & Gallagher, S.S. (2017). Using the Socio-Ecological Model to Frame Agricultural Safety and Health Interventions. *Journal of Agro medicine*, 22(4):298-303. doi: 10.1080/1059924X.2017.1356780

Leininger A. (1978). A Serious Valuation of Models Applied in Health Communication for HIV/AIDS, *Journal of Health Communication*, 5:5-15, DOI: 10.1080/10810730050019528.

Leninger, M. (2006). *Transcultural Nursing: Theories, concepts and practices*. New York: Wiley and Sons. (3rd Ed.).

Lesedi, C., Hoque, M. & Ngcobo, B. N. (2011). Youth's perception towards sexual and reproductive health services at Family Welfare Association centres in Botswana. *Journal of Social Sciences,* 28**,** 137-143.

Lester, S. (1999). An introduction to phenomenological research. Taunton UK, Stan Lester Developments.

Lewis S. (1992). *Discovering our human tapestry: a cultural competence curriculum*. Newark, NJ: National Pediatric and Family HIV Resource Center.

Lewis, B & Lewis, J. (2015). Media, Culture and Communication in Health Promotion. *In Health Communication: A media and cultural studies approach*. United Kingdom: Palgrave.

Li, Z., Morano, J.P., Khoshnood, K. et al. (2018). HIV-related stigma among people living with HIV/AIDS in rural central china. *BMC Health Services Research*, 18(453): https://doi.org/10.1186/s12913-018-3245-0

Liddell, C., Barrett, L., & Bydawell, M. (2005). Indigenous representations of illness and AIDS in sub-Saharan Africa. *Social Science and Medicine*, 60(4): 692-695.

Lindquist, R., Fran Tracy, M., Savik, K. & Watanuk, S. (2018). 'Regional use of complementary and alternative therapies by critical care nurses', *Critical Care Nurse* 25(2), 63–75.

Lubombo, M. & Dyll, L.E (2018). A Dialectic Analysis of Views on Participation in HIV/AIDS Communication of Selected South African People Living with HIV/AIDS: Beyond the Greater Involvement of People Living with HIV/AIDS, *Critical Arts*, 32(2):100-118, DOI: https://doi.org/10.1080/02560046.2018.1434218

Mahomoodally, F.M. (2013). Traditional medicines in Africa: An appraisal of ten potent African. *Medicinal Plants*. (2013):617459. https://doi.org/10.1155/2013/617459

Maier-Lorentz, MM. (2008). Transcultural nursing: its importance in nursing practice. *Journal of Cultural Diversity* 15(1):37-43.

Manganyi, T. (2013). *The Knowledge of Professional Nurses about culture competent care at selected medical wards, Oncology wards and outpatient department in Mopani District, Limpopo Province*. Unpublished Masters Dissertation, University of South Africa.

Maphumulo, T.W., Bhengu, R.B. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: a critical review. *Curationis* 42(1): doi: 1901.https://doi.org/10.4102/curationis.v42i1.1901

Marcinkiw, KL. (2003). A goal for nursing education. *Nurse Education Today* 23(3):174-182.

Matthew. W, et al. (2004). *The role of culture in health communication. Health Communication Research Laboratory*. Missouri: Department of Community Health

Maxwell, J. A. (2012). *Qualitative research design: An interactive approach*. London: Sage.

Mc Laughlin, L., & Braun, K. (1998). Asian and Pacific Islander cultural values: Considerations for health care decision-making. *Health and Social Work*. 23 (2):116-126.
Merriam, S.B. *Qualitative research and case study applications in education*, San Francisco: Jossey-Bass, 1998.
Mhlongo, P.T. (2016). Cultural competency in South Africa: A nursing education perspective. *Research on Humanities and Social Sciences*. 6(16): 135-145.
Mnggundaniso, N & Peltzer, K. (2008). Traditional healers and Nurses: A qualitative study on their role on sexually transmitted infections including HIV and AIDS in KwaZulu-Natal, South Africa. *Journal of Traditional, Complementary and Alternative Medicines*, 5(4):380-386
Mohapi, J.B & Pitsoane, M.E. (2017). Life skills as a behavior change strategy in the prevention of HIV and AIDS: perceptions of students in an open and distance learning institution. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*. 16(1):77-84 doi: 10.1080/17290376.2017.1374878.
Mokgobi, M. (2017). Health Care Practitioners' Attitudes towards Traditional African Healing. J Altern Complement Integr Med 3: 025.
Mokgobi, M.G. (2014). Understanding traditional African healing. *African Journal for physical health education, recreation, and dance*. 20(2):24-34
Mokgobi, MG. (2012). *Views on traditional healing: Implication for integration of traditional healing and Western medicine in South Africa*. Unpublished PhD Thesis submitted at University of South Africa, Discipline of Psychology.
Moshabela M, Pronyk P, Williams N, Schneider H, Lurie M. (2011). Patterns and implications of medical pluralism among HIV/AIDS patients in rural South Africa. *AIDS Behav*. 15(4):842–852. https://doi.org/10.1007/s10461-010-9747-3
Moshabela, M., Zuma, T. (2017). Patterns and implications of medical pluralism among HIV/AIDS patients in rural South Africa. *AIDS and Behavior*: 15 (4): 842-852.
Moshabela, M., Zuma, T., Gaede, B. (2016). Bridging the gap between biomedical and traditional health practitioners in South Africa. *Health Systems Trust*: *South Africa Health Review*, pages 83-92.
Mothibe, E.M. and Sibanda, M. (2019). African Traditional Medicine: South African Perspective. *Traditional and Complementary Medicine*, Cengiz Mordeniz, IntechOpen, DOI: 10.5772/intechopen.83790. retrieved from: https://www.intechopen.com/books/traditional-and-complementary-medicine/african-traditional-medicine-south-african-perspective
Mottiar, S & Lodge, T. (2018). The role of community health workers in supporting South Africa's HIV/ AIDS treatment programme. *African Journal of AIDS Research*, 17:(1) 54-61, DOI: 10.2989/16085906.2017.1402793
Mulaudzi, M., Dlamini, B. N., Coetzee, J., Sikkema, K., Gray, G. & Dietrich, J. J. (2018). Perceptions of counsellors and youth-serving professionals about sexual and reproductive health services for adolescents in Soweto, South Africa. *Reproductive health,* 15**,** 21.
Müller, A., Röhrs, S., Hoffman-Wanderer, Y. & Moult, K. (2016). "You have to make a judgment call".–Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa. *Social Science & Medicine,* 148**,** 71-78.
Mulwo, A.K., Tomaselli, K.G., Francis, M.D. (2012). HIV/AIDS and discourses of denial in sub-Saharan Africa: An Afro-optimist response?. *International Journal of cultural studies*, *15*(6):567-582.

