Published in final edited form as:

Glob Public Health. 2018 January ; 13(1): 115–127. doi:10.1080/17441692.2017.1359326.

‘These people who dig roots in the forests cannot treat HIV:’ Women and men in Durban, South Africa, reflect on traditional medicine and antiretroviral drugs (ARVs)

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Abstract

Relatively few empirical investigations of the intersection of HIV biomedical and traditional medicine have been undertaken. As part of preliminary work for a longitudinal study investigating health-seeking behaviours among newly-diagnosed individuals living with HIV, we conducted semi-structured interviews with 24 urban South Africans presenting for HIV testing or newly-enrolled in HIV care; here we explored participants’ views on African traditional medicine (TM) and biomedical HIV treatment. Notions of acceptance/non-acceptance were more nuanced than dichotomous, with participants expressing views ranging from favourable to reproachful, often referring to stories they had heard from others rather than drawing from personal experience. Respect for antiretrovirals and biomedicine was evident, but indigenous beliefs, particularly about the role of ancestors in healing, were common. Many endorsed the use of herbal remedies, which often were not considered TM. Given people’s diverse health-seeking practices, biomedical providers need to recognize the cultural importance of traditional health practices and routinely initiate respectful discussion of TM use with patients.

Keywords

Traditional medicine; traditional health practitioners; antiretroviral drugs; health beliefs; South Africa

Introduction

The African HIV/AIDS epidemic brings traditional and biomedical beliefs about healing and disease, therapeutic ideology, and practice into sharp focus. Antiretroviral (ARV) medications, propelled by PEPFAR and Global AIDS Fund investments, have become more widely available on the continent, transforming both the lives of people living with HIV (PLWHIV) and public health services (Hardon & Dilger, 2011). However, empirical investigations of the intersection of biomedical and traditional medicine (TM) in HIV treatment and care are limited. Understanding the interplay of “healthworlds” (Germond & Cochrane, 2010), or the therapeutic worldviews of TM and biomedicine, may positively impact the efficacy of healthcare programmes more generally and HIV/AIDS programmes in particular. South Africa, the country of focus in our study, is home to 6.4 million PLWHIV (Shisana et al., 2014), and traditional health practices have long been a part of the country’s healthcare landscape (Xaba, 2002). The high burden of HIV in South Africa demands a multifaceted and dynamic approach, especially due to the country’s expanded ARV coverage.

The World Health Organisation defines TM as “the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness” (WHO, 2000). Terms such as ‘alternative’, ‘complementary’, and ‘indigenous’ have been used interchangeably with TM. In this paper, we use the terms ‘traditional medicine’ and ‘traditional health practitioners’ (THPs) because a large body of literature, including from South Africa and the South African government, uses these terms.

Traditional and biomedical treatments around the world have long co-existed as concurrent or parallel explanatory models and methods to manage sickness and misfortune. China and Japan, for example, have successfully integrated TM and biomedicine (Bussmann, 2013; Leonti & Casu, 2013; Nissen & Manderson, 2013), an approach supported by the World Health Organisation (World Health Organisation, 2013) as part of medical pluralism, which describes the diverse ways in which illness can be perceived, understood and treated (Moshabela, Pronyk, Williams, Schneider & Lurie, 2011). Critics argue that TM is “irrational”, not “evidence-based” (Flint & Payne, 2013), and can interfere with biomedical therapies (Mills, Cooper, Seely, & Kanfer, 2005). Proponents point out that TM is important to cultural belief systems, particularly in Africa (Xaba, 1998; Ashforth, 2005), and is viewed as essential for treating health problems biomedicine cannot cure (Mander et al., 2007). Others highlight that TM and biomedicine are complementary, not antithetical, to each other (Xaba, 1998): biomedicine has appropriated elements of TM (Hampshire & Owusu, 2013), such as acupuncture and homeopathic remedies, whereas THPs have used biomedical terminology, referenced germ theory, and referred patients to biomedical practitioners (Hoyler, Martinez, Mehta, Nisonoff, & Boyd, 2016). Additionally, the effects of globalisation are reflected in the flow of traditional and biomedicines between diasporic and communities of origin across national and continental borders (Kane, 2012; Germond & Cochrane, 2010), suggesting that the two medical systems influence each other. For many patients, traditional and biomedicines are inextricably linked as part of a larger cultural

framework of health knowledge. Therefore, it is important to understand how the ethnomedical beliefs of PLWHIV may affect HIV treatment-seeking behaviours.

