

**UNIVERSITY OF MALAWI  
KAMUZU COLLEGE OF NURSING**

**CONCURRENT USE OF TRADITIONAL MEDICINE AND  
ANTIRETROVIRAL THERAPY AMONG AIDS SUPPORT GROUP  
MEMBERS IN LUNZU, BLANTYRE.**

**RESEARCH DISSERTATION SUBMITTED TO THE FACULTY OF  
NURSING IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR THE AWARD OF BACHELOR OF SCIENCE DEGREE IN  
NURSING MANAGEMENT.**

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**DECLARATION**

I hereby declare that this research dissertation is my original work and that it has not been presented elsewhere for a degree program.

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## **DEDICATION**

This research dissertation is dedicated to my wife Rita and our son Thandizo for standing by me through out the study period.

## ACKNOWLEDGEMENTS

I am very grateful to God Almighty for the giving me good health through out the study period.

I would also like to thank Mr A.N.K. Simwaka, Senior Sociology lecturer at Kamuzu College of Nursing who is the supervisor for this research, for his guidance and support.

Lastly, the researcher would like to thank Members of Lunzu AIDS support group for accepting to participate in the study.

## ABSTRACT

The descriptive study used both quantitative and qualitative approaches. The general aim of the study was to explore the practice of concurrent use of traditional medicine and highly active antiretroviral therapy among people living with AIDS in Lunzu, sub-urban of Blantyre in Malawi. Using purposive sampling, 30 participants were drawn from the Chisomo PLWHA support group. The sample comprised of 27 female and 3 males. Pilot study was conducted at Chisenjere AIDS support group in the same location. Permission to conduct the study was sought from relevant authorities and in addition, participants were requested to give informed consent. Data was collected using face to face interview with the participant using the semi-structured questionnaire as a data collection tool and guide. Analysis of the data was done using both SPSS 17 computer package and content analysis. The results were communicated to nursing faculty of Kamuzu college of Nursing, NAMPHAM secretariat, and the Blantyre District Health Officer. The study has found that 63% of AIDS support group members combine traditional medicine and antiretroviral therapy without the knowledge of the health care provider. Uncertified immune boosters and herbs are the most used traditional medicine by clients. Drug side effects and chronic nature of AIDS are some of predictors to the use of traditional medicine. It is recommended that traditional medicine policy be developed to protect the public from some potentially harmful medicine. Finally, more research is needed to explore the efficacy and safety of some the traditional medicines being used by AIDS clients.

## **LIST OF ABBREVIATIONS**

<b>AIDS:</b>	Acquired Immuno Deficiency Syndrome
<b>ART:</b>	Anti Retroviral Therapy
<b>ARV:</b>	Anti Retroviral Drug
<b>DC:</b>	District Commissioner
<b>DHO:</b>	District Health Office
<b>HAART:</b>	Highly Active Antiretroviral Therapy
<b>HCW:</b>	Health Care Worker
<b>HIV:</b>	Human Immunodeficiency Virus
<b>KCN:</b>	Kamuzu College of Nursing
<b>MOH:</b>	Ministry of Health
<b>NAPHAM:</b>	National Association of People Living with HIV/ AIDS in Malawi.
<b>PLWH/A:</b>	People Living With HIV/ AIDS
<b>UNIMA:</b>	University of Malawi
<b>RPC:</b>	Research and Publication Committee
<b>TM:</b>	Traditional Medicine
<b>WHO:</b>	World Health Organization

## **DEFINITION OF TERMS**

### **Traditional medicine**

Traditional medicine is the total sum of knowledge, skills, practices based on 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, 2005)

### **Conventional medicine**

This is a broad category of scientifically proven medical practices recognises as standard care which is practiced by doctors, nurses, and allied health professionals (WHO, 2005).

### **Complementary and alternative medicine (CAM)**

Often refers to a broad set of health-care practices that are not part of a country's own tradition and are not integrated into the dominant health-care system. Other terms associated are "non conventional" and "holistic medicine" (WHO, 2005).

### **Alternative therapy**

Is any practice initiated or prescribed by the patients themselves, their friends or family, or an alternative health care healer (Cady, 2009).

### **Complementary Therapy /medicine**

Complementary medicine means nonstandard treatments that you use along with standard ones. Standard care is what medical doctors, doctors of osteopathy and allied health professionals, such as registered nurses and physical therapists, practice. Alternative medicine means treatments that you use instead of standard ones (WHO, 2005).

**Allopathic medicine**

Allopathic medicine is a broad category of medical practice used interchangeably with western or conventional medicine (WHO, 2005)

**PLWH/A Support group**

This is a group of people comprised of people who have been tested HIV positive who have common purpose of strengthening one another to live positively with HIV or AIDS (MOH, 2004).

**OPERATIONAL DEFINITION****Traditional medicine**

For the purpose of this study, the term refers to the indigenous and non conventional therapies which include: belief in supernatural powers, prayer, use of uncertified claimed oral immune boosters, and herbal medicine.

## TABLE OF CONTENTS

Title page.....	i
Declaration.....	ii
Dedication.....	iii
Acknowledgements.....	iv
Abstract.....	v
List of abbreviations.....	vi
Definition of terms.....	vii
Table of contents.....	ix
List of appendices.....	xii
List of tables and figures.....	xiii

### 1.0 CHAPTER ONE: INTRODUCTION

1.1 Introduction.....	1
1.2 Background.....	1
1.3 Problem statement.....	3
1.4 Significance of the study.....	3
1.5 Broad objective.....	4
1.6 Specific objectives.....	4

### 2.0 CHAPTER TWO: LITERATURE REVIEW

2.1 Historical perspective of traditional medicine.....	5
2.2 Access and control of traditional medicine.....	6
2.3 Use of traditional medicine for various ailments.....	7
2.4 Use of traditional medicine among people with AIDS .....	8
2.5 Use of traditional medicine and adherence to antiretroviral therapy.....	9
2.6 Factors influencing patients to disclose use of traditional medicine.....	9
2.7 Integration of traditional and conventional medicine.....	10
2.8 Summary of literature review.....	11

### **3.0 CHAPTER THREE: THEORETICAL FRAMEWORK**

3.1 Introduction.....	12
3.2 Description of the theoretical framework.....	12
3.3 Application of the framework.....	14

### **4.0 CHAPTER FOUR: RESEARCH METHODOLOGY**

4.1 Study design.....	16
4.2 Study setting.....	16
4.3 Study population and sampling methods.....	17
4.4 Data collection.....	17
4.5 Data analysis and presentation.....	18
4.6 Reliability .....	18
4.7 Validity.....	19
4.8 Trustworthiness and credibility.....	19
4.9 Ethical consideration.....	19
4.10 Dissemination of the results.....	20

### **5.0 CHAPTER FIVE: RESEARCH RESULTS**

5.1 Introduction.....	21
5.2 Demographic data.....	21
5.3 Proportion of members combining traditional medicine and HAART.....	23
5.3.1 Types of traditional medicine used.....	24
5.3.2 Source of information on traditional medicine used.....	25
5.4 Factors influencing clients to use traditional medicine.....	25
5.5 Use of traditional medicine and adherence to HAART.....	28
5.6 Disclosing of traditional medicine use by clients.....	29
5.7 Views of members on integration of TM and conventional medicine.....	30
5.8 Summary of the findings.....	30

**6.0 CHAPTER SIX: DISCUSSION, RECOMMENDATIONS AND  
LIMITATIONS OF THE STUDY**

6.1 Introduction.....31

6.2 Discussion of the findings.....31

    6.2.1 Proportion of combining TM and antiretroviral therapy.....31

    6.2.2 Factors influencing AIDS clients to combine TM and ARVs.....33

    6.2.3 Disclosure of use of traditional medicine by clients.....35

    6.2.4 Use of traditional medicine and adherence to ARVs.....37.

    6.2.5 Integration of traditional and conventional medicine.....37

6.3 Conclusion.....38

6.4 Recommendations.....39

6.5 Implications of the study to nursing.....39

    6.5.1 Implications to nursing management.....39

    6.5.2 Implications to nursing practice.....40

    6.5.3 Implications to nursing education.....40

    6.5.4 Implications to nursing research.....41

6.6 Limitations of the study.....41

6.7 Areas for further research.....41

**7.0 REFERENCES.....42**

## 8.0 LIST OF APPENDICES

Appendix IA: Questionnaire (English).....	49
Appendix 1B: Questionnaire (Chichewa).....	53
Appendix 2A: Consent Form (English).....	58
Appendix 2B: Consent form (Chichewa).....	59
Appendix 3A: Letter seeking permission to conduct the study KCN- RPC.....	60
Appendix 3B: Letter granting permission to conduct the study from KCN-RPC.....	61
Appendix 4A: Letter seeking permission to conduct the study from the Blantyre DC...62	
Appendix 4B: Letter granting permission to conduct the study from the Blantyre DC..63	
Appendix 5: Letter granting permission to conduct the study from Blantyre DHO.....	64
Appendix 6A: Letter requesting permission from NAPHAM to conduct the study.....	65
Appendix 6B: Letter from NAPHAM granting permission to conduct the study.....	66
Appendix 7A: Letter requesting study permission from Lunzu AIDS support group...67	
Appendix 7B: Letter granting study permission from Lunzu AIDS support group.....	68
Appendix 8: Letter requesting permission from Chisenjere AIDS support group.....	69

## LIST OF FIGURES

Figure 3.1: Diagrammatic representation of the Health Belief Model.....	13
Figure 3.2: Modified Health belief model.....	15
Figure 5.1: Types of traditional medicine combined with antiretroviral therapy.....	24
Figure 5.2: Reasons for combining traditional medicine and antiretroviral therapy.....	26
Figure 5.3: Traditional medicine use in relation to age.....	27
Figure 5.4: Traditional medicine use in relation to educational level.....	28

## LIST OF TABLES

Table 5.1: demographic data of the participants.....	22
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## **1.0 CHAPTER ONE: INTRODUCTION**

### **1.1 Introduction**

Traditional medicine is the total sum of knowledge, skills and practices based on theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in prevention, diagnosis, improvement or treatment of physical and mental illness (WHO, 2005). Traditional Medicine is widely used in the prevention, diagnosis and treatment of an extensive range of ailments. In the western countries, since the 1960's, there has been a striking growth of consumer interest in traditional medicine while in Africa approximately 80% of the population use traditional medicine as a primary health care source (WHO, 2005; Chisala, 2005).

In the current HIV/AIDS pandemic burdened Africa, the western drugs of antiretroviral therapy (ART) continue to revitalise hope by prolonging life of those infected with HIV. In addition, support groups of people living with HIV have been playing a major role to provide social care. It is also at these forums where members exchange knowledge and positive living is reinforced. However, little is known of the prevalence and pattern of the use of traditional medicine among people living with HIV in Malawi. This study, therefore, wanted to explore the practice of concurrent use of traditional medicine and antiretroviral therapy among people living with AIDS.

### **1.2 Background**

In most societies, existence and use of traditional medicine precedes that of the conventional therapies. Chisala (2005) points out that traditional medicine prescription and use are inherent in one's own cultural values, practices and beliefs and as such vary from one society to another. Individuals do not only use cultural lens to perceive illness but also to decide where to seek care and treatment. Even though the most prevalent choices of health care are the use of traditional medicine or western medicine, people freely move between these paradigms (Peltzer, Anderson, Fomundan, & du-Preez, 2009).

In Africa, due to low access to medical services, traditional healers are the major health resource for a larger population (Chisala, 2005; Peltzer et al., 2009). However, the reasons why clients use traditional medicine seem to be more complex. Boon et al. (1999) as cited by Baarts & Pedersen (2009) reveals that there are mainly two motives for choosing traditional medicine and these are; bad experience with the conventional medicine and just a mere attraction to traditional drugs.

In general, use traditional medicine is highly correlated to chronic illness. This is the case because chronic illness continues to be a disruptive experience for the majority of people and thus involves adopting various approaches to health. Specifically, there is evidence that a higher proportion of people living with HIV/AIDS use traditional medicine. This is regardless of the fact that the clients are on highly active antiretroviral therapy (HAART) or not (Duggan, Peterson, & William, 2001; Peltzer et al., 2009; Thorpe, 2009).

The population in general and HIV Patients in particular access information on traditional HIV therapies through the media on the radio and other sources. To this researcher's knowledge, even after the introduction of free ARV, Government of Malawi for two occasions has been forced to refute allegations of HIV cure known as Mchape and Chambe concoctions respectively.

Chronic illness and AIDS management requires multi-sectored approach and community support for those affected and infected with HIV. In Malawi, support groups of people living with HIV/AIDS are referral point for those who have been found HIV positive. These support groups provide social support to its members. In addition, it is at a social group where knowledge and lived experiences are shared which helps to reduce stress and influence positive living (Kange'ethe, 2009). The study thus particularly aimed at finding out from members of one of these AIDS support groups on the practice of concurrent use of traditional medicine and conventional medicine among members of the people living with AIDS.

### **1.3 Problem statement**

Even though conventional medicine and traditional therapy paradigms operate parallel in Malawi, the country's constitution recognises the former only. Without traditional medicine policy, however, there could be some remedies that are helping and improving the quality of life of people living with HIV/AIDS. Conversely, the practice poses potential risk of interaction with and non-adherence to HAART regimen. This study thus, aimed at finding out from the AIDS patient's perspective the practice of concurrent use of HAART and traditional medicine.

### **1.4 Significance of the study**

Bearing in mind that there are few published studies on traditional medicine in Malawi, the research findings bring an awareness of the need to establish and maintain a regulatory mechanism for the control of traditional medicine in line with the National medicine policy for Malawi of 2009.

