Perceived Decision Making Factors in the Use of Traditional and Alternative Medicine for People Living with HIV and AIDS

by

TINASHE MUROMO

Student No. 212357409

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Promoter: Professor Diane Elkonin

Co-Promoter: Doctor Jill von der Marwitz

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DEDICATION

This thesis is dedicated to my family. Special dedication to Munashe and Kudakwashe, the seeds of my future descendants. Keep united. My late parents Techu and Rebbeca Muromo, your prayers should ensure permanent, very close and **genuine** unity between the two and their siblings.

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DECLARATION

I, **Tinashe Muromo**, hereby declare that the thesis for **Doctor of Philosophy** to be awarded is the product of my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another university or for another qualification.

Author: _____ Date_____

Tinashe Muromo

Promoter_____Date_____

Diane Elkonin

Co-Promoter:_____Date_____

Jill von der Marwitz

ABSTRACT

AIDS is one of the most destructive diseases humankind has ever faced and also brings with it profound social, economic and public health consequences, making it one of the most serious health and development challenges in the world today. Zimbabwe, situated in southeastern Africa, is not spared from the pandemic. It continues to be one of the Sub-SaharanAfrican countries mostly heavily impacted by the AIDS epidemic, with almost 1.2 million people infected and over 1.1 million orphans. It ranks, therefore, as fifth highest in the world in the impact HIV and AIDS has had on the country.

The most effective response has been to introduce programmes to reduce the number of new infections. Recent research has demonstrated treatment as a preventative measure to be very effective. This approach involves targeting those who are infected so that they are not able to transmit the disease. The decision that has to be made by an infected person, however, is whether to look for traditional treatment, conventional treatment or a combination of the two. Herbal medicine use is becoming very common in many countries, especially in the developing world, where public health safety has become a concern. It has become common to use herbal medicine concomitantly with allopathic or conventional medicine. The present study focused on investigating perceptions leading to the choice of treatment with the traditional alternative medicines (TAM) as (a)/n alternative or compliment to the conventional or allopathic option.

This is a qualitative study that explores and describes participant's perceptions, beliefs, attitudes and feelings around the use of traditional medicine, within the context of the Integrative Behaviour Model (IBM). Data was collected from 20 people living with HIV and AIDS from urban and rural settings of different ethnicities (Shona and Shangani). The data analysis was informed by The Interpretive Phenomenological Analysis with the aid of NVivo (V.10), a computer-assisted Qualitative Data Analysis Software.

As predicted by the IBM, both perceived individual and environmental factors were found to be key in influencing decision-making on the use of TAM by people living with HIV and AIDS. Although there were a number of incidents in which either

individual or environmental factors were perceived as independently influencing the TAM-use decision-making process, there was a lot of mutual influence between the environment and the individual. Such mutual causation was abstracted as reciprocal determinism. The IMB model assumed a unidirectional causation in which the environment could affect the individual factors. While the present study identified and demonstrated these environmental effects on the individual, it also identified and presented a reverse causation in which the individual would also affect the environment with respect to motivation for TAM use.

Individual factors were psychological properties that drove the individual to use TAM. Attitude, social influence and personal agency emerged as the three dimensions of individual factors. Attitudes helped in identification of orientations that located objects of thought on dimensions of judgment about the use of TAM. Social influence explained social pressure experienced and expected regarding the use of TAM. The study demonstrated the importance of both the descriptive and injunctive norm with participants indicating that they perceived important others to be using traditional medicine and that they felt perceived expectations from others to do the same and hence the motivation to comply. Personal agency pointed to the participants' capacities to originate and direct actions for the purposes of TAM use. All these constructs were found to be very important as perceived determinants of the behavioral intentions of people living with HIV and AIDS to use traditional medicines. In experiential attitude, generally the respondents showed more perceived positive evaluations of pleasurable experiences in their use of traditional medicines. However, there were other outcome evaluations that seemed to be ambivalent and which appeared to cause a lot of tension. The comprehension of experiential attitude was found therefore found to be trichotomous rather than dichotomous as per the IBM. The effects of the instrumental attitude were revealed in the ratings of the extent to which the use of traditional medicine was perceived as useful or rewarding, with the study revealing high ratings of usefulness.

It becomes clear, therefore, that for people living with HIV and AIDS social influence, perceived attitudes and personal agency are important decision-making factors in their use of traditional and alternative medicine. Efforts towards education, integration and behaviour change programmes should design messages targeting

these behavioral determinants. Understanding of these perceived determinants is crucial to influencing policy as well as the adoption of health practices through education, marketing and other modes of health promotion.

KEY WORDS: HIV and AIDS, Integrative Behaviour Model (IBM), people living with HIV and AIDS, perceived attitudes, social influence and personal agency, traditional alternative medicines (TAM), treatment as prevention.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychological Association
ART	Antiretroviral Therapy/Treatment
ARV	Antiretroviral
CAM	Complementary and Alternative Medicines
CD4	Cluster of Differentiation 4
CDC	Centre for Disease Control
CM	Conventional Medicine
CSO	Central Statistical Office
ECDC	European Centre for Disease Prevention and Control
EDLIZ	Essential Drugs List and Standard Treatment Guidelines for Zimbabwe
FOSNET	Food Security Network
FRTI	Faculty of Health Sciences' Research, Technology and Innovations
GDP	Gross Domestic Production
GIGO	Garbage-In-Garbage-Out
GoZ	Government of Zimbabwe
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HTA	Health Technology Assessment
ICAI	Independent Commission for Aid Impact
IBM	Integrative Behaviour Model
ILO	International Labour Organisation
IPA	Interpretive phenomenological nnalysis

ITPC	Investment and Trade Promotion Centre
KFF	Kaiser Family Foundation
KWIC	Keywords - In – Context
MASEM	Meta-Analytic Structural Equation Modeling
MC	Male Circumcision
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NAPOVC	National Action Plan for Orphans and Vulnerable Children
NAT	National AIDS Trust (UK)
NGO	Non-Governmental Organisation
NIMH	National Institute of Mental Health
NMMU	Nelson Mandela Metropolitan University
OI	Opportunistic Infection
PLHIV	People Living with HIV
PLWA	People Living With AIDS
PLWHA	People Living With HIV and AIDS
SAFAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SCT	Social Cognitive Theory
SEM	Structural Equation Modeling
SLT	Social Learning Theory
SSA	Sub-SaharanAfrica
STIs	Sexually Transmitted Infections
STDs	Sexually Transmitted Diseases

TAM	Traditional Alternative Medicines
TB	Tuberculosis
TIB	Theory of Interpersonal Behaviour
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UNAIDS	United Nations programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation
YAS	Young Adult Survey
ZDHS	Zimbabwe Demographic and Health Survey
ZIMSTAT	Zimbabwe National Statistics Agency
ZINATHA	Zimbabwe National Traditional Healers Association

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CHAPTER ONE

INTRODUCTION AND PROBLEM STATEMENT

1.1 INTRODUCTION

Human immunodeficiency virus infection and acquired immunodeficiency syndrome (HIV and AIDS) is a disease of the human immune system caused by infection from the human immunodeficiency virus (HIV) (Kent & Sepkowitz, 2001). Kent and Sepkowitz also indicate that the disease was first reported in 1981. This chapter gives an overview of the global, continental and regional status of the pandemic as well as Zimbabwe's current distribution status of HIV and AIDS. The impact of the pandemic on people is also highlighted. These population HIV/AIDS statistics are important for policy formulation research and public health decision-making processes. A presentation on the impact of HIV/AIDS on the people forms the second focus of this chapter. This section narrows down the discussion on the Zimbabwean situation looking specifically at the economic impact of the pandemic on households, the agricultural sector, industry and commerce (firms), health, transport, mining as well as water. Some of the issues raised in these sectors are cross-cutting and the subsections should not be perceived as repetitive. An overall view of the macroeconomic effects of HIV/AIDS is summarised. After the general introduction of the HIV/AIDS problem, the chapter introduces one of Zimbabwe's responses to the problem - treatment as prevention, specifically the traditional treatment and health care option for people living with HIV/AIDS (PLWHA). This is followed by the statement of the problem investigated by the present study, leading to the overall study aim and the objectives. The delimitation, limitations and chapter layout conclude the chapter.

1.2 GLOBAL HIV AND AIDS EPIDEMIC

The 20th International AIDS Conference held in Australia (2014) concluded that HIV/AIDS is one of the most destructive diseases humankind has ever faced. The conference also noted that AIDS brings with it profound social, economic and public health consequences and has become one of the world's most serious health and development challenges. The conference contended that AIDS, after its first case was reported in 1981, has become the leading cause of death worldwide. Globally,

an estimated 35.3 million people were living with HIV in 2012, an increase from previous years as by then more people were receiving antiretroviral therapy and therefore began living for longer (Joint United Nations Programme on HIV/AIDS (UNAIDS, Global Report for 2013, 2013). UNAIDS reported that there were more than 2.3 million new cases of HIV infections globally in 2013. This is an alarming figure. The UNAIDS also revealed, however, a 33% global decline in new infections as well as a reduced rate of AIDS deaths. The World Health Organisation (WHO, 2014) also observe that, since the beginning of the epidemic, approximately 78 million people have been infected with the HIV virus and almost 39 million people have died of AIDS. The WHO also indicate that, by the end of 2013, world-wide approximately 35 million people were living with HIV and that in that year alone approximately 1.5 million people died of AIDS-related illnesses. These figures agree with the findings summarised in the World AIDS Day Report (UNAIDS, 2014) that in 2013 there were between 33.2 million and 37.2 million people living with HIV. This report also indicated that since the start of the epidemic around 78 million, or between 71 million to 87 million, people became infected with HIV and around 39 million, or between 35 million and 43 million, people had died of AIDS-related illnesses worldwide.

Although the World AIDS Report of 2014 reports a worldwide decline in new infections, the figures are still very high and are even more worrying for children. The report shows that the rate of new HIV infections has fallen by 38% since 2001. Worldwide, 2.1 million [between 1.9 and 2.4 million] people became newly infected with HIV in 2013, down from 3.4 million [between 3.3 and 3.6 million] in 2001. New HIV infections amongst children has declined by 58% since 2001. Worldwide, 240 000 [between 210 000 to 280 000] children became newly infected with HIV in 2013, down from approximately 580 000 [between 530 000 and 640 000] in 2001. The report also depicts a corresponding decrease in AIDS related deaths, with figures of AIDS-related deaths having fallen by 35% since the peak in 2005. In 2013, 1.5 million [between 1.4 to 1.7 million] people died from AIDS-related causes worldwide compared to 2.4 million [2.2 – 2.6 million] in 2005 (UNAIDS, 2014). The report further reveals a very serious lack of access to treatment for infected people, with children more affected than adults, although both have poor access to antiretroviral therapy. The fact sheet of the World AIDS Day Report (2014) points out that, as of

June 2014, only 13.6 million people living with HIV had access to antiretroviral therapy. In 2013, the number was 12.9 million or 37% [35%-39%] of all people living with HIV and only 38% [36%-40%] of all adults living with HIV were receiving treatment. However, just 24% [22%-26%] of all children living with HIV were receiving this lifesaving medicine. This global picture shows clearly that serious efforts have to be made to ensure treatment is available to all. This study can therefore play an important role in this aspect in trying to understand the use of Traditional and Alternative Medicines (TAM) amongst people living with HIV and AIDS.

1.3 HIV AND AIDS EPIDEMIC IN AFRICA AND SUB-SAHARANAFRICA

HIV/AIDS is the major threat to development, economic growth and poverty alleviation in much of Africa and, as stated, is the most devastating epidemic in recent history (Whiteside, 2002). This observation is also shared by Mutangadura who observes that the HIV/AIDS epidemic in Africa is increasingly becoming one of the major impediments to sustainable development (Mutangadura, 2000). Whiteside went on to say that HIV/AIDS is in many ways a more lethal epidemic compared with, for example, Ebola fever, where people fall ill quickly and visibly, placing the general population and public health professionals on their guard and able to take precautions to stop the spread. HIV infection, however, moves through a population giving little sign of its presence. The HIV and AIDS pandemic marks a major development crisis in Africa, which remains by far the worst affected region in the world (Ogunbodede, 2004). Ogunbodede reported that 42 million people now live with HIV/AIDS of which 29.4 million (70.0%) are from Sub-SaharanAfrica and that approximately 5 million new infections occurred in 2002 with 3.5 million (70.0%) of these from Sub-SaharanAfrica. The report further indicated that the estimated number of children orphaned by AIDS living in the region is 11 million and in 2002, the epidemic claimed about 2.4 million lives in Africa, more than 70% of the 3.1 million deaths worldwide. It also highlighted that the average life expectancy in Sub-SaharanAfrica was reduced from 62 to 47 years as result of AIDS, and that HIV/AIDS stigma is still a major problem despite the extensivespread of the epidemic (Ogunbondede, 2004).

Although the UNAIDS and the WHO reports clearly show the global problem of HIV, the WHO further point out that Sub-SaharanAfrica remains the most severely affected, with nearly 1 in every 20 adults living with HIV, constituting nearly 71% of people living with HIV worldwide (WHO, 2014). The UNAIDS (2014) fact sheets depict that in 2013 there were approximately 24.7 million [between 23.5 and 26.1 million] people living with HIV in Sub-Saharan Africa, with women accounting for 58% of the total. The programme also concurred with WHO that Sub-Saharan Africa accounts for approximately 70% of the global total new HIV infections when they reported a 71% proportion (UNAIDS, 2014). As mentioned earlier, although the AIDS death rate has declined in Africa south of the Sahara, the figure of 1.1 million [between 1.0 to 1.3 million] deaths in 2013, as reported by UNAIDS in 2014, is still unacceptably high with UNAIDS also stating that three out of four people on antiretroviral treatment live in Sub-SaharanAfrica. Death brings with it serious negative income shocks to already poor households and communities. Collins and Leibbrandt (2007) report that death poses substantial and lingering burdens not only from the loss of income that the deceased used to bring into the household but also due to the funerals that surviving household members need to finance. These suddent extra costs have a large negative effect on household savings. The UNAIDS report also reveales the very worrying figures that 67% of men and 57% of women in the region are not receiving antiretroviral treatment. There was also a very disturbing figure of 210 000 new infections among Sub-Saharanchildren in 2013. These figures are highly disquieting in terms of HIV prevention, treatment and care in the Sub-Saharanregion.

Furthermore, the HIV/AIDS epidemic has a debilitating effect on rural families and their livelihoods in Sub-SaharanAfrica, “with more than 60% of Southern Africa’s population staying in rural areas and dependent on smallholder agricultural production as their major source of livelihoods” (United Nations Economic Commission for Africa, 2006, p. v). The Commission further contended that in Southern Africa where the HIV prevalence rates continue to be the highest in the world, the HIV/AIDS epidemic has been singled out to be “aggravating food insecurity and negatively impacting rural livelihoods” (p. viii). The Commission also indicated that HIV/AIDS negatively affects agriculture, food production and security as well as rural livelihoods through labour and capital shortages, loss of technical

knowledge and skills, loss of farm implements, loss of access to production assets such as land as well as loss of formal and informal institutional support. The aggregated HIV/AIDS impacts are a reduction in smallholder agricultural production, lowered income as well as reduction in household assets, resulting in reduced access of households to sufficient food, health and education.

According to the Stephen Lewis foundation (2012), of the 16.6 million children (aged 0–17) who have lost one or both parents to AIDS globally, 14.8 million are in Sub-SaharanAfrica where an estimated 1,360,000 pregnant women were living with HIV in 2010, only 42% of whom received HIV counselling and testing. Around 40 to 60% of the orphans live in grandmother-headed households. Therefore, more than a quarter of all new HIV infections globally are in young women in Sub-Saharan Africa between the ages of 15 to 24. The fact sheet further demonstrates the problem by showing that only about 21% of HIV-positive children in Sub-Saharan Africa who need antiretroviral treatment were receiving it in 2010, and that without treatment, an estimated one-third of infants infected with HIV die before reaching age one and half die by the age of 2.

1.4 HIV AND AIDS EPIDEMIC IN ZIMBABWE

Zimbabwe, situated in southeastern Africa, is not spared from the pandemic. It continues to be one of the Sub-Saharan African (SSA) countries most heavily impacted by the AIDS epidemic, with almost 1.2 million people infected and over 1.1 million orphans. Zimbabwe ranks as fifth highest in the world in the impact of HIV and AIDS, behind Swaziland, Botswana, Lesotho and South Africa (UNAIDS, 2012). The UNAIDS reported a life expectancy in Zimbabwe of less than 53 years old. The 2005-2006 Zimbabwe Demographic and Health Survey (ZDHS), which was Zimbabwe's first nationally representative sample done by the Zimbabwe National Statistics Agency showed that of individuals tested for HIV there is an overall 18% HIV prevalence among 15-49 year olds with women making up 21.1% of that and men 15.2% (ZIMSTAT, 2007). Another ZDHS (2010-2011) showed a slightly reduced overall prevalence rate of 15% among 15-49 year olds. This age group constitutes economically active people overall, 17.7% among women and 12% among men (ZIMSTAT, 2011). Mugurungi (2012) reports a high mortality rate in Zimbabwe among 25-59 year olds due to AIDS. Data from Zimbabwe shows about

62 000 new infections a year, and an estimated 180 950 people dying of AIDS year (UNAIDS, 2010). The majority of new infections in Zimbabwe occur in the 20-29 year old age group, with an estimate that almost 60% of those transmissions are occurring in low risk heterosexual encounters, and another 26% occurring as a result of casual partnerships, excluding commercial sex work. Sex work contributes another 8% of transmissions, either via sex workers (1.4% contribution) or clients of sex workers (6.4% contribution) (ZIMSTAT, 2011; ZNASP, 2011). ZIMSTAT (2011) also showed that there are socio-demographic differences in prevalence of HIV in Zimbabwe, with provincial and regional differences, and urban versus rural, employed versus unemployed individuals, as well as by marital status, including polygamy. The ZIMSTAT (2011) data also showed that among cohabiting couples tested, 79% were concordant for HIV negative status, 10% were concordant for HIV positive status and 11% were discordant.

Below is a summary of Statics from The Government of Zimbabwe (2011) National Action Plan for Orphans and Vulnerable Children Phase II 2011 – 2015 from the Zimbabwe Ministry of Labour and Social Services:

Table1.1: Main Statistics on HIV and AIDS and related factors

Zimbabweans infected with HIV as of 2009	1,102,864
Percentage of adults (15-49 years) who are HIV positive as of 2009	14.3%
Estimated number of children (0-14 years) living with HIV and AIDS at end of 2009	105,740
Estimated new HIV infections among adults during 2009	66,156
Estimated new HIV infections among children during 2009	14,957
Estimated number of children in need of ART in 2009	35,189
Estimated number of annual AIDS deaths in adults in 2009	56,676
Estimated number of annual AIDS deaths in children in 2009	9,397
Weekly estimated number of deaths due to AIDS in 2009	1,271
Life expectancy has fallen from 61 years to	39 years
Estimated number of orphans due to AIDS in 2009	989,009
Estimated number of children of school age living with disabilities in 2010	300,000
Children living on/off the streets	12,000

Percentage of children (5-17 years) engaged in economic activity in 2009	32%
Children living in institutions	5,000

Source National Action Plan for Orphans and Vulnerable Children Phase II (2011 – 2015)

The Zimbabwe National Action Plan for Vulnerable Children Phase II (ZNAPVC II) (2011-2015) pointed out a major problem caused by the AIDS pandemic that will be discussed in this chapter under various sectors. To summarise, the plan pointed out that most of these HIV/AIDS orphans are cared for by their extended families, including grandparents (grandparent headed households) or are living in child-headed households. Many orphans live in extreme poverty within households that are unlikely to access treatment and health care, attend school or have basic needs met including decent shelter and clothing, shoes and bedding. They are highly susceptible to psychological problems and child abuse, including forced sex in adolescence, which increases their probability of contracting HIV. Most of them are denied their inheritance rights and have to look after themselves from very young, at which they generally will not have acquired skills or capital, compelling them to rely on lowly paid casual jobs, ultimately locking them into a vicious poverty cycle (ZNAPVC II, 2011-2015). The plan revealed that 1.5 million households in Zimbabwe live in extreme poverty and food insecurity. These households include 3.5 million children, who urgently need free access to basic services and protection (ZNAPVC II, 2011). Many of these children engage in exploitative work to meet their basic needs, leading to unsafe migration, child trafficking, child prostitution, child labour and other forms of abuse (See sector discussions in the next sections).

1.5 MACROECONOMIC IMPACT OF HIV AND AIDS IN ZIMBABWE

In this segment, the study will highlight the cross-cutting challenges of the HIV pandemic inherent in all business establishments before giving detailed discussions of the impact of HIV and AIDS on specific sectors of the economy. The sectors that will be discussed are education, mining, transport, firms, agriculture and health. Individual households will also be discussed in this segment as the ‘bread basket’, where HIV and AIDS related medication has slipped into the family bread basket,

sharing an already inadequate household budget. This is largely indicative of the performance of the national economy.

While HIV ordinarily appears to be an individual's predicament, its aggregated effect impacts on the economy and the development of a country. AIDS-related illnesses and deaths affect a firm by both increasing expenditures and reducing revenues. Expenditures may be in the form of increased health care costs, burial fees as well as the recruitment and training of replacement employees. Revenue decreases due to absenteeism arising from illnesses and there is increased training expenditure as summarised below ((Bollinger, Stover, Kerkhoven, Mutangadura, & Mukurazita, 1999):

- AIDS related deaths lead directly to a reduction in the number of workers available as these deaths often occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced.
- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages. Longer-term costs consist of lost opportunities and the potential loss of skilled teachers, trainers and mentors within education and training institutes. This has an impact on overall educational levels and skills development, as effective human capital formation is essential for long term development and reduced population growth.
- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.
- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.
- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time (Bollinger, Stover, Kerkhoven, Mutangadura, & Mukurazita, 1999, p. 12).

Sunanda and Kureya (2003) also compiled the list below summarising the impact of HIV and AIDS in Zimbabwe. These are:

- A threat to national cohesion through the collapse of social networks and community structures due to illness and death of key social figures, from leaders to community workers;
- loss of skills, institutional knowledge and intellectual capital at all levels of the workforce;
- increased costs of employee benefits such as medical aid, insurance, funeral benefits, and pension schemes;
- reduced consumer purchasing power leading to reduced demand for products and reduced economic activity;
- reduced remittances from urban to rural economies, with reduced inputs into agriculture for fertiliser, pesticides and seeds;
- an estimated annual loss of 2.1% of teachers due to AIDS between 2000 and 2010;
- increased absenteeism and poor quality teaching because of sickness affecting teachers;
- projected fall of 24% in primary school age population by 2010 with affected families resorting to selling assets and withdrawing savings to cover extra healthcare costs and funerals;
- severe family hardship through loss of income due to illness and death of family bread winners;
- increasing gender inequity through impoverishment of widows and women headed households, burden of caring for sick family members, fewer opportunities for formal employment, poor negotiation ability for safer sex, poor access to treatment and declining family support;
- children taken out of school because of families' inability to pay school fees and because more children are taking on care-giving roles at home or working in agriculture to provide for family income and food needs;
- an estimated 780,000 orphans growing up without parental guidance and care, deprived of basic rights of shelter, food, health and education, and

- more street children growing up in environments of destitution, crime and commercial sex work.

Matshe and Pimhidzai (2008) also declare that Zimbabwe is one of the countries most severely affected by the HIV/AIDS epidemic. They also indicate that the high prevalence of the disease is not only limited to health problems but also economic problems, and that much effort needs to be directed at establishing the exact magnitude of the HIV/AIDS impact on the economy. This study does not attempt to follow up on Matshe and Pimhidzai's recommendations but contends that the economic impact, as espoused by Bollinger (1999) as well as other later scholars, informs the basis of the need to formulate strategies for coping with the epidemic, including health-seeking behaviour which is the focus of this study. Furthermore, this study takes interest in economic factors as they affect health seeking behaviours and social conduct. This discussion focuses on selected sectors of the Zimbabwean economy to demonstrate the magnitude of the impact of HIV/AIDS but it does not claim that the effects are restricted to those sectors.

1.5.1 Impact of AIDS on education in Zimbabwe

The psychological stress on individuals and households directly resulting from HIV/AIDS can compromise school and work performance as well as the household capacity to provide adequate care for the children in the home, leading them to drop out of school early as well as often to drug abuse and unsafe sexual behaviours (Coombe, 2002). Furthermore, one of the mechanisms households employ in order to care for the sick is to withdraw children from school (Alemu & Bezabih, 2008). It has been recorded that female children are most affected, being unable to fully realise the benefits of education and often leading to early marriages or commercial sex work whilst at the same time increasing their susceptibility to HIV infection (Barnett & Whiteside, 2002). Gumbi, Macherera, Moyo, Ncube's (2012) study found that children who are HIV positive reported stigma and discrimination both at school and community or societal level and felt safer at home because other children are aware of their HIV positive status due to the noticeable signs and symptoms associated with HIV infection. Children reported verbal and physical abuse from other children at school as well as not being able to attend due to illness as a result of the disease.

AIDS affects the education sector in a number of ways, including reduced availability of trained, experienced teachers as a result of AIDS-related illness and death. Training costs for teachers (and other education officers) are rising to replace those lost to the epidemic and experienced teachers who die as a result of AIDS are often replaced by untrained teachers (UNAIDS, 2004). Children may not go to school in order to care for sick family members and/or to work in the fields, farms and plantations to assist the family household income. They may also drop out of school if their families cannot afford school fees due to reduced household income as a result of an AIDS death (Alemu & Bezabih, 2008; Bollinger et al., 1999). Marachera et al. (2012) also found that lack of access to adequate food supplies also often forces children to begin begging for food on the streets in order to feed themselves and other family members. For children on Antiretroviral Therapy or Treatment (ART), this disrupts the ART programme as the children are not always at home and end up missing their drugs and even hospital visits for reviews and check-ups. Begging also exposes the children to sexual abuse, resulting in further spread of the virus along with resistance to certain ARV drugs as they would be defaulting from their medication routine.

1.5.2 Economic impact of AIDS on Zimbabwean agriculture

Agriculture is the largest economic sector in most African countries, accounting for a large portion of production and a majority of employment. In Zimbabwe, 67% of the population live in the rural areas (ZIMSTAT, 2012) where they engage in subsistence farming whilst at the same time commercial farmers are the largest employers in the country. The national economy is agri-based with agricultural activity accounting for 28% of the GDP and employing 26.9% of the total number of working people (FOSNET, 2007).

Agriculture is labour intensive and as such is easily affected by HIV as employees engage in absenteeism due to AIDS related illnesses. Bollinger et al. (1999) observe that the loss of manpower at periods of crucial farming operations, like planting and harvesting, can significantly reduce the yield as well as that preference will be given to less-labour-intensive crops, in most cases resulting in subsistence farming at the expense of commercial farming. A study conducted by FOSNET (2007) in the Chivi and Makoni Districts on the impact of HIV on food security in rural

families revealed that female-headed households are more vulnerable than male-headed families. Vulnerability is even worse in child-headed families. Subsistence farming is adversely affected by sickness or illness in the family as attention is focussed on the sick member of the family, sometimes during the planting season, leading to little or no yields and subsequently, failure to cope. This finding was also reported in the UNAIDS report on the Impacts of AIDS when it contented that, “Adult deaths from AIDS often lead to a loss of traditional knowledge of agricultural practices. Skills may not be transferred to children or relatives, a situation that has negative implications for food production. When mothers die, children are usually forced to take the place of adults in the subsistence economy, thus increasing child labour and lowering productivity. Over time, “HIV and AIDS can contribute to declines in land use, crop yields, and crop variety” (UNAIDS, 2004, p. 38).

The HIV pandemic has also led to an increase in funerals in a culture where communities are obliged to attend and cattle are slaughtered in honour of the deceased. These cattle are not only important for livestock production, but also form part of the physical resources that enable crop farming by providing ox-drawn labour and manure. Bollinger et al. (1999) maintain that negative impacts from HIV/AIDS are also found in livestock production, reduced contact hours between farmers, with extension of workers and other stakeholders experienced as a result of staff attrition and time the farmers spend attending funerals. du Guerny, Engh and Stloukal (2000), Haslwimmer (1994a) and Haslwimmer (1994b) make similar observations when they contend that widespread selling and slaughtering of livestock to cater for the ill and to fund funerals substantially reduces livestock and crop production due to the resultant reduction in availability of draught power and manure (du Guerny et al., 2000; Haslwimmer, 1994a, 1994b). They also share how serious future household food security and malnutrition problems result from the funding of funerals by the selling of livestock, and that the loss of draught animal power results in reduced cultivated areas in rural communities where mixing of crop and livestock farming is prominent, further affecting livelihoods. They regard the sacrifice or sale of cattle as one of the most destructive practices related to HIV/AIDS in the livestock sector.

The study carried out by Chitsike, Mutambirwa and Tawodzera (2005) on The Socio-Economic Impact of HIV/AIDS on Communal Agriculture established that HIV/AIDS is causing major increases in household medical and transport expenses, as affected persons require constant medical attention. The study also established that the premature death of a household member due to AIDS leads to statistically significant losses of household income due to foregone production from the deceased. With regard to crop production, the study contended that HIV/AIDS is causing significant declines of over 40% in the size of household cultivated areas for labour intensive crops such as cotton and tobacco (cash crops), and that HIV/AIDS is also causing a significant decline in harvested quantities of maize (staple food), cotton, tobacco and paprika crops. These findings are very crucial for Zimbabwe whose economy is mainly agro-based. The study attributed the crop production declines in HIV/AIDS-affected households as resulting in critical household food shortages. Significant declines in marketed crop quantities of cassava have also been recorded among HIV/AIDS-affected households in Zimbabwe (Chitsike et al., 2005). This, according to Tawodzerwa et al. (2005), is because affected households are consuming most of their cassava in the belief that the crop boosts the immune system of an HIV/AIDS patient.

The above stated impacts of HIV and AIDS on agriculture are summarised by Kormawa (2005) into the following categories:

- agricultural labour supply,
- farm size,
- crops and farming systems,
- farm technology adoption,
- knowledge and indigenous management skill,
- household nutrition and food security, and
- economic losses.

For impact on labour, he reiterates that the pandemic hits the most agriculturally active and productive age group of the society, thereby reducing agricultural productivity and food security because the quantity and quality of farm household labour is reduced as a result of incapacitation or death. The farm size is significant

because of lack of mechanisation and heavy dependence on human labour which is consequently reduced to more manageable peasant production sizes, with some of the fields being left fallow, rented out for meagre rentals or abandoned altogether. Cash crops are being abandoned for less labour-demanding subsistence crops like maize, millet and rapoko or finger millet. Kormawa (2005) also reports that because of the trauma resulting from stigmatisation, HIV/AIDS affected families may not avail themselves for training and/or exchange of extension information. Intergenerational transfer of knowledge is also being disrupted because parents die before being able to pass on the knowledge they have gained to their children. In the majority of these cases the level of literacy is not very high, so memory in a non-literate culture is transferred in-context. This therefore may not happen as result of illness and/or death.

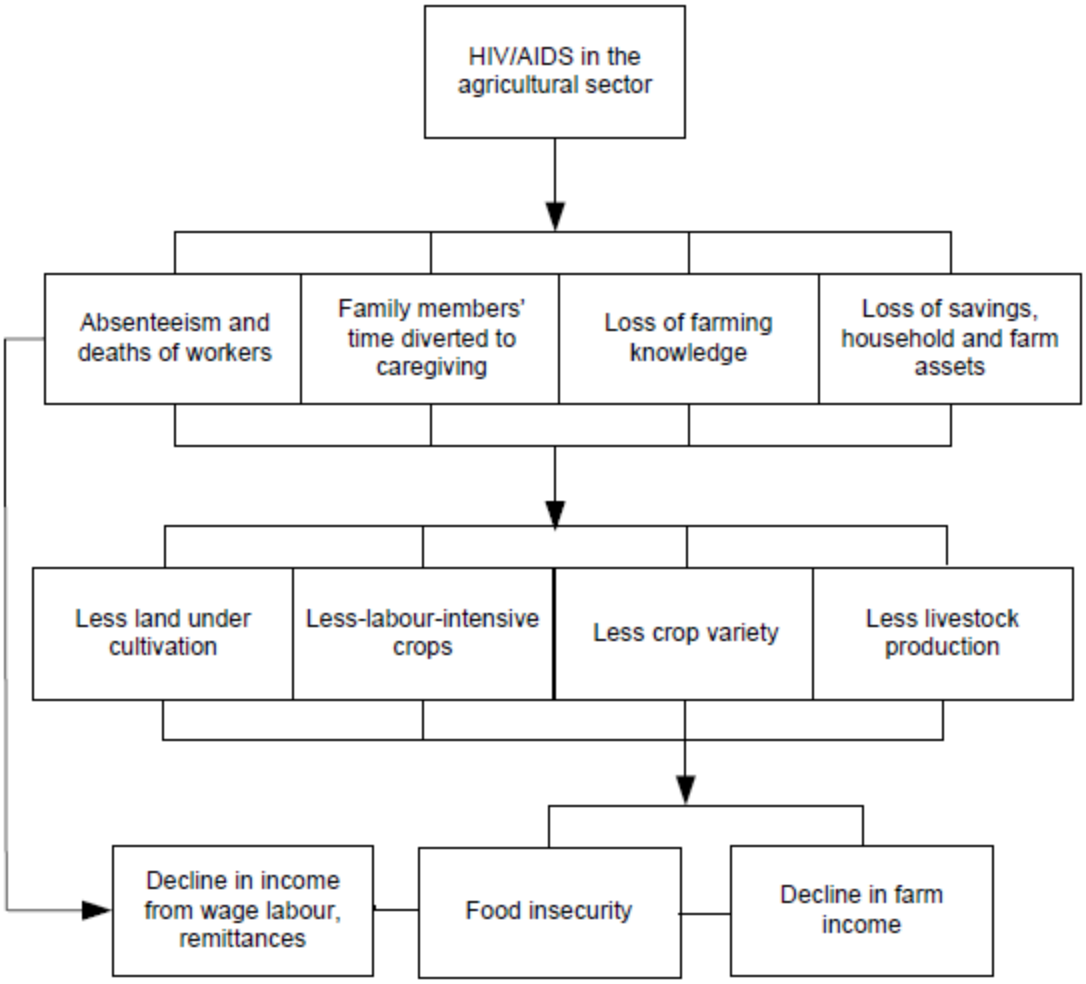
Kormawa's (2005) paper also highlights that decreased capacity for farming leads to corresponding decreases in subsistence ability of the impacted household. This is further exacerbated by lack of income to buy food as the AIDS sufferers have ceased to produce on their own land, leading to a natural shift to low quality foods as well as reduced meals and quantities of food. This leads to poor nutrition, low immunity and vulnerability of all the household members to HIV infection.

In commercial farming, similar effects are felt as employees fall sick and are not only absent from work, but also need assistance from the employer to get medical assistance. The farmer also incurs increased costs from paying hired labourers, who are in most instances less competent, as well as paying the sick employee. More costs also arise from recruitment, training, mediocrity due to high staff turnover, funeral bills and in some cases relocating the remaining members of the deceased employee's household to their rural areas as required by the Zimbabwe labour laws.

The agricultural sector forms the backbone of Zimbabwe's economy and as a result impacts more seriously on other economic spheres than any other sectors. Any impact on the agricultural sector therefore has a ripple effect on other sectors, especially household, health and the manufacturing industry. The agricultural sector also impacts on food security which is the basis for the nutrition of AIDS patients while the manufacturing sector depends on farm produce as raw material. When the

nutrition of HIV positive people is not met, they increasingly fall sick, thereby putting pressure on the health delivery system.

These impacts were summarised in the AIDS Impact on Agriculture Framework below:



Source: United Nations Department of Economic and Social Affairs, Population Division (2004, p. 62)

Figure 1.1: Conceptual framework for the Impact of AIDS on Agriculture

1.5.3 Impact of AIDS on health in Zimbabwe

From the year 2000 on political and socio-economic challenges experienced by Zimbabwe resulted in the country's social service delivery system being hard hit with the health sector being one of the highest casualties. By 2009, HIV/AIDS accounted for half of the disease burden in the country, according to the Independent Commission for Aid Impact, (ICAI, 2011). The high prevalence of HIV/AIDS in the

country further compounded the challenges in this sector as the pandemic caused major increase in the number of people seeking treatment for AIDS related illnesses (UNAIDS, 2004).

The Zimbabwe AIDS Response Progress Report (2014) reported a total number of PLWHA receiving ART's in Zimbabwe to be 65,299 of which 618,980 were adults and 46,319 were children with more than 9,000 PLHIV initiating treatment each month. The pediatric ART coverage remains at 46%, (ART coverage: Adults 77% and Children 46%) which is significantly below the universal access target of 85% (Zimbabwe AIDS Response Progress Report, 2014). Zimbabwe's conventional health delivery system is made up of hospitals (government, missionary and private) and clinics which are all manned by qualified personnel. The Zimbabwe AIDS Response Progress Report (2014) presents some of the challenges that are faced by the health sector. These include running out of stock of HIV testkits and ART medicine, low pediatric ART, limited funding due to withdrawal of other funders, some HIV+ pregnant women still receiving a single dose regimen (less efficacious), logistics and supply chain management challenges, slow decentralisation of ART initiation, especially for children and weak linkage between health and community systems.

The United Nations Department of Economic and Social Affairs/Population Division AIDS Impact (1990) also observe a number of impacts of AIDS on the health sector. They note that health workers themselves may be infected with the HIV virus, negatively affecting the delivery and quality of public health services. Health services have therefore also been greatly affected by the high AIDS-related mortality rate among health workers (UNAIDS, 2004). The morale of the health professionals may also be negatively affected as providing care for AIDS patients is challenging and stressful for the health services delivery staff involved. This was also presented by UNAIDS who report that some health workers became infected themselves and many suffer from the intense physical and emotional strain of caring for AIDS patients.

These high levels of stress may lead to high staff absenteeism, and staff may refuse to be transferred to high-prevalence centers. The absenteeism and death of health workers poses a serious threat to the health system of the country. Trained and

experienced personnel are lost and training of new personnel exerts more financial pressure on the country's fiscus. The UNAIDS report (1990) highlighted that, in some cases the quality of services may also be affected by the attitude of the health staff towards HIV/AIDS patients. The health workers' fear of contracting the disease compounded with the psychological stress involved in treating AIDS patients may lead to a reduction in the provision of quality of services. The report also contends that HIV/AID leads to increases in health expenditures in both the public and private sectors and may redirect resources towards the higher levels of care needed for AIDS patients. This observation was also shared by Case and Paxson (2009).

The Zimbabwe Ministry of Health and Child Welfare, for example, introduced programmes aimed at assisting HIV/AIDS affected and infected people such as home-based care. These programmes have their own challenges, however. While home-based care visits by trained personnel decongest the hospitals, they are more expensive to administer. Furthermore, healthcare and anti-retroviral drugs for AIDS patients are expensive yet essential for the security and development of a country.

The health sector in Zimbabwe operates alongside traditional and or spiritual medicines which have not been scientifically proven but are widely used, sometimes supported by results. Some HIV/AIDS patients use medical drugs together with traditional medicines while others only use traditional medicines. In some cases, those who believe more in traditional medicines are eventually forced to consult medical doctors in order to secure sick leave certificates that are mostly andatory for employees to prove that absence from duty was a result of illness. These certificates are only deemed acceptable if they are certified by conventional medical doctors.

1.5.4 Impact of AIDS on households

Bollinger et al. (1999) emphasise that the impact on households commence at the point where a member of the household (in most cases the main breadwinner) starts to suffer from HIV-related illnesses resulting in loss of income and substantially increased household expenditure for medical expenses. They go on to point out that this subsequently leads to other members of the household, usually female children and women, missing school or having to work less in order to care for the sick

person. This concurs with Foster and Williamson's (2000) findings that children are affected by HIV/AIDS before they are orphaned. When a parent develops an HIV-related illness, children often assume new responsibilities. These include but are not limited to domestic chores such as "cooking, cleaning, carrying water and laundry, care giving activities such as feeding, bathing, toileting, giving medication and accompanying relatives for treatment, agricultural or income generating activities and childcare duties" (p. 5). They further share similar findings with Bollinger et al. (1999) by pointing out that when a parent is ill, children's school attendance drops because they have to go and work in order to pay medical expenses or because families are no longer able to pay school fees. The decision that children should drop out of school to provide care for sick relatives or young siblings are often made by adults.

In the worst case scenario, where the main breadwinner dies, there is a "permanent loss of income, from less labour on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labour, resulting in a severe loss of future earning potential" (Foster & Williamson, 2000, p. 4). Most of the land tenure offer-letters are not bankable, resulting in severe farming capital funding crises for the widows who, when the husband dies, take over as head of the deceased's household as well as breadwinners. Female-headed households therefore generally have a much smaller land size than the male-headed ones (Alemu & Bezabih, 2008). Alemu and Bezabih further observe in the differences in the size of land owned and its useage that non- affected households rent more land from others while the affected households rent out more land, hence affected households have less land to cultivate. They conclude that HIV/AIDS affected households produce less quantities of food. This negative impact on production becomes much more pronounced with time as affected households sell more and more productive assets such as livestock (including for draught power), farming implements and/or even inputs out of desperation as chronically ill adults in the household die.

As will be mentioned and has been mentioned under other sections, the children of the widowed husbands subsequently drop out of school. Thee 10% concordant rate for HIV positive status that was earlier reported also implies that with time both

parents will pass away, leaving child-headed households. Child-headed households are fast becoming an integral part of our society (Chigwenya, Chuma & Nyanga, 2008). Approximately 1.1 million children have been orphaned since the first case of HIV/AIDS was recorded in Zimbabwe in 1985 (Francis-Chizororo, 2010). Francis-Chizororo further observes that the growing number of orphans in Zimbabwe brings with it heavy socio-economic strain on a society whose demographic profile is pyramidal, as children and youth constituted 50 per cent of the population in 2002. She also points out that families are losing their breadwinners and at the same time using their most valued and often limited resources to care for the sick and orphaned children, with the extended family continuing to absorb the majority of the orphans. As a result, nearly one household in five have taken in orphans, naturally leading to compromised quality of the standard of living of the families involved (the broken family and the receiving or fostering family). The orphans that do not join their relatives' families become child-headed families where one of the children (usually the oldest) has to drop out of school to take the role of the breadwinner and become child labourers (Rau, 2002), with highly compromised bargaining power leading to perpetuated poverty and vulnerability to HIV/AIDS infection, especially for the girl child. The girl child becomes susceptible to commercial sex work at an early age as a result of dropping out of school. In addition, these children are vulernable to abuse, neglect, exploitation, and malnutrition. Gumbi et al. (2012) also highlight that the lack of community support as well as stigma and discrimination affect their school attendance and hospital visits. The lack of adult love and lack of parental or adult affection and attachment also severely negatively affects their cognitive and emotional development. Fostera and Williamson (2000) express that children may experience a reduction in their quality of life when their mother leave to provide home care for an HIV/AIDS-affected relative or because of the transfer of money to a sick relative's household. This is more common in Africa south of the Sahara as a result of the extended family network as opposed to the developed countries' nuclear family structure. Fostera and Williamson (2000), also later observed by Francis Chizororo (2010), point out that children may also see their standard of living deteriorate when cousins come to live with them following the death of an aunt or uncle. Similarly, they can have such experiences when they have to leave their families to join their cousins as a result of their mother or father's death.

1.5.5 Economic impact of AIDS on Zimbabwean industry and firms

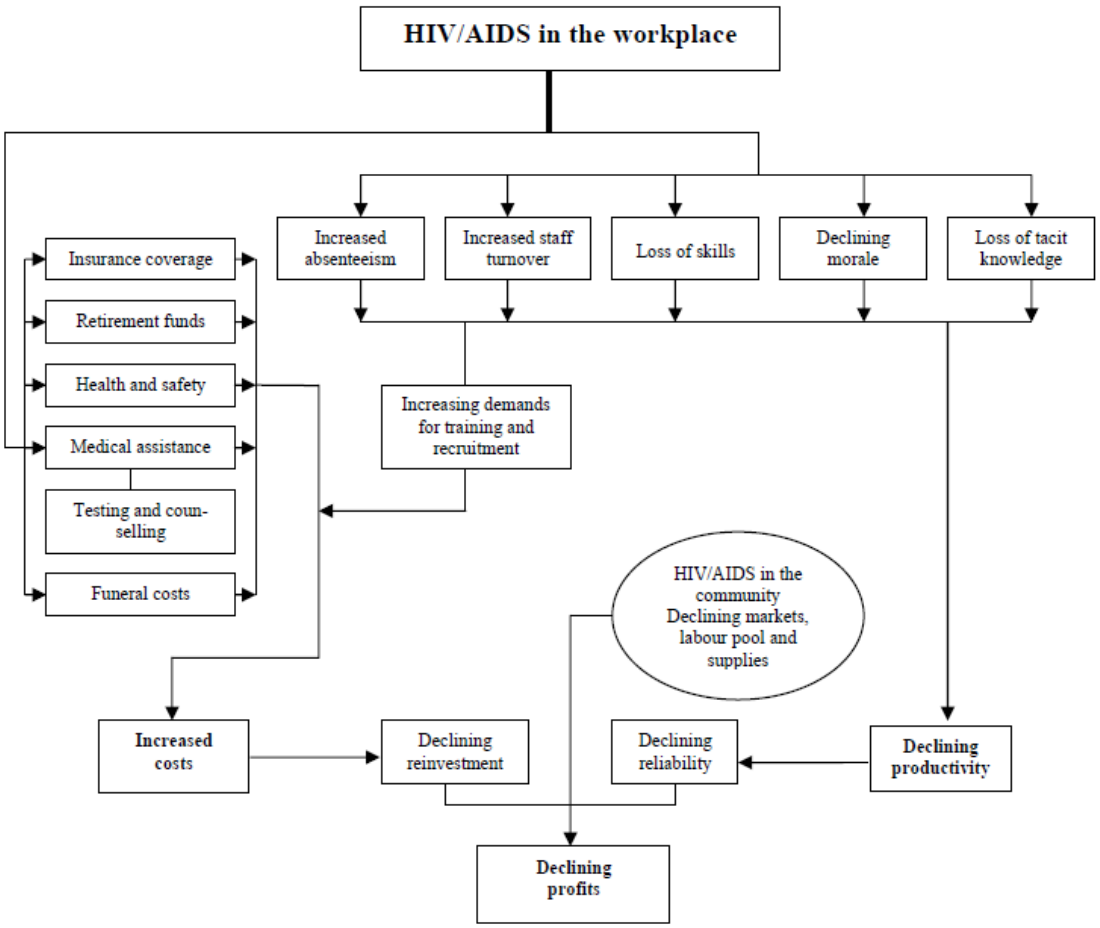
Human capital or human resources are the knowledge, skills and good health that enable people to work in order to pursue livelihood outcomes, hence, household human capital is determined by the quantity and quality of labour availability which, also depends upon several variables, such as household size, age structure, skill and knowledge levels as well as health status (Daly & Price-Smith, 2004). Alemu and Bezabih (2008) suggest that "AIDS affects the quantity and quality of productive labour through the death and chronic illness of household members productive and reproductive age group, through the amount of time taken by others to care for the chronically sick (taking into account HIV/AIDS is a protracted illness), time is lost during customary mourning period and loss in knowledge/ skills transfers" (p. 17). Consequently, AIDS has a significant impact on some companies and production and processing industries. AIDS-related illnesses and deaths to employees push operations of these organisations to escalating expenditures and plummeting revenues. Areas where expenditures are increased overlap sectors. These include but are not restricted to health care costs, burial fees and training and recruitment of replacement employees (ILO 2003; UNAIDS 2004). The absenteeism due to illness or attendance at funerals and time spent on training reduces revenues. Labour turnover leads organisations to resort to using a less experienced labour force that is less efficient.

The public service has not been spared. The International Labour Organisation (ILO) report of 2003 pointed out that the ability of the Public Service to deliver its mandate has been seriously compromised by the HIV and AIDS pandemic in the following way (ILO, 2003a):

- Loss of productivity through absenteeism due to illness, deaths and attending to others who are sick or their funerals,
- increased stress at the work place leading to lower productivity,
- reduced number of qualified and experienced personnel due to the high rate of attrition,
- reduced efficiency and effectiveness at the workplace,
- increased costs of health services, funeral and pension benefits,
- increased costs of recruitment and training of new personnel, and

- increased workload covering up for those who are sick/deceased,

UNAIDS (2000b) provided a summary of these impacts also indicating that there is a declining level of profits resulting from a declining level of productivity while production costs for the firm are not declining at a corresponding or higher rate. The summary highlights that reduction in production is largely because of increased absenteeism and increased organisational disruption as a result of HIV and AIDS-related illnesses affecting the employees. The UNAIDS (2000b) report also revealed that HIV/AIDS illnesses of employees results in increased cost for the firm due to recruitment and training, insurance cover and pensions as well as health management and funeral costs. Zimbabwe was given as an example where over a two year period, life insurance premiums quadrupled as a result of HIV/AIDS (p. 16). The summary is presented in the framework below:



Source: UNAIDS, Global Business Council on HIV/AIDS and Prince of Wales Business Leaders Forum, The Business Response to AIDS: Impact and Lessons Learned (UNAIDS, 2000b, p. 15).

Figure 1.2: Conceptual framework for the socio-economic impact of HIV/AIDS at the workplace

1.5.6 Economic impact of AIDS on Zimbabwean mining

The mining sector is composed of a majority of male workers who are in the sexually active age group. Most of them are far from their families and they engage in casual sex. The International Labour Organisation (ILO)'s guidelines for the mining sector revealed that in the mining sector, workers are disproportionately affected by tuberculosis (TB) because of their working and living conditions (ILO, 2012). The guidelines also contend that HIV infection increases the rate of the progression of TB. Promiscuity is rampant due to the high male/female ratio in the communities, further compounded by the availability of cash amongst the male workers to pay for sex. In Zimbabwe, the communities are small and secluded, often leaving the interchange of sexual partners inescapable. These communities are also often made up of people of different cultural backgrounds, some of them foreign, thereby easily accommodating promiscuous values that would otherwise be unacceptable in the community of origin. The HIV/AIDS Guide for the Mining Sector (2000), and the SAFAIDS Information Dissemination Service website ascribe the environment and set up of mining communities to be the key driver of risk and transmission of HIV.

In the same manner as in other sectors, production suffers from absenteeism due to illness, high costs of medical insurance, deaths/funerals and costs of replacements and training. Mining is labour intensive and is affected by illnesses even more than other sectors. The cost of replacement is very high as the sector is production oriented and the skills and tacit knowledge are acquired over long periods of time (Mutangi, 2006). Labour intensity also translates into more vulnerability to the effects of HIV/AIDS. Matangi further contends that despite the availability of miners on the labour market due to the closure of several gold mines, the replacement of workers lost as a result of HIV/AIDS remaines a challenge because the skills acquired are firm specific. Mining engineers are high skill employees who are

difficult and expensive to replace once they fall sick and fail to attend duties or die from AIDS.

Most mines have clinics that provide primary health care while some even have hospitals. These assist in providing HIV/AIDS awareness as well as testing and counselling to the mining communities. Alongside the conventional health care systems are traditional healers, mostly in the form of *n'angas,* who also offer treatment to sufferers of HIV/AIDS illnesses. While employees may be entitled to free treatment at the mine clinics and hospitals, some still turn to traditional healers due to belief systems, fear of stigmatisation in the small communities or even the testimonies of colleagues who have recovered after herbal treatments from the *n'angas.* Mining communities in Zimbabwe have traditional healers such as these, most of whom are of Malawian and Mozambican in origin. Mining production is thus negatively affected by HIV/AIDS, making treatment an urgent matter not only to mining development but to the economy as a whole. There is need to enhance the dual health delivery systems for the sustenance of the economy.

1.5.7 Impact on transport

The transport sector is highly vulnerable to the HIV and AIDS pandemic due to the mobility of the workforce (ILO, 2003b). As with the mining sector, the transport industry employs a very large workforce of men as truck drivers and train crews who are highly mobile and spend a considerable time in a month away from their families or sexual partners, increasing the chances of engaging in extra-marital relations. Bollinger et al. (1999, p. 10) note that "governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families".

Employees who are not healthy increase the operating costs of their companies. Medical insurance, which is a shared cost between the employer and the employee, absenteeism due to illness as well as failure to perform prescribed duties leading to alternate assignments all increase costs thereby diminishing profits for companies. This has a ripple effect on the national economy. High transport operating costs lead to high prices, not only in transport services but in the transported goods as well.

Thus, as the transport industry suffers the brunt of the HIV/AIDS pandemic, the whole nation is equally adversely affected.

The transport **s**ector was identified as not only vulnerable to the pandemic, but also important to the control of the spread of HIV and AIDS. This led to the development of a sector specific Zimbabwe HIV/AIDS Policy (2003) which guides and directs procedures of dealing with the pandemic at the work place with the intention of customising solutions to the affected persons.

1.5.8 Business and the legal framework

The government of Zimbabwe regulates the legal framework which guides the business sector and all other enterprises in dealing with HIV and AIDS affected employees. The country has a National Policy on HIV/AIDS which is buttressed in the form of the Statutory Instrument 202 of 1998 (1998), Labour Relations (HIV/AIDS) Regulations, (1998) (1998). The legal provisions spell out that there shall be no discrimination of HIV infected employees, stating that even when an employee becomes incapacitated to perform their duties, he/she may be reassigned to another section without loss of status or benefits to mitigate stigmatisation and possible loss of income. The provisions compel the employer to continue to engage a non-productive employee for the benefit of the employee. This employee-centric approach exposes the employer to high labour costs whilst diminishing profits in an already harsh economic environment, but nonetheless provides the basis for the formulation of unified solutions.

The legal framework does not, however, provide for the acceptance of absenteeism from work while being attended by a traditional healer for sickness. Traditional healers are not legally empowered to provide such certification yet many employees consult theses healers for AIDS related illnesses. Similarly, deaths of patients under the care of traditional healers are a matter for police investigation and medical insurances are only tenable at conventional hospitals. Nonetheless, beneficiaries often resort to traditional healers regardless. The legal provisions guiding business and enterprise completely disregard the existence of a bimodal health delivery system. Inspite of all these disadvantages, people in Zimbabwe still consult

traditional healers for treatment of HIV/AIDS related illnesses as well as other ailments. This problem is articulated in the next section of this chapter.

1.6 STATEMENT OF THE PROBLEM

The scenario presented in the preceding analysis reveals that Zimbabwe is highly vulnerable to threats posed by HIV and AIDS. As stated earlier, Zimbabwe has among the world's highest rates of HIV infection and AIDS, with a national HIV prevalence approximating 15% (ZIMSTAT, 2011). This makes the Zimbabwean population highly susceptible to the impacts of HIV/AIDS discussed in this chapter and hence the need for a very effective response to the AIDS problem. The most effective response is to put up programmes to reduce the number of new infections. Recent research has demonstrated treatment as prevention to be very effective (CDC, 2013; ECDC, 2012; NAT, 2011; WHO, 2012). This approach involves targeting the infected person with treatment so that, through reducing their infectiousness, they are less able to transmit the virus (ECDC, 2012). As put by CDC (2013), providing treatment to people living with HIV infection in order to improve their health must always be the first priority. The use of ART to prevent onward HIV transmission has moved to the forefront of public health programmes of HIV prevention because of the heightened tolerance of the medications, cost effectiveness, and the limitations of other approaches (Mayer & Venkatesh, 2011). Treatment reduces the index person's viral load to levels that reduce infectiousness, hence lowering the rate of transmission. This lessens transmission rates, thereby lessening disease burden from a public health point of view as well as reducing morbidity and mortality. As already mentioned, PLWHA also use traditional medicines. Studies on the use of traditional medicines are therefore very important as they help to inform public health policy, practice and education. It seems, although not documented, this treatment and care option also reduces the index person's viral load to levels that reduce HIV onward transmission. The idea of treatment as prevention is therefore central and a consensus of all, but the decision that has to be made by an infected person is whether to look for traditional treatment, conventional treatment or both. Marachera et al. (2012) reveal that the success rate of antiretroviral therapy (ART) in rural communities of Zimbabwe is low with few children covered on therapy whilst those on ART have a poor health situation

worsened by the poor conditions in the remote rural communities. The present study focuses on investigating perceptions leading to the choice of treatment with the traditional alternative medicines (TAM) as (a)/n alternative/complement to the conventional or allopathic option.

The population of Zimbabwe has a long tradition of both traditional health care, broadly based on divining what ancestral spirits may want, and the use of herbal products alongside conventional (biomedical) health care. Respect and utilisation of conventional health care reflects the country's several decades of successful development and modernisation, which includes one of the most widely respected medical schools in Africa, an extensive system of public clinics, and high levels of education and dual language literacy. At the same time, traditional health care thrives, reflecting the population's historic rural and tribal roots, and traditional healers (n'angas or sangomas) play perceived significant roles in the prevention, diagnosis and treatment of illnesses (Abdullahi & Amzat, 2008; Homsy & King, 1997; Richter, 2003; UNAIDS, 2000b). These historical factors, as well as a few small, non-representative studies, suggest a substantial likelihood that use of herbal therapies may be common among some HIV infected persons, either along with or without conventional care (Flint, 2015; Henderson, 2011; Mahlatini & Mbereko, 2014). On the other hand, data collected as part of two large National Institute of Health HIV-Prevention Projects provides contradictory findings, showing a small proportion of individuals using traditional health care related to HIV and other sexually transmitted diseases (STDs). The data collected may have missed the fact that despite widespread practice of traditional health seeking behaviour, doing so remains a guarded secret in the everyday life of most African people. Therefore, the non-availability of records of people who consult traditional healers and the reasons why they do so, may impact these findings. Thus, the proportion of health care for HIV/AIDS and other STIs obtained in traditional versus conventional settings and the use of traditional and conventional medications along with the perceptions around this are largely unknown in Zimbabwe. The economic, political and social disruptions in Zimbabwe over the past decade have impacted the utilisation of conventional health care, including impaired access to antiretroviral therapy (ART). It is logical to suppose that these factors, in addition to historical traditions, might have influenced the use of conventional versus traditional modalities by HIV infected

persons. Similar considerations are probably pertinent to most or all Sub-Saharan African countries with generalised HIV/AIDS epidemics.

In addition to lack of systematic data on how HIV infected persons apportion their health care between traditional and conventional options; little or no data exists on the perceived determinants of those selections. Behavioural research over the past two decades has validated the importance of a persons' perceived beliefs, attitudes, barriers, facilitators and cultural factors influencing the adoption of recommended health maintenance and disease prevention behaviours, such as visiting health care providers, adherence to recommended treatments and prevention, and use of traditional or conventional car (Fishbein, 2000; Ajzen & Fishbein, 2010; Cappella & Fishbein, 2006; Karspryzk & Montano in Ajzen, Albarracin & Hornick, 2007 & Wolitski & Zhang in Ajzen, Albarracin & Hornick, 2007). Understanding of these perceived determinants is crucial to influencing the adoption of health practices through education, marketing, and other modes of health promotion. Accordingly, the present research examined the perceived determinants of individuals' choices, including cultural and individual level factors such as attitudes, beliefs, and norms regarding the use of traditional and conventional health care in Zimbabwe, for the treatment and prevention of HIV/AIDS and to understand traditional health services consumers' recommendations about the use of traditional herbal therapy for HIV/AIDS prevention and treatment in Zimbabwe.

This research has provided the first and most comprehensive description, in a country with a high HIV prevalence, of the perceived health-seeking behavioural motivations that lead individuals to choose traditional versus conventional therapies and health care. It has also ascertained when and why these therapies are used along with other perceptions associated with their choices. Beyond these immediate aims, the outcomes of this study provides a basis and resources for building a comprehensive program of research on the choice between traditional and conventional health care for HIV/AIDS in Zimbabwe. The study determines how and why individuals choose traditional medical practices (TAM) instead of conventional medicine or along with conventional medicine.

As already indicated, this study makes a scientific contribution to the understanding of how individual, socio-cultural and environmental factors affect TAM motivation

among PLWA. The study is premised within the theoretical framework of the integrative behaviour model (IBM) (Ajzen & Fishbein, 2000). The framework provides a unique comprehensive and multi-perspective understanding of why PLWHA are motivated to use TAM. It utilises the comparative strengths resulting from a synergy of five theories of health behaviour instead of fragmented theoretical approaches. The HIV/AIDS medical world focuses on antiretroviral treatment which is not readily available after a CD4 count in Zimbabwe and other developing countries (Kureya & Sunanda, 2003; WHO, 2014). For Zimbabwe 79% of adults and 45% of children eligible for treatment are receiving it (Avert, 2012). As already mentioned, this study looked at perceived motivations for PLWHA to use traditional medicine by investigating whether it is because there is no other option or that the use of traditional medicine is a choice of preference. As adequately documented in both the results section and the recomendations, there is need for closer communication between those in traditional and modern medicine.

The study adopted a western-developed explanation of health seeking behavior (IBM) and applied it in a local setting in dealing with the complex issue of AIDS in different socio-economic environment where not much relevant literature is available. Henderson (2011) points out that studies of a more anthropogenic nature have emphasised the emergence of localised explanatory frameworks for HIV and AIDS at odds with common universal claims. Fishbein (2000) stresses that each of the constructs in the IBM can be found in any culture or population. He illuminates that “the theoretical variables contained in the model … have been tested in over 50 counrties in both the developed and developing world” (Fishbein, 2000, p. 275), including Zimbabwe (See Karsprzyk & Montano in Ajzen, Albarracin & Hornik, 2007 in Glanz, Rimer, & Viswanath, 2008). This research study also adopted the phenomenological approach to analyse local experiential data leading to the development of an explanatory framework for Zimbabwean PLWHA perceived motives in using traditional medicine. As already highlighted, the uniqueness of the present study is in its use of the comparative strengths of the five theoretical approaches to the understanding of health-seeking behaviours within the Zimbabwean context, thereby generating new experiential data on perceived motivations of PLWHA to use traditional medicine in Zimbabwe. The findings of this

study have broad applicability to Sub-Saharan Africa as well as potentially to other geographic areas affected by the pandemic.

1.7 GENERAL AIM

This research aimed to explore and describe the perceived beliefs, attitudes, facilitators, barriers, cultural traditions, social influences, perceptions of efficacy, and other determinants of individuals in Zimbabwe's use of traditional therapy, healthcare and treatment for the prevention and treatment of HIV/AIDS. This aim was achieved by a qualitative, phenomenological study of 20 People Living with HIV and AIDS who have sought treatment from traditional healers in an urban (predominantly Shona-speaking community) (10) and a rural (predominantly Shangani speaking community) (10) in Zimbabwe.

1.8 SPECIFIC OBJECTIVES

The study's general aim was achieved by the following specific objectives:

1.8.1 To explore and describe the perceived effects of the following individual-level factors (derived from the IBM) on motivation to use traditional medicine by people living with HIV/AIDS in Zimbabwe:

(a) Attitude

(i) Experiential attitude: feelings about the behaviour determined by the individual's emotional response to the idea of performing the behaviour

(ii) Instrumental attitude: behavoural beliefs determined by beliefs about the outcomes of the behavior

(b) Social influence (perceived norm)

(i) Injunctive norm: perceptions of others' expectations or what others think one should do and motivation to comply

(ii) (ii) Descriptive norm: perceptions about what others in one's social or personal networks are doing

(c) Personal agency

(i) Perceived control: an individual's perception of the degree to which various environmental factors make it easy or difficult to perform a behavior

(ii) (ii) Self-efficacy: an individual's belief in his/her effectiveness in performing specific tasks as well as by their skill

1.8.2 To explore and describe the perceived effects of the following environmental level factors (derived from IBM) on motivation to use traditional medicine by people living with AIDS in Zimbabwe:

(i) Socio-cultural experiences: an individual's exposure to a particular socio-cultural environment

(ii) Capacity: knowledge and skills to perform the behavior

(iii) Structural/systems constrains: barriers and facilitators

These objectives guided the construction of the interview guide (see Appendix 1). The study design (qualitative) led logically to the choice of the study's epistemological, ontological and methodological positions as well as the particular method that was used for data collection. (See the Methodology Chapter)

1.9 DELIMITATIONS OF THE STUDY

The study was conducted in Harare (urban) and Chiredzi (rural) in Zimbabwe. The two settings were chosen in order to cater for any possible perceptual determinants that may arise from rural and urban differences. Harare is predominantly Shona ethnicity while Chiredzi is Shangani. The selection of the research sites was also meant to accommodate ethnicity related perceptual differences.

The focus of the study was on people living with HIV/AIDS who have sought treatment from traditional healers. Data about their perceived motivations to use traditional and alternative medicines including their experiences was collected. This was intended to collect an insider-out perspective of people living with HIV/AIDS' motivations to use TAM.

1.10 THE SAMPLE

The study used non-probability sampling techniques, purposive sampling as well as snowball sampling. This sampling procedure was followed because of the sensitive nature of the issue under study. Participants in the study were only people living with HIV/AIDS who had sought treatment from traditional healers. Twenty participants (8 males and 12 females) were interviewed because theoretical saturation had been reached by the 16th interview.

1.11 LAYOUT OF THE STUDY

The thesis is organised as follows:

Chapter 1 orientates the reader towards the study. It presents the research background, research problem and justification of the study. The chapter discusses the overall global, continental, regional and Zimbabwean morbidity of HIV/AIDS. Summative discussions of sector-specific impacts of the epidemic are then presented. The chapter then states the general aim as well as the specific objectives of the research. A presentation of the delimitation and limitation of the study concludes the chapter.

Chapter 2 presents the contextual settings of the study. It begins by operational definitions of traditional and alternative medicines in order to put the study into a common contextual understanding followed by a discussion on the global use of traditional and alternative medicines. The use of TAM in Zimbabwe is summarised, followed by TAM use by PLWHA globally, and finally concluding with TAM use by PLWHA in Zimbabwe specifically.

Chapter 3 presents an evaluative review of relevant literature. The theoretical framework of the present study, the Integrative Behaviour Model (IBM)'s constituent theories (Health Belief Model, Transtheoretical Model, Social Cognitive Theory, theory of reasoned action and theory of planned behaviour) theoretical and empirical literature is reviewed. The chapter concludes by presenting the theoretical and empirical reviews of the Integrated Behaviour Model as the framework informing this research.

Chapter 4 presents the research design, the methodology as well as the method used for the present study. The chapter discusses the development of the instruments and pretesting followed by a discussion of the participants and sampling methods used. Data analysis, trustworthiness and ethical considerations are discussed at the end of this chapter.

Chapter 5 is a presentation of the results and discussions on perceived attitude based TAM use motivations while **Chapter 6** focuses on perceived social influence based TAM use motivations. Results on perceived personal agency based TAM use motivations are summarised in **Chapter 7** and **Chapter 8** concludes presentation and discussion of results with perceived environment based TAM use motivations.

The final chapter, **Chapter 9,** presents the study's summary of results, conclusions drawn from the results and recommendations for further related studies and policy directions. References and appendices are at the end of the study report.

The next chapter contextualises the present research.

CHAPTER TWO

CONTEXTUAL SETTINGS

2.1 INTRODUCTION

Chapter 1 presented the HIV/AIDS problem and discussed how the problem is affecting the world, Africa, Sub-Saharan Africa and Zimbabwe. Chapter one's sector by sector presentation of the HIV/AIDS problem clearly shows the need for research focusing on gathering data that informs policy makers as well as those taking measures to treat the affected in order to prevent new cases of HIV infection. The preceding chapter observed the advantages of treatment as a means of preventing further infections as one of the best routes to take. This chapter puts into context the treatment as prevention of HIV/AIDS with respect to the traditional methods by showing the widespread use of traditional and alternative medicines by people living with HIV/AIDS in Zimbabwe. Contextual positioning of the study to focus on the health seeking behaviours of PLWHA from the traditional health care system begins with the provision of detailed operational definitions and descriptions of traditional and alternative medicines, followed by a summary of some of the global evidence of TAM use. Traditional medical practises in Zimbabwe are then discussed before a summary of the epidemiology and treatment of HIV infection and AIDS in Zimbabwe is presented. This is then followed by a section on the use of traditional medicines amongst HIV infected individuals. The chapter concludes with a brief presentation on the use of traditional medicines amongst HIV-infected individuals in Zimbabwe. As indicated earlier, understanding why HIV/AIDS affected individuals choose to use TAM or to use TAM together with ART (as shown in this chapter) is the focus of the present study in an attempt to inform policy and practice.

2.2 TRADITIONAL AND ALTERNATIVE MEDICINE

Traditional medicine, referred to in the present research as traditional and alternative medicine (TAM), refers to traditional health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illness or maintain wellbeing (WHO, 2003). Complementary and alternative medicine (CAM) is defined as forms of treatment that are used in

addition to (complementary) or instead of (alternative) standard treatments. CAM may include dietary supplements, megadose vitamins, herbal preparations, special teas, acupuncture, massage therapy, magnet therapy, spiritual healing, the use of traditional healers, plants and herbs as well as meditation (National Cancer Institute, 2004). The majority of TAM practices focus on the therapeutic use of herbs and plants while CAM refers to the additional or supplementary forms of treatment. In this literature summary, we used the terms traditional medicine (or healthcare), TAM, and CAM interchangeably usually following the terminology employed in the studies under discussion. Further, the term conventional/allopathic medicine (or health care) is used to mean clinical care and prevention in the biomedical scientific tradition. This research study examined the factors determining health-seeking behaviours (personal actions to promote optimal wellness, recovery and rehabilitation) of PLWA in Zimbabwe to choose the traditional health care option as opposed to, or together with, or even before the conventional one.

2.3 INTERNATIONAL USE OF TRADITIONAL MEDICINES

Use of traditional medicines is prevalent in all parts of the world, among all societies and cultures, under diverse terminologies such as herbal medicine, ayurvedic medicine, unani medicine, acupuncture, traditional Chinese medicine, South African *muti* and Yoruba ifa. As an indicator of the pervasive nature of traditional therapies in some societies, in China herbal preparations are estimated to account for 30% - 50% of the total medicinal consumption (WHO, 2003). Among all traditional medical approaches in that country, the most common modalities were herbal remedies (85.9%) followed by acupuncture (11.0%) (Chen et al., 2007). In India, traditional healers use over 2,500 plant species, of which about 100 can be considered sources of medicine (Pei, 2001). While each country has its own TAM practices, it is likely that China and India are not unique in their reliance on alternative approaches to health care.

Frequent use of TAM is not limited to developing countries. In fact, most of the quantitative research assessing the prevalence of TAM has been conducted in the United States (US) and Europe, where interest in CAM increased substantially in the 1990s (Ahmad, 2004; Barnes, McFann, Nahin & Powell-Griner, 2004). CAM use is reported by 40% - 80% of individuals in the United States, Canada, Australia and

Europe, with dramatic increases in recent decades in both reported use and expenditure (Boon, 2002; MacLennan, Taylor & Wilson, 1996; Reilly, 2001). There is particularly frequent use by patients suffering from a wide variety of chronic conditions, especially when conventional therapy has had limited efficacy or is not readily available. For example, CAM appears to be used especially frequently in the management of chronic conditions such as multiple sclerosis (Hekking, Husted, Niederman & Pham, 1999), arthritis (Bradley, Kroenke, Mihaliak, Rao, Tierney & Weinberger, 1999), osteoarthritis (Gaby, 1999), breast cancer (Boon et al., 2000; Buiatti, Crocetti, Crotti, Feltrin, Geddes, Ponton, 1998), asthma (Blanc, Katz, Kuschner & Yelin, 2000), inflammatory bowel disease (Rawsthorne et al., 1999), headaches (Arnberg, Brendstrup & Launso, 1999) and fibromyalgia (Berman, Creamer, Hadhazy & Singh, 1998).

Research in developing countries regarding TAM is less well-established, though in one international project conducted by the World Health Organisation (WHO, 2003) approximations showed that alternative therapies were used by about 80% of persons, with usage up to 90% or higher in some rural areas. These TAM use estimates may be especially frequent in Africa (Bukenya-Ziraba, Hoft & Kamatenesi-Mugisha, 2000; Bukenya-Ziraba & Kamatenesi-Mugisha, 2002). As in the US and Europe, limited research in Africa shows that alternative therapies appear to be especially utilised in the management of chronic conditions. For example, in South Africa, Harries, Singh and Raidoo (2004) found that the most commonly reported use of TAM was for diabetes mellitus (22.1%), headaches (22.1%), arthritis or joint pains (18.2%), stress (16.9%), skin disorders (16.9%), backache (15.6%), hypertension (15.6%) and nasal disorders (10.4%). In Uganda, traditional remedies have been used with great frequency in the management of sexual disorders, such as erectile dysfunction (Kamatenesi-Mugisha & Oryem-Origa, 2005).

In contrast to the apparently frequent use of TAM for non-infectious chronic conditions, few studies document frequent use of TAM to treat infectious diseases. However, in Swaziland, Mozambique, South Africa and Liberia traditional healers have roles in the treatment of Sexually Transmitted Infections (STIs) (Green, 1994; Friend-du Preez, Formundam, Peltzer & Ramilagan, 2008). Taxonomies of sexually transmitted infections (STIs) and traditional treatment exist among some populations

in these countries. STIs are widely believed to respond better to traditional than to conventional management (Green, 1994).

While documentation of the specific herbal remedies individuals use for various conditions is common, there is little reported on the perceptions, attitudes, beliefs, motivations and other behavioural and cultural determinants that affect the use of TAM. One study found that users of traditional medicines perceived TAM to have greater or equal efficacy compared to conventional medicines (Clement et al., 2007), while another study reported conflicting findings that among cancer patients almost 70% were disappointed with the effects of TAM (Anarado & Ezeome, 2007). Cultural or environmental factors may also play a role in individuals accessing the traditional medical systems in their countries. For example, Drummond, Gelfand, Mavi and Ndemera (1985) in Zimbabwe and Green (1994) in four African countries document more favourable ratios of traditional healers to patients than ratios of conventional health workers to patients. These observations support the central role played by traditional healers and traditional treatment modalities in primary health care in much of Africa. These researchers also conclude that because traditional healers are perceived to target the spiritual aspects of disease, they may serve an important function in communities' and individual's perceptions about the root origins and causes of many, if not all, illnesses (Carter, 2008; Chinsembu, 2009; Drummond et al. 1985; Green, 1994; Generali, Grauer, King & Russett, 2009).

2.4 TRADITIONAL MEDICAL PRACTICES IN ZIMBABWE

As in many cultures around the world, the available data in Zimbabwe suggests that many people turn to indigenous traditional medical practices to cure their illnesses. Traditional medical practices common in Zimbabwe are broadly based on spirituality and the use of traditional herbs, and appear to be widely used for many ailments (Benet, Guglielmo, Monera, Maponga & Wolfe, 2008; Dolezal, Holmes, Taylor & Tross, 2008; Gelfand, et al., 1985; Sebit et al., 2000). Traditional healers (n'angas) play significant roles in preventing, divining the cause of, and treating diseases (Gelfand, et al., 1985). There has not been much published research on traditional therapies coming out of Zimbabwe, particularly since the onset of the AIDS epidemic (Benet et al., 2008; Sebit et al., 2000; Dolezal et al., 2008) but it is known that traditional healers were historically, and continue to be, an important part of many

communities, especially in rural settings where about 70% of Zimbabweans reside (ZIMSTAT, 2012). Even among urban families in Zimbabwe, many people who were born and raised in rural communities maintain strong ties with rural homesteads and relatives, including that of the extended families, and travel frequently to their communities of origin. Most of them also prefer to be buried in their rural homesteads when they die and therefore still share the same values with those in the rural communities.

The classical work by Gelfandet et al. (1985), conducted by the Zimbabwe National Herbarium and Botanic Garden in the 1980s, is a comprehensive ethnographic and ethno-botanical study of 250 traditional healers (n'angas) in Zimbabwe. N'angas were found to have widespread practices among both urban and rural communities, and at the time used over 340 genera of plants from a wide range of plant species to treat hundreds of common symptoms. The research also included direct observation of 34 n'angas as they provided care to five to ten patients each. N'angas were observed to use divination or spiritual means to diagnose patients' symptoms and prescribed traditional (usually herbal) medicines accordingly. In contrast to conventional healers, n'angas was observed not to initially ask patients their symptoms, but to divine patients' symptoms and their causes. Patients then confirmed or denied symptoms and sometimes subsequently sought help from additional n'angas. Others pursued conventional health care if symptoms persisted. The study addressed management of sexually transmitted diseases (STDs) and documented over 85 plants used for traditional STD treatment and two used primarily for STD prevention. Although HIV transmission undoubtedly was common and accelerating in Zimbabwe in the early and mid 1980s, HIV and AIDS were not prominent or obviously visible health problems and the study did not address traditional health care practices for HIV and AIDS (Gelfand et al.,1985). Although this could be a reflection on the relative newness of HIV and AIDS, it was important for the study to have looked at the traditional health care practice as well with regards to the new epidemic.

Traditional health care has prominent and respectable structures in Zimbabwe, reflecting the overall importance of the discipline. In 2001 the Zimbabwean Parliament passed The Traditional Medical Practitioners Council Act (2001) and the

Ministry of Health and Child Welfare (MOHCW) created the Traditional Medical Practitioners Council. This Act is one of the best pieces of legislation on the practice of traditional medicine that has been enacted anywhere in the world (WHO, 2001). The objectives of this Council are to supervise the control and practice of traditional medical practitioners, promote the practice of traditional medical practitioners, foster research into traditional medical practice, develop knowledge of traditional practice, provide a venue for discussion of policies related to the interaction of traditional and conventional health care, and to regulate and develop guidelines for the care of HIV patients (The Herald, 2008; WHO, 2001).

In addition, the Zimbabwe National Traditional Healers Association (ZINATHA) is a non-governmental organisation of traditional medicine providers whose mission is to describe, regulate, reinforce and govern practices among traditional healers. Gelfandet et al. (1985) estimated in that there was one traditional healer for every 575 persons in Zimbabwe in 1975, but a more recent estimate is that there are 50,000 traditional healers, one for every 240 persons (MOHCW, 2008). Whether the various estimates reflect a true increase in the population of traditional healers is unknown, but if so, it is possible that reliance on traditional care might have increased in Zimbabwe over the past three decades. This also includes people living with AIDS.

2.5 EPIDEMIOLOGY AND TREATMENT OF HIV INFECTION AND AIDS IN ZIMBABWE

The introductory chapter has already highlighted that Sub-Saharan Africa continues to be the area in the world most heavily impacted by the AIDS epidemic, with over two-thirds of the world's HIV infected persons (UNAIDS, 2009a). UNAIDS (2014) further indicated a figure of 24.7 million (UNAIDS, 2014). Like most southern African countries, Zimbabwe is experiencing a generalised HIV epidemic and has one of the highest HIV prevalence rates in the world, peaking at an estimated 35% prevalence in 1999 (UNAIDS/WHO, 2002; Dube, Kububa, Midzi, Nesara, & St Louis, 2002). The UNAIDS (2012) report, however, indicated a prevalence rate of 15% (UNAIDS, 2012). This figure is still very high. Subsequent sentinel surveys of pregnant women in antenatal clinics and nationally representative population based surveys, including the Young Adult Survey (YAS) in 2001-2002 and the Zimbabwe Demographic and

Health Survey (ZDHS) in 2005-6, indicate the nationwide prevalence has declined to an estimated 18% (UNAIDS, 2009b). Zimbabwe's average life span is 43 years (WHO, 2009) and the decline in prevalence over the past decade is believed to be attributed largely to rising AIDS mortality in persons under 28 years old, in other words those probably infected below the age of 10 years. Only a modest portion of the decline reflects lower incidence due to reduced behavioural risks (CSO, 2007; Gregson et al., 2006; UNAIDS, 2006; UNAIDS, 2005; UNAIDS, 2007). National-level data from a cohort study conducted 7 years ago of young adults (NIMH Collaborative HIV/STD Prevention Trial Group, 2007a, 2007b, 2007c, 2007d, 2007e) shows an incidence of 3.8 HIV infections per 100 person-years, a rate not substantially lower than that estimated in the mid-1990s (Mbizvo et al. 1996). The cohort study examined the seroconversion rates of individuals, finding that 11% of initially seronegative individuals acquired HIV over the course of 24 months. This acquisition was significantly associated with behavioural risks. The 2009 seroprevalence of HIV in Zimbabwe translated to over 1.1 million cases of HIV in the country (among a population of 12 million then), including more than 680,000 women and more than 120,000 children age 14 years or over (Garnett, Gonese, Gregson, Hallett & Mugurungi, 2009). HIV/AIDS mortality was estimated at 140,000 deaths per annum, making AIDS the leading cause of death in Zimbabwe (UNAIDS, 2008; MOHCW, 2005; Garnett et al., 2009). In 2012, the life expectancy was estimated at 53 years with an adult prevalence rate of 14.7% (Avert, 2012).

In spite of the political and economic challenges facing Zimbabwe, antiretroviral therapy (ART), based on a government program committed to improving treatment access for People Living with HIV/AIDS (PLWHA), is making modest inroads. According to MOHCW, in 2007 ART was being used by an estimated 91,000 (35%) of 250,000 individuals meeting currently standard criteria for therapy, in other words a CD4 count $\leq$200 cells/mm^3 or diagnosis of an AIDS-defining opportunistic disease (ITPC, 2007; CSO, 2007). However, in contrast to government estimates, WHO/UNAIDS estimates double the number of Zimbabweans meeting the criteria for ART (about 570,000 individuals) and estimate that about 98,000 (17%) were receiving it in 2008. Of those taking ART, UNAIDS estimates that treatment for approximately half is supported by the President's Emergency Plan for AIDS Relief Funding (PEPFAR) (UNAIDS, 2008; PEPFAR, 2009). The demand for ART will rise

dramatically when, as anticipated, revised guidelines recommend lower thresholds for treatment, such as CD4 counts of $\leq$350 cells/mm^3 or even treatment of all HIV-infected individuals upon diagnosis of HIV. Zimbabwe's declining economy resulted in a shortage of (ARVs) over the last decade leading to the 2002 government declaration of the AIDS treatment shortage as a national emergency, allowing Zimbabwe to manufacture and/or buy AIDS drugs locally in order to lower their cost (Avert, 2012).

Reduced access to conventional health care, partly due to reduced availability of health care personnel in Zimbabwe, likely plays a role in ART access. Five years ago, WHO estimated that there were about 2,300 doctors in Zimbabwe, a ratio of 1 per 5,000 residents, and 8,050 nurses and midwives, a ratio of 1:1428 nurses to patients (KFF, 2009). There has been a net loss of health care personnel, especially nurses, over the last decade in Zimbabwe. Thus it stands to reason that these larger structural or environmental factors play a role in the proportion of individuals being treated with conventional ART, which in turn is likely to be impacting the individuals who may seek traditional medicine in Zimbabwe. The large majority of HIV-infected individuals receive their conventional HIV/AIDS management through 89 government and mission (church-run) health facilities. It is estimated that in 2007 only about 10,000 people received their care through the private sector (CSO, 2007; ITPC, 2007; UNAIDS, 2008). To enter the HIV/AIDS care system in Zimbabwe, an individual must have been tested for HIV at one of the primary or antenatal care clinics, or one of the Voluntary Counseling and Testing (VCT) Centers. Individuals are then referred to centralised HIV centers for extensive clinical assessment, including CD4 testing. Patients must pay for the CD4 testing required to enter the HIV care program as well as for liver function tests for the monitoring of ART. Together these can add up to a civil servant's average monthly salary, posing a high barrier to ART access for many patients. After CD4 test results are available, the HIV/AIDS specialty clinic makes recommendations for opportunistic infection (OI) prophylaxis, and/or ART, according to standard national protocols (EDLIZ, 2006). The patients then return to their primary care clinics for day-to-day follow-up, with periodic follow-ups at the HIV/AIDS specialty clinic. Patients are extensively counseled on the importance of adherence to ART and to OI prophylaxis, and are assessed for adherence to OI prophylaxis before their ARVs are begun. Those who

do not meet criteria for ART are returned to their primary care clinics or health care providers for ongoing monitoring, typically including plans for periodic (usually annual) reassessment of their CD4 counts.