Traditional Health Practitioners and Medicine in South Africa

In South Africa, apartheid created a structural disjuncture in which Whites relied on biomedicine, and Blacks used TM (Xaba, 1998; Decoteau, 2013). The government historically supported TM use, but there has been persistent debate about how to institutionalize and regulate it. The 2007 Traditional Health Practitioners Act defined TM as “an object or substance used in traditional health practice for the diagnosis, treatment or prevention of a physical or mental illness; or any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings” (Republic of South Africa, Department of Health, 2008). This Act aimed to establish an Interim Traditional Health Practitioners Council and to register and train THPs (Republic of South Africa Department of Health, 2015). In 2008, the government published a Draft Policy on African TM with a framework for integrating TM into the biomedical healthcare system, and the Western Cape Inyangi Forum signed a Memorandum of Understanding with the Western Cape Department of Health to collaborate (Qotole & Naledi, 2015). However, only recently did the National Department of Health propose regulating how THPs administer medicine, including standardisation, registration and certification of practitioners, and formalization of training methods (Stassen, 2010; Kargbo, 2016).

South African TM to improve physical health are mainly plant-based, but use of minerals and animal parts has been documented (Xaba, 1998; Sodi et al., 2011). Colloquially called ‘muthi’ in *isiZulu*, TM is most commonly sold at informal street markets or indoor shops (also called muthi chemists). TM is often discussed in the context of chemists, but TM may be prescribed by THPs after consultation or self-administrated after self-diagnosis. The four most common types of THPs are: (1) spiritual diviners (*isangomas*) who communicate with ancestors; (2) herbalists (*inyangas* or *traditional doctors*) with expert knowledge on traditional herbal remedies; (3) faith healers (*umthandazi*) who use mostly holy water and prayer (Kale, 1995); and (4) traditional birth attendants (Sodi et al., 2011). Viewed by many as trustworthy and effective, THPs are consulted for many primary healthcare needs and also provide spiritual guidance to patients. Trust in THPs is largely due to cultural perspectives on pathogenesis. For many Black South Africans, beliefs about the spiritual world are inextricably linked to how illness is understood (Nkosi, 2012). Pleasing ancestral spirits is the most powerful force for promoting health (Bogopa, 2010; Liddell, Barrett, & Bydawell, 2006). Sickness and infertility are often attributed to ancestral displeasure or evil spirits (Mashamba, 2007; 2009). For those who believe that poor health is spirit-based, ailments are treated via ritual ceremonies. In the early 2000s, some PLWHIV viewed AIDS as a bewitchment that could be healed by *isangomas* (Nattrass, 2005; Ashforth, 2005). Even among those living a more Westernized lifestyle, many still see merit in performing rituals in times of uncertainty or tragedy (Bogopa, 2010).