Munoz, CC, DoBroka, CC & Mohammad, S. (2009). Development of a multidisciplinary course in cultural competence for nursing and human service professionals. *Journal of Nursing Education* 48(9):495-503.

Muula, A. S and Mfusto-Bengo, J. M. (2005). When is public disclosure of HIV seropositivity acceptable? *Nursing Ethics*. https://doi.org/10.1191%2F0969733005ne790oa

Mwaka AD, Okello ES, Orach CG. (2015). Barriers to biomedical care and use of traditional medicines for treatment of cervical cancer: an exploratory qualitative study in northern Uganda. *Eur J Cancer Care (Engl)*. 24(4):503–513. doi:10.1111/ecc.12211

Nabieva, J & Souares, A. (2019). Factors influencing decision to seek health care: a qualitative study among labour-migrants' wives in northern Tajikistan. *BMC Pregnancy and Childbirth*, 19(7): https://doi.org/10.1186/s12884-018-2166-6

Nangalama, L.M. (2016). *Modern medicine vs. traditional medicine or a combination*. Retried from http://nangalama.blogspot.com/2016/03/modern-medicine-vs-traditional-medicine.html.

Napier, D. (2014). Culture and Health. *The Lancet Commission* 384: 1607-1638.

National Minority AIDS Council. NMAC. (n.d) Extending the reach of the Ryan White CARE Act: *The Minority AIDS Initiative*. p. 3.

NDA. (2014). *State of poverty and its manifestation in the nine provinces of South Africa*. South Africa: Human Sciences Research Council & Economic Performance and Development.

Nemutandani, S.M., Hendricks, J.S., Mulaudzi, F.M. (2018). Decolonizing the mind-sets, attitudes and practices of the allopathic and indigenous health practitioners in postcolonial society: An exploratory approach in the management of patients. *African Journal of Primary Health Care & Family Medicine.* Vol 10(1).

Nemutendani, M.S., Hendricks, J.S., Mulaudzi, F.M. (2016). Perceptions and experiences of allopathic health practitioners on collaboration with traditional health practitioners in post-apartheid South Africa. *African Journal of Primary Health Care & Family Medicine*. 8(2)

Ngubane, H., 1977. *Body and mind in Zulu medicine. An ethnography of health and disease in Nyuswa-Zulu thought and practice*. Academic Press Inc.: London.

Nompumelelo, M., Gomo, E., Gqaleni, N., Ngcobo, M. (2019). Core competencies acquired in indigenous training of traditional health practitioners in Kwazulu-Natal. *Afr Health Sci,* 19(4):3100-3106. 10.4314/ahs.v19i4.32. PMID: 32127886; PMCID: PMC7040309

Nota, P.B. (2019). *An exploration of the social-cultural factors that influence oral preexposure prophylaxis uptake and integration into Sexual and Reproductive Healthcare services for young women in KwaZulu-Natal*. Unpublished Doctoral Dissertation, University of KwaZulu-Natal.

Ntombana, L., (2011). Should Xhosa male initiation be abolished? *International Journal of Cultural Studies*, 14 (6): 631-640. Https://doi.org/10.1177/1367877911405755.

Nyang, Sulayman (1980) "Essay Reflections On Traditional African Cosmology," *New Directions*: Vol. 8 (1) Article 8. Available at: http://dh.howard.edu/newdirections/vol8/iss1/8

Nyindo M. (2005). Complementary factors contributing to the rapid spread of HIV-I in sub-Saharan Africa: a review. *East African Medical Journal*. 82(1):40–46

O'Conner BB. (1996). Promoting cultural competence in HIV/AIDS care. *J Assoc Nurses AIDS Care*;7(1):41-53.

Opoku, K.J., Addai-Mensah, P & Wiafe, F. (2015). Traditional and modern medicine: a survey of views on its integration in Ghana. *International Journal of African Society, Cultures and Traditions.* 3(5):37-51

Orr, R. (2006). Treating patients from other cultures. *American Family Physician*; 53 (6): 2004-2006.

Oyebode, O., Kandala, N.B., Chilton, J.P., Lilford, J.R. (2016). Use of traditional medicine in middle-income countries: a WHO-SAGE study. *Health Policy and Planning*, 31(8):948-991

Ozioma, J.E and Chinwe, N.A.O. (2019). Herbal medicine in African Traditional Medicine. *Herbal Medicine*. DOI: 10.5772/intechopen.80348. Available from: https://www.intechopen.com/books/herbal-medicine/herbal-medicines-in-african-traditional-medicine

Papadopoulos, I & Omeri, A. (2008). Transcultural nursing theory and models: the challenges of application. *Contemporary Nurse* 28(1):45-47.

Parrinder, G. (1969). *African's three Religions.* London: Sheldon Press.

Patel, VL, et al., (2018). "Discerning patterns of human immunodeficiency virus risk in healthy young adults". *The American Journal of Medicine. 121 (9): 758–64.*

Patton, M.Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks: Sage

Pear R. (2017). AMA rules that doctors are obliged to treat AIDS. *New York Times.* November 13, 2017. Available at www.nytimes.com/1987/06/06/us/government-plans-random-aids-tests-for-45000-in-us.html

Peltzer, K et al. (2009) 'Determinants of knowledge of HIV status in South Africa: results from a population-based HIV survey', BMC Public Health, Volume 9, p.174.