The Zimbabwean government included voluntary counseling and testing for HIV (VCT) in its National AIDS Policy in 1999, resulting in 1.8 million people being tested in 2011 (UNGASS, 2012). Avert (2012) reports, however, that there is still a strong resistance to testing amongst most people because people living with HIV face a very high level of discrimination in Zimbabwe. Many are afraid of victimisation and stigma should they test HIV-positive. Avert also reports that in areas where there is little or no access to ARVs, people see testing as a pointless exercise which just exposes one to discrimination. This fear of being tested has had a negative effect on the country's blood supply. The fear also has implications for the mother-to-child transmission, with Avert (2012) reporting that mother-to-child transmission accounts for the highest number of HIV infections, after heterosexual sex (the primary route of transmission). In Zimbabwe, around 14,600 children are infected with HIV every year, mainly through mother-to-child transmission (UNAIDS, 2012). The UNAIDS (2012) report further highlights that around 25% of infants born to HIV infected mothers are also infected and approximately 200,000 children are living with HIV in Zimbabwe, most of whom contracted the infection through mother-to-child transmission. Treatment for expectant mothers is also costly, hence straining them financially. Other factors include long distances to healthcare centers as well as discrimination and stigma associated with taking of ARVs, resulting in mothers defaulting on treatment. This is particularly disturbing especially when one considers that among children in need of treatment, only 45% had access to treatment in 2012 (WHO, 2003).

All Africa (2008; 2010) observed that women and children who live in rural areas and resettlement areas have problems accessing ARVs because their household income is low, and most of them rely on remittances from husbands working in urban areas for financial support. This amount is often not sufficient to cover the cost of the drugs. As stated earlier, long distances to health centers to access ARV's is a barrier because it is a financial burden. The report further points out that, even at sites where treatment has been made accessible, a severe national shortage of

healthcare workers has led to long waiting lists and administration problems (Avert, 2012).

2.6 USE OF TRADITIONAL MEDICINES AMONG HIV INFECTED INDIVIDUALS

Herbal medicine use, especially its concomitant use with allopathic or conventional medicine, is becoming very common in many countries, particularly in the developed world where public health safety has become a concern (Oguntibeju & Orisatoki, 2010). Oguntibeju & Orisatoki further point out that the devastating effects of the HIV/AIDS pandemic worsened with the severe shortage of health personnel which has pushed patients to come up with coping strategies by shifting to or adding complementary and alternative sources of primary health care, one of which has been the use of herbal therapies. In view of this, Orisatoki and Oguntibeju (2010) recommend that mainstreaming of herbal medicine into the current medical curriculum will encourage future health personnel to communicate better with their patients on this evolving healthcare system. They also contend that TAM use has continued to be the major source of healthcare in the rural communities, especially in developing countries where conventional medicine has not been able to reach most of the people.

Several studies have examined the use of CAM among people infected with HIV (Bartos, De Visser & Ezzy, 2000; Bauer, Sparber & Wooton, 2000; Chiodo & Manfredi, 2000; Dhar, Farooquee & Kala, 2004; Knippels & Weiss, 2000; Nguyen, Singh, Sivek, Squier, Wagener & Yu, 1996; O'Leary, Suarez & Raffaelli, 1996; Scheinman, 2002). In rural Tanzania, 75 plant species belonging to 66 genera and 41 families were reported to be used to treat one or more HIV/AIDS related conditions (Hosea, Joseph, Kisangau & Lyaruu, 2007). In Nigeria, extracts of Baissea axillaries Hua (Apocynaceae) have shown antimicrobial activity against clinical strains of some microorganisms and show potential for application in the treatment of HIV associated diarrhea (Abere & Agoreyo, 2006). A national survey investigating the use of CAM in the United States found that about 25% of HIV patients reported using at least one type of alternative medicine-based therapy to manage pain (Dobalian, Myers, Tsao & Zeltzer, 2005). A survey in a clinic in South Africa also documented that approximately half of HIV-positive patients had used

TAM in the preceding 6 months, with most saying they used these medicines for pain relief (Friend-du Preez et al., 2008). Many Africans also have access to conventional therapies for treatment of HIV/AIDS, but poverty, difficulties accessing health care due to transportation, the high cost of ART and therapies for common opportunistic infections, for example tuberculosis, HIV resistance to available ART drugs, and ART toxicity are serious impediments to effective biomedical management (Hosea et al., 2007).

Complementary and alternative medicine use among people living with HIV and AIDS remains popular even though there are few methodologically rigorous studies documenting its effectiveness (Hoogbruin, 2011; DiCle-mente, DePadilla & Owen-Smith, 2011). Some studies have documented that PLWHA report that complementary and alternative medicine is useful in ameliorating their quality of life with few risk factors resulting from the use thereof (DiCle-mente et al., 2011; Hoogbruin, 2011; Littlewood & Vanable, 2011). Others also reported that PLWHA indicated that CAM use assists them in preventing and treating symptoms related to HIV/AIDS, as well as the side effects of ART (DiCle-mente et al., 2011; Hoogbruin, 2011; Littlewood & Vanable, 2011).

Gardiner, Grodin & MacDuff (2011) report that there is little research documenting the frequency of CAM use for AIDS treatment in Africa and the Caribbean. However, the available research indicates that, in African countries with a strong traditional system of medicine, PLWHA often seek treatment from traditional healers or take herbal medicines prior to accessing ART. In addition, traditional medicine in Africa is used as both primary and secondary treatment for HIV/ AIDS and other diseases. DiCle-mente et al. (2011) highlight that, since the beginning of the HIV epidemic, complementary and alternative medicine has been common among people living with HIV and AIDS because of lack of effective treatments early in the epidemic and a perpetual lack of access to ART in developing countries. Gyasi, Tagoe-Darko & Mensah's (2013) cross-sectional study to assess the use of traditional medicine by people living with HIV adhering to antiretroviral therapies in Kumasi Metropolis, Ghana, found that traditional medicine is commonly used for HIV/AIDS and that herbal therapy remains the most commonly used form of traditional medicine (23,70%). Traditional medicines are accessed for appetite (90.9%), pain relief

(87.9%), stress relief (63.6%) and general wellbeing (75.8%). They go on to report that about 70% of Ghanaians depend on traditional therapies for their healthcare needs. This is recognised by the Ministry of Health in Ghana. PLWHA in Ghana use TAM together with ARTs. Traditional medicine use is common among individuals with moderate and advanced HIV (Babb, Charalambous, Churchyard, Pemba, 2007). Babb et al. further found that this is particularly relevant in South Africa, where the government is making traditional medicines available for HIV-infected individuals.

People living with HIV and AIDS use complementary and alternative medicine for many reasons (Liu, Manheimer & Yang, 2005). Hoogbruin (2011) contends that, despite the popularity of complementary and alternative medicine, the decision of people living with HIV/AIDS to choose these types of treatment are often poorly informed. The present study's findings are a clear explanation of some of the perceived decision-making factors leading to such choices. These findings continue to be important in guiding health systems to design programmes to ensure that people such as these make accurately informed personal health choices. Hoogbruin (2011) also reports high rates of traditional and alternative medicine use among people living with HIV/AIDS in Canada. According to Hoogbruin's (2011) study of 104 people living with HIV/AIDS, 70% of the participants used complementary and alternative medicine in 2003, 38% used a complementary and alternative medicine provider and 89% used micronutrients that included vitamins, minerals and multivitamins. Hoogbruin recommends therefore that it is important that more research be conducted on TAM use among the African, Caribbean and Black population because people living with HIV and AIDS are often poorly informed regarding their decision to use complementary and alternative medicine, especially with respect to possible interactions with antiretroviral drugs. This study looks at the African population, specifically the Zimbabwean population's perceived behavioural determinants of their personal health choices with respect to the use of TAM.

Despite the lack of adequate research evidence for the benefits of complementary and alternative medicine as part of HIV and AIDS treatment, there remains a high frequency of use of traditional and alternative medicine amongst people living with HIV (Ernst, Mills & Wu, 2005; DiClemente, Owen-Smith & Wingood, 2007).

DiClemente et al. (2011) as well as Littlewood and Vanable (2011) documented self reports from PLWHA's indicating that CAM use relieved them of symptoms including fever, flu, pain, skin irritations, abdominal pain, nausea, diarrhoea, quality of sleep, appetite, increasing body weight, depression and other clinical outcomes. Byakika-Kibwika, Lamorde, Lanvero, Obua, Kukunda-Byobona and Tabuti (2010) identify 103 different types of plants as being used for HIV treatment based on interviews with 25 traditional healers in Uganda. DiClemente, Hanker-son-Dyson, McCarty and Owen-Smith (2012) found that 94% of African American people living with HIV and AIDS reported having used at least one form of complementary and alternative medicine, and that the majority of them use this type of medicine together with ART. They also observe that more than 50% had not discussed their complementary and alternative medicine use with their doctor. Use of TAM among PLWHA in African countries was reported. Peltzer (2009) documented that complementary and alternative medicine was used for pain relief (87.1%) as well as for spiritual practices such as prayer to relieve stress (77.6%) in South Africa.

2.7 USE OF TRADITIONAL MEDICINES AMONG HIV INFECTED INDIVIDUALS IN ZIMBABWE

Since the late 1980s, Zimbabwe's National AIDS Council (NAC) has sought to educate traditional healers regarding HIV and AIDS (Simmons, 2000). Very little research in Zimbabwe, however, has examined how individuals use the traditional and conventional health care sectors in the context of HIV and AIDS. The NAC/ZINATHA recommendations focus on using traditional care systems to provide support (rather than treatment) to those affected by HIV/AIDS, to work on developing traditional methods aimed at reducing HIV/AIDS transmission, to increasing awareness of HIV/AIDS for prevention and care of people with AIDS, and creating a supportive environment for those living with the disease (Jijide, 1994). In spite of the fact that ZINATHA and NAC have developed a comprehensive plan for HIV/AIDS management employing both traditional and conventional health care (NAC, 2006), research documenting how this has played out in communities across Zimbabwe does not exist. Recent data regarding traditional or conventional medical care for HIV or AIDS–related symptoms from Zimbabwe are scant. Small studies (N ~ 50-250), suggest that a large proportion of Zimbabweans continue to use traditional

medical practices, and that some HIV-infected persons use herbal medicines both before and whilst taking conventional antiretroviral therapy (ART) (Benet, Guglielmo, Maponga, Monera & Wolfe, 2008; Sebit et al., 2000; Dolezal et al., 2008). These studies, however, have largely used convenience samples or were conducted in conventional health care settings.

In Zimbabwe, HIV may be treated by practitioners who come from different traditions such as biomedicine, traditional medicine and faith healing. The relatively late introduction of ART into Zimbabwe has meant that it came into a context where traditional treatment and healthcare systems were pre-existing and well-established (Broom & O'Brien, 2014). Chitura and Manyanhaire's 2013 study in Manicaland Province in Zimbabwe also reported acknowledgement of the need to have both ARVs and local traditional herbs for HIV and AIDS treatment, pointing out that traditional medicines are at the heart of most communities in Zimbabwe since for most people in rural settings it is the first place they go to if sickness befalls a family. Chitura and Manyanhaire (2013) further discovered that the use of complementary and alternative medicine is popular among people living with HIV and AIDS in Zimbabwe.

The earlier cited recent study by Broom and O'Brien that is similar to this study was carried out in Harare, Zimbabwe to explore the experiences of people living with and affected by HIV. It aimed specifically at documenting, interrogating and reflecting on the patient's perceptions and experiences of biomedicine in relation to traditional medicine and spiritual healing. The study revealed that traditional medicine and spiritual beliefs continue to significantly shape the way in which HIV is perceived, and the health-seeking behavior of those infected (Broom & O'Brien, 2014). In view of these revelations, they proposed that, even if witchcraft, spiritual healing and superstition based on religion may appear to be niche issues within a broader economic sphere of care, they still control and influence peoples' lived experiences of HIV. Broom and O'Brien contend that in this sense, TAM must "be central to any contemporary understanding of the problem of how to make life-saving therapies efficiently available on a mass scale in a way that is not just tied to drugs but holistically to economic empowerment, food security, nutrition and overall wellbeing" (Broom & O'Brien, 2014, p. 102). The study advocates for engagement with

traditional and spiritual healing, recognising that this is part of culture, individuality and community identity which add meaning to people's lives, and should that these should not simply be regarded as barriers to compliance. This conclusion resonates well with Makadzange and Pearson's earlier observation that "health is grounded in the cultural, spiritual and religious context of Zimbabwean men's lives,… men interpreted sexual-health concerns as due to either natural (disease, psychological stress) or supernatural (displeased ancestral and religious spirits, witchcraft) causes" (Makadzange & Pearson, 2008, p. 361). Makadzange and Pearson also observed that these perceptions shape the patient's choice of treatment and health service provider.

Dolezal et al. (2008) also had findings that are similar to the preceding when they compared HIV/AIDS-specific quality of life change in Zimbabwean patients at western medicine versus traditional African medicine care sites. Dolezal et al. maintain that traditional healing is an important component of African culture and society and is the primary system of health care for more than 80% of rural Africans, with the majority of Africans with HIV turning to traditional healing through the course of their illness. In addition to the cultural dimension, as previously shown, Nyika (2007) points out that poor Africans living with HIV/AIDS (including Zimbabweans) rely on traditional and alternative medicine mainly because it is relatively cheaper and more accessible to the poor populations unable to afford allopathic medicines. This is very applicable to Zimbabweans whose country's economy has been performing very poorly over the past 10 years.

CHAPTER THREE

THEORATICAL UNDERPINNINGS

3.1 INTRODUCTION

The present study is an application of the reasoned action approach as conceptualised by Ajzen and Fishbein (2010) who opined that an identified behavior of interest can be examined in terms of its underlying determinants. The behaviour in question is the use of traditional and alternative medicine by people living with HIV and AIDS. Ajzen and Fishbein's assumption, which informed this study, is that human behaviour results reasonably and spontaneously from the information or beliefs people possess about the behaviour under consideration, and these beliefs result from the individual's personal experiences. The reasoned action approach goes on to emphasise that these beliefs serve to guide the decision to perform or not to perform the behaviour. As indicated earlier on, the study specifically used the Integrative Behaviour Model which is a combination of several behavioral theories with a reasoned action approach.

The Integrated Behaviour Model (IBM) (Ajzen & Fishbein, 2010) in Figure (3.6) includes elements from the Theory of Reasoned Action (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980), the Theory of Planned Behavior (Ajzen, 1991; Ajzen & Driver, 1991; Ajzen & Madden, 1986), the Health Belief Model (Becker, 1974), the Theory of Interpersonal Behavior (Triandis, 1977) and the Social Cognitive Theory (Bandura, 1991). This chapter briefly presents evaluative descriptions of the basic tenets of these theories and explains how they converge to form the IBM. Key constructs will be defined and explained. Studies that have applied the IBM will also be cited. The empirical presentation of the strengths and weaknesses of the applications of these theories to the study of health-related behaviours will conclude the chapter. The relevance of the theories with the behaviour in question (TAM uptake) will be clarified throughout the chapter. In summary, both theoretical and empirical literature reviews of these theories are presented.

3.2 THEORETICAL LITERATURE

3.2.1 The Health Belief Model

3.2.1.1 The origins of the Health Belief Model

The Health Belief Model (HBM), according to Glanz et al. (2008), was a UnitedStates of America social psychologists' initiative in the 1950s meant to explain people's failure to participate in programs to prevent and detect disease. It was later used to study people's response to symptoms (Kirscht, 1974). Becker (1974) also extended the application of the model to study people's behaviours in response to a diagnosed illness, particularly their adherence to medical regiments. Sanderson, (2004) points out that the HBM is one of the oldest and most widely used theories to study and explain people's health-related behaviours. She further gives an example that researchers were particularly surprised why so few people were taking advantage of free government tuberculosis screening for early detection and treatment at centers conveniently located in their neighborhood. She likens this to amazement by professors who do not get any visits during students' office consultation times. The model was developed then as a response to examine the factors that led to more people using the screening services. The theory was subsequently adapted and used to explore other health-related behaviours particularly in regard to health seeking behaviours, especially the uptake of health services. The present study is not excluded from this as it focuses on some of the HBM to explain TAM uptake by people living with HIV. This is presented towards the end of this chapter when the relevant HBM constructs form part of the IBM.

3.2.1.2 The HBM's theoretical constructs

(a) Perceived susceptibility

The HBM posits that perceived susceptibility is the subjective assessment of one's likelihood of getting a disease or a health problem. Perceived susceptibility can be the individual's general beliefs about the risks of engaging in a behaviour. According to the model, individuals who perceive and consider themselves susceptible to a given health problem or disease engage in behaviours that they perceive to reduce their risk of developing the disease or health problem. Low perceived susceptibility

may lead to denial of risk and even perhaps to risky behaviour due to the perceived low probability of risk, while on the other hand, perceived high risk of being personally affected by a particular health problem is likely to lead to engaging in behaviours that decrease one's risk of developing the condition.

(b) Perceived severity

According to HBM, perceived severity refers to the individual's subjective assessment leading to beliefs that the disease or the health problem and its related consequences are severe. It is the HBM's prediction that individuals who evaluate a particular health problem or disease as severe are likely to be motivated to engage in behaviours that prevent the health problem from occurring or motivated to engage in behaviours that reduce the problem's severity. This evaluation of a condition or disease's perceived severity can also include consequences others in one's social network would face if one was experiencing the illness or condition

The HBM refers to the combination of perceived severity or seriousness and perceived susceptibility as perceived threat, and predicts the higher likelihood of engagement in health promoting behaviours as a function of high perceived threat. The present study considers this interaction of the constructs resulting in predictions of the likelihood to engage in or motivation towards the uptake of TAM by people living with HIV.

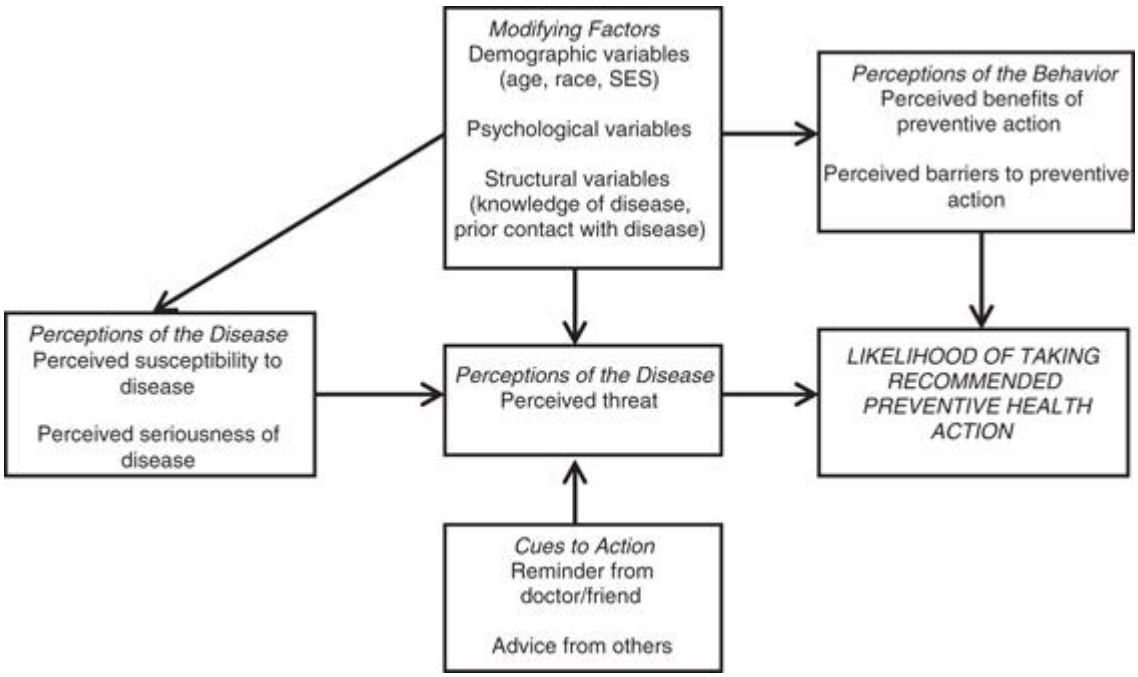
(c) Perceived benefits

Even if an individual perceives high threat from a serious health condition, translating that into behaviour change involves the individual's beliefs regarding the perceived benefits of the available behaviour options for reducing the disease or health condition threat. Other non-health related perceptions may also influence heath-related behavioural decisions, (Glanz et al., 2008). Glanz et al., 2008) go on to opine that "...individuals exhibiting optimal beliefs in susceptibility and severity are not expected to accept any recommended health action unless they also perceive the action as potentially beneficial by reducing the treat" (p. 47).

(d) Perceived barriers

The HBM refers to the potentially negative aspects of a particular health action as perceived barriers, and points out that these perceived barriers may act as impediments to undertaking recommended behaviours as a result of a kind of nonconscious, cost-benefit analysis that results in perceived barriers outweighing the perceived benefits. For example, it is expensive, dangerous, painful, has side effects, is unpleasant, time consuming or detestable. On the other hand perceived benefits that outweigh perceived barriers result in behaviour change.

Glanz et al. summarise that, “If individuals regard themselves as susceptible to a condition, believe that condition would have potentially serious consequences, believe that a course of action available to them would be beneficial in reducing either their susceptibility or severity of the condition, and believe the anticipated benefits of taking action outweigh the barriers, to (or costs of) action, they are likely to take action that they believe will reduce their risk.” (Glanz et al. 2008, p. 47). This position provided a good framework for exploration of how these issues could have led to the TAM uptake motivation among people living with HIV/AIDS in this study.



Adapted from Rosenstock (1974, p. 7)

Figure 3.1: The Health Belief Model

(e) Cues to action

Sanderson (2004) points out that the original version of the Health Belief Model included only the four components of perceived susceptibility, severity, benefits and costs/barriers (see Figure 1), but Becker and Janz (1984) revised the original version of the model to include cues to action. This refers to any type of reminder about a potential health problem that could motivate behavior change. They act as triggers or just final pushes to trigger the action. These can be internal, for example pain or symptoms, or external, such as reminders or information from both electronic and/or print media.

(f) Self-efficacy

Sanderson (2004) further pointed at a criticism for the HBM by researchers, saying that it lacks usefulness because it does not include the component of self-efficacy or a person's confidence that he or she can effectively engage in a behavior change. More recent theories such as Social Cognitive Theory (see Section 3.3.) and the theory of Planned Behaviour (see Section 3.2.) incorporates this. This might have been an oversight on the work that Becker, Rosenstock and Strecher (1988) had done by not suggesting the inclusion of self-efficacy to the HBM as a separate construct, while including the model's original constructsof susceptibility, severity, benefits and barriers.

3.2.1.3 Conclusion

Overall, results of studies on the Health Belief Model have generally been favourable, (Sanderson, 2004) and summary results for reviews conducted so far provide substantial empirical support for the model (Glanz et al., 2008), which has been widely used for explaining and predicting health-related behaviour (Carpenter, 2010). The present study considered this contribution of the HBM as relevant to its attempt to document motivational factors determining TAM use by people living with HIV. However, Sanderson went on to point out "that researchers have raised some questions about its usefulness" (p. 65) and further indicates that the model is more applicable in describing relatively simple behaviours and cannot be useful to describe complex behaviours.

Janz and Becker (1984) pointed out that the model focuses on individual factors to predict and describe behavior, negating other factors such as habits related to health as well as environmental factors. Glanz, Rimer and Viswanath (2008) concurr with this limited focus of the model, when they point out that the model is cognitively based and negates the emotional domain of behaviour such as fear, which they indicate might be helpful in explaining the relationship among HBM constructs, Rogers and Printice-Dunn's Protection Motivation Theory as well as Witte's 1992 observation (as cited in Glanz et al. 2008). Glanz et al. go on to observe that the HBM does not look at the interactional effects of its constructs in describing and predicting behaviour. Their study, rather, considered that in spite of the limitations of the Health Belief Model, its constructs can be combined with other models (see IBM in section 3.7)

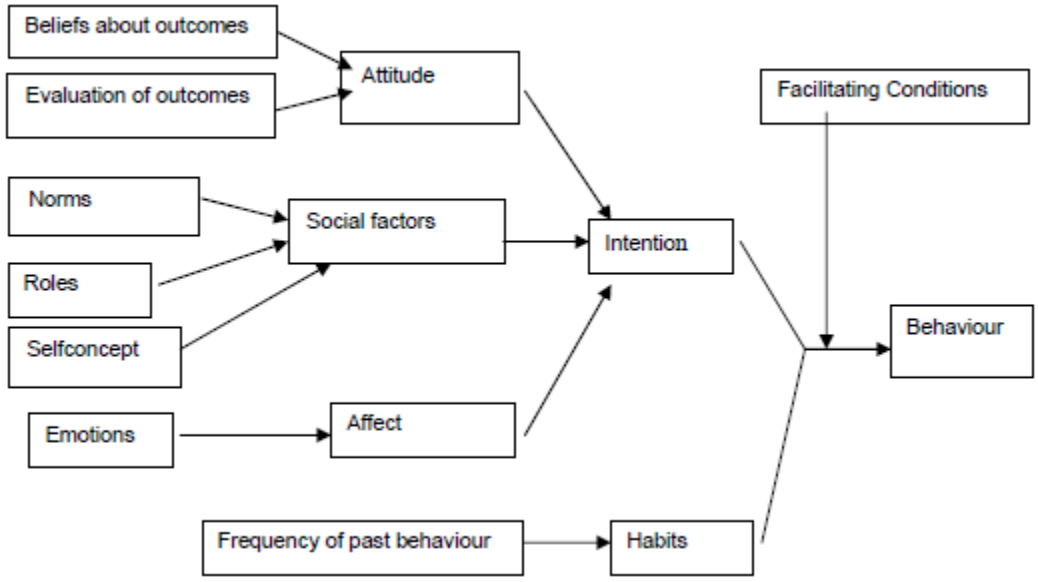
3.2.2 The Theory of Interpersonal Behaviour

Triandis (1977) developed an integrated model of 'interpersonal' behaviour. Egmont and Bruel adequately documented that Triandis observed the major role played by both social and emotional factors in forming intentions, and also emphasised the importance of past behaviour on the present. They further revealed that, based on this, Triandis formulated a theory of interpersonal behaviour (See Figure 3.2) in which he proposed that intentions, as in many of the other models such as the Theory of Reasoned Action and the Theory of Planned Behaviour, (see Section 3.2.5.) are immediate antecedents of behaviour. He pointed out, however, that habits also mediate behaviour, and that the influence of intentions and habits are moderated by facilitating conditions. Behaviour in any situation is, according to Triandis (1977), a function partly of the intention, partly of the habitual responses, and partly of the situational constraints and conditions which face the individual. He went on to observe that the intention is influenced by social and affective factors as well as by rational deliberations.

In Triandis' model an individual is partly deliberative, and partly automatic as well as partly autonomous and partly social. Accordingly, he proposed that behaviour is influenced by moral beliefs, but the impact of these is moderated both by emotional drives and cognitive limitations.

The theory further explains that social factors include norms, roles and self-concept, where norms are the social rules about what should and should not be done and roles are sets of behaviours that are considered appropriate for persons holding particular positions in a group and "self-concept refers to the idea that a person has of his/herself, the goals that it is appropriate for the person to pursue or to avoid, and the behaviours that the person does or does not engage in" (Triandis, 1977, p.8)

The Theory of Interpersonal Behaviour also posits that emotional responses to a decision or to a decision situation are assumed distinct from rational-instrumental evaluations of consequences resulting from the decision, and may include both positive and negative emotional responses of varying strengths. The affective domain has a more or less unconscious input to decision-making, and is governed by instinctive behavioural responses to particular situations (See Figure 3.2 below).



Source: Triandis, 1977

Figure 3.2: Triandis' Theory of Interpersonal Behaviour

Triandis offers a clear role for the influence of emotional factors on behavioural intentions. Bagozzi and Dholakia (2002) greatly support the idea to incorporate emotional antecedents into a model of action. The theory has been used as a framework for the empirical analysis of the component factors in different kinds of situations, and it appears to have additional explanatory value to Ajzen's model, especially so, by including role beliefs and habits.

3.2.3 The Social Cognitive Theory

3.2.3.1 The theory

The Social Learning theory (SLT) (later relabeled the Social Cognitive Theory (SCT)), developed by Bandura (1986), is based on vicarious learning. Bandura proposes that behaviour is learned by observation, imitation and vicarious positive reinforcement. The theory posits that role models facilitate learning, in that individuals reenact behaviours they have observed directly or seen in the media. According to the SLT behaviour change, in this case health-related behaviour change is determined by environmental, social, personal and behavioural factors. Although Rainggruber (2014) identified six key concepts in the SCT, namely reciprocal determinism, behavioural capability, expectations, self-efficacy, observational learning and reinforcements, the same key concepts were reported by Glanz et al. (2008). There is a difference, however, in terms used as well as in that Glanz, Rimer and Viswanath identify nine rather than six key concepts. They look at self-efficacy at an individual level as well as at a collective level. In other words, a group's collective efficacy. They also add self-regulation and moral disengagement. While the original theory looked at reciprocal determinism in terms of an individual and the environment influencing each other, Glanz, Rimer and Viswanath consider this in terms of individuals and groups influencing the environment and vice versa. As indicated earlier they also include the concept of self-regulation, controlling oneself through self-monitoring, goal-setting, feedback, self-reward, self-instruction and enlistment of social support. In addition, they mention moral disengagement as a way of thinking about harmful behaviours and that affected people accept the suffering by disengaging self-regulatory moral standards.

According to Bandura (2004) the Social Learning Theory (later relabeled the Social Cognitive Theory) (SCT), proposes a set of determinants, how they work, and the ways of translating this knowledge into effective health practices. They continue by pointing out that these core determinants include *knowledge* of health risks and benefits of different health practices, *perceived self-efficacy* that one can exercise control over one's health habits, *outcome expectations* about the expected costs and benefits for different health habits, the health *goals* people set for themselves and the concrete plans and strategies for realizing them, and the *perceived facilitators*

and social and structural *impediments* to the changes they seek. The knowledge of health risks and benefits creates the precondition for behaviour change.

Becker e (1988) also point out that the theory holds that behaviour is determined by expectancies and incentives. They summarise this as follows (p. 76):

(1) Expectancies

For heuristic purposes these may be divided into three types:

(a) Expectancies about environmental cues: beliefs about how events are connected and about what leads to what
(b) (b)Expectancies about the consequences of one's own actions: opinions about how individu
(c) (c)Expectancies about one's own competence to perform the behavior needed to influence c

(2) Incentives

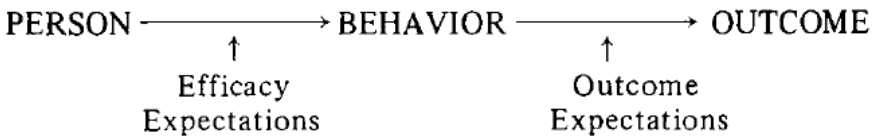
Incentive (or reinforcement) is defined as the value of a particular object or outcome. The outcome may be health status, physical appearance, approval of others, economic gain, or other consequences. Behaviour is regulated by its consequences (reinforcements), but only as those consequences are interpreted and understood by the individual (p. 176).

Thus, people change their health-related behaviour if they know that their current behaviours are a threat to their health. This is similar to the Health Belief Models' construct of threat, which the model holds to be a combination of perceived susceptibility and severity of the disease or of the health condition. The theory goes on to propose that health related behaviour change can also result from knowledge that those particular behavioral changes will reduce the threats (outcome expectations), which compares with the Health Belief Model's proposition that health-related behaviour or life style change results from an analysis of perceived benefits of taking that action less perceived costs or barriers of doing so. Although the heath belief model does not explicitly propose that people change their life style because they know that they are personally capable of adopting the new behaviors (efficacy expectations) as proposed by the SCT, the HBM's construct of the health motive (value of reduction of perceived threats) is very similar to Bandura's SCT's notion of

incentive. Macdonald (2000) opined that the most applicable theory for health education and health promotion programs is the SCT.

3.2.3.2 The Health Belief Model and the Social Learning Theory

Rosenstock et al. (1988) observe that the SCT has added two constructs to the HBM. Firstly, by its emphasis on the many varied sources of information for acquiring expectations, specifically with regard to the informative and motivational role of reinforcement and on the importance of modeling (imitating) the behavior of others. This suggests many potentially-effective strategies for changing behaviour through altering expectations. SCT's second important contribution to the HBM is the introduction of the concept of self-efficacy (efficacy expectation) as an independent construct from outcome expectation. This has to do with a person's estimate that a given behavior will lead to certain outcomes. This construct is very comparable to the HBM construct of perceived benefits (Rosenstock et al., 1988). Efficacy expectation is the belief that one can successfully carry out the behavior required to produce the outcomes. Outcome and efficacy expectations are different but both are required for behavior (Bandura, 1977). He illustrates this relationship in the following diagram:



Source: Bandura (1977) (as cited in Rosenstock et al., 1988)

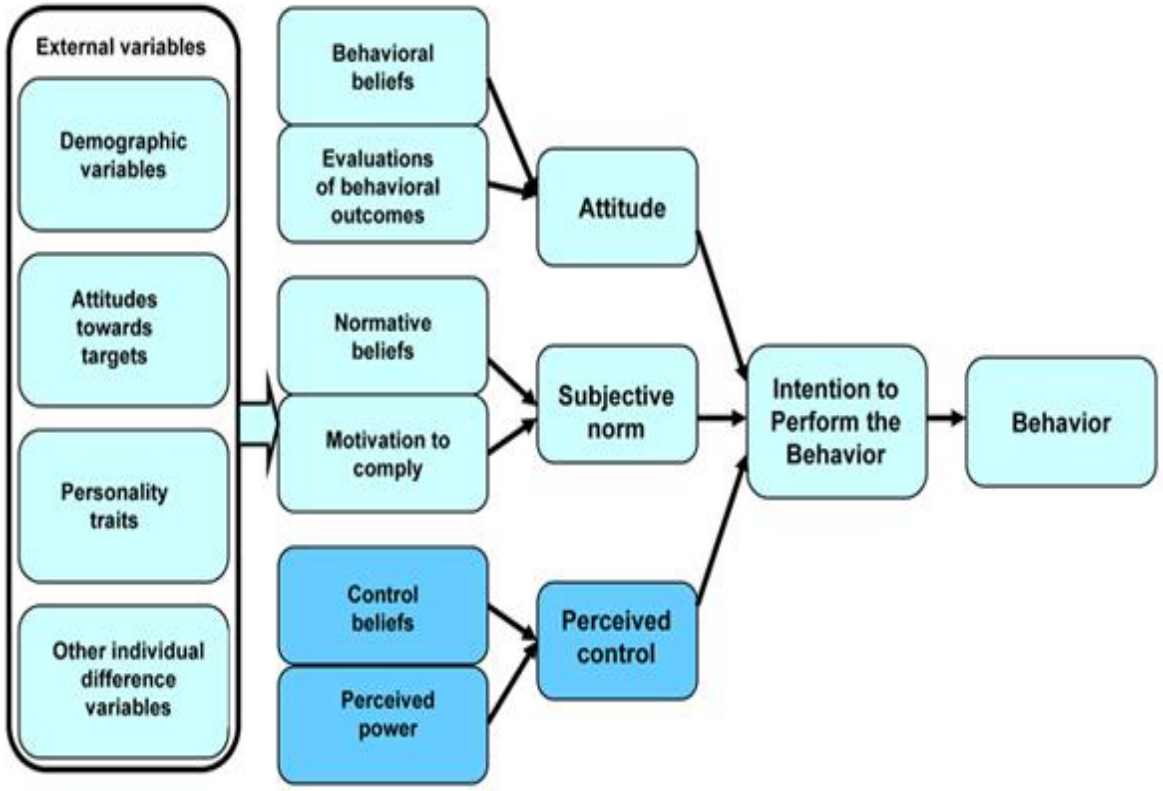
Figure 3.3: The distinction between outcome and efficacy

An example that summarises what the diagram illustrates with reference to this study is that for a person to decide on some type of medication for treatment (outcome), the individual must believe that the treatment will cure them (outcome expectation) and also that they are capable of taking and adhering to the treatment regime (efficacy expectation). Particularly intriguing is the observed conceptual overlap between the HBM and the SCT. Bandura (2004) observes that the models have overlapping determinants of behaviour but refers to them with different terms.

3.2.4 The Theory of Reasoned Action/ The Theory of Planned Behaviour

3.2.4.1 The Origins of the Theory of Reasoned Action

The Theory of Reasoned Action was developed to better explain relationship attitudes, intentions and behaviors (Fishbein, 1967). According to Ajzen and Fishbein, the reasoned action conceptual framework can be used to explain any social behaviour of interest and can deal with emerging issues and behaviours as they come up. They go on to point out that the framework allows for understanding of the role played by domain-specific attitudes, personality and other factors in determining behaviour (Fishbein & Ajzen, 2010). They acknowledge that the original formulation of the framework is an adaptation from Dulany's (1968) theory of propositional control (cited in Fishbein & Ajzen, 2010). According to Ajzen, Albaracin and Hornick (2007), Fishbein produced one of the first and most complete statements of the model in his summation theory of attitude when he proposed the expectancy-value model. In this theory, people's salient or readily accessible beliefs about an object determine their evaluations of or attitude toward that object. Ajzen and Fishbein (1975) define a belief as a subjective probability that an object has a certain attribute, where "object" and "attribute" refer to any discriminable aspect of a person's world. On realisation that the theory focused more on individual perceptions and attitude without a normative construct, the concept of subjective norm was introduced to represent perceived social pressure (Fishbein & Ajzen, 2010). They go on to point out that their argument for the introduction of this additional higher-order construct was that it was just like the attitude, determined by underlying beliefs in the form of the sum of normative beliefs weighted by motivation to comply. This theory was then referred to as the Theory of Reasoned Action (TRA), and included background factors such as demographic, and other individual difference in the theory (See diagram below) (Fishbein & Ajzen, 2010).



Source: Montano & Karsprzyk in Glanz, Rimer & Viswanath, 2008: p.70

Figure 3.4: Theory of Reasoned Action and Theory of Planned Behaviour

According to Ajzen and Fishbein (2010), they parted ways after the finalisation of their Theory of Reasoned Action in 1980, where Fishbein pursued work on the application of TRA to HIV prevention research. Ajzen continued laboratory validation of the theory, resulting in his conclusion that not all behaviours and goals are under volitional control, and subsequently introduced the construct of perceived behavioural control as an additional predictor of both intention and behaviour (Ajzen, 1985; 1988). Just like attitude and normative constructs, the perceived behavioural control construct was proposed as a function of control beliefs. This version of TRA Ajzen termed the Theory of Planned Behaviour (TPB).

The United States of America's National Institute of Mental Health (NIMH) was concerned with the lack of a unified theory to guide HIV prevention research and in the 1980s decided to look for the difference and similarities amongst the various health-related behaviour theorists (Ajzen & Fishbein, 2010; Glanz et al., 2008). Thus, in 1991, the NIMH sponsored a workshop with Martin Fishbein, Marshal Becker, Albert Bandura, Harry Triandis and Frederick Kanfer, some of the primary

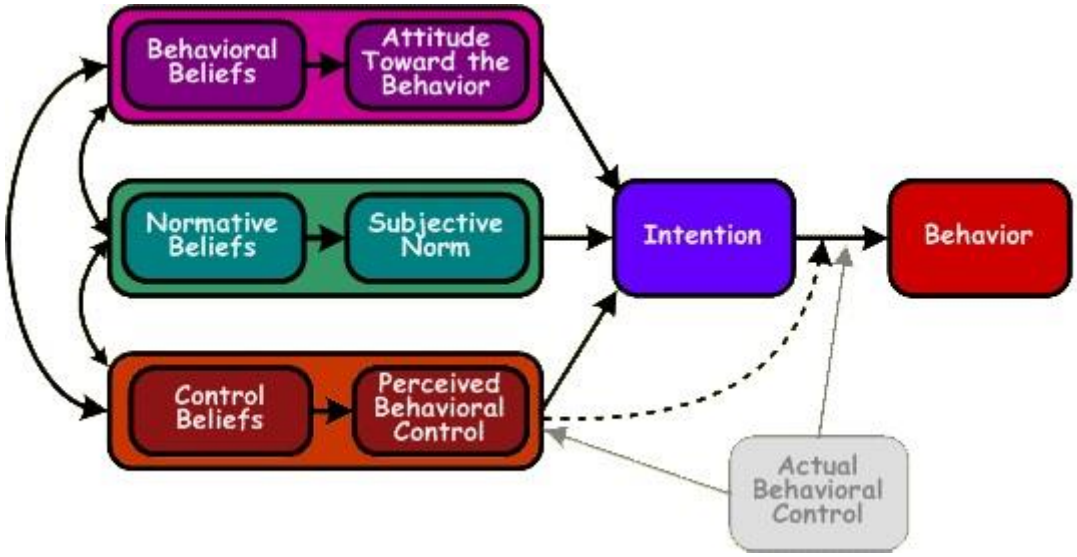
architects of these theories, to develop a set of integrated constructs that can be used in any behavioural analysis (Ajzen & Fishbein, 2010). There was no consensus, but a compromise was arrived at that for an individual to perform an identified behaviour, one or more of the following must be true, as summarised by Ajzen and Fishbein (2010):

- The person has formed a strong positive intention (or made a commitment to perform the behavior).
- There are no environmental constraints that make it impossible for the behaviour to occur.
- The person has the skills to perform the behavior
- The person believes that the advantages (benefits, anticipated positive outcomes) of performing the behaviour outweigh the disadvantages (costs, anticipated negative outcomes). In other words, the person has a positive attitude toward performing the behaviour.
- The person perceives more social (normative) pressure to perform the behaviour than to not perform the behaviour.
- The person perceives that performance of the behaviour is more consistent than inconsistent with his or her self-image or that its performance does not violate personal standards that activate negative self-sanctions.
- The person's emotional reaction to performing the behaviour is more positive than negative.
- The person perceives that he or she has the capabilities to perform the behaviour under a number of different circumstances. In other words, the person has perceived self-efficacy to execute the behaviour in question (Ajzen & Fishbein, 2010, p. 19). See also Bartholomew, Gottlieb, Kok & Parcel, 2006).

Ajzen and Fishbein go on to mention that the first three were the most popular with the majority of the theorists in terms of their necessity to produce behaviour while the rest were considered as necessary for producing the intention.

3.2.4.2 Summary of the reasoned action approach

It is important to begin this summary by pointing out that although the terms 'reasoned action' and 'planned behavior' are key to the reasoned action approach, Ajzen and Fishbein (2010) state that it does not follow that human behaviour is rational. Both rational and irrational decisions are encompassed and people's beliefs can be illogical, inaccurate or biased. They go on to propose that the starting point of a reasoned action approach to analysis of a particular behaviour is to clearly identify and operationalise the behaviour before one examines its determinants. Their assumption is that the beliefs people reasonably hold will naturally lead to their exhibiting human social behaviour, and that these beliefs spontaneously form attitudes and norms (see diagram below):



Source: Ajzen, 2006

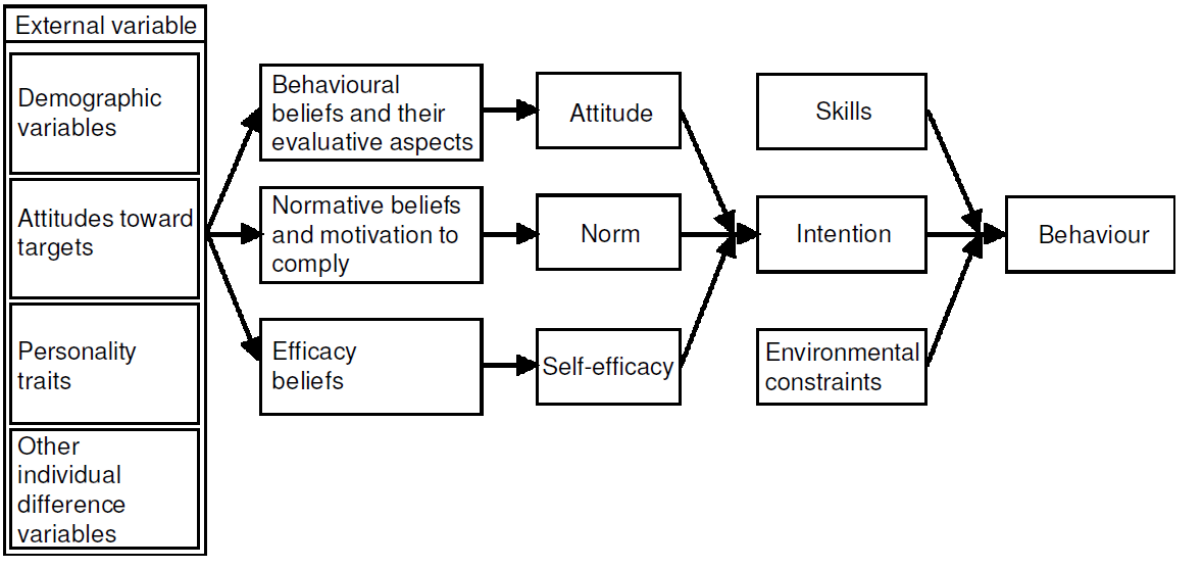
Figure 3.5: Summary of the reasoned action approach

3.2.5 The Intergrated Behaviour Model

The Integrative Behaviour Model (IBM), at times referred to as the Integrated Bevaviour Model (Fishbein, Kasprzyk & Montano, 1998), as already stated, emphasises three main constructs as determinants of behavioural intention, which were derived from the five theories. These are: (1) attitude toward performing the behaviour, (2) social norms associated with the behaviour and personal agency, including self-efficacy and (3) perceived control with regard to the behaviour (Ajzen & Fishbein, 2010). They proceed to refer to attitude as an individual's overall

perception of favourableness or unfavourableness towards a behavior (comprised of affective and cognitive dimensions). Perceived norm is referred to as the social pressure one feels to perform or not to perform a particular behaviour (comprised of the injunctive or subjective and descriptive norm) and personal agency is referred to as the individual's capability to originate and direct actions for given purposes (comprised of self-efficacy and perceived control) (Ajzen, Albarracin, & Hornik, 2007). The theories overlap with the concept of perceptions about outcomes of performing the behavior as the main determinant of behaviour. They concur that behavioural performance is greater where expected positive outcomes outweigh expected negative outcomes (Fishbein, Kasprzyk & Montano, 1998). They go on to indicate that according to these theories, the second important concept is social support or social outcomes associated with behavioral performance. The third main concept included in these theories is concerned with the effect of environmental or situational conditions on behavioural performance. These are the control beliefs. Ajzen and Fishbein (1975) opined that "…a belief is a subjective probability that the object has a certain attribute" (cited in Ajzen, Albarracin, & Hornik, 2007, p. 5). The IBM assumes that other factors affect behaviour through these constructs.

The present study objectives all fit in this framework, as explained below:



Source: Ajzen & Fishbein, 2000

Figure 3.6: Integrated Behaviour Model

The present research is an application of the Integrated Behaviour Model (IBM) (Ajzen & Fishbein, 2000) in Figure 3.6. It is important to reemphasise that the framework attempts to capture both perceived environmental and individual factors that may shape the use of TAM by PLWHA in Zimbabwe. Thus, the model is concerned with understanding behavioural motivation towards TAM use. The model depicts that a person's behavioural motivation or intention is shaped by individual-level (personal agency, social influence and attitude) factors, as well as by environmental–level (capacity, salience, system constrains and cultural) factors. Individual-level factors maybe direct determinants of behaviour, and may in turn be shaped by environmental factors. Additionally, environmental factors, particularly socio-cultural, may have direct effects or interact with individual factors to influence behavioural motivation. According to the model, individuals' experiences with their environment affect their beliefs, attitudes and norms. Thus, a person's perceptions about TAM may be determined by their experiences, including interaction with their socio-cultural environment. For example, the most important driver of a person's use of TAM may be their own motivation to do so, which is determined by their attitude, social influence and personal agency. The beliefs underlying these model constructs are a reflection of the person's experiences. Different individuals' belief strengths and the relative importance of different beliefs in determining behavioural motivation may result from variations in those individuals' socio-cultural experiences. Lavesque and Z.Li (2014) also report that culture, health conceptions and practices are interrelated.

The model stresses that each of these constructs has substantial internal complexity. For example, attitude toward the behaviour (the extent to which it is viewed as favourable or unfavourable) has both affective and cognitive dimensions. Perceived norms reflect the social pressure for and against the behaviour, as well as the perception of what peers or others are doing. The model goes on to indicate that personal agency consists of two constructs, self-efficacy (confidence in ability to perform the behaviour) and perceived control (barriers and facilitators) over behavioural performance. Each of these constructs can be examined by specific kinds of inquiry. For example, self-efficacy can be tested by asking respondents how they rate their behavioural confidence in carrying out specific behaviours. Each of

the other constructs can be assessed by particular questions (See Interview Guide, Appendix 1) (Ajzen & Fishbeiben 2010).

This research was guided by this model in order to identify and understand the underlying beliefs that are perceived to be shaped by each person's socio-cultural and other experiences, and that determine their model constructs and motivation to use TAM, as depicted in the IBM model. In addition, as noted earlier and as depicted in the IBM model (See Figure 3.6), perceived socio-cultural and other environmental factors may have a direct effect on TAM motivation since individual-level beliefs may not completely capture their effects. For example, individuals may hold cultural values regarding TAM, and these may affect individual-level constructs, as demonstrated in Figure 3.6. In addition, cultural practices may directly affect TAM motivation and behaviour. All these constructs were investigated in this study (see Interview Guide, Appendix 1).

The strength of the proposed framework is that while it defines high-level, theory based constructs known to be linked to behaviours (Ajzen & Fishbein, 2010; Ajzen & Fishbein, 2000; Ajzen & Fishbein, 1975; Cappella & Fishbein, 2006), it does not define the specific content of variables included in these constructs that shape the motivation to use herbal and conventional therapies. Rather, this framework assumes the particular issues underlying each construct can be elicited from individuals using qualitative research, allowing the researcher to elicit the perceived drivers that may shape TAM motivations and behaviours. The framework also allows the researcher to assess perceived important socio-cultural environmental factors, and determine how they may shape individual factors (See more in the Empirical literature section). Thus, as mentioned earlier, the proposed research aims to provide an important scientific contribution to understand how perceived individual, socio-cultural and environmental factors may affect TAM use among PLWA.

3.3 EMPIRICAL LITERATURE

3.3.1 Empirical support for Health Belief Model

Janz and Becker (1974) observe that the Health Belief Model (HBM) has continued to be the focus of considerable theoretical and research attention and has gained substantial empirical support since its development in the 1950s. In their 1974 review of 18 prospective and 28 retrospective studies, they discover that the evidence for each component of the Health Belief Model is strong. They evaluate the model with diverse populations, health conditions, and health-related behaviors and the various study designs and assessments but still find notable empirical support for the Health Belief Model.

Carpenter (2010) conducts a meta-analysis of 18 studies (2,702 subjects) and observes that the HBM remains one of the most widely used and well-tested models for explaining and predicting health-related behaviour. He also reports strong support for perceived benefits and perceived barriers predicting health-related behaviors, but weak evidence for the predictive power of perceived seriousness and perceived susceptibility. The meta-analysis suggests the examination of potential moderated and mediated relationships between components of the model otherwise, based on the weakness of two of the predictors, the continued use of the direct effects version of the HBM is not recommended (Carpenter, 2010).

Carpenter (2010) concurs with Rosenstock et al. (1988) that the Health Belief Model has been used to develop effective interventions to change health-related behaviors by targeting various aspects of the model's key constructs by aiming to increase perceived susceptibility to and perceived seriousness of a health condition through the provision of information and education on nature and prevalence of the illness, including levels of risk, and potential subsequent consequences of disease, for example medical, financial, and social. The intervention programs applying the HBM constructs may also aim to alter the cost-benefit analysis of engaging in a health-promoting behavior. In other words, increasing perceived benefits and decreasing perceived barriers. Educational programs that teach people the efficacy of various behaviors to reduce risk of disease, identifying common perceived barriers, providing incentives to engage in health-promoting behaviors, and engaging social support or

other resources to encourage health-promoting behaviours can also be put in place (Glanz et al., 2008). They go on to propose that as also highlighted by Rosenstock et al. (1988), interventions based on the Health Belief Model may apply the HBM construct of cues to action and utilise media messages, health care providers, and reminders to encourage people to engage in health-promoting behaviours. Self-efficacy should be enhanced through the teaching and training of specific health-promoting behaviours.

The Health Belief Model has been extensively used in empirical studies investigating mammographic and Papanicolaou (pap) screening (Glanz et al., 2008; Tanner-Smith & Brown, 2010). Glanz et al. point out that mammography and pap promotion interventions addressed at least one HBM construct, especially perceived barriers, and had pronounced effects on mammography outcomes. One of the criticisms leveled against HBM constructs as compared to the reasoned action approach is that they are somewhat intuitive. Glanz et al. opine that because of their fairly intuitive nature, the HBM constructs have been applied to a number of community-based interventions conducted among underserved groups with lower educational levels using lay health advisers who have been equipped to assess their peers' HBM-related perceptions in order to appropriately address those issues to facilitate mammography uptake.

Tanner-Smith and Brown (2010) conducted a study to address the utility of HBM by conducting a comprehensive literature review using 10 electronic databases and identified 39 published studies applying the HBM to mammographic and/or Papanicolaou (pap) screening. They reported stronger support for the HBM's perceived benefit and barrier constructs, compared to other constructs. They found the weakest support for the HBM's perceptions of the disease construct.

Jones, Smith and Llewellyn (2014) identified eighteen interventional studies that describe the use of the HBM in the design of an intervention to improve health care adherence and the majority (15/18, 83%) achieved statistically significant improvements in adherence. They also reported that studies using health-professional-led interventions most commonly reported significant improvements in adherence with large effects. There was a confluence of opinions among Sanderson (2004), Glanz et al. (2008) and Jones et al. (2014) regarding the notion that HBM

constructs are better suited for application to simple behaviours than complex behaviours. Jones et al. (2014) further discover that studies using written or audio material alone had greater impact on adherence behaviours than more complex interventions involving health professionals with the addition of written or audio materials, “In general, tailoring messages for breast cancer screening using the HBM constructs of susceptibility, benefits and barriers has been found to increase mammography adherence” (Glanz et al., 2008, p. 56). They also report the use of HBM constructs in letter and telephone counseling, interactive computer programs including computer games result in increased mammography use because of these HBM-based interactive interventions. The HBM constructs were also used to promote health-related behaviours, including sexual behaviours. It is the emphasis the HBM puts on the importance of a person’s *specific* perceptions about susceptibility, benefits, barriers and self-efficacy that resonate well with the IBM constructs which inform the present study that makes the HBM in combination with other models and frameworks discussed in this study very important in guiding the study.

3.3.2 Limitations of the Health Belief Model

As earlier discussed, overall, results of studies on the Health Belief Model have generally been favourable (Carpenter, 2010; Glanz et al., 2008; Sanderson, 2004; Tanner-Smith & Brown, 2010). Summary results for reviews conducted so far provide substantial empirical support for the model (Glanz et al., 2008) and have been widely used for explaining and predicting health-related behaviour (Carpenter, 2010; Tanner-Smith & Brown, 2010). The present study considered this contribution of the HBM as relevant to its attempt to document motivational factors determining TAM use by people living with HIV. However, Sanderson goes on to point out “that researchers have raised some questions about its usefulness” (Sanderson, 2004, p. 65) and further indicates that the model is more applicable in describing relatively simple behaviours and therefore cannot be useful to describe complex behaviours. As indicated earlier, Jones et al. (2014) also report similar findings in their systematic review of 18 intervention studies applying HBM constructs. They report that interventions using written or audio material alone had greater impact on adherence behaviours than more complex interventions involving health professionals, with the

addition of written or audio materials. They proposed that it may be that the more complex interventions, including a multi-component approach, could weaken the effect of the active component of the intervention. They further point out that the HBM was originally developed for population-based health promotion, and all three of the studies they reviewed reported large significant effects on adherence were aimed at primary prevention of disease. Accordingly, they opine that their observation is perhaps suggestive of some dilution of relevance and impact when the HBM is used in the context of secondary prevention of disease. Jones et al. (2014) conclude that "overall, evidence for endorsing the model for use in adherence-enhancing interventions is weak, with no consistent relationship between HBM construct addressed and intervention success. It may be behaviour change technique rather than theoretical application of the HBM that is related to intervention success. To facilitate better understanding and ensure methodological rigour, interventions should be described in full to allow for the identification of effective components" (pp. 266 -7).

Becker and Janz (1984) point out that the model focuses on individual factors to predict and describe behaviour negating other factors such as habits related to health and environmental factors. Glanz et al. (2008) concurred with this observed limited focus of the model, when they point out that the model is cognitively based and negates the emotional domain of behaviour, such as fear, which they indicate might be helpful in explaining the relationship among HBM constructs. Glanz et al. go on to observe that the HBM does not look at the interactional effects of its constructs in describing and predicting behaviour. They indicate that the combination of the perceived susceptibility and severity to constitute threat is not clear. They observe that this is because the threat can only be there if susceptibility and severity are there, but high severity is necessary for perceived susceptibility to be a powerful behaviour predictor. If the perceived severity is low and an individual is susceptible to the disease or health condition, they may not perceive any threat from the health condition or disease. This study considers that in spite of the limitations of the Health Belief Model, its constructs can be combined with other models (see IBM in Section 3.5 and its empirical underpinnings Section 3.6.8-9)

3.3.3 Empirical support for the Theory of Interpersonal Behaviour

Triandis' theory of interpersonal behaviour (TIB) has been widely applied in behavioural research and interventions such as Vegetarian Diets (Helne & Salonen, 2012), Pro-Environmental Behavior in the Workplace (McDonald, 2014), Nurses' Awareness of and Intention to Use Music Therapy (Lok, 2013), Predicting Students' Car Use for University Routes (Bamberg & Schmidt, 2003) and energy behaviour (Chatterton, 2011) just to cite a few examples. These studies, along with others, demonstrate the empirical validity of some of the central propositions of TIB. For example, a study on psychosocial factors influencing physician intention to use health technology assessment (HTA) recommendations by Gagnon, Sánchez and Pons, (2006) also provides support to the cultural adaptability of a psychosocial theoretical framework such as the TIB, as the items forming theoretical constructs were adapted to the specific context in which their study took place. They conclude that the TIB framework can be adapted and applied to a variety of settings in the field of implementation science.

A study by Bamberg and Schmid (2003), on Predicting Students' Car Use for University Routes, empirically compared three social-psychological models: the norm activation model (Schwartz, 1977; Howard & Schwartz, 1981), the theory of planned behavior (Ajzen, 1991), and the Theory of Interpersonal Behaviour (TIB) (Triandis, 1977), (cited in Bamberg & Schmid 2003). They demonstrate "that the personal norm explains 14% of the behavioral variance, intention alone explains 45% and intention and habit together 51% of the behavioral variance" (p. 279). As for intention, the study reports that personal norm does not directly influence behaviour, a finding that confirms Ajzen and Triandis' proposition that forming an intention marks the end of the conscious choice process, in which an individual decides between alternative behavioural options by considering their desirability and feasibility (Bamberg & Schmid, 2003).Furthermore, the study confirmed the TIB's position that in the case of frequently performed everyday behavior patterns, such as travel mode choice, the behavior is not only determined and controlled by conscious voluntary processes, as suggested by the Ajzen model. Instead the TIB added that it is influenced by an automatic, habitualised process. The findings further indicate that "after controlling the effect of intention, habit has a significant, even stronger effect on behavior, and the explained behavioral variance increased from 45% to

51%" (Bamberg & Schmidt, 2003, p. 280). This confirms the view that car use is a habitual choice process that usually involves routine-shaped automatic associations between stimulus situations and habitually chosen options.

The TPB and TIB do not concur in their opinions concerning the factors determining formation of intentions. The TPB suggests that attitude, subjective norm and perceived behavior mediate the influence of all kinds of outcome expectations on intention, making it generally more parsimonious than the TIB. The TIB does not consider these three mediating constructs and proposes diverse categories of anticipated outcome expectations as direct determinants of intention instead. The empirical evidence concerning these alternative assumptions is mixed. Compared with the parsimonious TPB, the much more complex Triandis (1980), cited in Bamberg & Schmid (2003), model explains 8% more intentional variance. Their study findings go further to demonstrate that, even after controlling the effect of the subjective norm, the TIB construct role beliefs have a very strong effect on intention. This confirms Triandis' position that the subjective norm construct used by the TPB is most likely too narrow to reflect all the social factors influencing the intention formation process, and therefore only reflects the influence of perceived social pressure.

The question is, which model should a pactitioner and/or researcher apply in a practical intervention? Just like other propositions, for example the Intergrated Behaviour Model, Bamberg and Schmid's (2003) results support the view that the three models should not be viewed as alternative but as supplementary models because they were developed in different research settings and focus on different aspects of social behavior. This approach provides robust theoretical frameworks that maximally utilise important factors that determine ecologically relevant behavior patterns. The present study adopted a similar integrated approach as its framework (including some of the constructs described in this section) to answer its question, "What are the perceived motivational factors for people living with HIV to take TAM?"

3.3.4 Limitations of the Theory of Interpersonal Behaviour

Danton (2008), in his overview of behaviour change models and their uses, points out that there is a limit to how far models will stretch because they are derived from a

specific behavioural context, such as research data, usually quantitative, and that they therefore tend to be most applicable in that context. For instance, the Theory of Reasoned Action and Valence Politics Mode are good for predicting voter choice whereas the Theory of Planned Behaviour and General Incentives Model are good at predicting voter turnout.

Danton (2008) further emphasises that some models have wider applicability, but they nonetheless are better at predicting behaviours in some areas than in others. Models don't tend to differentiate between people. They are what this study could refer to as 'one size fits all' and Danton refers to this notion as "everyman" models, because most of them either show the relationships between the factors conceptually or they have data which aggregates the behaviour of all people in the given study, showing only the factors driving a behaviour for all respondents. Triandis' Theory of Interpersonal Behaviour is not an exception to this limitation. Further, the Theory of Interpersonal Behaviour also has its own shortcomings, both as a framework for guiding research and as a guide to informing intervention and policy formulation. For example, after checking for the effects of attitude and behavioral control, Bamberg and Schmid (2003) report that the affective attitudinal component, the behavioural, control, social normative and moral beliefs do not have any direct effect on intention. Be that as it may, the present study addresses these limitations by combining some constructs of this theory with other theories of behaviour in the form of the IBM in order to enjoy the resultant comparative advantages of the combined strengths of the theories or models (See Section 3.6.9).

3.3.5 Empirical support for Social Cognitive Theory

Bandura's Social Cognitive Theory (SCT) (1977, 1986, 1997 & 1999) has been widely applied in behavioural research, health interventions, education and health promotion. Adeleke and Akinbobola (2013) used the theory to examine the influence of user efficacy and expectation on Koha version 3.0.1 integrated library management software actual system use. It has also been used in many other studies, such as the role of interactivity in student satisfaction and persistence in online learning (Croxton, 2014), career assessment (Betz & Hackett, 2006), health promotion (Bandura, 2004), improving the human-centric risk communication (Guo, Ito & Li, 2014), condom use, tolerance towards immigrants and refugees (Liebkind &

McAlister, 1999), attitudes and intentions towards disabled people (Cameron & Rutland, 2006) and Perceptions and Practices of Adults With Asthma (Andrews, Jones, & Mullan, 2013), to mention a few.

McAlister et al. (2004) conclude that SCT provides a well-supported conceptual framework for examining human behavioural determinants and learning processes related to different health-related issues, specifically in designing medical and public health interventions. Most of the empirical work presented in this section in support of the SCT will be borrowed from McAlister et al.'s observations. In a related vein, Randolph and Viswanath, (2004) opine that SCT has many virtues including but not limited to availing a number of theoretical constructs, for example modeling, self-efficacy and outcome expectations, that have been extensively used in health education and other theories and models. Bandura (2004) also points out the strength of SCT in that the theory specifies a core set of determinants, how they work and the best ways of translating this knowledge into healthful practices. Bandura further indicates these core determinants as *knowledge* of health risks and benefits of different health behaviours, *perceived self-efficacy* that one has control over one's health habits, *outcome expectations* beliefs about costs and benefits for different health habits, the health *goals* people set for themselves and the specific plans and means for realising the set goals, and finally the *perceived facilitators* and social and structural *barriers* to the envisioned changes.

In addition to applications stated earlier in the first paragraph, McAlister et al. (2004) also report that the SCT informed the development of cognitive behaviour therapies for change or management of unwanted behaviours through the therapists' guidance during the initial phases of the treatment followed by gradual phasing out of the modeling process. Adams and Bandura (1977), cited in McAlister et al. (2004), show that increasing self-efficacy is a common way through which various therapies achieved behaviour change. Accordingly this construct of the SCT has been targeted by several interventions to achieve behaviour change. They also summarise ways through which self-efficacy can be increased (see Table 3.1 below).

Table 3.1: Methods of increasing self-efficacy

Method	Description
Mastery experience	Enabling the person to succed in attainable but increasingly challenging performances of desired behaviours. The experience of performance mastery is the strongest influence on self-efficacy belief.
Social modelling	Showing the person that others like themselves can do it. This should include detailed demostrations of the small stepps taken in the attainment of a complex objective.
Improving physical and emotional states	Making sure people are well-rested and relaxed before attempting a new behaviour. This can include efforts to reduce stress and depression while buiding positive emotions-as when “fear” is relabelled as “excitement.”
Verbal persuasion	Telling the person that he or she can do it. Strong encouragement can boost confidence enough to induce the first efforts towards behaviour change.

Source: Bandura, 1977 cited by McAlister, et al. (2004) in Glanz et al. (2008)

Bandura (1999) developed and included concepts from the existentialist perspective in psychology that focus on self-determination, altruism and moral behaviour. He describes self-regulation as the ability to control oneself through self-monitoring, setting goals, getting feedback, self-reinforcement, self-instruction and enlistment of social support. These six self-regulatory processes were used by the American Cancer society to construct decision trees they then used to generate counseling scripts to assist smokers to quit. They guided the smokers by providing guidance in self-regulation, a construct of the SCT. “The theory was also used to develop community-based initiatives to prevent heart diseases in California and a long term project in Finland to reduce cardiovascular and other chronic diseases” (McAlister et al., 2004, p. 176). They state that the Finland project was a televised mass media peer modeling campaign code named “North Karelia Project” to assist people to learn to quit smoking, control hypertension and weight through direct modeling as well as social rewards for the targeted new healthful behaviours. They further report

the application of SCT in peer modeling and peer reinforcement projects to promote cancer screening to Spanish-speaking women. Puska (2002) reported that there was a 70% reduction in cardiovascular disorders, 65% reduction in lung cancer and a six year longer life expectancy for men and a seven-year longer life expectancy for women. McAlister et al. (2004) furthermore present that the SCT has also been applied in projects to reduce the problems of tobacco use as well as school-based programmes that increased self-efficacy for school children to cope with the desire to smoke (Ford, Hu, McAlister, Meshack, Peters & Shegog, 2005). It has also been effective in community level programmes to prevent drunk driving and other non-healthful alcohol abuses. Adeleke and Akinbobola (2013), in their study of the influence of user efficacy and expectation on Koha version 3.0.1 integrated library management software actual system use, also reported that self-efficacy had an influence on outcome expectancy. The United States of America's Centre for Disease Control (CDC) financed AIDS Community Demonstration Projects to increase condom use among groups perceived to be at risk of HIV infection. The projects used the SCT through conducting waves of qualitative elicitation studies that assessed outcome expectations, self-efficacy beliefs exposure to other sources of information and so on. McAlister et al., (2004) reported a significant increase in the proportion of programme participants carrying condoms, and overall, they reported a significant AIDS Community Demonstration Project effect on consistent condom use with non-main partners but not on main partners. Evaluation data attributes the accelerated diffusion of condom use to the theoretical processes that informed their design. The present study carried out qualitative interviews to assess some of the SCT constructs combined with constructs from other theories and models based on such empirical support given to theory (see Method Section).

As earlier indicated, most of the empirical support will be documented from selected McAlister et al., (2004)'s observations. This section concludes by presenting some of the selected computer and internet-based applications of SCT to the interventions for individual and public health that they documented. They point out that SCT is suitable for new technologies and specifically developing cognitive and behavioural skills through computer-assisted guidance, as well as internet communication that can be used both for modeling, social support and reinforcement at virtual interaction centers. These includ but are not limited to healthful behaviours such as

“management of asthma, reduced adolescent tobacco use, peer modeling to counter risky beliefs. Peer modeling was also found useful in promoting tolerance towards immigrants, refugees and disabled people” (p. 183).

The SCT was also found to be applicable to increasing preparedness for infectious diseases and disasters as well as in promoting environmentally responsible behaviours. This is very important, especially in this era of climate change where resilience, coping and adaption and mitigation climate smart strategies can be developed.

3.3.6 Limitations of the Social Cognitive Theory

Although the SCT has been empirically supported as described in the preceding subsection, it also has its share of limitations. The section on theoretical literature on the SCT indicates that it is a wide theory with nine major constructs, as depicted in that section. This makes it difficult to comprehensively test all the concepts. Most empirical applications of the theoretical constructs tend to focus on self-efficacy and outcome expectations and modeling but these are only part of the theory. Empirical studies that test the entire theory would give a more comprehensive empirical support of the SCT. Betz and Hackett (2006), in their study on career assessment, were clear that self-efficacy is a cognitive appraisal or judgment of future performance capabilities, not a trait concept. Therefore, self-efficacy must be measured against some type of behavior in order for it to have meaning. There is the tendency of researchers to overlook that fact.

3.3.7 Empirical support for the theory of reasoned action/ planned behaviour

The Theory of Reasoned Action (TRA) (Ajzen & Fishbein, 1975) and the Theory of Planned Behaviour (TPB) (Ajzen, 1985; 1988) are jointly discussed in this study because the Theory of Planned Behaviour is Ajzen’s modification of the Theory of Reasoned Action. The modification involved Ajzen’s introduction of the concept of perceived behaviour control to the TRA’s predictors of intention and behavior (Ajzen, 1985). Be that as it may, the TRA and TPB have been extensively used to explain and predict many different health-related behaviours as well as behaviours and intentions in other domains. A meta-analysis by Armitage and Corner (2001) which included 185 studies published up to the end of 1997, reported that the TPB

accounted for 27% and 39% of the variance in behaviour and intention, respectively. The study findings provide empirical support for the TPB constructs as valid predictors of intentions and behaviour. Prediction was found to be superior for self-reported to observed behaviour. This finding informed the present study that collected self-reported data. The meta-analysis concluded that the TPB is still capable of explaining 20% of the variance in prospective measures of actual behaviour (Armitage & Corner, 2001). They further observed that their findings support those of previous TPB meta-analyses, as well as expanding on some of the theoretical debate on the theory. Karsprzyk and Montano (2004) observed that "TRA and TPB provide a framework to identify key behavioural, normative, and control beliefs affecting behaviors. Interventions can then be designed to target and change these beliefs or the value placed on them, thereby affecting attitude, subjective norm, or perceived control and leading to changes in intentions and behaviors" (Karsprzyk & Montano &, 2004, p. 76). This observation is very important to studies such as this one, which seeka to examine the behavioral determinants leading to PLWHA motivation to take TAM, hence the use of the extended version of TPB, in other words IBM.

Truong (2009) evaluated the applicability of the Theory of Planned Behaviour in predicting user acceptance of online video services. They justified their study by observing that validating the TPB model would improve the understanding of both academics and practitioners of the most influential antecedents of user acceptance. The present study is also interested in the user acceptance or TAM uptake by PLWHA. Tuong used a structural equation modelling procedure for data analysis. The results of the study support the strong viability of the TPB model in predicting user acceptance of online video services. The study also reports that perceived behavioural control was the highest contributor to predicting intention to use online video services. Moderate predictive power was observed for attitude toward use and subjective norm, mostly because online video services present obvious benefits to users and are consumed privately (Truong, 2009). The present study also took the assumption that there are perceived benefits of TAM use to PLWHA, and that they also take the medication privately.

Moriano and Topa (2010) evaluate the success of the TPB as a predictor of smoking behavior through meta-analytic structural equation modeling (MASEM), involving the techniques of synthesising correlation matrices and fitting structural equation modeling (SEM). They conclude that according to the goodness-of-fit computations, the TPB adequately predicts smoking behavior intention and perceived behavioural control predicted smoking behavior and attitude, social norm and perceived behavioural control predicted intention (Topa & Moriano, 2010). The Theory of Planned Behaviour was also used in a study that investigated the determinants of voting intentions (Hansen & Jensen, 2007). They likened or compared voters to consumers who are consuming a service, in the form of the decisions and the actions of the political party. The study involved collecting data through a web-based survey of Danish voters using self-administered questionnaires. The study findings suggest that the TPB constructs, from perceived behavioral control to attitude, show a good fit to the data and explains a high proportion (63.2%) of variance in voting intention (Hansen & Jensen, 2007).

The TPB has been widely applied in studies investigating health-related behaviours. One such study is a meta-analysis of prospective prediction of health-related behaviors with the Theory of Planned Behavior (Ajzen, 2011). The study points out that studies on the TPB have made substantial progress since the theory was introduced more than twenty years ago. Earlier research mostly attempted to assess the model's validity in a variety of behavioural domains, including healthful behaviours. Most of the empirical evidence, including data from meta-analytic studies, clearly supports the model and points out that the TPB constructs in fact predict intentions and behaviour very well. Unlike earlier studies that focused on empirical tests of the predictive validity of TPB constructs, the issues raised by Ajzen's meta-analysis highlight some of the questions that inform the focus of contemporary researchers. Ajzen indicated that, among other things, the study aimed at gaining:

a better understanding of the role of automatic or spontaneous processes involved in habitual behaviour, processes that may be in play side-by-side with more reasoned modes of operation; to explore impulsivity and the ability to inhibit it when required for self-regulation; to examine the utility of making detailed plans as a way to

improve ability to act on intentions; to test the ideas that adding anticipated affect or the motive to avoid uncertainty may improve prediction of intentions; to demonstrate individual differences in the relative weights assigned to the predictors in the TPB; and to study the role of such background factors aspersonality traits and depression. I have tried to show that some of these variables and processes, such as willingness to perform a behaviour or social support that appear to go beyond the TPB can actually be accommodated within it, whereas others, such as habit formation and various background factors, can expand and enrich our understanding of human social behaviour (2011, p. 1124)

The present study, although guided by an extended version of the TPB (the IBM) made a provision for elicitation of such issues because it is qualitative.

Velarde and Krontalis (2012) applied the TPB to investigate the determinants of online purchasing behavior by conducting an online survey with a link led to a web-based questionnaire. The findings from the study led Krontalis and Velarde to conclude that ovarall their study provides empirical support to the TPB model in the context of online behavior, as it further confirmed the importance of attitude and perceived behavioural control as predictors of behavioral intention and behavioral intention as a direct determinant of behavior (Krontalis & Velarde, 2012). Another supporting study was on the decision to have a child. The study examined behavioral, normative and control beliefs about having a child (Ajzen & Klobas, 2013). They state therefore that empirical support for the TPB comes from tests of the theory in many various behavioural domains. They indicate that “meta-analyses of research findings have confirmed that behavioral, normative, and control beliefs correlate, as expected, with direct measures of attitudes, subjective norms, and perceptions of control; and that these variables account for a great deal of the variance in intention” (p. 214). They also conclude that theory-based interventions are superior to interventions that are not based on any theoretical framework and that of all theory-based interventions, those that rely on the Theory of Planned Behavior have the strongest impact. The present study rides on an extension of the TPB as an attempt to generate data to inform future interventions promoting healthful use of TAM.

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3.3.8 Limitations of the Theory of Reasoned Action/ Planned Behaviour

Tlo and Van Dyk in Tlo's (2009) doctoral thesis investigated if the variables of the TRA and TPB would predict intentions to change HIV/AIDS health behaviour, whether a theory-based intervention would result in health behaviour change over time and if there would be any significant health behaviour differences between participants who received a theory-based intervention and those who received an information-only intervention. Tlo & Van Dyk's findings indicate that intervention informed by concepts of the Theories of Reasoned Action and Planned Behaviour do not bring about health-related behaviour change. Although Armitage and Corner (2001) provide overall empirical support for the TPB, they point out that their meta-analysis involving a quantitative integration and review of 185 independent studies also provides evidence to suggest that measures of intention, self-prediction and desires possess discriminant validity, although only relatively weak evidence for the proposed self-efficacy–perceived control over behaviour distinction. Tlo and Van Dyk's study also identifies barriers to AIDS health behaviour in the South African context that the Theories of Reasoned Action and Planned Behaviour fail to explain (Tlo & Van Dyk, 2009). Tlo & Van Dyk used the method of a narrow elicitation study, followed by a content analysis informing the quantitative study. Although the study is an improvement of previous similar studies by using an African sample, it followed the same methodological approach. The present study did not just do a simple

content analysis, but subjected data to a thorough interpretive analysis (See Methodology Section).

Angus, Bryce, Cairns, Gordon, MacDonald and Purves (2013) systematic literature review to examine the evidence for the effectiveness of interventions that use theories and models of behaviour change towards the prevention and control of communicable diseases reports conflicting findings. Their study shows that interventions in seven studies which aimed to change behaviour to improve a target population's engagement with healthcare services reported significant changes in behaviour. Specifically, three interventions increased immunisation or vaccination uptake; two increased health screening attendance and two reduced the use and prescription of antibiotics (Angus et al., 2013).

Kyle, White, Hyde and Occhipinti's (2014) study to assess the utility of the Theory of Planned Behaviour in the prediction of academic performance provided partial support for the TPB, given their theory-based assumption that perceived behavioural control predicts intentions and intention predicts behaviour. However, the study findings suggest that neither attitude nor subjective norm predicts intention and perceived behavioural control emerged as a significant predictor of behaviour (Kyle et al., 2014)

Sniehotta (2009) observe that, although the TPB is one of the leading theories of health behaviour, its supporting evidence is mainly based on correlational studies. Accordingly, Sniehotta changed the validation methodology and proceeded to conduct a full-factorial experimental test of the TPB using post-intervention assessment of TPB cognitions and behavioral outcome measures over a time period following the interventions. The interventions involved brief online delivery of short interventions targeting behaviour change. The results indicated small changes in cognitions related to the use of the university's sport and recreation facilities. Sniehotta concluded that, "(a) the TPB does not specify techniques to modify hypothesised cognitive determinants of intention and behavior, (b) possible changes in beliefs will be attenuated through the hypothesised causal chain of events from beliefs, to intention, to behavior caused by the imperfect empirical relationships between these variables, and (c) the TPB does not account for intention–behavior discrepancies" (Sniehotta, 2009, p. 268). In view of these empirical shortcommings

of the TPB, the present study is going to further interrogate qualitative data from an extension of the TRA/TPB to include constructs from other theories in the form of an Intergrated Behaviour Model (see next section for IBM empirical literature).

3.3.9 Empirical support for the Integrated Behaviour Model

The Integrated Behaviour Model has been used to inform a number of studies. The IBM was applied to understand intention and predict condom use among four groups who are at a higher risk for HIV, namely injecting drug users, commercial sex workers, men who have sex with men, and multipartnered heterosexuals (Fishbein, Kasprzyk & Montano, 1998). Their findings indicate the usefulness of the framework, indicating that perceived control and facilitators or constraints are distinct constructs and both, along with attitude and social norm, contribute to explaining behavioral intention. Fishbein et al. conclude that their data, whose collection and analysis were guided by IBM, provide for the development of theory-driven intervention efforts to change condom use intention and behaviour. They argue that the IBM as a theoretical framework provides the basis for assessing behaviour change interventions because it provides guides for predictions about how the intervention programmes targeting a set of items will affect the construct composed by those items, subsequently affecting intention and behaviour. In another application of the IBM, Yzer contends that “the integrative model can identify in any given population which variables most importantly determine a given behavior, and proposes that a health message should address those critical determinants in order to improve the recommended behavior in the particular population” (Yzer in Cho, 2012, p. 22). Yzer futher points out a meta-analytical support for the IBM’s ability to explain different health behaviours Yzer also revealed the model’s application as a guide for health intervention programmes. In addition, there is emphasis on the model’s usefulness in health message design as the theory can assist in identifying the beliefs that the health messages should address in order to effect behaviour change. This occurs through two routes, namely changing the beliefs that are mostly linked to the behavioural intention and strengthening existing beliefs about the recommended health behaviour.

Karspryzk and Montano, in Ajzen, Albarracin and Hornick (2007), applied the Integrated Behaviour Model in a study to understand HIV prevention behaviour of

high-risk men in Zimbabwe. They used IBM behavioural model constructs in regards to condom use, alcohol use, monogamy and avoiding commercial sex workers. The study identified beliefs within each construct that were most highly correlated with each behavioural intention. These beliefs are targets for messages designed to promote HIV prevention behaviours among the high-risk men.

The Integrated Behavior Model (IBM) was used as a framework to investigate the factors affecting male circumcision (MC) motivation among men in Zimbabwe (Gorn, Hamilton, Kasprzyk, Montano & Tshimanga, 2014). It is discovered that all five IBM constructs significantly explaine MC Intention. The study results reveale that all beliefs underlying the IBM constructs were significantly correlated with MC Intention in the group and that 13 behavioral beliefs, five normative beliefs, four descriptive norm beliefs, six efficacy beliefs, and 10 control beliefs were significant in explaining MC Intention (Montano et al., 2014). Like Yzer in Cho (2012) Montano et al.'s study aimed to inform the process of designing messages targeting specific beliefs in order to create demand for male circumcision in Zimbabwe.

3.3.10 Limitations of the Integrated Behaviour Model

The Integrated Behaviour Model (Ajzen & Fishbein, 2000) can be critcised on the basis that it focuses more on the Theory of Reasoned Action and Theory of Planned Behaviour (the reasoned action approach), ignoring emotion or affect as part of attitude although Karspryzyk and Montano (2007) mention both the cognitive and affective components of the attitude. The present study addressed this issue by probing individuals on how they felt with regards to TAM use. These feelings appeared to be very important determinants of the attitude subsequently affecting behavioural intentions to use TAM (see results section on attitude based TAM use). IBM can also be criticised for its lack of emphasis on an individual's background and experiential life as important determinants of their attitude and behavioural intention. Instead, Ajzen et al. (2007) identified background factors like personality, race, gender and past action to indirectly influence behaviour through their effects on salient beliefs. The present study revealed that respondents who grew up in families practicing TAM-use reported difficulties in stopping the practice and stressed it as a major perceived motive for their continued TAM use even with the CM available and accessible.

Ajzen and Fishbein (2010) admitted that there is a weakness in their reasoned action approach with respect to their assumption of concordance between the two factors of the attitude (instrumental and experiential). They did not forsee a situation where one can be negative while the other is positive, resulting in conflicting evaluations of the same superordinate attitude towards a behaviour. The instrumental attitude has to do with ratings of the extent to which the behaviour is useful or beneficial, whereas the experiential has to do with ratings of behaviour as pleasurable or boring. The present study gives an elaborate discussion on this finding not anticipated by the IBM. There were reported perceptions of the usefulness of traditional medicines, including claims that they cured AIDS (positive instrumental attitude) whereas problems related to dosages, hygiene and bitter taste rendering it not suitable for young children were also reported (negative experiential attitude). The superordinate attitude was clearly illuminated as full of tension. The study proposed a neither positive nor negative position which was coined “ambivalent” (see Results section).

The IBM also emphasises the importance of normative beliefs in determining an individual’s behavior. It identifies two types, the descriptive norm and the injunctive norm. Both norms require a generalised social agent for correct evaluation. The injunctive norm has to do with perceptions of others’ expectations or what others think one should do and motivation to comply whereas the descriptive norm has to do with perceptions about what others in one’s social or personal networks are doing. The issue is which of the two outweighs the other in terms of their relative importance in influencing the behaviour? These scenarios are adequately articulated in the present study. The study also observes that although some IBM constructs were taken from the Social Cognitive Theory, the model should have considered the reciprocal determination construct from the same theory. The present study revealed this scenario, where the important others within the environmement were themselves influenced by the individual whom the model had assumed to be influenced by the same in a one way linear manner. As is captured in the recommendations section, the model should consider the aforementioned issues in addition to the inclusion of additional variables or factors in order to improve its predictive validity.