TM as HIV Treatment in South Africa

Whereas TM can be important to the healing process, some elements could delay, interfere with, or counteract biomedical HIV treatment. In sub-Saharan Africa, indigenous medicines have been a popular option for those not yet prescribed ARVs (Peltzer, Preez, Ramlagan, & Fomundam, 2008), and their use has been linked to delays in both HIV testing (Audet et al., 2014, Tariq et al., 2017) and ARV initiation (Moshabela, Pronyk, Williams, Schneider, & Lurie, 2011). Additionally, some South Africans use ARVs and TM concurrently (Appelbaum Belisle et al., 2015; Babb et al., 2007; Malangu, 2007; Moshabela et al., 2011; Peltzer, 2009; Peltzer et al., 2011; Peltzer & Mngqundaniso, 2008), or discontinue ARVs in favour of TM (Dahab et al., 2008; Peltzer & Mngqundaniso, 2008), both of which are cause for concern among South African healthcare workers (Mall, 2005; Puoane, Hughes, Uwimana, Johnson, & Folk, 2012). Some traditional healing practices, e.g. inducing vomiting, administering enemas, and breaking the skin, are potentially detrimental to a patient's health (Peltzer, Mngqundaniso, & Petros, 2006). Poorly regulated and under-researched herbal medicines and 'natural health products' may also be risky options for PLWHIV (Mills, Cooper, Seely, & Kanfer, 2005). According to a study of South African THPs in Limpopo Province, for example, ancestral consultation is the primary means of determining the efficacy of herbal treatments (Semenya & Potgieter, 2014). The limited extant research shows some herbal remedies have adverse health effects, including probable ARV interactions (Mills, Cooper, Seely, & Kanfer, 2005). Given the cultural importance of THPs and individuals' diverse health-seeking practices, we sought to understand a range of South African perspectives on TM both in general and in relation to HIV.

Methods

Setting and participants

We conducted exploratory interviews with a convenience sample of 24 men and women in eThekweni (Durban) between December, 2009 and February, 2010, to inform the development of a longitudinal cohort study, *Pathways to Engagement in HIV Care for Newly-Diagnosed South Africans*. Participants were undergoing HIV testing or were recently diagnosed with HIV and linked to care. Those undergoing testing had done so either at a local public-sector healthcare clinic or for determining eligibility for an HIV prevention trial (women only). We also interviewed individuals who had tested positive within the previous six months and then successfully linked to public sector HIV care.

Eligible participants were: (1) aged 18 years or older; (2) English- or *isiZulu*-speaking; (3) not pregnant (women); (4) not previously told they were HIV+, and if positive, received their first diagnosis within the past 6 months; (5) able to give informed consent; and (6) willing to be audio-recorded. Testing clients were ineligible if they had previously tested HIV-positive or were testing for antenatal screening.

Recruitment and procedures

Individuals presenting for HIV testing were recruited by clinic staff and referred to the study team to be assessed for eligibility prior to testing. Participants were reimbursed the equivalent of \$7.00 for their time.

Following written informed consent, bilingual (*isiZulu*-English) bachelors-level interviewers, trained in qualitative assessment, interviewed participants for about one hour in the clinic. Topic areas included motivation for HIV testing, HIV disclosure, and attitudes towards ARVs, other HIV treatments and government programmes. Interviews were conducted and audio-recorded in *isiZulu* and then transcribed and translated verbatim into English. The Institutional Review Board of the New York State Psychiatric Institute/ Department of Psychiatry, Columbia University, and the Biomedical Research Ethics Committee of the University of KwaZulu-Natal approved the study.

Data analysis

Analysis was based on responses to three questions about HIV: *What are your own thoughts about getting help from traditional healers? What have you heard other people in the community say about getting help from traditional healers? What are your thoughts about using treatments other than ARVs (such as special medicines, herbs or foods)?* The discussions following each of these questions were determined by the participants' responses.

Data relevant to TM and TMHs were extracted. Two members of the study team read this material several times to identify broad themes. Analysis then entailed identifying salient themes and outlier themes, comparing themes between testing clients and those returning for care and between women and men. Team members met regularly to consider the emergent analytic framework and discrepancies in coding were discussed until consensus was reached. Grids of codes were then developed and summarised by three team members. Transcripts and coding reports and summaries were then read and further analysed by a fourth team member to categorize sub-themes.

Results

Participant characteristics

Twenty-four participants (10 men, 14 women) were recruited: four men and four women were undergoing HIV testing through a public-sector clinic; four women were tested for eligibility in an HIV prevention trial; and six men and six women were engaged in HIV care post-diagnosis (6 months). Thus, half were not certain of their status and half were diagnosed. Table 1 describes selected participant demographic characteristics.