In addition, the results of the study may also help health care workers to improve communication so that they can facilitate AIDS clients to reveal the use traditional medicine and be able provide appropriate guidance.

The results of the study may also provide foresight to the research institutions of the need to conduct further researches on some of claimed HIV traditional therapies so that the population can have access to information which is evidence based. Large scale studies on traditional medicine use will also help to determine the magnitude of perceived interference between HAAT and traditional medicine.

Nursing training institution may benefit from these findings by reviewing curriculum so that issues and trends on traditional medicine are included. Such a curriculum will help to train nurses who would competently advise HIV clients who are combining traditional and conventional medicine.

### **1.5 Broad objective**

To explore the practice of combining traditional and highly active antiretroviral therapy (HAART) among people living with AIDS in Lunzu, Blantyre.

### **1.6 Specific objectives**

1. To estimate the proportion of AIDS patients on HAART using traditional medicine.
2. To identify factors that influence use of traditional medicine among AIDS support group members who are on HAART.
3. To determine facilitators to disclosing use of traditional medicine to the professional health care workers by AIDS patients.
4. To assess adherence level to HAART regimen among patients who are using both traditional medicine and antiretroviral therapy.
5. To find out the views of AIDS patients on the integration of traditional HIV therapies and conventional medicine.

## **2.0 CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Historical perspective on traditional medicine**

Traditional medicines meaning, prescription and use is inherent in the societal culture (Chisala, 2005). Through research some of the traditional medicines proven to be helpful have been incorporated into the conventional health system (WHO, 2005). For example, a prayer which has its base from the belief in supernatural powers is now considered part of the formal nursing care (Basford & Slevin, 2007). Thus to a larger extent traditional medicine represents a subset of scientifically unproven medicine for which evidence is lacking (Pal, 2002). These unproven therapies are used either to complement or as an alternative medicine (CAM) to conventional medicine.

Though there is recognised common definition of tradition medicine, cultural relativeness to the use of traditional medicine makes it difficult to categorise and classify the traditional medicine (WHO, 2005). However, there are two most agreed categories of traditional medicines namely; body and mind therapies and physical therapies. The body and mind therapies include; the belief in supernatural powers not only as the route cause of illness but as also the source of healing power (Pal, 2002). On the other hand, the physical therapies involve, but not least, the ingestion of substances like herbs, minerals and animal products (Pal, 2002; WHO, 2005; Peltzer et al., 2009).

Some of wide spread systems of complementary or alternative medicine are Ayurveda, Chinese Medicine, Chiropractic, Homeopathy, acupuncture, and Unani (WHO, 2001). Even though traditional medicines are well recognised in African society, the dawn of colonialism and introduction of Christianity made traditional medicines unpopular especially because it was being likened to witch craft (Chisala, 2005). In Africa in general and Malawi in particular, the most widely used are herbal medicine and body and mind therapies (Duggan et al., 2001; WHO, 2005).

## **2.2 Control, access and marketing of traditional medicine**

Regulation of traditional medicine has been a public health issue in pursuit to protect the consumer of health services from harmful practices (Bodeker, Gemma, & Carter, 2006; Mills, Cooper, Seely, & Kanfer, 2005; WHO, 2005). While this is possible with conventional biomedical products, diverse in definition of traditional medicine from one country to another makes regulation a challenge (Chisala, 2005). World health organization survey on registration and regulation of traditional medicine (2005) indicated that 48% of its members had policy on traditional medicine. In the United States of America, with mandate of the congress, the office of alternative medicine oversees the issues related to traditional medicine was established in (Pal, 2002).

In Europe at the conference of European presidents of European Parliament in 1995 recommended the committee on Environment, public health and consumer protection to be conducting studies on traditional medicine and advice parliament on how non conventional medicine would be allowed (WHO, 2005). African presidents, as well, are not lacking behind, at their meeting in Zambia, they declared the period 2001-2010 a decade for African medicine (Chipolombwe, 2004; Mkoka, 2007). In South Africa, there is a department of traditional medicine in the Health ministry. While in Zimbabwe the Zimbabwean traditional healers association coordinates issues related to traditional medicine in the country (Chisala, 2005).

The situation in Malawi is relatively different, though the traditional healers association of Malawi coordinates the activities of the traditional healers, the current Nursing and medical Acts do not include traditional practitioners (The laws of Malawi, 2004). In addition, marketing of traditional medicine in Malawi is liberalised. For example, daily times News of 23 May, 2010 advertised selling of traditional medicine claiming to cure AIDS. However, majority of people learn more about traditional medicine from their relatives and friends. Mills et al. (2005) concludes that for safety of the consumer tradition medicines have to be researched and regulated.

### **2.3 Use of traditional medicine for various ailments**

Baarts (2009) reports that in the United States of America, one third of the population use traditional medicine. In Denmark's (2005) National health Interview Survey it was estimated that 45.2% had drawn services from the traditional practitioner. Use of traditional medicine has been reported among Cancer patients in Iran a (Montazeri et al., 2007). Ben-Arye et al. (2009) conducted a study in Israel on integration of herbal medicine in primary care among Jews and Arabs in Israel. The results revealed that 42% of the respondents had used alternative medicine in the previous year and 31% of these used herbal medicine. It is estimated that one third of the world population use traditional medicine while more than half of the population in Africa use traditional medicine (WHO, 2005).

In Africa use of traditional medicine has been reported in several countries. For example, Van de Kooi Van der Kooi and Theobald (2006) did a study South Africa to explore the use of traditional medicine in pregnancy. The results revealed that traditional medicine called KAGBA is used in pregnancy to induce labour. In Malawi, the health seeking behaviour of the people starts with home remedies followed by seeking care from the traditional practice and finally seeking care from the clinic or hospital (Kaponda, Chihana, Chilemba, Hatchet, Nyando, Simwaka, & Levy, 2004).

Documentation exists in Malawi on the use of traditional medicine among patients with corneal eye disease (Courtright, Divala, Kanjaloti, & Lewallen, 1994). Brower, Boeree, and Harries (1998) reported use of traditional medicine among Tuberculosis patients while Zacharia et al. (2002) identified use of traditional medicine among patients with sexually transmitted infections. In another study, Brouzan et al. (2007) found out that prior use of traditional medicine (herbs) before admission was a contributory factor to bacteraemia among admitted children with severe Malaria at the Queen Elizabeth central hospital.

Globally and locally, there is evidence that use of traditional medicine is common among patients with chronic illnesses like cancer, Diabetes Mellitus and HIV/AIDS (Peltzer et al. 2009; Thorpe, 2009). Prevalence in use is supported by the fact that chronic conditions are disruptive and thus influence individual health seeking behaviour towards intense need to have decent quality life and therefore broadening the options for managing chronic illness (Sugimoto, Ichikawa, & Siriliang, 2005; Owen-Smith, Diclemente, & Wingood, 2007 ).

#### **2.4 Use of traditional medicine Among People living with HIV/ AIDS and on HAART**

It is estimated that a larger proportion of about 80% of people living with HIV/AIDS (PLWHA) use traditional medicine and that the majority use these, practices in addition to biomedical practices (Thorpe, 2009). In general, chronic illness like HIV alters the self concept or image, this is perpetuated by physical incapacitation and loss of body mass (*A.N.K. Simwaka, senior lecturer in sociology (UNIMA), personal information, 1<sup>st</sup> July, 2010*). In developed countries like the United States of America people use traditional medicine or complementary medicine for the treatment of HAART side effects and to boost immunity and also to have control over their daily treatment practices (Bodeker et al., 2006; Liverpool et al., 2004; Owen-Smith et al., 2007).

In Africa, however, prevalent use of traditional medicine among people living with HIV is attributed to low access to antiretroviral therapy (Bodeker et al., 2006; Peltzer, 2009). However there are more reasons than low accessibility because even when AIDS patient have been started on antiretroviral therapy, a considerable proportion still use traditional medicine (Duggan et al., 2001; Langlois-Klasser, Gian, Kip, & Rubalo, 2007; Peltzer et al., 2009). Dahab et al. (2008) found that long waiting at the clinic and belief in traditional are some of other contributory factors while Sugimoto et al. (2005) identified improvement in mental among clients using both HAART and traditional medicine. However, in Malawi pattern and use traditional medicine among HIV patients has not been recorded.

## **2.5 Use of traditional medicine and adherence to HAART**

Effectiveness of antiretroviral therapy to a larger extent depends on adherence to therapy and advice (Nyambura, 2009). Owen-smith et al. (2007) did a study in Alabama on the relationship between use of complementary medicine and adherence to antiretroviral among female patients. The results revealed that use of complementary and alternative therapies was related to missing of the dose of HAART. This is in agreement with the results of the similar studies done in Africa on adherence to HAART among AIDS patients who are using traditional medicine (Stevens, Kaye, & Corrah, 2004; Nyambura, 2005; Dahab et al. 2008; Peltzer et al., 2009).

In a clinical study Mills et al. (2005) found that traditional medicinal herb called *Hypoxis* reduces efficacy of antiretroviral therapy and has long term auto immune effects. However, relationship between use of traditional medicine and adherence to HAART has not been explored in Malawi.

## **2.6 Factors influencing clients to disclose the use of traditional medicine to the conventional health care providers.**

Sources of information on available traditional medicine are but not exhaust; relatives, friends, health care worker, media and support groups (Liu et al, 2009; Chipolombwe & Muula, 2004). Most clients are not comfortable to inform the health provider on their use of traditional medicine (Faragon et al., 2002; Thorpe, 2009). The main reason for not revealing is for want of control over the treatment as opposed to conventional therapy where the client has little autonomy (Cady, 2009). Effective communication between the client and the professional has been identified as an effective way of collecting information on the use of traditional medicine (Montazeri et al., 2007; Liu et al., 2009). However without any policy on this, the health professional would fail to appropriately assist the client.

Studies have revealed higher correlation between not disclosing of traditional medicine use and non adherence to conventional medicine including the antiretroviral therapy. In their study, Liu, et al. (2009) concluded that patients who do not reveal their usage of traditional medicine are likely not to adhere to conventional medicine and advice.

## **2.7 Integration of traditional medicine and conventional medicine**

Although traditional medicine and conventional medicine and practices complement each other, in the sense that the patient has variation in seeking health care, there is still a gap between the two sides (Peltzer et al., 2009). Some of the factors leading to incongruence are; power struggle, little or no knowledge of the counterpart scope of practice (Chipolombwe, 2004; Faye et al., 2010). However, WHO from 2003 has been taking deliberate step to close the gap of between the traditional and conventional health care.

The current global traditional medicine strategy has the following aims: framing the policy, enhancing safety; efficacy and quality; ensuring rational use; and ensuring access (WHO, 2005).

In the southern Africa, the government of Zimbabwe and South Africa promotes traditional medicine practice and research on the traditional healing methods for possible integration into the main health system (Chisala, 2005). While in Malawi the traditional healers have been part of the primary health care providers, there are no clear guidelines and terms of reference between the traditional and conventional medicine practitioner with susceptibility of the counterpart's role (Chipolombwe, 2004).

The debate on incorporating traditional medicine into the main health care system and related regulation is long overdue especially with the HIV pandemic which requires multi sectored approach (Kaponda et al., 2004; Bodeker et al., 2006; Mills et al., 2006; Owensmith et al., 2007). Early diagnosis and treatment of HIV requires increased awareness and knowledge of HIV/AIDS appropriate referral system from the community to the health facility. Traditional healers in particular have a role to play in the fight against HIV because they are consulted at the primary level (Faye, Traore, Wone, Ndiaye, & Tal-Dia, 2010).

## **2.8 Summary of literature review**

One third of the world's population use scientifically unproven medicine either as a complement or an alternative to conventional therapy. Traditional medicine is a subset of these complementary and alternative therapies. In Africa, where essential drugs are in short supply, 80% of the population use traditional medicine as the first line of care. Furthermore, 50% of people living with HIV/AIDS use traditional medicine before or after they have been started on active antiretroviral therapy (HAART). On one hand traditional medicines improve quality of health but on the other hand it is associated with non-adherence to HAART. In Malawi, there is no policy regulating use and marketing of traditional medicine. Further more, a gap still exists on studies related to pattern in use of traditional medicine among people living AIDS who are on HAART.

### **3.0 CHAPTER THREE: THEORETICAL FRAME WORK**

#### **3.1 Introduction**

A framework is primarily a borrowed word from engineering. It generally means an infrastructure upon which structure is built (Basford and Slevin, 2003). This physical concept may, however, become a metaphor for thinking frame work. In this context, there are set of principles and guidelines become the frame of how we think and act in respect of particular phenomena (George, 2007). The conceptual frame work, after being tested and applied later becomes a model or a theory but to a greater extent serve the same purpose. This study, in particular, was influenced by the Health belief model by Albert Bandura (Basford & Slevin 2007).