CHAPTER FOUR

METHODOLOGY

4.1 INTRODUCTION

The first part of this chapter presents the methodological issues or the general approach that was used for the present study as directly informed by the ontological and epistemological position of the reseach, which is qualitative and specifically a phenomenological study. The choice of the methodology was informed by Berman and Symth's pedagogical model for conceptual frameworks in the doctoral research process, which emphasises the need for alignment between the ontology, epistemology and methodology of doctoral research, with specific articulation of aspects of each dimension (Berman & Smyth, 2013). They highlight that the theoretical framework of a study (see Chapter 3) informs the research design and contributes to the trusworthiness of the study. Hammond and Wellington (2013) make a related point when they state that "ontology occupies the top of the hierarchy where epistemology, methodology and methods all get into line" (Hammond & Wellington, 2013, p. 115). This part of the chapter ends with a dicsusion of the theoretical underpinings of the Interpretive Phenomenological Analysis and how they offered theoretical insights for this research.

Accordingly, the second part of this chapter articulates the research method or technique that was used in this study in terms of the design, participants and sampling instruments (inluding inclusion and exclusion criteria) and the pre-test and data analysis within the theoretical framework of the Integrated Behaviour Model (see Chapter 3) as a point of reference. The application of the Interpretive Phenomenological Analysis (IPA) which was adopted as a tool for data collection and analysis within the context of the Integrated Behaviour Model, will also be discussed. The chapter concludes with the presentation of the trustworthiness of the study and the study's ethical considerations.

4.2 METHODOLOGICAL ISSUES

4.2.1 Qualitative research

Descombe (2008) viewed qualitative research as a wide term for various styles of social science research, drawing on various diciplines such as sociology, social anthropology and social psychology. This observation converges with Willig's (2013, p. 8) position that "there are 'qualitative methodologies' rather than 'qualitative methodology.'" She further points out that although qualitative researchers differ in their epistemological positions, for example empirists and social constructionists, they share common concerns which are commonly referred to as "qualitative methodology". These studies have certain common elements that make them qualitative. Descombe identifies two preferences for qualititave research as the concern with meanings and the way people understand things as well as qualititave research's interest with patterns of behaviour. Qualitative research is a systematic, subjective approach used to describe life experiences and give them significance (Descombe, 2008). He goes on to indicate that, in addition, the qualitative methodological styles are similar in their special approach to the collection and analysis of data, which are different from the quantitative approaches.

Newman (2011) points out that qualitative studies give data meaning by beginning qualitative interpretation from the point of view of the participants (first-order interpretation) followed by the researcher's discovery and reconstruction of this first-order interpretation, resulting in a second-order interpretation. He further points out that when the researcher goes on to to generalise or link the second-order interpretation to a theory or general knowledge, they move to third-order interpretation. A third order interpretation involves assigning general theoretical significance to the data. Willig (2013) also indicates that qualitative researchers are concerned with meaning, that is how people make sense of the world and how they experience it. The aim is to describe and explain events and experiences and the meanings given to the events by the research participants themselves from their own ways of making sense of the phenomenon under investigation.

4.2.2 Epistemological position for the study

Epistemology is the philosophy of the theory of knowledge that addresses issues to do with what the researcher wants to know and how he/she can proceed to know. It considers the nature of the knowledge, the scope as well as issues to do with reliability and validity of the researcher's claim(s) to knowledge (Willig, 2013). Similarly, Hammond and Wellington (2013) refer to epistemology as what we believe about the way we come to know and comprehend the world around us. It is important for the researcher to consider these issues in relation to the researcher's research question as well as the research goals and objectives. In so doing, the researcher will have a clear sense of what is possible for them to find and how. In other words, the researcher has adopted an epistemological position. Sarantakos (2005) also emphasises the importance of ontological and epistemological principles of a research strategy in determining how the research is done. As mentioned in the introduction to this chapter, the researcher's ontological and epistemological position informs the research methodology which in turn determines the research method. In other words, the methodology gives the framework and the method informs of the data collecting means. The present study ensured an alignment of the ontology, epistemology and the method in order for it to be coherent and consistent in terms of logic. As indicated earlier, the present study employed a qualitative research methodology.

Willig (2013) further points out that it is important to note that qualitative studies can have different epistemological orientations, depending on the types of knowledge they seek to generate. These are based on the research question's ontological assumptions about knowledge, what can be known and how. These assumptions are to do with the kind of knowledge the research aims to create, the social, psychological, material and environments the study is situated in and the role of the researcher in the research process (Willig, 2013). Willig, however, also points out that a study can employ more than one strategy. This is methodological pluralism.

While the researcher acknowledges the advantages of methodological pluralism, where the critical realist approach and a social constructionist approach could have been combined with the chosen phenomenological approach, since they are not mutually exclusive, resource and time constraints did not allow for the limitless

analysis of the data (see recommendations section section). The study epistemologically placed itself within the phenomenological orientation because it aimed to produce knowledge about the subjective experience of research participants, rather than discover what is really going on (realism) or how people create versions of reality through use of language (social constructionist). This study not only arrived at descriptions of experience, but went further to look at the meaning of the experience in a wider social, cultural and theoretical context. Larkin, Watts and Clifton (2006) refer to this type of analysis as interpretive phenomenological (IPA) as opposed to descriptive phenomenological. Sarantakos (2005) refers to the central principle of this methodology as being taken from an interpretivist epistemology. The next section summarises the theoretical underpinings of IPA.

4.2.3 Phenomenology

Phenomenology is the philosophical approach to the study of the world as it is experienced by human beings within particular contexts and particular times, and mainly concerned with phenomena that appear in our consciousness as we engage with the world around us (Flowers, Larkin & Smith, 2009; Moran, 2000; Moustakas, 1994; Willig, 2013). Athough there are various emphases and interests amongst phenomenologists, they converge in their particular interest in the human experience in the lived world. According to Flowers et al., “For psychologists, one key value of phenomenological philosophy is that it provides us with a rich source of ideas about how to examine and comprehend lived experience” (Flowers et al., 2009, p. 11). This philosophical position is the key informant for the present study’s data collection and analysis through the application of interpretive phenomenological analysis (IPA), as informed by the objectives of the study. In this section, the work of phenomenological philosophers Husserl and Heideger, Merleau-Ponty and Sartre will be briefly discussed as the theoretical foundations of IPA. Another major theoretical underpinning of IPA comes from the philosophy of hermeneutics. Consequently, work by Schleiermacher, Heidegger and Gadamer as well as issues to do with the hermeneutic circle will be considered.

4.2.3.1 Husserl

According to Willig (Willig, 2013, p. 251) " transcendental phenomenology, as formulated by Hussel in the early twentieth century, is concerned with the world as it presents itself to humans". Moran (2012) also adequately documented this. The concept was also discussed by Smith et al. (2009) who indicate that "...for Hussel, phenomenology involves the careful examination of human experience (Flowers et al., 2009, p. 12). Willig went on to make a related point that for Husserl, transcendental phenomenology aims to return to phenomena as they appear and to bracket or set aside that which we already know about them, which Smith et al. refer to as "our taken-for-granted ways of living in the familiar, everyday world of objects" (Flowers et al., 2009, p. 14), in order to concentrate on the experiential content of consciousness. According to Chapman, Francis and McConnell-Henry (2009), Hussel advocated for the use of phenomenological epoche, which means 'bracketing' in Greek. In other words he believed that in order to get the true essence of 'lived experience' any preconcieved ideas had to be put aside

It is important to note that Husserl developed his phenomenology as an alternative to the empirically based positivist approach, because he was a mathematcian. Smith et al. went on to point out that Husserl referred to this as leaving aside our daily experiences which he called the 'natural attitude' and adopting what he termed the 'phenomenological attitude', or directing ourselves towards our perceptions of those objects. His emphasis was on the conscious experiences of the individual and his/her relationship with the object of attention, and he termed this 'intentionality' (Crowell, 2013; Moustakas, 1994). Moustakas (1994) illuminated that "Husserl's transcendental phenomenology is intimately bound up in the concept of intentionality" (p. 28). Hussel was interested in what he termed 'eidetic reduction' aimed at getting the essence of the essential features of the content of conscious experience. McConnel-Henry et al. (2009) further pointed out that for Hussel, 'to know is to see', and bracketing was an attempt to use his positivist lens to objectify research findings, and therefore achieve the scientific rigour important for the posivist approach. This was also adequately documented by Moran (2000). Flowers et al. (2009) went on to point out that Husserl's work has helped IPA to consider the process of reflection and focusing on the content of consciousness and our lived experiences, which is key to the present study. McConnel-Henry et al. (2009) make

it clear that “Husselian phenomenology is descriptive, with the intent to raise awareness” (Chapman et al., 2009), an important issue for this study, although this study, in addition, considered the Heideggerian approach to phenomenology which takes interest in people as interpreting beings, as discussed in the next section.

4.2.3.2 Heidegger

Heidegger was Hussel’s student who differed in his focus on hermeneutic and existential phenomenology as opposed to Hussel’s trancendental phenomenology (Moran, 2000). Compared to Hussel who was primarily epistemological in focus, Hedegger’s focus was ontological. His desire was to uncover and unravel the meaning of being (Crowell, 2013). For Hedegger, “people are, by nature, interpreting beings, and any attempt to bracket oneself from a phenomenon will fail because it is intrinsically impossible” (Chapman et al., 2009, p. 10). Heidegger coined the term ‘Dasein’, literally meaning ‘there being’ and ‘being in time’. For him, Dasein is ‘always already’ implying that people are always in an already existing world and cannot be detached from it (Osborn & Smith, 2008). Flower et al. (2009) potray Heidegger’s view of a person as always and indelibly ‘person-in-context’ where the Heideggerian phenomenological concept of ‘intersubjectivity’, or the shared, overlapping and relational nature of our engagement in the world is central. In other words, interpretation of people’s meaning-making activities is crucial to the phenomenological inquiry in psychology. For this study, it is important to note that focus is also on the meaning of being in the world of people living with HIV and using TAM.

For Heidegger, in interpretation there is no bracketing because the fore-structure is always there, implying that presuppostions are always there. For McConnel-Henry et al. (2009), the fore-structure ensures that the questions asked are really pertinet. The present study presupposes motivational factors for TAM uptake as presented by the intergrated behaviour model constructs, which were used to construct the questions (see instrument, Appendix 1). However, Heidegger went on to emphasise that, during the process of interpretation, priority should be given to the new data, in this case the data as it comes from the participants. The implication here, and as considered by this study, is the participants’ interpretations of their lived experience, although presented to the researcher who has a fore-structure, if given the priority,

can affect our understanding of the fore-structure. Gadamar, picked up from Heidegger's position of the fore-structure and new data relation and opined that " ...working out this fore-projection which is constantly revised in terms of what emerges as he penetrates into the meaning, is understanding what is there" (Gadamer, in Flowers et al., 2009, p. 26). Smith et al. go on to highlight that the new data can influence the interpretation which in turn can influence the fore-structure, which can then itself influence the interpretation. This study's approach therefore was informed by this philosophical position where the data transcripts were given priority during interpretation but ensuring that there was dialogue between the IBM and the data, including the possibility of revising and/or modifying the IBM in terms of what emerged from the participants (See Results chapter).

This discussion on the relation between fore-structure or fore-projection and new data from the research participants cannot be concluded without the discussion of the hermeneutic circle depicting the dynamic relationship between the part and the whole. It relies on the circular or back and forth interpretation or meaning-searching movement between the whole and the parts, including deconstruction and reconstruction, where, to understand the parts, one needs to look at the whole or the parts in context, and to understand the whole, one needs to understand the cummulative meanings of the parts (Schleiermacher, 1998 in Willig, 2013). For this study, the whole can be looked at as the IBM, and the parts are the new experiential data from the participants. The resarcher moved back and forth between his interpretation of the participant's interpretations of their experience with TAM and the IBM.

4.2.3.3 Merleau-Ponty

Merleau-Ponty concurs with Husserl's and Heidegger's opinions on the importance of understanding our being-in-the-world, but he further shares some of Heidegger's preference for a more contextualised phenomenology which Heideger referred to as worldliness of experience, while he coined it the embodied nature of an individual's relationship to the world (Moran, 2000; Flowers et al., 2009). He suggested that humans look at the world as opposed to being subsumed into it. He also further converges with Husserl in their view of science, as the source of second-order knowledge derived from a first-order experiential base, although he differs in the

view of empirical science failing to adequately capture or recognise the important mechanisms of perception and judgement. For him, “The lived experience of being a body-in-the-world can never be entirely captured or absorbed, but equally, must not be ignored or overlooked (Flowers et al., 2009, p. 19).

4.2.3.4 Sartre

As described by Flowers et al. (2009), Sartre advanced existential phenomenology in line with Heidegger, by emphasising that humans have self-consciousness and seek after meaning, which he understood as an action-oriented, meaning-making, self-consciousness which engages with the world we live in. This way, he sees an individual as not pre-existing but engaged in an ongoing process of becoming oneself, hence his focus is on what one will be as opposed to what one is (Moran, 2000). There is a convergence with IBM descriptions of social influence on human behaviour especially when Sartre observed that, “The world is not mine alone and furthermore my perception of the world is shaped largely by the presence of others and others have their own projects they are engaged in” (p. 20). This is further illustrated in his illumination that self-consciousness only becomes clear as one becomes aware of being the object of the observation of the other and that the resultant feeling, shame, only makes sense when seen within its interpersonal context (Moran, 2000). This implies the importance of IPA being able to explore people as beings in the world with respect to their interpersonal, affective and moral nature of those interactions.

4.2.3.5 Schleiermacher

Schleiermacher, like Heideger and Gadama, focused on the theory of interpretation (hermeneutics) that is key to IPA. He identified two componets involved in interpretation as grammatical and psychological. He described grammatical interpretation as that which focuses on exact and objective meaning of the text and psychological interpretation as the individuality of the the writer or the speaker. This points to the importance of understanding both the text and the author (Moran, 2000). The present study considered this very much to the extent that the translations of the transcripts were as much as possible verbatim except where meaning could be distorted. This involved identifying connections within the entire data set as well as convering the data with psychological theory (IBM) as

Schleiermacher would advise. Flowers et al. (2009) documented that for Schleiermacher, interpretation depends on individuals' receptiveness of others and that "everyone carries a minimum of everyone else within themselves" (p. 23), which leads to comparison with oneself. This position appeared to be a forerunner of intersubjectivity philosophy.

4.2.3.6 Gadamer

Gadamer was particularly interested in the analysis of historical and literary texts. This led him to focus on the importance of history and how tradition influences the interpretation process. In his lens, intrepretation leads to replacement of foreconceptions by more suitable ones which can themselves influence the interpretation during the process of sense-making. Thus according to Gadamma, interpretation is a dialogue between past and present "...and more than any other follower of Heidegger, Gadamer has made hermeneutics central to the practice of philosophy itself" (Moran, 2000, p. 248). He also echoed Schleimarcher's observation that language is the medium in which understanding is realised.

4.3 THE METHOD

4.3.1 Interpretive phenomenological analysis

Interpretive phenomenological analysis (IPA) is concerned with human lived experiences (Flowers et al., 2009). Smith and Osborn (2008, p. 53) emhasise that the aim of IPA is to "explore in detail how participants are making sense of their personal and social world, and the main currency of an IPA study is the meanings particular experiences, events and states hold for individuals". Forrester (2010) emphasises IPA's focus on human experience and the need to understand human experience. Frost (2010) (2010) makes a related point by indicating that IPA acknowledges the role of the cultural context and socio-historical meanings in the interpretation of data.

This study is exploratory, descriptive and interpretative. It is a qualitative study within the phenomenological research paradigm. Exploratory studies involved research, which investigates new areas and seeks to generate new theories and concepts, while the descriptive part involves research, which provides detailed

accounts of events or situations in order to gain a clearer picture of *what* is going on (Newman, 2011). These two processes lead to construction of emerging themes. As indicated by Willig, (2013), most IPA studies end at construction of master themes. However, Willig, (2013) also points out that more recent researchers have gone further with their analyses to provide an explicit interpretation of the themes identified in the research. The present study explores and describes the perceptions and meanings, beliefs, attitudes, feelings and emotions within the context of IBM, of people living with HIV who have used traditional and alternative medicines and moved beyond this to complete the data analysis. More explicit interpretations of the themes are identified in the research. The data analysis was informed by the interpretive phenomenological analysis (IPA) approach (Osborn & Smith, 2003; Flowers, Larkin & Smith 2009; Willig, 2013). Analysis was done with the aid of NVivo (V.10), a Computer Aided Qualitative Data Analysis Software. (See analysis section)

4.3.2 Development of the instrument and pretesting

A qualitative open-ended interview guide was developed and designed to capture the perceived environmental and individual-level factors (Integrated Behaviour Model constructs) affecting the motivation of people living with HIV/AIDS in Zimbabwe to use traditional medicine (see Appendix 1). The first section of the interview guide asks questions on basic demographic information. Subsequent sections ask questions on IBM constructs. The second section captured information on the perceived effects of the socio-cultural environment on the motivation of PLWHA in Zimbabwe to use traditional medicine. The next section focused on perceived individual-level factors (attitude, social influence and personal agency) namely, experiential attitudes (feelings about the behaviour), instrumental attitudes (beliefs about the behaviour), injunctive norms (beliefs about others' expectations), descriptive norms (beliefs about others' behaviours), perceived control (beliefs about barriers and facilitators) and self-efficacy (ability to overcome barriers). Finally, the participants were asked if they had any issues or thoughts that had not been discussed that they thought could be useful or important to talk about.

The interview guide was translated from English into local research sites languages, Shona and Shangani (See Appendix 1). The translations were done in the

Department of Linquistics at The University of Zimbabwe. The instrument was pre-tested with a sample of four individuals (two males and two females) from each site who are living with HIV and have had treatment for HIV-related illnesses from a traditional healer. The pilot participants were recruited from Chitungwiza City and Save Communal Areas in Zimbabwe (See sampling section for recruitment procedure). These sites were selected to pretest the instruments because they are adjacent to the research sites (see participants and sampling section) and were therefore considered similar in characteristic to the research sites. In addition they were feasible in terms of the researcher's budget and time constrains. The pretest respondents answered questions regarding understandabilty of questions and also whether the interviews adequately captured their peceptions regarding their motivations to use traditional medicine. They indicated clear understanding of the questions implying high validity of the instrument. Pilot data was transcribed, cleaned and analysed (see analysis section). Pilot data indicated that the sample size of four for the pre-test of the instrument was sufficient to assess the clarity and reliability of the instrument and the approximate time the interviews take. Although data from the pilot did not reach saturation, the data also formed the initial basis for theme identification and or generation for the main study. Pilot data was included in the main study.

As shown in Table 1 below, a total of four interviews were conducted for the pilot. The time taken ranged from 0:55:04 to 1:15:03, with an average of 1:02:27. The average time taken during the pilot was adopted as the expected time for all the interviews. However, during the interviews, the interviewees were told a duration of approximately an hour.

Table 4.1: Time taken for pilot interviews

Interviewer	Time	Comment
Muromo	1:03:23	First interview
Muromo	0:56:18	Second interview
Gift	1:15:03	First interview
Gift	0:55:04	Second interview
Total	**4:09:48**	
Average	**1:02:27**	Became the expected time for the interview

Data was collected using two digital voice recorders; *BELL OFFICE* pro-series voice recorders (model no: DVR-6006). The interviews were conducted using the Interview guide (See Appendix 1).

The pilot presented some challenges that helped in the latter engagement of participants. The first interviews were conducted on the default dates on the recorders because of removal of the batteries. Once the batteries are removed, the recorders reset to default dates, for example 2010. This was to be avoided in later interviews. There was also a problem with the pause button. If one paused for a few minutes, the recorder would go off and as a result there ended up being more than one file for one interview. This presented challenges on handling and manipulation of such audio files. This was insufficiently explained in the manuals and the process of identifying this was not only a problem in itself but also caused untidiness in the presentation of broken interviews.

It was also noticed that the Shona guide version was inconsistent with the English one on the numbering. The first Shona question was not numbered and as a result it would appear invisible. Therefore in some interviews during the pilot it was not asked. Therefore, the numbering was adjusted to start on age, to match the English version. The numbering on the Shona version was also formatted to clearly separate the numbering from the number's contents, as was on the English version. On item 2 (Shona) which was 3 (English), page 1; it was not clear on the distinction between option 1 and 2. They seem to be telling the same thing on the Shona version. It was also found necessary to strongly probe, especially for those for options 3-6, to find out about other active relationships. On item 5 (Shona) which was 6 (English), page 2: It was difficult to understand the translation of home village (*Musha here?*). Generally, it was found necessary to probe about rural connections, in other words visits to rural areas or lack thereof, period stayed there, if ever, active connections or lack of, and so on. It also seemed important to ask about where the participant was currently staying and for how long.

For the IBM constructs, on item 1 of *I,* it was found important to probe more on past experience, even childhood experiences. This question was very important as it served as an orientation to the whole interview. On item 2 of *I* for Shona version, there was need to translate to accommodate relationships other than marriage, like

'Munonzwa sei nenyaya yokuti munhu wamakaroorana naye/wamurikufambidzana naye/wamugere naye mumba ashandise mishonga yechivanhu? On item 3 of *I,* given that others do not have children, we could use this to ask about other people and children in general. On item 3 of *III* for Shona; there was a typo: *Ndiani kana kuti chii chingakutsigirai* ***~~kauti~~ kuti*** *mwana wenyu ashandise mishonga yechivanhu?* On item 4 of *IV* for Shona; the item was not numbered and therefore invisible or asked together with item 3, so it was numbered to appear like other substantive questions. On item 2 of *V* for Shona; there was a repetition of *kuti*: *Ndezvipi zvingaite kuti zvive nyore kuti wamakaroorana naye kana wamunogara naye* ***~~kuti~~*** *ashandise mishonga yechivanhu?* Items 4, 5 and 6 of *V* for Shona were incorrectly numbered 1, 2 and 3 respectively and this was adjusted accordingly. There was a typo on *VII,* it should be; ***Hutungamiri nemamiriro ezvinhu*** *zvi****ngakuvhiringai: Kuvhiringidzwa kwamungaitwa nemamiriro ezvinhu muhutungamiri hwenyaya dzeutano.*** Item 2 and 3 of *VII* for Shona were not numbered and this was rectified. There was a typo on item 3 of *VII* for Shona, it should be; *Ndezvipi zvikonzero zvamunofunga kuti zvinechekuita nekugona kwenyu kushandisa mishonga yechivanhu?*

During the pilot, it was very intriguing to ask participants to provide a pseudonym to attach to the conversation at the end of the interview and ask why they chose that pseudonym. Most of the names given were metaphorical, (*Kushingirira* (Its trying hard), *Tinomboedza* (We would try), *Zvisinei* (It doesn't matter), *Batsiranai* (Help each other), etc.). General probing about why they opted for TAM was also very important. The length of time using TAM and how effective they perceive TAM to be with or without comparison to ARVs was also worthy of interogation. Generally, the interviews were interesting, although there was some monotony especially on the sets of six positive and negative questions on the same construct. Another interesting finding was that Shangani speaking participants preferred being interviewed in Shona. They use both languages.

4.3.3 Participants and sampling

The participants consisted of 8 males and 12 females living with HIV who had treatment from a traditonal healer for HIV related illnesses. The study could have recruited a sample of more than 20 participants, but the data saturated after the 16th

interview. Backer contends that the best answer for the sample size in qualitative research is simply to gather data until empirical saturation is reached (Baker, 2012). The participants for this research were recruited from the city of Harare and the Chiredzi Rural District in Zimbabwe. Four of the eight males and six of the 12 females were from the rural setting, while the other four males and six females were from an urban environment. An urban and a rural setting were chosen in order to cater for their environmental differences. The two selected geographical areas also differ in ethnicity (Shangani & Shona). The sample size was informed by IPA which makes use of small, purposive and carefully selected samples, including case studies (Flowers et al., 2009). Accordingly, the study sample size of 20 was sufficient to assure that most of or all the perceptions were captured (saturation), hence reducing the probability of discovery failure while at the same time working within the constrains of the available resources including budget and time.

The participants were people in Zimbabwe who are sixteen years and above. Sixteen years is the Zimbabwean age that legally allows consent to sex although the legal age of the majority is 18 years in Zimbabwe. For those below 18 years of age and who were still living with their parents, parental assent could have been sought but for this study, there were no participants under 18.

The snowball (or chain, chain-referral, referral) sampling technique was used. This is a non-probability sampling technique that involves existing study participants recruiting their peers. The first participants were identified through an HIV support group where information on people living with HIV who had disclosed their HIV status and also used traditional medicine was available. These provided information that was used to locate other eligible members whom they happened to know. They also identified participants who were not members of the support group. All the recruitment was done by the researcher who explained the purpose of the study to the potential participants as explained under procedure (See recruitment script, Appendix 6). This procedure is appropriate when members of special populations are difficult to locate (Babbie, 2002; Newman, 2011). The method was particularly suitable for the study because some of the participants required for the study were reluctant to disclose that they are living with HIV and had used traditional medicine.

All the participants were:

(i) Male or female aged 16 years and above
(ii) Living with HIV and AIDS
(iii) People who had treatment for HIV related illnesses from a traditional healer
(iv) Living in Harare City or in Chiredzi Rural District, Zimbabwe

4.3.4 Procedure

The initial approval to carry out the study was sought from the Nelson Mandela Metropolitan University's (NMMU) Faculty of Health Sciences' Research, Technology and Innovations (FRTI) Committee and the NMMU Research Ethics Committee (Human) (Appendix 7) followed by approval from the Harere and Chiredzi district in Masvingo's local provincial medical authorities. Finally, the Medical Research Council of Zimbabwe's approval (Apendix 11) was obtained. Community entry was conducted according to well-established protocols. To enter any community in Zimbabwe, one must go through formal permission with the administrative structures, provincial, district and in addition the identified village, for rural areas. The written permissions from the local authorities were used by the district health officials to introduce the researcher to the provinces and districts. The gatekeepers were the district medical officers of the selected districts where the reseach sites are located (Harare and Chiredzi).

After the research had been approved by all the required authorities, the reseacher recruited and trained a research assistant with a university Honours degree in Psychology who conducted some of the interviews under the researcher's close supervision, while the researcher conducted tother interviews. The reseach assistant responded to an advertisement and aquited himself in an interview that looked for a research assistant who had passed Shona and Shangani languages at a Zimbabwean high school Advanced level in addition to them having an Honours degree in Sociology or Psychology. An interviewer training meeting was conducted in order to train the interviewer how to carry out the interviews and also to standardise both our understanding of the instruments including the translated versions. The training meeting also consisted of : 1) an overview of the study goals and timeline; 2) a session on research ethics and how to obtain consent/assent from

a potential participant, or parent of a potential participant; 3) interviewing techniques; 4) the instrument item by item; and 5) review, role-playing and practice exercises for administering the translated versions of the instrument.

Data collection for the pilot was done soon after the training of the research assistant. The researcher closely monitored the data collection process, including the holding of daily progress review meetings with the research assistant. These meetings provided the team with opportunities to share challenges and best practices based on their daily experiences under the guidance of the researcher.

The interviews began with the interviewer's introduction (see interview introduction, Appendix 3) to the interviewee and proceeded to explain the purpose of the study. Possible advantages and disadvantages resulting from participating in the study were explained and an opportunity to consent or decline to take part in the study was given. Written informed consent was obtained. Only those respondents who voluntarily agreed to participate signed the consent forms. They were also told that they may withdraw from the study at any given time. The interviewer sought permission from the participants prior to the interview to audio record the interviews (See Informed Consent form Appendix 2). The respondents were reassured that only the research team members had access to the recordings. All the interviews were conducted privately at the interviewees' homes or other places of their choice.

After the consent process, the interviewer gave some information orally to the interviewee (see Appendix 4) and proceeded to conduct one-on-one in-depth interviews with the participant. Interviews were conducted in the preferred language of the respondent (English, Shona or Shangani) and were audio recorded. All the interviewees preferred to be interviewed in Shona. The explicit objective of an in-depth interview is to understand the respondent's experience from his/her point of view (Gorbach & Galea, 2007). Some of the questions were pre-written by the researcher (see Appendix 1) whilst maintaining an open-ended response format, which allowed the interviewer to probe with follow-up questions for clarification. The data collection was done until the data reached saturation.

4.3.5 Data preparation and transcription

The verbal responses were recorded verbatim using *BELL OFFICE* pro-series voice recorders (model no: DVR-6006) with internal memory of 4 Gigabytes. The recordings from these devices were very clear and the memory was enough to accommodate all the interviews. Data from the digital audio recorders was transferred to a computer and uploaded in Express Scribe (v 5.56) for transcription. Express Scribe is free professional audio player software designed to assist the transcription of audio files (Express Scribe Transcription Software Website; http://www.nch.com.au/scribe/index.html). This transcribing software offered valuable features such as variable speed playback, multi-channel control and file management. Transcripts were made using MS Word and using the hot keys; Express scribe was played and controlled in the background. During the transcription, all the substantive questions were formatted into Heading 1 in preparation for the autocoding during the Nvivo analysis.

The transcripts were made in four versions. First, the original transcripts had both the direct verbatim in the first column and English translation in the second. These original transcripts are very good as they show how the translation was done. The data consisted of 20 original transcripts with both the direct verbatim and the English translation side by side. It was difficult, however, to upload the original transcripts that contain both direct verbatim and English transcripts. Firstly, this was because some of the transcripts, the longer ones, contained more than 64k of text data in a single table row. In an attempt to solve this each of the eight long transcripts (Batsirai, Charity, Dread, Grey, Indigenous, Muyengwa, Tatenda, Tararama, and Zvisinei) was split into four rows to reduce the amount of data in each row. Fortunately this resolved the problem and the files were uploaded only to find out that the files could not be read well as the right side of the table was cut. The file was therefore split into a direct verbatim transcript (largely in Shona) and the English translated transcript as separate portrait word files. The original side-by-side transcripts were also kept for the purposes of verification and reference to how the translation was done. Lastly, audio transcripts were made using the Nvivo audio transcription facility. The audio and English transcripts were synchronised so that the reader can read whilst listening from the audio file. The Nvivo transcript also interpolated the timespan on the sections of the interviews. These transcripts were

exported in the form of both word document (with timespan) and the richer Data Webs in the form of HTML documents with both the time-spanned transcript and the audio file.

4.3.6 Data Analysis

4.3.6.1 Interpretive Phenomenological Analysis

The study will apply the Interpretive Phenomenological Analysis (IPA) to explore perceptions of lived experiences of PLWA who have had or are having traditional treatment. IPA is a qualitative research approach committed to the detailed examination of how people interpret their major life experiences (Osborn & Smith, 2003). This qualitative approach whose birth is specifically in psychology, centers on individual experiences and focuses on the meanings particular events or emotional states hold for the individuals. IPA assumes that people are self-interpreting beings and relies on people's ability to verbalise their experiences (Flowers, 2009).

Interpretative Phenomenological Analysis is informed by three key theoretical perspectives namely, phenomenology, hermeneutics and ideography (Smith, J., 2007; Flowers, et al., 2009). Phenomenology is a philosophical approach concerned with exploring and understanding human experience (Langdridge, 2007). IPA is concerned with how experiences appear to individuals and how individuals perceive and talk about objects and events (Flowers, et al, 2009). Hermeneutics is the theory of interpretation which views people as interpreting and sense-making individuals (Flowers, et al, 2009). IPA is a double hermeneutic process which according to Smith and Osborn (Smith & Osborn, 2003, p. 35) is a process where "the researcher is making sense of the participant, who is making sense of *x*". Ideography is concerned with the particular (Flowers, et al, 2009). Flowers, et al. explaine that IPA operates with the particular at two levels namely, the particular in the sense of detail and depth of analysis and the particular in the sense of trying to understand how particular experiential phenomena have been perceived by particular people in a particular context. Accordingly IPA makes use of small, purposive and carefully selected samples including case studies. This does not mean that IPA studies' results cannot be generalized, but rather ideography prescribes a different way of

arriving at those generalizations (Harre, 1979as cited in (Smith, Flowers, & Larkin, 2009). (See trustworthiness section.

4.3.6.2 The Process

As already highlighted, the data were analysed using Interpretative Phenomenological Analysis (IPA) (Smith, 2003). This analysis was concerned with how the participants got motivated or formed the intention to use TAM. Although IBM was used to identify these motivations and intention, bracketing was used to treat each participant as a case and they created their own peculiar themes. Analysis was done with the aid of NVivo (V.10), a Computer Aided Qualitative Data Analysis Software. The software program was found appropriate, because it effectively manage large amounts of qualitative data. Nvivo facilitated the construction of relational networks identifying the content and structure of respondents' opinions (Smyth, 2006). The whole analysis took six steps which are: reading and rereading; initial noting; developing emergent themes; searching for connections across emergent themes; moving to the next case and lastly, looking for patterns across cases. These steps were not necessarily chronological, but each offers a way of thinking about the data (Smith, Flowers, & Larkin, 2009). Frequent returns to former steps were common.

4.3.6.3 Reading and rereading

The first step involved reading the transcript a number of times. Reading from the Nvivo data webs enabled the researcher to both listen and read the data. The simultaneous engagement of the auditory and visual system resulted in the development of a more interpretative account. This engagement started during the transcription process. In a way, it facilitated the development of an identity to each transcript. The richer transcripts were read first. Grey, Batsiranai, Charity, Zvisinei and Muyengwa were found to be the most detailed, complex and engaging (Flowers et al., 2009).

4.3.6.4 Initial noting / comments

Semantic content and language use was examined mainly at an exploratory level (Flowers et al., 2009). The comments were intended to develop a comprehensive and detailed set of interpretative notes and/or comments for each transcript. This

was done for every respondent and these were captured in the form of Nvivo's memos and annotations. Below is a memo extract from Grey's section 3. Initial noting was very time consuming and was done at three levels namely: descriptive, linguistic and conceptual comments (Flowers et al., 2009). In those Memos, descriptive comments were normal font from Grey's Memo, extract for section 3. The linguistical comments were in italics and these focused on language use. Lastly the conceptual comments were more interpretative and abstract (Flowers et al., 2009). The conceptual comments were in bold format.

sec 3: Memo Extract for Grey

Childhood experiences might influence health preferences and behaviours.

Success of TAM on other STDs can be used to inform a decision to use it on HIV/AIDS

Quite knowledgeable about other STIs and how they are treated

linked TAM to promiscuity and mischievousness

why linking TAM to promiscuity and mischievousness? Could it be possible that promiscuity and mischievousness are catalytic factors?

Intergenerational socialization and passage of the know how. Maybe reinforcing the promiscuity and mischievousness of the growing boy!!

….

why making the success a matter of chance?

referred to a n'anga (traditional healer) by a relative. *he made a sound o-oh showing that he was not too sure if it was going to work.*

could it be possible that the trustworthness/credibility of the sister contributed to his decision to go?

….

Very happy during this narration of his 'miracle'. Conventional methods being used for concrete truths! The **less tolerance of error in conventional medicine** helps to increase the certainty of the improvement and healing. However, why did he shun it at the beginning? The conventional medicine operates in a continuum, one edge is good and the other is not.

Getting to cotrimoxazoles is a sign of success *'***cotrimoxazolization**'

…

His previous experience with TAM is helping him to trust it.

He laughed after demonstrated how strong he was…

The memos were comprehensive and separate from the transcript. However, the annotations were quick and could be read together with the transcripts since they would appear as footnotes to the transcript. Below is an example of annotations;

My doctor said, 'right! If you are using TAM, we are now weaning you on pills because the way you have boosted means that the TAM you are using is helping.'[1]s/he dropped me..allowed… I accepted it was interested such that if I look the way I was helped, I even look at myself to say is it really me? Who is now reaching this level? Coming and being told, 'we are now removing you on these pills, we are now putting you on cotrimoxazoles, its now enough.'[2] <Internals\\Audio\\Batsiranai> - § 3 references coded [40.76% Coverage]

That's when they said to me, *'what we are now doing to you is that we are now giving you cotrimoxazoles only, you no longer take ARVs.'* That's what my child did as well, and that's what Simon did as well.[3]<Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

Annotations

[1] Could it be that the patient would then like to keep on shocking them with this self-searched improvement and come to present to them to measure it in medical terms?

[2] cotrimoxazolization

3 cotrimoxazolization.there is a feeling attached to cotrimoxazoles especially if you remain on them or if you are reversed to them.

Above are extracts from Batsiranai and Grey. The superscript numbers in text link to the comments at the bottom in small font as annotations. These annotations helped a lot to remember, not only the comments made but also the words to which such comments are attached to.

4.3.6.5 Developing emergent themes

Memos and annotations helped to develop emergent themes. Emergent themes captured and reflect an understanding. Coding into nodes (themes) started at this level. Nodes were used to group ideas and extract that revealed relatedness and links.

4.3.6.6 Developing super-ordinate themes

Further refinement of emergent themes resulted in development of super-ordinate themes. At this stage, IBM was crucial and used to insert the emergent themes into IBM constructs that would help explain or clarify such constructs. Emergent themes that did not match some of the constructs were added or modified. A number of methods were used to classify and group these emergent themes into IBM constructs and other themes. These were: abstraction, subsumption, polarization, contextualization and numeration.

After engaging with one transcript to this level, the analysis continued as the researcher returned to other transcripts, and looking for connections across cases. Eventually the themes were nested in a tree like structure of relationships between and among the themes (nodes). Data were coded to nodes that were nested in the way that showed the way the relationships were understood. As a result, parent, child, grandparent and sibling nodes were used. Below, is an example of a model of how the thematic grounded nodes were organised;

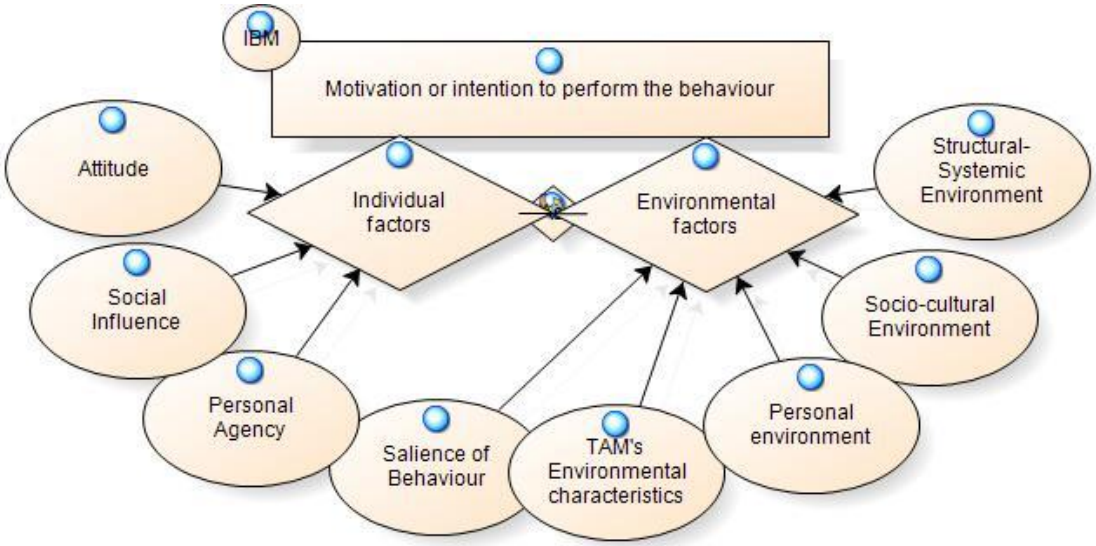

Figure 4.1: Model Example

4.3.6.7 Data exportation

After the coding and analysis was done using Nvivo, data was exported in the form of word documents and pictures. A number of other methods were used for the manipulation and understanding the data. These methods were text queries, model development, charts, tree maps, classifications, word frequencies, range coding, auto coding and etc. such analyses yielded results most of which required pictorial presentations. For example, keywords - in – context (KWIC) were utilized to reveal how respondents used words in context by comparing words that appear before and after “key words”. This is exemplified below;

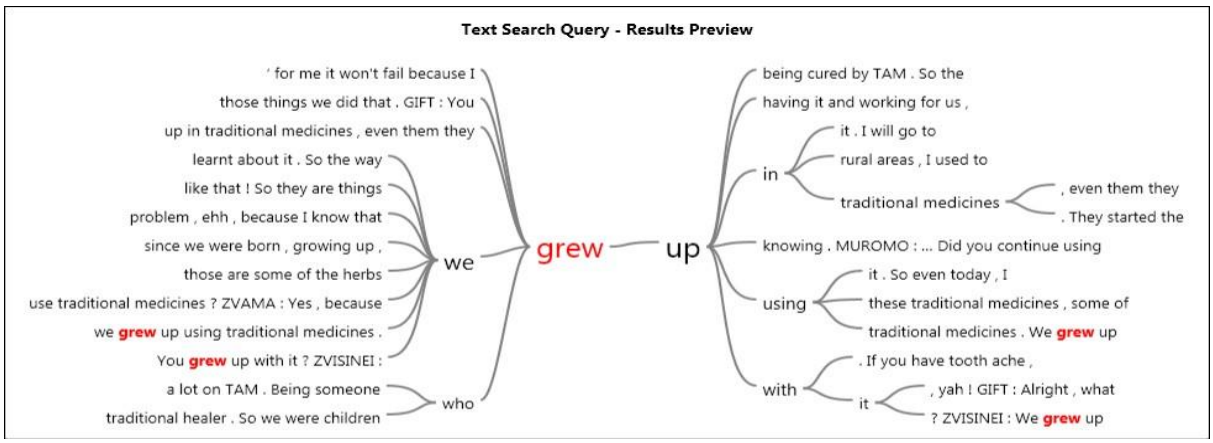

Figure 4.2: Text Query Example

Extracts from the transcripts were the most common and these showed the referenced extracts. These data displays were a framework of data analysis characterized by referenced text extracts. Extracts from Nvivo were suffixed with an automatically generated link to the original data and the percentage of that text relative to the total text in that transcript if it is continuous or a percentage of that section. Below, is an example of a text extract from Batsiranai;

I am now strong… the doctor said to me '…*Even if you want to carry a child (being pregnant); you are now able to, you can carry it' …*initially I was given a period that I was not allowed to have a child. So far I have been given a go ahead to say if you want to have a child you can have it… I was like a stick (very thin), if I walk there, if the wind blows, people would say, '*is that person going to live up to tomorrow or is she going to die?*' But I have seen that I have recovered to my normal health… <Internals\\Audio\\Batsiranai> - § 6 references coded [40.76% Coverage]

The link at the bottom shows that the data came from internal uploads (<Internals), in the folder of audio files (\\Audio), it was Batsiranai's transcript (\\Batsiranai >) and finally this constituted 40.76% of the section [40.76% Coverage]. Such referencing increased the trustworthiness and conformability of the data and the interpretation process. Italics were used to indicate where the respondent quoted another person.

Cluster analysis was also done to analyse word and coding similarities. Below is an example of these analyses:

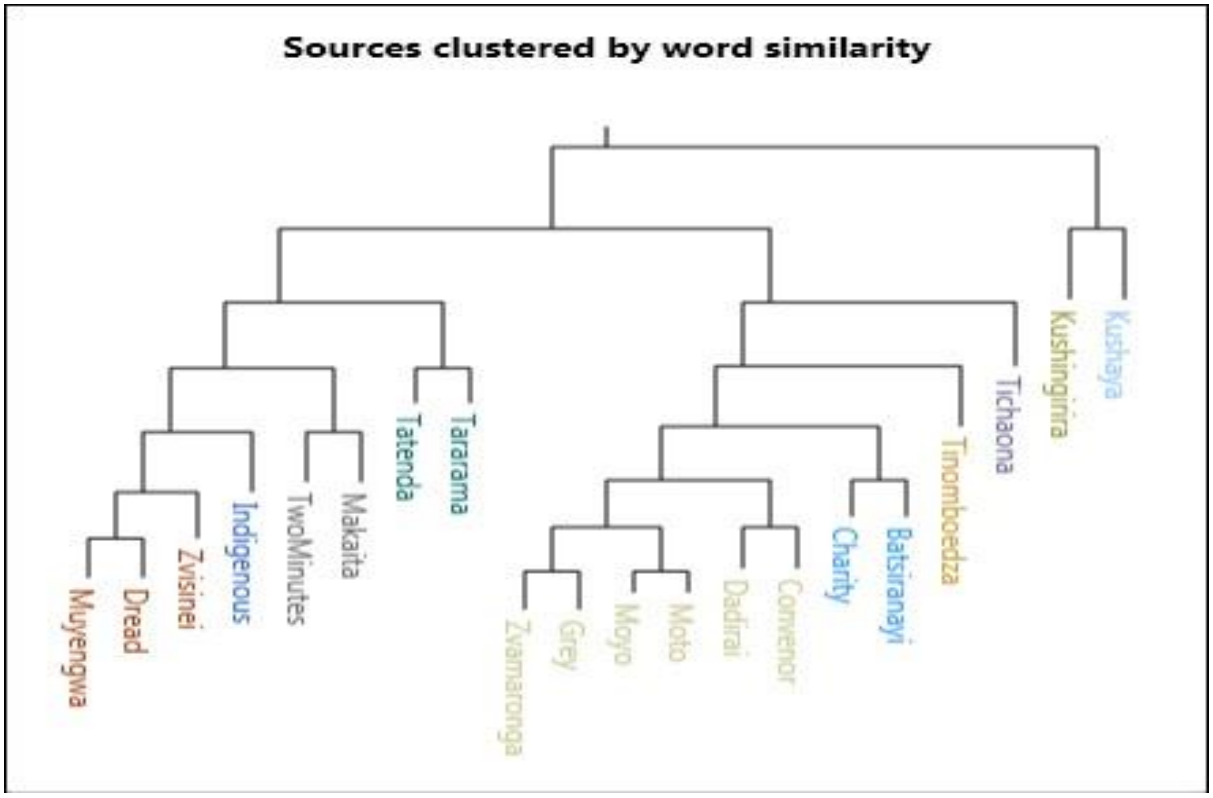

Figure 4.3: Cluster analysis example

Tree maps were also produced to show the spread and proportion of codes in the node. The size of the rectangles represents the proportion of references extracted from the data for each particular theme indicated at the top of the rectangle. A typical map is shown below:

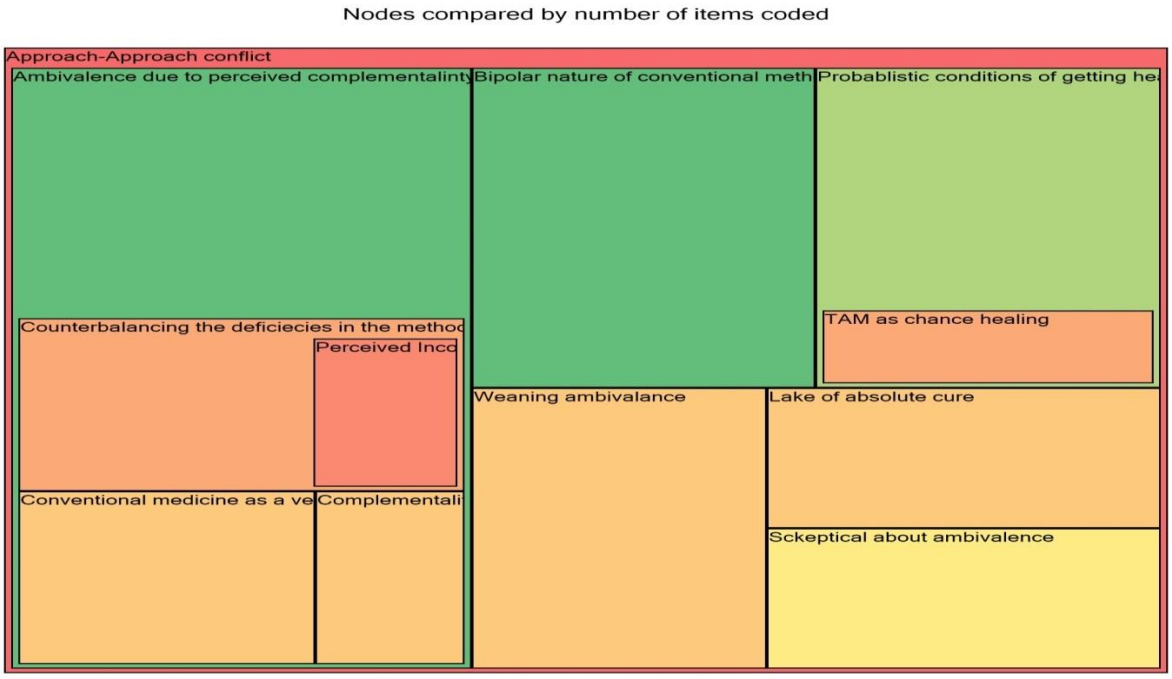

Figure 4.4: Tree Map Example

Word frequencies were also used to show popularity of opinions and expressions. Below is an example;

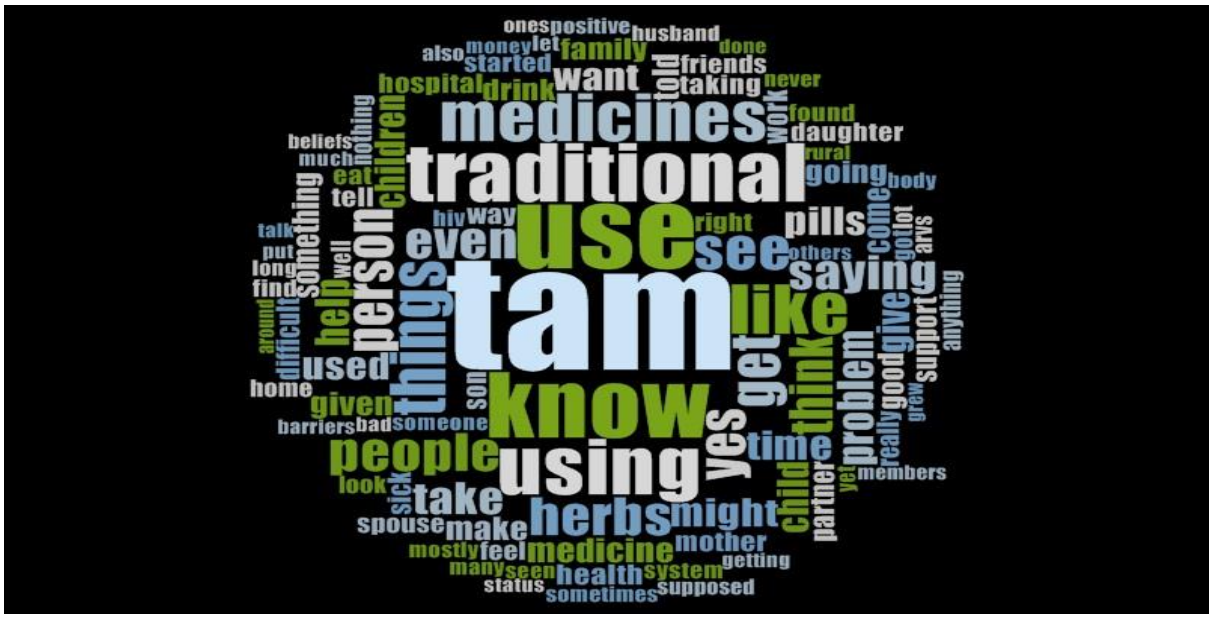

Figure 4.5: Word cloud example

Classification was also used to manage some quantitative variables such as gender, age and employment status. As a result the data was able to be presented in the form of charts and statistical graphs as shown below;

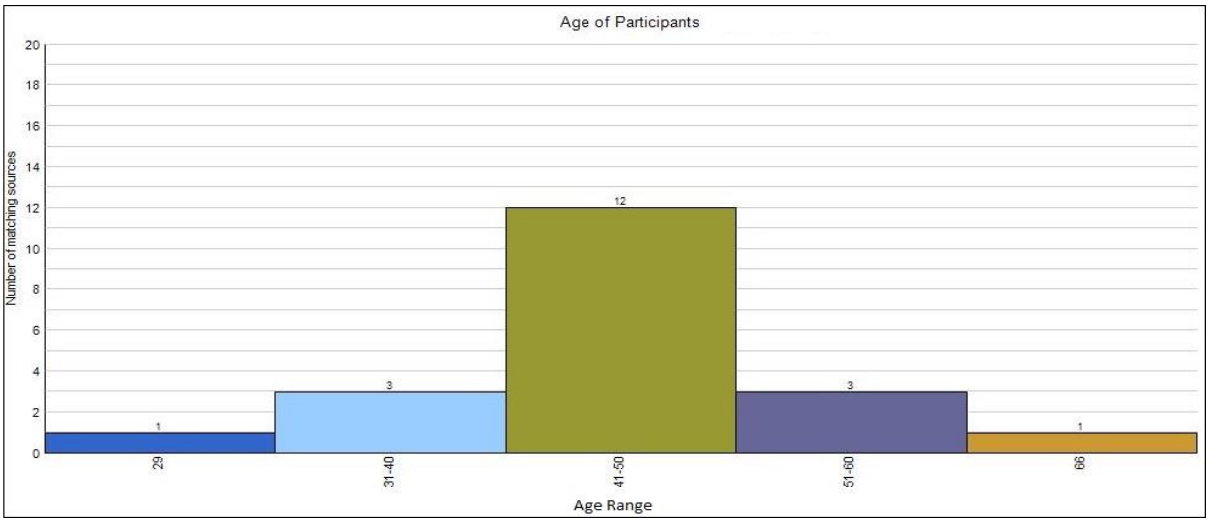

Figure 4.6: example of Graphical Presentations

Succinctly, Nvivo was helpful in the management and analysis of this huge data set as informed by the IBM constructs. It helped in creating nodes directly from the data; use of the memos, annotations and links to record and incorporate ideas, reflections and interpretations as data analysis unfolds; development of models from a tentative conceptual framework, compiling models that demonstrate the connections of the data by showing the arrangement of a tree and free nodes in concept maps. This project would stand as a historical record as everything that was done, from the day of project creation to the last project save (including creation of a node and statistics about the number and type of responses collected to all nodes) was recorded in date and time saved in the project which can be accessed and verified if the need arises. It forms an excellent audit trail to the analysis process.

4.4 TRUSTWORTHINESS

4.4.1 Validity and Reliability

The quality of qualitative research can be assessed with broad concepts like validity used for quantitative approaches, but there is a need to operationalise these concepts differently to take into account the distinctive goals of qualitative research

(Mays & Pope, 2000) .Reflexivity involves avoiding deployment of one's subjectivity to assist the data collection and analysis (Hollway & Jefferson, 2000). Validity and reliability are constructs mostly peculiar to quantitative methods. Trustworthiness, however, was ensured to match these constructs. Credibility was used to match internal validity; transferability to match external validity; dependability to match reliability and conformability for objectivity. These four constructs demonstrated trustworthiness (Guba & Lincoln, 1995).

4.4.2 Credibility

Credibility was the extent to which the researcher captured and represented the reality of how things really are from participants' standpoints (Yin, 2003). Closer relationship, especially visits in the participant's home environments and settings, provided a richer context and a grounded basis for hermeneutics for both empathy and suspicion (Huberman & Miles, 1994). Therefore, credibility was accomplished through methodological rigor (Yin, 2003).

The home visits provided familiarity with the home culture of participants and assisted in establishing a relationship of trust between the researcher and participants (Guba & Lincoln, 1995; Shenton, 2004). Member checking which Guba and Lincoln (1995) consider the most important provision, was also used during the interviews. It helped to check data accuracy right at the moment it was given. Repeating the respondent's response for them to confirm was used and all the conversations were recorded verbatim to avoid later distortions. Nvivo also helped as it afforded the sync of these audio files to the transicripts so that, if needed, the translation can be checked as one can read transcript concurrently listening to the audio recording. Nvivo helped with the evaluation of consistency (Smyth, 2006).

Finally, credibility was also accomplished through extensive literature review. Such effort increases my ability to relate the findings to an existing body of knowledge (Silverman, 2000 in (Shenton, 2004).

4.4.3 Transferability

Transferability was achieved by vivid description of the methodology and the data analysis process. IPA was the method used for data analysis and with the aid of

Nvivo, the participants' extracts were elaborate and referenced. Nvivo also shows how hermeneutics were used in the form of memos, annotations and the tree-like relations of nodes (Smyth, 2006).

4.4.4 Dependability

Had it been a quantitative method, reliability would ensure repeatability, however, Lincoln and Guba (1995) pointed that in practice demonstration of credibility largely ensures dependability. Generally, dependability was achieved using Nvivo which formed a comprehensive audit trail as it can showthe comments and construction of relational nodes that preserve integrity of the data (Richards, 1999 in (Smyth, 2006).

4.4.5 Conformability

Conformability was achieved through an accurate exposure of the perceptions of the participants (Onwuegbuzie & Teddlie, 2003 in (Smyth, 2006). The hermeneutics of empathy in combination with the hermeneutics of suspicion were used to form a double hermeutics. The interaction of these were all grounded in the data and these can be confirmed by following how the analysis unfoded in the NVivo project which stands as an audit trail to the whole process of how the interpretations were made. All the models and illustrative data derived from Nvivo are grouded in the data and can be opened to show the data that created them. The hemeutics can also be found in the memos, annotations, relationships and classifications. All aspects are transparent and cannot be hidden with Nvivo (Smyth, 2006).

4.5 ETHICAL CONSIDERATIONS

Ethical approval was sought from the Nelson Mandela Metropolitan University (NMMU)'s Faculty of Health Sciences' Research, Technology and Innovations (FRTI) Committee, Nelson Mandela Metropolitan University's Human Ethics Committee and the Medical Research Council of Zimbabwe prior to conducting the research. Factors related to respect for autonomy (recognising the rights of individuals to self-dtermination), beneficence (having the welfare of individulas as a goal) and non-maleficience (doing no harm to participants) and justice (moral rightness), were strictly observed. It is the researcher's intention to present the

findings at national, regional and international conferences. This written report will be made available in the NMMU library.

Beneficence and non-maleficence was maintained through safeguarding the welfare of the participants (APA, 2002). There was no any deliberate intent to harm any participants. Arrangements were also made to refer cases that required counselling services. The participants' welfare was also maintained by guarding the factors that might lead to misuse of the researcher's influence and/or presence to the participants.

Fidelity and responsibility (APA, 2002) was also upheld through the sought to establish trust with the participants involved. The research was clarified to the participants to make sure that they consent to what they have been requested to do. As part of fidelity and responsibility, the researcher strived to contribute a portion of academic and/or professional time towards the understanding of decision making in TAM use through his faithful and responsible devotion.

Promotion of accuracy, honesty, and truthfulness formed the basis for integrity in this research (APA, 2002). The researcher abstained from plagiarism, cheating and deception.

The research was conducted within the boundary of the researcher's competence as a doctor of philosophy student. This idea addresses justice (APA, 2002) relative to this research. Reasonable judgment and precautions were taken to ensure that biases, the boundary of competence, and the limitations of the study do not stand in place of just practices.

In this study, participants' rights and dignity (APA, 2002) were upheld through the respect of their privacy, confidentiality, and self-determination (Borasky, Carayon, Rice & Rivera, 2001). The researcher did not knowingly encourage discrimination of others based upon familial, cultural, individual, and role differences.

For data collection, written informed consent was sought from the participant. Each participant was given two copies of the consent forms (Appendix 2) and after reading and agreeable to the explanations, they signed all copies and returned one and the

other would remain with them as a later reference. The consent form was offered in the language preferred by the participant (APA, 2002). Therefore, there were English, Shona and Shangani consent forms. For those who could not read and write, the consent forms were read for them and they signed if agreeable to the explanations. The participants were free to decline to participate and to withdraw from the research at any stage of the research. On the consent form, the researcher's conduct details were provided in case they had questions about the research later. Before the written informed consent, participants were given a chance to ask questions. The informed consent also covered informed consent to record their voices for data collection.

Respondents were also made to know the limits of confidentiality involved in this study (APA, 2002). The participants were asked to provide pseudonyms to protect them from personalization. To reduce intrusions on privacy, the research was restricted only to information perceived relevant to the purpose of the research. The participants were also informed that the extent and limits of confidentiality would be regulated by the researcher's scientific relationship with the supervisors and research assistants. As a result, the supervisors and research assistants had access to the data but only for the purpose of this study (APA, 2002), but these consultations did not disclose confidential information.

The researcher did not knowingly engage in harassing and/or demeaning to participants (APA, 2002) and refrained from sexual harassment. APA defined sexual harassment as 'sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature that occurs in connection with the psychologist's activities or roles as a psychologist…' (APA, 2002, p. 6). Mostly the interactions with these participants were in privacy since the subject was very sensitive and in some cases would encompass some sexual practises. The researcher abstained from using his influence to derive such sexual solicitations or physical advances concomitant to sexual harassment.

After research results were obtained, the researcher did not withhold the data on which the conclusions were based. Nvivo project stand as an audit trail and historical record that, if need arises, it can be verified and reanalysed (APA, 2002).

CHAPTER FIVE

ATTITUDE BASED TAM-USE MOTIVATIONS

5.1 INTRODUCTION

Chapter 4 presented the methodological issues as well as the method used for this study. Chapters 5, 6, 7 and 8 present and discuss the results of the study. Chapter 5 commences with the summary of demographics for the study participants followed by results and discussions on attitude based TAM-use motivations. Chapter 6 is a summary of results and discussions of social influence based motivations to use TAM. Chapter 7 summarises results and discussions of TAM-use based on personal agency motivation. Results and discussions of environmentally based TAM-use motives are presented in Chapter 8. Chapter 9 summarises the results, presents recommendations based on the results and concludes with the study recommendations.

As already mentioned, the present study was based on an IPA methodology and it yielded qualitative data. The main purpose of this study, as was indicated earlier, was to ascertain perceived determinants of individuals' choices, including individual and cultural level factors such as beliefs, attitudes and norms regarding the use of Traditional and Alternative Medicine (TAM) by people living with HIV and AIDS (PLWHA) in Zimbabwe. The preceding chapter pointed out that data was collected through in-depth interviews, and the units of analysis in this study were the PLWHA's verbal responses. Verbal responses were collected from twenty PLWHA (Figure 5.1).

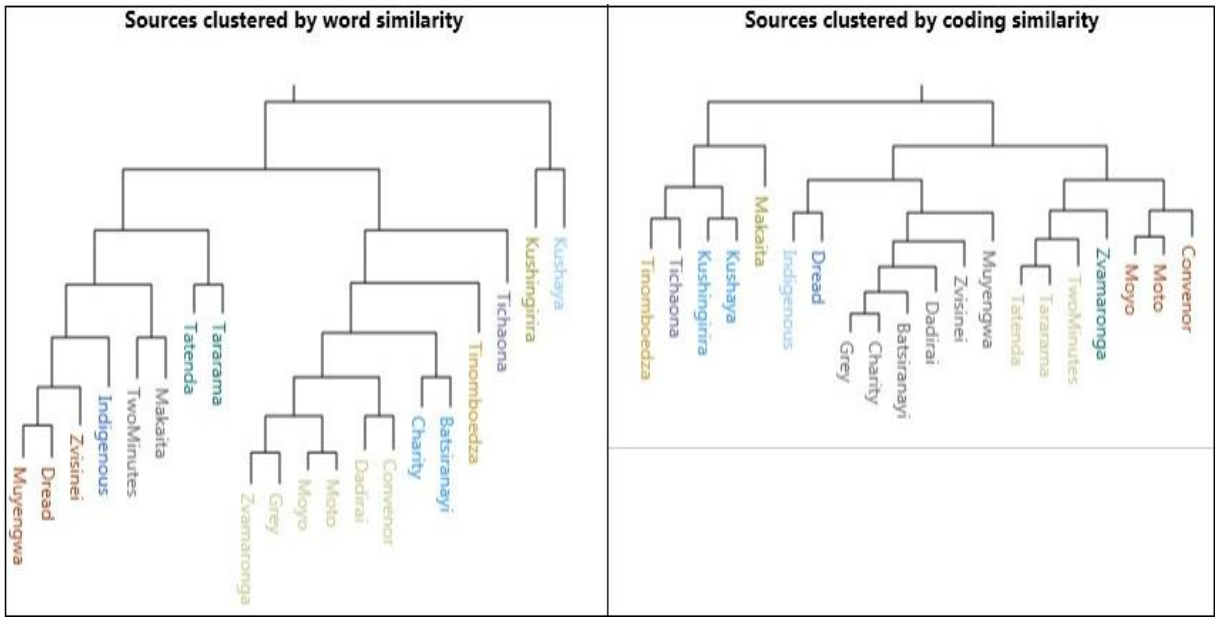

Figure 5.1: Word and Coding Source Cluster Analysis

The names (as shown in the cluster analysis above) and any other names used in this study in reference to PLWHA are pseudonyms; they were used for illustrative purposes only. Any resemblance to actual persons is unintentional. Interpretative Phenomenological Analysis (IPA) procedures guided the data analysis. Illustrations with anecdotes during discussions of results should not be perceived as repetitions but rather, various possible interpretations of the same or similar pieces of qualitative data.

5.2 DEMOGRAPHICS

A number of demographic variables were identified and these were not only results on their own but also provided strands on variations and centrality on some of the findings. Demographic information was used for NVivo classifications and this assisted as the classification attributes helped in creation of not only graphical charts but also comparative analysis. The majority of the respondents were females (Figure 5.2).

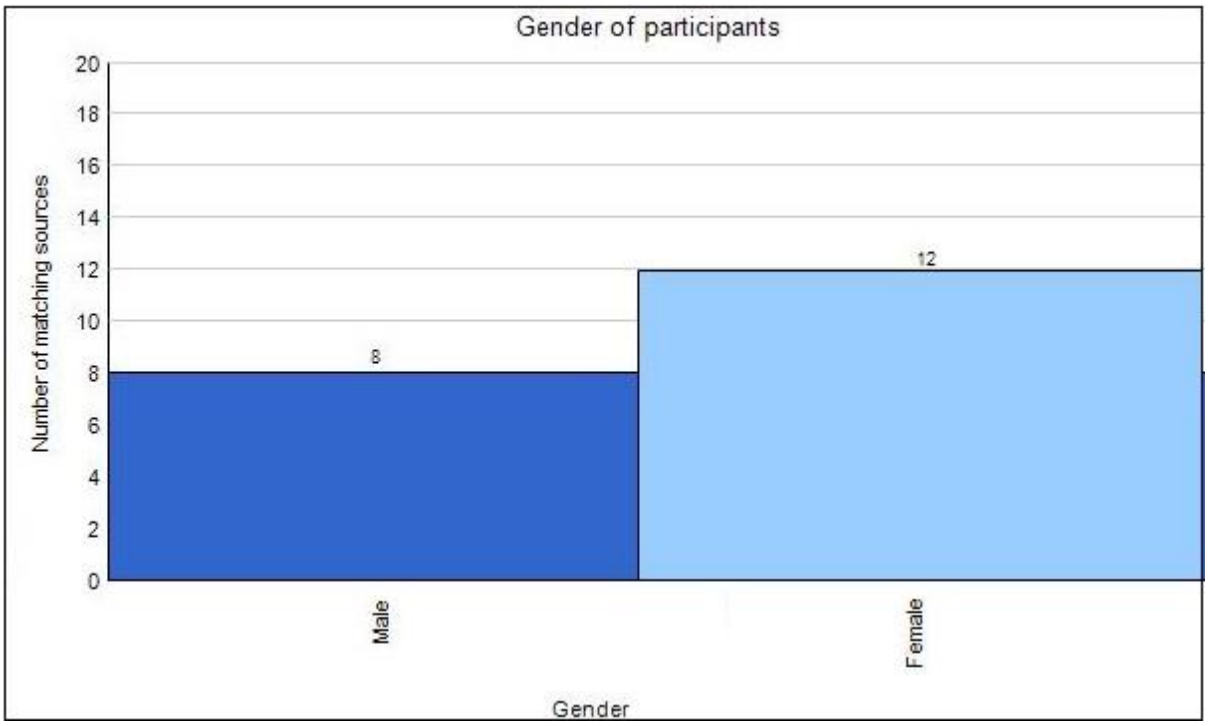

Figure 5.2: Gender

Participants were obtained through purposive sampling. Why is it that the referrals and snowballing yielded more females than males (60% versus 40%)? Could it be possible that females are more into TAM than males? Could it be possible that the males exhibit less health seeking behaviour than females? This demographic finding revealed more questions, and may indicate a variation on males and females not only on the use of TAM but also the health seeking behaviour in general. Most were also married (Figure 5.3). Widowhood was also quite prevalent. These findings can be further interrogated in future studies.

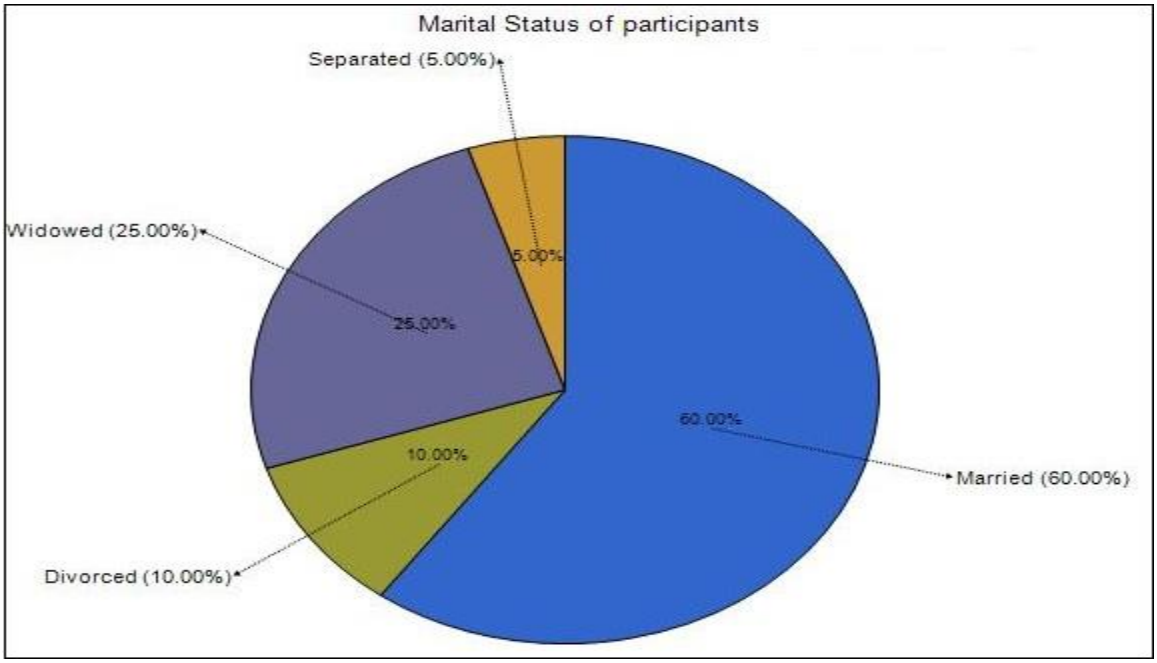

Figure 5.3: Marital Status

Those who were married reported that their partners were also using TAM. Widows were also common and it appeared as if widowhood was serving as a retrieval cue of the negative effects of HIV and AIDS, especially if the death of the partner was suspected or known to be linked to HIV and AIDS.

Most of the respondents were also unemployed (Figure 5.4) and this impacted on the issue of affordability, especially of conventional and traditional medicines, as it depicts an environment that might tempt one to go for the less expensive TAM.

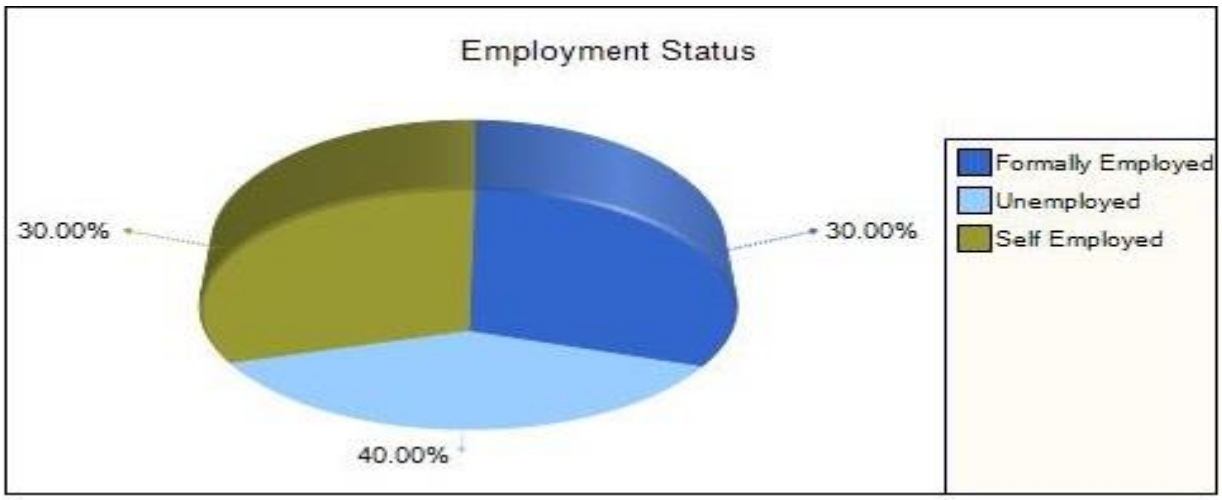

Figure 5.4: Employment Status

Most of the participants of the study had completed Zimbabwean Ordinary level Examinations (Figure 5.5), an observation that conforms to the high literacy rate in Zimbabwe in general (96%) (See ZIMSTAT, 2012, p. 67). The question raised, however, is how this conforms to health functional literacy?

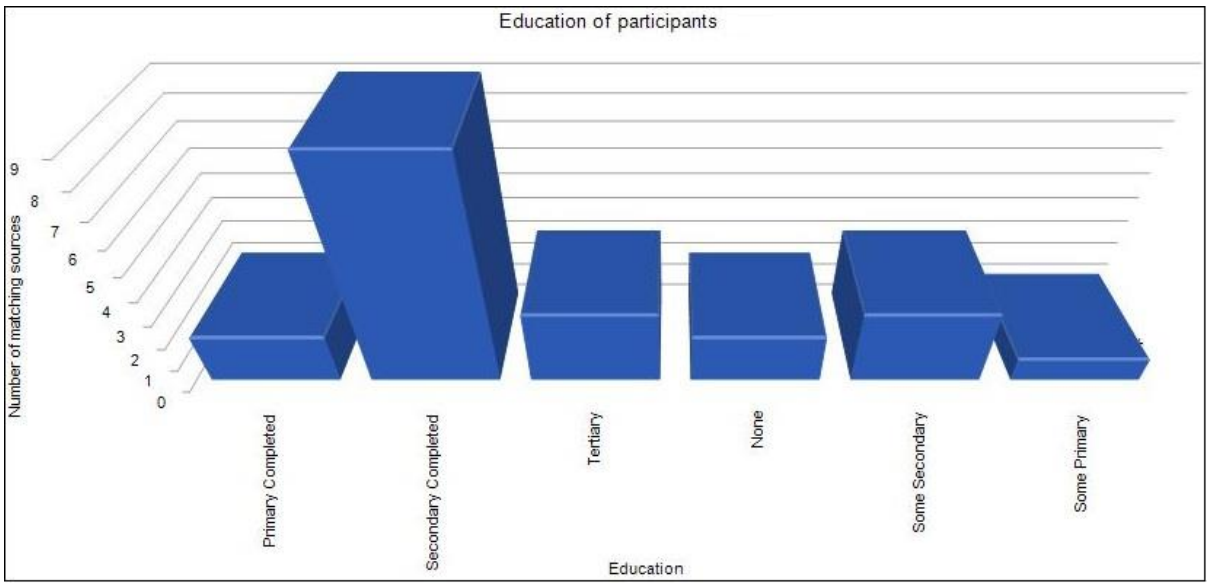

Figure 5.5: Education

Two was the mode for the number of children while 7 and 8 were outliers (Figure 5.6).

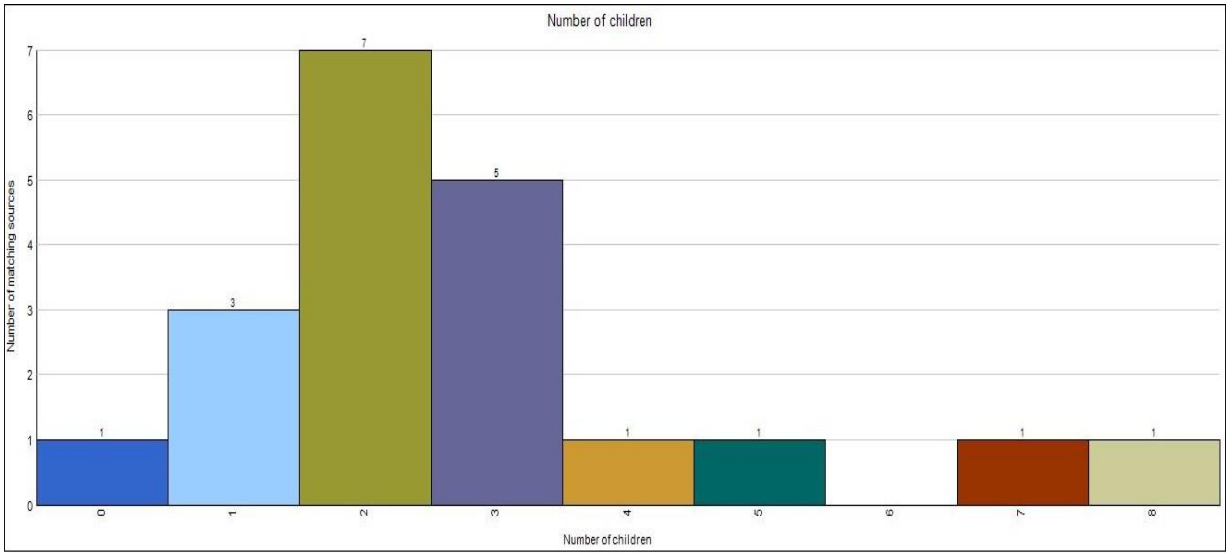

Figure 5.6: Number of children

Most of the study participants were born in rural areas (Figure 5.7);

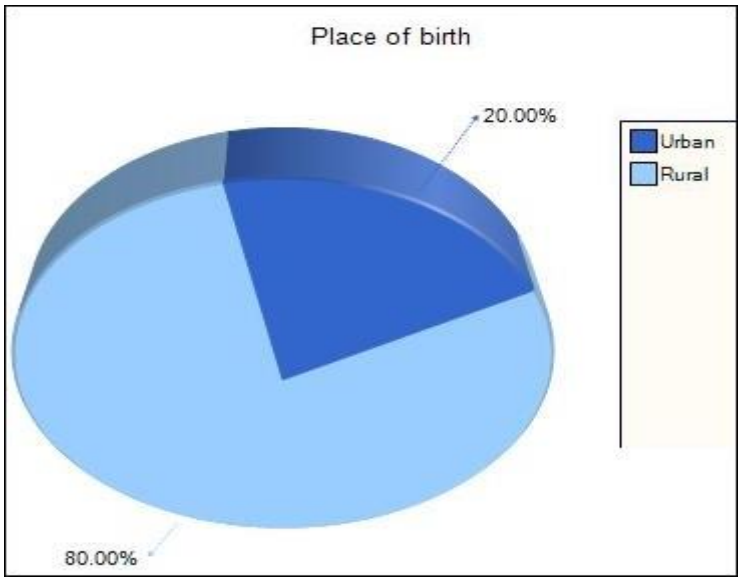

Figure 5.7: Place of birth

Most participants reported that they had used traditional and alternative medicine only and some had used TAM together with ARVs while others had stopped using ARVs altogether (Figure 5.8).

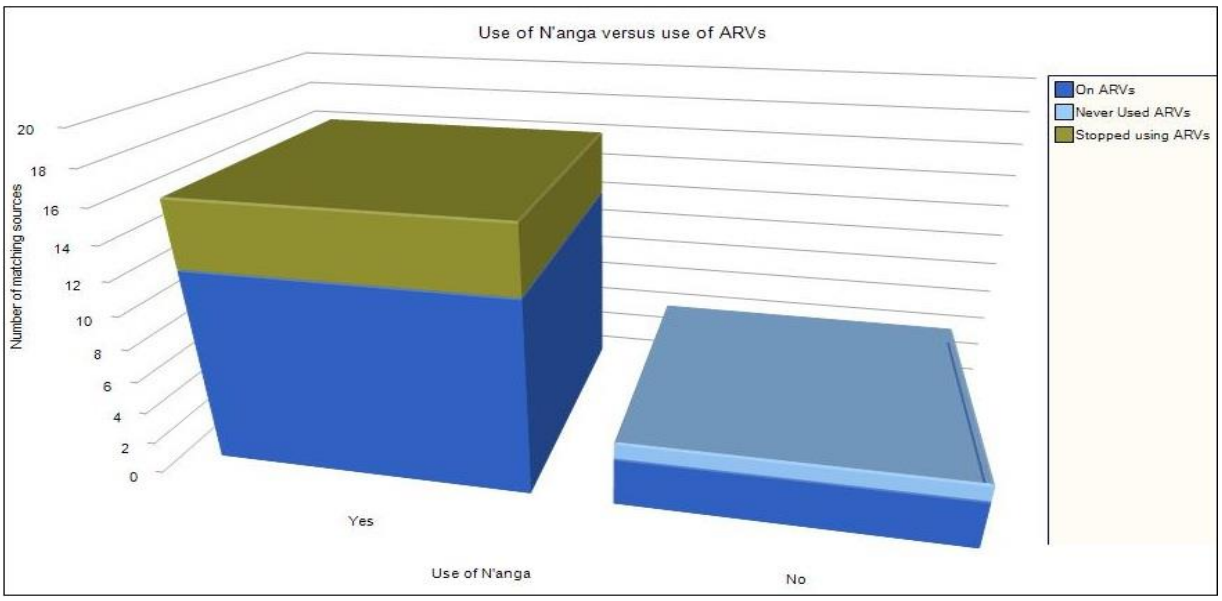

Figure 5.8: Use of N'anga versus ARVs

Very few reported cases of HIV positive children (Figure 5.9);

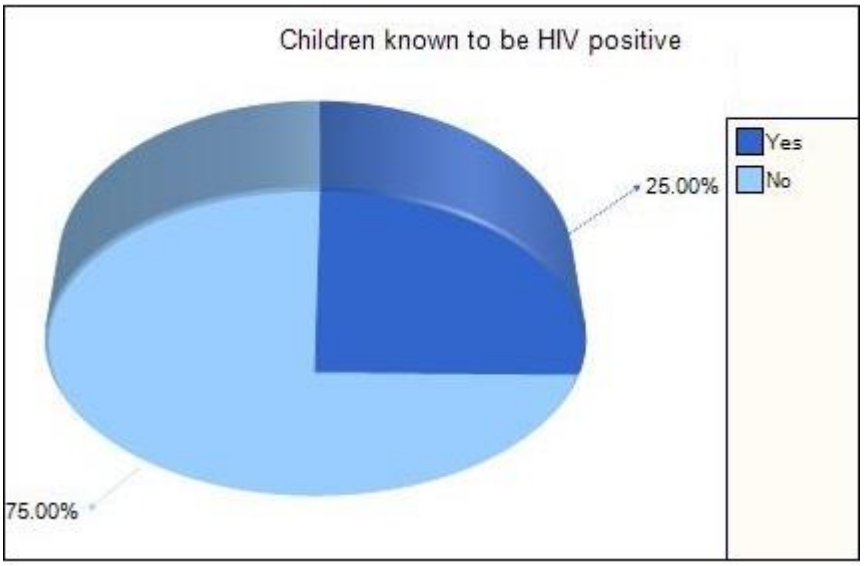

Figure 5.9: HIV status of children

The modal age of the participants was 41-50 years (Figure 5.10);

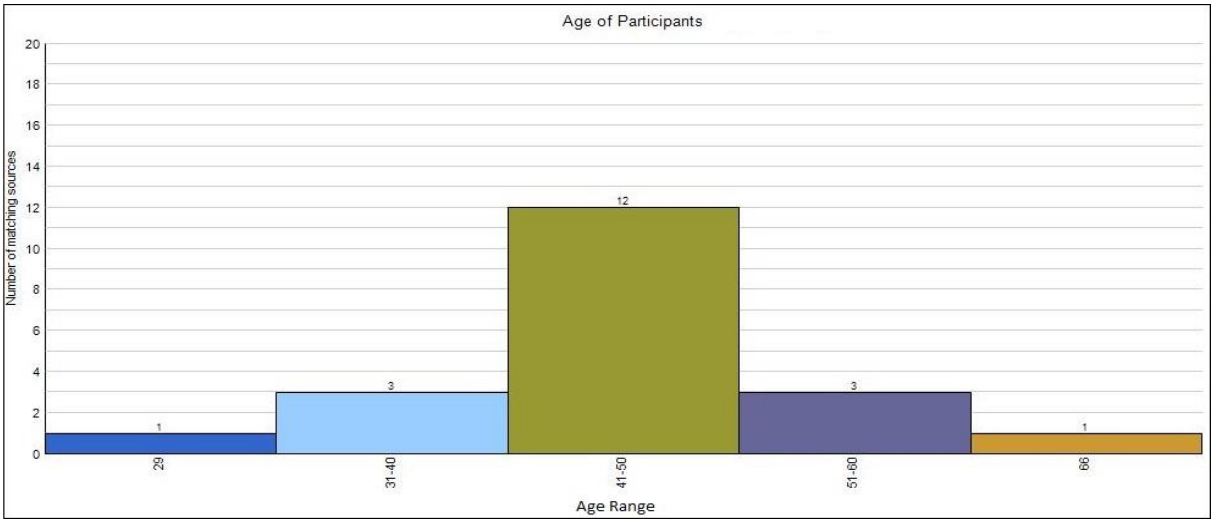

Figure 5.10: Age

5.3 FINDINGS

With the objective of exploring and describing perceived effects of individual and environmental factors, derived from IMB on motivation to use TAM by PLWHA, different themes exemplified and expanded some of the model's constructs. Below (Figure 5.11) is a model to show how the themes unfolded.