Peltzer, K; Friend-du Preez, N; Ramlagan, S; Fomundam, H; Anderson, J (2010) Traditional Complementary and Alternative Medicine and Antiretroviral Treatment Adherence Among HIV Patients in Kwazulu-Natal, South Africa. African journal of traditional, complementary, and alternative medicines, 7 (2). pp. 125-37. ISSN 0189-6016

Peltzer, K. (2009). Traditional health practitioners in South Africa. *The Lancet*: 374 (9694):956-957.

Peltzer, K. et al. (2008). HIV/AIDS/STI knowledge, attitudes, beliefs and behaviors in a rural South Africa adult population. *South African Journal of Psychology*, 33 (4): 250-260.

Perez-Stable, E. and Napoles-Springer, A. (2000). Interpreters of Communication in the Clinical Encounter. *American Journal of Medicine*, 108(6):509-5 10.

Pickard, A. (2013) *Research methods in information* (2nd ed.). Chicago: Neal-Schuman.

Pickard, J. A. (2018). *Research Methods in Information*. Cambridge University Press: Facet Publishing.

Pinikahana, J, Manias, E & Happel, B. 2003. Transcultural nursing in Australian nursing curricula. *Nursing and Health Sciences* 5(2):149-154.

Prejean J, et al. (2010). *Estimated HIV incidence in the United States, 2010-2011.* Available at: www.plosone.org/article/info:doi/10.1371/journal.pone.0017502.

Pretorious, E. (1999). Traditional healers. In Crisp N, Ntuli A, editors*. South African Health Review.* Durban: Health Systems Trust: 18:249-56.

Puoane TR, Hughes GD, Uwimana J, Johnson Q, Folk WR. (2012). Why HIV positive patients on antiretroviral treatment and/or cotrimoxazole prophylaxis use traditional medicine: Perceptions of health workers, traditional healers and patients: A study in two provinces of South Africa. *Afr J Tradit Complement Altern Med*. 9(4):495–502. https://doi.org/10.4314/ajtcam.v9i4.6

Purnell L, Paulanka B. (2008). *Transcultural Healthcare: A Culturally Competent Approach*. Philadelphia: FA Davis.
Rathore, S. and Krumholz, H. (2011). Differences, disparities, and biases: clarifying racial variations in health care use. *Annals of Internal Medicine*: 141(8): 635-638.
Republic of South Africa. (2004). *Traditional Health Practitioners Act, Act 35 of 2004*. Pretoria: Government Printers.
Resnicow K, Baranowski T, Ahluwalia J, Braithwaite R. (1999). Cultural sensitivity in public health: defined and demystified. *Ethn Dis*.9:10-21
Romeo, H.R., Hall, J., Cluver, L., Steinert, J. (2018). Socioeconomically disadvantaged adolescents and educational delay in two provinces in South Africa: impacts of personal, family and school characteristics. *Education as change,* 22(1). *http://dx.doi.org/10.25159/1947-9417/2308*
Rosenstock, I. M. (1974). Historical origins of the health belief model. *Health Education Monographs*, vol. 2, pp. 328-335
Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1994). The health belief model and HIV risk behavior change, in *Preventing AIDS: Theories and methods of behavioral interventions*, R. J. DiClemente, ed., pp. 5-24
Ross, E. (2010). Inaugural lecture: African spirituality, ethics and traditional healing implications for indigenous South African social work education and practice. *South African Journal Bioeth Law*. 3 (1): 44-51.
Rouleau G, Richard L, Côté J, Gagnon MP, Pelletier J. (2019). Nursing Practice to Support People Living With HIV With Antiretroviral Therapy Adherence: A Qualitative Study. *J Assoc Nurses AIDS Care*. 30(4):e20–e37. doi:10.1097/JNC.0000000000000103
Ryan, W. (2015). A living story. The Ryan White HIV/AIDS Program. *In cultured competency and capacity building.* 24: 234-258.
Sallis, J.F., Owen, N. and Fisher, E. (2015). Ecological models of health behavior. *Health behavior: Theory, research, and practice*, *5*:43-64.
Salminem, L. et al. (2010). Future challenges for nursing education- A European perspective. *Nurse Education Today*. 30: 233-238.
Sealey, L, Burnett, M & Johnson, G. (2006). Cultural competence of Baccalaureate Nursing Faculty: are we up to the task? *Journal of Cultural Diversity* 13(3):132-140.
Semenya, SS, Potgieter, MG. (2014). Bapedi traditional healers in the Limpopo Province, South Africa: Their socio-cultural profile and traditional healing practice, South Africa. *Journal of Ethnobiol Ethnormed*. 10(10):104. doi:10.1186/1746-4269-10-4
Shenton, A.K., 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), pp.63-75.
Shisana, O., Rehle, T., Simbayi, L. C., Zuma, K., Jooste, S., Zungu, N. & Zuma, K. (2014*). South African national HIV prevalence, incidence and behaviour survey (2012).* Cape Town: Human Sciences Research Council.
Shorofi, S. & Arbon, P. (2017), 'Complementary and alternative medicine (CAM) among Australian hospital-based nurses: Knowledge, attitude, personal and professional use, reasons for use, CAM referrals, and socio-demographic predictors of CAM users', *Complementary Therapies in Clinical Practice* 27(5), 37–45.
Sibiya, M., Maharaj, L. & Bhagwan, R. (2017), 'Perceptions of professional nurses towards complementary and alternative modalities (CAM) in the uMgungundlovu District, KwaZulu-Natal', *International Journal of Africa Nursing Sciences* 7, 18–23.
Siegfried N, et al., (2014). Male circumcision for prevention of heterosexual acquisition of HIV in men. *The Cochrane Database of Systematic Reviews (2): CD003362*
Simbayi, LC., Zuma, K., Zungu, N., Moyo,S., Marinda, E., Jooste, S., Mabaso, M., Ramlagan, S., North, A., Van Zyl, J., Mohlabane, N., Diertrich, C., Naidoo, I and the