Themes

Participants expressed a wide range of views regarding THPs, TM, and HIV treatment. Six key themes emerged, framed through the lens of HIV care: (1) disapproval of TM; (2) need for biomedicine to treat HIV; (3) upholding of traditional beliefs about treatment; (4) perspectives on concurrent treatments; (5) community attitudes towards TM; and (6)

reluctance to discuss or confusion surrounding TM. As we were unable to discern any patterns of differences by participant characteristics, results are presented for the total sample, with participant descriptors included after each quote.

Disapproval of TM: ‘A person who uses TM ends up dead’

Many participants expressed negative attitudes towards TM and THPs, e.g. that TM was generally harmful:

...You find that when they were taking ARVs, they were just sick. But after taking traditional medicines, they ended up dead. (#2, female, age 46, clinic tester)

Others expressed dislike for THPs because of seemingly less-than-honest motives and ineffective treatment. For example, THPs allegedly only care about profits:

...traditional healers are full of lies. They just want money most of the time. They do something because they want money, and at the end of the day, it doesn't help. (#13, female, age 25, PLWHIV)

Relatedly, some participants had avoided TM because of the price. A few participants considered TM dirty, made from roots or trees that are not purified:

You know traditional medicines, they mix trees. When they mix these trees, they don't wash them. They cut trees, chop them, and crush them to water. Then [they] put [it] in a bottle, then drink. (#19, male, age 28, PLWHIV)

Participants cautioned about other deleterious methods used in TM, such as induced vomiting and *ukugcaba* (creating an incision and applying TM). One participant believed she contracted HIV from a traditional healing ceremony.

Half of the participants stated that TM was bad for PLWHIV and that THPs dispense ineffective medicines:

Well I think that they [THPs] are not trained for this [treating HIV]. They'll go pick that medicine, even if you had a sore inside you. They'll give you that medicine to take and it won't go to this thing directly. Then I think that maybe it's better to come to the clinic straight because they're [biomedical practitioners] educated about human health. (#9, male, age 47, PLWHIV)

They [THPs] are all nonsense because they are doing no good for you. They are just telling you and giving you something that they don't know if it is going to work. When it comes to the hospitals, clinics and doctors, they are giving you something that they know and they will tell you what is happening.... (#4, male, age 20, clinic tester)

Participants explained that biomedical treatments for HIV were preferable, and many warned of the dangers of PLWHIV using TM:

...Traditional medicine doesn't help; instead this water from the medicine will go straight to the lungs and in the liver.... it will make you become worse. (#19, male, age 28, PLWHIV)

'I can come to the clinic': A biomedical lens

Some participants described HIV as a Western, 'White man', or 'modern' disease, hence supporting ARVs over TM for treatment:

...Whites made it clear that it is incurable...then there is nowhere I can go except coming to the clinic.... I think they are the ones who know everything. (#18, male, age 33, PLWHIV)

No, HIV is something that has to be healed by Whites. These people who dig roots in the forests cannot treat [cure] HIV. No, no, they can't. (#6, male, age 60, clinic tester)

Many participants supported ARVs as the only, or most effective, HIV treatment:

...I don't believe in traditional medicines. Tablets are better, taking tablets is right. (#5, female, age 23, clinic tester)

Participants' positive views about ARVs and the clinic aligned. They frequently noted the utility of going to the clinic:

...if I know my status, I can come to the clinic. Maybe they have the pills to boost my blood cells. (#1, female, age 21, clinic tester)

So I think you just go to the one clinic, get your ARVs. They have your information over there so they can keep checking up on you, to check how is your immune system.... (#3, female, age 19, clinic tester)

For some, respect for the clinic was influenced by educational sessions provided in HIV testing and treatment programmes. One man stated that these sessions completely changed his mind about the value of TM in treating HIV and suggested that the biomedical system has negative views towards TM:

I have thought about not taking pills and go to traditional healers instead. But when I attended classes here, I learned that traditional medicine doesn't help...it won't help you, but it will make you become worse. (#19, male, age 28, PLWHIV)

Upholding traditional beliefs: 'You bring the ancestors into your home'

Participants also spoke of the merits of TM, suggesting that it is still an important part of the accepted healthworld for some. Whereas some participants expressed negative views on TM generally, ancestor relations were evaluated separately. Participants explained how proper relations with ancestors can improve or even cure health conditions. One man simultaneously endorsed ARVs and strongly criticized healers, but also acknowledged the healing power of ancestors:

I don't want to be healed by people because they are liars. If you go for ukubhula [divination], they tell you a lot of lies... [TM] works better with ancestors. You know, if the ancestors are not looking at you, it means it's bad. Even if your [medicine] is not working well, once you bring the ancestors into your home, you are healed and that means your ancestors are looking at you. It can't heal it by miracle, but it can heal it in a way that [the ancestor] is in the medicine you are

using and the medicine you are using is in the ancestor. (#6, male, age 60, clinic tester)

Others saw merit in seeking spiritual guidance and explained that THPs are often well-intentioned:

They are doing their job, and they are doing it according to their procedures...and considering the information they have at that time. (#14, male, age 32, PLWHIV)

A few pointed out that some THPs are principled, even referring people for HIV testing:

...they don't send you away and say "we can't help you..." Instead, they will say that "I see what your problem is, but the thing is, you should go for testing. (#22, female, age 33, HIV Prevention)

The incompatibility between HIV and TM was attributed to the physiological nature of HIV (internal, blood) being an inaccessible domain for otherwise-effective TM:

Traditional healers...examine what you've got. Maybe [they] see this and that....The thing that's inside the blood, maybe like HIV, they aren't able to find it. (#16, male, age 28, PLWHIV)

The benefits of TM were often described within the context of rumours, gossip, and even advertisements, typically with a tinge of scepticism, but rarely with outright dismissal. A participant who subsequently described the THPs as being "full of lies" shared a story she had heard about a PLWHIV who had been "*healed*":

...there's someone else that went to some other sangoma elsewhere. They made her some medicine which [she] took for 6 months. Then after she got tested and she was negative....I didn't see the results, but I heard. (#13, female, age 25, PLWHIV)

Some noted that THPs and hospitals sometimes coordinated. One participant told of a healer who was given continued access to her patient and made decisions about his hospital care.

Perspectives on concurrent treatments: 'You cannot use two healers at the same time'

Only two participants advocated using both ARVs and TM to treat HIV. The remainder expressed negative views about using TM and biomedicine together, based on their own or others' experiences:

I heard that if you started by going to them [traditional healers] and got help from them, you don't have to take ARVs and [the] treatment they gave you at the same time. They [THPs] want you to use what they've given you and use only that bottle. And you don't have to use anything else like pills. (#24, female, age 23, Prevention Trial)

One woman described a couple who took both ARVs and TM and consequently died. Another woman speculated that people around her got sick from mixing biomedicine and TM:

I think they get sick due to the fact that they are mixing ARVs with traditional medicines, but I am not sure whether it is that or not...because [THPs] are so many and have a lot of medicines. Then you end up confused about which one to buy because...people mix everything (#2, female, age 46, clinic tester)

Participants gave various reasons why one should not use TM and ARVs concurrently. Some stated that ARVs “should be good enough” and pointed to the unpredictable effects of TM on one’s immune system. Multiple participants stated that they were instructed by clinic staff not to mix treatments or participate in traditional healing rituals:

We don’t have to gcaba [making an incision and applying TM there]. We don’t douche. We don’t have to induce vomiting.... A person who is HIV+ should not bleed, should not vomit, and should not douche.... You might die. (#18, male, age 33, PLWHIV)

Some participants, however, believed that TM sold at pharmacies were safer and more effective compared to those obtained from THPs.