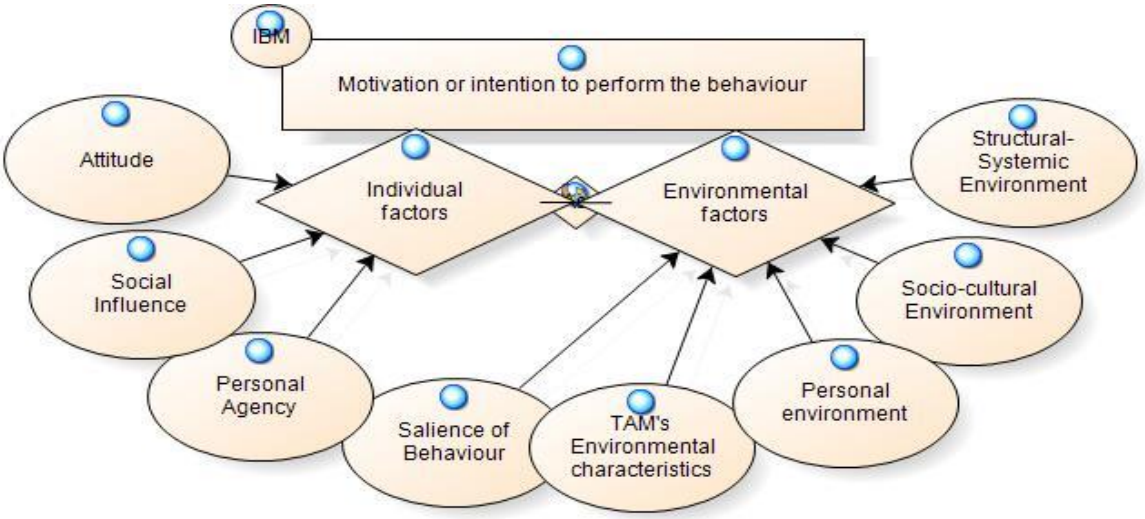

Figure 5.11: Summary of findings

Each sub-node was expanded. Individual factors were perceived as psychological motives that drove the individual to use TAM. As shown in Figure 5.12 below, three themes emerged;

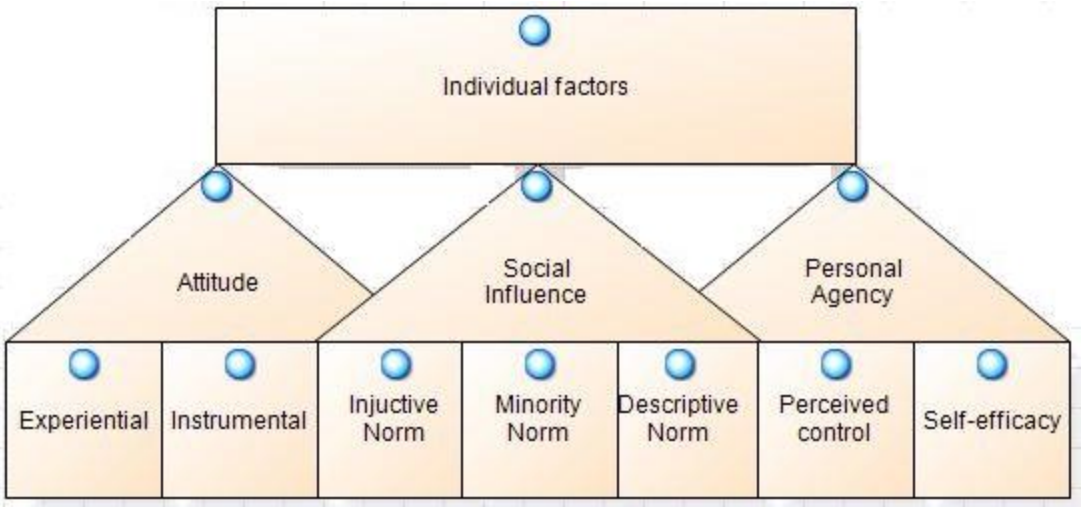

Figure 5.12: Individual Factors

5.4 ATTITUDE

As IBM constructs, attitude was contextualised as a person's evaluation of how favourable or unfavourable his or her use of TAM would be. This achieved the identification of orientations that locate objects of thought on dimensions of

judgement about the use of TAM. Experiential and instrumental attitudes were identified.

5.5 EXPERIENTIAL ATTITUDE

Experiential attitude was contextualised as an affective evaluation of perceived TAM use outcomes in terms of good or bad. Figure 5.13 below shows the glimpse of affect associated with personal use of TAM. Generally the respondents showed more perceived positive evaluations of the outcomes. Most of the participants revealed sustained and repeated use of TAM which spans from childhood.

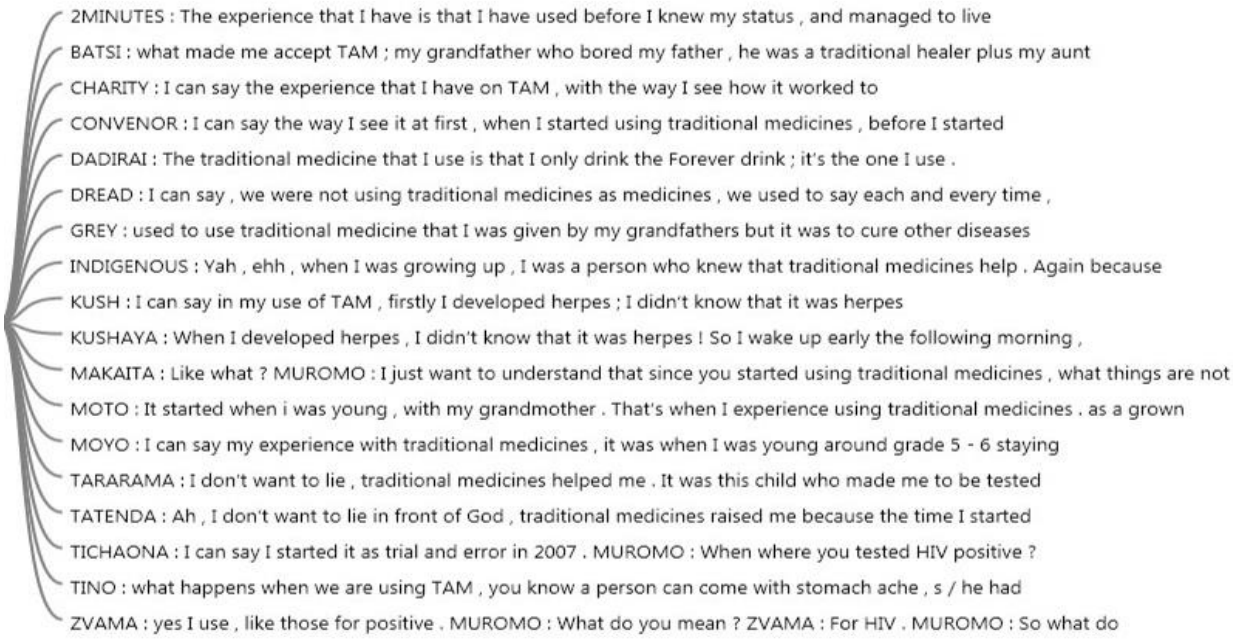

Figure 5.13: Affect associated with personal use of TAM

Although there were mixed feelings about the partners' use of TAM, many also reported positive feelings about the partner's use of TAM. Figure 5.14 below shows the glimpse of affect associated with partner's use of TAM.

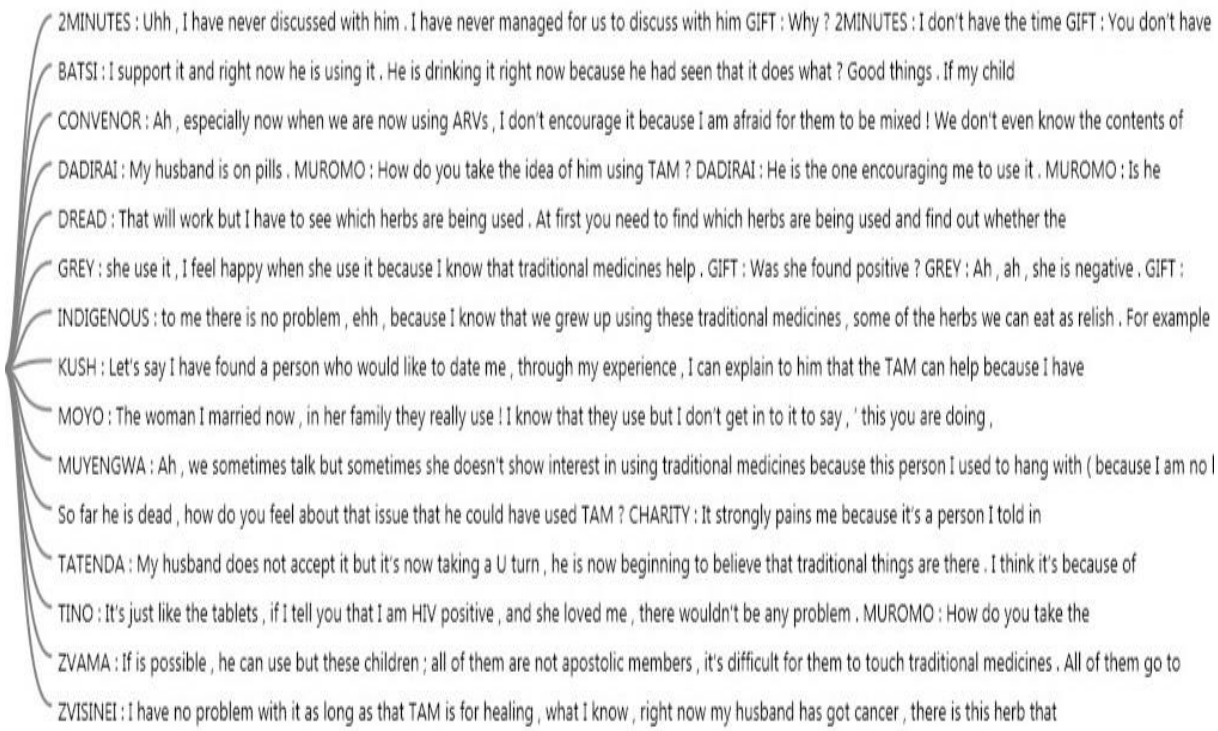

Figure 5.14: Affect associated with partner's use of TAM

Similarly, the thread of suspicion sprawled to the affect associated with children's use of TAM. However most participants reported quite permissible and positive attitudes about their children's use of TAM. Figure 5.15 below shows the glimpse of affect associated with children's use of TAM.

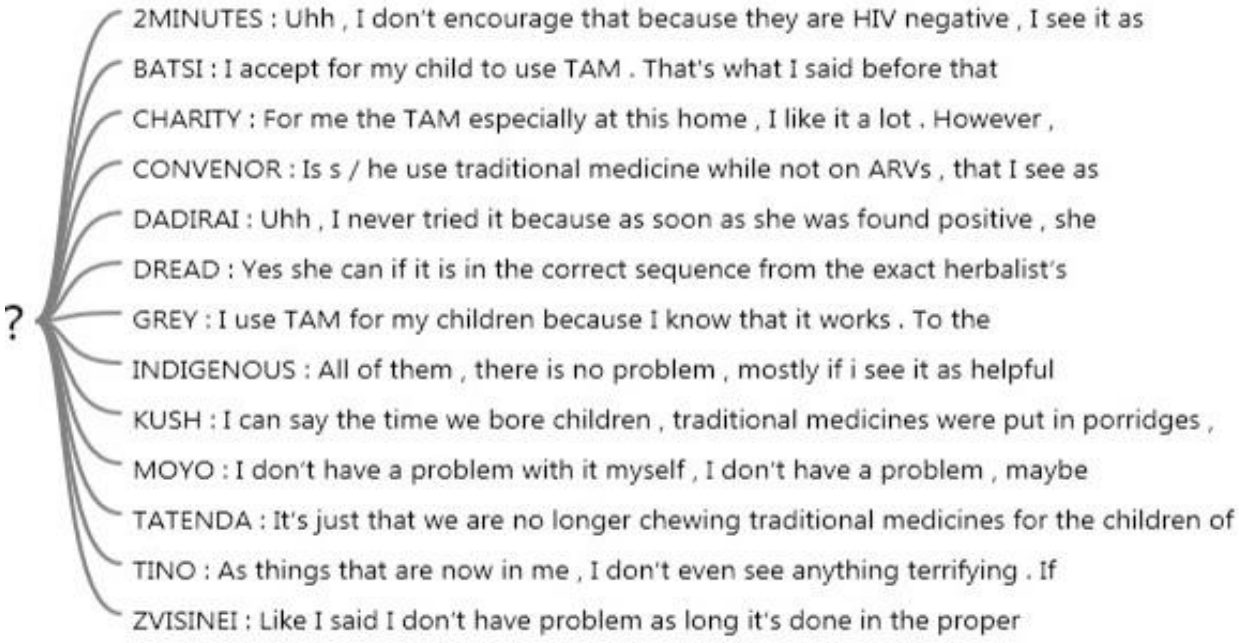

Figure 5.15: Affect associated with children's use of TAM

Engagement with the data revealed that the experience of these participants yielded not only positive and negative evaluation of outcomes. There were a number of other reported evaluations that seemed to be ambivalent and causing a lot of tension. Therefore, the comprehension of experiential attitude was found to be trichotomous rather than dichotomous (Figure 5.16).

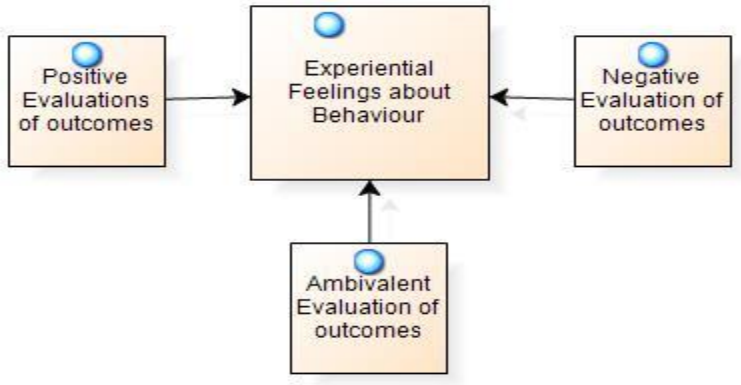

Figure 5.16: Experiential Attitude Model

While the positive and negative evaluations were easy and almost self-asserting, the ambivalent evaluations were difficult and appeared riddled with conflicts.

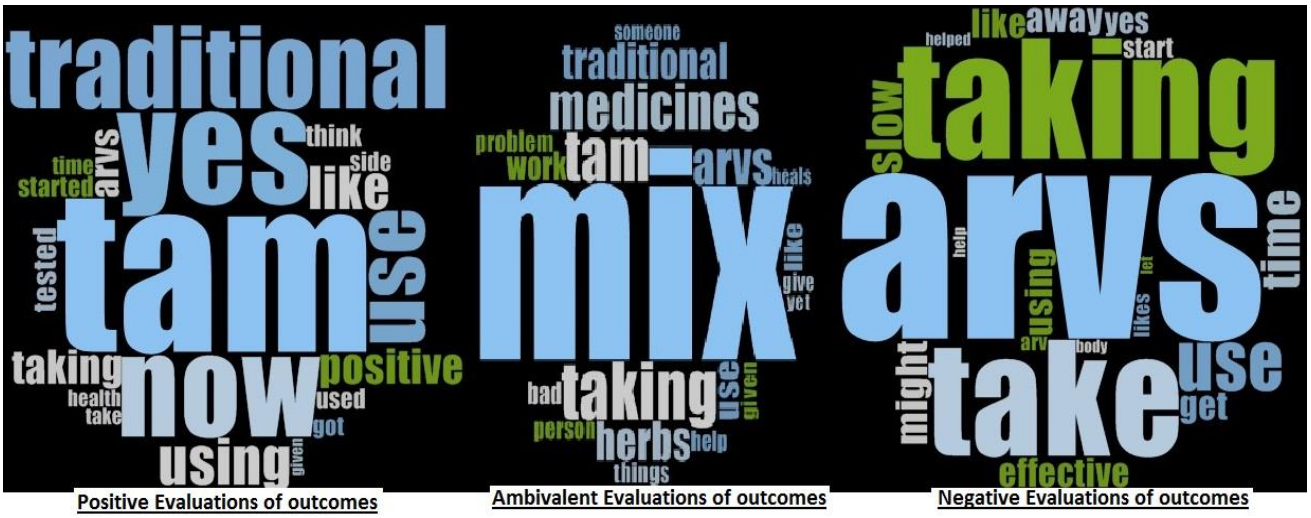

Figure 5.17: Clouds for Experiential attitude

As shown in the clouds above (Figure 5.17), participants reported positive evaluations in the sense of how good and healthy they feel and how they like using TAM. Negative evaluations were mostly seen in how they praised the use of ARVs rather than TAM. Ambivalence was also significantly registered as it portrayed elements of various conflicts regarding TAM and its relation and/or comparison to Contemporary Medicine (CM). Mixing was the indicator of ambivalence.

5.5.1 Positive Evaluation of Outcomes

For the positive evaluations, as shown in Figure 5.18 below, there was a positive affect associated with the perception of satisfaction with the outcome. These were reinforced and evident in observed emotional attachment to herbalists, subjective resourcefulness and pleasant affects associated with reluctant acceptance from Health Care Workers (HCWs).

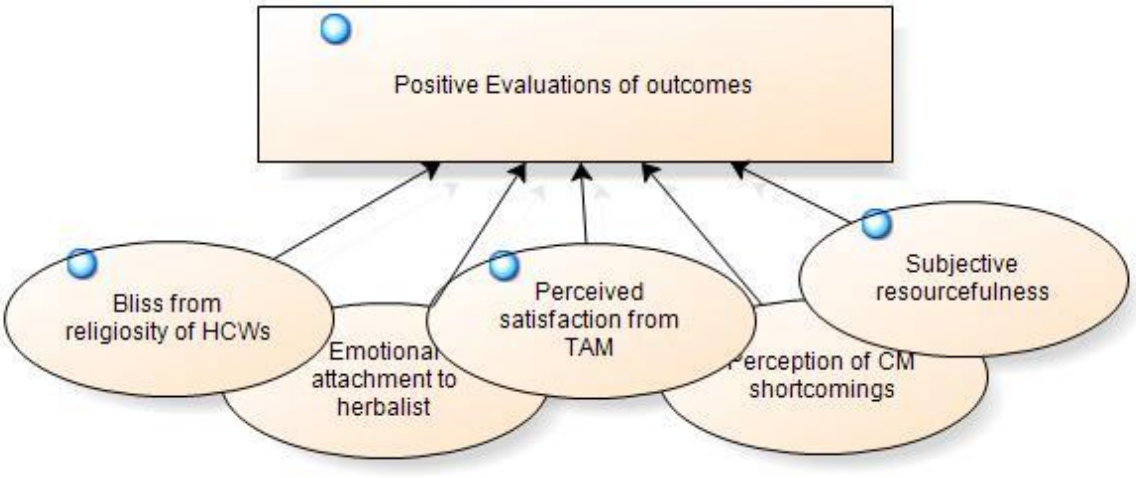

Figure 4.18: Positive Evaluations of Outcomes

5.5.1.1 Perceived satisfaction from TAM

There appeared to be a general sense of satisfaction as shown below;

ZVAMA: I feel better, its better… After using traditional medicines, I gain appetite and develop a strong craving for food. I even wake up strong and do my ordinary chores without problems. <Internals\\Audio\\Zvamaronga> - § 2 references coded [14.38% Coverage]

The health of those on TAM is better than those of people who take pills only. There is a clear difference, and you can easily distinguish a person who takes pills, and another on TAM. For the one who takes TAM, you wouldn't tell if s/he is HIV positive. You will be tempted to think there is something just unusual just troubling him/her…TAM…has a permanent cure. Our conventional medicines just treat the pain, but do not kill the virus. <Internals\\Audio\\Grey> - § 2 references coded [24.38% Coverage]

CHARITY: I was sick to the extent that I was no longer functional… I lost hope for life but TAM rescued me. <Internals\\Audio\\Charity> - § 1 reference coded [18.15% Coverage]

5.5.1.2 Perception of remarkable improvements

This satisfaction was reportedly experienced in varying ways.

Perception of remarkable improvements was a major one in which *negatisation effec*t, *normalisation effect* and *co-trimoxazole effect* were the common affectionate expressions. Participants reported that these perceived 'effects' motivated them to continue to use TAM. This is consistent with IBM's prediction that positive evaluations of outcomes positively affect the behavioural intention thereby increasing the probability of the behaviour.

Negatisation effect

Negatisation effect was contexualised as perceived negative and near-negative affective experiences characterised by the feeling that TAM literally aided in removal of the virus from the body. Standing out was the experience of Grey who purportedly eventually tested negative at a mission hospital (Name withheld);

GREY: I was given TAM by a traditional healer...I returned to the hospital… And I was found positive… I returned for the second time to that same hospital and I was found negative. I returned again to the hospital for the third and forth time and I was still found HIV negative…<Internals\\Audio\\Grey> - § 2 references coded [24.38% Coverage]

This purportedly happened also to his son and another friend:

GREY: For my son there (in wall picture) and Simon in Botswana…they went to be tested for HIV… and were found positive… they used traditional medicines… they went for HIV testing and were found negative. <Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

The other respondents also reported the near-negative-experiences as well. Batsiranai narrated her encounter with the doctor who was shocked with her results and almost said, '*could it be that you are negative?*' after s/he noticed that the improvement was beyond his/her experience with conventional medicines:

‘a-ah, what? Could it be that you are? Are these all soldiers (white blood cells) we are finding? They have reached a satisfactory level. What are you using?’ <Internals\\Audio\\Batsiranai> - § 4 references coded [21.35% Coverage]

Similarly, Charity suspected that if she continued to use TAM, her results would eventually test negative, she said;

CHARITY: My results, were due to reflect negative, and the doctors kept on examining me continually. You could tell that if I kept on using TAM, I will eventually test HIV negative. That would be a reality.. … Ah, from my observations, continuous use of TAM would end up eliminating the virus. Internals\\Audio\\Charity> - § 2 references coded [18.15% Coverage]

Zvamaronga also felt that continued use of TAM can lead to the elimination of the virus:

So if you go for your CD4 count, the chances are that one day you will be told that you are now HIV negative. The doctors would tell you to stop taking pills because you would have boosted the number of your soldiers (white blood cells). <Internals\\Audio\\Zvamaronga> - § 1 reference coded [19.19% Coverage]

Tinomboedza felt comparably negative as those said to be negative;

TINO: Ah, I do not have a problem; I am not different from a person who is HIV negative. I do not have problem, you may confuse me for a sickly person who appears HIV positive, but would in actual fact be negative. I may be having occasional health problems, but they would warrant me being bed ridden. <Internals\\Audio\\Tinomboedza> - § 1 reference coded [18.26% Coverage]

Generally there appeared to be a strong feeling that TAM could eliminate the virus in the body. While other’s experiences can be suspected to have been imaginary and maybe based on wishful thinking, Grey’s cases were extremely exceptional and raised questions beyond the scope of this paper. Not only was it raising more health seeking behavioural questions but also pharmacological underpinnings. What is clear is that the aspiration and reported acquisition of a negative status played a key factor in his

decision to use TAM. These reported experiences and perceptions can also influence others to use TAM. As mentioned earlier, pharmacological research on such drugs is essential to get a scientific position on the pharmacological actions of such drugs.

Normalisation effect

Related to the negatisation effect is the normalisation effect which is contextualised as the affective expressions associated with the feeling of being the same as others or indistinguishable. This perception creates a very strong motive towards TAM use because of the reported effect which deals greatly with issues related to stigma. People will be motivated to take TAM if the perceived effects are such that they do not appear ill after TAM use and thereby avoid problems associated with stigma, including segregation.

Grey reasoned that if a person is on pills alone he will be distinguishable, saying,

'*If a person is on pills only, you would notice that s/he is taking pills and is also HIV - positive. The one who takes TAM, you would not notice something unusual, but you would still be tempted to think that there is just something else troubling him/her*' (See reference above).

Similarly, others felt that TAM made them more normal. Batsiranai clearly stated that her state had deteriorated but TAM stabilised her and she could now do manual work like other women;

Even myself, I am now realising that I have recovered. I can go whereever I want to go. I also carry my *tswanda* (basket) like other women do. I can also spend the day jogging along the road (Sign of fitness), to my satisfaction. I can do all the family errands. I am now cooking and eating any food of my choice, without being unnecessarily selective like a sick person. This because I am now strong… the doctor said to me '…*Even if you want to carry a child (being pregnant); you are now able to, you can carry the pregnancy' …*initially I was given a period that I was not allowed to have a child. So far I have been given a go ahead to have a child. You see? So it means that TAM helps…I

was like a stick (very thin), when I had a walk, people would think that I would be blown away. Some would ask, '*is that person going to live up to tomorrow … will she ever survive?*' But I have seen that I have recovered to my normal health… <Internals\\Audio\\Batsiranai> - § 6 references coded [40.76% Coverage]

Not only was Batsiranai reporting working like other normal women but also was now able to reproduce like other normal women. This assertion was further substantiated by Convenor who revealed that her reproductive success was comparable to those who are considered to be healthy;

CONVENOR: When I went for my CD4 count, it was high. But I wasn't feeling sick nor where any signs showing. I even breastfed my child for six months without taking any medication and my child wasn't even infected and even the results came out negative… This means my soldiers that fight diseases (white blood cells) were strengthened by the use of traditional medicines<Internals\\Audio\\Convenor> - § 2 references coded [8.92% Coverage]

Kushingirira also reported that she felt that she was just functioning normally;

I feel comfortable with myself, quite strong and don't have a feeling anything can go wrong within my system, or there could be something that might cause me problems. I just feel fit. As you can see the involving work I perform. I do cook using these big pots mabhodho (iron or chrome pots). It is a difficult and hard job but I can cook using these mabhodho, cleaning the utensils, cooking much of the day until we finish, be it around 9pm or 10pm. We spend most of the time standing doing our job. <Internals\\Audio\\Kushingirira> - § 1 reference coded [26.12% Coverage]

Kushingirira used Mabhodho metaphorically to signify normality. The metaphor was used to emphasise the satisfaction with TAM. Batsiranai also metaphorically referred to '(*a place I was seated all days) my usual undisturbed normal state*', appearing to imply the normalisation effect of TAM. To her it now seemed as if nothing happened (she never got sick). She also felt that her frequency and type of infections were highly comparable to those in good health. It can be seen that Batsiranai has a strong intention

to continue using TAM, a finding that is consistent with Fishbein (2000)'s observation that attitude is a strong determinant of behavioural intention. This experiential attitude seems to be deriving from perceived feeling of satisfaction from using TAM.

Batsiranai used the stick as a metaphor to exaggerate the state of her deterioration in order to emphasise her satisfaction with the normalisation effect of TAM. Zvamaronga also used the sugarcane to emphasise the same satisfaction:

ZVAMA: I keep taking TAM because it is helping me because my new condition was significantly different from my previous sickly state. I was thin and wasted. My hand was like that of a sugarcane there (body as thin as sugarcane), but I am seeing that it is helping me. <Internals\\Audio\\Zvamaronga> - § 2 references coded [19.19% Coverage]

Generally use of TAM appeared associated with the crossing-back effect in which they felt normal again. There were euphoric reactions to this crossing back as they felt like they were closing the stigma gap and becoming more like others. The reported feeling of being comparably the same as others, especially in appearance and activities they engage in, seemed important in making the decision to continue using TAM.

Co-trimoxazole effect

Co-trimoxazole effect was subsumed as the affective expressions associated with the feeling of major improvements that would suffice for one to be recommended to be removed from more rigorous medical treatment and maintained on co-trimoxazoles. In a way, co-trimoxazole was used as a measure of wellness from the most deteriorated state of HIV. It was seen as a safe zone. Generally, it was evaluated as good to be maintained on co-trimoxazoles. Therefore, co-trimoxazole effect was conceptualised as the delightful affective expressions associated with the return to and maintenance of the use of co-trimoxazoles. There was a feeling attached to co-trimoxazoles, especially if one remained on them or if one was reversed to them. Batsiranai illustrated the co-trimoxazoles effect below:

My doctor said, ‘Right. If you are using TAM, we are now weaning you from pills because the way you have improved means that the TAM you are using is helpful. They removed me from the stronger pills I was taking and gave me co-trimoxazoles. Since 2010 I am taking co-trimoxazoles. I run (go) to Chaka (the traditional healer) to take TAM. So far she has dropped the dosage for me. I used to take thrice and she said, ‘ah, now we are reducing the dosage because your doctors statements suggests that you have recovered.’… I now do not take them regularly because I have been removed from the pills I was using and put on co-trimoxazoles because the doctor was happy. Recently when I visited the hospital for a review, my CD4 count was very high that is when the doctor said that I could now even get pregnant… <Internals\\Audio\\Batsiranai> - § 3 references coded [40.76% Coverage]

Batsiranai felt being ‘*dropped*’ and ‘*weaned*’ from ARVs this reinforced her to her ‘*run*’ and to keep on running to Chaka (the traditional healer) for more TAM. The same co-trimoxazoles effect was revealed by Grey;

That was when they said to me, *‘What we are now doing to you is that we are now giving you co-trimoxazoles only, you no longer take ARVs.’* My child and Simon were also removed from ARVs to co-trimoxazoles.<Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

It appears as if the patient would then like to continue surprising the doctors with this reported TAM-based improvement and come for reviews to confirm their claims. Co-trimoxazoles help measure the progress being made in the use of TAM. Based on, this Dadirai strongly expressed that she would never start using ARVs. She reported to have never used ARVs; she felt that she had only deteriorated to the co-trimoxazoles, which sometimes she advised others to stop using. That perception made her feel safe:

DADIRAI: Ever since I knew that I am positive in 2010, I started using TAM. I was put on co-trimoxazoles. I used cotrimoxazoles only and I delivered this child (pointing to her child) and I was advised to stop taking them. When I stopped, I was put back on co-trimoxazoles and I used those co-trimoxazoles. After taking co-trimoxazoles I was

stopped again, so far I am only using that drink and those relishes (referring to TAM). <Internals\\Audio\\Dairai> - § 1 reference coded [20.44% Coverage]

Dadirai attributed her maintenance of pre-cotrimoxazoles affect and/or co-trimoxazoled affect to her repeated use of TAM and her life style.

Clearly, therefore, it seems that participants view the co-trimoxazole effect as a pleasurable affect used to measure the sense of security to be felt as it helped to estimate HIV deterioration. Therefore, the feeling of the co-trimoxazole effect was comparable to feeling safe. Such a blunt and seemingly illogical heuristic seemed to have been yielding not only repeated use of TAM but also more positive living and more proved attractive than being told precise numbers and figures such as CD4 counts. Such perceptions appear not only to sustain the use of TAM by PLWHA, but also to direct health-seeking behaviours of others towards motivation to use TAM.

5.5.1.3 Perceived efficiency and permanency of TAM

The positive affect associated with the perception of TAM efficiency and permanency both in relation to the elimination of the virus and the treatment of opportunistic infections was reported. Charity said:

So when she (traditional healer) was giving me all those TAM I noticed my condition improving. She also had TAM that she said it is for the virus. Myself, I realised that TAM was effective in fighting the virus because ever since I started to take the TAM, I never got bed ridden… <Internals\\Audio\\Charity> - § 1 reference coded [18.15% Coverage]

Grey also felt that unlike conventional medicines, TAM does not heal in parts, it heals for ever:

GREY: Because if it is a disease it would be healed permanently. These conventional medicines…heal but temporarily. It only relieves the pain but it does not treat. However, our traditional medicines treat permanently.<Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

This supposed instantaneous and complete treatment was also reported by Kushingirira and Zvisinei:

Even if you have a sexually transmitted infection, even genital warts, skin disease, if you rub TAM it would disappear. Even cancer; if you rub TAM before you are injected or cut, it would be treated. <Internals\\Audio\\Kushingirira> - § 1 reference coded [4.97% Coverage]

ZVISINEI: It is a herb, if you chew it, ah, it heals instantly. It is very bitter but if you chew and swallow, the last you release out (with a running stomach) will be the last time (diarrhoea will stop); you will never run again, so those are the types of herbs that we normally use… Then, there is what I like most on traditional medicines, its effect, unlike antibiotics, is instant...<Internals\\Audio\\Zvisinei> - § 3 references coded [32.52% Coverage]

Batsiranai also felt that treatment from TAM is permanent and does not 'expire' in the body:

BATSI: Eh, what happens with the conventional medicines is that, sometimes we are given medicines that expire. There are some pills that are said are supposed to be taken after every 24 hours. If they are finished you go back again to collect more. Sometimes I would not have the money to go back to see the doctor who also has to be paid consultation fees. However, when I get TAM, I know that will be long lasting…<Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

It appears that in addition to perceptions of TAM treatment being relatively cheaper than contemporary conventional medicine, its effects are perceived to be relatively longer lasting or permanent as compared to CM. The issue of reported affordability can be another major motive towards TAM use in Zimbabwe, especially considering the current hard economic times being experienced in Zimbabwe resulting from the general macroeconomic decline.

Batsiranai believes that TAM stays in the blood forever. The permanency of TAM was also reported by Two Minutes whose STI and child's incessant flu and coughing were hard to clear using conventional medication until she used TAM:

I tried CM, in some of the areas, ha, it did not work. It refused to work. I would only recover for one week only, and it would recur. That is when I realised that, I did not know my status, it used to recur and disappear repeatedly, that's when I started using the traditional medicines. It never recurred again.…Ah. Ah. that one is effective (TAM), it is excellent because at the hospitals you can be given drugs that might take a week to heal that flu. I experienced it when the child was coughing, incessant flue in June. The child was given tablets, antibiotics to drink from the clinic, but it didn't heal. Last minute I boiled some herbs and gave her to drink. I saw the flu weathering and vanished. <Internals\\Audio\\TwoMinutes> - § 2 references coded [22.81% Coverage]

5.5.1.4 Perception of absence of side effects in TAM

There were also some positive affects associated with the perception of a lack of side effects, ability to overdose as well as allergies in TAM, hence unlike ARVs, you do not necessarily have to keep it beyond the reach of children;

It is also rare for a person to be allergic to TAM, it is rare to find such a person, and I have never heard of a person who says I have had side effects after taking TAM… I can drink pills, and it's easy to take an overdose of the pills. However, even if I pour the whole pocket of TAM, it will never damage me. There is never an overdose of TAM. It might even add me more blood, if it is designed to assist my blood levels.… It is a type of medicine that could be left in the open. It wouldn't affect or harm a child, even if it were to be taken raw. It would even improve the health of the child. There is nowhere it can affect the child's health but it is not poisonous..... I have my youngest child, she is not here, and she has gone somewhere. There is some TAM I left within her reach, like I said before; I have done it a number of times. She is that type of a child who does not want to miss anything; she would want to find out more about anything new that comes within her reach or sight. I returned to find that she had taken all of my TAM and drank and finished it all. It is sweetish, I do not know what she thought it was, and she poured

it in a cup and she drank and finished it. There was no time she slept or fell sick. <Internals\\Audio\\Charity> - § 4 references coded [9.29% Coverage]

This was perceived as good compared to 'modern' medication which has age restrictions, strict dosages and usually warns to keep out of reach of children and can have adverse effects if overdose occurs. This revelation also implies a perceived positive evaluation of TAM-use that has a direct influence on the behavioral intention to continue to use TAM instead of ARVs.

Dread and Makaita also reported the absence of side effects:

I have a feeling it is healthy. It is so healthy to the extent that the side effects found with ARVs are not there in herbs. <Internals\\Audio\\Dread> - § 1 reference coded [12.07% Coverage]

MAKAITA: These days when we are already adults it's being said that traditional medicines are causing diseases such as cancer, and other diseases. I do not know understand this, and I don't agree because I grew up using these things. I have not had any side effects from traditional medicines since I was young. If I had stomach ache, I looked for herbs for the stomach ache and drank, I have not had any problem. <Internals\\Audio\\Makaita> - § 1 reference coded [15.04% Coverage]

Moyo also believed that TAM worked efficiently in the body;

The advantage that I heard is that TAM comes out of your system, TAM does not stay, TAM does not have side effects, after finishing its work it gets out, there is no residue left inside… <Internals\\Audio\\Moyo> - § 3 references coded [13.03% Coverage]

Tatenda and Zvisinei also denied ever hearing of the side effects;

TATENDA: If we consider side effects on TAM, yes they might be there, here and there but I have never heard of any <Internals\\Audio\\Tatenda> - § 1 reference coded [10.28% Coverage]

ZVISINEI: I think, I see as if, basically, there are no side effects, no side effects at all. I have not seen any... Whether it is more or less, but the good thing is that if you take more, it does not have side effects like the one from the modern medical side, if you have taken overdose, the excess can treat other illnesses, ahh.<Internals\\Audio\\Zvisinei> - § 2 references coded [18.98% Coverage]

5.5.1.5 Perception of superiority of TAM over CM

TAM was also believed to be superior to some conventional medicines (CM), including ARVs. An intriguing finding was of the reported case by Charity who stated that her husband died because he refused to use TAM, insteaed religiously sticking to ARVs;

CHARITY: …TAM is working better than ARVs for me… And there is no one who knows that I am affected to date, because I never got sick since that time I started taking TAM. I can say my husband (who was on ARVs) is the one who used to have big problems but as for me I never had any problem.

GIFT: So you started using TAM when your husband was still there?

CHARITY: Yes, and he refused and said, *'I am drinking pills (ARVs).'…* he died taking those pills like that…So I am seeing that the herbs have far much better health…<Internals\\Audio\\Charity> - § 4 references coded [18.15% Coverage]

Charity strongly registered regret. She seemed to strongly feel that had it not been that her husband refused TAM, he would have been alive today. To Charity (who reportedly reacted to ARVs), TAM was superior to ARVs. Similarly Batsiranai also felt that TAM had more healing properties than CM, which she perceived as only a *'booster'*:

The pill boosts us but they are not 100%, some of their healing properties have been removed (referring to the tablet making process). On the other hand TAM has the raw *muti* (herb)… So you quickly heal if you use TAM… <Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

Two Minutes also expressed his feelings that TAM is more effective than CM in fighting opportunistic infections:

GIFT: So if you compare these herbs to other pills other than ARVs; for example taking ARVs and Ndorani (type of herb) how does it compare with taking ARVs and pain killers? Is it the same or the other is more effective than the other?

2MINUTES: It is more effective

GIFT: Which one is more effective?

2MINUTES: Taking ARVs and Ndorani

GIFT: Are you saying these herbs are more effective than other conventional medicines other than ARVs?

2MINUTES: For me they work better. <Internals\\Audio\\TwoMinutes> - § 1 reference coded [10.74% Coverage]

5.5.1.6 Perception of life in TAM

Overall, there was a perception of well-being and sustainability of health in TAM. Coded raw in-vivo, this theme was subsumed to capture the positive affective assertions in relation to well-being, longevity and health associated with TAM use. Tatenda succinctly said, '…*we are saying there is life in traditional medicines*…' Yes, the allusion of 'life' in TAM can be said to have been what emerged in all the positive evaluations. As a result this theme can help to concisely capture the affective assertions and the strength of their emotional rooting to the positive evaluation. This reflects a positive experiential attitude towards the use of TAM. This supports Cooke and French (2008)'s findings in their meta-analysis of 33 studies when they documented that attitude has the largest relationship with intention, followed by subjective norms and perceived behavioral control. However, there were moments when some participants stated this belief more directly than others such as when Zvamaronga outrightly regarded '*going to hospital*' as a waste of time, and she indicated "*most people*":

ZVAMA: There is nothing I can say about this one because all of them are helpful; most people say that going to the hospital is a waste of time. You would see a person getting well with these traditional medicines.<Internals\\Audio\\Zvamaronga> - § 1 reference coded [19.19% Coverage]

The idea of 'life' and maintained life was also insinuated in how TAM would keep the body strong, as shown in the text query (Figure 5.19) below:

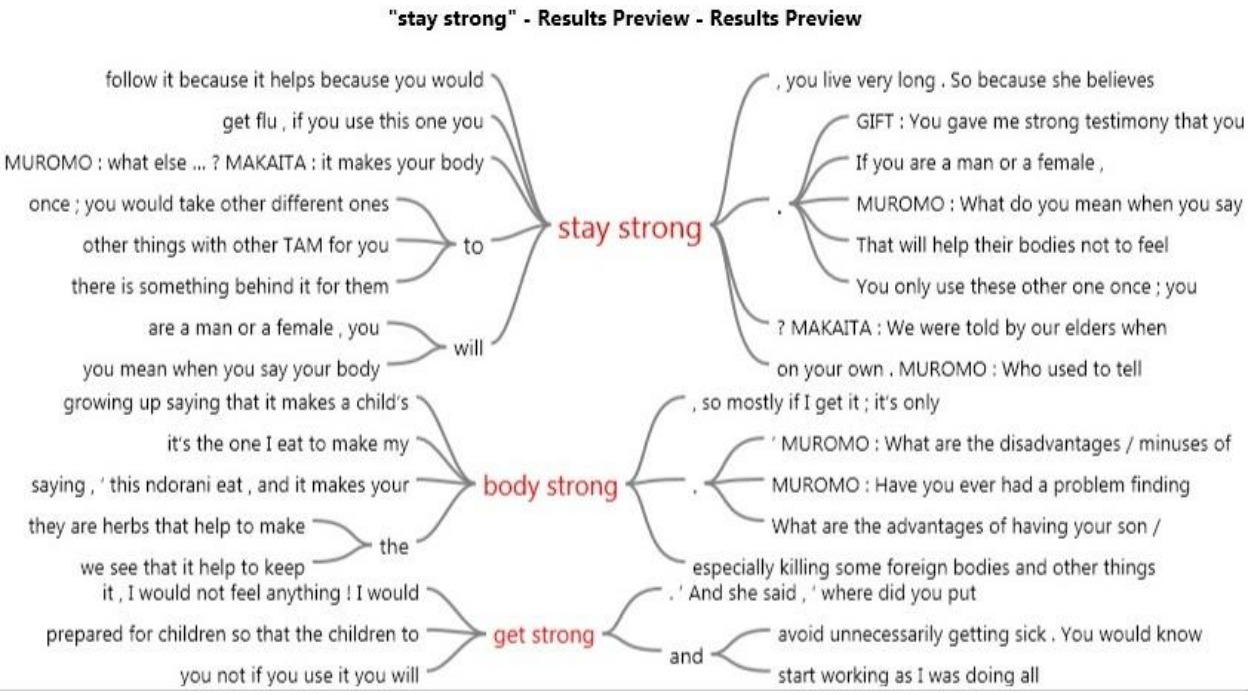

Figure 5.19: Text Query for Stay strong

This strength was also associated with longevity as Tinomboedza revealed below:

…if you use traditional medicine; there are those elderly people, if you look, even in your clan, if you look at my father, he is now elderly, I can say around 80 or 70+ years old, but you would see him walking straight. However if you look at people of our ages, we are now like broiler chickens that are used to eating soft foods. But if you look at them, they ate traditional medicines, herbs, they took even the *mazondo* (cattle hooves), and you would see them even mixing *mazondo* with traditional medicine in the cooking pot. So TAM strengthened their back muscles. <Internals\\Audio\\Tinomboedza> - § 1 reference coded [13.90% Coverage]

Because of this perceived strength and effectiveness some ended up over-straining themselves and testing the limits of their healing by engaging in compensatory work:

…if you do a lot of work due to the excitement of having a healthy body, like I did, the temptation to become to do very difficult tasks is high that would end up causing painful side effects. Like this rainy season, there is plenty of work. I was doing lumps for sweet potatoes and this and that. You cannot fail to feel pain when you spend the day making those lumps, but you would know that this is only the pain due to the work one did.[1]<Internals\\Audio\\Batsiranai> - § 1 reference coded [19.41% Coverage]

Due to this apparent derived realisation and satisfaction, some of them aspired to and were highly motivated to sustainably continue to use TAM:

CHARITY: So far I am expecting to strongly keep on taking it so that my health will be boosted., I expect to eat it because it is strongly helping me improve my health. <Internals\\Audio\\Charity> - § 1 reference coded [18.15% Coverage]

5.5.1.7 Perception of CM shortcomings

The positive evaluation of TAM was also implied in the negative evaluation of CM. Although the evaluations where understood as a trichotomy; in which this aspect was relevant in the formulation of conflict-relevant constructs for ambivalence; the shortcomings of CM seemed to reinforce the motivation to use TAM. This was even more emphasized when TAM was perceived to help alleviate the perceived shortcomings of CM. Allergies (side effects) of ARVs, assumption of being sick on CM, monotony in the use of CM, 'unnecessary formalities' in CM and failure of CM in other ailments, were the most cited shortcomings among which allergies (side effects) were the most popular. Figure 5.20 is a cloud on the perception of CM shortcomings:

Figure 5.20: Cloud on the perception of CM shortcomings

A number of the respondents seemed to have tried the ARVs and other concomitant CM and experienced some side effects and allergic reactions:

I think I took pills for one week and I was allergic to them…She said, *'I am having a problem with pills, this and that.'* and I said, '*I have Mbuya* (referring to a female traditional healer*) who helped me, she uses TAM, I do not know if you can come?*' She came and I went with her, she had more problems because she was having a running stomach and vomiting so the traditional healer started by giving her TAM to stop the running stomach. After giving her that TAM, I think she used it for three days and she stopped the running stomach and vomiting. She started giving her the TAM courses.<Internals\\Audio\\Charity> - § 2 references coded [18.15% Coverage]

DREAD: ... It is so healthy to the extent that the side effects found with ARVs there is none with herbs.<Internals\\Audio\\Dread> - § 1 reference coded [12.07% Coverage]

… I have used cotrimoxazoles, when I used them I reacted badly, I got sick and got admitted in hospital… my eyes were damaged… I even ended up quitting my job…<Internals\\Audio\\Muyengwa> - § 2 references coded [16.61% Coverage]

So my CD4 count had really dropped, they had tried me on the first line, it failed, second line, it failed and I was being told to go on the third line.I got stressed with these reactions. My hair started falling off, my nails turned black... So I was taken by this

Mbuya (traditional healer) and she put me on her traditional medicines and my hope was restored. <Internals\\Audio\\Tatenda> - § 2 references coded [25.73% Coverage]

ZVAMA: If I use these pills, I would get sick, sometimes developing wounds in the mouth. However if I use only traditional medicines, I feel getting better. Internals\\Audio\\Zvamaronga> - § 1 reference coded [14.38% Coverage]

Therefore, in this case, it can be inferred that the use of TAM appears to be an escape behaviour that was conditioned by the aversion from CM. The aversion caused a negative evaluation as it caused a negative affective outcome (unhappiness). TAM appears to have offered an escape window, whose veracity might be insufficiently scrutinised. Notwithstanding the (in)sufficiency of the scrutiny, the presence of the 'window' seemed to be directing these escape behaviours towards TAM which was perceived to be vicariously succeeding, at least in the perception of its efficacy and efficiency. This apparent social learning process might vicariously reinforce the initiation and continued use of TAM from parents to children, including non-family members who might have had the opportunity to observe and share the positive evaluations and perceptions of TAM use.

The perceived escape behaviour is also reinforced with the assumption of a sick role in CM:

DREAD: Taking TAM is like taking relish, you do not feel that this time I am taking medicine as what comes in your mind when you are about to take ARVs. There will be a kind of fear when you are about to take ARVs, some even say they have a prayer, they pray before they take every ARV, every time they pray. This means they are praying twice per day. Some… say we give a prayer to that tablet before taking it.<Internals\\Audio\\Dread> - § 1 reference coded [12.07% Coverage]

The conscientiousness and orderliness required in the use of ARVs was perceived to be too demanding to be maintained for an entire lifetime. It requires times, daily, that one needs to remind oneself that you are sick as the time approaches, you have to play the sick role and repeatedly do that for the rest of your life. Dread associated the pill taking

time is compared with prayer time, revealing that pill time is associated with a moment of reflection and review of the probabilities of the success of the pill. This can be conjectured to be leading to anxiety and mood shifts. This seems to reveal a negative evaluation of the ARVs, subsequently leading to the negative experiential attitude predicted by the IBM and the reasoned action approach to negatively affect the behavioral intention to use ARVs. Associated with this derogation of the assumption of the 'sick role' is the monotony alluded to by Grey and Muyengwa:

…because when you are HIV positive, eh, you keep on taking medication every day. If you stop you would fall sick. …with these traditional medicines, you would not continue using the HIV treatment for the whole of your life…You only use it once; you would take other different ones to just stay strong. <Internals\\Audio\\Grey> - § 2 references coded [30.94% Coverage]

For me to keep on taking other antibiotics out there, it is difficult to keep on taking them every day. <Internals\\Audio\\Muyengwa> - § 1 reference coded [11.96% Coverage]

In their response, Grey and Muyengwa used an exclamatory perpetuity, '*every day*'. This shows that the repetitiveness is monotonous. As a suffix to his exclamation, Grey also insinuated that this monotony is difficult to break given that the behaviour is negatively reinforced. Falling sick (removal of health) can be construed as a negative reinforcement of allegiance to ARVs. It is false to assume that such a negatively reinforced behaviour would be maintained by fear and symptomatic alertness alone. As shown by Dread and Grey, the relative inflexibility in the times and frequencies of ARV treatment were too sensitive to errors of omission, leading to defaulting. Thereby TAM ois nce again perceived to have offered an escape route through its flexibility in use (from Dread) and multiplicity (from Grey).

CM was also declared to have 'unnecessary formalities'. Batsiranai decreed:

BATSI: I got sick that is why I told you that I became a paper (very thin) due to wasting, I was not fitting any clothes showing that I was wasting to the extent that; had it not been that I was quickly assisted by TAM, I would not be here. I was saying, when I went

to get pills, there were some lessons we were getting. It would take me a long time again for me to pass the lessons yet I was in pain. <Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

Batsiranai metaphorically exaggerated her weight as being like a '*paper*', apparently in order to demean the lessons she was to first attend before she could be assisted with CM. She was a '*paper*' in pain that was supposed to attend lessons. The lessons also require some intellectual adherence that might be devoid in the capacity of an ill person. This adds to the stress of an already anxious patient.

The reported failure of CM in other ailments was seen above as TwoMinutes and Grey revealed that CM could not permanently treat their related ailments, especially STIs.

Generally, the shortcomings of CM appear to offer aversion that produces negative affective evaluations (unhappiness). The perceived effectiveness, efficacy and efficiency of TAM appears to offer an escape route to a patient, resulting in learned escape behaviours. It can also be inferred that the euphoric engagement with TAM became a sign of avoidance behaviour especially among those who showed remarkable improvement and were weaned off ARVs. Reported remarkable cases were those of Charity (who reacted to ARVs) and Grey (who dreaded the monotony of ARVs).

5.5.1.8 Freedom from the religiosity of HCWs

As variously illustrated above, there were a number of cases in which the conventional Health Care workers (HCWs) pretended to be in public what they were not in private. In so doing, they presented a level of religiosity in the taking of the medicine that appeared to reinforce the participants' continued use of TAM. An example is that of Batsiranai whose '*running to Chaka (the traditional healer) for TAM*' was positively reinforced by the doctor:

My doctor said, 'a-ah, what? Could it be that you are? …What are you using?'… 'right. If you are using TAM, we are now weaning you off pills because the way you have boosted means that the TAM you are using is helping… Since 2010… until now I run

there (to Chaka) to take (TAM)…I have been removed on the pills… s/he (Doctor) was happy.<Internals\\Audio\\Batsiranai> - § 4 references coded [21.35% Coverage]

The HCWs are not excempt from being infected by the virus and some were even reportedly seen going for and using TAM. For example, Tararama and Tatenda who are Volunteer Peer Counsellors and Convenor and TwoMinutes who are experts as support group coordinators, both of whom were on record previously discouraging TAM use.

5.5.1.9 Emotional attachment to herbalist

The positive evaluation of the outcome appeared to have an affective association with the source of the treatment. Below is an extract that showed Batsiranai's perceived compulsive possessive affection for her herbalist;

…you would see that this person is my spiritual medium that protected me and surely that woman I do not like with her… (I will not give her away) <Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

5.5.1.10 Subjective resourcefulness

The positive evaluation of outcome was also seen in how the respondents subjectively engaged with the resources that positively align with TAM and passively ignored the other resources possibly counter to TAM. With the intention of reducing cognitive dissonance, they selectively engaged with only those sources that are consonant with TAM. This subjective resourcefulness was seen in how some participants completely denied any negatives or problems associated with TAM;

CHARITY: I have not seen anything bad with TAM. I only see good things in it. …<Internals\\Audio\\Charity> - § 3 references coded [9.29% Coverage]

KUSH: I do not see anything bad about the use of TAM because it is helpful… <Internals\\Audio\\Kushingirira> - § 2 references coded [4.97% Coverage]

Both Charity and Kushingirira completely denied the negativity of TAM. It seems they perceived 'no negative outcomes' associated with TAM, or were possibly blocking them as shown by Dadirai below:

DADIRAI: You would be told, '*he-e, traditional medicines disturbs, he-e it does this.*' But I have never experienced it. … They say it would causes wounds but I have never experienced it. <Internals\\Audio\\Dairai> - § 2 references coded [12.17% Coverage]

5.5.2 Ambivalent evaluation of outcomes

Ambivalent evaluation of outcome was abstracted to capture the affective expressions that posed a conflict in making a decision about the treatment method. This theme emerged as complementary, if not an addition, to the traditionally existing dichotomous evaluation of outcomes as predicted by the IBM. It offered a transitory trichotomous thread of conflicts that the decision-maker had to go through. The perception of ambiguity, (in) compatibility and multiplicity of the outcomes seemed to draw the decision-maker into a deep set of conflicts as s/he is torn between and among motivations and goals of varying priorities. Although, it seemed that these ambivalent evaluations would eventually lead to either a positive or negative evaluation, it also seemed that some ambivalent evaluations remained as the ultimate answer to not only the use of TAM but also ambivalent use of both TAM and CM. This finding is a conflicting or rather additional revelation to the reasoned action approach that predicts either negative or positive affective evaluations of performing behaviour. The resulting experiential attitude is neither outrightly negative nor positive. As a response to an ailment without cure, an assumption of an ambivalent position seemed satisfactory. The present study's findings fit well within constructs of ambivalence as proposed by Lewin in Sanderson (2004) as outlined in Figure 5.21 below;

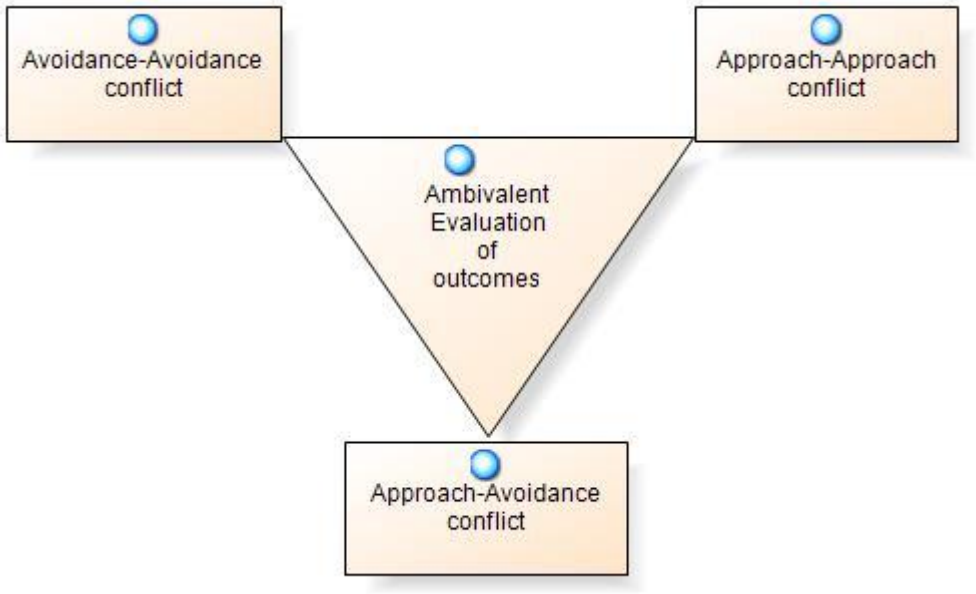

Figure 5.21: Ambivalent Evaluation of outcomes

5.5.2.1 Approach-approach conflict

An approach-approach conflict is an expencience of wanting to do two things that are incompatible with each other (Lewin 1935 in (Sanderson, 2004). For this study, approach-approach conflict was abstracted as the affective evaluations hanging in the balance of the preference for both TAM and CM. As shown in Figure 5.22 below, the lack of absolute cure, probabilistic conditions of cure in TAM, perceived complementarity of TAM and CM had created mixed affective evaluations, out of which, remaining in the balance seemed to be the answer. This dilemma can be summed up with what was said by Zvisinei:

ZVISINEI: Yah, I do not see anything that will stop me from using TAM because, like I said, my conscience will tell me it is right here and I will use. It is just the same with what we do in our lives every day, there are Dos and Do nots in life but sometimes you find yourself doing Do nots, you will find that the Do nots are helping you better than the Dos. That is how we do it even on herbs. We hear them saying, '*it is bad to take herbs, do not give to children, we do not want to see it, this and that'*, truly, you have spoken,

but for me, for my children, I will give them TAM. <Internals\\English transcripts\\Zvisinei> - § 1 reference coded [1.32% Coverage]

Figure 5.22 below presents the tree map of the approach-approach conflict. The sizes of the rectangles represent the proportion of references extracted from the data for each particular theme indicated at the top of the rectangle.

Figure 5.22: Tree map for Aprroach-Approach conflict

Lack of an absolute cure caused the patients develop split loyalties as were not sure of what could help them. As said by Zvisinei, they ended up doing the '*Do nots*' because they could not be sure. Presented below is a word tree (Figure 5.23) showing a proverb that was used by some participants in their response, saying that they ended up doing anything and everything because they would not know what 'made the pig fat' (meaning that people should take opportunities as they come).

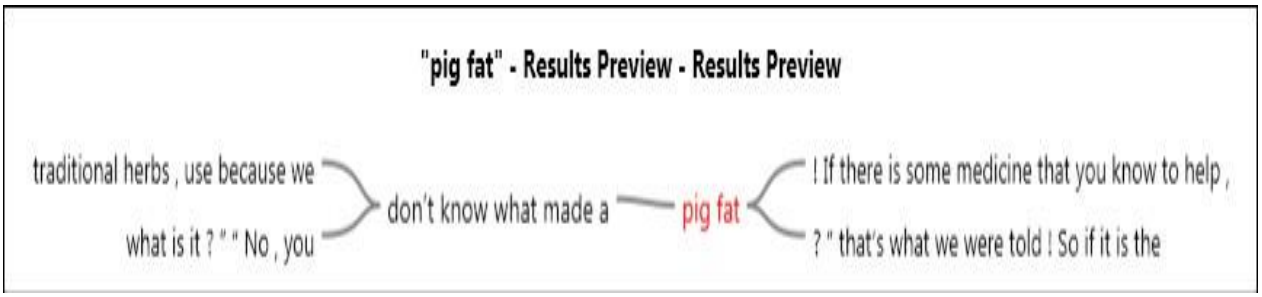

Figure 5.23: Word tree for pig fat

This clearly shows how they were forced to develop split loyalties as they were trying to find the solutions and ended up being attracted simultaneously to two or more equally appealing methods. As a result they ended up doing a lot of trial and error (Figure 5.24).

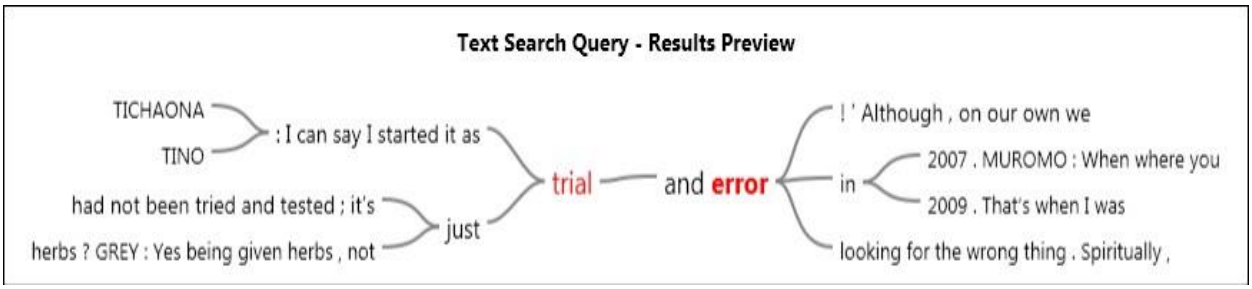

Figure 5.24: Word tree for trial and error

Tatenda and Dread indicated that 'HIV was dreadful' and as a result people were fearful and would not stop looking for help:

…*'I need 14 people*'; the traditional healer came with her letter from the ministry of health for her to conduct her research with people, her trials.<Internals\\Audio\\Tatenda> - § 2 references coded [25.73% Coverage]

DREAD: Even that time when you go to the hospital, when you start using ARVs, when you are on the drugs, that is the time which is most problematic because that time you will be trying each and every thing, you would not be content with one thing. … <Internals\\Audio\\Dread> - § 2 references coded [11.06% Coverage]

Absence of treatment of the disease made people susceptible to non-discrimination. The rate of volunteering for research and trials became high as shown by Tatenda

above. Tinomboedza and Tichaona also revealed this (Figure 5.24 above) through the pseudonym they chose for themselves, '*Tinomboedza*' meaning 'we will try' and '*Tichaona*' meaning 'we will see'. Their names have connotations of probabilistic positive expectations that could drive the decision maker to making a proactive engagement.

The probabilistic condition of healing also appeared to lead to split loyalties:

I told her problem and she said, 'no, wait for me to see if my TAM can boost you on the problem you have.'…she said, 'these are my TAM, if it fails on you, you go back to the hospital.' <Internals\\Audio\\Batsiranai> - § 2 references coded [21.35% Coverage]

If the medicine is compatible with you, and you are lucky, the HIV would be eliminated…She told me that if I am lucky she would help me… I can say it depends with your luck...what is good about traditional medicines is that if you meet a person who knows true traditional medicines that cures, who is not a bogus, it works.<Internals\\Audio\\Grey> - § 5 references coded [55.28% Coverage]

TINO: Ah, it works; it is not anything to lie about. It really works nicely, nicely, as long as it is compatible with your blood, ha-a.

<Internals\\Audio\\Tinomboedza> - § 1 reference coded [18.26% Coverage]

The probabilistic language from the traditional healer and the compatibility with blood that Tinomboedza refered to, makes them vulnerable to split loyalties. They would not like to leave TAM given that there could be some chance that they will improve.

For some they openly mix and have been told the criteria of mixing (Figure 5.25):

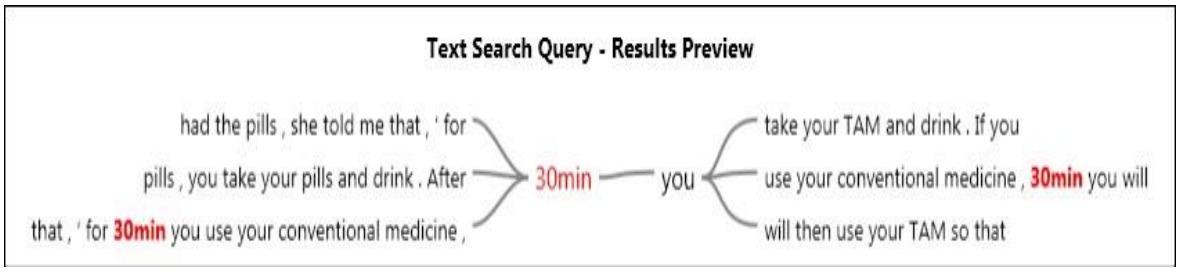

Figure 5.25: Word tree for 30min

I used TAM concurrently with the pills. When I had the pills, she told me that, 'for 30 min you use your conventional medicine, 30min you will then use your TAM so that it will balance all side not leaving one side.' <Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

Weaning ambivalence also showed that they are hesitant to drop:

…drop bit by bit, but we did not stop everything. We selected, saying, *'ah, I think these ones, but I think these are better'*, depending on what was said by those who teach about how herbs interact with ARVs<Internals\\Audio\\Convenor> - § 1 reference coded [8.92% Coverage]

GREY: at first I mixed with ARVs but I ended up not using ARVs, using traditional medicines only…<Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

Perceived complementarity also appeared to cause split loyalties:

The pill boosts us but TAM cures more because they are natural, TAM is raw muti (herb) dug and given to you without processing it. … So at the hospital it was taking me long because I was taking the pill only… so I went to the hospital exclusively initially but later on I mixed those pills and TAM and as a result of that mixing, right now I am being allowed to have a child. <Internals\\Audio\\Batsiranai> - § 3 references coded [21.35% Coverage]

Batsiranai realised that TAM and CM work together and so did Grey:

So we stayed in the hospital, we got out when we were better and strong, after we were given pills, the conventional medicines. However, we were also given traditional medicines by this other woman for it to really work well. If there was no traditional medicine, you would not get well. These pills, yes they make you feel better, is it not? Because they make your veins work properly… However, TAM heals the disease forever. Conventional medicines heal but not for ever. It only cures the pain but it does not end. <Internals\\Audio\\Grey> - § 2 references coded [24.38% Coverage]

Similar perceptions were also reported by TwoMinutes:

2MINUTES: Ah, I have more confidence because it took me five years before I took pills. Right now if I take ARVs only, if I do not take herbs, I will feel that something is happening, headaches, sometimes stomachaches…<Internals\\Audio\\TwoMinutes> - § 1 reference coded [10.74% Coverage]

Dread also reported making adjustments to accommodate his ambivalence:

…When I started using ARVs, I reduced my intake of those TAM…ARV is the one compressed with the correct medication. These herbs are just accompanying, we are just using them as if they just helping (Complimentary). We are not taking them as the substantive. They are not. They are not because we do not have the presciption from the hospital. We just use in the way I said, random use. <Internals\\Audio\\Dread> - § 2 references coded [23.13% Coverage]

The complementarity was also seen in how they relied on CM for verification of progress with TAM:

... I kept on working with the herbalist since 2009... in April 2010, I said let me go back to the hospital, for me to find out, maybe I might say I am boosting yet nothing will be happening. <Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

GREY: When I was found positive, I went to Mission hospital (Name withheld) and I stayed for 2weeks, and I started the ARV medication....But I continued taking TAM and kept on going to be tested at the hospital. <Internals\\Audio\\Grey> - § 2 references coded [24.38% Coverage]

The endeavour to counterbalance the perceived deficiencies in both TAM and CM would make the patient prone to split loyalties, wanting to use both CM and TAM:

...their health is better than a person taking only ARVs. It is very easy to identify an HIV positive person who is taking ARVs only. However, that is not possible with the one who is mixing with TAM, if s/he is sick you would think that it's just another disease troubling him/her, you will not suspect that s/he is HIV positive… <Internals\\Audio\\Grey> - § 3 references coded [24.38% Coverage]

DREAD: ...When you start using ARVs... that is the time which is most problematic because that time you will be trying each and every thing, you would not be content with one thing.[2] …I have seen that there are some that are incompatible with ARVs. You might start having side effects, let us say something like vomiting or just feeling like you are getting sick such that you will spend the whole day in bed because there will be some kind of incompatibility, I have felt that.<Internals\\Audio\\Dread> - § 2 references coded [11.06% Coverage]

Incompatibility with the medication, as raised by Dread, could lead a person to keep on searching for more treatments. The decision-making can be assumed to be marred with tension. In a way, through these trials, that was how Dread would then decide which TAM to drop and which TAM to mix with, as he said earlier. Generally discontentment with everything lead to lack of discrimination. Lack of certainty on either side (TAM or CM) led to acquisition of both, to eliminate the chances of losing in the event that the answer lies in either of them. Grey spoke about counterbalancing the methods (TAM and CM).

Ambivalence is easy; it is associated with dangers and scepticism:

CONVENOR: Ah, especially now that I am using ARVs, I do not encourage using TAM because I am afraid of them being mixed.…Even my wife, she is afraid of mixing them, she is exclusively using TAM... So I say our traditional medicines work but it's dangerous if mixed up. <Internals\\Audio\\Convenor> - § 3 references coded [8.92% Coverage]

DREAD: So I ended up reducing quantity of TAM. When I started using ARVs, I reduced my intake of those herbs. <Internals\\Audio\\Dread> - § 1 reference coded [11.06% Coverage]

It seems paradoxical to say a conflict can be solved by remaining in it. Generally discontentment with everything leads to lack of discrimination. Lack of certainty on either side (TAM or CM) led the participants to the acquisition of both in case the answer lies in either one. Therefore, ambivalence was, in a way, an answer to the drive towards the use of TAM and also in conjunction with CM.

5.5.2.2 Approach-avoidance conflict

Approach-avoidance conflict is being trapped in making a decision to do one thing that has both negative and positive outcomes (Lewin 1935 in (Sanderson, 2004). For this study, approach-avoidance was abstracted as the affective evaluations that were associated with both the positive and negative evaluations of using TAM. There were evaluations that seemed to show conflict for the decision-maker as they would be trapped in making a decision to use TAM even though this has both positive and negative aspects. As shown in Figure 5.26, TAM was understood as characterised with an unfavourable Garbage-In-Garbage-Out (GIGO) concept since both black magic and healing are found there, or at least perceived as coming from the same sources. The perception of divergence of TAM from contemporary, the so called 'in-things', also made TAM less desirable, at least when perceived as being used by the public, yet showing favourable healing outcomes. There was also a fear for self-deception in which some of the participants were sceptical about the veracity of the healing (though perceived) from TAM.

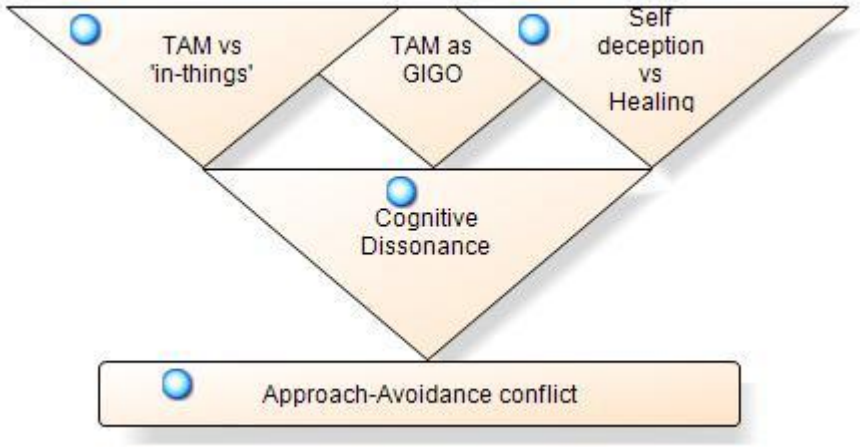

Figure 5.26: Approach-Avoidance conflict

Such tension around the use of TAM was understood as causing cognitive dissonance since the decision-maker would be holding two conflicting and or opposing cognitions about his or her beliefs and the use of TAM.

5.5.2.3 TAM as GIGO

The Garbage-In-Garbage-Out (GIGO) concept was perceived as indicated in the association of TAM with black magic which is commonly believed as deadly;

…there are some people bewitching each other with those traditional medicines…. there are traditional medicines that can bewitch, used in damaging people. <Internals\\Audio\\Zvisinei> - § 1 reference coded [18.98% Coverage]

The GIGO concept came in when both bewitching medicines and healing TAM were believed to be coming from the same source. The public could be assumed to be assuming an all-or-none principle in the perception of the users and this would be to the discomfort of the user since they would end up being associated with '*damaging people*'. Kushingirira revealed:

KUSH: Haa, its right because what is needed is for the person to get well, what is bad is causing more harm to the person but healing is encouraged. <Internals\\Audio\\Kushingirira> - § 1 reference coded [26.12% Coverage]

When Kushingirira spoke of damaging a person, he was alluding to the perceived ramifications of black magic. However, he was clear that the healing is also part of the package. Tinomboedza also alluded to this damage:

TINO: Its bad on that aspect, if you use TAM that you do not know or give someone TAM that you do not really understand, you might cause adverse effects to yourself or that other person. That is why we always say you are supposed to taste everything before giving another person. <Internals\\Audio\\Tinomboedza> - § 1 reference coded [13.90% Coverage]

The idea of tasting everything is meant to demystify the assumption of any dangers in the TAM. The concept of tasting everything shows that there is risk in TAM and that GIGO is highly possible, in other words anything could happen. Suspicion for evil intents, therefore, marred TAM use. This was also revealed by Convenor:

...for parnado from my next door, I would not have any doubts, I could see to myself that these are parnados.... however, it is not the same with TAM, for instance there was this other day I came carrying my things and my neighbour got jealousy. Because of that I got suspicious of the TAM she gave me for my stomach ache. So TAM is not a type of medication for you to be free to ask from others and sometimes even a traditional healer can make a mistake <Internals\\Audio\\Convenor> - § 1 reference coded [5.03% Coverage]

As indicated by Zvisinei and Convenor, bewitching was also consistent with TAM and they believed some people might use it to achieve evil intent. Such an association might cause approach-avoidance in the TAM users. Moyo also indicated that there are other undesirable practises in the use of TAM:

...maybe I would have problem with cutting *nyora*. (using razor blades to make small cuts on the skin and squeezing herbs through the cut as a means of applying the herbs intravenously). Otherwise if it is about drinking and eating, I do not have problem with it. <Internals\\Audio\\Moyo> - § 1 reference coded [17.59% Coverage]

To Moyo, '*Nyora*' symbolised the undesirable aspects associated with the use of TAM. He would approach the healing but avoid the cutting. Muyengwa also over-emphasised

his explanation to distinguish the two sides, possibly associated as the two sides of the coin for TAM;

When we are saying traditional medicine it is not about throwing bones but its trees created by God and we know that our pills are made from those trees. <Internals\\Audio\\Muyengwa> - § 1 reference coded [16.61% Coverage]

Muyengwa emphasised the differences in order to distinguish his use of TAM from black magic or its other form. He wanted it to be understood as different. In as much as the participants wanted to get the healing, the association with black magic detracted from the perceived value of TAM, leaving some of the users and potential users in a conflict and with the task of emancipating themselves by trying to justify and distinguish their purpose from evil intents. The general public's view was feared the most as they might mistake their use of TAM as with evil intent. This was revealed in Tatenda's extract below;:

…because if I am to be given choice to choose what I want, *'do you belief that traditional medicine helps?'* Sure, you would find me on the traditional medicines' side, I do not want to lie. <Internals\\Audio\\Tatenda> - § 1 reference coded [25.73% Coverage]

It seemed social 'opinion' made Tatenda believe that there was no choice but to use TAM. It seems as if there are other social influences making TAM less of a choice. The perception of the public assumed an all-or-none perceptual orientation that made Tatenda feel that TAM was not an option as it is imbued with ambiguity and suspicion and she would not like to be associated with '*damaging people.*'

The main question about GIGO was: If people perceive TAM use as the 'all-or-none', what would they think of me if they find out that I am using TAM? Maybe the answer was in the privacy in the use of TAM. It seems the secret use of TAM is a coping method to counteract the GIGO of TAM. Tararama and Charity implied that they were not open to the use of TAM, hence Tararama was waiting for TAM to be publicly acknowledged for her to openly accept it and Charity was very sensitive as to whom it was that she might open up to:

…if I am to be given choice to choose what I want and asked, *'do you believe that traditional medicine helps?'* Sure, you would find me on the traditional medicines' side; I do not want to lie. … I see that nowadays traditional things are concealed, if the voice was to be raised as it is done for paracetamol, I would no see anything bad. So TAM use is suppressed yet you would see people using those traditional medicines again. <Internals\\English Transcripts\\Tararama> - § 2 references coded [39.73% Coverage]

Secretive use was also revealed in the use of coded language (restricted code) between Batsiranai and her son:

…my son knew that the time had come, he would ask me that, '*mother, have you juiced?*' he says that when there are many people around he does not like people to know about my use of TAM…so people would think that it is a phone that needs to be recharged with airtime. <Internals\\Audio\\Batsiranai> - § 2 references coded [19.41% Coverage]

Batsiranai revealed that she wanted her TAM use to be concealed from the public. This idea is also shared with her son and together they have developed coded language to try and hide the use from other people. In this conversation, 'juicing' was used as a coded word representing use of TAM but intended to conceal from people, manipulating them to think of a juice card that is used to top up airtime in a cell phone. This seemed to demonstrate a mixed evaluation of TAM in which it is both liked and disliked leading to a tension, an approach- avoidance conflict.

The association with, as well as the perceived vulnerability and ambiguity in the use of TAM, seemed to reveal hesitancy as the decision-maker reviews the use of TAM. The perception of healing and ambiguity, and/or vulnerability, seemed to raise mixed emotions. On the one hand it could heal and on the other it could endanger. This illustrates GIGO as if one is not sure of what one is looking for, one could end up with anything which might not be what one was looking for, thereby making oneself vulnerable and in further danger. The perception of this possibility seemed to create tension in some of the participants as hope advanced for finding a cure to an incurable disease and fear pointed to vulnerability and ambiguity. Muyengwa illustrated this below:

in our tradition, traditional healers do not tell the type of herbs nor the use of it, they just tell you that I am giving you herbs that will help you… <Internals\\Audio\\Muyengwa> - § 2 references coded [16.61% Coverage]

Some traditional healers' reported the practice of not explicitly telling their patients what they use and how the healing was going to be achieved, creating a chance for other bogus practitioners to benefit from this tradition and thereby leaving the patient vulnerable. Muyengwa spoke of the false prophets who, in the name of healing, would bewitch the patients and only remove the 'bewitching' later with the intention to deceive the patients into thinkinig that they have been healed:

So the [false] prophets, hah. Recently I spoke to someone who goes to those prophets he was saying, 'no if someone whom we see to have money arrives', he said, 'we plant and make him/her carry bad spiritual object, s/he will go to his/her house but we will tell him/her that there is something at his/her house. When s/he agrees we go and remove that very big object for free and s/he will believe.' So to the prophets it is just going but there is nothing of any healing significance that will come out there especially when we focus on this disease (HIV/AIDS). <Internals\\Audio\\Muyengwa> - § 2 references coded [16.61% Coverage]

In the end there would, however, not actually be any advance in the treatment of HIV/AIDS in the patient. However, Zvamaronga revealed that they are mixed as some traditional healers focus on healing and others specialise in '*potions for abortion'*. She said:

…there are those who are just said to be healers when they are not, they would just give potions for abortion, those are the bad types of TAM. But if it is TAM that heals, there is nothing I see as bad. <Internals\\Audio\\Zvamaronga> - § 1 reference coded [19.19% Coverage]

The much feared GIGO might come when you go to the specialist on '*potions for abortion*' for the treatment of HIV. The prevalence of 'bogus' practitioners such as these seems to be high. This was also revealed by Grey who spoke of his extra caution;:

…what is good about traditional medicines is that if you meet a genuine traditional healer who knows true traditional medicines that cures, that TAM will work. … Ha-a as for me I did not meet with the bogus as such, I did not like to hasten to do it. I wanted to look at a special place, not the bogus, places <Internals\\Audio\\Grey> - § 2 references coded [30.94% Coverage]

Moyo also revealed this in his emphasis on the issue of trust in the use of TAM:

What is not advisable is to be given TAM by someone you do not know because you would not be having an idea about whether the medicine is toxic or not, or its function. I think it would depend on the trust you have with that person, whether s/he had tried it and whether it worked well. <Internals\\Audio\\Moyo> - § 1 reference coded [13.03% Coverage]

Similarly, Zvisinei shows extra caution, especially for her children:

Like I said I do not have problems as long it is done in the proper way… As a parent with grown up children, I still feel that I am responsible for them. I would like to know what is happening to them and I would always say let us go with this TAM and this lets not do it. … As long as it is transparent and clear… I do not think I have anything against that. <Internals\\Audio\\Zvisinei> - § 1 reference coded [13.54% Coverage]

Even though the children are grown-ups with their own families, Zvisinei still does not trust her children to consult traditional healers and use TAM on their own. Why is she not confident that her grown-up children can use TAM by themselves? It seems that there is a perceived high risk involved that requires experience, which she felt she had not relayed adequately to her children, having, in her perception, passed on the know-how without enough training as a result confidence being lost with the succession of generations. Nonetheless, it seems that there are perceived dangers associated with TAM, not without hope for healing. Convenor also revealed this below:

There is some time that you hear someone saying, '*that one is the one that works more than that one.'* So probably you would have been using the latter, so if you hear that the other one is better, you would leave yours and take the new one....it endangers you sometimes … The lack of accurate information and proper measurement may result in

overdose… If you put more water it will not work again yet it would be the correct medicine. It is like the pills as, a mature person if I had a head ache; instead of me taking 2 tablets, I would take a quarter (underdose), it would seem as if it does not work. If it is too much again you will have overdose. Instead of healing it will be harmful.. If it is someone who looks for TAM for him/herself in the forest, sometimes there are trees that seem alike yet different. So you might go and dig the wrong one or eat leaves from the wrong tree sometimes being poisonous. Maybe it might not be poisonous but having other undesired effects… <Internals\\Audio\\Convenor> - § 4 references coded [22.98% Coverage]

Convenor speaks of the dangers of peer pressure, overdosing, under-dosing and the ambiguity of the herbs. All these are dangers that have to be assessed concurrently with the hope of finding a cure. Therefore, the use of TAM is not without tension and hesitancy. Such perceptions lead people to develop negative experiential attitudes that then negatively affect TAM-uptake behavioural intentions. Similarly, Dread spoke of these measurements and the resemblance of herbs:

On that I would not be quick to accept that because on the measurement I spoke about, that would not be resolved unless if you had gone to a specialist, a herbalist who can give you measurements. If it comes from there it will be fine. …Yes my wife can use TAM if it is in the correct sequence from the genuine herbalist's instruction not just taking on her own, just saying I have gone to the market, just buying because you felt chest pain. Hah. Not that. We would like it to come through a specialist like a traditional doctor, who knows the herbs, who can put her for example on a course or anything of those herbs depending again on the type of her disease… what is bad about using traditional medicines is that sometimes it is grown with unsuitable and dirty water. On watering they might be using water with soap and other things as a result those herbs would not have their good effect. On taking the herbs, it is terrifying because one might take a wrong flower. There is a lot of resemblance among the flowers. Some take alovera, there is one that is pointed by others yet it is not the one, but it is in the plant family. So there are dangers.... You might take the wrong one . This may be a result of being given by someone who does not know and gives you the wrong one thinking that it is the correct one.<Internals\\Audio\\Dread> - § 4 references coded [23.13% Coverage]

The issue of vulnerability and ambiguity seems to make tension inevitable in making a decision about the use of TAM. However, the lack of known treatment to the virus mobilised hope and courage to continue in the tension as hope for finding a cure to an incurable disease was stronger than the fear. Scepticism points to vulnerability and ambiguity, leading to a perpetual and vicious circle of approach-avoidance conflict.