SABSSM V Team. (2019). *South Africa National HIV prevalence, Incidence, Behaviour and Communication Survey, 2017*. Cape Town: HSRC Press.
Simons, H. (2009). *Case study research in practice*. London: SAGE
Sindayigaya, F. (2016). *How do nurses feel about their cultural competence? A literature review.* Bachelor's Thesis submitted at JAMK University of Applied Sciences.
Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press (US).
Smith, L., Diergaardt, C., Fourie, S., Matshikwe, N. & Letsoalo M. (2011). Nurses, HIV and Paediatrics. *Journal of HIV Nursing Matters*, 2(3), 10-13.
Solomon, W.A. (2017). Cultural intelligence and its role in the leadership style and leadership effectiveness domain. Unpublished PhD, submitted to the University of South Africa.
South African Republic. (2004). *The nursing act*. Pretoria: Government printers.
Sovran, S. (2013). Understanding culture and HIV/AIDS in sub-Saharan Africa. *SAHARA-J.* 10(1):32-41. https://doi.org/10.1080/17290376.2013.807071.
South African National AIDS Council (SANAC) (2017) 'Let our actions count: South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022' [pdf]
Spector, RE. (2011). Culture, health and illness. *In: Spector RE. Cultural diversity in health and illness*. Stamford, CT: Appleton and Lange:63-88.
Starman, B.A. (2013). The case study as a type of qualitative research. *Journal of contemporary educational studies*, 1(13):28-43
Statistics South Africa. (2013). *Midyear statistics estimates*. Retrieved from https://www.statssa.gov.za/publications/PO302/PO30220.Pdf Accessed July 2. 2018.
Steward, P. (2001). *Traditional healers: traditional medicine in Botswana*. Gabarone: Ipeleng Publishers.
Summerton, J.V. (2006a). Western health practitioners' view about African traditional health practitioners' treatment and care of people living with HIV/AIDS. *Curationis*, 29(3):15-23.
Summerton, JV. (2006b). The organization and infrastructure of the African traditional healing system. Reflections from a sub-district of South Africa, *African Studies,* 65 (2):297-319.
Taylor, S. J and Bogdan, R. (1998). *Introduction to qualitative research methods: A guidebook and resource*. John Wiley and Sons.
Teherani A, Martimianakis T, Stenfors-Hayes T, Wadhwa A, Varpio L. (2015). Choosing a Qualitative Research Approach. *J Grad Med Educ*. 7(4):669–670. doi:10.4300/JGME-D-15-00414.1
Terre Blanche, M. and Durrheim, K. (1999). *Research in Practice: Applied methods for the Social Science*. South Africa: University of Cape Town Press.
Terre Blanche, M., Kelly, K., and Durrheim, K. (2006). Why Qualitative Research? Pp 271-284. In: Terre Blanche, M., and Durrheim, K. (eds.). *Research in Practice. Applied methods for the Social Sciences*. University of Cape Town Press: Cape Town. Pp594.
The US Department of Health. USDH. (2004). *Operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa*. Pretoria: National Department of Health. Retrieved from http://www.who.int/nmh/publications/ncd_report2010/en/
Thomas, J. and Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, 8(1):45-51.

Tiatia, J. and Foliaki, L. (2005). *Pacific cultural competency framework for DHBs (draft 4*). Unpublished Report, Waitemata District Health Board, Auckland.
Tomaselli, K.G & Dyll, L. (2018) Navigating ethical clearance: farce and force. In Tomaselli, K.G. (ed.) *Making Sense of Research.* South Africa: van Schaik publishers, pg. 289-299.
Tomaselli, K.G. (2011). 'Seeing red': cultural studies in global comparison. *Journal of Multicultural Discourses.* 11(4):375-388.
Tomaselli, KG. (2011). Sham reasoning, myths and mediatisation (attached). In the book: In K.G Tomaselli & C. Chasi (eds.) *Development and Health Communication*. Cape Town: Pearson Publishing
Tonya, H. (2019). *The Self-Perceived Cultural Competency of HIV Interventionists*. *Walden Dissertations and Doctoral Studies*. Retrieved from: https://scholarworks.waldenu.edu/dissertations/6838
Tortumluoglu, G. (2006). The implications of transcultural nursing models in the provision of culturally competent care. *ICUS NURS WEB J*, Issue 25:1-11.
Towerll, V.& Rodney, C. (2010). Newspaper coverage of health issues in Nigeria. *African Communication Research*. 3(2):235-255.
Tucker, C.M., Marsiske, M., Rice, K.G., Nielson, J.J. and Herman, K., (2011). Patient-centered culturally sensitive health care: model testing and refinement. *Health Psychology*, *30*(3):342-331.
Twumasi P. A. (1988). A social history of the Ghanaian pluralistic medical system. *Social Sciences and Medicine*, 13B(4):349-365.
Tylor, D., Bury, M., Campling, N., Carter, S., Garfied, S., Newbould, J., Rennie, T. (2006). A review of the use of the Health Belief Model (HBM), the Theory of Reasoned Action (TRA), the Theory of Planned Behaviour (TPB) and the Trans-Theoretical Model (TTM) to study and predict health related behaviour change. University of London: School of Pharmacy.
Ulin, P.R., Robinson, E.T., Tolley, E.E., & McNeill, E.T. (2002). *Qualitative methods: a field guide for applied research in sexual and reproductive health*. North Caroline, USA: Family Health International.
United Nations General Assembly. (2011). *Political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases*. United Nations. Retrieved from: http://www.un.org/ga/search/view_doc.asp?symbol=A% 2F66%2FL.1&Lang=E
Upvall, M.J. (1992). Nursing perceptions of collaboration with indigenous healers in Swaziland, *International Journal of Nursing Studies. 29 (1): 27-36.*
US Department of Health and Human Services [USHHS]. (2017). "*What Are HIV and AIDS*? USHHS. Retrieved from: HIV.gov". www.hiv.gov. U.S. (Retrieved 10 August 2018).
USAIDS. (2008). *The 2008 report on the global epidemic*. Geneva (Switzerland): UNAIDS
Van Der Merwe, A.S. (1999). The power of women in South Africa. *Journal of Advanced Nursing*.30(6):1272-1279.
Van Dyk, AC. (2001). Traditional African beliefs and customs: Implications for AIDS Education and Prevention in Africa. *Scientific Journal of Psychology*: 31 (2):60-66
van Rensburg, R., Razlog, R. & Pellow, J. (2020). Knowledge and attitudes towards complementary medicine by nursing students at a University in South Africa. *Health SA Gesondheid,* 25(0), a1436.
van Rooyen, M.R., Pretorius, B., Tembani, M.N & Ham-Baloyi, T.W. (2017). Evidence-based recommendations to facilitate professional collaboration between allopathic and traditional health practitioners. *Health SA Gesondheid*. 22(8):292-299.