Community attitudes towards TM: ‘People hide these things’

Participants were asked general questions about community attitudes towards TM and if they personally knew anyone who used THPs/TM. Many participants reported that most people in their communities regarded TM positively. However, many were said to hide their TM use:

...when it comes to using special medicines, I can’t be sure because people hide these things when using them. Others put them in cupboards, and others in wardrobes, so now you can’t see what that person uses mostly. But you sometimes see them carrying the bottles. (#8, male, age 42, clinic tester)

More than half reported knowing someone who had used TM, or they told a story suggesting that they did. Some stories were positive:

They say they are better; they come back having suppressed it [HIV]. Yes, it weakens the virus. (#16, male, age 28, PLWHIV)

Most stories, however, were negative:

There was a traditional healer that I saw on TV who killed the whole family. You have to go to a person who has got a certificate and you have to see it...a real certificate that certifies that he is really doing this job. And then when he gives you those medicines, you have to have an assurance and to know in order to be able to use them. (#8, male, age 42, (clinic tester)

Some people in the community use them, others end up dead; others remain sick and end up going to the clinic. (#5, female, age 23, clinic tester)

Others said that they did not know anyone who had benefitted from using TM.

Refusal, reluctance, and confusion: *'Let me say I don't know'*

Two noteworthy patterns emerged in response to the interviews' first mention of TM. In one, participants immediately rejected the discussion (prompted by a simple question on their thoughts on TM), often claiming ignorance about TM, only to later reveal familiarity with it. Many would first respond with 'no' or 'I don't have any thoughts;' when further probed, one participant, for example, expressed that TM is bad for HIV, but good for other diseases. Another warned of THP's frequent dishonesty. Some claimed to be unaware of various TM methods. One reported that he did not know specific, widely popular TMs and then later said that some THPs make good medicines for restoring ancestral relations. Some distanced themselves from the TM discussion by saying they do not use it:

...I don't know because I haven't used them, and I haven't even thought about it, and I can't because it's something that is not on my mind (#12, female, age 23, PLWHIV)

Again, when probed, this participant had clearly thought about it, discussing costliness and ineffectiveness:

...you'll buy this medicine. Maybe [it] cost[s] R500, R600 and [you] use it; then you'll find that your CD4 count is right; after that you get sick only to find that you don't have that R600 and what are you going to do then (#12, female, age 23, PLWHIV)

The second pattern made a distinction between TM sold by chemists and the practices of THPs. The former often were often viewed as cleaner and 'tested,' i.e. safer, more effective, more legitimate. One man, reluctant to seek assistance from healers, unequivocally supported medicines from chemists. A somewhat large subset of participants (almost 1/3) initially claimed that medicines from healers were dangerous, and then subsequently expressed apparent ambivalence toward, ignorance of, and/or approval of medicines from chemists. The participant who said that people who take TM from healers end up dead later said that she was unsure of whether or not treatments from chemists were safe, suggesting that she viewed them as in a different category from TM:

I don't know how they like are, their risks, and I am not sure whether they are acceptable or not acceptable.... (#2, female, age 46, clinic tester)

Some who disavowed healers later actively endorsed chemist medicines as healing:

I have heard like some herbal stuff but...it's natural stuff. They said that it helps your immune system or gives you energy and stuff like that. (#3, female, age 19, clinic tester)

I have never believed in them [TM] and that is the truth...I will say it straight; you know there is something that has helped me from a chemist. (#14, male, age 32, PLWHIV)

Discussion

This study of PLWHIV and those undergoing HIV testing, which was conducted three to four years after the roll-out of ARVs in South African public-sector clinics, can inform understanding of the response to ARVs in a setting with a strong tradition of TM and one in which the President Thabo Mbeki (1999–2008) tried to restrict access to ARVs by arguing that they were toxic and had deleterious side effects (Chigwedere, Seage, Gruskin, Lee, & Essex, 2008; Nattrass, 2008; Weber, 2009). Although some studies suggest that the high costs of HIV medications and cultural preferences may encourage PLWHIV in low-resource countries to use TM (Bodeker, Carter, Burford, & Dvorak-Little, 2006), or that PLWHIV may prefer THPs because of their respect for, and ability to communicate with, patients (Groh et al., 2011), this was not evident in our study.