5.5.2.4 Self-deception versus healing

There was also some level of confusion as to whether TAM would be healing or not amongst the participants in this study. There was fear of self-deception in which the decision maker was not sure or was confused about the ultimate and eventual outcome of TAM use. This was illustrated below:

If he fails to properly use TAM, it would damage him or it might not produce the desired effect. There are some diseases that can be cured and disappear by traditional medicines but if treatment is delayed that disease can endanger yourself. So you can be unknowingly self-deceived, thinking that you are taking herbs that are helping you yet making the mistake of taking inadequate amounts that will cause your condition to deteriorate to the extent that when you finally to the hospital they would say, '*you are late, why did you not come early?*' Yet you were unsuspectingly waiting thinking that you are taking correct traditional medicines, thiunking you will eventually get well. <Internals\\Audio\\Convenor> - § 1 reference coded [14.07% Coverage]

Also, there are other herbs, maybe if one has a headache and takes some herbs thinking that they will heal the headache, it may end up causing other health related complications because the medication could not have been meant for that purpose. Instead of helping you, it will cause other problems. So we are supposed to exercise caution, use with caution.<Internals\\Audio\\Indigenous> - § 1 reference coded [18.42% Coverage]

but I would not know what that TAM would cause in the future because my husband is mixing TAM with pills <Internals\\Audio\\Dairai> - § 1 reference coded [12.17% Coverage]

You know if you have confidence in something, you feel your body getting better. So when I was using moringa (a type of herb) I felt my body getting better. But I do not

know, maybe it was just my confidence in the herb, but I have realised that it was a herb that was doing me good.[1] <Internals\\Audio\\Muyengwa> - § 1 reference coded [16.61% Coverage]

The confusion around self-deception versus healing was also seen in the fear for the duplication of treatment versus perceived effectiveness and efficiency of TAM:

…you might mix the same things on the medication that you will be taking. The doctors used the word 'duplicating'. You will damage yourself because you have repeated, obviously it will cause overdose…

Generally, when I discovered that these herbs work, it was my discovery that herbs work more that you thought. That is one thing I have seen good for me. There is also the issue of its effectiveness, in most cases it is like lightning. (Very fast healing effect) <Internals\\Audio\\Zvisinei> - § 1 reference coded [8.88% Coverage]

Zvisinei is afraid of duplication of treatment but at the same time she likes the perceived '*lightning*' effectiveness of TAM. Similarly Convenor and Dread feared mixing the medication types but still continued to do so due to the belief that TAM works:

CONVENOR: Ah, especially now when we are using ARVs, I do not encourage using TAM because I am afraid to mix the treatments. We do not even know the contents of ARVs, so you might use traditional medicines that are also used to make ARVs and you will do overdose. So I am not comfortable in using TAM… So I say our traditional medicines work but it is dangerous if mixed up. <Internals\\Audio\\Convenor> - § 3 references coded [8.92% Coverage]

So you end up reducing quantity. When I started using ARVs, I reduced my intake of those herbs. <Internals\\Audio\\Dread> - § 1 reference coded [11.06% Coverage]

Fear of overdose was also revealed, although there was never a known case or tangible side effects in TAM use:

…there is something bad in using TAM, we do not understand the issues of dosage. If you go to n'anga they just give you in a big cup and you will be told to go and put in

porridge this amount, you do not have the right dosage. Even us when we are moving around as I have said about Nasturtium. I just take 2 or 3 leaves and chew. I do not know the right dosage. Even the ginger that I eat. I just chew but I do not know the correct dosage, I do not know what it will do in the body.... So, the problem is on dosage… it can damage your body organs, like there other drugs; we know that if we eat food it goes in our bodies, in the blood stream and liver. Now on the liver, I see that there are other herbs if taken in large quantities, it can damage the liver cells and when damaged you will have a more dangerous disease than the one you had at the beginning yet you were trying to cure the disease and you are now causing more damage than before.

GIFT: So far are there any side effects that you have felt?

MUYENGWA: So far there are no side effects I have felt as yet.

GIFT: So are you are suspecting that just because of different dosages and different amounts and taking it differently, you might get a problem?

MUYENGWA: Yes

GIFT: Are there others you have heard who experienced side effects?

MUYENGWA: What is difficult is to know whether it is a side effect of taking TAM or not but we just hear a person saying, '*I was told I am sick, I have cancer on my side', hee, I have this disease, I have a growth, I have developed this'*, One wonders if it is because of herbs taken by people. At the end of the day when a person gets sick and goes to the hospital and dies, the doctor will just write that the person died due to meningitis, or died because of this; for him to know and say that it came from the traditional medicines that will not come out like that. So there are many people whom we see who get sick, for us to know that is it because of herbs, we do not know. Plus, we eat, generally, just eating; it causes something because the food that we eat, it is not all the food that we eat that is good, some cause other ailments. <Internals\\Audio\\Muyengwa> - § 3 references coded [11.96% Coverage]

As shown by Muyengwa, there is general fear that there might be incorrect dosages given, a fear shared by a number of respondents:

DREAD: I have seen that on using TAM, it needs a lot of care because you would not know the quantity. The quantity is unlike a tablet that has been measured and has known quantity, grams and what, what. So in our use of our TAM, sometimes you do not have the measurements, the exact quantity. So you might take slightly more and sometimes you will feel that; you feel it in your body that something is wrong such that you might think that these herbs are not working well… the herbs pulls you, even give you some pain, if you drink them, you might have stomach ache and feel that; you might have an hour or so feeling that things are not well. So those will be signs that the quantity taken might be more… <Internals\\Audio\\Dread> - § 4 references coded [11.06% Coverage]

Dread is advocating for regularisation of TAM in which there would be standardisation of the dosages. Similarly, TwoMinutes, Convenor and Zvisinei spoke against 'hit-or-miss' measurements:

What is bad is that we do not know measurements. That is the problem, for me to drink few or more, no one knows. For the tablets we know that if I take one it has three measures, if I take this one it has medicine for the night. So for us to know the measurements, even alovera, you can just put it in a cup and drink it all, for you to know the proper amount, you do not know, you will do overdose. That is why it is a problem, the instructions do not specify the dosage. <Internals\\Audio\\TwoMinutes> - § 1 reference coded [22.81% Coverage]

Then the other problem that might happen is that of dosage. Since we were growing up, porridge was prepared for us, we did not know the quantity of TAM that our mother put, to the extent that when I am cooking giving my children, I do not have standard quantity, I will just put until I see it turning reddish then I give children. <Internals\\Audio\\Zvisinei> - § 1 reference coded [18.98% Coverage]

… we end up using more, like overdose is the one that happens a lot, it would happen… I would feel that, uhh, the way I am feeling in my body, getting tired or sweating, it could be the traditional medicines I drank.... The lack of proper measurement; that overdose is the one that endanger us… <Internals\\Audio\\Convenor> - § 5 references coded [22.98% Coverage]

Although Moyo is aware of the possibility of overdose, he seemed defensive and not bothered about it:

What I see as a problem, usually said by people, is that you would not know whether the quantity you are taking is more or less, but otherwise I do not have any problem. <Internals\\Audio\\Moyo> - § 1 reference coded [13.03% Coverage]

Moyo attributed this to 'others' and therefore did not see it as his problem. It seems he is denying, trying to establish congruence with his cognition on TAM as he would not like to continuously hold conflicting cognitions. Below is a cloud (Figure 5.27) with key words on the fear of duplicating treatment.

Figure 5.27: Fear of Dublicating Treatment

The tension was mostly seen when the person perceived some improvements they ascribed to TAM. They would start to wonder whether it was a genuine or fake treatment, independent or a duplication of ARVs/CM and the right quantity or an

overdose? Such tensions left the decision-maker in a quagmire of approach-avoidance conflict.

The use of self in TAM trials was also understood as indicative of approach-avoidance conflict, especially when such trials were attempted by the person but refused and/or condemned in significant vulnerable others, such as children, for which the person (parent) could be held accountable for possible adverse effects:

… I cannot experiment that with a young child. So I first test the medicine myself to check if it would create problems for me… so to me, for this child I was hesitant because we are always criticised at the hospital…<Internals\\Audio\\Dairai> - § 1 reference coded [12.17% Coverage]

Why did Dadirai continue to use TAM after being told at the hospital never to use it? Although she would continue on herself, she vowed never to try it on her HIV positive child:

DADIRAI: Uhh, I never tried it because as soon as she was found positive (child), she was started on pills, since then we only use those pills for her I have not changed her or used these medicines (TAM).<Internals\\Audio\\Dairai> - § 1 reference coded [20.44% Coverage]

Approach-avoidance conflict is indicative of cognitive dissonance that the decision maker has to go through, holding two conflicting cognitions on the use of TAM (Festinger, 1957 in Barker, 2003).

5.5.2.5 TAM versus 'in-things'

TAM was perceived to heal but was at the same time associated with antiquity, backwardness and takers to be uncivilised. Whilst the patients could be perceived to like to cling to the good outcome of TAM, that would not happen without the disturbing realisation that such a preference does not go along with the so called contemporary 'in-things' and therefore it is now an 'out-thing':

TATENDA: The reason why they hide is because it's said that it belongs to the past, so these days there is what is being called the '*in-thing*', they want conventional things, you

even hear that now, have you not heard a person saying, '*I am going for op* [an operation]', creating the impression that getting operated upon is something prestigious thing, yet it involves cutting a person. It's said as if it is a very prestigious thing. <Internals\\English transcripts\\Tatenda> - § 1 reference coded [1.21% Coverage]

As said by Tatenda, the realisation that TAM is so associated with the past causes users to be caught in the tension of approach- avoidance conflict. Tatenda added that the use of TAM can lead some people to be labelled 'crazy':

Maybe some are running away from TAM due to fear that they would be labelled insane, I do not know that word that we label each other with. <Internals\\Audio\\Tatenda> - § 1 reference coded [10.28% Coverage]

As indicated by Tatenda, some end up 'running away' from TAM due to the fear of the label 'insane'. The 'insane' she was referring to is the deviation from the norm, a marked dissimilarity from the majority who are following the contemporary 'in-things'. Tatenda preferred to use 'running away' as a descriptor of the non-preference of TAM, to indicate how such deviation is sanctioned by the social world through attitude formation. Maybe the question is: Are they running away or just imbued in the clandestine use of TAM to 'save face'? Even Tatenda confirmed that she engages in clandestine use as she said, '*The reason why they hide it's because it is being said to belong to the past, so these days there is what is being called the* '*in-thing*". Therefore, the use of TAM would mean the perpetual tension of the approach-avoidance conflict as they continue to like the healing outcome and fear being labelled 'insane.'

TwoMunites and Dread revealed that the conflict is even worse for the younger generation who might be forced to practise TAM in a world that is 'weaning off' such practises:

DREAD: Her upbringing will affect her TAM uptake . She will not use TAM again; yet she can't live without herbs. For this child, with the way things and lifestyles are changing, it might be a problem such that she would not travel. She will get a job in another country where she would not get the herbs and that would affect her. Probably she will go to school, to a university in the United Kingdom or other countries and there

are no Moringa, and it will be difficult for her. <Internals\\English transcripts\\Dread> - § 1 reference coded [1.32% Coverage]

2MINUTES: Uhh, even the children, they do not want to use TAM, that is the problem… probably it is how they are growing up these days… <Internals\\Audio\\TwoMinutes> - § 1 reference coded [10.74% Coverage]

Education and training on conventional health issues was also perceived as the catalyst to the cognitive dissonance since those who are educated will find it difficult to reconcile TAM and conventional medicine. It was mostly those respondents who had exposure to support groups who raised issues to do with dosage problems and TwoMinutes was quick to notice that such education was trapping them into approach-avoidance conflict:

2MINUTES: If you have learnt a lot about the conventional medicines that have measurements, we are now used to measured medicines where we are instructed for example, '*take 2 tablets once a day, take one tablet once a day'*, that is what is clicking in our minds that, '*these herbs you are taking, yes it heals, but the measurement.'* It is not possible for me to take three tenarum in the morning and one neverapine in the evening. It is hard. It is overdose, so we have been used to the system of instructions, that is why it is terrifying, but for me to say I have heard of someone who reacted, no.

GIFT: What did you get to know first; traditional medicines or conventional ones? Who is most afraid, the one who knew conventional first or what… what type of person is mostly afraid of this?

2MINUTES: The one who was educated on this

GIFT: Are the ones having this problem?

2MINUTES: But they have never had any side effects.

GIFT: Is it now a problem in their mind?

2MINUTES: Yes. <Internals\\Audio\\TwoMinutes> - § 1 reference coded [22.81% Coverage]

Zvisinei also concured that the acquisition of some medical knowledge impeded and conflicted some of the TAM practices:

GIFT: In your own view, does that lack of dosage pose any problem?

ZVISINEI: Yah, that one, if you talk to a person like me, because I now have some knowledge, I think we have done those researches with people from University of Zimbabwe's department of Pharmacology, and we were told that if you take too much drugs in your body, you can damage your liver and kidneys.<Internals\\Audio\\Zvisinei> - § 1 reference coded [18.98% Coverage]

Generally, fear of self-deception, GIGO and deviation from the current 'in-thing' were the issues that seemed to cause the decision-makers to experience approach-avoidance conflict and tension as they were making affective evaluations of their use of and experience with TAM. Nevertheless, they still chose to remain in the tension as they continued with the use of their TAM.

5.5.2.6 Avoidance-avoidance conflict

Avoidance-avoidance conflict occurs when a person is being torn between two undesirable choices (Lewin 1935 in Sanderson 2004). For this study, avoidance-avoidance was abstracted as the affective evaluations that were associated with dislike and dissatisfaction of both TAM and CM. Whilst the CM was largely viewed as having side-effects and monotony, TAM also had its own problems, causing the respondents to be tangled in an avoidance-avoidance conflict in which either side was associated with unpleasant effects. Although the respondents had already resolved this conflict (as seen in their use of TAM or ambivalent use of TAM and CM), the tension in which both sides were not preferred was high. For example, in the coded language used by Batsiranai and her son showed they did not want others to know about both ARVs and TAM:

…he would tell me that, '*mother, had you juiced?*' he would be seeing that many people are still there outside, he would not like people to know about what his mother does, he would say, '*mother, do you want to juice?*' so people would think that it is a phone that

needs to be juiced, you would see him running with a cup with water, some pills and his TAM and say, '*mother.*' I know that if he says have you juiced, even if there are too many people, he would follow me and say, '*mother, had you juiced, time is passing.*'…<Internals\\Audio\\Batsiranai> - § 2 references coded [19.41% Coverage]

Batsiranai did not like both the pills and TAM. She did not like the connotations associated with both of these treatments, especially those connotations coming from the people's perceptions of it. It can be conjectured that due to this avoidance-avoidance conflict, the patients are in a desperate search for the treatment that will treat them once and for all as well as for quick fixes. However, in that quest they would reportedly get into problems with 'bogus' and false prophets who pretended to be neither from TAM nor CM, yet would be reportedly false and/or alias to evil spirit mediums in TAM and/or CM:

So the [false] prophets, hah. Recently I spoke to someone who goes to those prophets he was saying, 'no if someone whom we think has money arrives', he said, 'we plant and make him/her carry bad spiritual object, s/he will go to his/her house but we will tell him/her that there is something at his/her house. When s/he agrees we go and remove that very big object for free and s/he will believe.' So to the prophets it is just going but there is nothing that will come out there especially when we focus on this disease (HIV/AIDS). <Internals\\Audio\\Muyengwa> - § 2 references coded [16.61% Coverage]

It can be assumed that both false traditional healers and 'false prophets' prey on the avoidance-avoidance conflict, leaving patients restless in search for quick fixes and miraculous healings (see Figure 5.28).

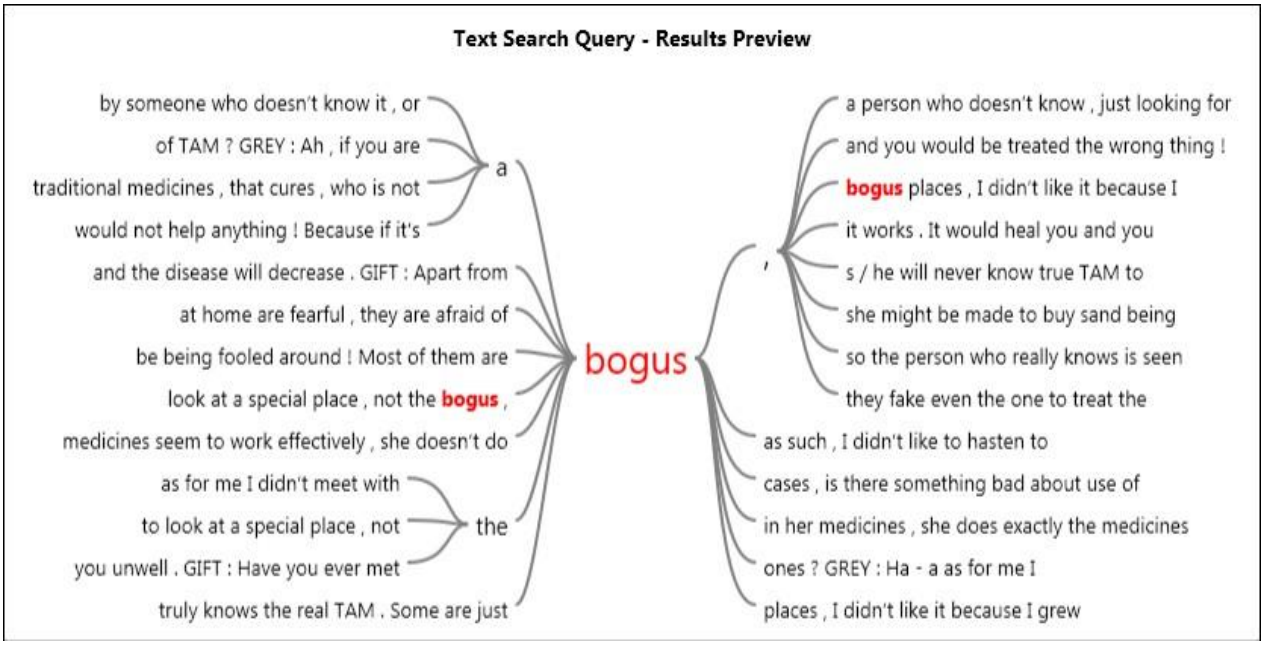

Figure 5.28: Text query for bogus

5.5.3 Negative Evaluation of Outcomes

The negative evaluation of outcomes was abstracted to capture the negative affective expressions, as shown in Figure 5.29 below. These mostly distracted the user from continuing to use TAM. They can be understood as dissatisfaction with TAM. Some participants felt that TAM use would seems to be contrary to the contemporary modernisation. From a reasoned action perspective, this negative experiencial attitude towards TAM-use predicts a negative behavioral intention leading to non-performance of the behaviour. Specifically, this finding confirms the IBM's proposition regarding the strength of attitude as a predictor of behaviour. The finding also confirms Bandura's (2004) position that "human health is a social matter not just an individual one" (p. 143) (See next chapter on social influence). Below is a tree diagram depicting the nodes expressing dissatification with TAM with the sizes of the rectangles indicating the proportions of the thematic extracts as they emerged in the data. The themes are indicated at the top of each rectangle.

Figure 5.29: Tree map for dissatisfaction with TAM

5.5.3.1 TAM for trivial issues

TAM was said to help only minor issues in 'buying time':

You can buy time temporarily helping yourself with TAM, if it deteriorates that is when you go to the hospital. You will have had time to look for the money and lessen your suffering . <Internals\\Audio\\Dairai> - § 1 reference coded [12.17% Coverage]

You will eventually decide to go to the hospital after realising that you cannot heal, which now would require medical attention at the hospital, that's when we go to the

hospital. However, if we see that the health problem can be easily dealt with, the herbs we have at home will then be used. That is why I make the suggestion that if you are using them, go ahead but find time to go to the hospital. To give an example, let us assume, ehh, a child is having a running stomach, or it is you or me having the running stomach, or my wife having a running stomach, there might be about five to ten kilometers to get to the hospital. Before I take off to hospital, I can use those herbs or those other waters that are boiled the sugar and salt solution, that will help to buy the time to reach the hospital with my partner or on my own. We are not supposed to use traditional medicines for a long time because we do not know the measurements, they may damage us because some of them have side effects that they may create. So if you go to the hospital you can be helped, so the encouragement is to use but knowing that you will go to the hospital to get help.<Internals\\Audio\\Indigenous> - § 2 references coded [18.42% Coverage]

5.5.3.2 ARVs superior to TAM

For some, CM was perceived to be superior to TAM:

DADIRAI: I think TAM is good though I think it's inferior to pills.<Internals\\Audio\\Dairai> - § 1 reference coded [20.44% Coverage]

MUYENGWA: ah, the pill seems to be more effective than the likes of Moringa because the likes of Moringa have slow release in terms of treatment. <Internals\\Audio\\Muyengwa> - § 1 reference coded [16.61% Coverage]

Dread also confirmed perceived superiority of ARVs to TAM, and reported that TAM only acted as auxiliary and cannot substitute ARVs:

So you may be encouraged to take this and that, but with time, when you get experienced, you will start to realise on your own that the ARVs are more effective. These herbs, you will remain with only about two or three that you might be taking.[1] …ARV is compressed with the correct medication. These herbs are just complementary; we are just using them as if they are assisting ARVs. We are not taking them as the substantive. They are not. They are not because we do not have the

prescription coming from the hospital. We just use in the way I term, random use.<Internals\\Audio\\Dread> - § 2 references coded [23.13% Coverage]

5.5.3.3 Incompatibility with ARVs

Incompatibility with ARVs was also found as a negative aspect that brought negative affective evaluations of TAM. This negative affective evaluation of TAM, consistent with IBM prediction, leads to negative intentions to use TAM. This is shown in Figure 5.30 below:

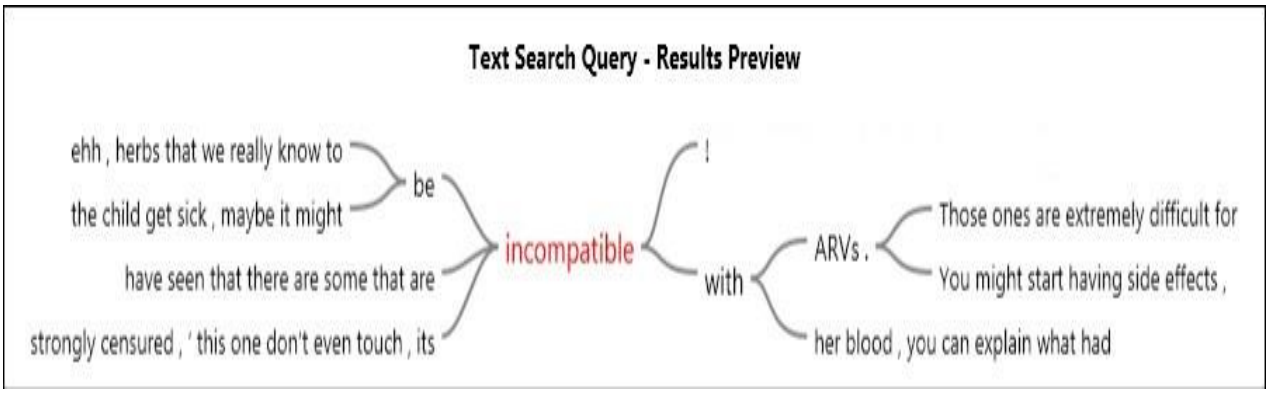

Figure 5.30: Text query for incompatible

This incompatibility was believed to wash the ARVs out of the blood. This is shown in the text querie below (Figure 5.31):

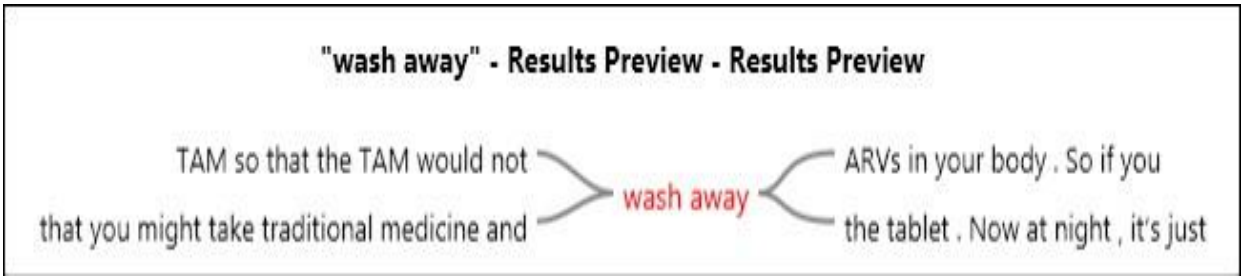

Figure 5.31: Text query for wash away

Indigenous and Dread explicitly spoke of this incompatibility:

INDIGENOUS: Ok, let us say, I can take myself as an example, assuming I am taking ARVs, ehh, I have traditional medicines that I can see that they are no longer viable for me to take. For example garlic, as I know and have heard, it is said that it neutralises the effectiveness of ARVs. So I see that if I take garlic together with ARVs, they will neutralise each other.<Internals\\Audio\\Indigenous> - § 1 reference coded [18.42% Coverage]

DREAD: I have seen that there are some that are incompatible with ARVs. You might start having side effects, like vomiting or just feeling like you are getting sick such that you will spend the whole day in bed because there will be some kind of incompatibility, I have experienced that.<Internals\\English transcripts\\Dread> - § 1 reference coded [0.82% Coverage]

Muyengwa and Tinomboedza insinuated this incompatibility in that they also think that TAM 'washes away' the ARV's:

You might take traditional medicine and wash away ARVs in your body. So if you wash it away you will be vulnerable again.<Internals\\English transcripts\\Muyengwa> - § 1 reference coded [0.28% Coverage]

In the morning before I take my tablet, I start by taking my TAM so that the TAM would not wash away the tablet.<Internals\\English transcripts\\Tinomboedza> - § 1 reference coded [0.62% Coverage]

Tinomboedza reported awareness of this incompatibility and may be what informed the 30min rule to separate the two medication types (Figure 5.25).

5.5.3.4 Stunting modernisation of children

For some, TAM was found to be inhibiting the modernity of children as well as to be unfriendly to the children. Dread emphasised this below:

DREAD: the way she is going to grow up, it is likely that she will not use again; she will not be able to live without herbs. For this child, with the way things and lifestyles are changing, it might be a problem such that she would not stay away from herbs. She will

get a job in another country where she would not get the herbs and that would affect her. Probably she will go to school, to University in UK other countries and there is no Moringa, there is no this, and it will be difficult for her.<Internals\\Audio\\Dread> - § 1 reference coded [12.07% Coverage]

A number of respondents felt that it is bitter, as shown in word tree below. As a result it would be unfriendly, especially to infants and young children (Figure 5.32)

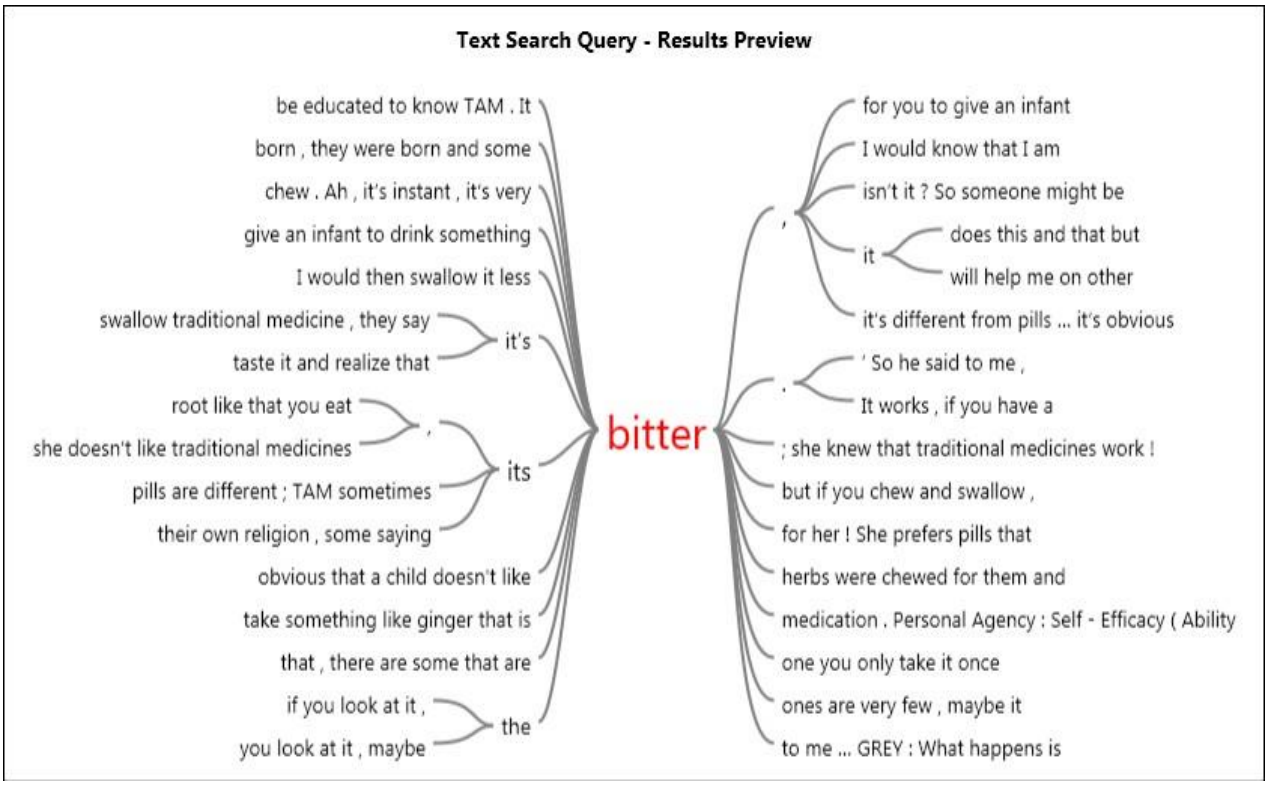

Figure 5.32: Text query for bitter

For some (in Figure 5.33 below) they also felt that it is sour and therefore to the discomfort of children:

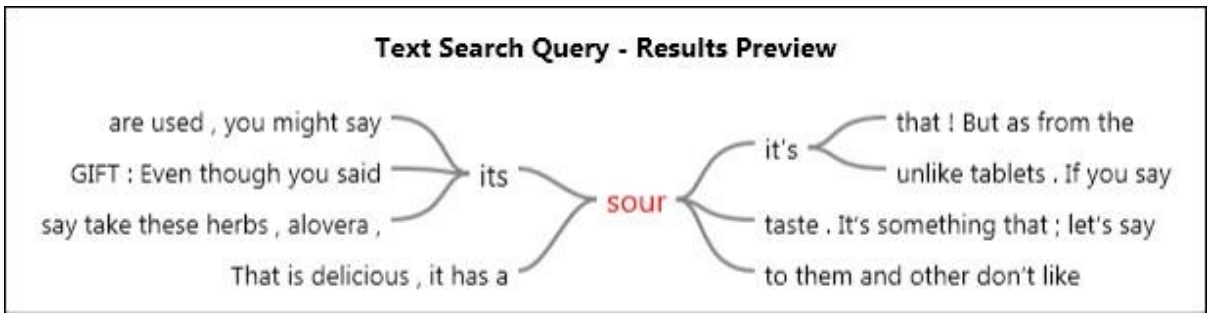

Figure 5.33: Text query for sour

To this bitterness and sourness, Charity, Dadirai and Zvisinei tried to devise some sweeteners, saying:

CHARITY: They don't have full knowledge about it, you know the children mostly they would refuse it. So if I cook it, I put peanut butter and they eat <Internals\\Audio\\Charity> - § 1 reference coded [18.15% Coverage]

DADIRAI: Yes, I sometimes mix with peanut butter and they like it like that. <Internals\\Audio\\Dairai> - § 1 reference coded [20.44% Coverage]

They take it as herbal but I would know that there is something behind it for them to stay strong. <Internals\\Audio\\Zvisinei> - § 1 reference coded [13.54% Coverage]

Although there were some negative affective evaluations, the TAM users tried to find ways to overcome these so that they could continue to use it and/or mix it with the ARVs or CM. For example, the technique of the 30 minute separation between the ARV and TAM as well as the addition of sweeteners are some of the methods devised to continue using TAM. Generally there was great enthusiasm and pro-TAM attitude that promoted continued use of TAM based on perceived TAM utility.

5.6 INSTRUMENTAL ATTITUDE

Instrumental attitude is contextualised as a cognitive evaluation of outcomes as a function of very specific beliefs about the likelihood that performing the behaviour would have certain outcomes (outcome beliefs). Instrumental attitude focuses more on the beliefs that inform an expectation of getting healed. In a way, it intends to unpack the

participants' predictions to use TAM resulting from perceived usefulness, as proposed by the IBM. As descriptive to the inquiry regarding the instrumental attitudes, below are a series of text queries for the responses regarding the advantages and disadvantages of TAM-use based on respondents' perceptions of its usefulness. To start with, Figure 5.34 is a text query on the advantages of the personal use of TAM:

Figure 5.34: Advantages to personal use of TAM

Generally, 'good' was the best descriptor of the utility of TAM as it stops pain, is cheap, made the participants stay strong, has no side effects, prevents infectious diseases, and so on. Below is the tree map for the responses to the disadvantages of the personal use of TAM:

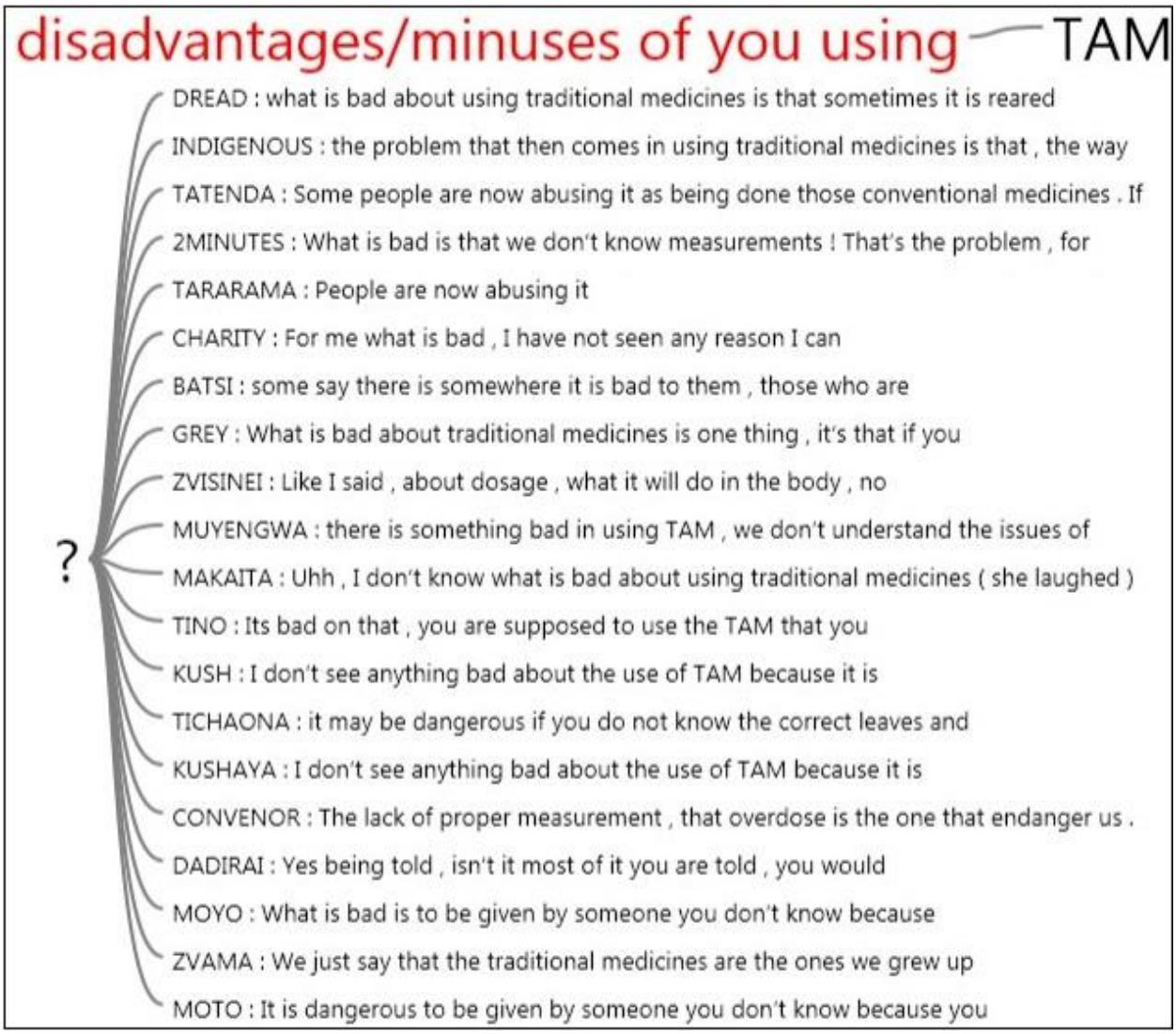

Figure 5.35: Disadvantages of personal use of TAM

The issue of 'hit-or-miss' measurements and dosages was the most claimed disadvantage of TAM useage. Some participants declared that one needs to have a trustworthy source, otherwise one would be given the wrong or damaging treatments. Some insisted that there was nothing bad about TAM. Below is a word tree for the responses to the advantages to the partners' use of TAM:

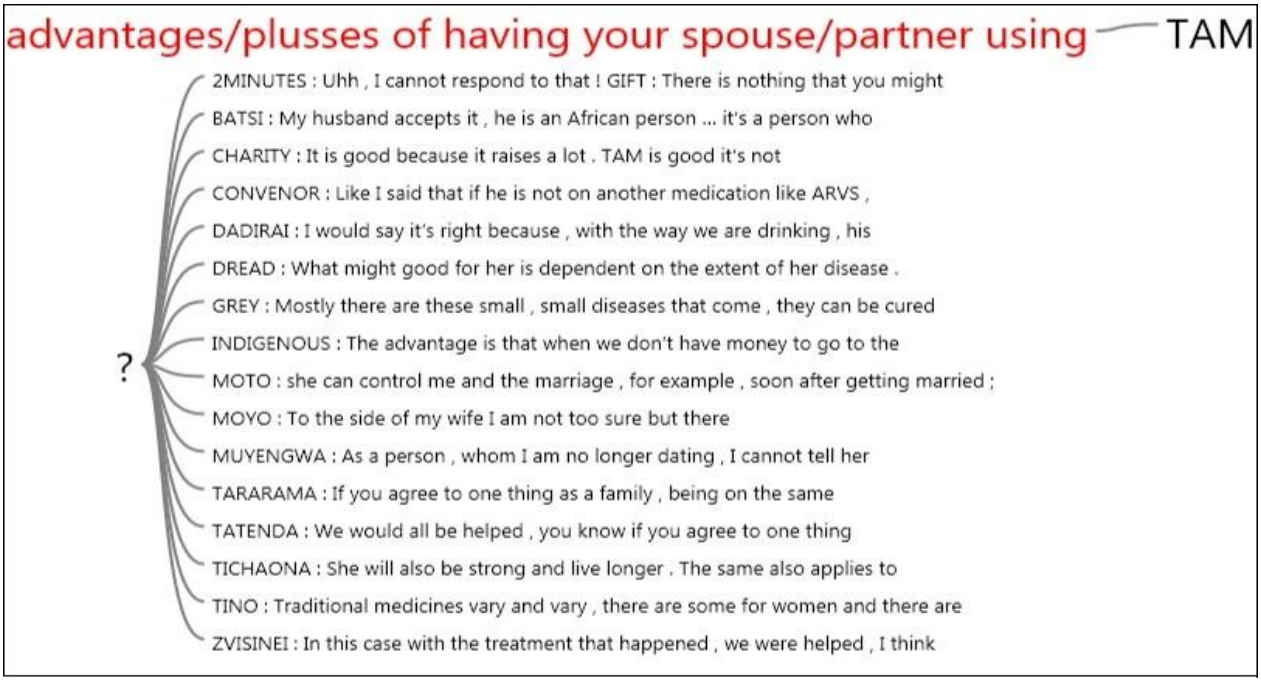

Figure 5.36: Advantages to the partners' use of TAM

As for the partner, some of the respondents felt that the partner's use brought unity as they would be 'on the same page'. Generally, their partners were in support and used TAM as well. Exceptions were those of TwoMinutes and Muyengwa whose use of TAM was not transparent to their partners. They also did not fully understand the treatments used by their partners. Maybe, it was attributable to their marital statuses, they were cohabitating. As for the disadvantage for the partner's use (Figure 5.37 below), most of them did not find anything wrong, although, the issue of prescription and trustworthiness popped up as above.

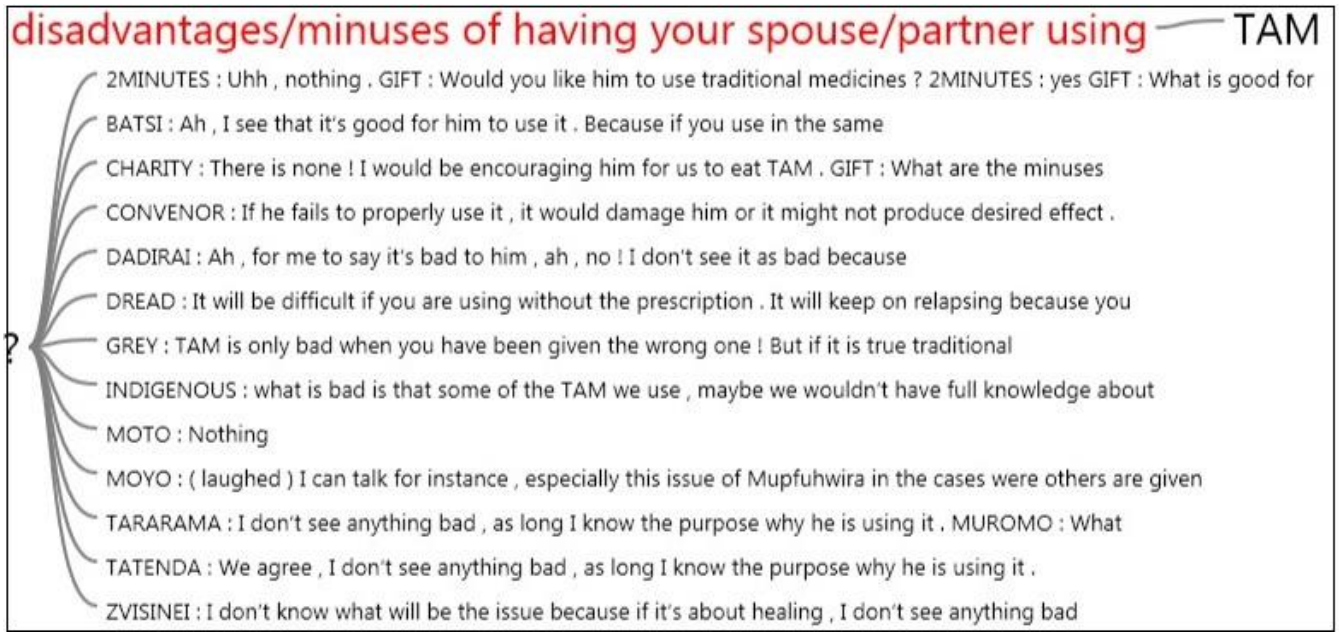

Figure 5.37: Disadvantage for the partner's use of TAM

For children, most participants stated they felt it is good for their children to use TAM and inherit the know how on this that they could pass on to their own children. Given below is a word tree for the responses to the advantages to the children's use of TAM:

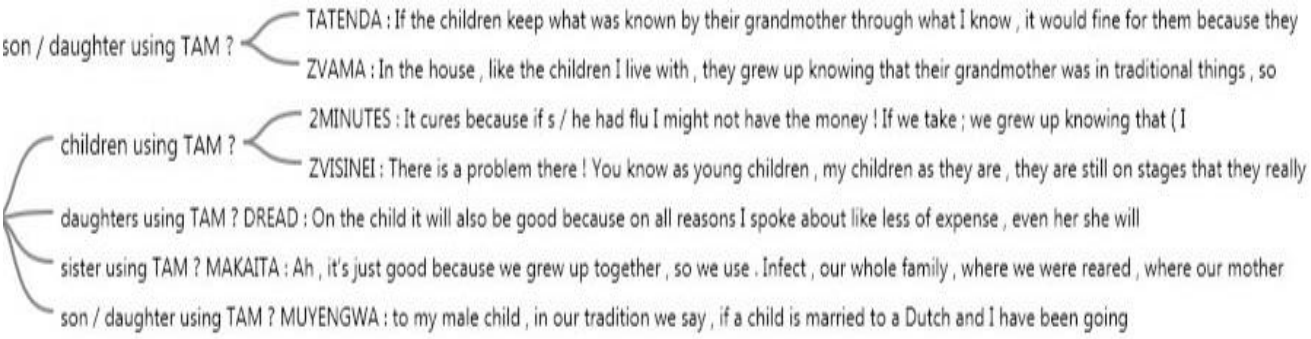

Figure 5.38: Advantages to the children's use of TAM

However, there was also a mix of opinions regarding the children's use of TAM. Below is a tree map to the responses showing the felt disadvantages of children's use of TAM:

TINO : its just the same , let's say its flu , I would do the same , but the ages varies depending on the ages . So the dosages

ZVAMA : To the child , for him to use traditional medicines ! He says they are not allowed at church to touch TAM . But all his childhood ,

child using TAM ? 2MINUTES : Those measurements ! They might have overdose ! GIFT : And get sick ? 2MINUTES : Yes GIFT : Even though there is n

children using TAM ? ZVISINEI : As long as they are using the way they are supposed to do , but for children to do on their own , that is bad for me !

Figure 5.39: Disadvantages of children's use of TAM

Some had no problem regarding the children's use but others found it difficult, especially due to the haphazard measurements and vulnerability. Some also found it difficult to make their children use TAM as there children now go to churches that do not allow the use of TAM.

A conceptual inquiry yielded four superordinate thematic areas as explanations of behavioural beliefs that constitute instrumental attitude. These superordinate themes are presented in the model below (Figure 5.40). This model captures the cognitive evaluation of outcomes as a function of very specific beliefs about the likelihood that using TAM would have favourable and rewarding outcomes (outcome beliefs).

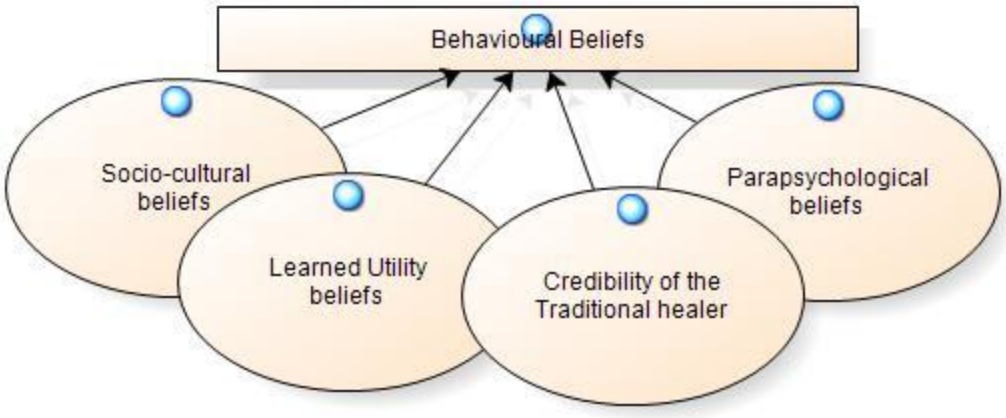

Figure 5.40: Instrumental attitude

5.6.1 Learned utility beliefs

Learned utility beliefs were abstracted as those beliefs that developed from positive reinforcement in previous use of TAM, especially in other ailments that were believed to

be comparably deadly and incurable. For example, the perceived success of TAM on the treatment of cancer and other ailments appeared to lead to a strong belief that TAM useage could lead to a favourable outcome in the treatment of HIV/AIDS. Below is the learned utility belief as demonstrated by Zvisinei's experience:

ZVISINEI: I have no problem with it as long as that TAM is for healing. I know, right now my husband has got cancer, there is this herb that he drank, he had cancer and had gone for, I think thrice going for chemotherapy, six done chemotherapies, and it would temporarily disappear. It started in 2005 and he was done chemotherapy in 2006, 2008 we returned for another chemotherapy, in 2012, no 2011, it recurred again, this time we did not have money, chemotherapy is very expensive. It was bad, and he was in pain… His nephew said, '*there is a herb that I heard can help to heal.*' … So he was given that herb, and took it. We can say he was treated by that woman. He had tests. Everyone was so interested to know the results, *'ah, the thing disappeared,…*So he went for the tests and he was told that he did not have cancer. Professor (Name withheld) said, '*if it was not me who diagnosed this disease, and it was someone else, I was going to say s/he lied to you, but no, it is me who found it and all this time I have been monitoring you seeing this thing giving you pain but right now you do not have it.*" S/he said, '*take even your blood, take it to Lancet (Medical laboratories) for it to be checked whether you still have cancer in your blood'*, we found out that there was nothing. That is how I discovered that it helps.<Internals\\Audio\\Zvisinei> - § 1 reference coded [13.54% Coverage]

Zvisinei's story seemed to be compelling and interesting. Such a reported successful previous experience was instrumental in establishing an expectation of belief for healing, even with HIV/AIDS. This was more of a vicarious positive reinforcement as it was happening to someone Zvisinei knows (a significant other). This learning by observing others helped to create the expectation of belief and optimism and hence the motivation to use TAM. This was not peculiar to Zvisinei. Batsiranai also reported a similar case:

…as for her, she had been treated cancer by that woman (traditional healer), her husband was cured cancer by that woman but initially he did not want. They were

treated that is why she encouraged me and said, '*go there.*' and I went to that woman. <Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

Through vicarious reinforcement, Batsiranai also developed the utility belief and was optimistic of a favourable outcome from TAM. Similarly, Charity learnt her belief from observing the progress from the patients she referred to the herbalist:

…she is someone I used to bring customers to. I directed patients for other diseases…<Internals\\Audio\\Charity> - § 1 reference coded [18.15% Coverage]

Charity started by bringing patients before she even disclosed her status to the herbalist. After being convinced, learning vicariously through others, she developed an expectation belief that made her optimistic and even disclosed her status to the herbalist in anticipation for the treatment. Zvamaronga also learnt from observing the patients who came to be treated by her mother, a traditional healer:

ZVAMA: I saw my mother helping people with TAM; people who were helped included those with mental and behavioural problems, she used to look for traditional medicine and s/he [patient] would get well. There were those who would have been struck by lighting, she used to look for traditional medicine to remove the lightning's spirit, removing that smoke (reversing the effects). Then came *zvipotswa* (evil borne curses), antenatal/postnatal care, *nhova* (baby dehydration), she was able to cure all these. I saw these people getting well because my mother was a known person, even in neighbouring countries like South Africa, she was known because of how she helped cure people.

MUROMO: Did you see people getting help?

ZVAMA: Ah, frequently… Like these days, she is helping people with cancer treatment, BP, Asthma, TB and those HIV positive, she is assisting in a big way, helping people..<Internals\\Audio\\Zvamaronga> - § 2 references coded [19.19% Coverage]

Zvamaronga had a strong utility belief of TAM. Such strong vicarious reinforcement was instrumental in establishing a high expectation belief for healing even with HIV/AIDS.

For some, it was directly their own previous use of TAM in other, especially recurrent and difficult ailments, which made them develop a strong utility belief in TAM use:

Ah, I do not want to lie to God, traditional medicines helped me… I had an incessant cough. In hospitals they were saying it was TB. So I went to be screened for TB and I was found negative. They gave me medication but the cough did not cease. TAM helped me. I went to this Sekuru (Male traditional healer) in Epworth (A high density residential area in Harare), he is a traditional healer, so this Sekuru gave me traditional medicine… Surely, inside three days I started seeing changes. Appetite returned after taking those medicines. <Internals\\Audio\\Tatenda> - § 3 references coded [25.73% Coverage]

These recurring, difficult to heal ailments included STIs. TwoMinutes and Grey revealed:

There is a problem like; I used to have that problem but I went and was given traditional medicine to drink before I started pills… before I was on ARVS, it worked for me and it disappeared. That problem ended. … Before, I had some pain on my vagina when urinating. So I went to this traditional healer who gave me traditional medicines and said, '*go and drink, put in the tea the other one you put in porridge*', so that problem disappeared… I tried conventional medicine but it did not work. It only worked temporarily and within a week I would relapse again…but when I started the traditional medicines, I got healed permanently. <Internals\\Audio\\TwoMinutes> - § 1 reference coded [22.81% Coverage]

GREY: I used to use traditional medicine that I was given by my grandfather when I was growing up but it was to cure other diseases other than related to HIV. It was meant to cure things like drop (an STI), or other things. <Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

The strength of utility beliefs was also seen in the predisposition of running to TAM when faced with health challenges generally:

BATSI: Soldiers, I was at 50 [CD4 Count]. When I went there I was at 50. I was almost dying. I do not wish to hide the truth from you. That time I was in pain. I was thinking that, *'ah, I now have go to the rural area to see my grandfather.'*[A traditional healer] That is when I saw that friend of mine who said, *'no, do not trouble yourself, there is someone I know.' S*he had been helped with cancer treatment by that woman. Her husband was also cured cancer by that woman. That is why she encouraged me and said, 'go there.' [to a traditional healer] and I met with the woman. So I thank her very much because if you look at me now, I am different from the way I looked. There is a significant change on me now. <Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

During that time it was not very common [HIV/AIDS] but we thought that it was sugar diabetes or another disease, we rushed to traditional healers, prophets and others. <Internals\\Audio\\Muyengwa> - § 1 reference coded [11.08% Coverage]

Generally, therefore, it was mainly previous or observed utility that caused a person to develop an expectation belief of optimism that TAM could help in the treatment and management of life with HIV/AIDS.

5.6.2 Parapsychological and religious beliefs

Beliefs that developed from religious practices and beliefs in parapsychological sensations in relation to motivation and anticipation for treatment from TAM were also identified. These beliefs were abstracted as parapsychological and religious beliefs. These findings support the IBM's proposition that positive perceived instrumental attitude is important in positively shaping behavioural intention, in this case, intention to use traditional medicine. Figure 5.41 below shows how the emergent nodes were gathered and nested to form this abstraction. The rectangle sizes also indicate the proportions of themes as they emerged from the data.

Figure 5.41: Parapsychological and Religious beliefs

There was a strong belief that there was spiritual intervention in both the search for TAM and the diagnosis of their ailments. They believed that the ability to use the TAM was passed on, not only through oral tradition but also and mainly as a special gift that one receives spiritually. There was the belief that the herbs were tried and tested by their ancestors and such knowledge and practices were passed on to successive generations, mostly as a spiritual gift to a few chosen ones. This deep-rooted identification with African Traditional Religion (ATR) made them develop high anticipatory belief that the spiritual intervention would inevitably assist in their healing.

It is believed, therefore, that the ancestors tried and tested the TAM and that through parapsychological sensations, such knowledge and practices were relayed to successive generations as spiritual inheritance and there was therefore an expectation that it would help. In other words, all the answers were understood to be in the ATR. To this, there were strong convictions on the rewards for the use of TAM that, as predicted by the IBM, resulted in the continued use of TAM:

CONVENOR: It is good because you really know where the herbs were taken from, and the contents. It is unlike these pills that we are just taking without knowing the contents. Later you will hear, '*Ah, the pills have these and those side effects because they were made by this and that.*' However, our own traditional medicines that we are used to and were also tested and used by our grandmothers and grandfathers, we understand them (herbs). <Internals\\Audio\\Convenor> - § 1 reference coded [14.07% Coverage]

Convenor believed that the ancestors (grandfathers and grandmothers) left a legacy; a tradition that she felt had a responsibility to also continue and be passed on. They have tried and tested it and they lived by it. This theme reveals both experiential dimensions (…easily found, it is not difficult for me to use) and instrumental dimension (…we are saying there is life in traditional medicines) of the attitude as a major determinant for TAM use. This finding is supportive of the IBM's predictive power of attitudinal beliefs on behavioural intention to use traditional medicine. Makaita and Tatenda also shared these sentiments;

…we grew up being told that it is preserving our tradition, the pills came later but the traditional medicines were already there.<Internals\\Audio\\Makaita> - § 1 reference coded [15.04% Coverage]

TATENDA: I do not want to lie, why is it being said traditional medicines no longer work yet they were used to treat people long ago? …But we are saying there is life in traditional medicines; if you look closely you will find out that some of the conventional medicines are extracted from TAM. So it is just that some people want to throw away our traditions and some of the things that helped and protected our ancestors and blindly adopt some things we do not understand. But we are saying for those who want to take those conventional medicines, it is ok, that is what they want, it is their choices but if I were asked to choose, I would like our traditional ones because they are easily found, it is not difficult for me to use them and it is part our tradition. <Internals\\Audio\\Tatenda> - § 2 references coded [10.28% Coverage]

However, for someone to get to know and use the TAM properly, it was believed that one had to inherit the spiritual inheritance that will allow one to be able to access and download this preserved and condensed know-how from the spiritual harbour;

For us these traditional medicines; our traditional healers did not just wake up and use the traditional medicines. They inherited the gift from their predecessors who knew. It's been passed from one person to the other, generation to generation by those that knew how it use the medicines. So that information and tradition kept being passed from one generation to the other, until it got to me today. If I die, there would be someone who would be given that spirit to heal. Traditional medicine has always been there since long time ago. <Internals\\Audio\\Grey> - § 1 reference coded [30.94% Coverage]

From the way I was brought up, I reached a stage where if I just look at a person, some a person, a spirit would come upon me advising me to tell that person something. I did not know what was compelling me to tell what was happening on someone's life. So I believe there is something that spiritually happened before I knew that <Internals\\Audio\\Tatenda> - § 1 reference coded [25.73% Coverage]

Spiritual inheritance was reported as a special gift, knowledge of the TAM that was passed from one generation to another through spiritual means. There was confidence that this knowledge was a package that would be transferred to another person after death. The belief seemed to indicate that it would be sudden knowledge that would come with the inheritance of that gift. There were strong beliefs in ATR and the spiritual intervention. If the TAM had always been there and is inherited, it therefore meant that it had been tried and tested and passed the test of time. Grey, Tatenda and others (Tinomboedza, Tararama, Tichaona and Charity) reported having the para-psychological abilities to access this know how. Generally, a traditional healer was believed to be using some parapsychological sensations to achieve the diagnosis and treatment of the ailments. Such an understanding resulted in the formation of beliefs of certainty and precision of the problem and its solution. With such confidence, they developed high expectation for treatment with TAM that is very indicative of a strong instrumental attitude towards TAM-use as proposed by the reasoned action approach.

Most of the respondents revealed that they have strong beliefs in African Traditional Religion (ATR):

BATSI: I accepted to use TAM because my grandfather was a traditional healer plus my aunt is possessed by a clan spirit (Mudzimu), she is also a traditional healer…. I told my husband that, '*for my HIV problem, I seem to have found where it can be solved.'* He said, '*Ah*, *can it be solved?'* I said, 'for *me it will not fail because I grew up in it. I will go to the hospital but I will first of all go to the traditional healer. If I go there and see it failing, I will come back to the hospital.*'… As for me I accept TAM not because I survived by it, no. I survived by it plus I was born in a TAM environment, all of us in our family use TAM because our grandfather, is a traditional healer. So these are things I quickly accept, or even when I was told by the traditional healer, I quickly accepted it because I was born in it. So that is why I quickly say it could make me live and surely it had made me live because right now I am healthy. <Internals\\Audio\\Batsiranai> - § 3 references coded [21.35% Coverage]

Batsiranai said she quickly accepted TAM because she was born in it. It was her religion. Kushingirira also believes in ATR and had grown up in it as depicted by the following probe:

MUROMO: Do you believe in African Tradition.

KUSH: Yes I believe, yes I do.

MUROMO: Why?

KUSH: we grew up doing it <Internals\\Audio\\Kushingirira> - § 1 reference coded [26.12% Coverage]

Tatenda also revealed her strong conviction for and identification with ATR:

Why should I refuse it now? Who am I? I am different from these others who are refusing it because if I am to be given choice to choose what I want, *'do you believe that traditional medicines help?'* Sure, you would find me on the traditional medicines' side, I

do not want to lie. <Internals\\Audio\\Tatenda> - § 1 reference coded [25.73% Coverage]

There was also a strong belief that the answer to HIV/AIDS was there in ATR package:

I thought to myself about how our great grandmothers, who were much older, survived without conventional medicines? … I am saying traditional medicines are there, people do not yet know who has TAM; it really works to raise your health . So it is just lack of knowledge, as for me I know that Mbuya and Sekuru (male and female traditional healers) in Epworth… <Internals\\Audio\\Tatenda> - § 3 references coded [25.73% Coverage]

BATSI: My husband accepts TAM because he is an African person… our country is an African country, so he is a person who knows our African tradition and accepts it because he knows that it makes people live from his ancestors until today TAM has always been there. Traditional healers have always been there, prophets have always been there. Hospitals came later after those things, that is what made people live in the past. So if you quickly understood what made our ancestors live before the coming of hospitals, they were living by those herbs. Even when our fathers were being born, they were born and some bitter herbs were chewed<Internals\\Audio\\Batsiranai> - § 2 references coded [19.41% Coverage]

Tatenda and Batsiranai believed that the answer was already there in the TAM and the CM was relatively new and young. This general strong belief in ATR made the respondents highly expectant of the healing outcome from TAM.

The spiritual intervention bred expectation beliefs mainly because of perceived precision in both diagnosis and treatment. Charity's case was "prophesied" below:

The traditional healer said to me, 'As for you I am seeing your health is deteriorating, you are supposed to habitually take TAM for your health to improve.' I did not tell her that I am HIV infected or anything. So when she said that I responded, 'ah, alright, you have done well to tell me.' She started to give me TAM that she said is for cleaning

blood, she said, ‘your blood might have some diseases that are in it’, you know how traditional healers talk, ‘so you are supposed to drink TAM that will clean your blood.’ <Internals\\Audio\\Charity> - § 1 reference coded [18.15% Coverage]

Whilst it is possible to argue that some of the symptoms of HIV/AIDS are observable with a naked eye, it takes great self-assurance and certainty to just intimate it to the suspected victim. However, this traditional healer reportedly revealed it and the idea that this information was coming from a spirit medium caused an expectational belief in Charity. If this traditional healer could spiritually identify the problem, what is the probability that she would pick the right treatment? With this spiritual intervention, there was a strong belief that the spirits would not mislead and Grey believed this too:

GREY: This woman threw bones, Chaka (Real name withheld) is a traditional healer. She knows herbs, she is spiritually directed to the herbs… it seems she dreams and goes to dig the herbs she had been shown in the dreams and brings it… In my view, spiritual intervention is there because she is made to dream the location of these herbs. She is given those things spiritually. She does not do trial and error looking for the wrong thing. Spiritually, that spirit always gives the correct medicine, it does not lie… <Internals\\Audio\\Grey> - § 4 references coded [55.28% Coverage]

For some they also believe that the outcome of any treatment is regulated in the spirit. As a possessed person, Tatenda believes that her family spirits had to first of all agree before she could use any medication:

My belief in traditional medicines is that if my family spirits did not approve of me to use some medicines, the medicines would not work. So there is something that I do to ask them to allow even those medicines from a traditional healer. I would privately say, ‘*I did not come here alone, it is you* (spirit) *who got me here.’* If you look at me, no one can tell that I can do the traditional things, they would say I am an urbanite yet right now inside myself I would say to the spirits, *‘it is you who directed this person come to me, let the medicine work’*, and it would work. I do not know what he (husband) was told when I was possessed; I do not know because sometimes I would be speaking in trance

directed by the spirit medium. <Internals\\Audio\\Tatenda> - § 1 reference coded [25.73% Coverage]

Could it be possible that a spirit could protect a person to the extent that it would block the pills? She had to unlock it to allow the other medication, the parapsychological release of inhibitory neurotransimetters. Tatenda also had a strong belief that every outcome is controlled in the spirit. She even attributed her resistance to ARVs to the inhibition from her family spirit in her:

So my CD4 count had really dropped, they had tried me the first line, it failed, second line, it failed and I was being told to go on the third line. So I was now a person who did not know how I was going to live, and the doctor had stopped me on medication in 2005 because of my reactions. My hair started falling, my nails turned black. So I was taken by this Mbuya (female traditional healer) and put on her traditional medicines and care… I started to improve. My CD4 count ranged around 5 to 7, it even reached 4 and rose to 7 and to 9 and then to 150 and even much higher due to those medicines. So that is when I realised that these medicines were greatly working for me.<Internals\\Audio\\Tatenda> - § 3 references coded [25.73% Coverage]

If an analogy is to be made with the computer world, Tatenda perceived the family spirit as anti-virus software that would not easily allow alterations. It claimed, '*I am protecting mine*', but such protection turned to overprotection as it ended up inhibiting the ARVs. Maybe the spirit wanted her to be treated using the TAM and not CM because she responded well to TAM. Maybe it was just a normal reaction to ARVs. Nevertheless, the traditional healer noticed that even though the improvement was there with TAM, the improvement was minimal and slow. She indicated that the traditional healer noticed this inhibition and told her that the medication was not working effectively unless other traditional issues were dealt with:

So because of the challenges I was facing, I spent almost a year going there but I was now going for other problems or issues she had realised I had, the traditional issues because she said to me, *'If I deal with one thing it is not working. There are spirits I*

have seen (identified) in you.'[1] <Internals\\Audio\\Tatenda> - § 2 references coded [25.73% Coverage]

After the spiritual inhibition was purportedly removed, she noticed great improvement and due to insecurity, she wanted to go back to ARVs, reporting that it worked well the second time:

…when I had realised my health improving, I said to myself, right now if I want to go back to medication, first line refused. Second line refused. Doctors are now trying the third line with this other professor called Akim (not real name). Akim did not find a donor willing to buy me [third line pills] and he said, *'go back to the doctor who started you on this medication and tell him/her what is happening.'* I returned to doctor Kurakura (not real name) and I told him/her, *'this is what is happening. So I am now afraid to stay without medication for a long time.'* The doctor said, *'I do not know what to do with you*?' I said, *'Doctor I am now risking, return me to the medication you gave me at first'*, I knew I was banking on my traditional medicines, so I kept on mixing my traditional medicines with the conventional ones. I astonishingly improved, I do not want to lie.[2] <Internals\\Audio\\Tatenda> - § 2 references coded [25.73% Coverage]

It seems possible that the claimed removal of the spiritual obstacles was perceived as instrumental to improved treatment. Given that it did not work initially, the first and second lines failed to work until she went for spiritual cleansing. Tatenda believed that the failure of the ARVs was due to the spiritual inhibition that she went to unlock.

Despite being true or false, rational or irrational, these parapsychological and religious beliefs had a bearing on the development of belief outcomes on the use of TAM. There were strong, deep-seated beliefs in the ATR and spiritual intervention whose accuracy and effectiveness were assumed to be beyond human ability and this gave rise to high anticipatory beliefs for the effectiveness of TAM.

5.6.3 Socio-cultural beliefs

Socio-cultural beliefs were contextualised as those beliefs that developed from socialisations (especially childhood) and cultural practices. These socialisations and

cultural practices gave the participants repeated exposure to the use of TAM thereby creating a predisposition and optimism that TAM would work for them. For some they took TAM as interwoven with their identity and to them the effectiveness of TAM was inevitable. Figure 5.42 below shows the three socio-cultural emergent themes.

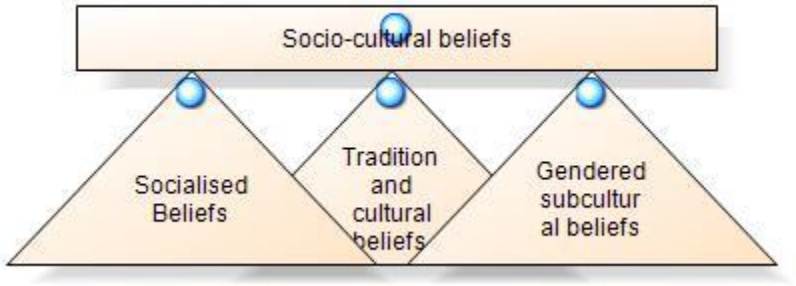

Figure 5.42: Socio-cultural beliefs

5.6.3.1 Socialised beliefs

The phrase '*we grew up'* was very prominent in this study. It succinctly captured the early socialisation to TAM. Childhood experiences seemed instrumental in influencing health preferences and behaviours. Figure 5.42 below indicates the word tree for this phrase:

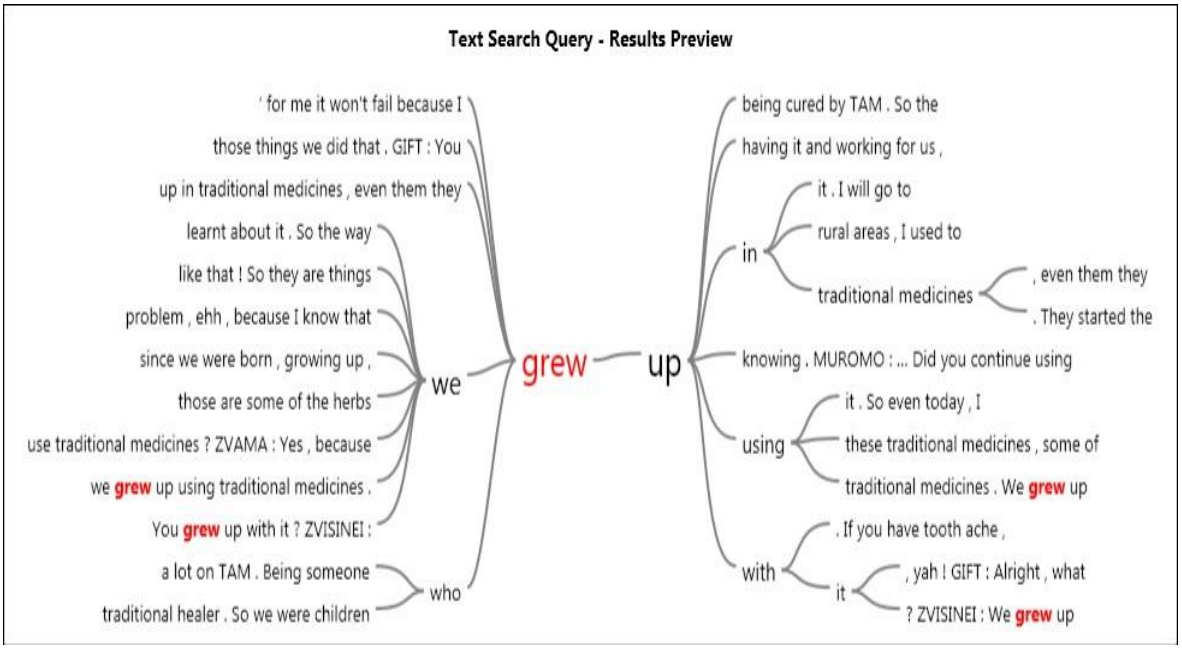

Figure 5.43: text query for grew up

Early socialisation into or about TAM was found to be very instrumental in the development of pro-TAM attitudes as predicted by the IBM:

MAKAITA: Uhh, I can just say since we were born, growing up, we grew up using traditional medicines. We grew up using it. So even today, I have not stopped using. I would say if I am told that these certain ailments, I will take and use. I have not had any problems in my use of them.<Internals\\Audio\\Makaita> - § 1 reference coded [6.30% Coverage]

Makaita revealed that her expectancy for cure from TAM was nurtured from childhood. Many others also concurred, and below is the rubric of various childhood socialisation into TAM:

MOYO: I can say my experience with traditional medicines began when I was young around grade 5-6 staying with my grandmother. That is when I experienced using traditional medicines.<Internals\\Audio\\Moyo> - § 1 reference coded [17.59% Coverage]

INDIGENOUS: Yah, ehh, when I was growing up, I knew that traditional medicines help… Mostly herbs that cure stomach aches, herbs for eyes, headaches, ehh, those are some of the herbs we grew up knowing and using…to me there is no problem, ehh, because I know that we grew up using these traditional medicines<Internals\\Audio\\Indigenous> - § 2 references coded [11.07% Coverage]

KUSH: I can say the time we were born and growing up, traditional medicines were put in porridges, in those shupa spoken about, and a child would grow fit…I was not going to traditional healers but my parents; my father was possessed, he was a traditional healer, so he healed people with TAM.<Internals\\Audio\\Kushingirira> - § 2 references coded [26.12% Coverage]

TATENDA: It is just that we are no longer chewing traditional medicines for the children of nowadays, as for me traditional medicine was chewed and given them to me to eat. I am 49years old, my mother chewed traditional medicine for me, she would chew it to reduce it's bitterness and make it tender, I would then swallow it less bitter; she knew that traditional medicines work. <Internals\\Audio\\Tatenda> - § 1 reference coded [25.73% Coverage]

ZVAMA: Yes, because we grew up using traditional medicines, even them they grew up using traditional medicines. <Internals\\Audio\\Zvamaronga> - § 1 reference coded [14.38% Coverage]

This induction to TAM in early life nurtured optimistic belief for the healing from TAM. Batsiranai also revealed the same:

So we are children who grew up using and being cured by TAM. So would just go to hospital at times as a formality when we fall sick, but mostly we were given TAM to the extent that even up to today, I just go to the hospital here and there only if I have other treatments that needs pills or other things that can be easily dealt with at hospital. Most of the times I would say if I got sick, I would run home (rural) to fetch TAM and I would be given…

I felt and said, 'for me it will not fail because I grew up in it. I will go to the hospital but I will first of all go there to TAM. If I go there and see it failing, I will come back to the hospital.' As for me I accept it not only because I survived by it, no. I survived by it plus where I was born in the family, all of us we use TAM because our grandfather, that is the job he does. So these are things I quickly accepted, or even when I was told by this woman, I quickly accepted it because I was born and grew up it. So that is why I quickly say it could make me live and surely it had made me live because right now I am healthy… <Internals\\Audio\\Batsiranai> - § 5 references coded [21.35% Coverage]

Batsiranai revealed strong conviction and customary socialised belief about the use of TAM. She said, '*So these are things I quickly accepted, or even when I was told by this woman, I quickly accepted it because I was born it'.* Her statement assumed that she blindly accepted it because of her early and repeated exposure to the use of TAM. She also believed that growing up using TAM was the main reason behind her use of TAM, she said, '*As for me I accept it not because I survived by it, no. I survived by it plus where I was born in, all of us we use TAM…*' She delighted to this socialised belief, and believed in its effectiveness before she began the TAM treatment. To her, the utility of TAM was well-socialised. Convenor also revealed her childhood experience with TAM:

I encourage use of TAM because when we were growing up, we used to say, if you had a stomach problem, you would be told, *'Go and chew Munhunguru leaves* (a herb)*, your stomach problem will get well'*, and it would be like that, the stomach will heal up. That tree is found in the forest it is not found at the home, the time that you would walk to that forest to chew the leaves, when you return home, you will come back with a healed stomach… that is how and where we learnt about it. So the way we grew up using TAM and having it working for us, that is the information we are now passing to our children… <Internals\\Audio\\Convenor> - § 2 references coded [22.98% Coverage]

Convenor revealed the practical socialisation in which the children were told and helped to identify, fetch and use TAM. Like learning to walk, the children were told step-by-step and the outcome became socialised beliefs that were influencing the optimism and predisposition to use TAM. This practical socialisation was also revealed by Zvisinei:

Being someone who grew up in rural areas, I used to know that if I have stomach aches, I would take leaves from *Mutukutu (herb)* or *makavi (bark)* from *Munhondo (herb)*. If you have throat problems you chew *makavi (bark)*from *Mushamba (tree),* things like that. So they are things we grew up doing. If you have tooth ache, you take *Murima (herb)* and hold in your mouth, all those things we did that. If you want to brighten your teeth you take *Muchenura (for toothpaste)* and clean your teeth, all those things we did that…We grew up with it, yah.<Internals\\Audio\\Zvisinei> - § 1 reference coded [13.54% Coverage]

There was also inter-generational socialisation that seemed vital to the development of these socialised beliefs. Grandparents, especially grandfathers, were revealed as active socialisation agents. Figure 5.43 below shows the word tree for the intergenerational socialisation.

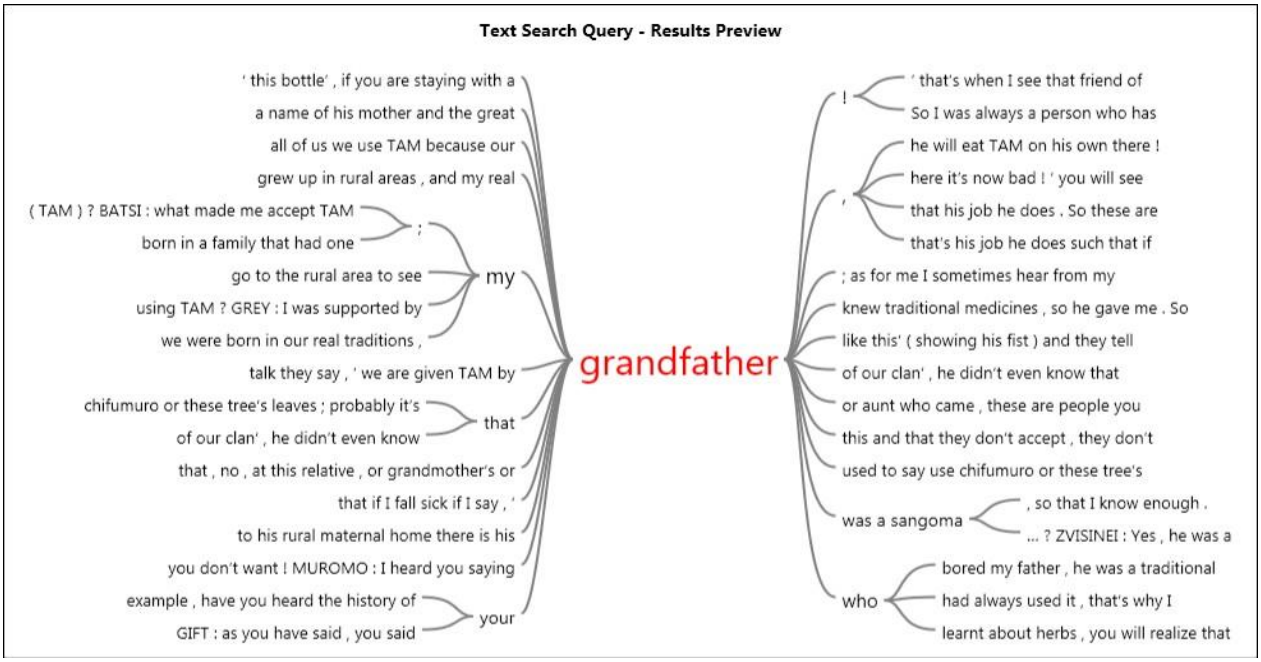

Figure 5.44: Text query for grandfather

5.6.3.2 Traditional and cultural beliefs

For some they had traditional and cultural beliefs that made them optimistic in expecting healing from TAM. To them TAM was part of their life. TAM seemed to be interwoven with their identity. To that end, TAM gave them a sense of pride, originality, uniqueness and prestige. Embedded in this was also the engagement into preservation activities to preserve and transmit these traditional and cultural beliefs to the next generation. Consequently, optimistic beliefs for the effectiveness of TAM were inevitable. The most common traditional and cultural identity constructs (as shown in Figure 5.44 below) were identifications with Africanism and ruralism.

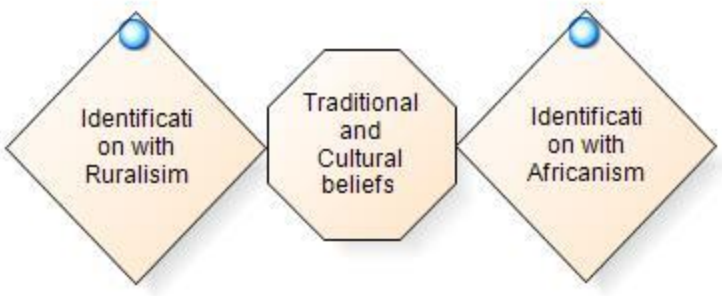

Figure 5.45: Traditional and cultural beliefs

5.6.3.3 Identification with ruralism

Identification with ruralism was largely marked with active connection, frequent visits and attachment to the rural home area in relation to the use and efficiency of TAM. There was a marked belief that the rural home community knew the remedy to some ailments:

BATSI: Soldiers, I was in 50 (CD Count), when I went there I was in 50, It was so low that I thought I was dying, I do not want to hide it to you, I was dead, I was in 50, that short period I was in pain. I was thinking that, *'ah, I now go to the rural area to see my grandfather.'* <Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

Batsiranai felt that if she went to the rural areas her problem would be solved. Grey also reported frequent visits to the rural areas for TAM:

GREY: If I go to the rural home, I would dig it, I know it. If I was there I would be digging because I know how it is like. When I go there next week, I would bring it and prepare it for others who need to be helped…

GIFT: How often do you go to your rural home?

GREY: Monthly <Internals\\Audio\\Grey> - § 2 references coded [24.38% Coverage]

Equally, TwoMinutes reported frequent visits and regular use of TAM in the rural home:

GIFT: How often do you go to your rural home?

2MINUTES: Every holiday

GIFT: Every holiday?

2MINUTES: Yes

GIFT: How often are traditional medicines used in your rural home?

2MINUTES: Ah, a lot <Internals\\Audio\\TwoMinutes> - § 2 references coded [22.81% Coverage]

Zvisinei also correlated the know-how of TAM to growing up in rural areas:

Being someone who grew up in rural areas, I used to know that if I have stomach aches, I would take leaves from *Mutukutu* or *makavi* from *Munhondo…* <Internals\\Audio\\Zvisinei> - § 1 reference coded [13.54% Coverage]

Generally, the identification with ruralism helped to develop some instrumental attitudes as it nurtured the development of expectation of treatment. In a way it gave a sense that TAM was their way of life, a way defined by their origin, their parents and grandparents. Identification with ruralism gave them a sense of identity and justification to use TAM.