#### **3.2 Description of the theory**

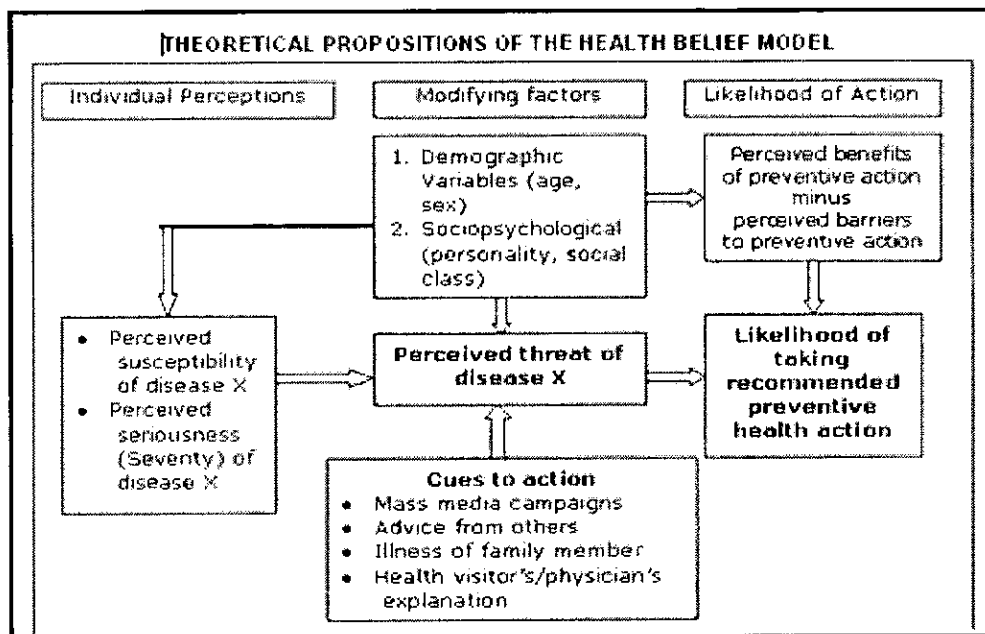
The major concepts of the theory includes; perceived susceptibility, perceived severity, perceived benefits , perceived costs, motivation, and enabling factors (George, 2009).

Perceived susceptibility refers to a person's perception that a health problem is personally relevant or that the diagnosis of illness is accurate. Compliance to prescription or preventive measures will be a problem if the client has not found any relevance and association between the prevailing situations and himself.

However, even if the person has recognized personal susceptibility, action will not occur unless the client perceives the severity to be high enough to have serous organic or social implications (Burns and Grove, 2009). In general, motivation is necessary for the client to take the action. Motivation includes the desire to comply with a treatment but specifically, the costs related to duration, accessibility to treatment determines probability of how one will comply with prescription (figure 3.1).

The theory further explains that personality variables termed modifying factors like age and socio-demographic factors have a bearing factor on health seeking behaviour and treatment compliance (George, 2009).

External to the patient or client are cues to action. Cues to action are strategies to activate readiness to follow the treatment or advice. Some of the cues that may activate the client are; access to information, observing others benefiting from the treatment also referred to as vicarious reinforcement and regulation or punishment attached to the action.



Reference: E:\Health Belief Model.

Fig 3.1: diagrammatic representation of the original formulation of health belief model (Chen & Land, 1986)

### **3.3 Application of the Health belief Model to the study**

Both the popular and conventional sectors of health provide arena where one can seek treatment. Using of conventional or traditional medicine or both remedies by HIV patients would be greatly influenced by perceived severity of the problem physically, socially, and psychologically.

AIDS which is at the moment scientifically pronounced incurable it has death as its ultimate end hence this may be perceived severity of the disease. In addition, changes in physical appearance and physical activity abilities (Figure 3.2) may influence the patient to acknowledge the threat of the disease and seek any alternative therapy to improve quality of life depending on perceived benefits, motivation and modifying factors.

The economic status of the client can be a modifying factor for one to use traditional medicine in areas where antiretroviral therapy is scarce or provided with a fee attached. There are some institutions which provide free antiretroviral therapy but the management of the side effects is charged for. In such situations, clients still may opt for traditional medicine to relieve the ARV side effects like numbness of the fee among others.

Based on the health belief model various sources of information from friends, mass media, and health care workers can be cues to action that would activate readiness of an HIV patient to seek treatment either from conventional medicine practitioners or traditional medicine practitioners or a combination of both (figure 3.2).

There are some challenges that may be experienced when the client has chosen to combine the antiretroviral therapy and traditional medicine includes and these include; non-adherence to ARVs, and possible drug interactions.

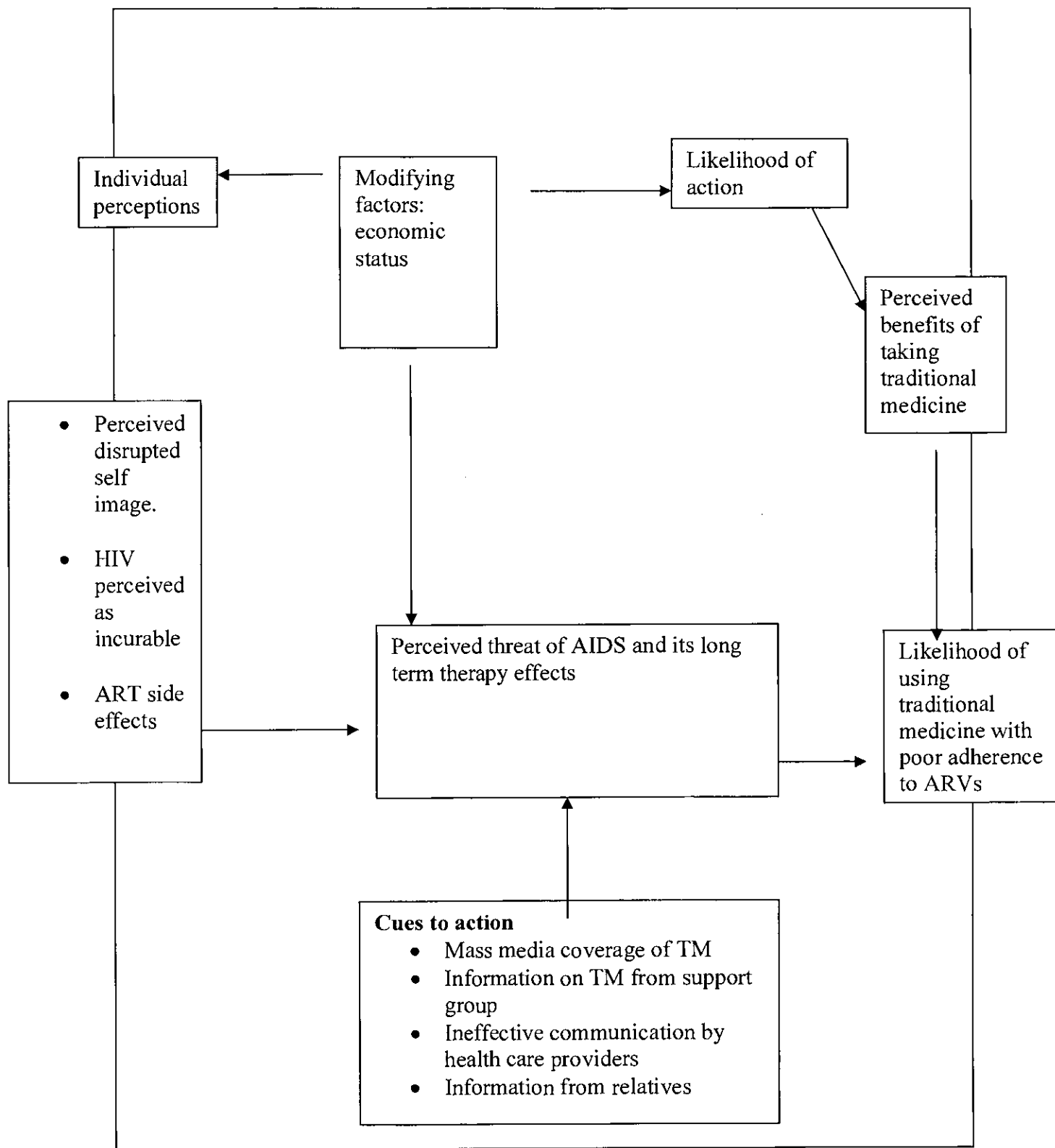


Diagram 3.2: modified health belief model theoretical framework

## **4.0 CHAPTER FOUR: RESEARCH METHODOLOGY**

### **4.1 Study design**

The descriptive study design adopted both qualitative and quantitative approaches. The research design is influenced by the purpose and objectives of the study (Burns and Groove, 2009). The researcher would like to explore use of traditional medicine which most people are not comfortable to reveal as such descriptive design is ideal because it permit studying a phenomenon as it naturally happen without predictions (Rees, 2003).

The purpose of descriptive study is to provide a picture of phenomenon or situations as they naturally happen (Burns and Grove, 2009). Typical descriptive design is ideal for studies, like this one, requiring knowledge in an area in which little research has been conducted. Further more, descriptive studies help to unearth problems with the current practice, justify current practice, and make judgements (Munhall, 2007).

The study had included quantitative methods not only to estimate the proportion of the support group members using traditional medicine but also to identify predictors to the use traditional medicine. In relation to its premise, quantitative approach is ideal when the purpose is to generalise the findings to the study population as well as in predicting behaviours or parameters under study (Burns and Groove, 2009; Rees, 2003).

### **4.2 Setting**

The study was conducted in rural area of Blantyre district called Lunzu. The site was chosen because there was already an existing and well established support group of people living with AIDS called Chisomo. The support group also operate as a referral point for clients who have tested HIV and or have been started on HAART at Mlambe Mission hospital for social support. The main purpose of conducting the study close to the client's environment was in an effort to maintain the environment as natural as possible so that the patients could express themselves freely than it could have been the case at the health facility.

### **4.3 Population and sampling methods**

The population is clearly defined group who share common characteristics as specified by the researcher (Rees, 2003). In this study, the study population comprised of members of Chisomo support group of people living with HIV/AIDS in Lunzu, Blantyre. From this population, a sample of 30 participants was drawn. The inclusion criteria included recruiting members who were 18 years and above, HIV positive and on antiretroviral therapy at the time of the study.

The participants to the study were drawn using purposive sampling method. Streubert and Carpenter (1999) as cited by Rees (2003) states that using this method the researcher includes individual or events on the basis of the researcher's knowledge of their relevance for the study. Although this seem to produce biased sample, the advantage of the method is that the sample is known to possess key characteristics felt should be included in the study. In addition the method is practical and efficient of time and money.

The intention was to recruit both sexes equally thus 15 male and 15 female. However, only three men volunteered to participate in the study hence the sample composed of 27 females and 3 males.

### **4.4 Data collection**

Face to face interview with the participants was the method of data collection using semi-structured questionnaire as a guide and data collection tool (Appendix 1A&B). This method has been used in several studies with the aim of exploring the practice of using traditional medicine and yielded intended results (Mesmer, 2001; Sugimoto et al., 2004; Langlois-Klasser, 2007; Ben-Arye et al., 2009; Liu, 2009). Though prepared in English, the translated Chichewa questionnaire was administered during the interviews (Appendix 1B). The researcher and one data collector conducted the interviews on all participants approximately each interview had taken 20 minutes.

Face to face interview helps to build rapport between the researcher and the informant in addition, clarification on the responses can be made spontaneously on the open ended questions or where clarification is needed (Polit and Beck, 2008).

It was also necessary to access the health passport book of the patient to verify if the patient was on antiretroviral drugs hence face to face interaction was a necessity. However, face to face interview disrupts communication between data collector and the informant as notes are being written (Burns & Grove, 2009).

#### **4.5 Data analysis and presentation**

Data analysis is the method of organizing data in order to answer research questions (Burns and Grove, 2009). After data collection, questionnaires were cross checked manually to identify areas that needed immediate clarification from the data collector. This process helped to ensure that data to be analysed represented what was collected in the field. Numerical data was analysed by descriptive statistics on computer package (SPSS 17). Before using the computer program, the data was coded. The program had been chosen because it is capable of analysing quantitative data and was also used in similar study by Mesmer (2001) and yielded the intended results.

Use of computer may alter the aesthetic of narrative data (Burns and Grove, 2009). For this reason, responses to unstructured questions were analysed using clustering. Firstly, such data was reduced in volume by identifying patterns or themes from the data. Then the themes were sorted into groups the process called clustering (Rees, 2003). This process is similar to content analysis method of data analysis (Burns and Grove, 2009). The numerical findings have been presented in descriptive statistics tables, charts and graphs. Responses to unstructured questions have been presented in narratives.

#### **4.6 Reliability of results**

Reliability is the ability of the study tool to produce same results if test it for several times. To assess its reliability, the questionnaire was piloted on five participants at Chisenjere AIDS support group in the Blantyre before using it "live" (see appendix 8).

Piloting the questionnaire helped the researcher to assess the clarity of instructions, to test ambiguity of the questions, and to find out if the lay out was easy to follow thus using test-retest method (Grove and Burns, 2009).

#### **4.7 Validity**

Validity in questionnaire studies is the extent to which the questions provide a true measure of what they are designed to measure (Rees, 2003). Partly this was addressed through piloting but also a review of the tool by the research supervisor. To ensure reliability during data collection, the data collector was trained on how to reduce bias during data collection (Munhall, 2007).

#### **4.8 Trustworthiness and credibility**

Trustworthiness refers to what degree the participants have been fully included in the research (Munhall, 2007). On the other hand credibility is the truth of the findings as judged by both participants and others within the discipline (LoBiondo-Wood & Haber, 2006). The researcher was operating under the supervision of well experienced researcher who also assisted in reviewing the data and the whole research process. In addition the researcher had made sure to bracket personal bias in the study for the findings to reflect participant's perspective. Combining both qualitative and quantitative approach to address research question also helped to have a wider perspective on the research question.

#### **4.9 Ethical consideration**

Nursing research requires not only expertise and diligence but also honesty and integrity (Burns and Grove, 2009). Before conducting the study, permission was sought from Kamuzu college of Nursing Research and Publication committee (Appendix 3A&B) to scrutinise the intent and process of the research with an aim of ensuring that participants were protected from harm. Secondly, the approval was sought to carry out the research from the following relevant authorities; the Director of National association of people living with HIV/AIDS, the District Assembly, the District Health Officer, the Executive committee of the support group, and the Village Headman (Appendix 3-7).