Van Wyk, BE. (2008). A broad review of commercially important southern African medicinal plants. *Journal of Ethnopharmacol*: 119 (3): 342-55.
Vanderpool HK. (2005). Report of the ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence. *Am J Health Syst Pharm*, 62(18):1924-1930.
Verotta, L., Macchi, P.M., Vnkatasubramanian, P. (2015). *Connecting Indian Wisdom and Western Science: Plant usage for nutrition and health*. Indian: CRC Press
Virpi Kemppainen, Kerttu Tossavainen, Hannele Turunen. (2013). Nurses' roles in health promotion practice: an integrative review, *Health Promotion International*. 28(4):490–501, https://doi.org/10.1093/heapro/das034
Warren EA, Paterson P, Schulz WS, Lees S, Eakle R, Stadler J, et al. (2018). Risk perception and the influence on uptake and use of biomedical prevention interventions for HIV in sub-Saharan Africa: A systematic literature review. *PLoS ONE* 13(6): e0198680. https://doi.org/10.1371/journal.pone.0198680
White, P. (2015). The concepts of diseases and health care in African traditional religion in Ghana. *HTS Teologiese Studies/Theological Studies*. 71(3):2762, 2767. http://dx.doi.org/10.4102/ hts.v71i3.2762
WHO. (1978). *Trends in traditional medicine use and maternal mortality*. WHO. 1970-1977.

WHO. (2000). *General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine*. Geneva, Switzerland: World Health Organisation.
WHO. (2008). People-centred health care. Technical papers presented at International Symposium on People-Centred Health Care: Reorienting health systems in the 21st century at the Tokyo International Forum in November 2007. Western Pacific Region: World Health Organisation.
WHO. (2009). *Towards the universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2009*. Geneva: World Health Organisation.
WHO. (2011b). Global status report on communicable HIV seropositivity. *Nursing Ethics*: 12: 288-295.

WHO. (2016). *Case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children*. Geneva: World Health Organization. Pp.6–16. ISBN 978-92-4-159562-9.
WHO.(2017). *About World Health Organization Constitution*. Accessed from: http://www.who.int/governance/eb/constitution/en/
Williams, G. B., Gupta, S., Wollmers, M & Granich, R. (2017). Progress and prospects for the control of HIV and tuberculosis in South Africa: a dynamical modelling study. *Lancet Public Health*. 2: e223-230. doi10.1016/S2468-2667(17)30066-X
Willis, J.W., Jost, M. and Nilakanta, R. (2007). *Foundations of qualitative research: Interpretive and critical approaches*. London: Sage.
Woloshin S, Bickell NA, Schwartz LM, Gany F, Welch HG. (1995). Language barriers in medicine in the United States. *JAMA*, 273(9):724-728.
Woods, M., Macklin, R & Lewis, G.K. (2016) Researcher reflexivity: exploring the impacts of CAQDAS use, *International Journal of Social Research Methodology*, 19(4):385-403, DOI: 10.1080/13645579.2015.1023964
Wreford, J. (2005). Missing each other: Problems and potential for collaborative efforts between biomedicine and traditional healers in South Africa in the time of AIDS. *Social Dynamics*. 31(2):55-89
Yoder, A (1997). An epidemic of witchcraft? Implications of AIDS for the post-apartheid state. *African Studies*. 61(1):121-143.

Zihindula, G., Ross, AJ., Gumede, DM., MacGregor, RG. (2019). A review on the contributions of NGOs in addressing the shortage of healthcare professionals in rural South Africa. *Cogent Social Sciences*. DOI: http://dx.doi.org/10.1080/23311886.2019.1674100

Zimmerman, R. S. & Verberg, D. (1994). Models of Preventive Health Behavior: Comparison, Critique, and Meta-Analysis. *Advances in Medical Sociology*, vol. 4, pp. 45-67

Zohrabi, M. (2013). Mixed method research: Instruments, validity, reliability and reporting findings. *Theory and Practice in Language Studies*, *3*(2), 254–262. https://doi.org/10.4304/tpls.3.2.254-262

Zuma T, Wight D, Rochat T, Moshabela M. (2018). Navigating Multiple Sources of Healing in the Context of HIV/AIDS and Wide Availability of Antiretroviral Treatment: A Qualitative Study of Community Participants' Perceptions and Experiences in Rural South Africa. *Front Public Health*. (6):73:1-14. doi:10.3389/fpubh.2018.00073

Zuma, T, Wight, D., Rochat, T., Moshabela, M. (2017). Traditional health practitioners' management of HIV/AIDS in rural South Africa in the era of widespread antiretroviral therapy. *Global Health Action*. 10(1): 1352210. Doi:10.1080/16549716.2017.1352210.

Zuma, T., Wight, D., Rochat, T., Moshabela, M. (2016). The role of traditional health practitioners in Rural Kwazulu-Natal, South Africa: generic or mode specific? *MBC Complementary Altern Med* 16(1)304

Zwane S, Poggenpoel M. (2000). Student nurses' experiences of interacting with culturally diverse psychiatric patients. *Curationis*, 23(2):25-31

Appendices

APPENDIX A1: INFORMED CONSENT FORM ENGLISH VERSION

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

Note to researchers: Notwithstanding the need for scientific and legal accuracy, every effort should be made to produce a consent document that is as linguistically clear and simple as possible, without omitting important details as outlined below. Certified translated versions will be required once the original version is approved. There are specific circumstances where witnessed verbal consent might be acceptable, and circumstances where individual informed consent may be waived by HSSREC.