5.6.3.4 Identification with Africanism

Closely related to the notion of ruralism was the Africanism; identification with Africanism was also used for the development of instrumental attitudes. Being an African was associated with inevitable use of TAM;

BATSI: My husband accepts it (TAM), he is an African person… He was born in African set up, in our country, so he is a person who knows our African tradition and accepts it because he knows that it made people survive from his ancestors until today TAM has always been there. What is happening is that it is us who are not accepting it. As for my husband, he accepts it because he knows that our tradition has always been there. Traditional healers have always been there, prophets have always been there. Hospitals came later after those things, that is what made people live in the past. So if you quickly understood what made our ancestors live before the coming of hospitals, they were surviving from those herbs. Even when our fathers were born, some bitter herbs were chewed for them and given. That was the important “hospital”; it was now diminishing with these conventional things that are coming. Especially me and my husband we strongly accept it because we were born in our traditions. My grandfather, that is his job such that if I fall sick if I say, ‘grandfather, I am not feeling well,’ Someone who will be possessed by the clan spirit will go and take the TAM and give directions on how to use it and i will heal.<Internals\\Audio\\Batsiranai> - § 1 reference coded [19.41% Coverage]

Africanism was taken as an inevitable identity that predisposed them to use TAM.

5.6.3.5 Gendered subcultural beliefs

Gendered subcultural belief was abstracted as TAM related activities and beliefs perceived to be peculiar to each gender, yielding an instrumental attitude. It seemed that some of the participants believed that TAM worked differently depending on gender. These gendered groupings seemed to be sharing and promoting some special peculiar reproductive health issues, out of which some of the problems, for example STIs, were resolved successfully using TAM. Some of these gendered subcultural beliefs were reared from childhood, in which each gender was somehow socialised differently as to what, when, how and why they use TAM. Figure 6.52 below shows the nesting of how gendered subcultural beliefs were conceptualised.

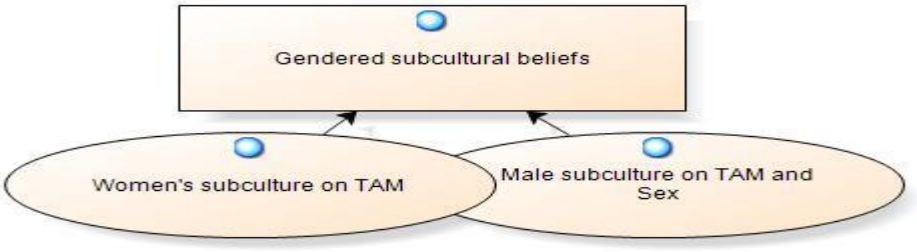

Figure 5.46: Gendered subcultural beliefs

5.6.3.6 Male subculture on TAM and sex

The male subculture on TAM seemed very common and started in early life. Dread and Moyo revealed this below:

DREAD: I can say, we were not using traditional medicines as medicines for cure. We were advised that as boys and men, we should pass through where there is traditional medicines and take herbs like alovera whether we were sick or not.<Internals\\Audio\\Dread> - § 1 reference coded [11.06% Coverage]

MOYO: When I am grown up like this I do not have a lot, you know what happens with us men, sometimes you would be given traditional medicine to strengthen your back, *Guchu* (calabash with liquid herbs) and so on and so on…., I am a man, I sometimes

talk about those sex issues, there are these other tablets I was given, being said to have been made by traditional medicines.<Internals\\Audio\\Moyo> - § 2 references coded [30.63% Coverage]

Guchu seems to be a perculiar terminology used to refer to the TAM concoctions. Grey and Tinomboedza also revealed that men have their own issues:

TINO: you know on our man issues, on the issue of having sex with many women, you get a lot of STIs, so that is when you learn these things. When you have sex with someone you will be advised to take herbs until you understand how effective they are.… Traditional medicines vary, there are some for women and there are some for men, they are used differently <Internals\\Audio\\Tinomboedza> - § 2 references coded [32.16% Coverage]

GREY: These are male elders in the clan; you would be asking, *'see elder, I am feeling this?*' they would go and dig traditional medicine and give you and you would live <Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

Although women might not know what exactly happened in this male subculture, they knew that it existed. Dadirai had this to say about her husband:

Then we are also living differently. As a man, probably he takes TAM elsewhere and does this and that; as a person who moves around, maybe he secretly uses it, I would not know it. He would drink it there, maybe. He can drink <Internals\\Audio\\Dairai> - § 1 reference coded [20.44% Coverage]

Like Tinomboedza, Dadirai acknowledged that not only the male subculture, but also the female subculture. Generally, the male subculture is highly marked with the reinforcement of promiscuity and mischievousness, as such men were continuously given TAM concoctions to treat various STIs.

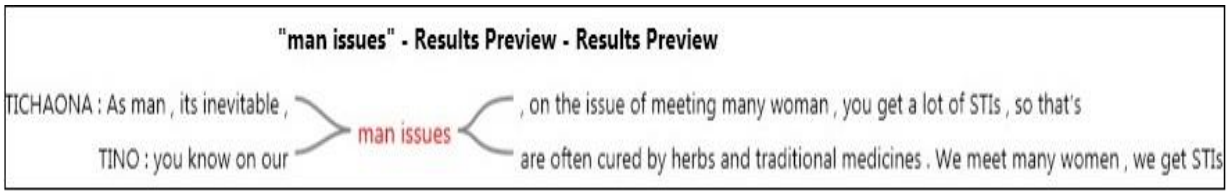

Figure 5.47:

As shown by Tinomboedza and Tichaona, men have their own issues related to meeting many women:

TINO: you know on our man related issues, on the issue of having sex with many women, you get a lot of STIs, so that is when you learn these things. You will meet someone who would advise you to take herbs until you develop a good appreciation of them. I now understand them… <Internals\\Audio\\Tinomboedza> - § 2 references coded [32.16% Coverage]

Tinomboedza and Tichaona's instrumental attitude first developed in their involvement with this subculture that they often turned to for assistance with STIs and '*issues of meeting many women*.' Tinomboedza acknowledged that he now knows it, showing that he held such subcultural beliefs promoting his optimism and expectancy from TAM on men issues to which HIV/AIDS was equally qualified. Grey also openly said TAM helped him more for STIs:

GREY: I used to use traditional medicine that I was given by my grandfathers when I was growing up[1]but it was to cure other diseases other than related to HIV. It was meant to cure things like drop or other things… Drop is a STI; if you have sex with a woman, you would continually produce pus; those traditional medicines are there that cure that.

GIFT: Here you are referring to the time you were growing up?

GREY: Yes

GIFT: What of the times when you were young?

GREY: We were still too young, we were not mischievous and promiscuous.

GIFT: You said when you were grown up, you were meeting with grandfathers, which grandfathers are you referring to?

GREY: These are male elders in the clan; you would be asking, *'see elder, I am feeling this?*' they would go and dig traditional medicine and give you and you would heal.<Internals\\Audio\\Grey> - § 2 references coded [24.38% Coverage]

Generally, being involved in the male subculture seemed to be instrumental in informing health preferences and behaviours. TAM is linked to promiscuity as it helps to cure the consequent STIs and this is generalised to the treatment of HIV/AIDS as well.

5.6.3.7 Women's subculture on TAM

On the other hand women also form their own subculture on TAM. As already demonstrated by Dadirai and Tinomboedza, women have their own TAM concoctions. Tino said:

TINO: Traditional medicines vary, there are some for women and there are some for men, they are used differently<Internals\\Audio\\Tinomboedza> - § 1 reference coded [13.90% Coverage]

The subculture was demonstrated by how some of the female respondents were hesitant to talk about some of their gender perculiar use of TAM. For some women it was even difficult to talk about some of their subcultural secrets, they were shy and nervous to talk about it to the male interviewer. This was demonstrated by TwoMinutes below:

2MINUTES: The likes of *Ndorani* (herb), the one that treats constipation…

GIFT: Which one is the one that treats the constipation?

2MINUTES: It is reddish like…So that the air or pressure will not build up in the stomach (bloated tummy)

GIFT: In the stomach?

2MINUTES: (*Nervously laughing*) Ah, your questions are tricky brother.... The one that treats the bloated tummy. You put it in the porridge or in the water and you drink…there is also the other that warms the body, it will not get cold. There are a lot, so they will sell to you straight….

GIFT: You did not clear on the bloated tummy issue; will this bloated "air" cause stomach problems?

2MINUTES: It is not a good pressure building up

GIFT: Is it the bloated tummy that gets in through the mouth?

2MINUTES: Through the vagina. (*Nervously laughing*)

GIFT: So it will get out through the vagina?

2MINUTES: yes

GIFT: Alright, so you said your sisters support you and friends; on friend which friends are you talking about?

2MINUTES: Ha, just friends, the ones I hang with, females.

GIFT: Are there no male ones?

2MINUTES: Ah, we do not have.

GIFT: Why do you not support each other with male friends?

2MINUTES: Ah, I have never talked with male friends about these issues.

GIFT: Why?

2MINUTES: Uhh, we do not exactly match; things that they want and what we use are different. The herbs are different.

GIFT: So it is different, it is unlike ARVs that works…

2MINUTES: On everyone? No, there are types for women and types for males, so I do not know how it works for males. That is why we discuss as females only.

GIFT: Do these herbs differ in relation to HIV and AIDS, to say that this works for women in relation to HIV/AIDS…

2MINUTES: Yes

GIFT: This one works for men in relation to HIV/AIDS?

2MINUTES: On that one I do not have enough knowledge to understand that…

GIFT: But you are saying traditional medicines vary depending on whether it is a male or female?

2MINUTES: Yes

GIFT: Which is the reason why you discuss as females?

2MINUTES: Yes <Internals\\Audio\\TwoMinutes> - § 1 reference coded [18.63% Coverage]

TwoMinutes found it very difficult to talk about this activity. It is quite perculiar to their subculture and she could not comfortably share it with a male. However, she revealed that they have their own subculture as woman. Zvisinei confidently explained how women differently use Ndorani and Zumbani, the issue that TwoMinutes failed to openly explain:

ZVISINEI: As a grown up, basically, I can say, the only herb that I use now and again, it *is this one, Ndorani. It is used to sort a bloated tummy. I also use the likes of Zumbani*, things that remove pressure in the body…To women, I do not know what happens, as you grow, you will be releasing a lot of "bad air" a lot (virginal), so if you take those herbs that will be reduced, it is embarrassing. The elders tried to prevent so that it will not happen to women. I do not know what will be happening to the human body, I think

it is aging, it will get loose, or something that is why there is that remedy for us to keep on taking,<Internals\\Audio\\Zvisinei> - § 2 references coded [13.54% Coverage]

TwoMinutes also referred to other TAM used to keep the body warm as a remedy for low sex drive in women. Like *Guchu* for men, women have some of their own that help them especially in regards to sex and reproductive health issues. This engagement in these sex and reproductive TAM-related activities helped to develop an expectation and optimism that it can help, especially when coming from the one who normally gave for other success on sex and reproductive predicaments.

5.6.4 Credibility of the traditional healer

The credibility of the traditional healer was also directly important in attitude change and the shifting of the latitude of acceptance. As shown in Figure 5.46 below, perception of orderliness of the herbalist, dedication of the herbalist, free provider initiated treatment, herbalist visits and credibility of referrals all assisted in positive shifting of the degree of acceptance as most of them started to develop more positive instrumental attitudes, developing optimism and anticipation for treatment. This was shown by the development of confidence with the traditional healer and even to an extent of trying to buy the know-how.

Figure 5.478: Credibility of the Traditional healer

5.6.4.1 Dedication of the herbalist/traditional healer

The latitude of acceptance was largely shifted to be positive due to the perception of the dedication of the herbalist/traditional healer:

I might indicate that I have a terrible head ache, and she would arrive and say let me give you TAM to lower the pain… She would really sit down with you, the first days, if you are a person who stays nearby or somewhere close. If she sees that you may have problems using TAM, she would try to assist you. She would come and assist you like she did to me.

GIFT: She comes?

CHARITY: Yes she comes, like me I was a person who was close to her as friends and where we lived. She wanted to know if I have taken the TAM, and she would arrive in the morning and say there is the morning's porridge. We normally used it in porridge

and mahewu, *'did you eat your porridge in the morning?'* if she fails to come in the afternoon, normally in the evening she comes to check if you have eaten that porridge.<Internals\\Audio\\Charity> - § 2 references coded [18.15% Coverage]

So if it is TAM, it is not difficult. Right now if I tell herbalist that I am sick, I have done this and that, she will come and give me TAM. She will check on me and diagnose what is wrong with me; she would look for TAM that treats what I am feeling and give me.<Internals\\Audio\\Charity> - § 1 reference coded [9.29% Coverage]

This commitment from the herbalist helped the patient to develop an instrumental attitude. This assisted in the shifting of the latitude of acceptance and increase the chances that the patient would also continue to use TAM. Such commitment encouraged patient's perceptions of the credibility of the herbalist which was important for not only attitude formation, but also the change of an existing one. Charity was a good example; she used to despise the use of TAM. However, due to the perception of credible commitment from the herbalist, she developed some credibility related beliefs that made her change her negative attitude into a positive instrumental attitude about TAM.

Batsiranai also implied being driven by the commitment of the traditional healer as well:

…. As for me I was bed ridden, she brought her TAM here at my place. She left her place she operates from and her family and sacrificed to come and treat me here. She was committed..<Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

For Charity the herbalist even offered to help:

The traditional healer said to me, 'As for you I am seeing your health has slightly deteriorated, you are supposed to habitually take TAM for your health to improve.' I did not tell her that I was affected or anything. So when she said that I said, 'ah, alright, you done a good thing to advise me to take TAM.' She started to give me TAM that she said is for cleaning blood, she said, 'your blood might have some diseases that are in it', you know how traditional healers talk, 'so you are supposed to drink TAM that will clean your

blood.' So that's when s\he started giving me the TAM…<Internals\\Audio\\Charity> - § 1 reference coded [18.15% Coverage]

5.6.4.2 Credibility of referrals to the Traditional Healer

Credibility of the referral was also used and helped to develop instrumental attitude. Degree of acceptance shifted positively;

I was told by this other woman, a friend who was a workmate that, ' ah, you are saying your body is in pain; and you are saying you are used to TAM, there is someone I know who knows that TAM she is from ZINATA.' I said, 'where is she?' and she said, 'ah, Whitecliff.' I said, 'so how are you going to get me there?' that woman took me there and we saw the one who was called Mai Cosmas, AKA Chaka. <Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

I got to know her after being told by my sister who is living in South Africa now. She is the other one who was positive, she is the one who told me that this mother seems to know traditional medicines.[2]<Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

The friend, for Batsiranai, and sister, for Grey, were credible referrals. The trust from these people helped the patients to develop optimism and expectation.

5.6.4.3 Confidence with Traditional Healers

The perception of orderliness of the herbalist also gave impetus to the development of an instrumental attitude. The appealing methodical strategies were used heuristically to estimate the high chances of TAM's veracity. Charity narrated the methodology of her herbalist:

She gave me two types, one that was in liquid form, and the other powdered. I used them in the porridge and in Mahewu those TAM. Then she gave me TAM that she said it was to strengthen the body and surely it worked well for me… So she gave me TAM that was like a course, it was a course, she used to give us as a course, a monthly course.

GIFT: What was this course composed of?

CHARITY: The course consisted of four or five depending on your stage. So those were the TAM she gave me.

GIFT: How does the Mbuya know your stage?

CHARITY: She tells from your appearance, your skin would tell that it now needs you to improve the health of your body, to restore your body to its original state. So she gave me TAM and appetizer for you to boost your appetite for food. So if she gives you TAM to boost your appetite, you will certainly like to eat food. After you have eaten, you will then be given TAM to restore your health...She doesn't give you those courses at once; she gives you one at a time. If you get given all the courses at once, it means that you are now strong, plus you would be now knowledgeable on how to use those courses. She might give you the first course to say, *'go and eat this course, I want you to clean your blood.'* You would use it lets say for two weeks or for one week depending on your state. After using it, she would give you another one depending on your stages, until she had seen that you are now in good health. <Internals\\Audio\\Charity> - § 3 references coded [18.15% Coverage]

Equally, Batsiranai was also following some organised method:

I used it for a month her TAM, some I used in the porridge, some I inhaled it's steam/smoke, some I drank, some I was told to bath with it and I used it differently. I used these concurrently with the pills. When I had the pills, she told me that, '*for 30min you use your conventional medicine, 30min you will then use your TAM so that it will balance all side not leaving one side.' …*yet it has dosages… sh e told me that, like me with pills, she told me that if 6 o'clock is the time to takes your pills, you take your pills and drink. After 30min you take your TAM and drink. If you are taking your pills thrice that is what you also do, you would space them with 30minutes so that they (medicines) give each other a chance. '<Internals\\Audio\\Batsiranai> - § 2 references coded [40.76% Coverage]

Grey also reported following similar methodical instructions:

GREY: Eh, my son got well after he was given traditional medicines by this woman, they were given enough for 2weeks, … being given to drink. They were given three bottles monthly, from there they were changed. She kept on changing the traditional medicines, there is the one for stage one, stage two and stage three. If the medicine is compatible with you and you are lucky, the HIV would vanish, they would not find anything.[2]… So its stage one, two and three, monthly and you would finish them all drinking. You would be given another one for another stage one, two and three. You would be given again another stage one, two and three. If you go and discover that you no longer test positive or you still test negative, you would still be a healed person because it could be that you would have been sick for a long time, it might take time for it to finish. But if you have been sick for 2-3years, no, that can be finished by my traditional medicine. <Internals\\Audio\\Grey> - § 2 references coded [24.38% Coverage]

As a result of this perception of orderliness, some of the patients developed loyalty, a sign that they now have strong instrumental attitudes about the veracity of the TAM. Charity and Grey demonstrated this below:

CHARITY: Ah, before 21days you would be right. You would be fit and greatly strong. If you are a person who religiously follow what you have really been told to do, at 21days you would be fine.<Internals\\Audio\\Charity> - § 1 reference coded [18.15% Coverage]

GIFT: So you only use TAM from this mother?

GREY: It is the only one that I used; I did not use other TAM.

GIFT: On treatments related to HIV?

GREY: For HIV it was only this mother, yes.<Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

Charity revealed that thorough loyalty to the meticulous orderliness demonstrated by the traditional healer the desired result was achieved. Equally, Grey reported dropping any

other TAM, which seemed to be a sign of trust and contentment with the new one due to the perception of, among other things, the orderliness of the traditional healer. Grey went even further. He even paid to buy the know-how:

As a person who has prior experience, I was sick as well. I understand what I was suffering from, because I experimenting with TAM, I could understand them, and now I have knowledge about them. I used to seek to understand the traditional medicines, I would look for some few cents and s/he would show me the herb (tree) and I would develop knowledge about it.<Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

The credibility of the traditional healer was seen in how the patients were confident with their healers. This confidence in the traditional healer helped to develop an instrumental attitude about the veracity of TAM:

'…no, what I am doing doctor, I will not hide it from you because that wouldn't be advisable. It's not allowed, I am using TAM, I got it from people who are able to use TAM.'<Internals\\Audio\\Batsiranai> - § 1 reference coded [21.35% Coverage]

Batsiranai was overwhelmed with confidence with her traditional healer as she explained to her doctor about her 'miraculous' CD4 count increase. Grey also oozed with confidence as he talked of his herbalist who made him test HIV negative:

Ah, this woman's traditional medicines seem to work effectively, she does not use bogus medicines. She uses traditional medicines that work, that she knows and understand their effects. <Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

TwoMinutes had a lot of confidence:

GIFT: How much confidence do you have in n'anga (traditional healers)?

2MINUTES: Ah, a lot. <Internals\\Audio\\TwoMinutes> - § 1 reference coded [22.81% Coverage]

The credibility of the herbalist/traditional healer seemed very meritorious to the development and positive shift of degree of acceptance about use of TAM. This

credibility was found to be critical especially in the regulation and conversion of negative attitudes about the use of TAM. The traditional healer either acquired this credibility from his/her own direct activities such as home visits, orderliness and trustworthiness, or it was through referrals from credible referent others such as friends and relatives. Nonetheless, such credibility nurtured optimism and expectation belief that compounded in an instrumental positive attitude about the veracity of TAM.

CHAPTER SIX

SOCIAL INFLUENCE BASED TAM MOTIVATIONS

6.1 INTRODUCTION

As a construct of IBM, social influence was contextualised as social pressure one expected regarding performing the behavioural concomitants of using TAM. According to IBM, social influence is understood to be constituted with descriptive norms and injunctive norms. In this study, descriptive norms were found to influence decision-making to use TAM through the extent to which members of important networks were perceived to perform the behaviour of using TAM themselves. On the other side, injunctive norms influenced decision-making to use TAM through the extent to which important social networks were perceived to be supportive of the person's use of TAM. However, unlike what the IBM posits, the present study found out that there was another strand of responses that seemed to suggest another form of social influence, which was neither the injunctive nor descriptive norm. This strand pointed to the extent to which the influential minority manipulated the majority and important social networks to support and perform the behaviour of using TAM, inversely reinforcing the minority to continue using TAM. Such minority social influence was coined the minority norm (see section 6.3). Figure 6.1 below illustrated the conception of social influence derived from this study which is slightly different from what is documented by the IBM.

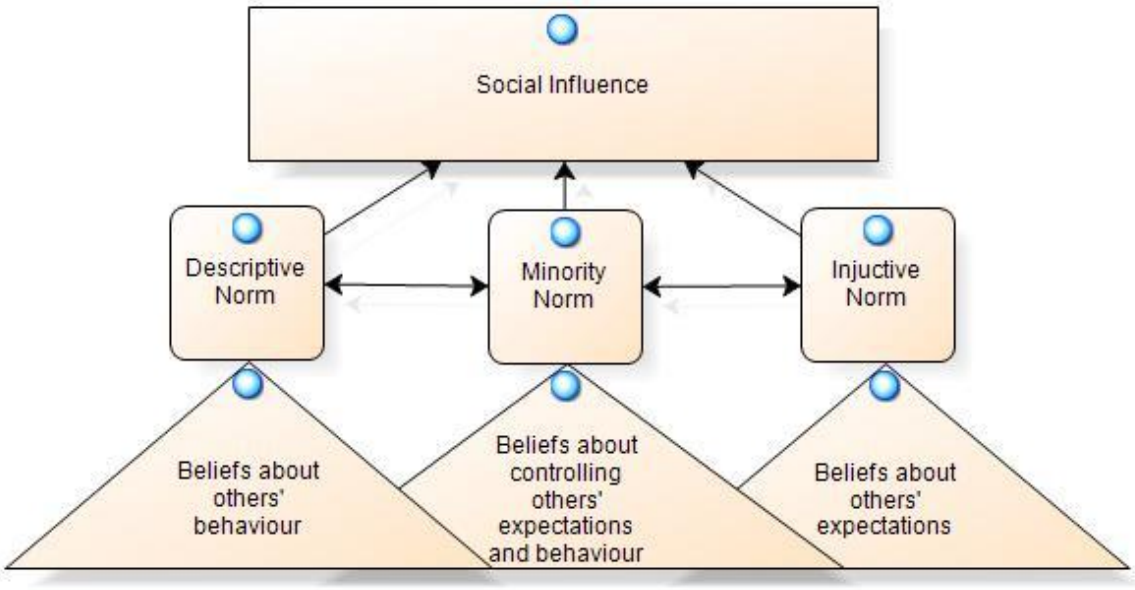

Figure 6.1: Social Influence

6.2 INJUNCTIVE NORM

The injunctive norm is conceptualised as influence through the extent to which important social networks are expected to be supportive of the person's use of TAM. As shown in Figure 6.2 below, promotion and inhibition are the two ends of the continuum of supportiveness. The promotion iss revealed through the family support, support from the custodians of African tradition, government and institutional support as well as gendered subcultural groups. On the other hand, inhibition is reinforced by conventionality, gospel/apostolic churches' restrictions, incompatibilities with contemporaries/in-things, doctor's censorship, marital discords, and lack of knowledge.

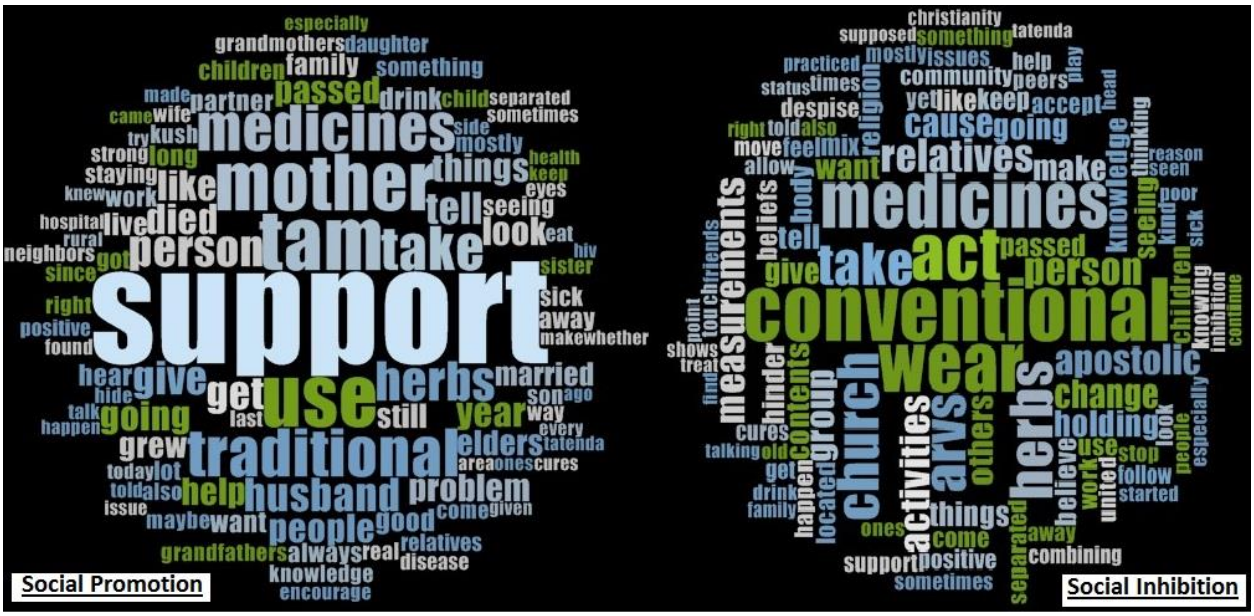

Figure 6.2: Clouds on beliefs about others' expectations

6.2.1 Social Promotion

Social promotion was abstracted as at least the perception of supportive influence or social networks towards a person's use of TAM. However, such social support to use TAM seemed to be very scanty. This was revealed by Makaita below:

MUROMO: Who or what would support you using TAM?

MAKAITA: uhh, that one is hard (She laughed)…It is hard to answer that one… I am supported by my family, those can support me… Just advising me that traditional medicines are effective … my family consist of my parent, my older sisters, all my brothers support me.<Internals\\Audio\\Makaita> - § 1 reference coded [9.36% Coverage]

It was 'hard' for Makaita to find support to use TAM. Maybe due to shared plight, the family was found to be the main source of social support.

6.2.1.1 Support from family

Generally, the mothers were the most common supporters (see Figure 6.3).

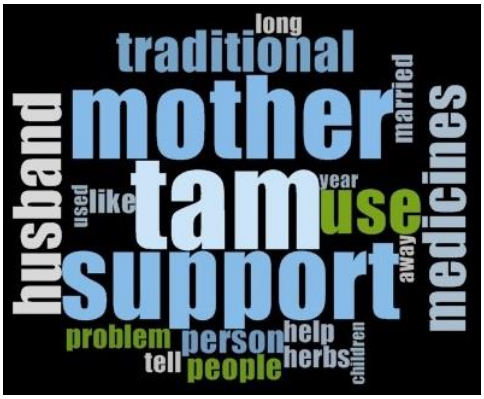

Figure 6.3: Family support

Great support came from the family. This family covered both the near and extended family members:

MOYO: Ha, If I am to analyse my wife's family, her mother is the one who mostly deals with traditional medicines…S/he would know from me if I have used it. The immediate relatives, in their long chain, would either use it or not, but they would have been encouraged to use them with desired results.<Internals\\Audio\\Moyo> - § 2 references coded [8.98% Coverage]

Moyo revealed links and social support from his wife, mother-in-law and grandmother-in-law. Similarly, Tatenda revealed links and support from husband, mother-in-law and grandmother-in-law:

TATENDA: His real mother is still alive, you hear her saying; his mother's mother was still alive, she passed away last year but, he used to say, *'Had it been that she used to go to hospitals and get operations, she should have died long ago.*' Right now his mother is still strong, she is just having problems with legs as an elderly person but you hear it being said, *'Had it been that she eats Anglicized things or drinking, she would have been damaged long ago.'* So it is showing that with their background, that is what it is. Even if my mother-in-law visits us here, if you say, '*here is the medicines brought for you'*, her grand child is a nurse, you hear her saying, *'Haa, these medicines are difficult for me to take.'* So you would see that there is something she depends on. <Internals\\Audio\\Tatenda> - § 1 reference coded [14.51% Coverage]

The rural home was also found very important in provision of social support. Both Moyo and Tatenda revealed some links to the homes of orientation which in most situations would be in the rural areas. Similarly, Zvisinei and TwoMinutes pointed to strong rural home support:

ZVISINEI: For me basically, I have to turn back to those in the rural area… there is my sister, if I say there is an herb I want, she is the one that I will tell to look for it and send it to me.

GIFT: Where is your sister?

ZVISINEI: Rural area

GIFT: How often do you communicate with her?

ZVISINEI: Ah, a lot, to the extent that these days with these cellphones, no, it's even worse.

GIFT: So how will you get these herbs from the rural area…? Can you say more about your relationship, the herbs and the arrangements…?

ZVISINEI: In our rural area we have, like I said, I was born in Mangwende, is it not? It is the same area in which I was married so I just pass through our parents' home going to where I am married. So when we say today we are going to our rural home, we would pass through seeing others and I will collect. So there is no problem, my sister was married close to our parents' home, it is just a matter of saying to her, ' *we will pass through and see you, go and wait at mother's place'*, because the mother's place is near to the road*, 'wait at mother's place and we will see you, bring me this, that and that.'* So she prepares, if she cannot wait, she will leave and tell them to give to us when passing.
<Internals\\Audio\\Zvisinei> - § 2 references coded [15.99% Coverage]

Zvisinei had a very strong connection to her sister and the rural home. The communications and procedures are well set out to facilitate the search and provision of TAM. TwoMinutes also reported having a lot of support from the rural home:

GIFT: What support do you receive from them (Parents in rural home)?

2MINUTES: A lot, the other herbs they tell me, the other herbs they were given to plant at the home.

GIFT: Who gave them?<Internals\\Audio\\TwoMinutes> - § 1 reference coded [22.81% Coverage]

6.2.1.2 The nuclear family

Generally, support from family mainly came from nuclear family members or close relatives. The above cases of Zvisinei, TwoMinutes, Tatenda, Tararama, Moto and Moyo revealed strong connections with close extended family members, especially those from their families of orientation. It can be conjectured that the close family involvement in the promotion of the use of TAM inhibits the endorsement of social promotion beyond the family. Most of the respondents were quick to point to their nuclear family as a source of support:

If I failed to go and take the TAM, if I fail to drink the TAM he (Husband) would tell me that, *'mother, what had gotten into you? Go to Mai Cosmas and get your TAM if what you have has run out'*, because he knows that it helps…Ah, my husband supports me. He now supports me even more. Even his relatives they now encourage me to keep using TAM. My husband uses that TAM because he also got sick. He grew up using TAM, up to today he is still drinking, so it is a thing that had gotten in our home to the extent that I do not see anyone who can remove it, there is no one because we live in it … So I keep on enlightening my husband… So we keep on strengthening each other me and my husband so that we cannot go back because that is what can keep us health. s\\Audio\\Batsiranai> - § 4 references coded [35.45% Coverage]

Batsiranai reported receiving a lot of support from her husband and they keep on encouraging each other to keep on using TAM because they both recovered significantly through the use of TAM. At their nuclear family level they were strong and so were Convenor, Dadirai and their husbands:

CONVENOR: When you are living with someone every day, that person advises, even if you refuse some of the advise from you husband, but as a person you are living with, you end up listening and understanding.<Internals\\Audio\\Convenor> - § 1 reference coded [13.73% Coverage]

DADIRAI: My husband is on pills.

MUROMO: How do you take the idea of him using TAM?

DADIRAI: He is the one encouraging me to use it.

MUROMO: Is he using it as well?

DADIRAI: Ah, just when the drink is there, he drinks but not often.

DADIRAI: There is no one in the community; the person who supports me is my husband.<Internals\\Audio\\Dairai> - § 2 references coded [35.57% Coverage]

Dadirai also revealed the scarcity of support in the community, stating that support was much stronger back at home. Dread also spoke of home support:

DREAD: We are just supporting each other, and that entirely depends on where we both came from and our traditional beliefs. Whatever perceptions or differenced we both have, we discuss them. If we are solely on herbs we will not go to ARVs, we will stick to herbs no matter what anybody says.<Internals\\Audio\\Dread> - § 1 reference coded [11.60% Coverage]

Grey appeared the greatest advocate of home support and he made it a family culture for his family to customarily use TAM:

All of us here we are united; we support each other the use TAM…For us our children we monitor them, as they grow, each day as a parent you monitor how s/he spends the day. A young child does not know what is causing pain to him/her. So you ask him/her, '*what is the problem? What is causing that?*' if s/he says the eyes, you go and fetch TAM for the eyes and treat him/her. If s/he says it is the tooth, you go and fetch TAM for

the tooth and you make him/her drink. Sometimes the small child would be having a toothache and she would blame an eye. So you try to find what is paining him/her.[1]<Internals\\Audio\\Grey> - § 1 reference coded [6.93% Coverage]

Similarly, Tatenda found support from her family:

Who or what support would you give your son/daughter using TAM?

TATENDA: It is me, their father or me their mother.<Internals\\Audio\\Tatenda> - § 1 reference coded [14.51% Coverage]

Like Grey, Zvisinei also found support from her children. Her husband was not supportive despite all her effort to help him to start on TAM. She actually did not get any support from the extended family, maybe except from the sister-in-law she helped:

…When you look at me, especially my husband's relatives, they have known me to be a Christian to the extent that even when my husband was sick, he took long time being sick because they were afraid to come and tell me that they have some herb that we want to try that can help him. So basically he gets the support from me because even himself he said, '*Ah, will it work?*' But I encouraged him and said, *ah, ah, people are giving you to eat, look at me in my eyes, you are going to die today or tomorrow, so whether you drink this herb, you will die, or you did not drink, you still die, so if this is trying to help, try it and we will see what will happen'*, and it helped. So I would say it is me who supports him; seeng that he has eaten the herbs, whether we are doing it correctly and get the results together.<Internals\\Audio\\Zvisinei> - § 1 reference coded [15.99% Coverage]

Social support from the nuclear family seemed not to be limited only to support but also the safe guarding of the family secret. As a result it would form a family culture (Grey's case) in which the children are habitually encouraged and treated with TAM in order to grow/rear a child who would regard TAM as a family culture and tradition.

However, support from the partner was found to be complicated in which even the lack of the support from the partner would paradoxically result in a supporting effect. For

those partners who both used TAM, their stories were simple as they portray positive affect and linear social support:

GREY: she uses it, I feel happy when she uses it because I know that traditional medicines help. <Internals\\Audio\\Grey> - § 1 reference coded [24.38% Coverage]

INDIGENOUS: to me there is no problem, ehh, because I know that we grew up using these traditional medicines,<Internals\\Audio\\Indigenous> - § 1 reference coded [11.07% Coverage]

TATENDA: I do not have a problem with it, I do not have. You know when God created things, if you look at it, each season has its own diseases that emerge, it also have fruits and things that help in that season but people only just do not take advantage of it. <Internals\\Audio\\Tatenda> - § 1 reference coded [25.73% Coverage]

The above cases were from harmonious relationships in which both partners were using TAM. The same cannot be said to Charity's case in which the partner was resisting the use of TAM and as a result they ended up becoming competitors in searching and proving the best treatment:

The death of my husband strongly pained me because I warned him before about the effectiveness of TAM. So it is a thing that greatly pains me. He was a person who had an advantage. When I am looking at it, I see as if the pills were not working for him because he was a person who had swollen legs, he had almost a year with swollen legs. So I told him that, '*the pills have failed to work for you, please leave them and try the traditional medicines.'* And he said, *'ah, for me to stop. These issues of traditional medicines are problematic. For me to take these traditional medicines, this does not work. I am taking these pills, it would be fine.'* For me, TAM was working well, so it was something that hurts me that the person did not understand until he passed on. I am even certain that it was the pills that killed him because even when he went to the doctor, there is this other doctor he went to, there was an allergy he had developed in his body, he developed capo Tisa coma (type of cancer). It was said to have been caused by the pills. So I got to a point of knowing that pills weren't working and I told

him to use traditional medicine but he refused. … I know he would have lived longer if he had agreed to use TAM. I am not saying he was going to live forever but would have lived longer.<Internals\\Audio\\Charity> - § 2 references coded [18.15% Coverage]

It seemed as if the competition with the husband in which each was pursuing a different treatment ended up in an unfortunate outcome in which Charity lost her husband, to which she reasoned that it was because the husband was following a wrong/less effective method. Although this was unfortunate and unpleasant, it created a vicarious positive punishment for Charity. She vicariously observed her husband being positively punished for non-compliance to use TAM. As a result she was reinforced to continue using her TAM. This is a form of indirect social support from the interaction and relational disputes with the partner. Even in the death of her partner, she found greater support and justification to use TAM:

CHARITY: Yes but the husband is no more, he died.

GIFT: The death of your husband; could it be due to this disease?

CHARITY: Yes, a lot.

GIFT: Can you tell me your experience if you are free to?

CHARITY: I say it was that exactly because he had tested HIV positive.

GIFT: So you both knew your status?

CHARITY: Yes, we knew…I looked after my husband since 2011 up to his death…I felt he was going to live many more years, I would not say he was going to live forever but we know that the years were going to be more, and that would have been better.<Internals\\Audio\\Charity> - § 3 references coded [28.53% Coverage]

Charity expected to live many more years, just as she thought her husband was going to live had he listened to her. This shows therefore that generally, the death of the partner raises reality issues of HIV/AIDS and reinforces the use of TAM. It is indirect social support emanating from relational contexts. It vicariously reinforced the use of

TAM. It can be reasoned that widowhood (especially caused by HIV/AIDS) is one of the relational contexts that promoted the use of TAM. Charity's case might not be peculiar; widowhood was a thread that permeated in a number of the respondents (25%).

6.2.1.3 Support from community

As shown above, support from the community was scant; it was limited to a few like '*real, real neighbours'* whom they trusted. This was emphasised by Indigenous below;:

INDIGENOUS: In the community I live, those who support me in the use of traditional medicines are my real neighbours, I can say they support me because even themselves they find it helpful… Sometimes we help each other cutting grass.. we are together , we assist each other in the fields.

MUROMO: So why do you think your neighbours so supportive for?

INDIGENOUS: there are some close relatives among those we stay with, some even know it… So they encouraged us because we have opened up to them, and we made our told them about our problem, they know them. These are not the problems I can hide to them. Hiding is concealing information that might help someone. So if I became open, that will be helpful even to others.<Internals\\Audio\\Indigenous> - § 4 references coded [15.26% Coverage]

Indigenous repeated the qualifier '*real*' to show the importance of trust required from the social supporters. He defined these '*real, real neighbours*' as those who understood and were in the same use of TAM. Such people could be trusted and were supportive. So who were these real neighbours? Among them were the custodians of tradition, some gendered subcultural groups, government and other supportive organisations.

6.1.2.4 Indirect vicarious community support

Another indirect social support came from observing other community members who were HIV positive but non-compliant in using TAM. In a way the observers got reinforced to continue using TAM by vicarious punishment:

KUSH: In the community what support us, we see people who frequently fall sick. So if you start TAM it would assist you get better. You won't deteriorate, you will remain fit.

MUROMO: How do you get the support?

KUSH: We are supported because what we do is effective and has good results.

MUROMO: Who would be supporting you?

KUSH: As we drink it, the people who would see us strong, attractive and all that; that is what would help us<Internals\\Audio\\Kushingirira> - § 1 reference coded [9.55% Coverage]

Kushingirira found motivation from the positive perceptions of those who supported the use of but were not themselves using TAM. She got reinforcement from perceiving the punishment of non-compliance.

Generally, the support was very scant outside the comfort zone of family and '*real, real*' friends and neighbours. It seemed to be marred by secrecy and unpopularity that the users did not want to be identified with, yet helpful. This can be substantiated with a lot of social inhibition that came from others, especially those outside the comfort zone.

6.1.2.5 Support from custodians of tradition

Outside the family, support also came from the custodians of African tradition like traditional healers/herbalists, elders and in the spiritual realms (Figure 6.4).

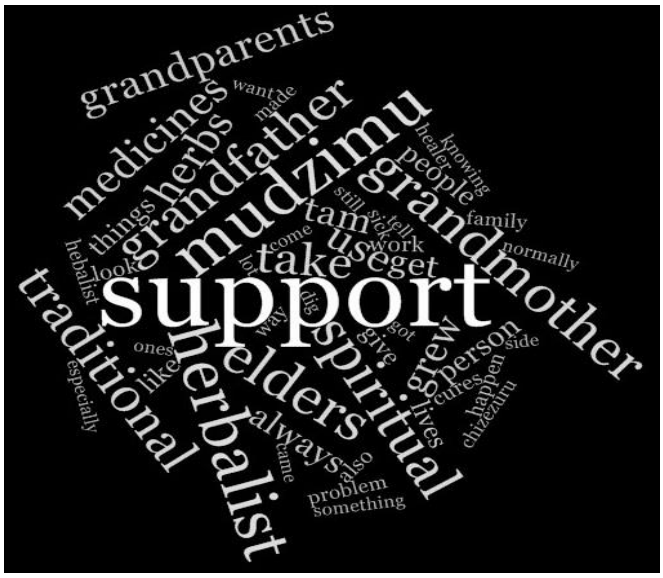

Figure 6.4: Support from custodians of tradition

Most of these TAM users felt that their strong support came from the traditional healers/herbalists, especially the one from whom they got their TAM:

CHARITY: The issue was a secret in my life, and the person who knew my status was my herbalist who was curing me. She is the one who was able to know the way I could improve ...<Internals\\Audio\\Charity> - § 1 reference coded [18.30% Coverage]

Charity also revealed that these traditional healers/herbalists can be trusted with secretes especially regarding their HIV status. Batsiranai also reveal great support:

The herbalist sits with you down like I am right now and says, '*have you understood the nature and form of my TAM? You will use it at such and such time.*' She comes here, especially if I say I am not feeling well, she will come to see what would be happening, trying to find out the problem and give me TAM that cures the problem she would have identified <Internals\\Audio\\Batsiranai> - § 1 reference coded [14.11% Coverage]

Batsiranai's traditional healer/herbalist paid home visits and exhibited empathy. Dadirai also indicated that her husband got support from the people who sold TAM to him:

My husband has supporters from those who sell him TAM… it is like a shop…That is where he is helped<Internals\\Audio\\Dairai> - § 1 reference coded [15.13% Coverage]

The elders also supported the use of TAM as they believed this aided in the preservation of African beliefs and culture. Dread said his grandfather supported him strongly:

My elders are still alive and they support me a lot in using TAM because they have never got the knowledge about conventional medicines, they are even afraid of pills… My grandfathers said, '*my grandchild should take herbs, they are the ones we grew up taking, and it helped us. These diseases you are talking about they were always there it is just that it would not come out because we were always each and every time using herbs, each and every time not waiting to get sick'*<Internals\\Audio\\Dread> - § 2 references coded [11.60% Coverage]

Grey also revealed support from his grandfather;

I was supported by my grandfather who had always used it; that is why I know that it works, it is true… My wife has always been using TAM, together we have always been on the traditional side; where she came from they had their Chizezuru (Zimbabwean tradition) and we also had ours and we got married… Chizezuru…my wife's mother had strong beliefs in traditional medicines and my parents also believed in traditional medicines…<Internals\\Audio\\Grey> - § 2 references coded [6.93% Coverage]

Grey used the term Chizezuru to refer to Zimbabwean traditional life style that id regarded as the main source of support and nurture of the use of TAM. He also alluded to his and his wife's mate selection preferences. It seemed similarity on this aspect of using TAM was at work when they chose to get married as it helped them to remove disparity with regards to their health seeking behaviours and use of TAM. Chizezuru was a common factor and they both went to similar kinds of churches that permit the use of TAM. The idea of growing up with elders in an African traditional life style was also revealed by Indigenous:

INDIGENOUS: To my wife…I do not see any problem because she is a person who grew up in our traditional ways like I did and is a black person who grew up following our traditions <Internals\\Audio\\Indigenous> - § 1 reference coded [15.26% Coverage]

Similarly Zvisinei and Zvamaronga also grew up with grandparents who, not only support in them how to use TAM, but also taught them:

ZVISINEI: What normally supports me in using these herbs, I think, the experience that I had when I was growing up is the one that makes me say it works because luckily, I grew up with grandparents. So they were people, if something happens, whom you would return and ask this, that and that and they will give advice, so we were covered. <Internals\\Audio\\Zvisinei> - § 1 reference coded [15.99% Coverage]

ZVAMA: my friend also learnt use of TAM from her grandmothers. <Internals\\Audio\\Zvamaronga> - § 1 reference coded [11.52% Coverage]

For some they felt that their support came from spiritual beings and realms:

TATENDA: First and foremost, I would say my Mudzimu (ancestral spirit) is the one that supports me. How it does that is now personal, personal. But for me Mudzimu, I do not want to lie to you, I tell my ancestors even things that have something to do with my health, anything I want to do on my health, I firstly start by talking to my Mudzimu. <Internals\\Audio\\Tatenda> - § 2 references coded [14.51% Coverage]

To Tatenda the traditional family spirit (Mudzimu) is the source of her support. She felt that she had the support of her ancestors. Zvamaronga also felt that she is supported by the long dead elders:

Sometimes even myself, I am made to dream about it but I would wake up forgotten to identify the herbs. I would not know but it would have been pointed for me in that dream as helpful to a person… Sometimes I dream getting in water or flying and getting into water and I would get out with medicines but I would be told that this one is for this and that one is for that. Sometimes I am made to dream of elderly people, the elders telling me, *'all your problems would end with traditional medicines, you should dig this one, that one and that one. All these would end.'* But when I wake up I would not know. <Internals\\Audio\\Zvamaronga> - § 1 reference coded [11.52% Coverage]

6.2.1.6 Gendered subcultural groups

Outside the family, support also emerged from gendered subcultural groups. This was revealed by TwoMinutes below when she was asked about her source of support to use TAM:

2MINUTES: Ha, just friends, the ones I hang out with, females.

GIFT: Are there no male ones?

2MINUTES: Ah, we do not have male friends on that.

GIFT: Why do you not support each other with male friends?

2MINUTES: Ah, I have never talked with male friends about these issues.

GIFT: Why?

2MINUTES: Uhh, we do not exactly match; things that they want and what we use are different. The herbs are different.

GIFT: So it is different, it is unlike ARVs that work…

2MINUTES: on everyone. So there is types for women and types for males, so for me to know how it works for males, I do not know. That is why we discuss as females only.

GIFT: Do these herbs differ in relation to HIV and AIDS, to say that this works for women in relation to HIV/AIDS…

2MINUTES: Yes

GIFT: This one works for men in relation to HIV/AIDS?

2MINUTES: On that one I do not have enough knowledge to know that…

GIFT: But you are saying traditional medicines vary depending on whether it is a male or female?

2MINUTES: Yes

GIFT: Is that the reason why you discuss as females?

2MINUTES: Yes<Internals\\Audio\\TwoMinutes> - § 1 reference coded [18.63% Coverage]

6.2.1.7 Government and other organisations

The government and other organisations were also identified as supportive of TAM use:

TATENDA: the other supporter is the government through these hospitals like Parirenyatwa that support us with groups in which we can talk about herbs. They can even do better if they can provide a room that deals with herbs, a room that if I do not want to go on ARVs, there are herbs that I can use. That would help a lot because there are many herbs that boost immune system…There are experts who know about these traditional medicines.<Internals\\Audio\\Tatenda> - § 2 references coded [14.51% Coverage]

Tatenda identified the government as her source of support to use TAM. She appeared to fantasise about having a traditional healer at a health care centre. Such apparent fantasies indicated a strong belief in the efficacy of TAM. The support was also revealed by Muyengwa:

MUYENGWA: there was a time when a Non Governmental Organisation (NGO) came in Chitungwiza (Part of Harare), they educated us. This NGO was called… they were jointly doing it with Africare, ok, if I remember the name I will tell. Ok, its Mercy Corps, they are the one who came and trained us about these herbs, that is where we first got that knowledge and we went to Parirenyatwa at OI (Opportunistic infections) there, we learnt again about these herbs, we have time that we learn about herbs… Mercy Corps came, they encouraged us a lot even with growing what they called “Keyhole gardens” that are prepared on high ground because in my area there is a lot of flowing sewage, so if they are on high ground, whatever you plant will not get dirty. So we were using those keyhole gardens. With that support we found it to be valuable. Those are the

people who supported us a lot. Also, when we went there, we had time that we talked about herbs that we grow in our homes. I am in a support group at Parirenyatwa, so we have time that we talk about herbs. <Internals\\Audio\\Muyengwa> - § 2 references coded [36.18% Coverage]

Muyengwa revealed that he had not only government support to use TAM but also the support of some NGOs like Mercy Corps. Generally this support from government institutions was mixed and some of the conventional healthcare practitioners in these institutions only pretended to discourage the use of TAM. Pretence seemed prevalent among the healthcare practitioners and the patients were aware of it and that seemed to in turn encourage the patients to continue using TAM despite the concern to stop using TAM. The perception of this by patients was identified and abstracted as the patients' preying on the pretence of referential others:

…only if the government was strongly supporting TAM; if you look at it now, it does not have emphasis on TAM, it seems to the government that it is a useless thing yet some officials in government go to consult our traditional medical practitioners. Even the other churches they hide, those churches are using traditional medicines. So it does not work, these things are happening, and some of them even know that they need to take herbals for their lives to progress well. It is happening but when they are in public before the people, s/he portrays TAM as those things that are bad yet secretly s/he is using it again.<Internals\\Audio\\Tatenda> - § 1 reference coded [14.51% Coverage]

Confusingly, in spite of what they may say in government and in churches against the use of TAM, many government officials, churches and significant others support the use of TAM.

6.2.2 Social inhibition

Social inhibition was contexualised as reluctance to endorse the use of TAM by others and social networks. As shown in Figure 6.5 below, this reluctance to endorse the use of TAM was inherent in gospel/apostolic churches' restrictions, incompatibilities with contemporaries/in-things, marital discord, and lack of knowledge. Largely, social

inhibition was bred by the demands of contemporaries and/or in-things like doctor's censorship and restrictions from religious groups.

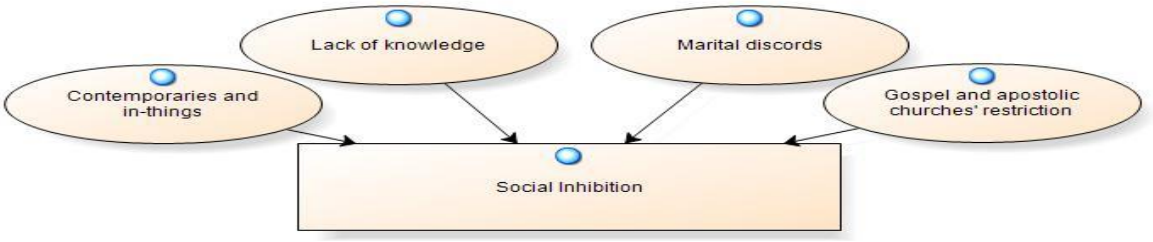

Figure 6.5: Social inhibition

6.2.2.1 Gospel and Apostolic churches' restrictions

A lot of inhibitory social influence was found to be emanating from Christian groupings. As shown in Figure 6.6, the church, the bible, apostolics and the gospel are said to be hindering the use of TAM.

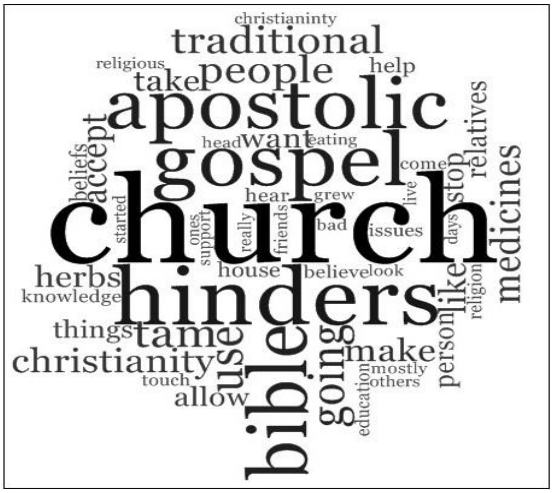

Figure 6.6: Gospel and apostolic churches' restrictions

Zvisinei spoke of how her mother brought them up in a Christian environment:

…my mother being Christian, we did not go where traditional rituals were done, like going to Bira (traditional ceremonies) and the like, we did not go because we were taught that it is not allowed…<Internals\\Audio\\Zvisinei> - § 1 reference coded [13.54% Coverage]

Zvisinei revealed that she grew up being told it was not good to practice African traditional activities. Christianity was found to be less tolerant of TAM use and associated TAM with “Satanism” and anti-Christ activities. However, apart from growing up in such an inhibitory environment, she still continues to use TAM. It is, however, her secret practice and she would not like many people to know. A lot of inhibition was said to be coming from the apostolic sect, Muyengwa revealed:

…my partner used to go to the apostolic sects, so these issues of using TAM she does not support it, she does not like it. So we were not getting along on those issues…<Internals\\Audio\\Muyengwa> - § 1 reference coded [16.61% Coverage]

Muyengwa spoke of his former partner who could not use TAM because of religious beliefs and they ended up separating. At first he even conformed and adjusted his behaviour to fit in:

MUYENGWA: …about those who go to the prophets, when we discuss, they talk against using traditional medicines. So if you want to fit in that group you have to just agree with them, and stop doing what they are denouncing...

GIFT: so in the days you were dating this apostolic woman, did you stop using the traditional medicines?

MUYENGWA: Yes, there were days that I stopped using traditional medicines, but it was not for long, it was just a short time that I stopped and then when I thought and asked myself, ‘*can I really stop taking herbs?*’ I would take, it is just that I was trying to make my partner happy by not taking the herbs.<Internals\\Audio\\Muyengwa> - § 2 references coded [19.57% Coverage]

Zvamaronga also revealed the strength of the restrains of the apostolic beliefs:

ZVAMA: All of children are apostolic, it is difficult for them to even touch traditional medicines. All of them go to apostolic church… They say that at Masowe (place of prayer), they are not allowed to use TAM… so the apostolic belief really got into them …<Internals\\Audio\\Zvamaronga> - § 2 references coded [33.57% Coverage]

The apostolic sect does not even allow touching TAM, they associat it with black magic. Batsiranai vividly pointed the social inhibition she got from Christian others:

BATSI: I am now hoping that let there won't a spirit that might make me get influenced by relatives and friends because they may say, '*ah, friend, this issues of TAM, ah, no, the bible says the TAM is bad or this and that.*' So I am praying to God to help me avoid getting separated from this woman (Traditional Healer) because people who influence are there, they will remove you from what is good …most people who say TAM is bad are the apostolic. They do not even want to hear about TAM. They tell you that it is cursed and forbidden in the bible.<Internals\\Audio\\Batsiranai> - § 2 references coded [14.11% Coverage]

Batsiranai, was now praying to the same God whom the others believe does not like the use of TAM. This is a paradox. Moyo also seemed defensive, despite the church rules; he would continue to use TAM:

… I do not have anything that can hinder me from using TAM even though we go to church; some churches forbid use of traditional medicines… but if it would help me I do not see any reason not to use them.<Internals\\Audio\\Moyo> - § 1 reference coded [8.98% Coverage]

Charity also faced a lot of Christian related inhibition from her husband and husband's family. She indicated that their church does not allow them to take any form of medication, even the conventional medicines. She revealed that they are only allowed to use what they referred to as holy water:

CHARITY: He is that person who grew up in the Marange Apostolic sect, he was born and grew up in the apostolic beliefs, his parents were worshiping in that church, he grew up in it... So even the pills, he found it difficult to take them. … So the issue of the TAM was a non starter, he would not like to hear what was called TAM. …Most of my in-laws' children and relatives are in the apostolic faith church…Plus they are those people who only believe in Christianity so they do not even like the use of pills. When their child (my husband) started taking pills they were not happy and requested that he should come to the rural areas. However, I knew that if he was to go there they were going to make him

stop taking ARVs and he was going to die earlier, so I refused to have him to go to the rural area. <Internals\\Audio\\Charity> - § 2 references coded [18.30% Coverage]

Some of the inhibition came from within the family. As shown above, Charity found most of her strongest inhibition from her husband and her in-laws. Zvamaronga also found it difficult to convince her child to use TAM:

ZVAMA: That one (pointing to the child) is hard headed, he would not accept. Right now, ha-a, because we tried to convince him and he said, no. Our church does not allow TAM.<Internals\\Audio\\Zvamaronga> - § 1 reference coded [11.52% Coverage]

Convenor also strongly pointed to apostolic religious beliefs as hindrance to the use of TAM:

CONVENOR: Mostly its religious beliefs… Here I am speaking on behalf of, like the Johanne Masowe apostolic sect; they say that if you go and dig a root or if you take leaves or barks, you have practiced sorcery, it is not allowed. I have since quit that church but I used to go to that church <Internals\\Audio\\Convenor> - § 3 references coded [13.73% Coverage]

TAM is associated with sorcery and witchcraft. Convenor ended up changing her church to reduce cognitive dissonance caused by holding conflicting cognitions: TAM heals as opposed to TAM is sorcery. By changing the church, going to a more permissive one would help to reduce such cognitive dissonance. Such permissive churches were understood as the '*Back to Eden*' churches:

MUYENGWA: On the issue of herbs; I have experienced it myself. I go to Seventh Day Adventist, I have been in that church for long. I have forgotten to say that it is one of the institutions that supported me a lot in using these herbs. There is what they call back to Eden…When they are saying Back to Eden they are saying using our traditional ways of living with issues of using traditional medicines.

GIFT: In that church?

MUYENGWA: In that church… Back to Eden…That is where they are encouraging using herbs but saying no to going to sangomas or throwing bones but encouraging growing your herbs and knowing that this herb helps to treat this ailment…<Internals\\Audio\\Muyengwa> - § 1 reference coded [12.14% Coverage]

The concept of '*Back to Eden*' was coded in-vivo in Muyengwa's account and he was one of the strongest escapers. Change of church and preference of '*Back to Eden*' permissive churches was not limited to Convenor and Muyengwa:

DREAD: … The apostolic churches and some gospel churches do not want to hear about these herbs. However, the churches that had been there all along, Catholic and Methodist, they do not mind, ah, they use herbs. These gospel and apostolic churches and others, they do not believe in that.

MUROMO: What are gospel churches?

DREAD: They are those churches that…even if they have only black people, all their sessions and everything are done using English. They will play guitars and this and that in the church. For all of their things they use English, its English language and they believe in the second testament, those gospels, they claim to be Jesus Christ's they do not follow the old testament…together with the apostolic sects, they do not accept TAM use. Those true apostolic, with bold heads, who wear garments, they do not even, even seeing the plant; if it is a flower probably they will remove it and throw it away…Churches are one of the biggest hinderances for people to use herbs, church is number one hindrance.<Internals\\Audio\\Dread> - § 1 reference coded [11.60% Coverage]

English language, guitars, (New) Testament and Jesus Christ were reported metaphors representing social inhibition. Dread appeared very emotional and felt that everything was now anglicised. To him the Old Testament was another metaphor which represented the past and it was more consonant with his cognition. So he would rather follow those who follow the Old Testament, such as Catholic and Methodist churches than these 'Gospel churches'. Apparently the term "a gospel church" is being used to

refer to “a pentecostal church”. Zvisinei felt that these churches are brainwashing people:

ZVISINEI: Then, I think with this Christianity, My husband was brainwashed a lot because some churches say they do not even touch TAM, so he knew that when he is in pain he will buy his pain killer. So to these herbs, he said, ‘ *These herbs of yours, they do not have dosages and things like that’*, that is what discouraged him, that is what made him afraid.

GIFT: You are saying he was brainwashed by Christianity?

ZVISINEI: (laughing) I do not know whether its Christianity or education, or civilization, I do not know, I do not pin point there.

GIFT: But which one can you think is most, in your knowledge of him, which one, could it be religion or education…?

ZVISINEI: Or just lack of knowledge only, yah<Internals\\Audio\\Zvisinei> - § 1 reference coded [15.99% Coverage]

The church was reported to be very inhibitory, it was also found to form a variant of the contemporaries and in-things, since church-going was a common practise and would be viewed with social esteem.

6.2.2.2 Contemporaries and in-things

The constraint originating from contemporaries and in-things in the use of TAM was identified as the perception of one’s deviation from contemporary practises and things that were presently in fashion (in-things). Inhibition came from others:

TATENDA: The reason why they hide it’s because it is being said it belongs to the past, so these days there is what is being called the ‘*in-thing*’, they want conventional things, you even hear now, have you not heard a person saying, ‘*I am going for op* [an operation]’, seeming as prestigious things yet a person is going to be cut and such

things, as if it is a very prestigious thing. …<Internals\\English transcripts\\Tatenda> - § 1 reference coded [1.21% Coverage]

It was better to say I am going for an operation (in-thing) than to say I am using TAM (out-thing). Tatenda indicated that they hide or end up using TAM secretly due to fear of this social inhibition. The fear is for ridicule and derision from their peers or contemporaries due to their association with this out-thing (TAM). Batsiranai was hoping that her husband would not conform to this kind of social inhibition from others, she said:

BATSI: … let him not find friends wherever he frequented, who will say, 'Ah you? Can you spend the day using TAM these times we are living, being regularly seen holding TAM in your hands?... ah, friend I don't think it's good, at that age of yours, to be seen with these traditional healing grandmothers? Do you want to be given evil powers?' <Internals\\Audio\\Batsiranai> - § 2 references coded [14.11% Coverage]

Generally, use of TAM was viewed as backward and devious and as a result some users ended up stopping using it or used it secretly. Batsiranai indicated that, even among those who inhibit you, some of them are pretenders:

BATSI: … I tell my husband that mostly whenever he was doing something; he should not mostly like to get advise from someone who isn't well acquainted with him because he wouldn't be knowing where that person was seeking or getting help. Sometimes he might ridicule you yet he was doing the same, living with a n'anga there. For if I you tell that most people that you work with deal with traditional healers, they laugh and tell you that you are lagging behind in life. <Internals\\Audio\\Batsiranai> - § 2 references coded [14.11% Coverage]

They would just ridicule you but do so after consulting the traditional healers secretly. Secrecy seemed common, even some of the respondents indicated that their TAM use is their secret. Charity, for example, indicated engaging in secret use:

I can say as an issue that was secret to me, a person who could know… was my herbalist who was curing me.<Internals\\Audio\\Charity> - § 1 reference coded [18.30% Coverage]

Modernity seemed to have been the factor, everyone needed to be modern and move with the times. Dread also found the same modernity related social inhibition:

DREAD: I might be hindered by the community or someone that I am working with because in this modern world , we are now using the pills and they are working such that everyone is seeing that ARV is working. The ARV is extending people's lives even up to 15years… So it's difficult to convince your family that you are leaving ARVs, they will not agree with you; I mean those who know that you are taking ARVs, those close to you, if they see you wanting to leave ARV to take herbs, you will quarrel with them…There is no-one who will ever allow you to take such traditional treatments with irregular measurements… <Internals\\Audio\\Dread> - § 2 references coded [11.60% Coverage]

Dread pointed that he would never get support from the community for him to leave the ARVs. Even those close to him would despise his decision and quarrel with him, refusing to allow him to use TAM. People would advise for the use of the modern medication. Zvisinei also acknowledged the cultural degradation caused by modernity:

ZVISINEI: I think my husband was too modern; he was just like his children, such that he does not know how the herbs work. <Internals\\Audio\\Zvisinei> - § 1 reference coded [15.99% Coverage]

The community is now inundated with modernity and even the current generation of parents are no longer that much in touch with these traditional practises and treatments. Zvisinei spoke of her husband who is 'too modern', such that he did not know how to use TAM. Embarrassment and ridicule were said to be associated with the use of TAM. Tatenda explained:

TATENDA: Maybe being despised by others at work that might hinder my husband again from using them… most people are now believing that the act of going to church is the very best, forgetting where we came from as black people. Is it not? There are things that have been created for us by God, but we leave them. So if a person is to say I have my traditional medicine I want to drink, and you would be seem producing Guchu wanting to drink for your stomach ache, you would be ridiculed. It seems as if it

embarrasses. But if I produce a bottle of conventional medicine for the stomach ache, it would create the impression that I have a lot of money , as it shows that I had been to a doctor. So the way we consider people's attitudes and concerns on our use of whether conventional and traditional medicines, it might hinder my husband from taking TAM…<Internals\\Audio\\Tatenda> - § 2 references coded [14.51% Coverage]

Generally, conventional medicine was seen as an 'in-thing' and TAM was associated with antiquity. Such a divide seemed to also be used as a rule of thumb to differentiate the rich and the poor. *Guchu* attracted ridicules while pills attracted merit. As a result, the affected families ended up keeping up appearances, pretending to be, in public, what they were not in private. Tatenda alluded to a situation in which families had to hide their use of TAM:

TATENDA: His/her peers. Youths of those ages, the 25-year olds, if you look at it, they are the ones called the "salads", most of them do not like a link to traditional things. Most of such youths that come from families that use TAM end up pretending; if s/he then go out there, s/he would appear as if s/he is in the same flow as her/his peers, yet at home s/he will be using TAM.<Internals\\Audio\\Tatenda> - § 2 references coded [14.51% Coverage]

A child would have to act like a '*salad*'(a contemporary youth) in public and yet using TAM back home with his/her parents. Children would like to belong to their contemporaries and such an intention would inhibit the children's liking and use of TAM since it would mean cognitive dissonance and lowered esteem. Indigenous also pointed out the rich and poor dichotomy and how embarrassing it was for the children to be found using TAM:

INDIGENOUS: Sometimes children can be embarrassed, saying, '*haa*', being shy to neighbours or other people, '*we will be seen using these, we will look like very poor people.*' …children take the use of traditional medicines as an old fashioned thing that will cause them to be looked down upon by their peers …fear of being seen with a big bottle with roots and drinking the water out of it… it attracts ridicule <Internals\\Audio\\Indigenous> - § 1 reference coded [15.26% Coverage]

Muyengwa also spoke about how children find it difficult to use TAM given the change in times and generations that results in peer pressure:

So if she is goes away from me, it's difficult to tell whether she will keep on using the herbs. I would not know because our children belong to another generation of people that has its own beliefs and perceptions about life. I do not spend the day with her. Right now she is somewhere with her peers. So there are other things they believe in, those things might stop her from using TAM because she will take what she believes with her peers and take what comes from parents and mix those beliefs, she will come up with her own conclusions. So I do not know whether what I am doing is going to cause her to continue using herbs or not.<Internals\\Audio\\Muyengwa> - § 1 reference coded [19.57% Coverage]

Makaita also acknowledge the changes in time, though she was denying its effect on her:

MAKAITA: Ah, there is no-one who can deter me, even though most are saying these days there are now pills, I will tell them to take the pills but my herbs I will drink. So there is no one to stop me.<Internals\\Audio\\Makaita> - § 1 reference coded [9.36% Coverage]

As indicated earlier, doctor's censorship was another contemporary and 'in-thing' that seemed to inhibit TAM users. The users would be afraid of the risks involved and they would end up reducing or stopping their use of TAM:

…some of the traditional medicines have been strongly censured, 'this one do not even touch, it is incompatible with ARVs. If you feel any other pain, just because you are on ARVs, you are not supposed to cure yourself, go to the nearest clinic and they will treat you and you have to clearly tell them the type of ARVs you are taking.' So this shows that if you use your own TAM to treat yourself you can endanger yourself. The main reason why they are censoring is because we do not know the contents of ARVs. <Internals\\Audio\\Convenor> - § 2 references coded [13.73% Coverage]

Muyengwa also reiterated the censorship;

MUYENGWA: …our doctors, especially our counsellors, they normally say do not use traditional medicines that you do not know. Also it is not good for you to use traditional medicines without being told to do so by the doctor. So that is something that makes us draw back in using those herbs because we heard one counsellor saying that you might take traditional medicine and wash away ARVs in your body. So if you wash it away you will be vulnerable again.<Internals\\Audio\\Muyengwa> - § 1 reference coded [19.57% Coverage]

The fear of mixing was a result of the censorship that came from the health care practitioners. Mixing ARVs and TAM was dreaded by some:

DADIRAI: My husband is on ARVs, so we are afraid because he is mixing with TAM and that can give him undesired results…It not good for him to keep on mixing both, keeping on mixing and mixing… <Internals\\Audio\\Dairai> - § 1 reference coded [15.13% Coverage]

Indigenous ended up reducing his TAM intake due to the censorship:

INDIGENOUS: Ever since I started taking ARVs, I am now limiting some herbs that contradict ARVs… I am limiting, leaving some of the herbs I used to use so that I can stand on one side, the ARV side. <Internals\\Audio\\Indigenous> - § 1 reference coded [15.26% Coverage]

Generally, open support for TAM seemed difficult to come by. The proponents of conventional medicine seem not to be very supportive of the use of TAM as an alternative treatment to HIV/AIDS. Family and close friends are the ones who might offer support, perhaps due to empathy but the community seemed to inhibit the use of TAM.

6.2.2.3 Marital discord

Earlier, Charity's case was presented in which she and her husband were in conflict, with each searching for his and her own medication. Their case was less of a conflict because at least they were communicating on what they were using. The same cannot be said of TwoMinutes whose marital relational context could not make her open up to her partner. She was in a relationship with a married man:

GIFT: Who or what would support you having your partner using TAM?

2MINUTES: It is me... I have to tell him.

GIFT: Why are you not telling him now or talking with him about it?

2MINUTES: We do not even have the time to discuss with him.

GIFT: I do not know, I just want to know, does he have another family somewhere?

2MINUTES: Yes

GIFT: Is that the reason why you are not talking about this issue?

2MINUTES: No, I did not have the time.

GIFT: Could it be because he has a family, where he has another wife again?

2MINUTES: Yes

GIFT: Be free to talk; how does this hinder you?

2MINUTES: Ha, it does not; I just do not have time to talk with him about it. I would be attending to my personal issues. Maybe he takes herbs, but I do not know it. But he takes pills. I did not even tell him that I mix pills and herbs; he just knows that I take ARVs only. So we have never talked.

GIFT: Had it been that he does not have another wife, would you be talking about these issues?

2MINUTES: Yes, or if we had promised to marry or staying together, it might be possible, I would be telling him.

GIFT: So how is his relationship with his wife disturbing you from talking about traditional medicines?

2MINUTES: I feel as if I am wasting time.

GIFT: Why?

2MINUTES: I do not know what he will think when he is now with his wife.

GIFT: So you would prefer him told there?

2MINUTES: Yes

GIFT: In your thinking, do you see as if he values the other woman more than you? Why are you saying, *'I do not want to talk with him, let him go and be told by his wife?'*

2MINUTES: Uhh, nothing

GIFT: You just do not do it?

2MINUTES: Yes

GIFT: But you said you are the one who is able…

2MINUTES: To encourage him to use traditional medicines?

GIFT: Yes

2MINUTES: Yes, it is me.

GIFT: How about the other woman?

2MINUTES: Ah, I do not know there. I am not concerned about it.<Internals\\Audio\\TwoMinutes> - § 1 reference coded [18.63% Coverage]

It appears that, had TwoMinutes been in a formal marriage, she could have shared with her partner, as shown by the majority of the other participants who were married. Rather she felt as if she would be wasting time and seems to be afraid of losing the partner in the event that he realised that she does this old and out dated-thing of using

TAM. She seemed to be afraid of being associated with witchcraft and black magic. She only wanted him to know that she was on ARVs maybe because the ARVs were merited and TAM was despised in the community. At the end, TwoMinutes was inhibiting the use of TAM to her partner, although there was a possibility that they were both hiding and using TAM secretly.

6.2.2.4 Lack of knowledge

Another form of inhibition also comes from lack of knowledge, which can be assigned to a society that is so secretive regarding information on TAM use. Dadirai openly acknowledged lack of access to the people who can help her identify the herbs:

DADIRAI: What would hinder me is because you would not have the knowledge; if you do not have the knowledge, you cannot use something you do not know about. If I get someone who knows how to use it and with adequate evidence, not just going to a person's home who will end up telling you, '*ah, this works this one.*' that one you cannot use because you would not know how it works.<Internals\\Audio\\Dairai> - § 1 reference coded [15.13% Coverage]

Similarly, Tatenda pointed to this socially deprived knowledge of TAM:

TATENDA: It is just lack of knowledge about the functions of the TAM that is the only thing that can hinder me. Had it been that we know the places it is located, we will help ourselves. Some of the places with these TAM are protected like here (Harare), there are such places, people just travel in vehicles not knowing what is contained in the fenced areas. There are trees that are valued such that if one wants to get in, s/he would bring a special permit to get in to fetch her/his desired herbs. So it is just lack of knowledge as to which one to use; what it cures; and the place it is found. <Internals\\Audio\\Tatenda> - § 1 reference coded [14.51% Coverage]

There appeared to be a lot of gaps in the knowledge of the use of TAM. As a result, such missing information like dosages and measurements, ended up hindering the use of TAM:

DREAD: The issue of measurement will hinder me. The measurements will hinder me because I cannot use the herbs regularly. I am now taking it here and there because I do not know the measurements, I do not know the time intervals, are they hours or what?<Internals\\Audio\\Dread> - § 1 reference coded [11.60% Coverage]

Secrative practices and negative scrutiny given to TAM has led to poor tranferral of information, as it used to with oral traditions. As a result, the lack of knowledge is inhibiting the use of TAM. Such a gap is not only depriving the potential users but also exposing them to misuse, abuse and incorrect directions. Fear of these would lead to inhibitory tendencies when one decides on the use of TAM. Nevertheless, individuals still found ways of using TAM as they indicated continued secret use.

6.3 DESCRIPTIVE NORMS

Descriptive norms are conceptualised as the perceived extent to which members of important networks are believed to be using TAM themselves. As shown in Figure 6.7 below, these beliefs about others' behaviour revealed both pro-engagement and sceptical beliefs.

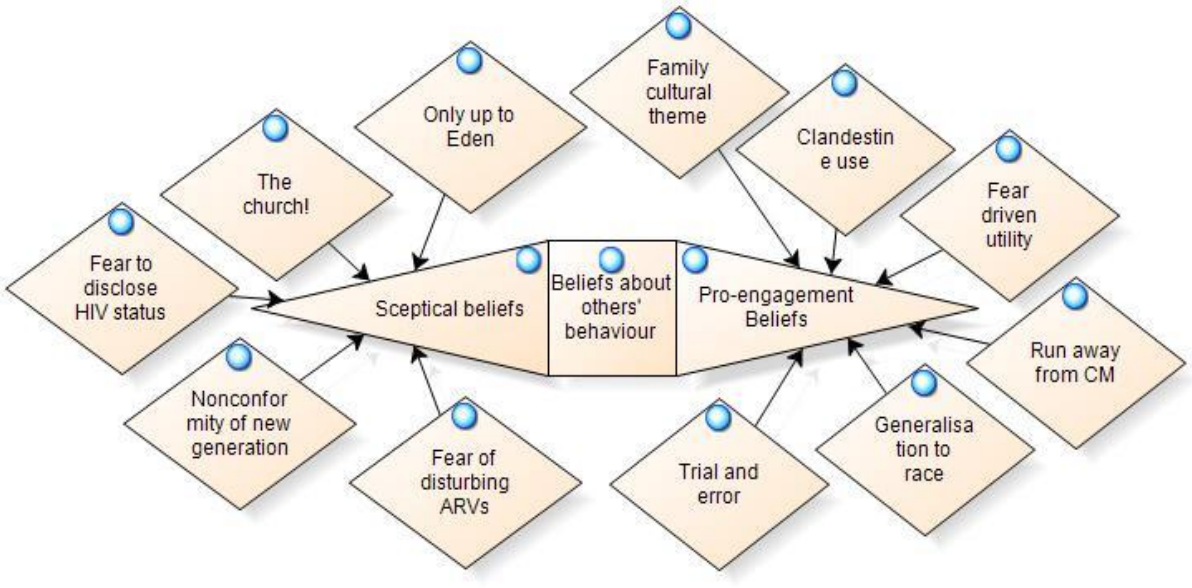

Figure 6.7: Descriptive Norm

6.3.1 Pro-engagement Beliefs

Pro-engagement beliefs are abstracted as those beliefs about active involvement of others in the use of TAM, either covertly or overtly. Generally, family cultural practices, secret use, fear driven utility, fear of conventional medicine (CM), trial and error as well as generalisation to the black (African) race, were the perceptions or ideas that cultivated the abstraction of pro-engagement beliefs. Below is a cloud (Figure 6.8) that shows that family, children and friends were most important referential others who were found to be pro-engaged in the use of TAM.

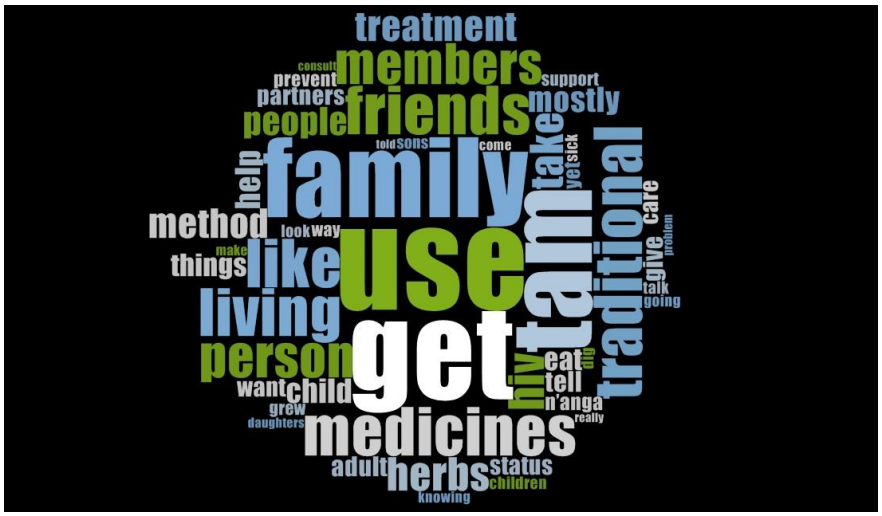

Figure 6.8: Cloud on proengagment beliefs

A number of participants reported that their partners, family members and friends were using TAM. Batsiranai said most of his friends and relatives use it and that is was doing well for them:

BATSI: Most of them use TAM, especially in our family, ah, they really use, I do not want to lie to you… my relatives and friends just do as I do… and it is going well for them.<Internals\\Audio\\Batsiranai> - § 2 references coded [4.76% Coverage]

Indigenous, Makaita and Moyo also revealed that they were observant of those they lived with using TAM:

INDIGENOUS: … we see in the way we live together… I discovered that my next door neighbour also uses TAM. Even relatives, let us say you have visited… they will tell you, *'ah, no, today we want to eat with black jack (herbal relish) or today we would like to eat; in your relish today, use garlic.'* …you would see that even all the people, neighbours and relatives; these are things we know that in most houses, they use.<Internals\\Audio\\Indigenous> - § 1 reference coded [11.05% Coverage]

Although he observes it, Indigenous revealed that the element of secrecy and personalised use seemed to permeate everywhere. Even at his personal level, he thought he was the only one doing it. As a result of this, Indigenous generalised that everyone used TAM and this gave him even more courage to use TAM.

Makaita also saw her relatives and friends using TAM:

MAKAITA: yes friends and family members mostly use TAM, I see them using<Internals\\Audio\\Makaita> - § 1 reference coded [11.82% Coverage]

Moyo also emphasised that as long as it was transparent, all his friends and relatives would use TAM:

MOYO: My view is that, as long as it had been explained to say these things work like this and that, I do not see any problem especially in my family and the people who surround me, people I associate with; as long as it is transparent, I do not think they would have a problem accepting TAM.<Internals\\Audio\\Moyo> - § 1 reference coded [10.63% Coverage]

Muyengwa and Tinomboedza also had siblings who used TAM:

…So my sisters go to different churches but I see them doing the same as me, they encourage herbs as well… my sister used to mix food with what is called comfrey (herbs). <Internals\\Audio\\Muyengwa> - § 1 reference coded [12.14% Coverage]

…we help each other with my brothers on issues of TAM use. <Internals\\Audio\\Tinomboedza> - § 1 reference coded [13.07% Coverage]

Tatenda also had HIV positive friends who reported doing well with TAM:

TATENDA: I have two friends I know to be using TAM and they are healthy, they are healthy… One is positive; the other one does not want to disclose the status. But it is someone I am suspect to be positive. The other one was in good health, the one who disclosed his/her status. S/he is not yet on medication but s/he is taking those traditional medicines. <Internals\\Audio\\Tatenda> - § 1 reference coded [14.01% Coverage]

TwoMinutes 'always' saw her friends and relatives using TAM:

2MINUTES: I always see herbs in their houses and some of them are not even yet on ARVs, some do not even know their status, they have not been tested… they are surviving on traditional medicines only and it is working well for my young sister. <Internals\\Audio\\TwoMinutes> - § 1 reference coded [10.14% Coverage]

Zvamaronga also reported having many friends and relatives using TAM:

ZVAMA: yes, many of them… because I have my sister who is into traditional medications and attitudes. If she gets sick it is rare for her to go to clinic. If she just gets in mountains there in Mutare (City located in a mountaneous area in Zimbabwe) there, she would dig her medicines and get well. <Internals\\Audio\\Zvamaronga> - § 1 reference coded [13.80% Coverage]

6.3.1.1 Beliefs in other's secret use of TAM

There is a strong belief that people use TAM secretly. Generally, there is a stronger belief that many people, if not all 'black' people use TAM. The generalisation of TAM use to a race by Zvisinei can be said to be the highest form of assumption of widespread use of TAM by others. She said:

ZVISINEI: I think that, it looks like every person in his/her house, every black person, basically, uses traditional medicines. <Internals\\Audio\\Zvisinei> - § 1 reference coded [25.69% Coverage]

Maybe this over-generalisation was cultivated by a lot of assumed secret use of TAM. It was said that most of the use is done privately and as such it can be said many people do use it:

CONVENOR: Yah they use but they do not want to be open about it. They use it secretly. Sometime you see it amongst relatives, like my aunt, or your older sister or younger sister, a person whom, if you go into her room and search, you will find these things. If you were to ask her, you would get an answer that will convince you that this person is hiding the fact that she is using them. She would not want me to know due to fear of being ridiculed or not wanting to be viewed as an extremely backward person… <Internals\\Audio\\Convenor> - § 5 references coded [16.66% Coverage]

Convernor believed that many people are hiding. However, everyone seemed to be hiding from others and in the process also noticed others who might be using the same hiding methods as one's self:

You would find the herbs in there and ask, '*What is this*?' You would be replied, '*Ah, it was for the child when s/he had a stomach ache, so we were given by that granny living over there.*' You would come again and find it in there again or maybe a new one different from the previous one. So, for you to keep on asking, you would find out that, you would appear you are talking or too inquisitive. However you would realise that each and every time you visit you would find different traditional medicines. Maybe you would have had a problem and got sick, you would hear them saying, '*ah, why can you not try this herb like this and that?*' You would say, '*Ah, I do not know it.*' They would say, '*I will look it for you.*' But there would not go far to fetch it, they would go and take it at their house…. <Internals\\Audio\\Convenor> - § 5 references coded [16.66% Coverage]

Why would Convenor say, *'I do not know?*' She seemed to be hiding as well. Why did these others seek an acceptable explanation for a child's use. It seemed the truth could disclose their statuses or it was just fear of association with TAM for personal use. The caution required between family members is quite serious lest you be accused as the witch responsible for any misfortunes in the family. Perhaps the respondents were self-

reflecting and projecting their behaviour to everyone as they also used TAM secretly. Clandestine use was not only mentioned by Convenor and Zvisinei:

CHARITY: Ah, if you look at it, those who would be using, they use secretly. So you will never catch them. Some of the people do hide them<Internals\\Audio\\Charity> - § 1 reference coded [17.51% Coverage]

It also seems as if Charity had never been caught as well, 'Those who would be using' referred to by Charity probably also include herself. As said by Convenor, there are a lot of evil beliefs about the use of TAM. Dread also concurred:

TAM has been destroyed by Christianity because they would say you are using medicines from sangomas. So the first thing, 'reject *sangomas'*…if it has been denounced to go to sangomas and herbalists. They are accused of using evil things, all of the products are not to be used and you will be told Christianity is the best, number one.<Internals\\Audio\\Dread> - § 1 reference coded [9.01% Coverage]

It seems that the response to and embracing of Christianity has cultivated hypocrisy in which people continue to use TAM but secretly. The perception that people use it secretly was very popular:

INDIGENOUS: On that one I do not know what they think in their homes because some of the things are done in privacy, it is done in secrecy. <Internals\\Audio\\Indigenous> - § 1 reference coded [11.05% Coverage]

Only self-reflection, can tell. Indigenous has done these 'things' in privacy and secret places and he was now suspicious that many people do the same. Zvisinei and Tatenda also revealed this:

GIFT: But in your thinking and knowing others who are positive, are you seeing them visiting places where herbs are said to be? Do you have evidence?