Many participants expressed both positive and negative views regarding TM. Most opposed the concurrent use of TM and biomedicine to treat HIV. No participant in our study expressed a clear opinion that TM was sufficient for dealing with HIV, and most believed ARVs were the most effective option for treating HIV infection. However, some participants suggested that traditional rituals could enhance the efficacy of ARVs, as ancestors would intervene to ensure that the ARVs worked, a view that is reflective of Zulu notions of healing (Appelbaum Belisle et al., 2015), wherein ailments sometimes require attending to both the physical and the social body, that is, the body as cultural artefact on which societal values and norms are imprinted (Scheper-Hughes & Locke 1987).

Participants also expressed many negative views on TM as HIV treatment. Many argued that HIV, a “modern” disease, required “modern” medicine (ARVs). Participants also highlighted the technical limits of THPs, whom they said were not trained to conduct blood tests for HIV or to test immune responses to ARVs, for example.

Our study adds to ongoing debates concerning TM and HIV treatment. Although many study participants expressed disapproval of TM use for HIV treatment, a few hinted that they had personally used TM concurrently with ARVs until they were educated against doing so by clinic staff. Studies have reported varying levels of concurrent TM and ARV use among PLWHIV and conflicting evidence of TM as a potential barrier to ART adherence (Naidoo, 2014; Hughes, Puoane, Clark, Wondwossen, Johnson, & Folk, 2012; Groh et al., 2011). One study in KwaZulu-Natal found that only 4.98% of 281 PLWHIV used TM and ARV concurrently (Sibanda, Nlooto, & Panjasaram, 2016). South African studies suggest a decrease in TM use among PLWHIV who commence ART (Moshabela et al., 2011; Peltzer et al., 2011). In contrast, some studies show that TM use interferes with ARV use. In Zimbabwe, a study of PLWHIV found that when ARV users interrupted treatment, they frequently relied on alternative therapies (O'Brien & Broom, 2014). In urban Kenya, religious events or encounters with TM users influenced PLWHIVs' discontinuation of ARVs (Unge et al., 2011).

We suggest that our participants' views on TM and biomedical treatment for HIV reflect general trends throughout South Africa. We found low TM use prior to diagnosis among 26 PLWHIV in another qualitative Pathways study in 2012; only two reported seeking

treatment for symptoms from THPs prior to HIV testing, although several sought help from chemists (Tariq et al., 2017). Some studies show that TM use has been steadily declining in the country. One review estimated that past-month use of THPs in South Africa was as low as 0.1% in 2009, down from 12.7% in 1995 (Peltzer, 2009). In 2014, a population-based survey found that only 0.5% of participants said they first consult a THP when members of their households fall ill (Statistics South Africa, 2014). The exact reasons for this drop-off are unknown. It is possible that attitudes on TM are now shifting due to the increasing availability of free ARVs and to greater community acceptance of their efficacy. These opinions could swing towards ARVs even more now that universal test and treat is official policy in South Africa (Essop, 2016).

TM nevertheless continues to be relevant in the everyday lives of many South Africans. Our participants did not reject TM altogether, but endorsed it for treating non-HIV-related health conditions, as also was found in a study of PLWHIV in eThekweni who were taking ARVs. In that sample, TM was used to achieve business success and increase sexual virility (Appelbaum Belisle et al., 2015). Participants in our study also differentiated between TM obtained from chemists, which they viewed as more reputable than TM obtained from THPs. Participants who bought *muthi* from chemists often did not consider it as TM use and recounted success stories of friends and family members who benefitted from chemists.