Information Sheet and Consent to Participate in Research

Date: 25 July 2018
Dear Sir/Madam
My name is Zandile Mthethwa, I am a master's student at University of KwaZulu-Natal, Howard College in the Discipline for Communication, Media and Society. My student number is 218082033, my contact details are 073 6000 392/ 072 7488 566 and my e-mail address is mthethwazandie@gmail.com/ZMthethwa@ahri.org

You are being invited to consider participating in a study that involves research on the intersection between traditional and western medicine and the role of culture in the treatment of HIV/AIDS in Umkhanyakude District, South Africa: A nursing cultural competence perspective. This study aims to explore the interconnection between the two systems of health service providers in the treatment of HIV/AIDS in the rural areas of South Africa at Umkhanyakude District. The study seeks to explore the ways in which traditional and modern medicine intersect in the health seeking behaviors of people living with HIV and AIDS (PLHIV), particularly the driving forces to seek traditional healing services before or after attending public health facilities for modern medicine assistance. The study is expected to enroll 10 nurses from the HIV/AIDS Units in different clinics and Hospitals within Umkhanyakude District. The duration of your participation if you choose to enroll and remain in the study is expected to be thirty minutes interview. The study is not funded since it is for academic purposes.

There is no risk in participating in this study. The study will provide no direct benefits to the participants.
This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions you may contact the researcher at 073 6000 392/072 7488 566 or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

The participation in this study is voluntary and that in the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or other benefit to which they are normally entitled. There are no consequences for participants if they decide not to participate.
There is no incentives or reimbursements for participation in the study. All information provided will be strictly confidential and collected anonymously. The information that will be provided by the participant will be digitally stored by the study team and securely archived after the study.

CONSENT

I ----------have been informed about the study entitled the intersection between traditional and western medicine and the role of culture in the treatment of HIV/AIDS in Umkhanyakude District, South Africa: A nursing cultural competence perspective by Zandile Mthethwa.

I understand the purpose and procedures of the study as this study aims to explore the interconnection between the two systems of health service providers in the treatment of HIV/AIDS in the rural areas of South Africa at Umkhanyakude District.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 073 6000 392/072 7488 566.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion	YES / NO
Video-record my interview / focus group discussion	YES / NO
Use of my photographs for research purposes	YES / NO

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness (Where applicable) **Date**

_____ _____

Signature of Translator (Where applicable) **Date**

APPENDIX A2: INFORMED CONSENT FORM ZULU VERSION

IKOMIDI LEZENQUBONHLE KWEZOCWANINGO LEKOLISHI LEZESINTU ESIKOLENI SEZIFUNDO NGENHLALO YOMPHAKATHI (HSSREC)

ISICELO SOKUGUNYAZWA NGOKWEZENQUBONHLE
Okocwaningo olusebenza ngabantu

OKUKULEKELELA EKWAKHIWENI KWEFOMU LOKUVUMA

Okumele kuqashelwe abacwaningi: Noma kubalulekile ukutholakala kwemiphumela enembayo ngokwesayensi futhi esemthethweni, kumele kwenziwe konke okusemandleni ukuze kukhiqizwe umbhalo wokuvuma oqondakalayo ngokolimi futhi ocacile kakhulu ngaphandle kokushiya imininingwane ebalulekile njengoba kubaliwe ngezansi. Izihumusho ezigunyaziwe zizodingeka uma sekugunyazwe umbhalo wesiNgisi.

Kunezimo ngqo lapho imvume ngomlomo efakazelwe yamukelekile, nalapho imvume yomuntu ingeke idingwe yi-HSSREC.

Umbhalo Wemininingwane Nokuvuma Ukubamba Iqhaza Ocwaningweni

Usuku:

Mnumzane othandekayo/Madam

Igama lami ngingu- Zandile Mthethwa, ngingumfundi wase Nyuvesi yakwaZulu-Natal kwikolishi laseHoward kwi Siyalo zokuxhumana, Abezindaba Nemiphakathi. Inombolo yami yobufundi ithi 218083033, izinombolo zami zokuxhumana zithi: 073 6000 392/072 7466 588, i-imeyili sithi: mthethwazandie@gmail.com/ZMthethwa@ahri.org

Uyamenywa ukuba ubambe iqhaza ocwaningweni olumayelana nokuxhumana okuphakathi kwemithi yesintu nemithi yesimanje neqhaza elibanjwa isiko ekulapheni isifo sesandulela ngculaza nengculaza kwiDistrict yaseMkhanyakude eSouth Africa: Ngokombono wamanesi ekwenzeni kahle isiko. Inhloso nempokophelo yalolu cwaningo ukuthola kabanzi ukuxhumana okuphakathi kwalezinhlelo ezimbili zokunikezela usizo lwezempilo ekulapheni isifo sesandulela ngculaza nengculaza ezindaweni ezisemakhaya eSouth Africa kuMkhanyakude District. Lolucwaningo luhlose ukuthola izindlela imithi yesintu neyesimanje exhumana ngakhona ekufuneni ukuziphatha kwabantu abaphila nalesisifo ukwelashwa, kakhulukazi lokho okuphushela abantu abaphila nalezizifo ekufuneni usizo kubelaphi bendabuko ngaphambi noma emva kokuba bavakashele ezikhungweni zezempilo ukuthola usizo ngokwemithi yesimanje. Ucwaningo lulindeleke ukuthi lukhulumisane namanesi

ayishumi asebenzela kwingxenye yesandulela ngculaza nengculaza kumitholampilo nezibhedlela ezahlukene kwiDistrict yaseMkhanyakude. Ukubamba kwakho iqhaza uma uvuma futhi uhlala ocwaningweni kulindeleke ukuthi luthathe imizuzu engamashumi emithathu. Ucwaningo aluxhasiwe njengoba lwenzelwe injongo yokufunda.

Akukho bungcuphe noma ukungaphatheki kahle ngokubandakanya kulolucwaningo. Ucwaningo alunanzuzo kobambe iqhaza.

Lolu cwaningo luhloliwe ngokwenqubonhle lwagunyazwa i-UKZN Humanities and Social Sciences Research Ethics Committee (inombolo yokugunyazwa_:HSS/1973/018M).