ZVISINEI: Ah, ah, ah, they do not go openly.. They do not go openly. After being counselled here (hospital), they will not. Were we not told not to mix treatments? So that

person, even if it is your relative or someone you are looking after… even if s/he use TAM s/he will never tell you because s/he would like to be looked after.

GIFT: But in secret talks with others, do you hear them saying that they are mixing?

ZVISINEI: That is if they are here, in the support group here. In the support group they will talk because we had a research that we were doing being encouraged to take some herbs to see what will happen. So we talk freely because we will be doing it together, so people talk.

GIFT: But you believe that everyone positive mixes?

ZVISINEI: Yes, I think so.<Internals\\Audio\\Zvisinei> - § 1 reference coded [25.69% Coverage]

Zvisinei identified herself with a group. She said, '*Were we not told not to mix?*' She used a collective pronoun '*we*' showing that she was one of those who use clandestinely and she believed that everyone who was HIV positive used TAM. Tatenda also felt that use of TAM was concealed:

TATENDA: I see that nowadays traditional things are concealed, if a positive response was to be given to TAM, in the same manner it was being done for say paracetamol, I would not think it will be bad. So it is suppressed yet you would see again people using again those traditional things. <Internals\\Audio\\Tatenda> - § 1 reference coded [14.01% Coverage]

Believing and projecting that many people are using TAM seems to be very common. It seemed that accessibility to people's secret places and privacy is difficult to come by. Many of these respondents seemed to be talking from self-reflection on their own experiences. This adjustment of their own perceptions allowed them to become less unlike others. Holding such beliefs of secret use by others seemed to facilitate their own use of TAM as well as they felt justification to use it.

6.3.1.2 Beliefs in family cultural theme

Closely related to the above was the family's use of TAM. It seems that a number of families from which the respondents came had a family cultural theme of using TAM. Such a family cultural theme would perhaps also be a family secret but at least they would be acting and sharing within the confines of family members. A lot of learning and observing others using TAM seemed to come from the family. Growing and bringing up children with a family cultural theme of using TAM made the participants develop a schema of referent significant others who also use TAM. In Batsiranai's entire family of orientation, they all use TAM and she was reproducing this cultural theme in her biological family (family of procreation):

BATSI: …As for me I accept TAM because … It made me survive and I grew up using it, all of us in my family use TAM … I quickly accepted it because I was born doing it… for us in our family our sister-in-laws are told that in this family of ours, we use these (TAM). Our brides would accept it because they would know that what they would be carrying (babies in womb)that belong in our family with its traditions. They know that they are brides here, they would not argue with that. … As a parent you need to give TAM to your children in the early stages. As a parent you have to sit down with your children and educate them as I did in my family. I sat down with my son and explained about TAM use <Internals\\Audio\\Batsiranai> - § 7 references coded [45.51% Coverage]

Similarly, Grey belonged to a family that used TAM and he was passing on this culture to his own family:

GREY: I can say in my family they use it mostly because… in our family we have always been using TAM. So there is no one to tell us to stop… I use TAM for my children because I know that it works. To the hospital they go but I mostly use traditional medicines because we have always been using it… All the children we give them those traditional medicines <Internals\\Audio\\Grey> - § 2 references coded [33.72% Coverage]

Charity also had TAM as part of her family of origin's cultural theme and her children were also using TAM through Charity's influence:

So if it is traditional medicine, I like it. I have TAM to clean blood, when I cook porridge for everyone here I put TAM for everyone and I give them. I normally tell success stories of using TAM to my children, just talking as stories… saying, *'everyone must eat this relish, this is a medicine that cures a lot. Do you know that? If you have a real head ache it would heal with this.'* so they know that TAM can help me and that it can help you more than pills, maybe the pill might fail to work because that pill, if you look closely, it has chemicals that might not be compatible with your body but that one is a relish that you can eat.<Internals\\Audio\\Charity> - § 2 references coded [18.15% Coverage]

Dread also revealed a family cultural theme in which children were brought up using TAM, especially boys:

MUROMO: Do you think your friends and adult family members would get their sons/daughters to use TAM as an HIV treatment and care method? Why or why not?

DREAD: Yah some are there, on prevention. On prevention there are some who say, '*for me each and every time, do you see that bottle I have put over there, that bottle can last for about two years, it will not run out'*, it will be like a two liter, '*you just sip and leave it'*, they will tell you that each and every week you just sip once, just for prevention… To their children, especially the boy children, you start being taught whilst you are still at primary level at school saying, '*this bottle'*, if you are staying with a grandfather who learnt about herbs, you will realise that the health of a child on that bottle is totally different from the child who grew up in town without herb education and immunisation. The frequency the town child without herbal immunisation gets sick is higher than that of the rural child with herbal immunisation. If you see his body even when he is growing, you will see that this man is strong as if he goes to the gym. <Internals\\Audio\\Dread> - § 1 reference coded [9.01% Coverage]

The emphasis on male children was also brought up by Muyengwa:

MUYENGWA: I see that there could be my relatives who make their children take those herbs. I want to talk focusing on male children in the homes.I am saying so because we all know our tradition that if a boy is at home, he follows what is required of him. So if

the father and mother are saying those things, that child will follow and most of the times you hear that that child belongs to Mbiriyakura family. The Mbiriyakura family use this and that in terms of traditional medicines and truly you will go and find that boy using those traditional medicines… So if it is the Mbiriyakura family you would just know that these people use herbs. So when he had grown he would follow what was done by her forefathers and his fathers <Internals\\Audio\\Muyengwa> - § 1 reference coded [12.14% Coverage]

As discussed earlier in this chapter, the gendered socialisation of children into subcultural groups would eventually cultivate a child outcome that reveres the treatments from such a subcultural group. Dread, Muyengwa as well as Grey point out that male children were given separated, giving more emphasis when it comes to socialisation into TAM.

Convenor was also brought up with others using TAM:

like ourselves when we were young, our grandmother used to say when she was going to dig TAM, especially when she was old, she would say, '*take the hoe and help me to dig'*, she would stand there and say, '*dig there'*, and you dig, '*dig there'*, and you dig. So when you would be digging, you would see, so if it means that you grew up doing it, I would end up knowing it on my own, I can even go on my own without her and say this one is the one I am supposed to dig yet I am not a n'anga.<Internals\\Audio\\Convenor> - § 1 reference coded [16.66% Coverage]

Kushingirira also had siblings with whom they were brought up using TAM and they believed it made them survive;

KUSH: Some of my siblings are now going to church but most in my family do the traditional medicines. If one falls sick s/he would use traditional medicines…I can say it because I was brought up in it, believing that what we are doing would make us survive. When we were growing up, we took those medicines; we were easily fell ill. Getting sick easily is not possible. <Internals\\Audio\\Kushingirira> - § 2 references coded [8.14% Coverage]

Makaita also reported having three sisters also using TAM:

MAKAITA: …We were all girls (4) and all of us grew up using traditional medicines…<Internals\\Audio\\Makaita> - § 1 reference coded [11.82% Coverage]

Moyo also had uncles who used TAM and he grew up observing them and with them teaching him how to use TAM:

MOYO: I grew up with my uncles, my mother's brothers; those ones use TAM a lot. They were using and I know it because they told me and saw them using traditional medicines. The other one passed away but he used traditional medicines more than conventional medicines... I see it working well for them, then obviously, I ended up using it as well.<Internals\\Audio\\Moyo> - § 1 reference coded [10.63% Coverage]

Tatenda also spoke highly of her grandfather who brought him up using TAM:

TATENDA: My father in Highfield (residential area in Harare), ha, he uses TAM a lot. I say so because he was born in 1931, yet he does not have a single tooth removed, he even tells people the traditional medicine for teeth, he knows the herbs but he lives in Harare. These are the things he grew up doing when he was being reared at his mother's rural home. So he is a person who grew up knowing that this herb cures this, that herb cures that, so he is now like a traditional healer but he is not a traditional healer… So these are things I grew up in. <Internals\\Audio\\Tatenda> - § 2 references coded [14.01% Coverage]

Generally, siblings with whom the participants grew up together with using TAM formed the descriptive normative group from which the participants found support. Maybe it formed the family secret but these were the people they reported to be sure of their present, past and potential future use of TAM.

6.3.1.3 Beliefs in other's fear driven use of TAM

Related again to the secret use of TAM, there are other beliefs that would cause many people, especially affected by HIV/AIDS, to use TAM due to fear. This evidence seemed to come from assumptive cognition or self-reflection. Trial-and-error as well as

a reluctance to use conventional medicines are some of the fear related thematic contexts revealed.

Generally, there was an assumption that due to the terror of HIV/AIDS, many people use TAM, TwoMinutes and Kushingirira revealed:

GIFT: Do you think your friends and adult family members would get their spouses/partners to use TAM as an HIV treatment and care method? Why or why not?

2MINUTES: Yes… it is terrifying, they will be thinking that s/he might die. So are afraid. So they are afraid, they will be encouraging each other.<Internals\\Audio\\TwoMinutes> - § 1 reference coded [10.14% Coverage]

KUSH: They like it because there is no one who likes this disease. They like it to prevent with those TAM… They like, they would not refuse because that is life… I mean that it would help them in living their healthy lives.<Internals\\Audio\\Kushingirira> - § 2 references coded [8.14% Coverage]

Zvisinei substantiated this. She said that an affected person could take anything, pointing that anyone and everyone use TAM because everyone is perceived to be afraid and dislike HIV/AIDS:

ZVISINEI: With HIV, if a person is given anything… a person takes anything anywhere, even if they are the most disgusting of things, a person would prefer to take… everyone, relative or what, everybody, I think everybody because no one likes this disease.<Internals\\Audio\\Zvisinei> - § 1 reference coded [25.69% Coverage]

Batsiranai also revealed that the characteristics of HIV/AIDS were so dreadful that everyone affected would become restless, searching to extend life and eradicate pain:

BATSI: they like TAM because the problem with that disease is that it is difficult to fight and it stays in your body forever… So most people who are living with it, would want more years to be added to their lives and stop feeling the pain in the body.<Internals\\Audio\\Batsiranai> - § 1 reference coded [4.76% Coverage]

Batsiranai over-generalised that fear of HIV/AIDS would not leave any options for the person. Getting sick would just adjust the person to a less selective health seeking mode. Grey revealed that once sick the person would become more permissive and receptive to the use of TAM:

GREY: Mostly people do not want to prevent, they want after being infected… Mostly people,do not seek help before they get sick… it is rare to seek for help before illness… But if it comes out, that is when he needs to be treated. Sick people die because they are too shy to disclose it. But if they say the truth they will get help. However, if he is seriously affected, that is when he comes and gets help. So it needs enlightenment. <Internals\\Audio\\Grey> - § 3 references coded [9.34% Coverage]

Muyengwa also revealed that he heard others talking about fighting for the eradication and delaying the detectability of HIV positive statuses as well as AIDS:

I hear some talking especially among friends and relatives saying, that Moringa (a herb) can raise the number of white blood cells and CD4 count. If you have the virus it will not be detected at all, you will test negative… I heard some saying that taking traditional medicines made you to suppress the viral load, so people talk a lot saying that the TAM delays the detectability of the virus.<Internals\\Audio\\Muyengwa> - § 1 reference coded [12.14% Coverage]

Basically, there would be a lot of trial-and-error, Zvamaronga also revealed below:

ZVAMA: Yes my friends and relatives like TAM… because that is what is there these days, you might say we would use these other things, yet they would not work., so you have to keep on trying this and that <Internals\\Audio\\Zvamaronga> - § 1 reference coded [13.80% Coverage]

Generally, it seemed the respondents were not only reporting others' fears but also their own. They felt that their use of TAM was maintained by fear and trial and error to eradicate and delay HIV/AIDS.

Fear was also assumed to be associated with conventional medicines (CM) and methods. Some of the participants revealed that others use TAM as a way to avoid

going to CM. TwoMinutes revealed that some people are afraid to go and get tested so they would rather just start TAM even though they assume that they have been affected:

2MINUTES: I always see herbs in my friends' and relatives' houses and some of those people are not even yet on ARVs, some do not even know their status, they have not been tested… they are afraid to get tested at the clinic... yet you could see that they are supposed to be taking ARVs. …they are afraid to go for HIV testing, they do not want to be tested. ... Some of them listen to lies, being told that ARVs have side effects; they do this and that .<Internals\\Audio\\TwoMinutes> - § 1 reference coded [10.14% Coverage]

TwoMinutes was also talking from personal experience. She delayed going for HIV testing after she suspected that she was positive. She started to visit a traditional healer (Gogo) for a long time before she decided to go and get tested. In a way she was also projecting herself to others. However, her fears were shared. Tinomboedza revealed that others use TAM blindly and would be quick to point to other diseases yet they would be afraid to go and get tested for HIV:

TINO: Some people drink without knowing the purpose of the TAM they are taking. S/he would be saying I am feeling stomach ache, and you give him/her and it would stop… One might suspect something s/he ate (food poisoning), not knowing the reason. So that is where we would not understand each other. You would ask him/her, ' *Have you gone to the clinic? There is nothing to be afraid of, you can go openly, it does not embarrass any more, and you would know.'* But the person would be afraid and shy, you can just openly go and get tested and know your status, if you go you will know your status on your own, there in no one to ask you the results except your wife and your family members, maybe. Only if you like to tell others as I did, you would reveal to all. <Internals\\Audio\\Tinomboedza> - § 1 reference coded [13.07% Coverage]

Due to this fear, some use TAM to delay the CM's detection of the HIV status. They expect to try and eradicate it before they become aware of it. Muyengwa insinuated this:

I hear some talking especially among friends and relatives saying, that Moringa can raise the number of white blood cells and CD4 count. If you have the virus it will not be detected at all, you will test negative… some saying that taking traditional medicines … suppresses the increase of the virus, so people talk a lot saying that the TAM delays the detectability of the virus.<Internals\\Audio\\Muyengwa> - § 1 reference coded [12.14% Coverage]

The participants felt that fear would drive the infected person to use TAM. However, much of their utterances seemed to come from self-experience and the utterances are anchored-and-adjusted from within the self. In a way, these are factors which were used to justify their own use of TAM. It gave them comfort to perceive that 'everyone' was doing it.

6.1.4 Sceptical Beliefs

Sceptical beliefs were identified as those beliefs about factors that cause none or lack involvement of others in the use of TAM, either covertly or overtly. These are covered doubts and fears that are perceived to constrain others from using TAM. Generally, fear of disturbing ARVs, non-conformity of younger generations, fear of disclosing HIV status and the church were the factors perceived to inhibit others from using TAM.

Some of the participants really thought that only a few use TAM:

DADIRAI: Haa, a few would get their partners to use TAM as an HIV treatment and care method, most want to go for the pills. It is a few who know about TAM, most go for the pills. They can use as complementary but most go for the pills<Internals\\Audio\\Dairai> - § 1 reference coded [8.75% Coverage]

Dread also shared this as he emphasised that they are very few:

DREAD: Ah, there are a few who would get their partners to use TAM as an HIV treatment and care method… Because it has never been observed openly since the coming of HIV, there is nothing created, ehh, like a prescription for the herbs, like the ones for ARVs, one that is herbal only that has people who have used it for example

and it worked for them… So all the people started with ARVs, that is the first medication. <Internals\\Audio\\Dread> - § 3 references coded [9.01% Coverage]

Charity on the other hand reported that she had never heard of any other person who would get their spouses/partners to use TAM as an HIV treatment and care method:

CHARITY: …For me I cant say I know of someone who uses it? I would have lied because there is no one I have really know.<Internals\\Audio\\Charity> - § 1 reference coded [17.51% Coverage]

Previously Charity reported helping a lady in Dzivarasekwa (a high density surbub in Harare) and her sister-in-law. She exaggerated the absence of others to emphasise the scarcity of TAM use among others. Her message was that they were very few maybe to the extent that she hardly heard of others at least outside her influence.

6.1.4.1 Beliefs in others' fear of disturbing ARVs

Some believed that others do not use TAM because they fear that it might react with or disturb the ARVs:

MOYO: … when I got counselling here at the hospital, we were encouraged that if we are on ARVs, we are not supposed to touch again traditional medicines because it might disturb the system, I do not know how it works in the body.<Internals\\Audio\\Moyo> - § 1 reference coded [10.63% Coverage]

Dadirai also said only a few people use TAM and most were on pills as well as that people were more committed to pills because pills had been proven:

DADIRAI: Haa, a few friends and family members would get their partners to use TAM as an HIV treatment and care method because most want to go to the pills…My view is that most people died before we knew the ARVs. So when we heard and started using ARVs and proved to be helping, no one would like to keep on risking trying other medications on such a disease that found little hope in ARVs… so they would like to keep on doing what others are doing… ARVs are making most people live, it is different

from what happened in the past. So they see that the medication is helping… <Internals\\Audio\\Dairai> - § 1 reference coded [8.75% Coverage]

6.1.4.2 Non-conformity of younger generations

There were also beliefs that the younger generation was not receptive to the use of TAM:

MAKAITA: … the children growing up these days no longer like TAM… Haa, they are saying it belongs to the past…They are saying it was used by people of the past generations, now they have read books so they are no longer using those (she laughed)… yes the books also contain information on TAM but they say they have passed that time, it was meant for the past generation that used to use traditional medicines, they are a generation using pills.<Internals\\Audio\\Makaita> - § 1 reference coded [11.82% Coverage]

Tatenda also concurred saying that TAM was not in line with '*in-things*':

TATENDA: The reason why they hide is because it is being said to belong to the past, so these days there is what is being called the '*in-thing*', they want conventional things…<Internals\\Audio\\Tatenda> - § 1 reference coded [14.01% Coverage]

6.1.4.3 Fear to disclose HIV status

While some reported beliefs that fear to disclose HIV status would actually facilitate the use of TAM, others reoprtedly believed that it also inhibits. As such, people would be afraid that their statuses would be known:

GREY: …they are not many because what happens is that, people are shy to say that they are positive… especially our children they do not want but if it comes out later when they are really sick, that is when he needs to be treated. What causes sick people to die is being shy to say the truth. But if they open up they will get help. … <Internals\\Audio\\Grey> - § 1 reference coded [9.34% Coverage]

Due to fear of stigma and discrimination, children and other people might find it difficult to open up to their parents and others about their status, thereby delaying the parents'

and others' efforts to seek treatment, including TAM. Convenor concurred with these fears:

MUROMO: Do you think your friends and family members would use TAM as an HIV treatment and care method?

CONVENOR: Uhh, it is difficult on that one because it is a thing that is not yet really accepted, to the extent that if a person tells you her status, some of them will be shocked. Some would feel extremely sorry for you. So mostly they start getting worried about you, thinking about your condition, not about them. So they are not at liberty to talk about it. But with me, there is no one I have discussed with ..... the issues of HIV/AIDS, these are not issues that people can discuss as family, it is rare. It happens here and there but for you to know what people think about this issue, it is difficult because it is not an issue that is easily talked about…<Internals\\Audio\\Convenor> - § 2 references coded [16.66% Coverage]

6.1.4.4 The church

As already mentioned the church was found to be a great source of inhibition for others. The Apostilic sects were also reported as inhibiting other people from using TAM (Figure 6.9). Some relatives and friends were reported as going to the apostilic churches and the 'gospel' churches that forbid them to use TAM.

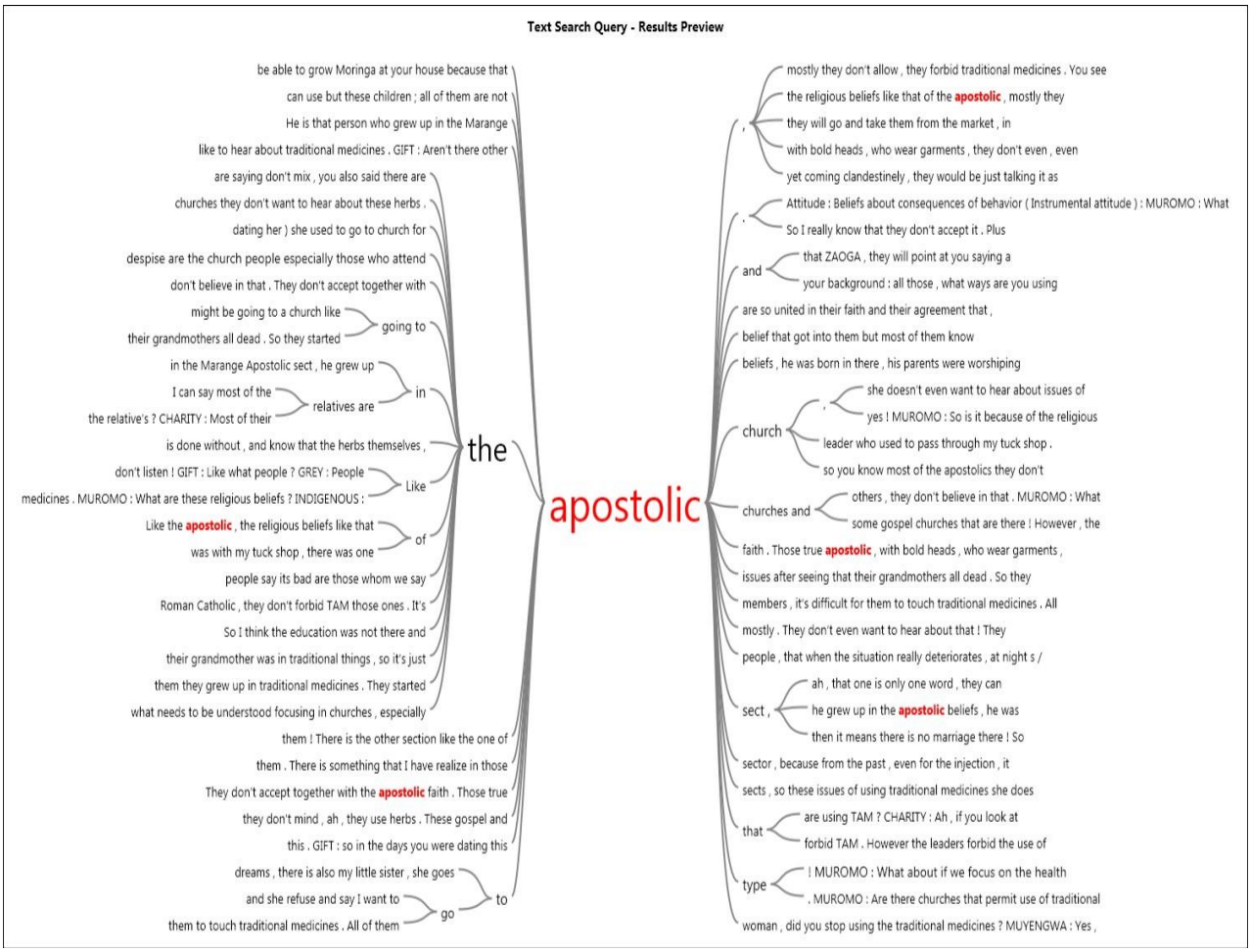

Figure 6.9: Inhibition from Apostilic churches

Generally, christianity was perceived as the main inhibitor as it associated TAM with witchraft.

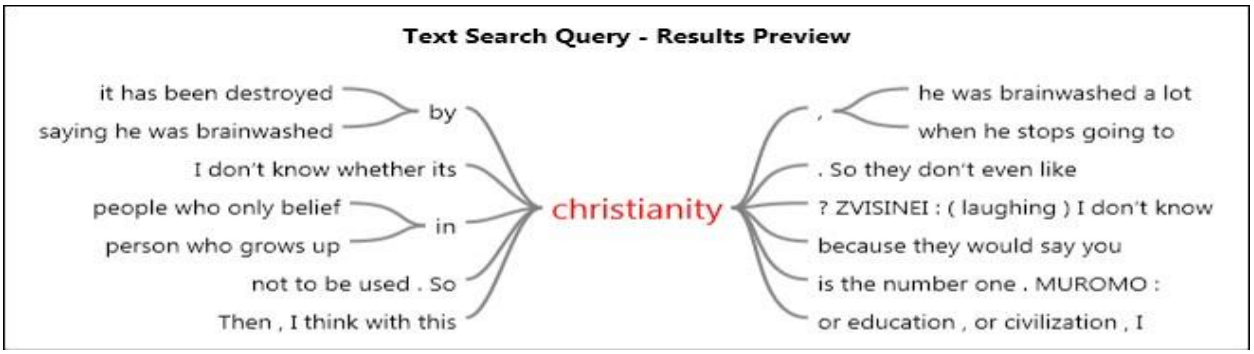

Figure 6.10: Christianity

However, Muyengwa felt that some churches inhibited but not very much. He pointed out that some churches that he referred to as '*Back to Eden*' churches, actually encourage the use of herbs but discourage consultation of traditional healers:

MUYENGWA: … On the issue of herbs; I have noticed that myself. I go to Seventh Day Adventist; I have been in that church for long… There is what they call back to Eden…When they are saying back to Eden they are saying using our tradition in issues of using traditional medicines…In that church… Back to Eden. …That is where they are encouraging using herbs but saying no to going to sangomas or throwing bones but encouraging growing your herbs and knowing that this herb help this, that one helps on this and you will take with your families.<Internals\\Audio\\Muyengwa> - § 2 references coded [12.14% Coverage]

It seemes the '*Back to Eden*' churches really on support and encourage the use of herbs. In these churches, the TAM users would not feel out of place as they might if they go to the apostolic and the 'gospel' churches. Preference of the '*Back to Eden*' churches can be understood as an escape behaviour. As demostrated ealier, most of the participants stopped going to (escape behaviour) the TAM non-permissive '*Apostolic-Gospel'* churches and joined and identified with TAM permissive '*Back to Eden*' churches that seemed to be promoting or at least not denouncing the use of TAM. Roman catholic, methodist and Seventh Day Adventist were some of examples

of '*Back to Eden*' churches mentioned while Johanne Marange, Johanne Masowe and ZAOGA were some of examples of '*Apostolic-Gospel'* churches mentioned.

6.2 MINORITY NORM

The minority norm was contextualised as the extent to which a small group of TAM users or individual TAM users influenced many other people to support and use TAM. As a result of this influence, the small groups of TAM users felt encouraged to continue using TAM since they would have motivated their important social networks to support and use. This norm can be said to be a product and a factor for both descriptive and injunctive norms since it will assist in the creation of other's support (injuctive norm) and others' use (descriptive norm). Below is a summary of the minority norm themes (Figure 6.11)

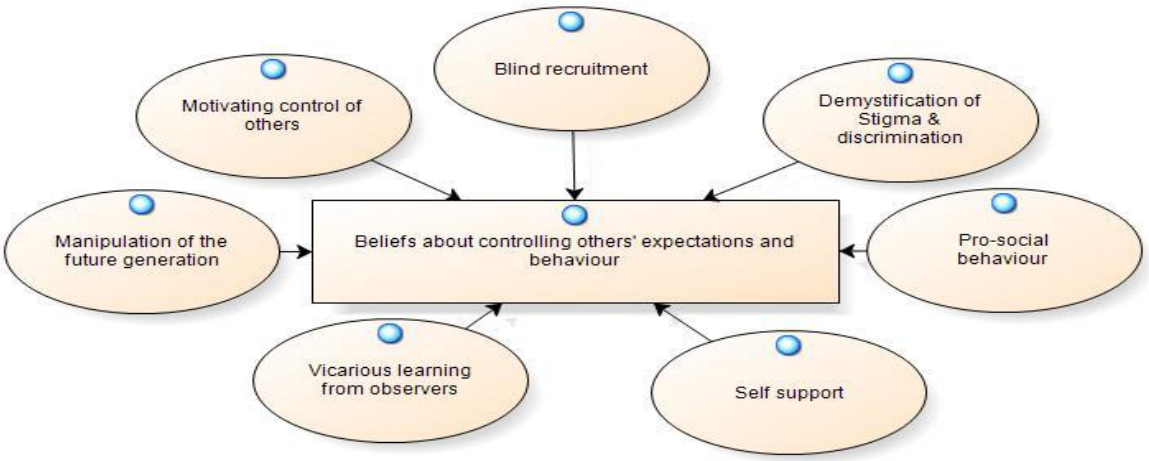

Figure 6.11: Minority Norm

6.2.1 Motivating control of others

The participants were motivated to continue using TAM by the extent to which they were controlling others' beliefs and behaviour on the use of TAM. The participants derived pleasure from motivating others to use TAM. Muyengwa delighted in and felt proud of how he motivated others through community meetings and social gatherings:

MUYENGWA: It is also a good thing that when we gather in community meetings, ah, people talk about herbs. So if you become open about the herbs that you know and help, people listen. So in having that knowledge and having people following you at home, supporting them, that will also give you strength to keep on using TAM. There are people whom I talk with in the community, assisting them on many issues about TAM use… I used to work as a facilitator for the Low Input Gardens (Mercy Corps project in Chitungwiza)… I was the one who followed people to their homes educating them about what they can do in their gardens, the ones I was talking about, keyhole gardens; how to plant herbs, mixing with vegetables and other things. <Internals\\Audio\\Muyengwa> - § 1 reference coded [19.57% Coverage]

Batsiranai also showed how she derived pleasure from positively changing others' attitudes towards TAM use:

I told them that, 'ladies, do you know how and where my problem was solved?' they were saying, 'i-ih, these days you are improving and changing.' I responded,, 'I am I changing? That woman who used to come here, she helped me with TAM. The pills, yes I used but I am more aligned to TAM because I realised that my health was significantly improving after taking them. Ladies TAM is good, that's why you are seeing many people inquiring about my sudden change in condition.' If they have similar problems, I advise them to go and see the traditional healer who helped me… so far I am not going to be influenced to stop using TAM. Ah, never, I will not go back to rely on pills. …<Internals\\Audio\\Batsiranai> - § 2 references coded [14.11% Coverage]

Batsiranai positively changed these ladies' attitude of acceptance in the use of TAM. She advertised her progress with an intention to influence others into using TAM. Similarly, Charity also aimed to positively change the level of acceptance for TAM use:

… I said, 'I am not saying the pills are not working, but what might be happening is that maybe the pills could be affecting you, not working for you. Yet you are not able to go to the hospital, what can we do? As for me, the money for me to carry you to go to the hospital I do not have it. Because at the hospital they encourage that if you find the pills not working for you, come so that we can check on another medication that can work for

you? . After explaining that I said, ‘so I will be looking for money for me to carry you to the hospital, you are not able to walk’, the hospital he was using, she was a person who had already started getting her pills from Epworth, from here it is very far. I said, ‘there is nowhere I can find the money to go and take your pills but if you start using TAM, it has the advantage that the herbalist can come and you will explain what you are feeling and gives you TAM concomitant with what is there.’ I fully explained to her to the extent she understood that this TAM could help her. She stopped the pills she was taking and started TAM. It is me who cooked (prepared) it for her; I was now experienced, so it was me who was cooking for her. To the herbalist I was just saying give me the TAM and I would come and heal her patient, cook for her patient with my knowledge as a person who was now experienced on it. She got well and became strong and we were now two of us looking after the other patient (husband). She got to be strong and right now she is staying on her own, she is now fit . She does not like to lack that TAM..... . <Internals\\Audio\\Charity> - § 3 references coded [35.81% Coverage]

Grey vehemently spoke of how he supported others’ use of TAM:

GREY: Ha, I am now supporting others. (He laughed)… I support people whom I see to be sick especially those who are HIV positive. Those are the ones I want to see how they are, I spent the day with them until they open up about their HIV status because often people are shy to say they are HIV positive , and some of them do not want to disclose the truth. They will eventually disclose and I will help them…so I will help them with TAM and they will refer each other to me… because if TAM helps this one today, s/he will tell another one tomorrow, tomorrow another one will tell yet another one. ..<Internals\\Audio\\Grey> - § 3 references coded [16.27% Coverage]

Instead of being supported, Grey supported others. He regarded himself as having reached the ceiling point of support in which any further support is no longer necessary, rather he was now supporting others. He derived pleasure and support from supporting others. Grey’s success of influencing others could also be seen in the children - the children were not afraid and ashamed of their use of TAM to the extent that they could invite their friends who would in turn bring their mothers to seek help. This networking brought support and reinforcement to Grey’s use of TAM. Grey perceived that the use

of TAM was growing and the numbers were increasing, *'2, 4, 6...*' He derived pleasure in the increase of these numbers. Indigenous also revealed that he opened up about his status and use of TAM in order to motivate others to use TAM:

INDIGENOUS: there are some close relatives among those we stay with; some even know that I am HIV positive. They encourage my family especially for the relishes like black jack and the likes of red spinach. Those ones they encourage us and even them, they understand that it is helpful to our health. So they encouraged us because we have opened up to them, and we made our problem known to them. These are not issues I have to go in circles or hide... Hiding would conceal information that might help someone. So if I became open I will be helpful even to my neighbours and friends <Internals\\Audio\\Indigenous> - § 1 reference coded [15.26% Coverage]

Generally, influencing of others into using TAM helped the participants to build social support from others.

6.2.2 Demystification of Stigma and Discrimination

In the quest to manipulate others, there was also a latent intent to demystify the notions of stigma and discrimination about HIV/AIDS and TAM use. Their fight was to show people (the majority) that they are no different from the HIV negative people:

BATSI: I also carry my stwanda (basket) like what is done by other women.[1] …anyone who had seen me, even if you ask all my neighbours they will tell you that, '*we were not supposed to have this one but because of that mother*',[2]<Internals\\Audio\\Batsiranai> - § 2 references coded [21.35% Coverage]

Batsiranai's intention was to show people that TAM was helping to reduce prejudice and now she was like any other woman. She fought to refute people's expectations. The intention was to motivate others into using TAM. Grey, Charity and Tinomboedza also raised the same notion:

GREY: … it kills a lot of health problems associated with HIV, and you would significantly improve and people would be shocked and say, 'Is it not him who is said to

have the disease?'…you will improve amazingly.<Internals\\Audio\\Grey> - § 2 references coded [24.38% Coverage]

TINO: Ah, I do not have a problem, I am just the same as a person who is negative. I do not have problems, it is the same as that other person you meet saying s/he is sick but s/he would be negative. I am not always sick, and not to the extent of being bed ridden.<Internals\\Audio\\Tinomboedza> - § 1 reference coded [18.26% Coverage]

CHARITY: And there is no one who knows that I am affected till today, because I never got sick since that time.<Internals\\Audio\\Charity> - § 1 reference coded [18.15% Coverage]

The quest to demystify HIV and AIDS and reduce discrimination resulted in efforts to gather support from others, who would have observed remarkable improvements consequently positively changing their attitudes towards use of TAM. The success of this demystification would in turn encourage the user to continue using TAM.

6.2.3 Pro-social behaviour

Helping behaviour was very common among the participants. Helping others to use TAM was the main source of motivation to continue using TAM, especially when others were receptive to it. Since the support from others was scant, it seemed many of the participants developed their own social support by recruiting others, increasing both descriptive and injunctive norms. As the number of other supporters and users increased, they gained confidence and support to continue using TAM. Grey narrated his experience in helping others:

GREY: …you can observe a person and realise that s/he HIV positive but you cannot tell him/her....Those HIV positive people also know that I use TAM, so they come to me and I help them. … It is working well for me now and some of them I helped them…I took some (TAM) and brought it here and gave people at a meeting where HIV positive people were being given food…they are many who seek help in relation to HIV/AIDS, they come because they know that TAM helped me, my son and Simon, ah, they are many who know that.<Internals\\Audio\\Grey> - § 4 references coded [33.72% Coverage]

Grey, together with his son and Simon, used TAM until they reportedly tested HIV negative. Grey revealed that he was now telling other people about it and a lot of people were coming to ask his help. He even went to a meeting where HIV positive people were gathered and helped other women there and those ladies significantly improved. Helping people recruited others and the numbers kept on growing:

GREY: …they want it because it is the one that mostly helped them. Because if it helps this one today, s/he will tell another one tomorrow, tomorrow another one will tell another. The other one will help another because if it helps one, s/he will bring another person and they will be 2, 4, and 6 with the way people will be talking and helping people.[4] <Internals\\Audio\\Grey> - § 3 references coded [16.27% Coverage]

Batsiranai also spoke of how she helped her neighbours and friends:

Even my neighbours whom I stay with, my lodgers, they are now appreciating … These friends of mine you see, most of them ask me to go and take it for them and I say, '*no I cannot go and take for you, I am not a traditional healer myself but I will show you where she is in case I give you the wrong thing. If I give mine that I have been given, it will distort course, what will I do? I will be short, if I share with you,?*' So I say, '*if you have a problem, you go to traditional healers and your problem will be solved there, you will get your own medication.*' <Internals\\Audio\\Batsiranai> - § 3 references coded [26.10% Coverage]

Unlike Grey who would act as the traditional healer (yet he would have gotten the TAM from the other Traditional healers), Batsiranai helped people by directing them to the real traditional healer who gave her the TAM. She delighted in helping them and people were now accepting TAM. When she said '*So they are accepting it'*, she was pointing to a positive shift in the latitude of acceptance. The shift was not only limited to the cognitive aspects of this pro-TAM belief but also behavioural since they were seeking directions as to where they can find it.

Charity also spoke highly of how she helped her sister-in-law and another lady in DZ (Residential area in Harare);

So I have many more others whom I have helped with these herbs. I have one who is in DZ who reacted to ARVs. I spoke with her and I came with her there and she (Traditional healer) helped her and up to today she is using those herbs…. My sister-inlaw is another person I really explained to about TAM and she understood. She used to take pills but she had since stopped and started taking TAM. I stayed with her during the sickness of her brother, my husband. After I introduced her to TAM, she said, *'since I started using TAM, I have not yet developed the health problems I used to have.'* <Internals\\Audio\\Charity> - § 3 references coded [35.65% Coverage]

Helping others was a way to help the self to feel support and the reason to continue using TAM.

6.2.4 Blind recruitment

Helping others was meant to boost or strengthen the descriptive and injunctive norms. However, it seems that at times the help was given blindly, without telling the person that it was TAM or how it was related to the treatment of HIV/AID. There was a lot of stigma around HIV/AIDS and the use of TAM so that the participant would use clever methods in which they used deception in the initial stages and only debrief later when the person had noticed the improvements and would be ripe for the involved person to justly evaluate the effectiveness of TAM. This has obvious ethical problems. Grey said, *'you would really notice that this person is HIV positive but you cannot tell him/her. But you would see it. Those people also know that this man does this, they come to me and I help them'*. He revealed that people also blindly come and seek help. Maybe they were afraid to go for HIV testing. However, this offered an opportunity for them to also blindly help and such people would form a pool for both injunctive and descriptive norms. Charity also reported experiencing this blind recruitment;

CHARITY: So, right now I have my friend… she likes those TAM, she does not know its purpose or what it cures or their immediate impact on the disease during use. She can just arrive saying, *'my friend I have a terrible stomach, please give me TAM.'* I would give her …*'I have a head ache, please give me TAM for my head, i-ih, I am hurt with my*

head, give me TAM for my head.' I would give her the TAM and she would get well.<Internals\\Audio\\Charity> - § 2 references coded [17.51% Coverage]

Dadirai and Tinomboedza also revealed that others just take TAM without knowing:

DADIRAI: Some take without knowing that this relish heals, just saying, '*ah, I like it'*, not knowing that there is something it can cure… so others use without knowing that it helps them. S/he can just see it where it was cooked and s/he will test it and like it not knowing that it heals something. <Internals\\Audio\\Dairai> - § 1 reference coded [8.75% Coverage]

TINO: …some drink without knowing the purpose of the TAM they are taking. S/he would be saying I am suffering from stomach ache, and you give him/her and it would stop<Internals\\Audio\\Tinomboedza> - § 1 reference coded [13.07% Coverage]

Blind recruitment seemed effective in gathering support since it would offer the others an opportunity to justly relate and evaluate the TAM.

6.2.5 Observers' vicarious learning

Vicarious learning from those who observe the participants was also the evidence of minority influence. Tatenda and Batsiranai spoke of how their husbands vicariously learnt from observing them:

TATENDA: My husband never used to accept TAM . He has now made a U-turn; he is now beginning to believe that TAM works. I think it is because of observing what is happening to me and the long experience I had, being sick… So, if someone gets sick you hear him saying, *'these conventional medicines are killing people, let us look for traditional medicines,'* that is what he now says. <Internals\\Audio\\Tatenda> - § 1 reference coded [25.73% Coverage]

Tetenda felt zeal from the way she had become a referent to her husband. Such an ability to cause a '*U-turn'* in others would not only increase the number of users but also reinforce the recruiter to continue using TAM. Similarly, Batsiranai's husband was now

using TAM and her child was now an enthusiast of TAM following the observation of how TAM had reportedly saved his mother:

BATSI: I support use of TAM and right now my husband is using it. He is drinking it right now because he has seen that it does good things… My son also observe my use of TAM, he even says, '*mother, today you did not put in my porridge the TAM you put in yours, why? You are eating all alone? What about me?... No mother, it is not fair for you to eat TAM alone, I also want to eat it.*' So it is a child who accepts TAM because he had leant by observing me, his parent <Internals\\Audio\\Batsiranai> - § 2 references coded [21.35% Coverage]

6.2.6 Self-support

Due to scarcity of social support, most of the participants said they support themselves. As shown in Figure 6.12, self-support was evident in how they engage in intrinsic motivation, selective attention, equation of treatments and defensive reaction to inhibition.

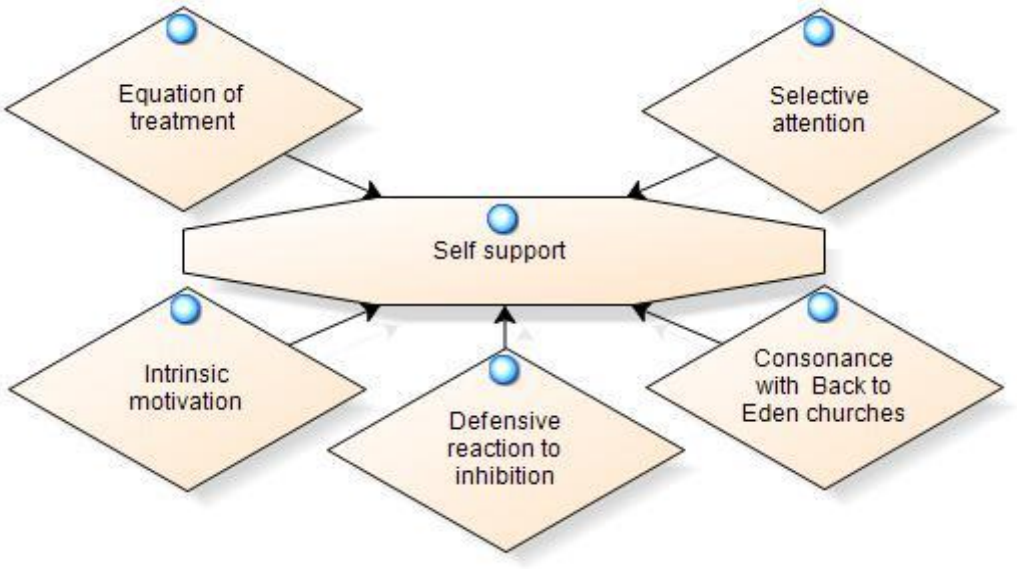

Figure 6.12: Self-Support

6.2.6.1 Intrinsic motivation

Most of the participants found support internally; they supported themselves and were reinforced by the perception of their own improvements:

BATSI: What is giving me strength is an observation about TAM impact on my health? Is it not that I told you that I am now doing work I was no longer previously able to do? Again my body parts that were weak, they are now strong. So my body feels the need for taking TAM. If I do not take it here, I would feel that there is something important that I missed. It reacts in a manner that informs me that I am missing TAM.<Internals\\Audio\\Batsiranai> - § 1 reference coded [14.11% Coverage]

Batsiranai appeaared to have a lot of intrinsic motivation which kept her using TAM. Such intrinsic motivation would make them a convincing minority that might brew both descriptive and injunctive social influence. Charity also shared the same intrinsic motivation;

CHARITY: I just continue on TAM use…it is good for me … My health is improving. As a person I can't feel that I am still positive, .. s/he will not notice or suspect that I am positive…there is no one who can stop me from using TAM… I am a person, who is confident, so I don't expect or think that anyone will ever stop me from using them. Ah, I do not think so. There is no one whom i think can hinder me from using TAM. <Internals\\Audio\\Charity> - § 2 references coded [18.30% Coverage]

Charity appeared to be a person who stood for herself. She was oozing with confidence from intrinsic support. Surely such confidence in the minority group would cause a lot of attitude change among the majority. With such confidence, the participants were able to convince others to not only support TAM but to use it as well. Intrinsic support was very common among the respondents; Convenor, Muyengwa and Tinomboedza were also reported being intrinsically motivated;

CONVENOR: Firstly, personally, you must have confidence in yourself and challenge whatever people say.<Internals\\Audio\\Convenor> - § 1 reference coded [13.73% Coverage]

DREAD: If we are solely on herbs we will not go to ARVs, we will stick to herbs no matter what anybody says.<Internals\\Audio\\Dread> - § 1 reference coded [11.60% Coverage]

MUYENGWA: Ah, for me what I only think about is my health, there is nothing that I can say will push me away from continued use. I use them because of the state of my health. <Internals\\Audio\\Muyengwa> - § 1 reference coded [19.57% Coverage]

TINO: There is nothing that would hinder me from using it . I am in control of my situation because I am in charge and responsible for my family affairs as a father. No-one would be able to control or redirect me, im in charge of my destiny as a father, no one else <Internals\\Audio\\Tinomboedza> - § 2 references coded [10.53% Coverage]

The users of TAM seemed to be more supported by their own perception of personal improvements than turning to social influence for what is right or wrong. However, it seems the more they ignore the social influence, the more they are creating more supporters and users of TAM. Their own self support as individuals and small groups gained the power ofn a influential minority; turning the social influential framework into becoming more supportive and finding utility in TAM. Kushingirira reported that they were even reinforced by their perceptions of being healthier than their HIV positive counterparts who were not using TAM:

KUSH: In the community we find more encouragement in using TAM, taking cues from how people who do not use TAM frequently deteriorate, especially those who are HIV positive. It encourages us to use TAM because when we compare ourselves with those who don't take, we realise we are much stronger than them, we don't regularly fall sick like them…Due to use of TAM, the community think we are strong, and they encourage us to take them.<Internals\\Audio\\Kushingirira> - § 1 reference coded [9.55% Coverage]

Kushingirira said they were fighting for social support by silently showing that they were '*strong, attractive and all that'* which showed that they were doing something good and worthy of support. Zvamaronga also reported that they had intrinsic motivation to find the cure so they would keep on being '*found in both groundnuts and roundnuts*':

ZVAMA: We are using traditional medicines with the hope of eliminating the virus . The cure could be found in both groundnuts and roundnuts, it is a search for a solution but I am seeing it changing our lives… and there is nothing that can stop me from usingTAM <Internals\\Audio\\Zvamaronga> - § 1 reference coded [11.52% Coverage]

Zvisinei also narrated the situation of her HIV positive son who had strong intrinsic motivation to find a cure and treatment. He was so certain that all his siblings ended up using TAM. He was an influential minority influencing even older siblings:

ZVISINEI: Then the younger boy (HIV positive), he is that type who is very experimental, he just tries out things. He is motivated by faith, I think. If he is told that it is possible, he will try. So in his trials, he discovered that this is helpful, this is helpful to the extent that he is now encouraging others saying, '*you, my sister…'*, sometime last week the girl had stomach ache, I heard him saying, '*chew this Murumanyama(herb).'*, holding it like this, compelling her to chew and the sister was crying, '*it is bitter, I am hurt, you are increasing the pain, it's hurting this bitterness', 'Ah, ah, chew.'* You see the younger brother (aged 18)…telling the older sister (aged 22, HIV negative)… I have realized that when someone is in pain, if given herbs, s/he will not refuse. … if you are told to eat the goat's droppings so that you can see, after you have gone blind, you will notice that a person would really eat them. <Internals\\Audio\\Zvisinei> - § 3 references coded [15.99% Coverage]

Tthe motivation may have been coming more from the lack of a definitive cure. Therefore, the infected people would be resistant and non-responsive to negative social influence. However, the tide of social influence would eventually support them as they showed boldness and evidence of the use of TAM.

6.2.6.2 Defensive reaction to inhibition

At a personal level, they strongly defended TAM use:

CONVENOR: Firstly, personally you must accept that TAM is effective and convince yourself it works despite what people would say. The way people criticise TAM, maybe it's because too much education, I do not know; you hear them saying people who use

traditional medicines are backward people. So you have to fortify yourself against such criticism, defending yourself when people are talking against it, let them understand and know why you are persistently maintaining your position..<Internals\\Audio\\Convenor> - § 1 reference coded [13.73% Coverage]

It appears the stronger the self-support the greater the effects of minority norm in yielding descriptive and injuctive norms. Most of the participants revealed that there was nothing that hindered them from using TAM. However this refusal to acknowledge the effects of obstacles could be more of defensiveness and a sign of self-support:

ZVISINEI: So far I have nothing TAM use because it has never failed to work on me. (She laughed)… maybe if something terrifying happens around its use, maybe , let's say, TAM has killed a person, if you hear that you will be frightened. So if something like that happens, I might be frightened, but so far there is nothing. Basically, I do not experiment with that I don't know, so I am not worried. <Internals\\Audio\\Zvisinei> - § 1 reference coded [15.99% Coverage]

2MINUTES: Nothing would stand against my use of TAM… Nothing <Internals\\Audio\\TwoMinutes> - § 1 reference coded [18.63% Coverage]

KUSH: there is nothing that would stop me from using it because for me it works. So I think I will keep on using it, putting in the porridge and eating. If it is a liquid, I would drink and continue doing that.<Internals\\Audio\\Kushingirira> - § 1 reference coded [9.55% Coverage]

MAKAITA: Ah, there is no-one who can stop me, even though most are saying these days there are pills …. what I can tell them is that though I take pills, I will keep drinking my herbs. So there is nothing to stop me.<Internals\\Audio\\Makaita> - § 1 reference coded [9.36% Coverage]

It seems there were no apparent obstacles to using TAM. Even if there were possible obstacles the participants defended their views against possible resistances;

If we are solely on herbs we will not go to ARVs, we will stick to herbs no matter what anybody says.<Internals\\Audio\\Dread> - § 1 reference coded [11.60% Coverage]

When Dread said, '*no matter what anybody says*', he referred to resistance and obstacles they faced in using TAM. The participants mostly gained their support from the self. They were sometimes defensive and emotional when talking about the opposition to their use of TAM:

BATSI: The church people do not know that the '*being cursed*' they are referring to, they just write it with a ballpoint writing that TAM is cursed yet I am using it and my life is getting well. <Internals\\Audio\\Batsiranai> - § 2 references coded [14.11% Coverage]

The defensiveness was also evident in how some of the participants exaggerated the religiosity among the non-permissive churches;

GREY: It is the apostolic church that forbid TAM. However the leaders themselves forbid the use of TAM yet they themselves use the TAM. That is what happens. They would be lying. …Yes, they would be lying, it is happening.... like those from Johanne Masowe sect, they lie because even the leaders you would see them coming to me to look for TAM.... Yes, I would give them and they drink but at the church he would be preaching against it's use, '*we do not want anyone who takes TAM, we do not want anyone who takes it.*' … so there is no one who forbids me from using TAM, not even the apostolic church members…who come secretly to take TAM. They act like hypocrites in a manner that conjures up images and behaviours of fiction movie actors, but in this case it will be playing out in churches.(he laughed). <Internals\\Audio\\Grey> - § 2 references coded [6.93% Coverage]

The apostolic churches forbid the use of TAM yet Grey said some of the apostolic leaders still use it. He seemed to be exaggerating the extent to which apostolic preachers use TAM in order to emphasise his self-support. Grey explicitly acknowledged that *'I do not even listen to the one who says that because they talk in many places but I do not listen.'* showing that he was defensive. This information was at odds with his beliefs and behaviour so he engaged in selective attention and maybe in thought suppression. Why was he blocking any possible hindrance and barriers? '*Threats are there but they are not threat*'. Muyengwa also found self-support from his perception of religiosity among the apostolic:

…That is why I said those people can lie to you that they are using prayer power and church related items, yet they will be using traditional medicines. I still remember this other year when I was operating my tuck shop, there are some of the apostolic church leaders who used to pass through my tuck shop. One of them was a great prophet. He will buy pain eases [medication for headaches] about 10 or 20 and go and dissolve them in 5liters of water. After prophesy at church he would give them that water to drink. In a few minutes a person would feel much better. So for me to say these people do not use, Ahh. (He laughed)… I saw him doing that, I saw it; right now I sometimes talk to him asking him whether he still remembers buying pills and he said, ' *right now I have changed, I am now on another church, I stopped doing that*.'<Internals\\Audio\\Muyengwa> - § 1 reference coded [19.57% Coverage]

Tinomboedza and Tatenda also share the same notions:

TATENDA: Even the other churches they hide their use, those churches are using traditional medicines. <Internals\\Audio\\Tatenda> - § 1 reference coded [14.51% Coverage]

TINO: Some people, or even the church elders, although I would not reveal the name of the church, some of the church elders go at night… they go clandestinely to get TAM, … <Internals\\Audio\\Tinomboedza> - § 2 references coded [10.53% Coverage]

Generally, the participants sought their own self support to gain the confidence to develop descriptive and injunctive norms.

6.1.6.3 Selective attention

To cope with a lot of inhibition and boost self-support, some participants reported engaging in selective attention to reduce cognitive dissonance. The more they reduce dissonance the more they gained confidence as the influential minority. As shown above, some participants chose to ignore information which contradicted their beliefs and behaviour. Below, Batsiranai also showed how she only saw praises:

BATSI: I am now hoping that no relatives or friends would ever influence to stop taking TAM. Some would say, '*ah, friend, these issues of TAM, ah, no, the bible says the TAM*

is bad or this and that.' … so far I have not heard of anyone who came to me telling me that except those with compliments about TAM use. I have never seen anyone who came despising TAM use or saying, '*no, ha-a, I did not grow up using it.*' Ah, ah, I just see those who support it's use, appreciating saying that it is something making us survive...<Internals\\Audio\\Batsiranai> - § 2 references coded [14.11% Coverage]

Batsiranai was aware of the hindrance but she chose to have seen nothing inhibitory. She only saw supporters and praises. This selective attention was also evident in church selection.

6.1.6.4 Consonance with Back to Eden Churches

The participants sought consolation with old churches because they seemed to be more permissive on TAM use. The intention was to reduce cognitive dissonance by embracing the '*Back to Eden*' principle which was more in accord with TAM. As shown earlier, Convenor changed her church:

CONVENOR: Here I am talking about a church like the Johanne Masowe; they say that if you go and dig a root or if you take leaves or barks, you have practiced sorcery, that it is not allowed. I used to go to that church but I have since stopped. <Internals\\Audio\\Convenor> - § 1 reference coded [13.73% Coverage]

Dread, Moyo, Grey and Muyengwa also revealed that some of the Back to Eden churches did not mind the use of TAM:

DREAD: the churches that had been there all along, Catholic and Methodist, they do not mind, ah, they use herbs. <Internals\\Audio\\Dread> - § 1 reference coded [11.60% Coverage]

GREY: we also go to church, our type is the likes of Salvation that allow use of TAM, and the likes of Roman Catholic, they do not forbid TAM use those ones. It is the apostolic that forbid TAM <Internals\\Audio\\Grey> - § 1 reference coded [6.93% Coverage]

MOYO: I do not think there is anything that can stop me from using TAM even though we go to church; some churches forbid using traditional medicines; but if it can be of

assistance to me, I do not see any reason not to use them.<Internals\\Audio\\Moyo> - § 1 reference coded [8.98% Coverage]

MUYENGWA: She also goes to church with others but there are no rules that say do not do this, that and that includes using herbs.<Internals\\Audio\\Muyengwa> - § 1 reference coded [19.57% Coverage]

Similarly, association with Back to Eden churches reduces cognitive dissonance and boosted confidence in recruiting others.

6.1.6.5 Equation of treatment

Self-support was also seen in how they equated TAM to other treatments, justifying the preferred treatment as equally competitive. Batsiranai equated the hospital treatments to the TAM treatment and the prophets' healing:

So I keep on enlightening my husband saying, 'no, each and every place where a person receives treatment, there is a possibility any one can die. If you have been using something with the full knowledge that it helps, based on your personal knowledge and experience, there is no good reason why you should stop using it because your life entirely depends on it…'' That is why I said everywhere where people go when they face problems isn't bad, because in every situation death will always occur. Myself I have survived using TAM, I am still alive to date is that not it? Others have used TAM and still died, other have died in hospitals and at prophets healing sites. Everywhere you go, there is still life and death prospects.. <Internals\\Audio\\Batsiranai> - § 2 references coded [14.11% Coverage]

Others also shared like sentiments:

You are supposed to convince yourself that which suits you the most, TAM or pills. Pick and choose one that suits you and stand by it. <Internals\\Audio\\Charity> - § 1 reference coded [18.30% Coverage]

Generally, the equation of treatment was intended to self-support and gain confidence in the use of TAM.

6.1.6.6 Manipulation of future generation

As part of self-support, the participants were working towards gaining the support of their own children. They reported supporting and encouraging their children to use TAM and this increased the amount of support to use TAM. Apart from creating and gaining support from their children, in a way they appeared to be manipulating the future generation for continued use of TAM:

BATSI: There is nothing that can stop my son. That is why I said up to this time I am still controlling him, he still understands, it is still effective, I have identified any problem with it yet… He asks me for advise on how the herbs are dug for him, and which herbs are appropriate for a particular problem. So it means that in his future he will live with the knowledge of herbs and how it cures. Internals\\Audio\\Batsiranai> - § 1 reference coded [14.11% Coverage]

Charity also made it a point that her children support and use TAM:

CHARITY: I encourage my children to use TAM… when I cook my food, I have some TAM I put even in relishes, I put it in like royco (cooking flavour ingredient) for them to eat. So I am a person who is happy for them to eat them because I know it is effective. With the passage of time they will start to use on their own when they have grown up. If I am around there is nothing that will stop them. Before they go to school, I put it in the porridge for them to eat. If it is at the church they go after eating it as well. They go to the same church I go to. They follow in my footsteps, and do everything I do. <Internals\\Audio\\Charity> - § 3 references coded [18.30% Coverage]

Muyengwa and Convenor also revealed that they (parents) were acting as role models to their children:

MUYENGWA: … you know how our children are brought up, what they call role models are the parents. They imitate and emulate their parents in what they use, drink or take.. if s/he sees her parents taking TAM, nothing will stop them from using TAM… I keep on encouraging them, saying if you eat this one, you will not get flu, if you use this one you will stay strong, you live longer. So because she follows whatever parents say, in as

much as he followed whatever our parents told us. Whatever our parents say or do, its accepted as the right thing. <Internals\\Audio\\Muyengwa> - § 2 references coded [19.57% Coverage]

CONVENOR: It's us the parents who encourage our children to use TAM. It is only us who have such power to do that…if there is no parental encouragement, the child cannot use because s/he would not have a way of knowing… <Internals\\Audio\\Convenor> - § 2 references coded [13.73% Coverage]

Grey was very concrete on monitoring children in order to have child outcomes that support and use TAM:

Some of us we monitor our children , we monitor them as they grow each and every day …. A young child does not know what is paining him/her. So you ask him/her, 'what is the problem? What is doing that?' if s/he says the eyes, you go and fetch TAM for the eyes and treat him/her. If s/he says it is the tooth, you go and fetch TAM for the tooth and you make her/her drink. Sometimes the small child would be feeling a tooth and s/he would say it is an eye. So you try to; you have to find what is paining him/her <Internals\\Audio\\Grey> - § 1 reference coded [6.93% Coverage]

Grey revealed a family culture of using TAM in which children were habitually treated using TAM in order to develop a child that regards TAM as a family culture and tradition, maybe a good thing they should support and continue doing. Kushingirira also used TAM with her children:

KUSH: It is me the parent; it is me who knows what is supposed to be taken by my child, so that my child stays healthy… I would be ensuring that my child faces no problems in future. <Internals\\Audio\\Kushingirira> - § 1 reference coded [9.55% Coverage]

Active socialisation of children into supporting and using TAM appeared to be attempts to change the social influence around the use and support of TAM. Such children would form part of descriptive and injunctive referent others from whom they found support.

CHAPTER SEVEN

PERSONAL AGENCY BASED TAM MOTIVATIONS

7.1 INTRODUCTION

Personal agency was understood as the participants' capacities to originate and direct actions for the purposes of TAM use. The IBM divides personal agency into two; self-efficacy and perceived control. Self-efficacy was understood as the participants' perceived capabilities to successfully use TAM. Perceived control was understood as a cognitive dimension of beliefs about barriers and facilitators around TAM use. The findings of this study support that self efficacy and perceived control are stong behavioural determinants of TAM-use.

7.2 SELF-EFFICACY

Efficacy Beliefs seemed to guide participants' behavioural attempts, efficacy sought to identify sources of confidence to use TAM and mechanisms used to avoid constrains in the use of TAM. As shown in Figure 7.1 below, Traditional practices, escape-avoidance beliefs, super confidence and dependence on TAM were the issues that were revealed as guiding the participants' behavioural attempts.

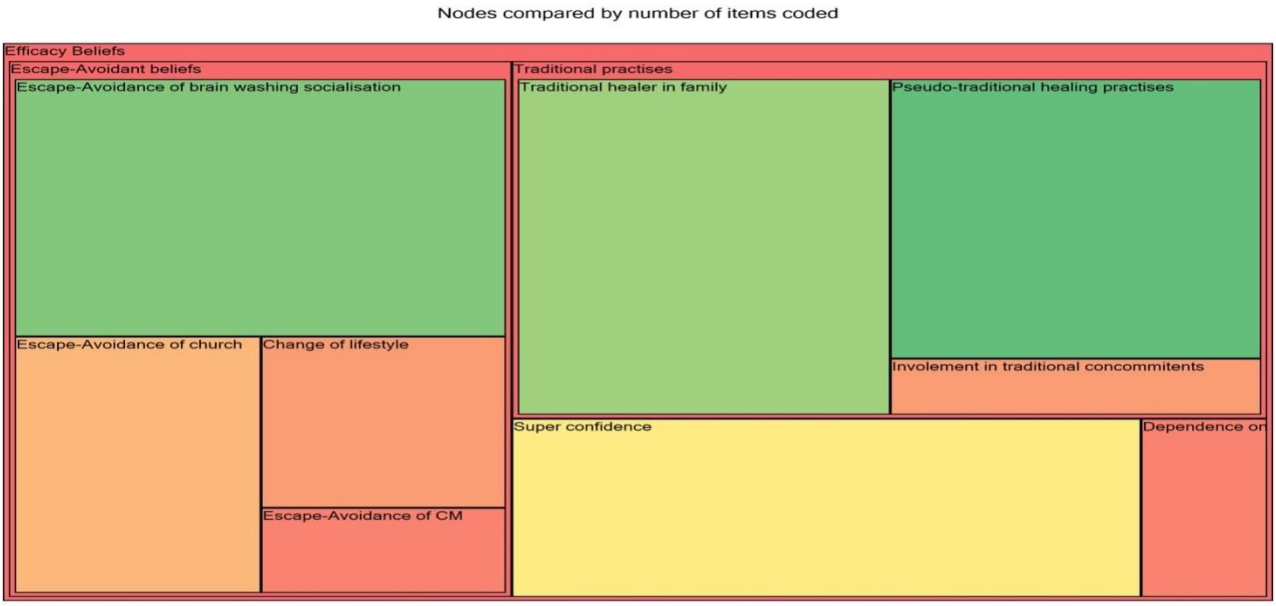

Figure 7.1: Efficacy beliefs

7.2.1 Traditional Practices

Traditional practices were one of the major sources of confidence that guided the participants' behavioural attempts. These were: pseudo-traditional healing practices; having a traditional healer or spirit medium in the family and involvement in traditional concomitants.

7.2.1.1 Pseudo-Traditional Healing practices

A lot of confidence and efficacy beliefs originated from those who claimed to be either traditional healers or spirit mediums themselves. Beliefs and behaviours related to being a traditional healer and/or spirit medium were contextualised as pseudo-traditional healing practices. Charity revealed that she was a traditional healer:

CHARITY: As for myself, I am a traditional healer. I am made to dream the traditional medicines. I let my herbs heal others. The herbs are not for myself. You are aware of that issue that a traditional healer does not heal herself. I can say since 1999… when I was young I used to go to church, I used to go to the Apostolic Johanne Marange church. So when I was in that church, I was a person who jingled with the Holy Spirit. I eventually left the church.. When I left the church I started having the dreams being told, '*you are supposed to heal.'* I refused to take the dream seriously thinking it was just a trivial issue. During the first days, I use to tell patients that would come to me with problems saying, *'a-ii, I have headache, or stomachache.'* I would ask them why do you not go to the hospital or clinic. When I sleep at night, I could dream being told that, *'the person who came to you, go there and take that muti (TAM), dig it and give him to drink, he will be right.'* The first days I ignored every dream that came like until i eventually got sick. When I got sick I went to a prophet, *'is it not that you are refusing the job you are being told to do in your dreams… is it not you left the church, you initially wanted to heal people while in the church but you left and said I no longer want to go to church. So you have to heal with the traditional methods as you are being instructed to do in your dreams.'* Ah, I ignored it at first but i kept on dreaming … until I reached a point that I had to comply with what the dreams were asking me to do. If I met a person with a

problem, I would tell him ‘come tomorrow and I will see your child.’ She would come, I would take that TAM I dreamt about and give her and the child would get healed. Within two days three days s/he would be right. So I got to a point of keeping on doing it until today, I heal people…<Internals\\Audio\\Charity> - § 2 references coded [17.51% Coverage]

Charity found her efficacy from the spiritual intervention which she believed guided her behavioural attempts and continued use of TAM. Grey also repeatedly revealed that he healed others. He went to the forest to search for herbs to cure other people. He said:

Ah, I only look for the ones (TAM) I know. If I am told by someone that I have this disease, I would go and fetch it (TAM) and bring it, and help a person who needs to be helped… As a person who understands TAM, I felt sick as well at some point. TAM that cure what I was suffering from were the herbs that I know because I used to ask a lot when I was being treated. I would search to understand the traditional medicines, I would look for some few cents and s/he would show me the herb (tree) and I would have immediate knowledge of it.[1]<Internals\\Audio\\Grey> - § 2 references coded [24.38% Coverage]

Grey reported that he learnt from his own experience with the traditional healer. Grey now had his own patients, treating those diseases he was cured of. It was these pseudo-traditional practises that gave him confidence and efficacy beliefs. Tatenda also believed that she had a family spirit that guided her behavioural attempts:

TATENDA: I started being troubled by traditional spiritual issues when I was in form 2, (two year level secondary education) It was being said that I had a family spirit (Mudzimu)… When i grew up, I reached a point where if I just looked at a person, I would feel being instructed to tell that person something. I did not know what was sending me to tell other people what was happening in their lives. So when my father started to travel with me consulting spirit mediums, that is when I started to know that there was some traditional family spirit on me… So that is what gave me the courage to appreciate it, especially as I got possessed by the family spirit. My appreciation of traditional spirits grew. <Internals\\Audio\\Tatenda> - § 4 references coded [25.73% Coverage]

Similarly, Zvamaronga also reported having a spirit that made her dream of herbs:

ZVAMA: I am made to dream about locations of TAM… <Internals\\Audio\\Zvamaronga> - § 1 reference coded [13.80% Coverage]

Tinomboedza also claimed to heal other people:

TINO: What happens when we are using TAM, is that when a person visits you with a stomach ache, s/he had not been tested or anything, if you give that person TAM, the health will improve and even get better.<Internals\\Audio\\Tinomboedza> - § 1 reference coded [18.26% Coverage]

Generally, the above pseudo-traditional healing practises created and compounded self-efficacy. Working as a practitioner appeared to be a sign of strong confidence and capacities to originate and direct actions for the purposes of TAM use.

7.2.1.2 Traditional Healer in family

A lot of confidence and efficacy beliefs also originated from those who claimed to have either (a) traditional healer(s) or spirit medium(s) in their family, especially close relatives such as (grand) parents and siblings. Batsiranai pointed out that with her husband they had self-efficacy due to how they grew up with their grandfather who was a traditional healer:

BATSI: Myself and my husband we strongly accept TAM because we were born in the real African traditional belief systems. My grandfather, that was his job. If I fall sick, I would say, '*grandfather, I am unwell, my condition is now bad.*' ... My aunt is the host of a clan spirit, the clan spirit that seizes her is the one that would say, '*go and take TAM there and give the person.*'<Internals\\Audio\\Batsiranai> - § 2 references coded [19.41% Coverage]

The grandfather and aunt were the sources of self-efficacy for Batsiranai. Similarly, Zvisinei found her confidence from her grandfather and Kushingirira from her father:

ZVISINEI: …my grandfather was a sangoma, (Traditional healer) so i know enough about this. It is something I grew up with <Internals\\Audio\\Zvisinei> - § 1 reference coded [13.54% Coverage]

KUSH: …my father was possessed, he was a traditional healer, so he healed people with TAM. <Internals\\Audio\\Kushingirira> - § 1 reference coded [26.12% Coverage]

All of Makaita's uncles whom he grew up with, as she indicated, were traditional healers:

MAKAITA: … our whole family, where we were reared, where our mother was born, there are sangomas, all my uncles are sangomas, so we all grew up using traditional medicines. <Internals\\Audio\\Makaita> - § 1 reference coded [15.04% Coverage]

Moyo also developed self-efficacy due to his mother-in-law:

I was given by my mother-in-law because she is involved with TAM ; it really works, it is like a root that you eat, its bitter… <Internals\\Audio\\Moyo> - § 1 reference coded [17.59% Coverage]

Apart from having spiritual dreams herself, Zvamaronga had a sister who was a traditional healer and her late mother was also a traditional healer, believing her spirit was now working with her sister:

ZVAMA: Ah, my (late) mother was a traditional healer… and I have my older sister who does those traditional things, she inherited the talent from my mother. If she gets sick, she rarely goes to the clinic. If she climbs up mountains in Mutare, she would dig her medicines and heal herself. She says sometimes she dreams our mother telling her*, 'I told you that when I am no longer there, if you have a problem, go and dig that and it would help you.'* <Internals\\Audio\\Zvamaronga> - § 2 references coded [28.18% Coverage]

The traditional healer and/or spirit medium in the family created and compounded self-efficacy. The users claimed to be very experienced and confident in originating and directing actions for TAM use.

7.2.1.3 Involvement in traditional concomitants

There were others who were involved in other activities that work with traditional healing. Dread's profession was the manufacturing of traditional musical instruments and traditional ornaments. Such instruments and ornaments are commonly used by traditional healers. He said:

I manufacture traditional musical instruments including beads.

MUROMO: Like this one you are wearing?

DREAD: Yes <Internals\\Audio\\Dread> - § 2 references coded [5.44% Coverage]

Dread seemed to be exhibiting sublimated liking of TAM in his preferred job. He not only used TAM but also promoted the preservation of traditional practices. His profession was a sign of strong confidence and capacity to start and direct actions for the purposes of TAM use.

7.2.2 Escape-Avoidance Behaviors and beliefs

Operand conditioning (0000) can be used to explain some of the behaviours and beliefs that seem to distance the self from constrains for TAM use. It seems as if repeated exposure to the constraints for TAM use made some of the participants develop escape methods or ways of overcoming the constraints (escape behaviour). Time seems also to have allowed the development of some ways of avoiding constraints completely, in other words they developed mechanisms to avoid ever getting caught in the constraints (avoidance behaviour). A lot of confidence and capacities to start and direct actions for the purposes of TAM use were also found in the creation and maintenance of escape-avoidance beliefs and behaviours meant to distance the self from the hindrance for TAM use. Escape-avoidance of perceived non-supportive socialisations, churches and conventional medicines were some of the thematic areas that were identified. Some also changed their lifestyles as a way of escaping and avoiding constrains to TAM use.

7.2.2.1 Escape-avoidance of non-supportive socialisation

A number of participants believed in solitude as a method of escape-avoidance barriers to TAM use. In response to how they got around the barriers most of the participants pointed to solitude and avoidance of incongruent socialisations:

CHARITY: What I do most to escape the barriers is that I just live on my own. No-one will ever disturb me during my use of TAM… I avoid people by going around my normal family social solitary schedule..<Internals\\Audio\\Charity> - § 1 reference coded [4.85% Coverage]

Charity believed in solitude as a way in which she could develop confidence and capacity for uninterrupted TAM use. Similarly, Indigenous found his confidence in isolating himself and his family and being very strict when it came to visiting and mixing with other relatives. In response to how he got around the barriers he said:

INDIGENOUS: Staying together as a family, ehh, limiting our travels and routine social visits of relatives and friends. Because some of these relatives, have what they believe in that will disturb my health - disturbing my normal social routine. Staying in one place as a family is the solution. I see it as a way of avoiding these inconveniences or disturbances. Other relatives do not believe in TAM, we try and avoid them to avoid unnecessary suspicions.

I would rather go to someone else who understands me, who can help me, whom I can trust, who can also help me with my problem. That person or s/he might be strongly knowledgeable than me…<Internals\\Audio\\Indigenous> - § 4 references coded [9.81% Coverage]

Indigenous was very eloquent in limiting the visits, selective engagement and cautious interaction with others. To this, Makaita was very succinct:

MUROMO: What kinds of things would help you get around any barriers to you using TAM if you wanted to?

MAKAITA: Not listening to discouraging and opposing people.

MUROMO: What else?

MAKAITA: Nothing<Internals\\Audio\\Makaita> - § 1 reference coded [7.32% Coverage]

Dread also felt that perceived brain washing socialisation should be avoided, especially for the children:

DREAD: I am supposed to block a lot of brain washing education. And the type; schools are the other issue. We have different schools, you might send your child to a school that you would say is the best in the town. Where s/he is taught that, *'to beat, or shout at your father and mother, is of no use.*' There are such schools. At other schools, the kind of education s/he gets there is corrupt, the children end up changing attitudes and getting wild.You should have a good appreciation of the school that you send your child to, hence they may get spoilt. Once they come back they will disregard your advise.

<Internals\\Audio\\Dread> - § 1 reference coded [5.15% Coverage]

Muyengwa found himself in an incompatible relationship with his partner from whom he separated and was now avoiding such relationships with people of other beliefs:

I can say the disputes I had with my former partner were the reasons that resulted in us separating because I realized that we were not in harmony. You also know our tradition, if you are the husband, you are not supposed to have a woman leading you. If you advise her to go to Seventh Day Adventist, and she refuses and insists on going to the apostolic sect, then it means she doesn't listen to you and there is no marriage. So I realise that our separation has assisted and facilitated my using TAM openly, that is important and number one. Two, the issue of us meeting in support groups, it really encouraged me to use TAM because when we say use this one, that one, these and those ones, and people will ask you how you do it, what really happens? That alone gives you the enthusiasm and zeal to use TAM. You will realise that TAM is good and that I should continue using it.<Internals\\Audio\\Muyengwa> - § 1 reference coded [5.59% Coverage]

Isolating oneself from incompatible relationships and interactions encouraged confidence in the decision to use TAM since it would have reduced cognitive dissonance.

7.2.2.2 Escape-avoidance of church

Some of the participants escaped by quitting churches whose beliefs are in contradiction to the use of TAM. Such escape-avoidance behaviours and beliefs helped develop confidence and capacities to use TAM. In response to how they got around the barriers, Charity and Tinomboedza said:

CHARITY: Ah, the religious issues I can say I have quit, it no longer has effect to me.<Internals\\Audio\\Charity> - § 1 reference coded [4.85% Coverage]

TINO: As for me I no longer go to church. I stopped, I now use traditional medicines because that is where my life is.<Internals\\Audio\\Tinomboedza> - § 1 reference coded [12.83% Coverage]

Charity escaped from the aversive stimulus (church) and now lives in avoidance. Her escape and avoidance learnt behaviours gave her confidence in TAM use. Tatenda also revealed that she lived in avoidance because she selects only those churches (Back to Eden churches) that mix pills and TAM use:

TATENDA: I look at the church, there are churches that are combining traditional and conventional things, they are there. So I really know that, ho-o if I go to this place, they advocate combining together… we pray together and even help me with my traditional things. <Internals\\Audio\\Tatenda> - § 1 reference coded [5.43% Coverage]

7.2.2.3 Escape-avoidance of conventional medicine (CM)

Some also developed their efficacy beliefs from escaping and avoiding conventional medicine (CM). The CM had been associated with shunning TAM and discouragement of taking TAM simultaneously with ARVs. To boost their ability to use TAM, some have quit the pills and anything else that comes from conventional health institutions:

CHARITY: If it is about the health institutions, I have since stopped going there, and I have gone for a long period without having been to a hospital. So it does not affect me. What is it that would have happened to in order to compel me to visit a doctor? Ah, what would have happened? I do not expect to do that. I expect that when I get sick, I believe

that if I take my TAM I will heal and get right. The way I was supposed to drink the pills, that is the way I am supposed to take my TAM and I will be fine… for my children there is no one who easily falls sick. So I see that the TAM is greatly helping them. It gives them good health.<Internals\\Audio\\Charity> - § 2 references coded [22.99% Coverage]

Charity had since stopped going to the hospital. She tried to quit ARVs. Her husband died and she believed that it was because of the ineffectiveness of ARVs. She was now following her TAM remedies.

7.2.2.4 Change of lifestyle

For some, they believed that they have changed their lifestyle, to follow the one that helps them develop and maintain behaviours that enhance continued use of TAM. Dread was very particular about this, he said:

DREAD: I do not use TAM the way I take medication. I have grown TAM in my garden, and I take appropriate TAM at the right time. If its tea time, the kinds of tea from shops like OK (a chain of stores) or these other shops and coffee, I do not use. I normally use greens, coming from gardens or dried ones because I would take them knowing their effectiveness. So as for me personally I am free because I have always been using herbs, so they see me taking the likes of my rosemary (type of herbal tea), even if its chicken being cooked or any other relish, I have a lot (of herbs) that are added in there besides the ordinary tomatoes and onion. <Internals\\Audio\\Dread> - § 1 reference coded [5.15% Coverage]

Dread revealed a lifestyle not as an event or a period that comes and goes. It was from this lifestyle that he derived confidence to use TAM. As shown before, Dread was keen about traditional things. Here it was also shown by maintenance of his garden from which he grew some TAM and he was not even shy of it since he was openly seen growing and harvesting. Grey also reported having a '*system*' of using TAM, he said:

GREY: Ah, as for me, my children know that here we drink TAM and there is no way they (children) can refuse it because it is a system practised in the house, that they are

also introducing to others who are coming to get help here.<Internals\\Audio\\Grey> - § 1 reference coded [3.70% Coverage]

He referred to TAM as a '*system*' to indicate that it was an inevitable component of the functioning of the family. Such a statement indicated that Grey introduced TAM as a lifestyle to his family and he and the family now have confidence and capacities to originate and direct actions for the purposes of TAM use.

7.2.3 Super confidence

Some became full of self-efficacy due to the learned utility of TAM. They had used it and were now super confident such that they could not yield to any criticims or pressure. Grey used it and he reported that he had tested HIV negative. Such an experience gave him super confidence:

GREY: What makes it difficult for me to accept any criticism of TAM use is that I found it effective. So there is no one who can stop me from using something useful, that I found helpful, taking me back to something that is not useful. Because if you are told that this sadza (Zimbabwean staple food) satisfies you, you would know that you are supposed to farm, if I farm and I will grow maize, I will cook sadza, eat and live. So this TAM helps. I cannot stop doing something that is helpful. It is just like eating sadza, porridge and tea, you eat to live… it is the same as a person coming to you saying do not drink tea or do not eat sadza, sadza you know it will make you survive. (He laughed) <Internals\\Audio\\Grey> - § 1 reference coded [3.70% Coverage]

He likened TAM to sadza (a staple food in Zimbabwe), a metaphor representing the perceived importance and effectiveness of TAM. He regarded any efforts to stop him from using TAM as attempts to stop him from eating sadza which he knows to be very vital to his survival. He was vehemently pointing to his self-efficacy in TAM use. He was super confident of it. Similarly, Zvisinei also said she had to be very confident and trusts her conscience:

…like I said, my conscience will tell me it is right and I will use it. It is just the same with what we do in our lives every day, there are ‘dos and do nots’ in life but sometimes you

find yourself doing ‘do nots’, you will find that if the ‘dos’ do not help me in what I want to do, I will stop.That is how we do it even on herbs. We hear them saying, ‘*it is bad to take herbs, do not give to children, we do not want to see it, this and that’*, truly, that what you believe, but for me, for my children, after some time I will give them. <Internals\\Audio\\Zvisinei> - § 1 reference coded [2.67% Coverage]

Convenor also pointed to the importance of super confidence:

CONVENOR: If you are strong in your views, you will stand and remain steadfast in whatever you do. You remain unwavering. Because if you want to listen to different views, you will be easily swayed. Haa, it is difficult. If you know the herbs you can go and fetch them on your own. You can pick a hoe and dig in broad day light. If the people ask you, you will confidently say you are digging for your herbs.<Internals\\Audio\\Convenor> - § 1 reference coded [5.62% Coverage]

As said by Zvisinei, it takes a lot of confidence for you to ‘*not do the dos*.’ It takes a clear and verified purpose, a lot of confidence and capacities to start and maintain actions for TAM use.

7.2.4 Dependence and/or conditioning

For some, their use of TAM seemed to have been conditioned and they were now dependent on TAM. As a result their use of TAM would be inevitable since they would be trying to ward off the aversion from withdrawal. TwoMunutes explained:

2MINUTES: If I stop using TAM there will be a problem. I stopped for one week and I got sick…I realized that the problem remained, so I made sure that I resumed my TAM use… <Internals\\Audio\\TwoMinutes> - § 1 reference coded [5.89% Coverage]

TwoMinutes seemed to have developed withdrawal symptoms and due to fear of these, she was now depended on TAM. This might be truly biological in which she was now really dependent or it can be psychological due to classical conditioning. Nevertheless, her confidence in TAM use was boosted since she attributed the relapse to withdrawal from TAM.

7.3 PERCEIVED CONTROL

Perceived control was contextualised as a cognitive dimension of beliefs about barriers and facilitators around TAM use. As shown in the cloud below (Figure 7.2), many things were said around barriers and facilitators; children, people, partners, nothing and many more.

Figure 7.2: Cloud on perceived control

Perceived control is going to be divided into three sections; the self, partner and children.

7.3.1 Beliefs about barriers and facilitators to self

Below is a summary of responses revealing things that made it easier for participants to use TAM.