The risks on participants related to the study involved; disclosing one's HIV status and treatment being taken and spending 20 minutes to respond to questions. To ensure right to anonymity, codes were used instead of names during data collection and analysis. In addition, no identifying details like phone number, address or work place were asked from the client to avoid linking information to the data source. Information was kept in a locked cabinet to avoid unauthorised access to the data and soon after report writing the information was destroyed.

Interviews were conducted in a room at the support groups' centre to provide audiovisual privacy. This environment had been chosen because it is away from the subject's home to avoid arousing suspicion from relatives who may not have known the participants HIV status hence upholding the client's right to disclosing HIV status.

In addition to seeking permission from the relevant authorities, the researcher had also sought informed consent (Appendix 2A&B) from the participants in respect for their right to participation and autonomy (Burns & Grove, 2009). To facilitate the ability of the patient to make the informed consent, explanation was given on the following: direct and indirect benefits, perceived discomfort involved, and assurance of how confidentiality will be maintained (Munhall, 2007).

During data collection, some of the AIDS group members had opted out of the study because of time constraints and commitment with other duties. Such informants were allowed not to participate in order to respect their human right of autonomy, and right to refuse or withdraw from the study.

#### **4.10 Dissemination of the results**

After data analysis a dissertation of the study was submitted to the faculty of nursing at Kamuzu College of Nursing because the study was partial fulfilment for the degree in nursing programme which the researcher was undergoing. Another copy was also made available to the Blantyre District Commissioner because the study was conducted in the area where they were responsible for coordinating services.

## **5.0 CHAPTER FIVE: RESEARCH RESULTS**

### **5.1 Introduction**

The data comprised of both quantitative (numeric) data and narrative data responses for question requiring explanations. Quantitative data was analysed using SPSS 17 computer package. However, data in narrative form was analysed manually by themes before being presented.

### **5.2 Demographic data**

#### **5.2.1 Sex, age and tribe of participants**

The study population was total of 30 participants, 27 (90%) ladies and 3 (10%) males. More participants 9 (30%) belonged to the age group of 46 years and above with least numbers of participants 1 (3.3) in age group of below 25 years. On the tribe of the participants, dominating were the Ngoni which were 11 (36%) and the least being the Tumbuka and the Sena with 3.3% representation respectively (Table 5.1).

#### **5.2.2 Education and marital status of participants**

In relation to the educational level of the participants, 1(3.3) could not write or read, 18 (60%) had attended primary education, 10 (33) attended secondary school education while only 1 (3.3%) had post secondary school educational qualification. Participants were also asked about their marital status and the results showed that 7 (23%) were single, 12(40%) were married, 2(6.7%) had been divorced, while 9 (30%) were widowed.

#### **5.2.3 Occupation of the participants**

Access and utilization of health services to a certain extent is determined by the availability of funds at individual level. The analysis of the study sample with n= 30 revealed that 10 (33.3%) were employed, 5 (16.7%) were business person, 7 (23.3%) were farmers while 8 (26.7%) had no occupation of some kind (Table 1). The portion of the sample that used traditional medicine before starting antiretroviral therapy had occupation pattern as follows: 7 (37%) were employed, 3 (16%) were doing business, 4 (21%) were farmers and 5 (26%). For those employed, 3 (30%) were teachers, 7 (70%) were support staff falling in subordinate class of workers.

<b>Variable</b>	<b>Frequency</b>	<b>percentage</b>
<b>Sex</b>		
Male	3	10
female	27	90
<b>age</b>		
21-25	1	3.3
26-30	2	6.7
31-35	4	13.3
36-40	8	26.7
41-45	6	20
46>	9	30
<b>Education</b>		
No education	1	3.3
Primary	18	60
secondary	10	33.3
Tertiary education	1	3.3
<b>Occupation</b>		
employed	10	33.3
Business	5	16.7
Farming	7	23.3
None	8	26.7
<b>Marital status</b>		
Single	7	23.3
married	12	40
Divorce	2	6.7
widowed	9	30
<b>Tribe</b>		
Tumbuka	1	3.3
Ngoni	11	36.7
Lomwe	6	20
Sena	1	3.3
Yao	8	26.7
Others	3	10

**Table 5.1: Frequencies and percentages of demographic data for the participants**

#### **5.2.4 Religion of the participants**

Traditional medicine use is more of cultural issue as such participants were asked of their religion; 7 (23%) belonged to Roman Catholic, 5 (16.7%) belonged to CCAP, 5 (16.7%) were seventh Day Adventists, 4 (13.3%) were Moslem while the remaining 9 (30%) belonged to other denominations (Table 5.1). Other denominations included; Baptist, Assemblies of God, Living waters church, and the Church of Christ.

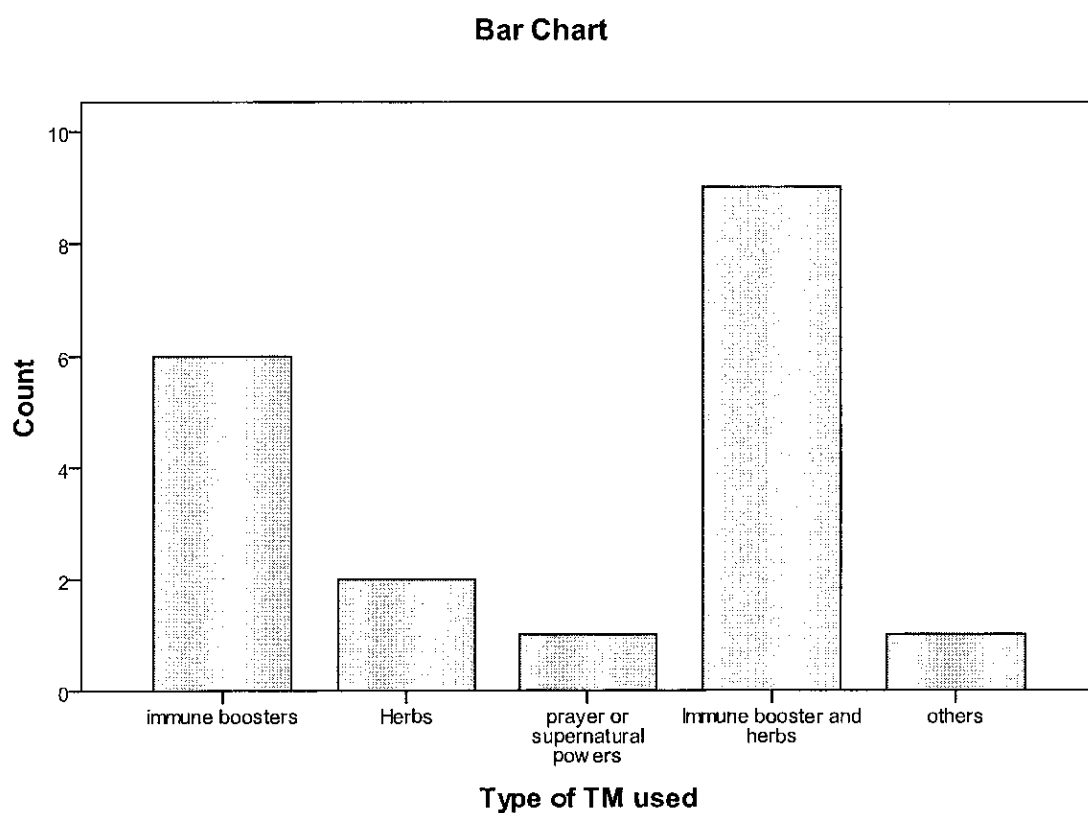
#### **5.3 Proportion of clients combining traditional medicine and highly active antiretroviral therapy**

The proportion of people using traditional medicine with N=30 showed that all the males 3 (100%) had used traditional medicine related to HIV/AIDS before being started on HAART. On the other hand, out of 27 females 16 (59.3%) had used traditional medicine while 11(40.7%) had not used traditional medicine before being started on antiretroviral therapy. This finding showed that after being tested HIV positive but before starting ARVs 19 (63%) had used traditional medicine while the remaining 11 (37%) had not.

The research also wanted to find out the difference if pattern of using traditional medicine before and after being started on antiretroviral therapy. It was found that there was no significant variance in use; in both cases the frequency in use was 19 (63%). Out of 11 patients who had denied using traditional medicine before starting HAART, 5 reported to have used traditional medicine after being started antiretroviral therapy. Conversely out of the 19 patients who reported use traditional medicine before starting HAART, 5 had not used traditional medicine after being started on ARVs.

### 5.3.1 Types of traditional medicine used

The participants who acknowledged use of traditional medicine were also asked to mention the type of the traditional medicine used. Most of the participants 9 (47%) were using both herbs and locally made or manufactured claimed immune boosters, 6 (32%) were using immune artificial immune booster whose ingredient was not known, 3 (16%) were using only herbs as traditional medicine while only one participant representing (5%) mentioned prayers as a traditional medicine (figure 5.1).



**Figure 5.1: Frequency and types of traditional medicine combined with ARVs**

Challenges in definition of Traditional medicine were noted. For example, almost all participants mentioned praying to God as healing source, however denied relating it to traditional medicine.

Some of the traditional medicines which were being used included but not exhaust; Power drink which is made from a combination of honey, Lemon juice, Garlic, a Ginger, and Aloe Vera. Other local medicines mentioned include, *Chamwamba*, Avocado pear Leaves, Baobab seeds, *Nimu*, *Mvunguti* fruit and *Mpolowoni* leaves.

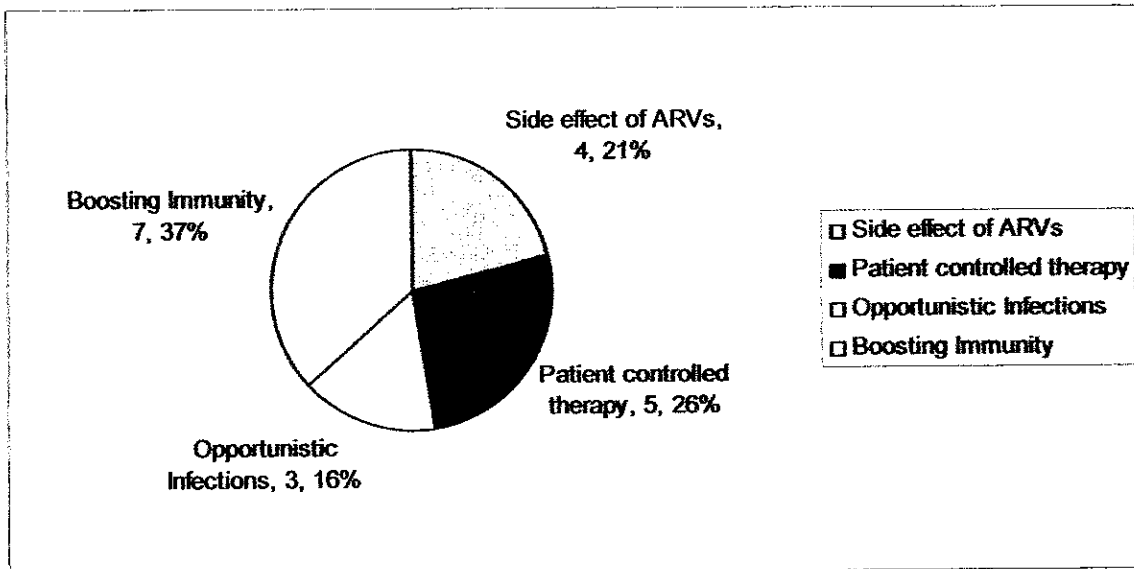
### **5.3.2 Source of information on Traditional medicine**

Source of information on the traditional medicines used varied from participant to another. However with N= 24, 18 (60%) had heard information from the support group, radio, 2 (6.7%) had heard from relatives and friends, the other 2(6.7%) got the information from the news paper. The remaining (27%) represented the group which did not use traditional medicine either before or after being started on antiretroviral therapy.

### **5.4.0 Factors influencing participants to use traditional medicine**

Participants had varied reasons for using traditional medicine before they had been started on HAART. Most of the participants 11 (57.9%) who acknowledged use of traditional medicine mentioned immune boosting as the reason for use, 6 (31.6) used traditional medicine as treatment of some opportunistic infections, and 10.5% n=3 had used traditional medicine due to inaccessibility to HAART. None of the participant mentioned use of traditional medicine as a substitute for antiretroviral therapy.

19 (63%) of the sample population had used traditional medicine after being started on highly active antiretroviral therapy. Out of this population, 5(26%) mentioned independence in use or patient controlled therapy, 7 (37%) said that they were using traditional therapy to boost immunity, 4 (21%) had used traditional medicine to control side effects of antiretroviral therapy while 3 (16%) used traditional medicine to control opportunistic infections (figure 5.2).