Uma kunezinkinga noma imibuzo/ukukhathazeka ungaxhumana nomcwaningi lapha (nikeza imininingwane yokuxhumana) noma i- UKZN Humanities & Social Sciences Research Ethics Committee, kulemininingwane elandelayo:

EZOKUPHATHWA KWEZENQUBONHLE KWEZOCWANINGO EKOLISHI LEZESINTU ESIKOLENI SEZIFUNDO NGENHLALO YOMPHAKATHI

Ihhovisi LezoCwaningo, iKhempasi i-Westville

Govan Mbeki Building

Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Ucingo: 27 31 2604557- Fax: 27 31 2604609
I-imeyili: HSSREC@ukzn.ac.za

Ukubamba iqhaza kulolu cwaningo akuphoqelekilenokuthi ababambe iqhaza bangayeka noma yinini, nokuthi uma bengathandi noma beyeka ukubamba iqhaza ngeke bahlawuliswe ngalokho noma baphelelwe ukwelashwa noma balahlakelwe yinoma yikuphi okunye abebekuzuza okufanele bakuthole. Akukho imiphumela engaba khona ngenxa yokuyeka ukubamba iqhaza nenqubo ekulindeleke ukuthi ilandelwe abayekayo ukuze kube nokuhleleka.

Akukho okutholakalayo okuyisibonelelo sokubamba iqhaza kulolucwaningo.

Lonke ulwazi oluqoqiwe luzogcinwa luyimfihlo luyoqoqwa ngaphandle kokuveza imininingwane yomubambi qhaza. Ulwazi oluyonikezelwa umbambi qhaza luzogcinwa iqembu locwaningo bese lugcinwa kuma archive emva sekusetshenziwe.

UKUVUMA

Mina …… ngazisiwe ngocwaningo olunesihloko esithi Ukuxhumana phakathi kwemithi yesintu nemithi yesimanje neqhaza elibanjwa isiko ekulapheni isifo sesandulela ngculaza nengculaza kwiDistrict yaseMkhanyakude eSouth Africa: Ngokombono wamanesi ekwenzeni kahle kwisiko.

Ngiyakuqonda okuphokophelwe nokuyimigomo zalolu cwaningo ukuthi lolucwaningo luhlose ukuhlola ukuxhumana phakathi kwezinhlelo ezimbili zabanikezeli bosizo lwezempilo ekulapheni isifo sesandulela ngculaza nengculaza endaweni yasemakhaya kuMkhanyakude District eSouth Afri

Nginikeziwe ithuba lokuphendula imibuzo mayelana nocwaningo futhi ngithole izimpendulo ezingigculisayo.

Ngiyaqinisekisa ukuthi ukubamba kwami iqhaza kulolu cwaningo akuphoqelekile futhi ngingayeka noma yinini nokuthi lokho ngeke kube nomthelela kwengikuzuzayo engijwayele ukukuthola.

Ngazisiwe ngazo zonke izinxephezelo noma ukwelashwa okutholakalayo uma ngilimala ngenxa yokuphathelene nocwaningo.

Uma ngineminye imibuzo/ukukhathazeka noma kukhona engidinga kucaciswe mayelana nocwaningo ngiyakuqonda ukuthi ngingathintana nomcwaningi lulezinombolo: 073 6000 392/072 7466 566.

Uma nginemibuzo noma ukukhathazeka ngamalungelo ami njengobambe iqhaza, noma ngikhathazekile nganoma yiluphi uhlangothi locwaningo noma abacwaningi ngingathintana nabe:

EZOKUPHATHWA KWEZENQUBONHLE KWEZOCWANINGO EKOLISHI LEZESINTU ESIKOLENI SEZIFUNDO NGENHLALO YOMPHAKATHI

Ihhovisi LezoCwaningo, iKhempasi i-Westville

Govan Mbeki Building

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Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Ucingo: 27 31 2604557 - iFeksi: 27 31 2604609
I-imeyili: HSSREC@ukzn.ac.za

Ukuvuma okwengeziwe, lapho kudingeka khona

Ngiyavuma ukuthi kwenziwe lokhu:

Kuqoshwe ingxoxo yami/yeqembu YEBO/CHA
Kuqoshwe ngevidiyo ingxoxo yami/yeqembu YEBO/CHA
Kusetshenziswe izithombe zami ngezinhloso zocwaningo YEBO/CHA

_____ _____
Ukusayina kobambe iqhaza **Usuku**

_____ _____
Ukusayina Kowufakazi **Usuku**
(Uma kunesidingo)

_____ _____
Ukusayina Kohumushayo **Usuku**
(Uma kunesidingo)

APPENDIX B: FULL APPROVAL FORM HSSREC

UNIVERSITY OF
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

14 March 2019

Ms Zandile P Mthethwa 218082033
School of Applied Human Sciences – CCMS
Howard Colledge Campus

Dear Ms Mthethwa

Protocol reference number: HSS/1973/018M
Project title: The role of culture in health care provision to people living with HIV (PLWHIV) in UMkhanyakude District, North of KwaZulu-Natal: A nurse's perspective.

Full Approval – Full Committee Reviewed Application

With regards to your response received on 04 March 2019 to our letter of 12 February 2019, the Humanities and Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Dr Rosemary Sib nda (Chair)

/px

cc Supervisor: Dr Lauren Dyll
cc Academic Leader Research: Dr Maud Mthembu
cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee
Dr Rosemary Sibanda (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** /
Website:

APPENDIX C: INTERVIEW GUIDE

Title: The role of culture in the provision of health care services to people who are living with HIV (PLHIV) in uMkhanyakude District, Northern of KwaZulu-Natal: A nurse's perspective

Cultural competence in negotiating traditional and modern treatment in the provision of care to PLHIV:

1. Can you tell me about yourself? Prompts: (place of birth, age, family background, educational level, occupation, work experience, hobbies etc.)
2. For how many years have you been consulting with PLHIV?
3. What is your general experience when consulting with clients/patients that use both traditional and modern (e.g. biomedical / ARVS) treatments?
4. Generally, what are the patient's reasons for using a.) traditional treatment b.) modern treatment?
5. If a patient / client has only ever used traditional treatment before, how do they generally react to the idea of 'modern treatment' and prevention?
6. How do you communicate the benefits and the shortcomings of using a.) traditional treatment b.) modern treatment?