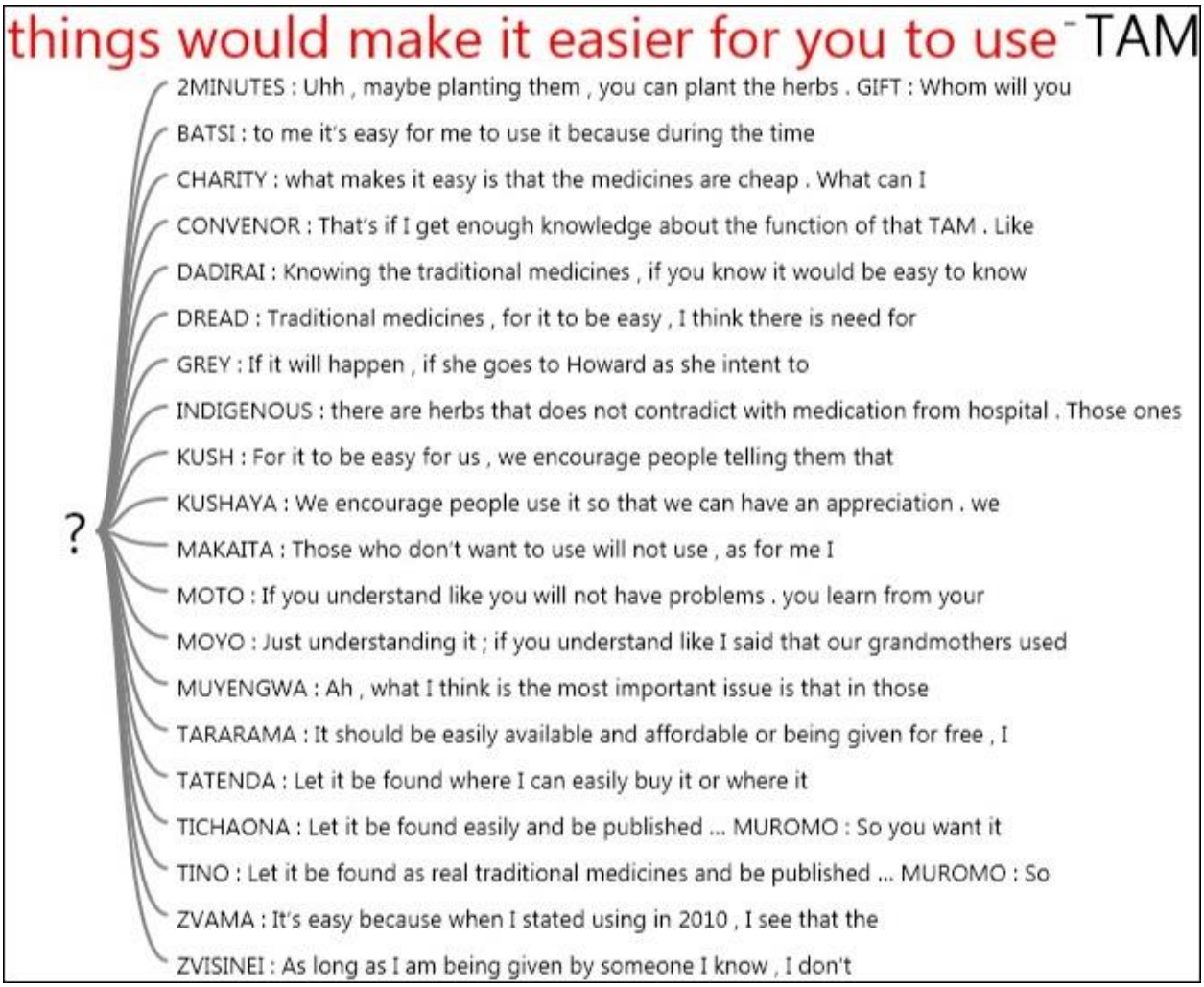

Figure 7.3: Things that made it easier for participants to use TAM

Generally, knowledge was helpful in making it easy to use TAM. Most of the participants reported feeling in control and were confident and had a lot of self-efficacy. As for barriers, below is the summary of the responses for the things that would make it difficult/harder for the participants to use TAM.

,

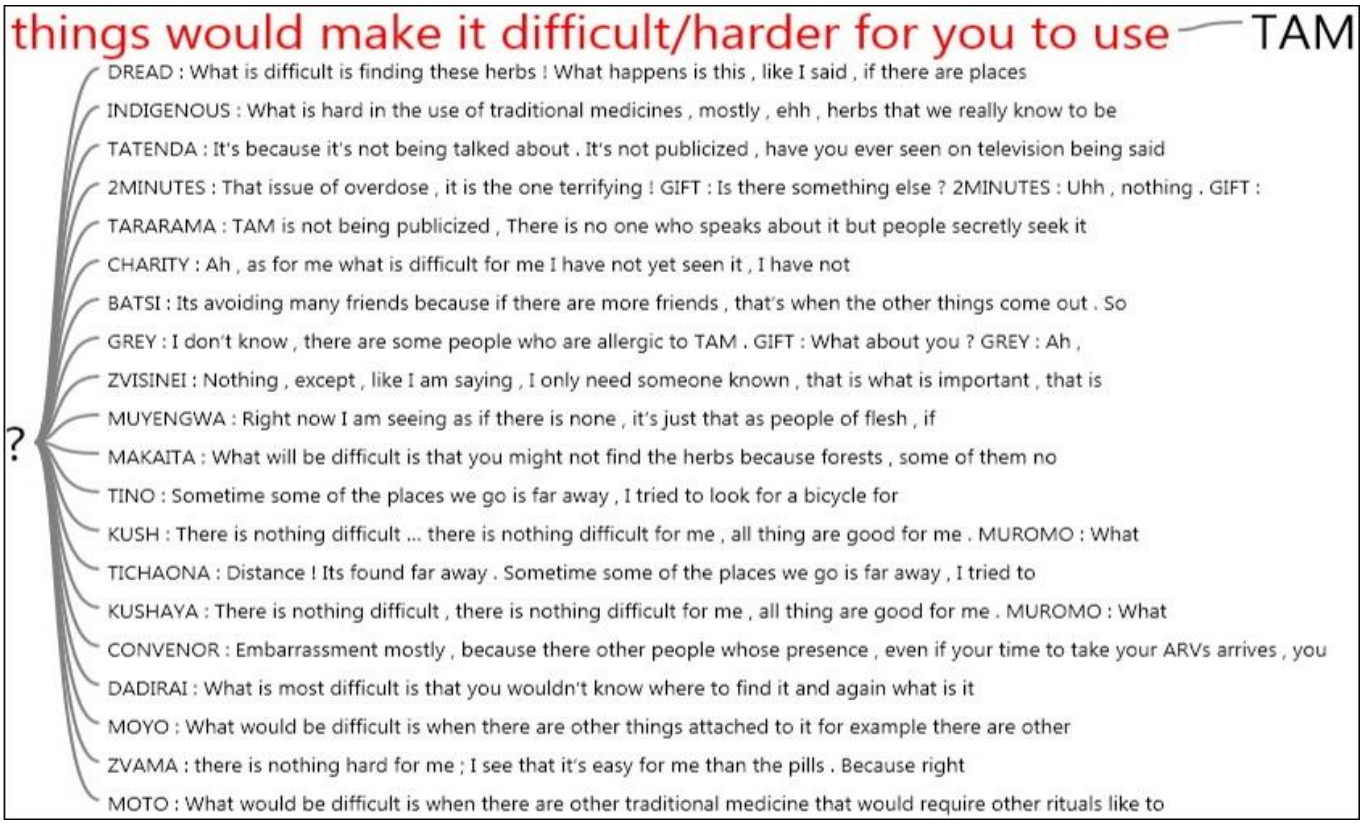

Figure 7.4: Things would make it difficult/harder for the participants to use TAM

Quite a number of participants revealed that there was nothing that made it difficult for them to use TAM. They reported feeling confidently in control. However, others indicated feelings that they were bugged by lack of information, embarrassment, allergies, lack of publicity, long distances to source and difficulty in finding the herbs.

7.3.2 Beliefs about barriers and facilitators to Partner

Below is a summary of responses revealing things that made it both easier and harder for participants to get their spouses/partners to use TAM.

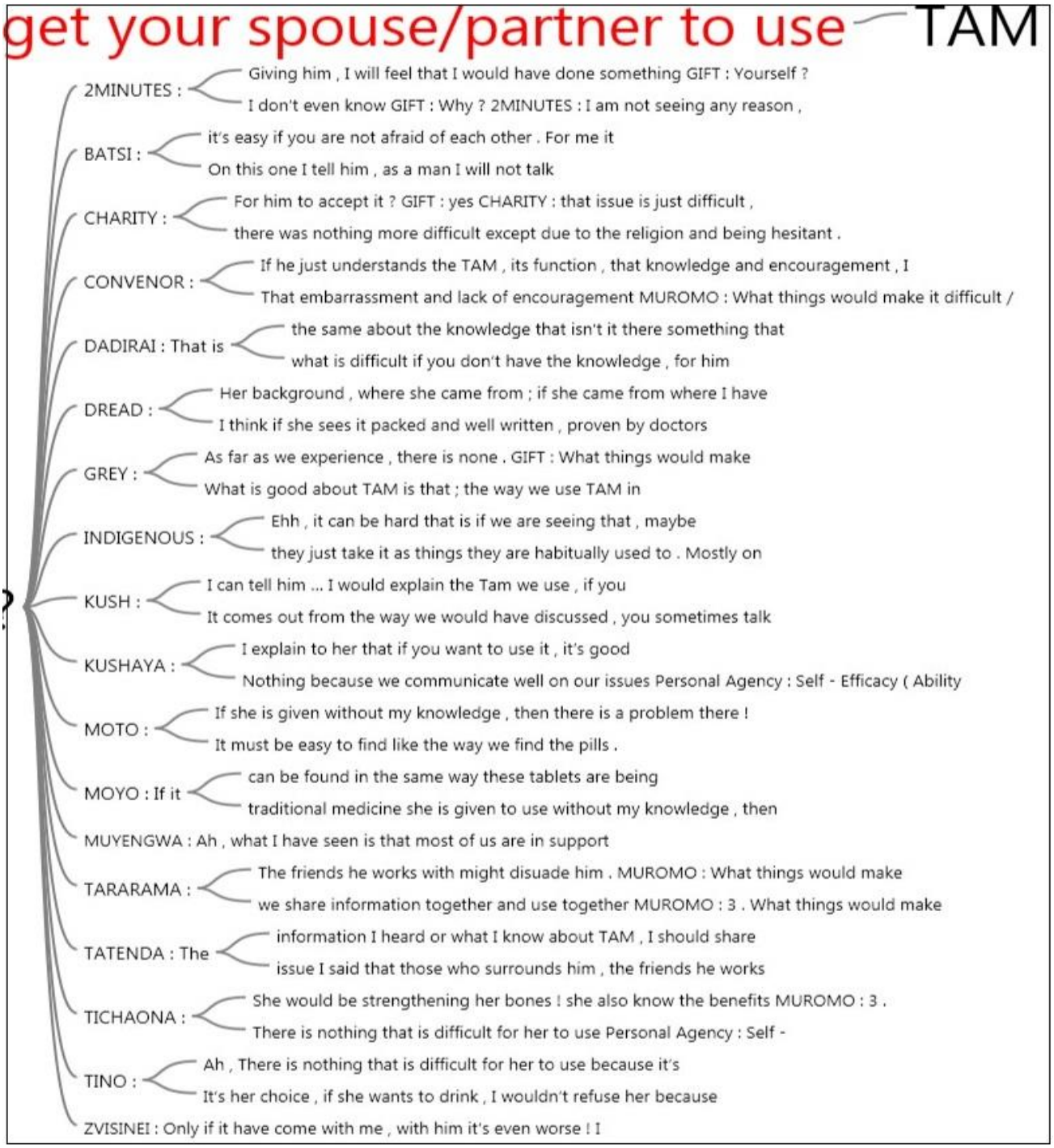

Figure 7.5: Things that made it easier and harder for spouses/partners to use TAM

For those who were married, like Grey, Zvisinei and Tinomboedza, it seemed that it was easier for them to encourage their partners use TAM. However, for those who had problematic relationships, like TwoMinutes and Charity, it was difficult as incompatible religions (Charity) and suspicion (TwoMinutes) blocked the flow of advice and assistance from the partners. The general problems to the self such as lack of information, embarrassment, allergies, lack of publicity, distances and difficulty in finding the herbs, also applied to the partner.

7.3.3 Beliefs about barriers and facilitators to children

Below is a summary of responses revealing things that made it both easier and harder for participants to get their children to use TAM.

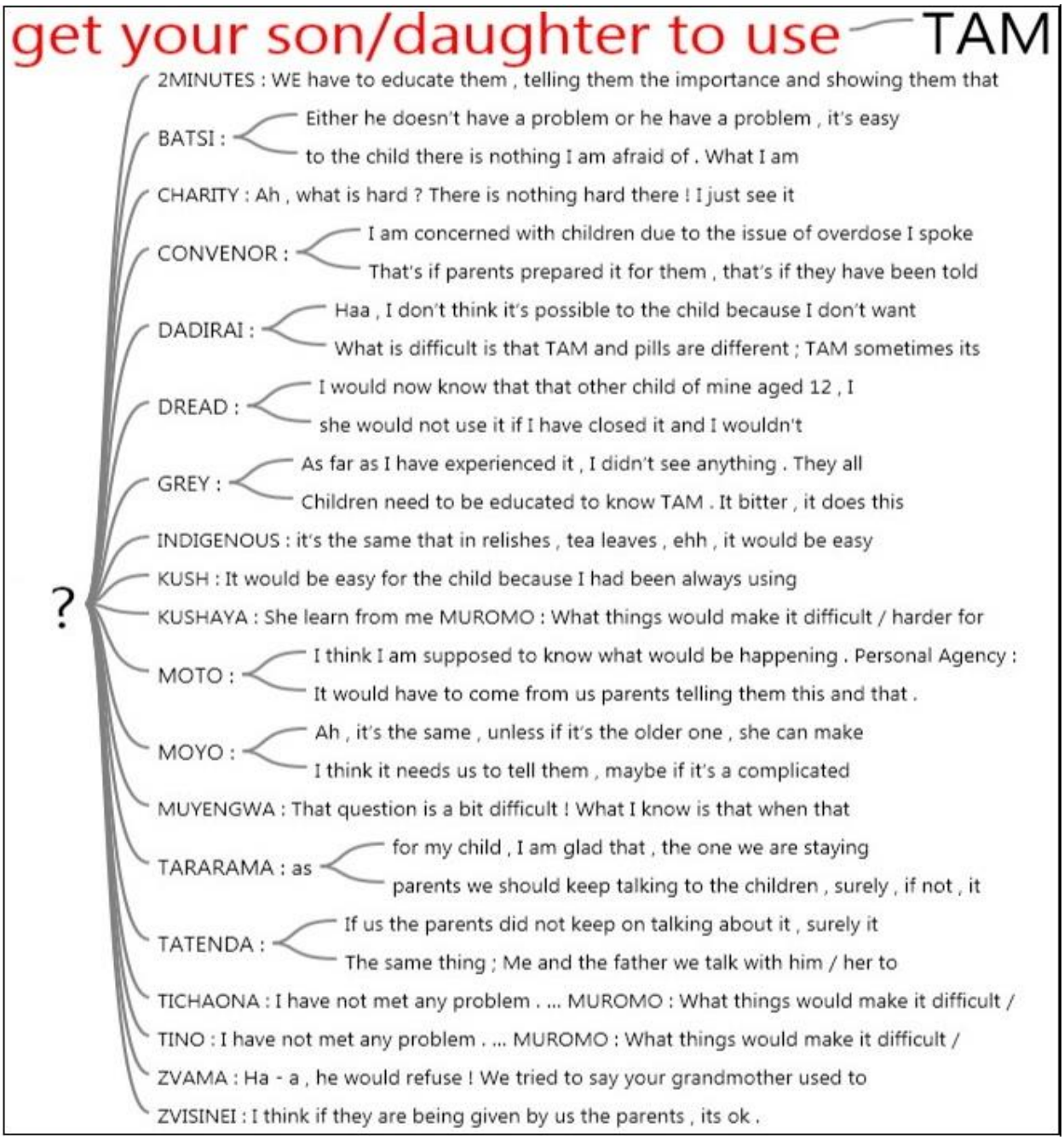

Figure 7.6: Things that made it easier and difficult forchildren to use TAM

Most of the participants said they were the main facilitators for their children to be able to use TAM. However, others, like Dadirai, were the main barriers because they did not like their children to use TAM. Generally, the participants did not trust their children to handle TAM on their own. As a result they felt that their guidance was meritorious in helping their children.

CHAPTER EIGHT

ENVIRONMENT BASED TAM MOTIVATIONS

8.1 INTRODUCTION

According to the IBM, the environment plays a role in the participants' decisions to use TAM. Results from this study confirm that the structural-systemic environment, socio-cultural environment, personal environment and TAM's environmental characteristics were some of the environmental factors that contributed in shaping decisions around TAM use. The findings overall support the behavioural predictions as proposed by the IBM.

8.2 STRUCTURAL-SYSTEMIC ENVIRONMENT

The system seemed to be three-edged, at one corner facilitating, at the other inhibitory and the other ambivalent. The system seemed suspicious yet curious with the system not yet fully developed to the extent that it feels confident that it fully understands the viccisitudes of HIV and AIDS. So there are a lot of experimentations, some of which involves giving room for those who will risk trying new medications. The system allows this to happen for it to learn more but at the same time making the risk takers vulnerable.

8.2.1 Facilitation

To some extent, the system was found to be supportive of TAM use:

BATSI: They are few health professionals who hinder the spread of the use of TAM because this program is now people's program. Which direction is the human's health taking? It is on TAM. So many people, I can say only a few who have not seen it working who are forbidding it. However those who are really in our healthcare system know where our real health stands… if you go to the doctor, is it not that I told you that I went to my doctor? The doctor was happy… Since that time s/he says, '*no, you should start by using the TAM of yours*', because he is realising its importance and making me

survive.…most are accepting the importance of TAM, and they want it to be introduced into clinics for use. That is why you heard me saying let's find somewhere free where traditional healers can really work with doctors in the hospitals, I think people might live longer… <Internals\\Audio\\Batsiranai> - § 2 references coded [12.71% Coverage]

Batsiranai reported receiving some recommendations and praises for TAM use from the health professionals. Grey also reported having gone through the same:

GREY: Eh, the health system does not forbid TAM, if you go to hospital like this hospital we are at, they allow you to use TAZ. If you tell them, 'this is my relative being treated, but we have this TAM that we use,' and you say this to a nurse or doctor who specializes in that, s/he would tell you to bring that TAM. If s/he wants to see and test it, they will realise that it helps. S/he will say, *'use it in the normal way you normally do. Does it not affect our pills?'* If you feel that it doesn't, you will be given the pills. <Internals\\Audio\\Grey> - § 1 reference coded [5.52% Coverage]

The support was there but you have to find the doctors who are sympathetic to it. Grey revealed this in his selective attention. He emphasised the issue of talking to a specialised doctor or nurse, indicating that the other doctors might not tolerate it. Indigenous also reported receiving encouragement from the conventional health institutions:

INDIGENOUS: Ehh, mostly they sometimes give us encouragement to use some of the traditional medicines. We can take for example, like I said, for the relishes, if you look in most hospitals, you might find them giving the patients some encouragement that, '*use the likes of black jack, the likes of red spinach, likes of mowa, use the likes of moringa, be it as relish, as tea leaves; use even the likes of garlic and ginger.'* They encourage us to use those things.<Internals\\Audio\\Indigenous> - § 1 reference coded [14.66% Coverage]

Kushingirira also revealed this support:

KUSH: Doctors really support, they say you are supposed to take your TAM because that is what is helping the people survive… They say if you eat, it strengthens your body…you would stay fit, you would be alright… they allow (mixing with herbs) because

I give my medication enough space, I space them, you do not take TAM and pills once at the same time… <Internals\\Audio\\Kushingirira> - § 1 reference coded [12.14% Coverage]

Tinomboedza also felt that she got the support, even from the president:

TINO: Those health professionals even encourage the use of TAM, even in the hospitals they really encourage… even the president, he endorses TAM use. <Internals\\Audio\\Tinomboedza> - § 1 reference coded [12.83% Coverage]

This support, however, is not necessarily real, just a perception and misattribution of the health institution's tolerance and sympathy. For example, Kushingirira gave her own adjustments in TAM use ("they allow because I give it space, I space them") as the justification for the support from health institutions. There is a probability of an unconscious distortion of reality in order to build self-support towards TAM use. The support may be there, as said by Indigenous, in the form of a supplementary dietary form but it seems there was overgeneralisation of this permissiveness to TAM in general.

8.2.2 Inhibitory health institution

On the contrary, the health institutions were also criticised for being inhibitory:

TATENDA: In the Ministry of Health, I have never seen any department that I know, as I have said, that have anything to do with traditional healers and such things, no, never. If a person has diabetes, it is difficult to imagine that person being advised that, '*today there are there people with diabetes here, let us go to Sekuru (traditional healer)'*, I have never heard it. They would be told to wait for the doctor in a waiting room, only conventional methods would be used and it would just end like that. But what is interesting is that things like cancer are being cured by traditional medicines. But people are now shunning it because it is being discouraged by statements like, "do not do it"; in fact it is not even spoken about. We are being told to use conventional medicines which are causing again a lot of side effects causing other diseases.<Internals\\Audio\\Tatenda> - § 1 reference coded [11.57% Coverage]

Tatenda was a worker in the conventional medical circles, she was a counsellor and she averred that the talk of TAM was highly prohibited. Charity also concurred that the workers in the conventional medical area are less tolerant:

CHARITY: Yes, there are others who do not even want to hear about TAM. This now depends on how one grew up. If you never grew up using it, it will be difficult to start it later in life. You can't force that person, and we don't wish to judge that person whether he is right or wrong.<Internals\\Audio\\Charity> - § 1 reference coded [8.93% Coverage]

Dadirai further revealed that the encouragement was only for the ARV pills:

DADIRAI: They would not encourage him to mix. They just encouraged him to use the pills and going to the hospital. But just because you are a person wanting to experiment, you can try but they will still encourage those pills… To the child it is the same, they encourage their conventional medication.<Internals\\Audio\\Dairai> - § 2 references coded [10.50% Coverage]

Muyengwa, also revealed the inhibition but raised the issue of the source of their resilience:

MUYENGWA: Yah, right, the health system encourages people not to use medicines that they do not know, especially traditional medicines because it can conflict with the pills that we are being given. So they say no, do not use traditional medicines. But some of us with knowledge of your traditional medicine, which we have been using for decades, it's difficult to stop. I have not yet seen any problems with them. But they still try to discourage us from using TAM.<Internals\\Audio\\Muyengwa> - § 1 reference coded [11.89% Coverage]

There was much learned utility in TAM that would make it difficult for them to stop using it. TwoMinutes also revealed that at one point she stopped due to the discouragements but ended up going back due to some withdrawal symptoms:

2MINUTES: we are being discouraged a lot by these health institutions…the way they are they are talking, it can minimise our use of TAM…There was a time I stopped using

TAM due to those negative statements… but I fell sick… and resumed taking TAM again <Internals\\Audio\\TwoMinutes> - § 1 reference coded [13.01% Coverage]

8.2.2.1 TAM as threat to ARVs

Conventional medical practitioners were said to be dissuading due to fear that TAM would be a threat to ARVs:

CONVENOR: …When I started ARVs I was vehemently told, '*Do not even touch at all. If you drink traditional medicines, ARVs will not work.*' so I became afraid to use a lot of medicines that I used to take, …<Internals\\Audio\\Convenor> - § 2 references coded [10.87% Coverage]

However, they will say to those on the program, on medication of ARVs, they would tell us that, *'No, the likes of this and that, do not use them, they will disturb the medication you are taking.'…*that it will contradict with conventional medication that we are using leading to lowering of the amount of drugs that are supposed to help me. Sometimes it might increase the amount of drug; I would be taking the conventional medication and traditional medication again, if I mix like that, it means that I am now doing what is called overdose and that endangers me again. <Internals\\Audio\\Indigenous> - § 2 references coded [14.66% Coverage]

CHARITY: The reasons I heard about mixing the medicines, what these medicines does when mixed, it was said that there might be one that might overpower the other. So the overpowered one, it would be waste in the body, it would be damaging the body. <Internals\\Audio\\Charity> - § 1 reference coded [8.93% Coverage]

You do not know its interaction with ARVs.<Internals\\Audio\\Muyengwa> - § 1 reference coded [11.89% Coverage]

TATENDA: They say conventional and traditional medicines fight each other. They say it is contradictory. <Internals\\Audio\\Tatenda> - § 1 reference coded [11.57% Coverage]

ZVAMA: At the hospital they say that the traditional medicines and pills are not compatible.<Internals\\Audio\\Zvamaronga> - § 1 reference coded [9.91% Coverage]

8.2.2.2 Dosage issues

Participants also believed that the health institutions were inhibitory due to uncertainties associated with the dosages:

CONVERNOR: It is the issue of proper measurement that we people would not know…<Internals\\Audio\\Convenor> - § 1 reference coded [10.87% Coverage]

DREAD: They will hinder because there would not be a prescribed way to use it. So the doctors will never encourage you to use it in Zimbabwe today… <Internals\\Audio\\Dread> - § 1 reference coded [8.23% Coverage]

MOYO: … if you buy tablets, they would say do not use TAM because you would not know its dosage. They say, 'Use this and this, that is what has been tried and tested. These traditional ones had not been tried and tested; it is just trial and error.' Although, on our own we know how these things work. <Internals\\Audio\\Moyo> - § 1 reference coded [17.61% Coverage]

You do not know its dosage.<Internals\\Audio\\Muyengwa> - § 1 reference coded [11.89% Coverage]

ZVISINEI: Basically, they discourage TAM mainly because the pills they give us in hospitals, were made from leaves, flowers, and barks of trees from which we are using to the extent that sometimes you will have overdose because same drug that you are taking as conventional medication, it is the same herb in our traditional medicine. So you will do double dose, probably you will take even more than double.<Internals\\Audio\\Zvisinei> - § 1 reference coded [8.88% Coverage]

8.2.2.3 Fear of TAM's independence

Conventional medical practitioners were also believed to fear the complications of the independence of TAM, a situation where exclusive use of TAM would end up complicating their work when they deal with resultant medical complications:

INDIGENOUS: Ehh, they can discourage us because we can develop a habitual tendency of saying traditional medicines help without going to the hospital which will

cause complications for them when my condition has deteriorated, or that of my partner or child. What happens is that, if you go to the hospital, the advantage there is that, if you arrive, they take a person's temperature, they take a person's weight. However, when we are at home, all those things cannot be recorded. At hospital they check blood pressure, test the quantity of sugar in the body, and all these things are done at a hospital. So at home, all the things we do, we would be working on assumptions. We just assume that if I use this it might work, and this makes medical practitioners lack trust, and discourage us because they know that there are no enough medical materials at home.<Internals\\Audio\\Indigenous> - § 1 reference coded [14.66% Coverage]

The issue raised by Indigenous was also revealed in Muyengwa's reported habitual tendency:

MUYENGWA: Ehh, there are times when we were visited by some brilliant counsellors. You will take about 2 to 3weeks saying, ah, let me do this only (taking ARVs), but when I develop some flu or other health problems, I would say let me take my ginger only once, and I use it. Then I will realize that it is the one giving me a healthy life, '*ah, we will see each other later (meaning I would abandon their programme) if there will be anything wrong I would tell them that is what I was doing (using TAM).'*…The problem will be that, if there is an interaction that will happen, maybe that will cause the pills not to work. You would go to Parirenyatwa (hospital), they will see as if you now need to go on second line, yet you are taking TAM, disturbing again your medication flow, you end up being dead.<Internals\\Audio\\Muyengwa> - § 2 references coded [11.89% Coverage]

TwoMinutes also reveal how the independence of TAM might mislead people:

That issue of measurements, because if you have overdose after taking the herbs, your CD4 might rise, your viral load will increase in your body, yet you will be thinking that you are fit. So the pills have measurements such that if this one fails, you will be put on second line, so that will boost you.<Internals\\Audio\\TwoMinutes> - § 1 reference coded [13.01% Coverage]

8.2.2.4 TAM causes cancer

There were also some speculations that the conventional medical institutions were propagating that TAM could cause cancer:

MAKAITA: They say some of it causes cancer, which are the most things they say. <Internals\\Audio\\Makaita> - § 1 reference coded [11.54% Coverage]

sometimes you would be told not to use that medicine because it causes cancer<Internals\\Audio\\Moyo> - § 1 reference coded [17.61% Coverage]

It's just an issue many are speaking about, though I haven't heard any health professional say that. Some say TAM if it is used, it might cause even cancer, this is according to the others… it is just an issue being said by people when you are at a hospital, people would be just be talkin.<Internals\\Audio\\Charity> - § 1 reference coded [8.93% Coverage]

8.2.2.5 TAM and hygiene

Batsiranai was very candid to point out that the conventional medical practitioners were inhibitory due to the unhygienic conditions associated with TAM (Figure 8.1)

Figure 8.1: Hygienic concerns

Batsiranai and TwoMunutes largely decried how the health professionals are concerned with unhygienic conditions in the traditional healers' places:

BATSI: …ah, I see that there are times when the doctor really wants to know where the TAM is stored? Because the medical professionals are concerned about TAM being used from a good hygienic place. They don't want an unhygienic place with napkins here, a pot there adjacent to a bed with laundry all over the place. These are very important issues that affect motivation to use TAM because medicine should be kept in a clean environment for it to be properly administered.<Internals\\Audio\\Batsiranai> - § 2 references coded [12.71% Coverage]

2MINUTES: They say it is not hygienic, it will cause disease… <Internals\\Audio\\TwoMinutes> - § 1 reference coded [13.01% Coverage]

Health systems are worried about unhygienic conditions in the traditional healers' places and they would like to examine the places before they can accept them as valid alternative sources of treatments. However, most traditional healers are found wanting on hygienic requirements:

So for the health professionals, those are the things that they want to examine first to say, since you said 'Zimbabwe National Traditional Healers' Association, *ZINATHA (Organisation for traditional healers in Zimbabwe) had provided medication that healed me, where was the TAM stored that cure you? Where is s/he keeping his/her TAM?*' They find it difficult to provide assistance when you were assisted from unhygiene environment. A traditional healer without hygiene at his/her house, without a bin, toilet, but she is a what? A healer. There are problems that, one: there is bacteria from the dirt that was already there, a patient coming to be cured would be having wounds, what would she be using to protect herself? That is where the health system would find fault because they want to know the status of the place... <Internals\\Audio\\Batsiranai> - § 2 references coded [12.71% Coverage]

Issues of packaging and storage were also said to be a hygienic issue among the traditional healers:

How does she package the TAM she gives you? How is TAM stored? Ours pills we store in plastics and bottles; what about yours, how does she package it? S/he asks everything because she wants to see whether your things are healthy… So I see that is where the health professionals have a problem with ZINATA… if dirt got into something good, it won't be effective. That is why I was saying that the health system is skeptical about. It heals but if it is now poison, or bacteria that would have gotten into that TAM, it becomes of no use. So there are diseases like cholera that will easily find their way into TAM, if it's left open, and not closed in containers. It will get in because it is not protected. Even yourself who have been given the TAM, you should keep it as we do the pills, you cover it and when your time to drink comes, you drink and store it in a nice place. Even from where it is coming, you have to determine if it is safe. So you must take care of the TAM you have been given plus consider the hygienic conditions it's coming from. <Internals\\Audio\\Batsiranai> - § 2 references coded [12.71% Coverage]

8.2.3 Ambivalent system

Generally, the system seemed to be tolerant as it seemed to be learning and trying to avoid throwing "the child away with the bath water", as such. On the issue of TAM, the system was divided, or at least perceived as such. Some were supportive and some were not:

DADIRAI: If you meet people who say, '*these herbs that you need, they endanger you,'* Then you would meet with another person who tells you, *'you are right, it helps this and that.*' In the health system there are some people who will tell you something, and the others would tell you something different, '*because I am at work'*, so s/he might tell you, '*there is nothing like that, those medicines are dangerous, do not follow it, use what you are given at the hospital.'* Then others close to you will say, '*use those ones that will make you live, they help,'* Did you see that? …They do not want you to mix. I think they want to find out if their pills are working. So if they are mixed, they would not know what worked and what did not work…. So if you mix, it would not be clear as to what healed the disease. You might have a leg problem and be given pills and go home and drink TAM, hot water mixed with a leaf. You would return for review tomorrow and told that

you have healed, you would not know what healed you. So they do not want you to mix because they would not know what healed you.<Internals\\Audio\\Dairai> - § 3 references coded [10.50% Coverage]

Even some of conventional health professionals were using TAM, like Tatenda:

TATENDA: Where I work, there is a rule that I am not supposed to talk about traditional medicines. If found talking about other medicines that help, security would be called and you would be fired. They do not allow it. The rules that are already put in place are the problem. If prohibitive rules had not been put in place and one sees that it (TAM) is helping people, people would be given a choice.<Internals\\Audio\\Tatenda> - § 1 reference coded [11.57% Coverage]

In some sense they seemed to provide it as an option, or at least they were understood as having said so:

CHARITY: The problems I heard about mixing the medicines were that some of the medication might overpower the other…I don't think that view is bad. I think it's a good opinion because the doctor did not forbid TAM because he wants to investigate the medication that works. That would help them assist the patient better. So I did not see it as a bad thing, I saw it as a very good thing.<Internals\\Audio\\Charity> - § 1 reference coded [8.93% Coverage]

Charity heard it as if the doctor did not forbid TAM, but rather gave an opportunity for those who are on TAM to disclose it so that the doctor would examine the amount of progress achieved by each method. In a way Charity heard of exclusive use of TAM and so did Makaita and TwoMinutes:

MAKAITA: … they tell you that it is not permissible for us to use it, that it will affect how the pills work, that is what they say… these pills that we are given are not allowed to be mixed with traditional medicines, that is what they say…You can exclusively use one type of medicine, if you want to use the pills, then use pills, if you have decided on traditional medicines you have to use traditional medicine only… <Internals\\Audio\\Makaita> - § 1 reference coded [11.54% Coverage]

2MINUTES: they are not recommending TAM, especially if you are on ARVs. They are recommending that if you are taking ARVs take them only; if you are taking traditional medicines take them only because if you mix it will be a problem…the other might be negative, Some take the herbs yet s/he is saying that it is not good yet s/he is taking…<Internals\\Audio\\TwoMinutes> - § 2 references coded [13.01% Coverage]

TwoMinutes revealed that they do not trust some of the advice they got from health institutions. She felt that the advice was not based on experiential evidence; rather it was advice from desk reviews. Therefore, they found it difficult to follow such advice. Consequently TwoMinutes and Makaita mixed even though they were sure of the prohibition.

8.2.3.1 Interdependence

The conventional medical side was thought of being ambivalent because they were perceived as if they also depend in some way on TAM. They also made referrals to TAM:

CHARITY: The health system, the way I mostly view them, it depends largely on who you engage, some of them are strongly encouraging these TAM. They strongly support its use to the extent that some of them can direct you after you have gone to the hospital saying, *'ah, you have fallen sick but the disease you have, maybe try the herbalist …there, s/he might help you the right way.'* So I think they are supporting it as good treatment points, because they say come here for us to treat you but you should also go there again. It is just like how we heal, it does not mean that we can heal everything, it does not mean that if a person comes here saying s/he is feeling a stomach pain, we give TAM and say that is enough. Ah, ah, we strongly encourage her to go to the hospital. I do not give her TAM and say that is enough we say, 'I have given you this TAM for you to feel better but if you see it being persisting go to the hospital.' so that is the same with the hospital, there are other things they realise that this disease you have to try the traditional methods, it might be of better help…Right now on that TAM for cancer, if you are said to have cancer, if you are given that TAM and you start feeling better, we will conclude that it has been treated. But this would now require a

doctor. Is it not that each person has his/her job, so it now needs a doctor to ascertain if surely it has been treated or it was a temporary treatment. At the hospital I go with the child if s/he has a disease that needs the hospital. They are not all diseases that are treated by traditional methods. I cannot cure a burnt child with TAM. Yes there TAM for burns but would still need to go to the hospital. It is there TAM treatment for burns, that if I run there and dig it and rub it I will be right. But there are some situations that need the hospital. So I need these two systems to be united like that.<Internals\\Audio\\Charity> - § 3 references coded [8.93% Coverage]

Charity felt that there is some structural and systemic interdependence and this also promoted ambivalence on the part of the users.

8.2.3.2 TAM as work in progress

It was also believed that the health institutions still have a lot to learn and that they were now leaning towards TAM useage:

DREAD: I think they know that they still have a lot to do to write this TAM story in books like what they did with pills (to research and document TAM). They have not finished what they are doing... they have not finished researching. If they had really finished, they would be giving people a choice, '*do you want to choose this TAM or this pill.*' … So the research is not yet done but they do not refuse TAM as such but they cannot direct you to take TAM without proof of its effctiveness, without evidence based recommendations.<Internals\\Audio\\Dread> - § 1 reference coded [8.23% Coverage]

Grey also supported this:

GREY: Eh, these days the health system does not know how TAM works, so they have to look for a person who knows, they encourage that person to help. However, the people who help are few, they are difficult to find, you see? They are not known and mostly they do not come forth themselves. What happens is that if a person s/he has her/his TAM, they are duped by health professionals especially doctors. A doctor can just tell you, 'ho-o, you have your TAM that you use to heal this and that?' His/her TAM would be taken from him, even his/her bags would be taken and s/he would be told that

we will give you this, and they will use that TAM for their experimentations… I heard it from one who used to heal, it happened to him… He used to heal from Chegutu (town 100km from Harare)… He cured a person and that person brought his/her doctor there. His medicines were taken and he was just given money. I think until now he is being given money and the TAM is being used by the doctor. <Internals\\Audio\\Grey> - § 1 reference coded [5.52% Coverage]

Grey even revealed some arrangements in which it was agreed that they would go to the institution at which he reported testing both positive and later negative, for further experimentations with more patients. Moyo also felt that the health professionals need to consult more:

MOYO: I think the health professionals should consult those who know. I spoke about my grandmother, my mother-in-law; they would tell them how these things work, and they would understand the way it works then they might understand how these roots work and they would stop discouraging people from using TAM… I think it is because of lack of knowledge about the way it is used… I heard that those doctors are now leaning towards looking for help from those traditional medicines… They are realizing that there is substance in those traditional medicines… <Internals\\Audio\\Moyo> - § 3 references coded [17.61% Coverage]

Muyengwa felt that, even as a country, we are at a vacillation point, we are not sure of which way to go, we are trying to understand:

MUYENGWA: What is happening is that, with the current state of our country, the government and so on, we are a people who are experimenting with many things to see how they can best to help ourselves. Why am I saying so? Even at the University, there is now a degree, I do not know if it is a degree or a diploma about sangomas. There are also organizations that look at TAM, they encourage, and they even talk on television or other places. They encourage people to use TAM.<Internals\\Audio\\Muyengwa> - § 1 reference coded [11.89% Coverage]

So the medical side seem to be ambivalent because they would like to and need to learn more.

8.3 SOCIOCULTURAL ENVIRONMENT

There are a number of social and cultural factors that facilitate the use of TAM. As demonstrated above, attitudes and social influence were formed mostly in reference to the socio-cultural and religious environments. The socio-scape was largely the control of the outside world, dictating what is right and wrong. The family, community and church were the major constitutes of the socio-scape. While the family was largely supportive, the church and community were indifferent.

8.4 TAM'S ENVIRONMENTAL CHARACTERISTICS

TAM was also largely said to be cheap, affordable and readily available. These were also factors that attracted people to use TAM.

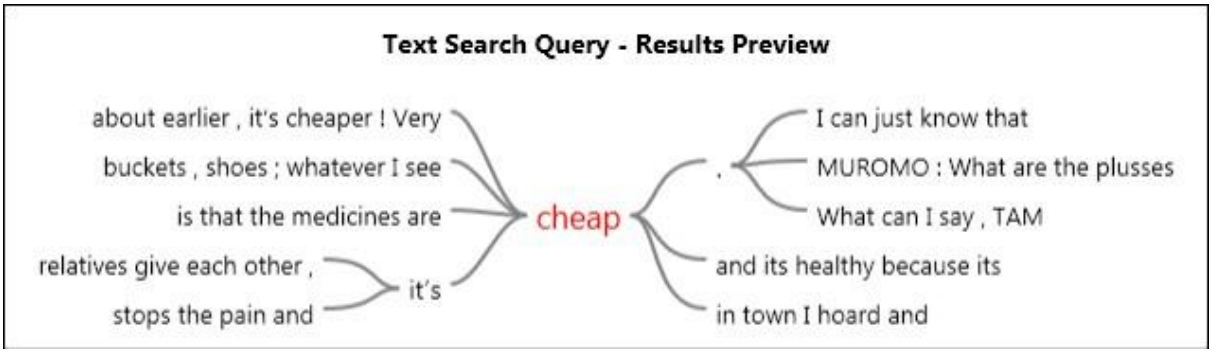

Figure 8.2: Text query for cheapness

8.5 PERSONAL ENVIRONMENT

At a personal level, there were some environmental factors such as education, employment, and responsibilities that seemed contributory to decisions about TAM use.

8.6 RECIPROCAL DETERMINISM

There was a strong relationship between the environment and the individual factors. Reciprocal determinism was strong especially when considering that the participants are both the products and factors in the construction of socio-cultural and religious environments.

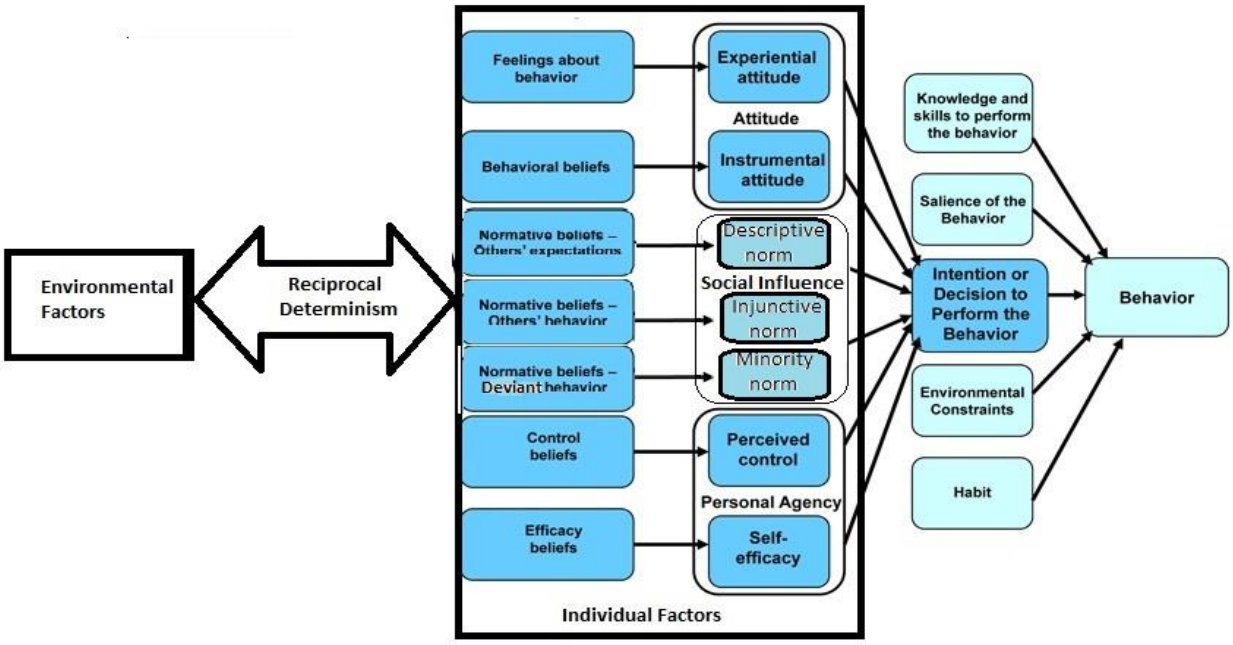

Figure 8.3: Reciprocal Determinism

CHAPTER NINE

SUMMARY OF RESULTS, CONCLUSION AND RECOMMENDATIONS

9.1 INTRODUCTION

The previous four chapters presented the results of the study. The epistemological stance of this study centered on an attempt to identify the perceived motivations of people living with HIV and AIDS to use traditional medicines and thereafter to bring these to the attention of policy makers and the mainstream medical discourse. The present chapter summarises the study results presented in Chapters 5, 6, 7 and 8. Conclusions and recommendations are drawn on the same.

9.2 SUMMARY OF KEY FINDINGS

As predicted by the IBM, both perceived individual and environmental factors were found to be key in influencing decision making on the use of TAM by people living with HIV and AIDS. Although there were a number of incidents in which either individual or environmental factors were perceived as independently influencing the TAM-use decision-making process, there was a lot of mutual influence between the environment and the individual. Such mutual causation was abstracted as reciprocal determinism as coined by Bandura (1986). The IMB model assumed a unidirectional causation in which the environment could affect the individual factors. While the present study identified and demonstrated these environmental effects on the individual, it also identified and presented a reverse causation in which the individual would also affect the environment with respect to motivation for use TAM.

Individual factors were psychological properties that drove the individual to use TAM. Attitude, social influence and personal agency emerged as the three dimensions of individual factors. Attitudes helped in identification of orientations that locate objects of thought on dimensions of judgement about the use of TAM. Social influence explained social pressure experienced and expected regarding using TAM. Personal agency pointed to the participants' capacities to originate and direct actions for the purposes of TAM use.

Following IBM, attitude was contextualised as a person's evaluation of how favourable or unfavourable his or her use of TAM would be. Experiential and instrumental attitudes were identified, the former focused on affective evaluation of outcomes of TAM use in terms of good or bad and the latter focused on the cognitive evaluation of outcomes as a function of very specific beliefs about the likelihood that using TAM would have certain outcomes (outcome beliefs).

For experiential attitude, generally the respondents showed more perceived positive evaluations of the outcomes. Most of the participants revealed sustained and repeated use of TAM which spanned from childhood. However, deeper engagement with the data revealed that the experience of these participants yielded not only positive and negative evaluation of outcomes. There were a number of other perceived evaluations that were existent between these two. There were other outcome evaluations that seemed to be ambivalent and appeared to cause a lot of tension. Therefore, the comprehension of experiential attitude was found to be trichotomous rather than dichotomous as per IBM.

For the perceived positive evaluations, there was a positive affect associated with perception of satisfaction with the outcome. There was a sensation of normalisation as some tremendously improved and others even purportedly tested negative eventually. There were even euphoric reactions to such improvements. These were reinforced and seen in emotional attachments to herbalists, subjective resourcefulness and pleasant affect associated with reluctant acceptance from conventional health care workers. On the other hand the negative evaluations were very few and focussed mostly on the dosage problems inherent in TAM use.

While the positive and negative evaluations were easy and almost self-asserting, the ambivalent evaluations were difficult and riddled with conflicts. Ambivalent evaluation offered a transitory trichotomous thread of conflicts that the decision-maker had to go through. The perception of ambiguity, (in)compatibility and multiplicity of the outcomes seemed to draw the decision-maker into a deep seat of conflicts as s/he was torn between and among motivations and goals of varying priorities. Although, it seemed

that these ambivalent evaluations would eventually lead to either positive or negative evaluations, it also seemed that some ambivalent evaluations remained as the ultimate answer to not only the use of TAM but also ambivalent use of both TAM and CM. As a response to an ailment without cure, assumption of an ambivalent position seemed satisfactory. For example, an approach-approach conflict was abstracted as the affective evaluations that were hanging on the balance of the preference for both TAM and CM and this was fuelled by the lack of absolute cure, probabilistic conditions of cure in TAM, perceived complementarity of TAM and CM, creating mixed affective evaluations, out of which, remaining in the balance seemed to be the answer.

Approach-avoidance conflict was abstracted as the affective evaluations that were associated with both positive and negative evaluations of using TAM. There were evaluations that seemed to show a conflict in which the decision-maker would be trapped in making a decision of using TAM that has both positive and negative aspects. TAM was understood as characterised by an unfavourable Garbage-In-Garbage-Out (GIGO) concept since both black magic and healing were found there, or at least perceived as coming from the same source. The perception of divergence of TAM from contemporary, so called 'in-things', also made TAM less desirable, at least when perceived by the public as it being used, yet showing perceived favourable healing outcomes. There also appeared to be a fear of self-deception in which some of the participants were skeptical about the veracity of the healing (though perceived) from TAM.

Lastly, avoidance-avoidance conflict was abstracted as the affective evaluations that were associated with dislike and dissatisfaction of either TAM or CM. Whilst the CM was largely viewed as having side-effects and monotony, TAM also had its own problems that caused the respondents to be tangled in an avoidance-avoidance conflict in which either side was associated with unpleasant affects. Although the respondents had already resolved this conflict (as seen in their use of TAM or ambivalent use of TAM and CM), the tension in which neither side was preferred was high.

Instrumental attitude focused more on the beliefs that informed an expectation of getting healed. In a way, it intended to unpack the predispositions to use TAM. Instrumental attitude yielded behavioural beliefs and these were learned utility, socio-cultural, credibility of the healer and parapsychological beliefs.

Learned utility beliefs revealed those beliefs that developed from positive reinforcement in previous use of TAM, especially in other ailments that were found comparably deadly and incurable. For example, the perceived success in cancer and other ailments led to a strong belief that TAM could lead to a favourable outcome in the treatment of HIV/AIDS.

Beliefs that developed from religious practices and beliefs in parapsychological situations in relation to motivation and anticipation of treatment form TAM were also identified. There was a strong belief in spiritual intervention in both the search for TAM and the diagnosis of their ailments. They believed that the ability to use TAM was passed on, not only through oral tradition and practice, but also, and mainly, as a special gift that one receives spiritually. There was the belief that the herbs were tried and tested by their ancestors and such knowledge and practices were passed to successive generations mostly as a spiritual gift to a few chosen ones, who also maintained this institutional memory and "medical intellectual property" for subsequent onward transmission to the next generation. This deep rooted identification with African Traditional Religion (ATR) made them develop a high anticipatory belief that spiritual intervention would inevitably assist in their healing on HIV/AIDS.

Socio-cultural beliefs were contextualised as those beliefs that developed from socialisations (especially childhood) and cultural practices. These socialisations and cultural practices gave the participants repeated exposure to the use of TAM, thereby creating a predisposition and optimism that TAM would work for them. For some they took TAM as interwoven with their identity and to them the effectiveness of TAM was inevitable. At this level there was a strong relationship between environmental and individual factors (reciprocal determinism). The phrase '*we grew up'* was very prominent in this study. It succinctly captured the early socialisation to TAM. Childhood

experiences seemed instrumental in influencing health preferences and behaviours. Some also had traditional and cultural beliefs that made them optimistic in expecting healing from TAM. To them, TAM was perceived as part of their life, seemingly interwoven into their identity and appearing to give them a sense of pride, originality, uniqueness and prestige. As indicated earlier, embedded in this was also the engagement in preservation activities to take care of and transmit these traditional and cultural beliefs to the next generation. Consequently, optimistic beliefs for the effectiveness of TAM were inevitable. The most common traditional and cultural identity constructs were identifications with Africanism and ruralism.

Gendered subcultural beliefs were identified and these were TAM-related activities and beliefs perceived to be peculiar to each gender. It seemed that some of the participants believed that TAM worked differently depending on gender. These gendered groupings seemed to be sharing and promoting some special peculiar reproductive health issues, out of which some of the problems, for example STIs, were reportedly resolved successfully using TAM. Some of these gendered subcultural beliefs were inculcated from childhood, in which each gender was somehow socialised differently as to what, when, how and why it was they used TAM.

The credit of the traditional healer also appeared to be directly important in attitude change and the shifting of the latitude of acceptance. Perception of orderliness of the herbalist, dedication of the herbalist, free provider initiated treatment, herbalist visits and credibility of referrals assisted in the shifting of the level of acceptance as most of them started to develop more positive instrumental attitudes, developing optimism and anticipation for treatment.

From the IBM, social influence is understood to be constituted with descriptive norm and injunctive norm. In this study, descriptive norms were found to influence decision-making to use TAM through the extent to which members of important networks performed the behaviour of using TAM themselves. On the other side, injunctive norms influenced through the extent to which important social networks were expected to be supportive of the person's use of TAM. However, there was another strand of

responses that seemed to suggest another form of social influence, which was neither an injunctive nor descriptive norm. This strand pointed to the extent to which the influential minority manipulated the majority and important social networks to support and perform the behaviour of using TAM, inversely reinforcing the minority to continue using TAM. Such minority social influence was abstracted as a minority norm.

For the injunctive norm, promotion and inhibition were the two ends of the continuum of supportiveness. The promotion was revealed through family support, support from the custodians of African tradition, government and institutional support as well as gendered subcultural groups. On the other hand, inhibition was reinforced by gospel/apostolic churches' restrictions, incompatibilities with contemporary or 'in-things', doctor's censorship, marital discord and lack of knowledge. Social promotion was abstracted as at the perception of supportive influence or social networks towards a person's use of TAM. However, such social support to use TAM seemed to be very scanty and was perhaps the reason for the mobilisation of the strength in the minority (minority norm). Social inhibition was abstracted as at the perception of inhibitory influence or social networks towards a person's use of TAM. This inhibition was inherent in the gospel/apostolic churches' restrictions, incompatibilities with contemporaries/in-things, marital discord and lack of knowledge. As already highlighted, social inhibition was largely from the demands of contemporary and/or 'in-things' like doctor's censorship and resistance from religious groups.

Descriptive norms focussed on the beliefs about others' behaviour and both pro-engagement and sceptical beliefs were found. There seemed to be generalised perceptions that many people, if not 'everyone' use TAM. These overgeneralisations were mostly to the Africans. It was believed that TAM was part of an African's identity. Therefore, it was believed, by some, that it was inevitable for an African to use TAM. In line with that Africanism, TAM was also taken as part of family culture. All these were generalisations that helped the creation of the belief that many people are pro-engaged with the use of TAM. Having such a belief appeared to help in supporting the self to continue using TAM.

It was also strongly believed that many people use TAM covertly. Response to and embracing of Christianity cultivated a level of hypocrisy in which people continued to use TAM, but covertly. However, the knowledge of private use seemed to emanate from self-reflection and projection. There was also recognition that many people were using TAM out of fear and through trial and error. These also seemed to have emanated from self-anchoring and adjustment. Nevertheless, holding such beliefs of popular use by others seemed to perpetuate their own use of TAM as well, since they felt justification in using it. However, there were some sceptics who felt that others were not using TAM, mainly due to fear of disturbing the possible beneficial effects of ARVs, non-conformity of the new generation, fear of disclosing HIV status and the church.

The minority norm was abstracted as the extent to which the influential minority manipulated the majority and important social networks to support and use TAM, inversely reinforcing the minority to continue using TAM. This norm is a product and a factor for both descriptive and injunctive norms. Generally, where social support was largely scanty, the users set to engineer attitude change amongst the majority. Generally, manipulation of others into using TAM helped the participants to build social support from others and as a result they created supportive injunctive and descriptive normative groups.

Pro-social or helping behaviour, demystification of stigma and discrimination, blind recruitments, manipulation of future generations and self-support were some of the tools reported to be used in creating attitude change, moving from the minority to the majority. Some of their successes were evident in the vicarious learning from the observers. As a result, they reaped motivation to continue using TAM.

IBM divides personal agency into two: perceived control and self-efficacy. Perceived control is understood as a cognitive dimension of beliefs about barriers and facilitators around TAM use. Self-efficacy is understood as the participants' perceived capabilities to successfully use TAM. Together, they revealed participants' capacities to start TAM use.

Efficacy beliefs focussed on behavioural attempts, revealing sources of confidence and attempts to escape the inhibitors around TAM use. Traditional practices, escape-avoidance beliefs, super-confidence and dependence on TAM are the things that guided the participants' behavioural attempts. Traditional practices were also reported as one of the major sources of confidence that guided the participants' behavioural attempts. These were pseudo-traditional healing practices; having a traditional healer or spirit medium in the family and involvement in traditional concomitants. A lot of confidence and capacities to originate and direct actions for the purposes of TAM use were also found in the creation and maintenance of escape-avoidance beliefs and behaviours meant to distance the self from the hindrance for TAM use. Escape-avoidance of brainwashing socialisation, church and conventional medicines were some of the thematic areas that emanated. Some also indicated that they changed their lifestyles as a way of escape and avoidance of hindrances. These were abstracted as escape-avoidance beliefs as it appears that most such beliefs and behaviours were a product of operant conditioning in which they experienced barriers and they escaped or were still doing so whilst others were then at the avoidance stage.

Perceived control was contextualised as a cognitive dimension of beliefs about barriers and facilitators around TAM use. A number of participants revealed that there was nothing that made it difficult for them to use TAM. They felt confidently in control. However, others indicated feelings of being hindered by lack of information, embarrassment, allergies, lack of publicity, long distances to sources and difficulty in finding the herbs. For those who were married, it seemed that it was easy for them to encourage their partners to use TAM. However, for those who had problematic relationships, it was difficult as incompatible religions and mutual suspicion blocked flow of advices and assistance. The general problems experienced by one partner, such as lack of information, embarrassment, allergies, lack of publicity, distances and difficulty in finding the herbs, also applied to the other partner. Most of the participants said they were the main facilitators for their children to be able to use TAM. Others, however, like Dadirai, were the main barriers because they did not like their children to use TAM. Generally, the participants did not trust their children to handle TAM on their own. As a

result they felt that their guidance was meritorious in helping their children. Overly, they felt in control and they reported being empowered by efficacy beliefs.

Inevitably, the environment seems to play a role in the participants' decisions to use TAM. The socio-cultural environment, personal environment, structural-systemic environment and TAM's environmental characteristics are some of the environmental factors that contributed in shaping decisions around TAM use. The CM system seems to be three-edged, at one corner facilitating, at the other inhibitory and the other ambivalent. The people in the CM system seemed suspicious yet curious. As the people in the CM system were trying to learn more about TAM, they made the HIV positive people vulnerable due tolerance of trial and error. People in the system seemed to be not yet sure of what is in TAM which could or could not effect a cure. As a result, they are giving room for some quasi-experimentation. With regards to the socio-cultural environment, most of the participants revealed that they grew up in environments that were natural and nurturing to TAM use. Rural homes were largely identified with and most of them said they frequently visit their rural homes. At a personal environment level, some were divorced and unemployed, situations that seem to predispose someone to TAM use because TAM is reportedly cheaper than CM. Responsibilities at home, especially when there are many children, results in competition for financial resources and that in turn encourages a search for alternative medications such as TAM. As already mentioned, characteristically, TAM was found to be cheap, affordable and readily available. Such characteristics of TAM also tended to attract people towards TAM use.

9.3 CONCLUSIONS

The research based conclusions presented in this section address the present research objectives stated in Chapter one that were aimed at achieving the stated overall research goal. These conclusions were drawn from the results and discussions adequately documented in Chapters 5, 6, 7, and 8 in terms of attitude, social influence, personal agency and structural system environment respectively, based on perceived determinants of motivation to use traditional medicines by people living with HIV and

AIDS. These conclusions on the research study on perceived decision-making factors in the use of traditional and alternative medicine for people living with HIV and AIDS can be highlighted as:

Conclusions based on data collected with respect to attitude:

Experiential Attitude

- Generally the respondents showed more perceived positive evaluations of the outcomes. Most of the participants revealed sustained and repeated use of traditional medicine which originates from childhood.

Instrumental Attitude

- Generally, 'good' was the best descriptor of the utility of TAM as it stops pain,
- is cheap, made the particpants stay strong, has no side effects, prevents infectious diseases, and so on.

Conclusions based on data collected with respect to social influence:

Injunctive Norm

- Promotion and inhibition were the two ends of the continuum of supportiveness. Promotion was revealed through the family support, support from the custodians of African tradition, government and institutional support as well as gendered sub-cultural groups. On the other hand, inhibition was reinforced by gospel/apostolic churches' restrictions, incompatibilities with contemporaries/in-things, doctor's censorship, marital discord and lack of knowledge.

Descriptive Norm

- These beliefs about others' behaviour revealed both pro-engagement and sceptical beliefs.

Pro-engagement: Pro-engagement beliefs were abstracted as those beliefs about active involvement of others in the use of TAM, either covertly or overtly. Generally,

family cultural practices, hidden or secret use, fear driven utility, fear of conventional medicine (CM), trial and error as well as generalisation to the black (African) race were the perceptual ideas that cultivated the abstraction of pro-engagement beliefs.

Sceptical beliefs: Sceptical beliefs were abstracted as those beliefs about lack of involvement of others in the use of TAM. This covered doubts and fears that inhibited others from using TAM. Generally, fear of disturbing ARVs, non-conformity of the new generation, fear of disclosing HIV status and the church were the factors perceived to inhibit others from using TAM.

Conclusions based on data collected with respect to Personal Agency

Efficacy Beliefs

- Self-efficacy seemed to guide and focus participants' behavioural attempts. Generally, these beliefs revealed their source of confidence and attempt to escape the inhibitors traditional practices. Escape-avoidance beliefs, super-confidence and dependence in TAM were the issues that were revealed as perceived to guide and energise the participants' behavioural attempts.

Perceived Control

- Generally, know-how was said to be meritorious in making it easy to use TAM. Most of the participants reported feeling in control and were confident and had a lot of self-efficacy**.** However, others indicated feelings that they were hampered by lack of information, embarrassment, allergies, lack of publicity, long distances to source and difficulty in finding the herbs. In short there were mixed feelings.

Conclusions based on data collected with respect to Structural-Systemic Environment

Facilitation

To some extent, the system was perceived to be supportive of TAM use. However, this support might not be real but just a perception and misattribution of the health

institution's tolerance. The support might be perceived to be there in the form of a supplementary dietary form but it seems there was over generalisation of this acceptance of TAM in general.

Inhibitory

Generally, the health institutions were perceived as being inhibitory. However, some perceptions were that the system was divided with some reportedly supportive and others not.

9.4 LIMITATIONS

This study had the same limitations associated with most research studies using qualitative design. These include non-probability sampling resulting in issues to do with possible limited external validity and generalisability. A small sample size, although saturation would have been achieved, is another limitation levelled against qualitative studies, including the present study. The geographical coverage of the study in relation to Zimbabwe is small because of financial and time constraints although sufficient data was collected for the purpose of the study. Data sought for the study involved sensitive personal experiences and opinions of a vulnerable population giving rise to ethical concerns, even though the informed consent procedures and other ethical considerations were made. The researcher resolved sensitivity by guaranteeing confidentiality and applying emotional intelligence in the questioning techniques during data collection. Trustworthiness remains a possible methodological limitation associated with qualitative studies although measures to address it were taken in the present study.

9.5 RECOMMENDATIONS

In the light of the above conclusions and limitations, it is recommended that:

- Future research studies on perceived psychosocial determinants should consider applying methodological pluralism by combining the critical realist approach,

social constructionist approach and the phenomenological approach in order to maximize on their comparative strengths.

- Future studies are recommended to select different study sites in anticipation of a higher data saturation threshold than that of the present study which occurred at the 12th interview. However, the sample is sufficient for a qualitative study.
- Building on the results of the present study, future studies should examine the extent to which the perceived psychosocial determinants of TAM-use are shared within the entire Zimbabwean population through a quantitative survey. The recommended research will determine whether the quantitative survey findings support these qualitative findings from the present research.
- As a follow up to the findings of this study, future studies should be designed to measure the frequency and extent of traditional medicine use and other traditional health practices among HIV infected and uninfected persons in Zimbabwe through a quantitative nationally representative survey. Building on the present study's qualitative phase, the survey should determine the frequency and types of herbal products employed in alternative health care; the AIDS-related symptoms and syndromes for which they are used; the conditions that affect selection of traditional or conventional health care for these indications; the sources where herbal medicinal products are obtained; and should examine and document the concurrent use of traditional and conventional treatments and medical care.
- As a follow up to the present study, future studies should use the same design to extricate the perceived motives of people living with HIV and AIDS who have not used traditional medicines and their reasons for not doing so in order to generate data for comparison with the findings of the present study.
- Future related research should conduct similar qualitative studies using strong behavioral theory to determine perceived psychosocial determinants of traditional medicines for other illnesses as a formative elicitation phase leading to rolling out of larger national surveys to assess how widely the qualitative themes are shared nationally.

Employing the Integrative Behaviour Model should consider issues highlighted as its weaknesses in the empirical literature by:

(a) Putting more emphases on examining the attitude in terms of both the cognitive and affective domains. Future studies should also consider how best to interpret the overall effect of the two structures of the attitude (instrumental and experiential) on the superordinate attitude. The present result has revealed that they can go in different directions where TAM was perceived to be useful (positive instrumental) whereas on the other hand it was revealed that it was not pleasurable to take (negative experiential), creating tension, a situation described in this study as 'ambivalent'.

(b) Modifying the model to accommodate the notion of the minority norm influencing perceived motives of the majority as well (as revealed in the findings of the present study), suiting very well with Bandura (1994)'s reciprocal determinism. The model should clearly show that the individuals are influenced by perceived environmental factors and vice versa.

(c) As documented by Ajzen and Fishbein (2000), Ajzen et al. (2007) concurred when they identified background factors like personality, race, gender and past action to indirectly influence behaviour through their effects on salient beliefs. The present study identified these factors as directly influencing behavioural intention. Based on this conflicting finding, it is recommended that future studies further examine the manner in which background variables influence behavioural intention.

The injunctive norm has to do with the perceptions of others' expectations or what others think one should do and the motivation to comply, whereas the descriptive norm has to do with perceptions about what others in one's social or personal networks are doing. (Fishbein & Ajzen, (2000). These two variables were found to be very important perceived psychosocial determinants of TAM-use motivation. The issue this study recommends for consideration in future studies is which of the two outweighs the other in terms of their relative importance in influencing TAM uptake?

9.5.1 Policy

The outcomes of this study provide a basis and resources for building a comprehensive programme of research on use and possible interactions between traditional and conventional health care for HIV/AIDS in Zimbabwe that the government of Zimbabwe is recommended to include in its health policy.

The present research can be summarised as confirming widespread accessibility to and a high frequency of use of traditional medicine in primary health care settings and among HIV-positive individuals in urban and rural areas in Zimbabwe. These findings imply a high potential for traditional health care to interact, and perhaps to overtly interfere, with conventional health care, either in inhibiting access or competing directly with conventional care, perhaps especially in patients without ready access to ART or those not meeting standard criteria for ART. Establishing the determinants of traditional versus conventional medicine use serve to better engage both traditional and conventional medical systems in the treatment and care of individuals with HIV and AIDS. Based on these findings, it is recommended to the government of Zimbabwe to introduce and/or strengthen policies that aim to mainstream, regularise, formalise, upgrade and quality control the use of traditional medicine and create measures to ensure that traditional and modern medicine can work more effectively together.

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APPENDICES

APPENDIX 1: REC Approval

• PO Box 77000 • Nelson Mandela Metropolitan University
• Port Elizabeth • 6031 • South Africa • www.nmmu.ac.za

Nelson Mandela Metropolitan University
for tomorrow

Chairperson: Research Ethics Committee (Human)
Tel: +27 (0)41 504-2235

Ref: [H13-HEA-PSY-005/Approval]

RECH Secretariat: Mrs U Spies

28 August 2013

Prof D Elkonin
Faculty of Health Sciences
M&P Building-OG-21
South Campus

Dear Prof Elkonin

PERCEIVED DECISION MAKING FACTORS IN THE USE OF TRADITIONAL AND ALTERNATIVE MEDICINE FOR PEOPLE LIVING WITH AIDS

PRP: Prof D Elkonin
PI: Mr T Muromo

Your above-entitled application for ethics approval served at the Research Ethics Committee (Human).

We take pleasure in informing you that the application was approved by the Committee.

The ethics clearance reference number is **H13-HEA-PSY-005**, and is valid for three years. Please inform the REC-H, via your faculty representative, if any changes (particularly in the methodology) occur during this time. An annual affirmation to the effect that the protocols in use are still those for which approval was granted, will be required from you. You will be reminded timeously of this responsibility, and will receive the necessary documentation well in advance of any deadline.

We wish you well with the project. Please inform your co-investigators of the outcome, and convey our best wishes.

Yours sincerely

CB Cilliers

Prof CB Cilliers
Chairperson: Research Ethics Committee (Human)

cc: Department of Research Capacity Development
Faculty Officer: Health Sciences

APPENDIX 2: Medical Research Council Of Zimbabwe Approval

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

Ref: MRCZ/A/1809

09 January, 2014

Mr. T. Muromo
Nelson Mandela Metropolitan University
Psychology Department
South Africa

RE:- Perceived decision making factors in the use of traditional and alternative medicine for people living with AIDS

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review:

a) Research Protocol
b) Informed Consent Form (English, Shangani and Shona)
c) Interview Guide (English, Shangani and Shona)

- **APPROVAL NUMBER** : **MRCZ/A/1809**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF REVIEW** : **Full Board**
- **EFFECTIVE APPROVAL DATE** : **09 January 2014**
- **EXPIRATION DATE** : **08 January 2015**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Website should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Website is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Website.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw
- **Other**
- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

.....

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2014 -01- 09
APPROVED
P.O. BOX CY 573 CAUSEWAY, HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

APPENDIX 3: Letter to the Ministry of Health and Child Welfare Zimbabwe

TinasheMuromo

17 Pandon Road

Sunridge

Harare

Zimbabwe

The Secretary

Ministry of Health and Child Welfare

Government of Zimbabwe

Harare

Date_14 February 2014

R**E: APPLICATION TO CARRY OUT RESEARCH FOR DOCTOR OF PHILOSOPHY STUDIES**

Dear Secretary,

The above-captioned refers. I am a DPhil candidate in the Department of Psychology, Faculty of Health Sciences, at Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth, South Africa. I am being supervised by Professor D. Elkonin from the Department of Psychology, Faculty of Health Sciences, at NMMU.

I am currently working on a research study that explores perceived decision making factors shaping the motivation of people living with AIDS in Zimbabwe to use traditional medicine.Apart from an extensive literature review, I plan to conduct in-depth interviews with People living with AIDS who have sought treatment from a traditional healer(s) in Zimbabwe. I propose to carry out the research in two selected districts of Chiredzi and Harare in Zimbabwe. The ethical integrity of the study has been approved by the Nelson Mandela Metropolitan University (NMMU)'s Faculty of Health Sciences' Research,

Technology and Innovations (FRTI) Committee and the NMMU Research Ethics Committee.

I kindly request your ministry to allow me to carry out the research and facilitate entry into the selected districts through your provincial and ditrict structures.The interview will be open-ended so the participants will have an opportunity to bring up issues they think are important and are not covered in my questions. It will be based on informed consent and conducted on a voluntary basis. The participants will be able to refuse to answer any questions and leave the process at any time.

To participate in the study, the participants will have to sign a written consent that they understand and agree to the conditions. Although the identity of participants will at all times remain confidential, the results of the research study may be presented at conferences, published in specialist publications and communicated to the media, international organizations and academic community.

Thank you in advance for your time and consideration.

Sincerely,

TinasheMuromo

tmuromo@gmail.com

Phone +263772100 963

APPENDIX 4: Harare City Council Approval

CITY OF HARARE

Director of Health Services

DR STANLEY MUNGOFA
MD (Cuba) MPH (Zim)

All correspondence to be addressed to the
DIRECTOR OF HEALTH SERVICES

Ref: ----------

Your Ref: ----------

DIRECTOR OF HEALTH SERVICES
Rowan Martin Building,
Civic Centre,
Pennefather Avenue,
off Rotten Row,
Harare, Zimbabwe.
P.O. Box 596
Telephone: 753326
753330/1/2
Fax: (263-4) 752093

04 December 2013

Mr Tinashe Muromo
17 Pandon Road
Sunridge
HARARE

Dear Sir

RE: PERMISSION TO CARRY OUT RESEARCH FOR DOCTOR OF PHILOSOPHY STUDIES

I acknowledge receipt of your letter dated 02 December 2013 in connection with the above.

Permission is granted for you to carry out the above research.

For further assistance please liaise with the Sisters In Charge of the clinics.

Yours faithfully

DIRECTOR OF HEALTH SERVICES
PC/rm

c.c. Sisters In Charge - Clinics

APPENDIX 5: Chiredzi Rural District Council Approval fromMasvingo Provincial Medical office

Telephone: 263 - 39-262465

Telegraphic Address
E-mail: 5:7211/2.3801
Fax: 265145
Internet:

ZIMBABWE

Reference:
EC Number:
MINISTRY OF HEALTH &
CHILD CARE
P O Box 147
MASVINGO

10 January 2014

THE SECRETARY
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

REF: STUDY BY MR T MUROMO: PERCEIVED DECISION MAKING FACTORS IN THE USE OF TRADITIONAL AND ALTERNATIVE MEDICINE FOR PEOPLE LIVING WITH AIDS

PMD Masvingo has no objection to the proposed study. May your Council proceed to evaluate it.

Thanking you

DR RF MUDYIRADIMA
PROVINCIAL MEDICAL DIRECTOR

APPENDIX 6: Recruitment Script for the Snowball Sample

TinasheMuromo

D.Phil Candidate in Psychology

Nelson Mandela Metropolitan University

Port Elizabeth, South Africa

Date:_____

My name is TinasheMuromo. I am a DPhil candidate in the Department of Psychology, Faculty of Health Sciences, at Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth, South Africa. I have been referred to you by _____.

I am currently working on a research study that explores perceived decision making factors shaping the motivation of people living with AIDS in Zimbabwe to use traditional and alternative medicine.Apart from an extensive literature review, I plan to conduct in-depth interviews with People living with AIDS who have sought treatment from a traditional healer(s). I am being supervised by Professor D. Elkonin from the Department of Psychology, Faculty of Health Sciences, at NMMU. The ethical integrity of the study has been approved by the Nelson Mandela Metropolitan University (NMMU)'s Faculty of Health Sciences Research Technology and Innovations (FRTI) Committee and the NMMU Research Ethics Committee and The Medical Research Council of Zimbabwe. I also have permission from the Ministry of Health and Child Welfare, Zimbabwe to carry out the study.

I would appreciate your participation in this study where we will discuss about the use of traditional and alternative medicines by people living with AIDS in Zimbabwe. The interview will be open-ended so the participants will have an opportunity to bring up issues they think are important and are not covered in my questions. It will be based on informed consent and conducted on a voluntary basis. The participants will be able to refuse to answer any questions and leave the process at any time.

To participate in the study, the participants will have to sign a written consent that they understand and agree to the conditions. Although the identity of participants will at all times remain confidential, the results of the research study may be presented at conferences, published in specialist publications and communicated to the media, international organizations and academic community. If you are agreeable let us schedule an interview with me or my research assistants.

Thank you in advance for your support. I also kindly ask you to refer me to another person you know lives with AIDS and have used traditional medicine.

APPENDIX 7: Oral Information given to Participant prior to Participation

Thank you for agreeing to help us with our interviews. The interview will take up to 1 hour. There are no right or wrong answers to the questions. If you do not understand a question, please tell me, and you can add further information at any stage. Your contribution will be of great importance to us.

APPENDIX 8: Interview Introduction

Tinashe Muromo

D.Phil Candidate in Psychology, Nelson Mandela Metropolitan University, Port Elizabeth, South Africa

Date: 14 February, 2014.

My name is_____. I am from Zimbabwe and I am (representing) Tinashe Muromo a DPhil candidate in the Department of Psychology, Faculty of Health Sciences, at Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth, South Africa.I am (He is) currently working on a research study that explores perceived decision making factors shaping the motivation of people living with AIDS in Zimbabwe to use traditional and alternative medicine.

Apart from an extensive literature review, I (He) plan(s) to conduct in-depth interviews with People living with AIDS who have sought treatment from a traditional healer(s). I am (He is) being supervised by Professor D. Elkonin from the Department of Psychology, Faculty of Health Sciences, at NMMU. The ethical integrity of the study has been approved by the Research Ethics Committee of the Nelson Mandela Metropolitan University and The Medical Research Council of Zimbabwe. I (He) also (have) (has) permission from the Ministry of Health and Child Welfare, Zimbabwe to carry out the study.

I would appreciate if you could participate in this study and answer my questions about the use of traditional and alternative medicines by people living with AIDS in Zimbabwe. The interview will be open-ended so you will have an opportunity to bring up issues you think are important and are not covered in my questions. It will be based on informed consent and conducted on a voluntary basis. You will be able to refuse to answer any questions and leave the process at any time.

To participate in the study, the part you will have to sign a written consent that you understand and agree to the conditions. Although your identity will at all times remain

confidential, the results of the research study may be presented at conferences, published in specialist publications and communicated to the media, international organizations and academic community.

Thank you in advance for your time and consideration.

Sincerely,

Tinashe Muromo

tmuromo@gmail.com

+263772100 963

APPENDIX 9: Informed Consent Form

Participant's full name: _____

ID or passport number, physical address and email address: _____

_____

I was invited to participate in the below-mentioned research project undertaken by Tinashe Muromo a DPhil student in the Department of Psychology at the Nelson Mandela Metropolitan University in Port Elizabeth, South Africa.

Title of the research project:

PECEIVED DECISION MAKING FACTORS IN THE USE OF TRADITIONAL AND ALTERNATIVE MEDICINE FOR PEOPLE LIVING WITH AIDS

Principal investigator: Tinashe Muromo
Address: 17 Parndon Rd Sunridge, P.O. Mabelreign, Harare Zimbabwe.
Phone: +263772100963

Research assistants: To be advised (Not yet recruited)

The following aspects of the study have been explained to me, the participant:

Aims and objectives of the research project:

The proposed study aims to examine the perceived beliefs, attitudes, facilitators, barriers, cultural traditions, social influences, perceptions of efficacy, perceptions of the therapy and other determinants of People Living with AIDS (PLWA) in Zimbabwe's use of traditional medicine and healthcare.

The study will also examine perceived environmental factors determining the use traditional and alternative medicines by PLWA in Zimbabwe, such as culture, structural constrains and other factors.

Procedures:

I understand that the investigator will use open ended questionnaire interviews to gather information on the use traditional medicine and healthcare by (PLWA) in Zimbabwe.

The data gathered will be used for the DPhil thesis.

Possible risks:

I might be revealing personal and sensitive information that may cause discomfort.

When discomfort occurs the researcher will organise counselling for me and I will also be free to withdraw from the study at any time.

Possible benefits:

- Better understanding of the motivators and expectations of PLWA in seeking traditional methods of treatment as an alternative to the conventional methods;
- Contribution to the academic debate about HIV/AIDS;
- Offering recommendations to improve current policy strategies in the implementation of health care systems.

Confidentiality:

My identity will not be revealed in any discussion, description or scientific publications by the researchers.

Access to findings:

An electronic copy of the findings will be available on the NMMU website and a printed copy will be in the NMMU library. Mr. Muromo will also send an electronic copy to my e-mail address.

My participation is voluntary and my decision whether or not to participate will in no way affect my present or future career/employment/lifestyle.

The information above was explained to me (the participant) by the interviewer in the English/Shona/Shangani language and I am in command of this language. I was given the opportunity to ask questions and all questions were answered satisfactorily.

No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalization. Participation in this study will not result in any additional cost to me.

I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT.

Signed in _____ Date _____

Name of participant _____ Signature _____

Name of witness _____ Signature _____

APPENDIX 10: Interview Guide

Date of Interview: _____/ _____ /_____ *Interview ID Code Number*_____

Day Month Year

*Dig. Recorder File Number:*_____

Start time: _____ *:* _____ *am/pm* *Location of interview:* _____

*Language of interview:*_____ *Interviewer ID Code Number:* _____

[After the Consent Process]

State Interview ID Number into recorder.

Thank you for agreeing to help us with our interviews. The interview will take up to 1 hour. There are no right or wrong answers to the questions. If you do not understand a question, please tell me, and you can add further information at any stage. Your contribution will be of great importance to us.

I would like to start by asking you some basic information.

1. Age at last birthday: SEX 1 Male_____2 Female_____

2. What is the highest level of education you have completed?

1. Primary
2. Secondary
3. University or higher
4. None

3. What is your current civil status?

1. Married
2. Living as married
3. Never married
4. Widowed
5. Divorced
6. Separated

4. What is your current employment status:

1. Unemployed
2. Formally employed
3. Student
4. Other_____

5. How many children do you have? _____

a. Number of Boys:_____ ages: ____ ____ ____ ____ ___ ____
b. Number of Girls:_____ ages: ____ ____ ____ ____ ___ ____

6. Place of birth? _____ Home village _____

a. Type of area: Rural ____ Town ____ City ____

Now, I will ask you your opinions about Traditional and Alternative Medicine.

IBM Construct

Individual Factors

I.Attitude: Feelings about behavior (Experiential attitude):

1. Describe your experience with traditional medicine?

2. How would you feel about the idea of your spouse/partner using traditional medicine

3. How would you feel about the idea of your child using traditional medicine

II.Attitude: Beliefs about consequences of behavior (Instrumental attitude):

1. What are the advantages/plusses of you using traditional medicine?

   a. *Probe*: What are the good things that might result from this?

2. What are the advantages/plusses of having your spouse/partner use traditional medicine?

   a. *Probe*: What are the good things that might result from this?

3. What are the advantages/plusses of having your child using traditional medicine?

   a. *Probe*: What are the good things that might result from this?

4. What are the disadvantages/minuses of you using traditional medicine?

   a. *Probe*: What are the bad things that might result from this?

5. What are the disadvantages/minuses of having your spouse/partner using traditional medicine?

   a. *Probe*: What are the bad things that might result from this?

6. What are the disadvantages/minuses of having your child using traditional medicine?

   a. *Probe*: What are the bad things that might result from this?

III. Social Influence: Beliefs about other's expectations (Injunctive norm)

1. Who or what would support you using traditional medicine?

2. Who or what would support you having your spouse/partner using traditional medicine?

3. Who or what would support you having your child using traditional medicine?

4. Who or what would be against you using traditional medicine?

5. Who or what would be against you having your spouse/partner using traditional medicine?

6. Who or what would be against you having your child using traditional medicine?

IV. Social Influence: Beliefs about other's behaviors (Descriptive norms)

1. Do you think your friends and family members mostly use traditional medicine? Why or why not?

2. Do you think your friends and family members would use traditional medicine as an AIDS treatment and care method? Why or why not?

3. Do you think your friends and adult family members would get their spouses/partners to use traditional medicine as an AIDS treatment and care method? Why or why not?

4. Do you think your friends and adult family members would get their children to use TAM as an AIDS treatment and care method? Why or why not?

V.Personal Agency: Perceived Control (Facilitators/Barriers):

1. What things would make it easier for you to use traditional medicine?

2. What things would make it easier for you to get your spouse/partner to use traditional medicine?

3. What things would make it easier for you to get your child to use traditional medicine?

4. What things would make it difficult/harder for you to use traditional medicine?

5. What things would make it difficult/harder for you to get your spouse/partner to use traditional medicine?

6. What things would make it difficult/harder for you to get your child to use traditional medicine?

VI.Personal Agency: Self-Efficacy (Ability to overcome barriers):

1. What kinds of things would help you get around any barriers to you using traditional medicine if you wanted to?

2. What kinds of things would help you get around any barriers to getting your spouse/partner use traditional if you wanted them to?

3. What kinds of things would help you get around any barriers to getting your son/daughter use traditional medicine if you wanted them to?

VII.Structural/system constraints: Effects of the health system on the behavior

1. How much do you think the health system affects the use of traditional medicine to:

a. you?
b. your spouse/partner?
c. child?

2. What factors do you think affect the health system's ability to implement the use of traditional medicine?

3. Are there any other factors that you think affect your ability to use traditional medicine?

VIII.Additional information:

Is there anything about TAM that we haven't discussed, that you think might be important, or useful, for us to talk about?

Express thanks to the respondent for their time and information. Remember to ask them if they have any questions for you. If you do not know the answer to a question, please say so.

Observations (complete at the end of the interview)

_____

_____

_____

_____

Interview end time: ___ : ___ am/pm