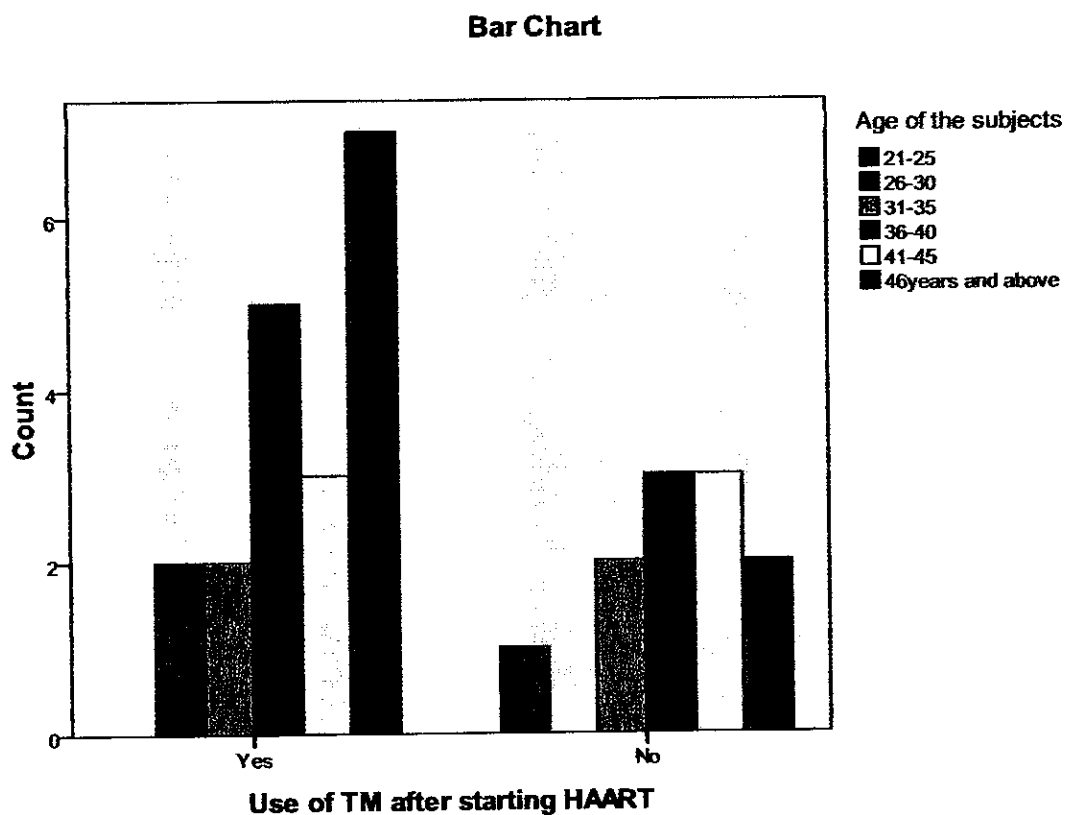


#### 5.4.1 Use of traditional medicine and tribe of the participant

In relation to the tribe of the participant and use of traditional medicine, Ngoni 7 (35%) were the highest group using traditional medicine followed by the Yao 5 (25%), Lomwe 4 (20%), Tumbuka 1 (5%) while other tribes registered (15%). However, tribes were not represented equally in the sample hence it was not the best indicator to substantiate tribe as a predictor to the use of traditional medicine.

#### 5.4.2 Use of traditional medicine and the age of the participant

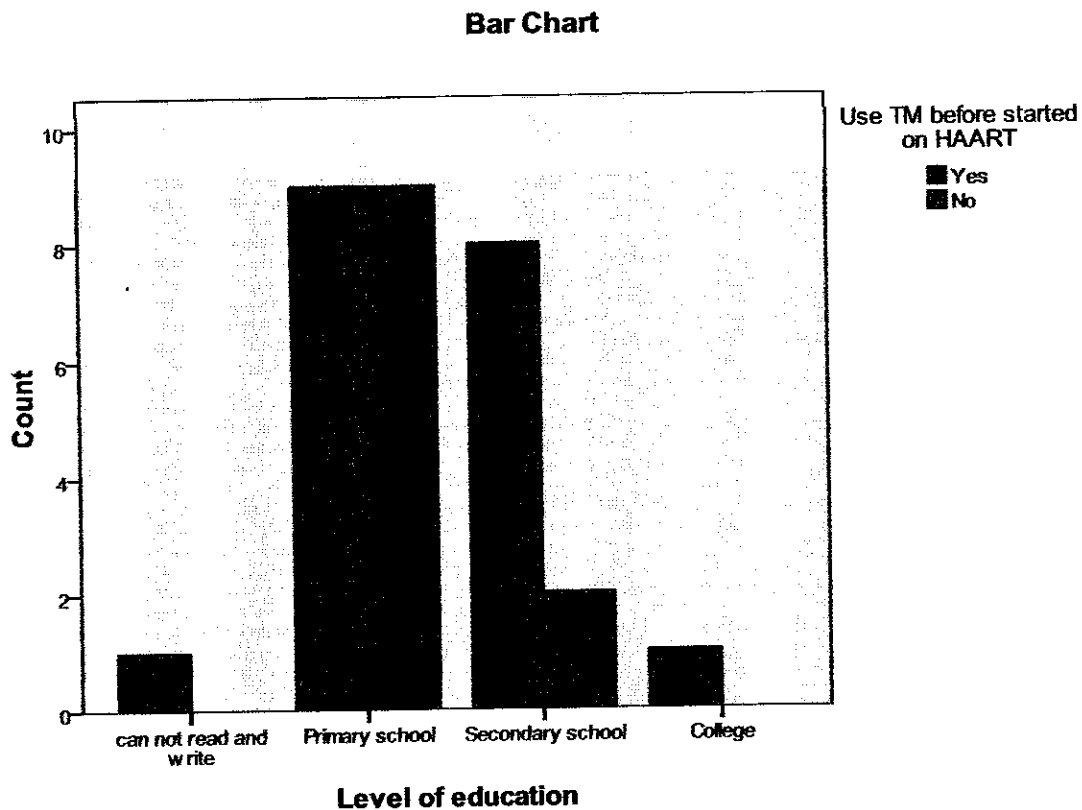
The results showed that participants of 46 years and above were using traditional medicine more than those below. The age of below 25 years represented the least age group in the sample to combine traditional medicine and antiretroviral therapy.



**Figure 5.3: Traditional medicines use in relation to age.**

### 5.4.3 Education and use of traditional medicine

No consistent relationship was observed between education and use of traditional medicine. In general, prevalence in use was noted among the population whose level of education ranged from primary school to secondary. On the other hand, those who could not read or write representing 3.3% n=1 as well as those who attended college education with the same portion had demonstrated minimal use of traditional medicine both before and after starting HAART.



**Figure 5.4: Relationship between traditional medicine use and education of the participants**

**5.4.4 Reason for not using traditional medicine**

The participants who had not used traditional medicine were asked to explain their stance; 5 (45%) mentioned that traditional medicines are not effective while 6 (55%) had mentioned relationship between traditional medicine to witch craft as the reason.

**5.5.0 Use of traditional therapy and adherence to antiretroviral therapy**

Out of the 19 participants using traditional medicine, 6 (31%) mentioned to have either delayed by six or more hours or forgotten to take antiretroviral therapy for a day due to traditional medicine use. However, 13 (69%) mentioned that they had been combining the two medicines without problems of missing the antiretroviral dosage.

### **5.5.1 How the two medicines are combined traditional medicine and HAART**

Participants were also asked to mention on how they combine traditional medicine and antiretroviral therapy. Most clients 17 (75%) mentioned that they combined with porridge and took as food or drink while 6 (23%) had been taking two drugs at different times 4 to 6 hours apart. 2 (6.6%) said that taking of traditional medicine was sporadic.

A notable proportion 14 (75%) explained that they use traditional medicine when they have ailments. The theme that was common in 17 (86%) of participants who were using traditional medicine was the belief that most of the herbs being taken were part of food.

*"We just add in porridge or relish for it is part of food though it is an immune booster"*

One participant commented.

### **5.6.0 Disclosing use of traditional medicine to the health care provider**

The participants who said to be using traditional medicine were also asked for history of disclosing traditional medicine use to the health care provider. Out of the 19 participants using traditional medicine, 3 (15%) had told their provider while 16(85%) said they had not told their health care provider.

Those participants who did not inform their provider mentioned the following as reasons for doing so; the health care provider did not ask them, they were afraid of being turned back from the health facility, and some felt that traditional medicine was not treatment but mere home remedy as one is expecting to seek medical treatment.

Participants who had informed the health care worker on the use of traditional medicine said they were advised to continue taking the antiretroviral therapy. Only one of the three explained that the health care worker had told her to stop taking traditional medicine for fear of unknown reactions.

### **5.7.0 Views of participants on the integration of conventional and traditional medicine**

The majority of the participants, 23 (76.7%), said they would want integration of traditional medicine and conventional medicine. While 7(23.3%) said they were not in support of integrating the two sides.

Some of the mentioned advantages for integrating traditional and conventional medicine included; people will stop hiding on their use of traditional medicine, Some of traditional medicine which are of help for other opportunistic infection will be known to all affected by HIV/AIDS, people will have adequate information on the claimed traditional medicine, some participants had found improvement in some ailments like anaemia, skin infection and numbness which is a side effect of ARVs.

On the other hand, the participants pointed out some of would be challenges with the integration. They feared that if traditional medicine is given more authority, more people will be cheated with fake drugs and there will be increase in price of the traditional medicine. Poor adherence to antiretroviral therapy was also mentioned as a challenge. Another challenge expressed was that witchcraft would be rampant.

### **5.8.0 Summary of the findings**

The study group comprised of 90% female and 10% male. There was a relatively high (63%) incidence rate of traditional medicine use among members of AIDS support group. The major source of information on traditional medicine related to HIV/AIDS is the support group. Pattern in use of traditional medicine before and after being started on ARVs is relatively the same. It has been noted; also that 85% of clients who use traditional medicine do not inform their health care provider. The most commonly used traditional medicines were uncertified immune boosters and herbal medicine. Factors influencing AIDS patients to use traditional medicine include; ARVs side effects, general preference to traditional medicine and personal effort to boost body immunity. In general, AIDS support group members, feel there is a need to integrate traditional and conventional medicine.

## **6.0 CHAPTER SIX: DISCUSSION OF THE RESULTS**

### **6.1 Introduction**

This study aimed to explore the practice of combining traditional medicine and antiretroviral among AIDS Support group members. These findings will also be discussed in relation to the health belief model and as applied to nursing practice, nursing management, nursing research, and nursing education.

### **6.2 Discussions of the findings**

#### **6.2.1 Proportion of members using traditional medicine in the support group**

One of the specific objectives of the study was to find the proportion of the support group using traditional medicine. It was found that 63% of the participants were using traditional medicine. In a related study done in South Africa, Duggan (2001) found out that 67% of the participants (PLWA) had used traditional medicine at some point in the course of getting antiretroviral therapy. Marked different results were of Langlois-Klasser et al (2007) in a similar study done in Kabarole, Uganda which found out that 37% of the participants were concomitant users of traditional medicine and antiretroviral therapy.

In this study all men, who represented 10% of the study population, were using traditional medicine before and after being started on antiretroviral therapies. The range of proportion in the study between males and female was just too wide, thus 1: 10 in favour of females. On one hand, this finding reflects the reality in Malawi whereby HIV prevalence rate is relatively higher in female than in males. In addition, men participate poorly in AIDS support group activities. However, the ratio in this study is too exaggerative basically because purposive sampling was employed during recruitment.

The female domination in the group is also consistent with those of another study by Brobrow (2004) whose aim was to explore community participation in the prevention of mother to child HIV transmission. The study, revealed that lack of male involvement affected women's' decision to reveal the HIV status and apply positive living knowledge in their families.

In the study sample only 40% were married the rest were single for one reason or another. Distribution of marital status also could be another reason for disparity in representation as members do not always come as couples.

#### **6.2.1.1 Knowledge of participants on traditional medicine**

It is important for the researcher and the participant to share common understanding of the definition of traditional medicine for the research to yield intended results. The World Health Organization (2005) reported that definition of traditional medicine is relative to culture and different from one area to another. In this study the definition was narrowed to physical therapies and body and mind therapies. Specifically, the categories were herbal medicine, belief in supernatural powers, uncertified immune boosters.

The research has found out that all members of the support groups knew about traditional medicine in the same context with researcher. However, while accepting the practice of praying to God for healing, almost all members of the support group mentioned that prayer was not part of traditional medicine but just a complementary.

#### **6.2.1.2 Categories of traditional medicine being combined with antiretroviral therapy**

The research wanted to find out the categories of the traditional medicine being used by the participants. Close to half (47%) of the participants using traditional medicine said they were using both herbs and locally sold uncertified manufactured immune boosters followed by herbs. The implication of results is that clients are combining unknown herbal medicine and unknown immune boosters with antiretroviral therapy.

The results of the study also indicate that some were using traditional medicine as food nutrient to boost immunity. In general, all food contain nutrients, therefore the limitation of the study was that it could not differentiate food and herbal medicine. Definition of the herbal medicine was dependent on participant view point. 75% of those using herbal medicine mentioned the following plants; Garlic, *Aloe Vera*, *Nimu* and *Lemon glass*.

The implication of this finding is that further qualitative studies would be ideal to specifically determining the categories of herbal medicines and immune boosters used by clients. Further experimental studies are necessary to explore the active ingredient of some of these herbal medicines to provide appropriate advice to the population.

Another important finding was that (6) 32% of the participants were using manufactured immune booster whose ingredient was not known. This finding suggests that on Market there are several types of immune boosters being sold taking advantage of the AIDS pandemic. However, the study failed to establish whether the claimed manufactured immune boosters were certified by the pharmacy and poisons board of the country. WHO (2005) in its annual report on traditional medicine explains that controlling traditional medicine becomes difficult especially because some products are sold as food not drugs.

#### **6.2.2 Factors influencing clients to combine traditional medicine and antiretroviral therapy**

The study also specifically wanted to find out the factors that influence use of traditional medicine among AIDS clients who are on antiretroviral therapy. The results indicated that factors were not only related to individual perception to AIDS disease but also to the antiretroviral treatment side effects.