To develop **cultural sensitivity** **5 components** should be included in the interaction between (in this case) nurse and patient (PLHIV). The next few questions are organized according to these components.

Cultural knowledge:

1. When did you receive NIMART training?
2. What was the focus of this training?
3. Does this training include the importance of being aware of and sensitive to the cultural background of a client/patient? If so, how. Please explain.
4. If it does not, what do you think the benefit would be of learning how to consider culture in training to be a nurse?
5. What is your knowledge of the types of traditional treatment PLHIV seek?
6. Do you ask patients about their health-related beliefs?
    a. If so, how?
    b. If not, why not?

7. Do you share information on disease incidence (risk of contracting and spreading the disease)?
    a. If so, how?
    b. If not, why not?
8. Do you advise the patients on treatment efficacy? In other words, how well some forms of treatment are over others?

a. If so, which forms of treatment do you usually suggest, and why?

Cultural awareness:

1. What are your personal beliefs about the type of treatment you suggest?
2. How do you reflect on ***your own*** cultural beliefs and values when consulting with a patient?
3. Do you think they affect ***how*** you speak to the patient and what you advise?
4. If so, do you think this is a good or bad thing, and why?

Cultural desire:

1. What motivates you *to* ***want to know*** about what is important to the patient in terms of their cultural beliefs etc.?
2. When you consult with a patient from a different cultural background to your own, how do ensure that you take this background into consideration in your practice and the advice you give to them?
3. How do you create health messages / give advice that is responsive to (or takes into consideration) a patient's cultural values and beliefs?
4. What ***helps*** you to offer advice that is culturally sensitive / aware (take into consideration their beliefs, values etc.)?
5. What makes it ***difficult*** to offer advice that is culturally sensitive / aware?

Cultural encounters:

1. In what way do you try to engage in cross-cultural interactions in terms of health and HIV prevention and treatment?
2. Do you visit patients in their homes (and learn of the reality of their needs etc.)
    a. If so, what do you learn from these experiences?
    b. If not, why not?
3. Do you speak with traditional healers?
    a. If so, what do you learn from these experiences?
    b. If not, why not?

4. What are the challenges you face in dealing with PLHIV seeking ***both*** a.) traditional and b.) modern treatment?

Cultural skills:

1. In a consultation room, how do you ensure that relevant cultural information is shared between you and the patient/client?
2. How does the communication with the patient usually work? For example – is there a two - way conversations or do they or you do most of the talking?
    a. Why do you think this is so?
3. What do you think you do ***well*** in this communication?
4. Do you conduct what some people call a "culturally physical assessment" which is an appraisal of the a.) individual, b.) their family / immediate group c.) community beliefs, values and practices in order to establish the patient's needs?
    a. If so, what do you learn from these experiences?
    b. If not, why not?

APPENDIX D1: HLABISA HOSPITAL LETTER

Department:
Health
PROVINCE OF KWAZULU-NATAL

05 October 2018

Permission to Conduct Research

Dear Mr. SR Dlamini

The Hlabisa Hospital Research Committee has reviewed the proposal entitled: **"The role of culture in health care provision to people living with HIV (PLHIV) in uMkhanyakude District, North of KwaZulu-Natal: A nurse's perspective"**
has granted permission for the study to proceed.

Please note the following:

1. Please ensure that the conduct of the study is in line with the stipulations of the KZN Health Act of 2009 and the National Health Act (Act 61 of 2003).
2. Hlabisa Hospital has the right to withdraw this permission at any time as per the conditions of the Memorandum of Agreement between the Africa Centre and the KZN Department of Health.
3. This research may only commence once the UKZN Biomedical Research Ethics Committee or other registered Institutional Review Board has granted the study full approval.
4. Final approval must be granted by the KZN Health Research and Knowledge Management Unit
5. The researchers must communicate the findings of the research to this committee before publication.
6. Any Hlabisa Hospital resource required to conduct this study including staff time be declared up front before commencement of the research for the consideration of the Hospital Management Team.
7. Please ensure that there shall be no distraction in the rendering of patients care and you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.

The following requirements for this study to proceed are noted:

- Recruitment of healthcare professionals and their participation in the study will not interfere with their duties or delivery of services.

Yours faithfully

[redacted]

Dr. Marun Tshipuk
Medical Manager on behalf of Hlabisa Research Committee

APPENDIX D2: DISTRICT LETTER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

304 Ntsinde Road, Jozini, 3969
PB X026, Jozini 3969
Tel: 035 572 1327 Fax: 035 572 1245 Email: hervey.williams@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
District Clinical Specialist Team
Umkhanyakude Health District Office

Enquiries : Dr CH Vaughan Williams
Telephone : 035-5721327 Ext 114

26 November 2018

Dear Zandile Mthethwa,

I have pleasure in informing you that permission has been granted to you by the District Office to conduct research in this district, entitled:

'The role of culture in health care provision to people living the HIV (PLHIV) in uMkhanyakude District, north of KwaZulu-Natal: A nurse's perspective'

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Sincerely,

[redacted]

C H Vaughan Williams
Family Physician, Umkhanyakude Health District Office

APPENDIX D3: DOH APPROVAL LETTER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: [redacted]
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

NHRD Ref: KZ_201902_026

Dear Ms ZP Mthethwa
UKZN

Approval of research

1. The research proposal titled **'The role of culture in health care provision to people living with HIV (PLHIV) in UMkhanyakude District, North of KZN: A nurse's perspective'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at Esiyembeni, Gunjaneni, KwaMsane, Machibini, Madwaleni, Mpukunyoni, Mtubatuba,Nkundisi, Ntondweni and Somkhele clinic.

2. You are requested to take note of the following:
   a. Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.
   b. Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.
   c. Provide an interim progress report and final report (electronic and hard copies) when your research is complete to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

[redacted]

Dr E Lutge
Chairperson, Health Research Committee
Date: 29/04/19