Our study had several limitations. First, participants may have under-reported concurrent ART and TM use because of embarrassment or belief that medical providers were against TM use (Puoane et al., 2012). Participants may also have framed TM as ineffective and biomedicine as the only acceptable HIV treatment because of extensive media coverage about ARVs, regardless of whether they believed this. Secondly, although we observed a range of opinions, the viewpoints might have been shaped by the nature of the sample, as these were people who were voluntarily utilising the public health system. Thirdly, participants may have been reluctant to express positive views towards TM because of the clinic study setting. Finally, our sample was an urban one; TM knowledge and use may be higher in a rural setting (Zuma, Wight, Rochat, & Moshabela, 2016).

Conclusion

In treating HIV, the medical necessity for ARVs is clear. At the same time, although TM for HIV may be fading in popularity, it remains part of the South African cultural framework and cannot be ignored. TM can be a valuable tool of spiritual and psychosocial support, barring the use of methods that may conflict with biomedical treatments. If PLWHIV are to benefit maximally, there is no place for unbridled antipathy towards traditional beliefs. Many therefore advocate for respecting local expertise and collaboration between biomedical and traditional medical systems (Bodeker et al., 2006; Mbawambo, Mahunnah, & Kayombo, 2007; Wreford & Esser, 2008; Gqaleni et al., 2011; Green & Ruark, 2011). Based on our findings, we advocate for an approach grounded in realism. A number of South African campaigns have been launched to educate THPs about HIV in general, and HIV testing and treatment in particular, but more targeted educational campaigns are needed to caution against the use of TM as HIV treatment. At the same time, healthcare providers need to be trained to recognize the full scope of TM and to understand that the type of THP sought may

depend on participants' cultural belief systems. Providers need to learn how to counsel patients about TM respectfully and openly, recognising patients' potential comfort in seeking guidance from THPs, while cautioning them of counterproductive practices and emphasising the importance of medically effective HIV treatment geared towards lowering viral loads, improving CD4 counts, and combating opportunistic infections. Given that educational sessions about HIV in clinics may strengthen and shape patients views about the positive value of biomedicine, clinics need to provide health literacy sessions to educate patients about health in general, and HIV in particular, especially about concurrent use of TM and ARVs. From a global perspective, other countries characterised by high HIV prevalence and substantial ARV coverage may also find diversity in beliefs about TM and biomedicine, have higher rates of THP use than in South Africa, and exhibit no clear-cut pattern regarding concurrent TM and ARV use. Further research is needed, both in South Africa and globally, not only on TM use among people on ARVs and how this might affect ARV effectiveness and adherence (Hughes, Puoane, Clark et al., 2012), but on individuals with not-yet diagnosed HIV infection faced with health-seeking dilemmas.

Acknowledgments

This research was supported by grants from the National Institute of Mental Health (NIMH) (R01-MH08356 and R01 MH083561-03S1) Principal Investigator: Susie Hoffman, DrPH) and a center grant from the National Institute of Mental Health to the HIV Center for Clinical and Behavioral Studies at NY State Psychiatric Institute and Columbia University [P30-MH43520; Principal Investigators: Anke A. Ehrhardt (1987-2013)/Robert H. Remien, Ph.D. (2013-2018)]. The content is solely the responsibility of the authors and does not necessarily represent the official views of NIMH or the MRC HIV Prevention Research Unit (HPRU).

We gratefully acknowledge the clients who shared their experiences and insights with study team members, the Medical Research Council (HPRU) staff, interviewers, and transcribers who worked on the Pathways Study, and the volunteers and staff at Ibis Reproductive Health who assisted with data management and coding.

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Table 1

Demographic characteristics of participants

Characteristics	n (%)
Race	
Black/African	22 (91.7)
Indian or Asian	2 (8.3)
Age group	
<25	3 (23.0)
25–34	8 (62.0)
35	2 (15.0)
Range =19–60 years	
Mean=31.8 years	
Median=28 years	
Education	
None or Standards 1–8	13 (54.2)
Standards 9–10	11 (45.8)
Employment status	
Unemployed	17 (70.8)
Employed	7 (29.3)
Receive government grants	
Yes	16 (33.3)
No	8 (66.7)