The main reason clients continued using traditional medicine after being started ARV was to boost body immunity and contribute to improvement in health. This was manifested in the fact that 7 (37%) of the participants were using traditional medicine to boost immunity. The main purpose of antiretroviral therapy is to boost immunity by increasing resistance of the body to diseases. The puzzle still remains on the reasons for using traditional medicine for the same purpose. It could, therefore in relation to the health belief model, be concluded that chronic infections in themselves are a threat that influence people to seek any alternate therapy including traditional medicine (Peltzer, 2009, Thorpe, 2009).

There also appears to be a common understanding between AIDS clients and medical practitioners that the underlying principle in the management of HIV is to boost body immunity. This explains reason for having more than a third (37%) of the participants utilizing traditional medicine to boost immunity. The implication of this finding is that uncontrolled claimed immune boosters are being utilized by the AIDS patients with the understanding that they are achieving synergy to HAART.

Out of 19 patients combining traditional medicine and antiretroviral therapy, 5 (26%) had used traditional medicine for want of a patient controlled therapy. These results support previous studies by Bodeker et al. (2006) and Liverpool et al. (2004) which found out that need for a controlled therapy was another reason for using traditional medicine. Another explanation relates to the findings of the related study done in Thailand by Sugimoto et al. (2005) which identified that traditional medicine improved more the psychological than physical aspect of the client.

The peculiar and different factor emerging after starting ARVs was the use of traditional medicine to relieve side effects of the antiretroviral therapy. About 10% of those combining traditional medicine and antiretroviral therapy stated ARVs side effects as the reason. Two clients mentioned numbness of the feet and anaemia as the two side effects of ARVs which were relived by traditional therapies. The result concurs with studies by Mills et al. (2005) and Dahab et al (2008) who had found out that that ARVs side effects are a predictor to concomitant use of traditional medicine and antiretroviral therapies.

The finding of the study that traditional medicine relieve ARV side effect relied heavily on client's point of view. While traditional medicine may be doing good work of alleviating side effects, it is feared that there may be unknown drug interactions with ARVs (Faragon, 2002; Mills et al., 2005 and Peltzer et al. 2009). Experimental studies are therefore needed to quantify and qualify the claims. In addition, providers of antiretroviral drugs should take a proactive role to find out how the client is coping with the side effects for they are a predictor of traditional medicine use.

The drug side effects, need for a controlled therapy and chronic nature of AIDS explain the reasons why a larger proportion of AIDS patients continued using traditional medicine after starting HAART. This finding differs with that of Kaponda et al (2005) who in their study called “health seeking patterns for AIDS in Malawi” found out that people start with home remedies then seek help from traditional medicine practitioners before finally seeking help from the conventional medicine centres. The implication of this finding is that there is relatively a higher probability that client with AIDS move back and forth the traditional and conventional medicine arena (Duggan et al, 2001).

This lack of variation in use of traditional medicine results also supports previous studies by Peltzer et al. (2009), Langlois-Klasser (2007) and Duggan et al. (2001) which found that pattern in use of traditional medicine does not change even when AIDS clients are started on ARVs. From this study, therefore, it can be concluded that chronic nature of AIDS and side effects of ARVs will perpetuate the vicious circle of traditional medicine use either before or after being started on antiretroviral therapy.

### **6.2.3 Disclosing of traditional medicine use to health care provider by the client**

The third objective of the study was to find out factors that influence clients to reveal their usage of traditional medicine to the health care provider. Nursing and Medicine are social disciplines that to a larger extent depend on effective interaction between the client and the provider. Effective interaction helps the provider to obtain adequate and useful information from the client; the basis for making right diagnosis and prescription.

The results of this study showed that out of the 19 persons who had used traditional medicines after starting antiretroviral therapy, 16 (85%) had not informed their ARVs provider while 3 (15%) had informed the provider. This finding is in agreement with Thorpe (2009) which showed that a larger proportion of AIDS patient do not inform he provider about their use of traditional medicine. However, this differs with Faragon et al. (2002) which found that more than half (54%) had informed their provider. The implication of these results is that clients who fail to disclose use of traditional medicine to their supervisor are more likely not to adhere to antiretroviral drugs (Liu, et al., 2009).

Surprisingly, 50% of those who did not inform the health care provider about traditional medicine use mentioned fear of being returned from the hospital or being shouted at as reason for not disclosing. The implication of this finding is that there is reserved communication between the client and health care worker on issues related to traditional medicine use. At the support group interaction appears to be at equal footing while interaction at the health care facility appear to remain of a senior and junior and the latter being the client (Chipolombwe and Muula, 2005).

Out of the same group that did not disclose use traditional medicine, 16 (84%) mentioned that they were not asked by the health care worker. This finding demonstrates that for most clients the health care worker is the initiator of communication at the health facility. The strange environment of the health facility put the client at the receiving end. In general, therefore, it could be advisable to say that unless the health care provider initiate conversation relating to traditional medicine among their clients, the issue will remain guarded and unexplored (Cady, 2009).

The finding contravenes that of Chipolombwe& Muula (2005) done in Lilongwe. The purpose of their study was to find out the perception allopathic health practitioners on traditional medicine. It was found that 43% of the participants had mentioned that their clients preferred traditional medicine. The argument is that if very few practitioners ask their clients about use of traditional medicine it is unlikely that they can know the views of clients on the subject.

An astonishing finding was that less than half (35%, N=7) of those using traditional medicine mentioned that they did not inform their provider because the treatment was part of home remedies for medical problems. The result indicates that a reliable population of Malawi still rely on traditional medicine as source of first level of care. A deliberate community survey need to be done by community nurses in their respective areas to explore efficacy and safety of some of these home remedies.

#### **6.2.4 Usage of traditional medicine and adherence to antiretroviral therapy**

The Fourth objective was to find out the relationship between use of traditional medicine and adherence to antiretroviral therapy. In this study the definition of missing dose related to delay in taking the dose by six hours or more. Out of 19 participants who were combining traditional medicine and antiretroviral therapy 6 (31%) mentioned to have either delayed or forgotten to take antiretroviral therapy due to traditional medicine use. However, 13 (69%) mentioned that they had been combining the two medicines without problems of missing the antiretroviral dosage.

These results indicates that significant number (<5%) of AIDS miss antiretroviral therapy due to Traditional medicine. This finding support the previous studies on similar topic by (Peltzer et al., 2009; Duggan et al., 2001 & Dahab Et al., 2008) who found out that non-adherence to antiretroviral therapy can be explained to some extent by use of traditional medicine. The effectiveness of antiretroviral therapy depend on adherence to the treatment as such efforts should be made to ensure that the provider asses use of traditional medicine among AIDS clients to provide appropriate advice.

#### **6.2.5 Integration of traditional medicine and conventional medicine**

The last objective of the study was to find out views of AIDS support group members on the integration of traditional medicine and conventional medicine. The results showed that a larger proportion (76%) n=23 favoured integration of traditional medicine into conventional medicine. These findings are consistent with those of Ben-Arye et al. (2009), Owen-Smith et al. (2007), and Mills (2006) who found that most clients prefer integration of the two sides. As the decade (2001-2010) for consideration of traditional medicine in Africa comes to an end, it would be advisable to take an active role in exploring the value of traditional medicine to better inform the population.

Out of 23 persons who were for integration (55%) n=13 mentioned that that integration would help the public to have verified information on the claimed traditional medicine but also some traditional medicines will be known that have some efficacy in improving particular opportunistic infections.

The implication of this finding is that even though government fail to take pro-active measure in studying and controlling traditional medicines, people are likely to continue seeking help from traditional practitioners but without adequate information on potential dangers.

However, some participants mentioned propagation of witchcraft as one of the challenges with integration. This finding supports the findings of the previous study by Chisala (2008) and Chipolombwe (2005) which found out that association of witchcraft and traditional medicine does not only make traditional medicine unpopular but also difficult to study. In addition, this study found that belief in supernatural powers like prayer to God was not regarded as a sole medicine but complementary to other medicines. It can therefore be concluded that while many authors have called for the integration of the two sides, witch craft and belief in unknown powers by traditional practitioners will still pose a challenge.

### **6.3 Conclusion**

The study aimed at exploring the practice of combining traditional medicine and antiretroviral therapy among members of AIDS support group. It has been found that 63% of the members use traditional medicine even after being started on antiretroviral therapy. Drug side effects, immune boosting and need for patient controlled therapy are some of the reasons AIDS patients use traditional medicine. The most common source of information of traditional medicines used is the support group. The most commonly used traditional medicines are locally found immune boosters and herbs. Status differences and ineffective communication between client and provider are major barriers preventing clients to disclose use of traditional medicines. There is an overwhelming call for integrating traditional and conventional medicine. However, it is only through big and small studies on traditional medicine that evidence based recommendations can be made. Therefore, the government should take stance in controlling and exploring some of the claimed immune boosters and traditional medicine to better inform the public.

## **6.4 Recommendations**

It has been found that 63% AIDS clients in the study group use traditional medicine. Therefore, in agreement with the medicine policy (2009), there is a need to intensify studies on traditional medicine in Malawi to provide evidence based information.

In relation to the identified barriers to disclosure of information on traditional medicine use, all clients should be asked about prior or current use of traditional medicine every time they come to the health facility. Inquiring for such information would help the health care provider to assist clients to adhere and comply with antiretroviral therapy.

Having realised the importance of support groups in transmission information, health facilities should ensure that there is coordination between the facility and the support group. This approach will help to ensure exchange of information between the support group and the facility.

There is a dilemma between the right to access traditional medicine and right to access safe medicine. However, it is recommended that government should develop policies to guide health care workers and safeguard the public from fake and harmful traditional medicines.

## **6.5 Implications of the study**

### **6.5.1 Implications to Nursing Management**

Nursing managers should develop departmental policies to guide their staff on how to ask, assist, advice and clients on issues concerning traditional medicines.

Nurse Managers in the District have a role to monitor and support the activities of the support groups to ensure coordinated efforts and consistence in information on HIV management both at the health facility and in the community.

Nurse Managers in consultation with the HIV coordinators need to assist the support groups in developing objective and key roles which can be basis for evaluation from time to time.

It is recommended that nurse managers should lobby for scale up of free antiretroviral treatment services in the country. In addition, the free antiretroviral treatment should also cover the treatment for the drug side effects.

### **6.5.2 Implications to Nursing Practice**

Nursing practice should be cultural relative and provided in an environment where the client can express herself or himself freely. Such an environment will help health care providers to get information on the use of traditional medicine and provide adequate advice.

It is recommended that nurse should examine the type of traditional medicine being used by the clients and learn their rationale from the client perspective. This will help to reduce prejudice and untoward attitudes on traditional medicine that have no direct or indirect interference with the conventional medicine.

Nurses are responsible for administering and sometimes prescribing drugs and treatments, effort should be made to find out other drugs the client is using including traditional medicines.

Nurses should provide information on scientifically approved home remedies for various ailment and methods of improving one's immunity to all AIDS patients.

### **6.5.3 Implications to Nursing Education**

Nursing education curriculum should include topics on traditional medicine in relation to the World Health Organization classification. Such a curriculum will prepare student nurses to appropriately assist clients on issues concerning traditional medicine without experiencing cultural shock.

All nursing educators should make sure that they facilitate communication skills in their students. Effective application of communication skills will help future nurses to be able to explore and get information which among others will include use of traditional medicine.

#### **6.5.4 Implication to Nursing Research**

Nursing research should be done on traditional medicine to explore how use of traditional medicine affects health seeking behaviour and compliance to treatment for various conditions.

#### **6.6 Limitations of the study**

The study population was small and purposive method of sampling was used hence the results can not be generalised to the entire population.

The information was collected at the support groups meeting area. However, the ideal site for collecting the information would have been at the ARV clinic where files could have been verified and the ARV bottle verified to ascertain level of adherence to ARVs.

#### **6.7 Areas for further research**

A cohort study needs to be done on the similar topic to follow-up level of adherence to ARVs among clients combining traditional and conventional medicine.

More research should be done to explore factors that influence health care personnel to fail asking the clients about use of traditional medicine in the health facilities.

Impact of liberalised sell of immune boosters is an important issue for future research.

Further research should be done to investigate effectiveness of the relationship between the health facilities and community AIDS support groups.

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**8.0 APPENDICES**

## APPENDIX 1 : ENGLISH QUESTIONNAIRE

TITLTE: STUDY ON CONCURRENT USE OF HAART AND TRADITIONAL MEDICINE AMONG PEOPLE LIVING WITH AIDS.

Principal Investigator: Dennis Gwesere

Research Supervisor: A.N.K Simwaka (Senior Lecturer, Kamuzu college of Nursing)

CODE NUMBER:

DATE:.....

### DATA SECTION A: DEMOGRAPHIC

INSTUCTION: Circle the response that is applicable to the participant and where explanation is needed write participant response in the space provided.

1. AGE

- i. Less than 20
- ii. 21-25
- iii. 26-30
- iv. 31-35
- v. 36-40
- vi. 41-45
- vii. 46 years and above

2. SEX

- i. Female
- ii. Male

3. Marital status

- i. Single
- ii. Married
- iii. Divorced
- iv. Widowed

4. Level of education

- i. Can not read and write
- ii. Primary school
- iii. Secondary school
- iv. College

5. Occupation
- i. Employed (mention the job)
  - ii. Farmer
  - iii. Businessperson
6. Religion
- i. Roman Catholic
  - ii. CCAP
  - iii. SDA
  - iv. Islam
  - v. Others (specify).....

7. Tribe
- i. Tumbuka
  - ii. Chewa
  - iii. Yao
  - iv. Ngoni
  - v. Ngonde
  - vi. Lomwe
  - vii. Sena
  - viii. Others (specify).....

**SECTION B: PROPORTION OF CLIENTS ON HAART USING TRADITIONAL MEDICINE AND THE INFLUENCING FACTORS.**

8. When were you tested HIV positive?
- i. less than a year ago
  - ii. one year ago
  - iii. 2 years ago
  - iv. 3 years ago
  - v. 4 or more years ago
9. When were you started on HAART?
- i. less than a year ago
  - ii. one year ago
  - iii. 2 years ago
  - iv. 3 years ago
  - v. 4 or more years ago
  - vi.

10. Since you tested HIV positive have you ever used traditional medicine?
- i. yes
  - ii. no
11. Before you were started HAART regimen were you using traditional medicine?
- i. Yes ( go to 12)
  - ii. No ( go to 12)
12. Would you please explain the reason?

.....  
 .....

13. After you had started HAART have you ever been using traditional medicine?
- i. Yes , (if yes go to 14)
  - ii. No

14. If yes, what type of traditional medicine is being used?
- i. immune booster oral preparations
  - ii. Herbs
  - iii. Prayer/ ancestral spiritual power
  - iv. Others specify.....

15. Where did you get the information on the traditional medicine being used?
- i. relatives
  - ii. colleagues
  - iii. health care worker
  - iv. mass media (radio)
  - v. news paper
  - vi. support group
  - vii. Others, specify.....

**SECTION C: ADHERENCE TO HAART REGIMEN**

16. Now that you are on HAART why are you using traditional medicine?
- i. influence from others
  - ii. side effects of HAART
  - iii. in place of HAART
  - iv. patient controlled therapy
  - v. Others specify.....

17. Would you explain how you combine the two treatments?

18. Have you ever missed a dose of HAART because of traditional medicine?
- i. Yes (for how long beyond the schedule time)
  - ii. no

**SECTION D: DISCLOSURE OF TRADITIONAL MEDICINE USE TO HEALTH CARE WORKER**

19. Have you ever informed your health care provider about your using traditional Medicine together with HAART?
- i. Yes (if yes what was the reaction of the provider).....
  - ii. No (if no explain the reason).....

**SECTION E: PARTICIPANT'S VIEWS ON INTEGRATING TRADITIONAL MEDICINE INTO CONVENTIONAL PRACTICE**

20. Would you please explain your views on the integration of the traditional and conventional medicine in the management of AIDS?  
.....  
.....  
.....

21. What do you think would be the benefit of integrating the traditional medicine and conventional medicine?  
.....  
.....  
.....

22. What do you think will be the challenges if traditional medicines are to be incorporated into conventional medicine in the management of AIDS?

**THANK YOU FOR PARTICIPATING IN THIS STUDY!!!!**

## APPENDIX 1B: QUESTIONNAIRE YA CHICHEWA

### MUTU WA KAFUFUKU: KUFUFUZA MCHITIDWE WOPHATIKIZA MANKWALA A CHIKUDA NDI MA ARV

Wofufuza: Dennis D Gwesere

Woyanganira kafukufuku: AN.K. Simwaka

NUMBER YA QUESTIONNAIRE:

TSIKU:

LAMULO: chonde zungulizani yankho loyenera ndipo pofunika kufotokoza lembani pa mpata omwe uli pansu pa funsolo.

### MBALI YOYAMBA: ZA INU

#### 1. ZAKA ZANU

- i. Zosakwana 20
- ii. 21-25
- iii. 26-30
- iv. 31-35
- v. 36-40
- vi. 41-45
- vii. 46 kapena kupitirira apo

#### 2. Kodi ndinu,

- i. mkazi
- ii. mwamuna

#### 3. Pazaukwati, ndinu

- i. wosakwatiwa
- ii. wokwatiwa
- iii. unatha ukwati
- iv. anamwalira

#### 4. Kodi munapitako kusukulu?

- i. eya
- ii. ayi

#### b.Nanga munalekera pati?

- i. primary
- ii. secondary
- iii. sukulu ya u kachenjede

5. kodi mumagwira ntchito yanji pamoyo wanu?
  - i. yolima
  - ii. yogulitsa malonda (bizinezi)
  - iii. yolembedwa (tchulani)
  
6. Kodi ndinu a chipermbedo chanji?
  - i. Roman catholic
  - ii. CCAP
  - iii. SDA
  - iv. Chisilamu
  - v. Tchulamu
  
7. Kodi ndinu a mtundu wanji?
  - i. Tumbuka
  - ii. Chewa
  - iii. Yao
  - iv. Ngoni
  - v. Ngonde
  - vi. Lomwe
  - vii. Sena
  - viii. Wina, tchulani

**MBALI YA CHIWIWI: KUGWIRITSA TCHITO MANKWALA ACHIKUDA KOMANSO ZIFUKWA ZAKE.**

8. Kodi munapezeka ndi kachilombo ka HIV liti?
  - i. osapitilira chaka chimodzi
  - ii. chaka chimodi chapitacho
  - iii. zaka ziwiri zapitazo
  - iv. zaka zitatu zapitazo
  - v. zaka zinayi kapena kuposa apo
  
9. Nanga munayamba liti kumwa mankwala a ARV.
  - i. osapitilira chaka chimodzi
  - ii. chaka chimodzi chapitacho
  - iii. zaka ziwiri zapitazo
  - iv. zaka zitatu zapitazo
  - v. zaka zinayi kapena kuposa apo

10. Kodi munagwiritsapo nchito mankwala a chikuda achipezekedwere

ndi kachilombo ka HIV?

- i. eya
- ii. ayi (mungafotokoze zifukwa)

11. munagwiritsa ntchito pa vuto lanji?

.....  
.....  
.....

12. Nanga tsopano mutayambitsidwa mankwala a ma ARV

Mukugwiritsa kapena munagwiritsapo mankwala achikuda?

- i. eya (pitani pa funso 13)
- ii. ayi

13. Nanga ndi mankwala anji achikuda amene munagwiritsapo ntchito

Chiyambire kumwa ma ARV.

- i. Oonjezera chitetezo ogulitsidwa ngati mankwala kwa anthu kapena pa msika (immune booster)
- ii. ochokera ku mitengo
- iii. mapemphero/ chikhulupiriro cha mizimu
- iv. ena, tchulani.....

14. Kodi munamvera kuti za mankwala amenewo?

- i. kwa a chibale
- ii. kwa anzawo
- iii. kwa a anthu achipatala
- iv. pa wailesi
- v. mu nyuzi pepala
- vi. kugulu la edzi
- vii. kwina, tchulani.....

**MBALI YA CHITATU: KUMWA MANKWALA A MA ARV  
MWANDONDOMEKO**

15. Tsopano pakuti mukumwa ma ARV, nanga ndizifukwa ziti

zomwe zikukupangitsani kugwiritsa mankwala a chikuda?

- i. kukamizidwa ndi ena
- ii. zotsatira za makhwala a chikuda
- iii. mmalo mwa ARV
- iv. kuti atenge mbali podzithandiza okha ku vuto lawo

16. kodi mumaphatikiza bwanji mankwala chikudawo ndi ma ARV?

.....  
.....  
.....  
.....  
.....

17. kodi pali nthawi imene mumayiwala kapena kulephera kumwa ma ARV chifukwa cha mankwala a chikuda?

- i. Eya (panadutsa nthawi yaitali bwanji)
- ii. ayi

**MBALI YA CHINAYI: KUULULIRA ACHIPATALA PA ZA KUGWIRITSA  
NTCHITO MANKWAL A CHIKUDA.**

18. kodi munawadziwitsapo a zachipatala omwe amakupatsani ma ARV pa zakugwiritsa kwanu mankwala achikuda?

- i. eya, (nanga iwo anati chiyani)
- ii. ayi, (chifukwa chiyani)

.....  
.....  
.....

**MBALI YA CHISANU: MAGANIZO ANU PA ZAKUONJERA MANKWALA  
ACHIKUDA MUDONGOSOLO LA BOMA POTHANDIZA ANTHU ODWALA  
EDZI**

19. mukuwona kwanu, mukuganiza kuti ndikoyenerera kuti boma  
liganizire zophatizapo mankhwala achikuda ngati mbali imodzi ya  
chithandizo kwa anthu odwala edzi.

- i.     eya
- ii.    ayi

20. Nanga ndi zabwino ziti zomwe mukuziona ngati kuphatikizaku  
Kungachitike?

.....  
.....  
.....

21. nanga ndizovuta ziti zomwe mukuziona zimene zingakhalepo ngati  
kuphatikizaku kungakhale?

.....  
.....

**ZIKOMO KWAMBIRI POLOWA NAWOMUKAFUKUYU!!!!!!!**

## APPENDIX 2A: PARTICIPANT'S INFORMED CONSENT FORM

Principal investigator: Dennis Gwesere

Supervisor : ANK Simwaka.

I am a final year student at Kamuzu college of Nursing a constituent college of the University of Malawi pursuing a Bachelor of Science in Nursing (Post Basic). In partial fulfilment of my studies I am supposed to conduct a research that will contribute to body of knowledge and benefit to nursing clients. The title of my study is concurrent use of traditional medicine and antiretroviral therapy among AIDS patients. you are therefore being invited to participate in this study.

In particular, you have been chosen because you meet thee criteria of targeted informants. The study will help to understand from the client's perspective the role of traditional medicine among HIV patient on HAART. The knowledge will guide the health workers to competently advise clients and develop polices in relation to use of traditional medicine and HIV/ AIDS management. Apart from this stated significance, there are no direct benefits and no monetary reward to you as the participant.

Disclosure of your HIV status and treatment being taken to the researcher, and spending maximum of twenty minutes responding to the questions to the best of your knowledge are some of the discomforts related to the study. However, all study information will be identified by code number not with names to protect your identity. In addition, all the information given will be kept confidential, and soon after report writing data will be destroyed. Your participation is completely voluntary and you can stop your participation at any time and this will not affect your access to care at your care centre. For more information you may contact the researcher on cell phone number **0999239954**.

If you have understood the purpose of study as well as your rights to participate and withdraw but voluntarily determined to participate, please sign in the space below.

Participant's Signature-----

Date \_\_\_\_\_

Investigator's Signature.....

Date \_\_\_\_\_

## APPENDIX 2B: CHILOLEZO CHOLOWERA NAWO MUKAFUFUKU

Mwini kafukufuku: Dennis Gwesere

Oyang'anira Kafukufukuyu: A.N.K Simwaka

Ine ndine wophunzira pa sukulu ya ukachenjede ya Kamuzu College of Nursing yomwe iri gawo limodzi la yunivesite ya Malawi. Ngati mabali imodzi ya maphunziro anga ndikuyenera kuchita kafukufuku yemwe zotsatira zake zidzapititse patsogolo nchito ya unamwino.

Choncho tikukuyitanirani ku kafukufuku yemwe cholinga chake ndi kufufuza mchitidwe wophatikiza mankwala a chikuda ndi mankwala a ARV Pakati pa anthu amene ali ndi EDZI. Izi zidzathandiza anthu ogwira ntchito za chipatala kupeza njira zabwino komanso nfunso zofunikira zolangizira anthu amene ali pa ARV pa nkhani ya mankwala a chikuda.

kulowa kafukufukuyu mudzayenera kuti ulirira ngati munapezeka ndi kachilombo ka HIV komanso ngati munayambitsidwa mankwala a ma ARV. Kuwonjezera apa mudzayankha mafunso kwamphindi zosapitira makumi awiri. Kuti tikusungireni chinsinsi, sitidzagwiritsa ntchito dzina lanu. Kuonjezera apa sitidzauzanso munthu wina zokambirana zathu amene Sali okhudzidwa ndi kafufukuyu. Simuli okakamizidwa kulowa kafufukuyu ndipo mukhoza kutuluka nthawi iri yonse. Ngati mwamvetsetsa zolinga zakafufukuyu komanso ufulu wanu wakulowa ndi kutuluka koma ndinu okonzeka kutenga nawo mbali pakafufukuyu chonde sainani mmusimu.

SIGNATURE.....TSIKU.....

SIGNATURE YOFUNSA MAFUNSO.....TSIKU.....

**APPENDIX 3A: LETTER TO RPC**

UNIVERSITY OF MALAWI  
KAMUZU COLLEGE OF NURSING

FROM: Dennis Dennis Gwesere

TO : The Chairperson,  
Research and Publications Committee,  
Kamuzu college of Nursing,  
Private Bag 1

LILONGWE.

**SUBJECT: REQUEST FOR PERMISSION TO CONDUCT A STUDY ON THE CONCURRENT USE OF TRADITIONAL MEDICINE AND ANTIRETROVIRAL THERAPY AMONG MEMBERS OF CHISOMO PLWHA SUPPORT GROUP IN LUNZU.**

I write to request for permission to conduct a study on the practice of concurrent use of traditional medicine and antiretroviral therapy among members of chisomo people with HIV/AIDS support group in Lunzu.

I am a second year Bachelor of Science in Nursing (post basic) student here at Kamuzu college of Nursing, a constituent college of the University of Malawi. I am intending to conduct this study as a requirement in partial fulfilment my degree programme.

Enclosed is the full proposal of the intended study for your scrutiny and approval. I will be grateful if you process the proposal within the work plan so that I can meet the programme timetable.

Yours Sincerely

Dennis Gwesere

**APPENDIX 3B: LETTER OF APPROVAL FROM THE RPC**



University of Malawi  
**KAMUZU COLLEGE OF NURSING**

**RESEARCH AND PUBLICATIONS COMMITTEE**

**APPROVAL CERTIFICATE**

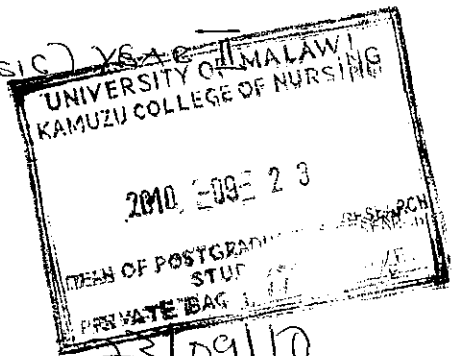
**TITLE:** Concurrent use of Traditional Medicine and Antiretroviral Therapy among Aids supported-group members in Lunzu, Blantyre

**INVESTIGATOR:** DENNIS GWESERE

**DEPARTMENT/YEAR OF STUDY:** BScN (POST BASIC) 2<sup>ND</sup> YEAR

**REVIEW DATE :** 08 SEPTEMBER 2010

**DECISION OF THE COMMITTEE:** Approved



**SIGNATURE:** *[Signature]* ..... **DATE:** 23/09/10  
CHAIRPERSON, RESEARCH AND PUBLICATIONS COMMITTEE

cc Supervisor:

**DECLARATION OF INVESTIGATOR(S)**

*I/we fully understand the conditions under which I am/we are authorized to carry out the above mentioned research and I/we guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/we will resubmit the proposal to the committee.*

DATE 22/10/2010 ..... SIGNATURE(S) *[Signature]* .....

**APPENDIX 4A: LETTER TO THE DISTRICT COMMISSIONER**

Kamuzu college of Nursing,  
Private Bag 1,  
Lilongwe.  
Cell: 0999239954

Date: 18<sup>th</sup> June, 2010

The District Commissioner  
Blantyre District Assembly  
P.O Box 3  
Blantyre

Dear Sir,

**SUBJECT: REQUEST FOR PERMISSION TO CONDUCT A STUDY ON THE PRACTICE OF CONCURRENT USE OF ANTIRETROVIRAL THERAPY AND TRADITIONAL MEDICINE AMONG MEMBERS ON CHISOMO PLWHA SUPPORT GROUP IN LUNZU.**

I write to request for permission to conduct a study among members of chisomo Mlambe PLWHA support group on the above mentioned topic.

I am a student at Kamuzu College of Nursing, a constituent college of the University of Malawi. I intend to conduct this study in partial fulfilment of Bachelor of Science in Nursing Programme which am currently pursuing. Participants to the study will be those members who are of age 18 years and above who were started on antiretroviral therapy and are willing to participate. Apart from revealing their HIV status to the researcher and answering questions in relation to the topic there are no other risks. The results will be communicated to interested parties, including your office.

I will be grateful if my request is honoured.

Yours sincerely,

Dennis Gwesere

**APPENDIX 4B: LETTER OF APPROVAL FROM THE DISTRICT  
COMMISSIONER**

All communication should be address to  
Telefax: 01 339 841



*In reply please quote Ref. No.*

DISTRICT COMMISSIONER,  
BLANTYRE DISTRICT ASSEMBLY,  
PRIVATE BAG 97,  
BLANTYRE,  
MALAWI.

6<sup>th</sup> October 2010

Dennis Gwesere  
C/O Kamuzu College of Nursing  
Private Bag 1  
Lilongwe

Dear Sir,

**PERMISSION TO CONDUCT A STUDY AT CHISOMO PLWHA SUPPORT GROUP IN LUNZU**

This letter serves as permission that you may conduct your study at Chisomo Mlambe PLWHA support group in Lunzu, Blantyre district. Further this letter serves as an introductory letter for you, to any person with authority in the district that may require production of a permission letter from this office.

May I request that you share the results with this office. May I, on behalf of the District Commissioner, wish you all the best in your endeavour.

Yours faithfully,

HENDERSON U. KAUMI (DISTRICT MONITORING AND EVALUATION OFFICER)

For: **DISTRICT COMMISSIONER**



**APPENDIX 5: LETTER OF APPROVAL FROM THE DHO**

Kamuzu College of nursing  
Private Bag 1,  
Lilongwe.  
Cell: 0999239954

Date: 18<sup>th</sup> June, 2010

The District Health officer,  
Blantyre District Assembly,  
Private Bag 67,  
Blantyre.

Dear Sir,

**SUBJECT: REQUEST FOR PERMISSION TO CONDUCT A STUDY ON THE PRACTICE OF CONCURRENT USE OF ANTIRETROVIRAL THERAPY AND TRADITIONAL MEDICINE AMONG MEMBERS ON CHISOMO PLWHA SUPPORT GROUP IN LUNZU.**

I write to request for permission to conduct a study among members of chisomo Mlambe PLWHA support group on the above mentioned topic.

I am a student at Kamuzu College of Nursing, a constituent college of the University of Malawi. I intend to conduct this study in partial fulfilment of Bachelor of Science in Nursing Programme which am currently pursuing. Participants to the study will be those members who are of age 18 years and above who were started on antiretroviral therapy and are willing to participate. Apart from revealing their HIV status to the researcher and answering questions in relation to the topic there are no other risks. The results will be communicated to interested parties, including your office.

I will be grateful if my request is honoured.

Yours sincerely,

  
Dennis Gwesere

24/06/10  
5-18-10  
Approved  
Dennis Gwesere

**APPENDIX 6A: PERMISSION LETTER TO NAPHAM**

Kamuzu college of Nursing,  
Private Bag 1,  
**Lilongwe.**  
Cell: 0999239954

Date: 18<sup>th</sup> June, 2010.

The District Coordinator,  
NAPHAM,  
Private Bag 38.  
**Blantyre 6.**

Dear Sir,

**SUBJECT: REQUEST FOR PERMISSION TO CONDUCT A STUDY ON THE PRACTICE OF CONCURRENT USE OF ANTIRETROVIRAL THERAPY AND TRADITIONAL MEDICINE AMONG MEMBERS ON CHISOMO PLWHA SUPPORT GROUP IN LUNZU.**

I write to request for permission to conduct a study among members of chisomo Mlambe PLWHA support group in Lunzu on the above mentioned topic.

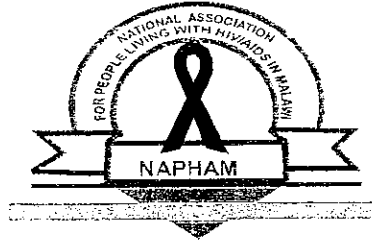
I am a student at Kamuzu College of Nursing, a constituent college of the University of Malawi. I intend to conduct this study in partial fulfilment of Bachelor of Science in Nursing Programme which am currently pursuing. Participants to the study will be those members who are of age 18 years and above who were started on antiretroviral therapy and are willing to participate. Apart from revealing their HIV status to the researcher and answering questions in relation to the topic there are no other risks. The results will be communicated to interested parties, including your office.

I will be grateful if my request is honoured.

Yours sincerely,

Dennis Gwesere

**APPENDIX 6B: LETTER OF APPROVAL FROM NAPHAM**



FROM: DISTRICT COORDINATOR  
NAPHAM BLANTYRE OFFICE

TO: CHAIRPERSON  
LUNZU SUPPORT GROUP{0888324401/0991289785}

TSIKU:05/10/2010

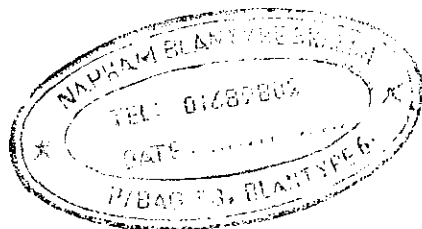
KALATA YOPEMPHA GULU LA LUNZU

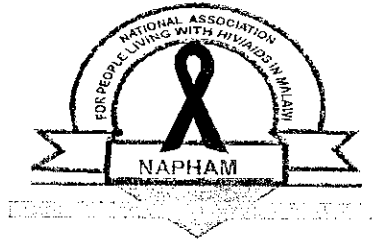
Talemba kalata yofuna kupempha gulu lonse la LUNZU SG kuti mukumane ndi Dennis Gwesere omwe amapanga maphuziro a Bachelor of science ku kamuzu college of nursing pa nkhani ya mankhwala achilengedwe {Home Remedies/Traditional medicine}

Cholinga cha ulendo wao ali pa reseach{kauniuni/kalondolodo m'mene mankhwala aachilengedwe akuthandizira pa mene tili m'chiyembekezo{Ukumwa ma ARV kapena ai uli ndi HIV koma mankhwala sunayambe}.

Iyi ndi njira imodzi yomwe ingakuthandizeni/kukulimbikitsani m'mene moyo wanu ungakhalire pamene mwapezeka ndi kachilombo

Ine m'malo mwa bungwe la NAPHAM  
Davis Halare





FROM: DISTRICT COORDINATOR  
NAPHAM BLANTYRE OFFICE

TO: CHAIRPERSON  
CHISOMO SUPPORT GROUP  
MKAIMBA VGE

TSIKU:05/10/2010

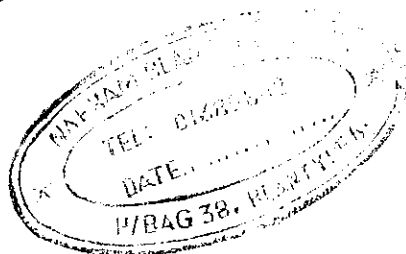
KALATA YOPEMPHA GULU LA LUNZU

Talembe kalata yofuna kupempha gulu lonse la CHISOMO SG kuti mukumane ndi Dennis Gwesere omwe amapanga maphuziro a Bachelor of science ku kamuzu college of nursing pa nkhani ya mankhwala achilengedwe {Home Remedies/Traditional medicine}

Cholinga cha ulendo wao ali pa reseach {kauniuni/kalondolodo m'mene mankhwala aachilengedwe akuthandidzira pa mene tili m'chiyembekezo {Ukumwa ma ARV kapena ai uli ndi HIV koma mankhwala sunayambe}.

Iyi ndi njira imodzi yomwe ingakuthandizeni/kukulimbikitsani m'mene moyo wanu ungakhalire pamene mwapezeka ndi kachilombo

Ine m'malo mwa bungwe la NAPHAM  
Davis Halare



**APPENDIX 7A: LETTER TO CHISOMO AIDS SUPPORT GROUP**

Kamuzu college of Nursing,

Private Bag 1,

**Lilongwe.**

Cell phone: 0999239954

Date: 18<sup>th</sup> June, 2010.

Att: The Chairperson/Patron,  
Chisomo Mlambe PLWHA support Group,  
C/O Mlambe Mission Hospital,  
P.O Box 45.

**Lunzu**

Dear Madam/ Sir,

**SUBJECT: REQUEST TO CONDUCT A STUDY ON THE PRACTICE OF  
CONCURRENT USE OF TRADITIONAL MEDICINE AND HAART AMONG  
MEMBERS OF YOUR SUPPORT GROUP.**

I write to request for permission to conduct a study among members of your support group on the practice of combining antiretroviral therapy and traditional medicine.

I am a student at Kamuzu college of Nursing pursuing Bachelor of Science in nursing course. I intend to do this research in partial fulfilment of the programme requirements. Participants to the study will be those members who are of age 18 years and above who were started on antiretroviral therapy and are willing to participate. Apart from revealing their HIV status to the researcher and answering questions in relation to the topic there are no other risks. The results will be communicated to interested parties, including your office.

I will be grateful if my request is honoured.

Yours sincerely,

Dennis Gwesere

**APPENDIX 7B: LETTER OF APPROVAL FROM CHISOMO AIDS SUPPORT  
GROUP**

Mlambe Chisomo Support Group  
Mkaimba Village  
T/A Kapeni  
P.O. Box 45  
**LUNZU**

Tel. 0888, 312, 534/0888 324, 401

Thursday, October 07, 2010

Kamuzu College of Nursing  
Private Bag 1  
**LILONGWE**

Cell: 0999 239 954

Dear Mr. D. Gwesere,

**YANKHO LA PEMPHO LANU**

Ife a Chisomo Mlambe Support Group tinali osangala kwambiri titalandira kalata yanu ndipo pempho lanu talilandira ndithu. Tidzakhala okondwera pakutiunikira m'gulu lathu kuno ku Lunzu.

Tikukufunirani zabwino zonse ife a Mlambe Support Group pamene mukudzatiyendera.

Ife m'malo mwa gulu la Mlambe Chisomo Support Group

*Jean Maiden*  
Jean Maiden  
**SECRETARY**

  
Ellenater Abril  
**CHAIRPERSON**

**APPENDIX 8: LETTER TO CHISENJERE AIDS SUPPORT GROUP**  
Kamuzu college of Nursing,

Private Bag 1.

**Lilongwe.**

Cell phone: 0999239954

Date: 18<sup>th</sup> June, 2010.

Att: The Chairperson/Patron,  
Chisenjere PLWHA support Group,  
C/O Mlambe Mission Hospita,  
P.O Box 45.  
**Lunzu.**

Dear Madam/ Sir,

**SUBJECT: REQUEST TO CONDUCT A STUDY ON THE PRACTICE OF CONCURRENT USE OF TRADITIONAL MEDICINE AND HAART AMONG MEMBERS OF YOUR SUPPORT GROUP.**

I write to request for permission to conduct a pilot study among members of your support group on the practice of combining antiretroviral therapy and traditional medicine.

I am a student at Kamuzu college of Nursing pursuing Bachelor of Science in nursing course. I intend to do this research in partial fulfilment of the programme requirements. As this is a pilot study only five participants will be recruited. Participants to the study will be those members who are of age 18 years and above who were started on antiretroviral therapy and are willing to participate. Apart from revealing their HIV status to the researcher and answering questions in relation to the topic there are no other risks.

I will be grateful if my request is honoured.

Yours sincerely,

Dennis Gwesere