A COMPARISON OF THE CONCEPTUAL UNDERSTANDING AND MANAGEMENT OF ACNE VULGARIS AMONGST REGISTERED HOMOEOPATHS AND IZINYANGA IN KWAZULU-NATAL.

Candice Sanelisiwe Cebekhulu

Dissertation submitted in partial compliance with the requirements of the Master's Degree in Technology: Homoeopathy in the Faculty of Health Sciences at the Durban University of Technology

Supervisor : Dr T. O. WULFSOHN

Co-supervisor : Dr N. S. DUBE

Date : DECEMBER 2019

DECLARATION

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

_____ _____

Signature of student Date

APPROVED FOR FINAL SUBMISSION

_____ _____

Signature of supervisor Date

Dr T.O Wulfsohn

_____ _____

Signature of co-supervisor Date

Dr N.S Dube

DEDICATION

I dedicate this work to my late father Mr. Thokozani Christopher Cebekhulu. Dad, thank you for showing me what a man's love is and for believing in me at the tender age of four. I hope you are proud of me and the woman I have become. I will forever cherish all our memories, you will forever be my best friend and the king of my heart.

ACKNOWLEDGEMENTS

Firstly, I wish to thank God my Lord and Saviour who has given me the strength to do and finish this research. I am all that I am today because he is.

Secondly, I would like to acknowledge the late Dr Euvette Taylor for all the support he gave throughout my research, may his beautiful soul rest in eternal peace.

A special thanks to my research supervisor Dr Ben Wulfsohn and my co-supervisor Dr Nontobeko Dube for their support and encouragement throughout my research, I am forever grateful.

To Dr Steele thank you for editing my research I appreciate your support.

To all the homoeopaths and the izinyanga who wholeheartedly took part in this study, thank you very much I appreciate your support.

To my mother Nothando Cebekhulu and my sisters Charlene and Zamalinda Cebekhulu together with all my family and friends who played a significant role throughout my academic journey, I am forever thankful.

Lastly, I wish to express my gratitude to my brother from another mother, Isheachida Manatsa for all the time spent on helping me with my research. I am forever thankful buddy.

ABSTRACT

INTRODUCTION

Acne vulgaris commonly known as ‘acne’ is a chronic skin disease that is caused by inflammation or blockage of the hair follicles and their associated pilosebaceous units. Acne vulgaris typically affects areas of high density of sebaceous follicles such as the face, neck and back. More than 85% of the adolescent population including 20% of adult women and men worldwide are affected by acne vulgaris. Acne vulgaris further accounts for more than 3.5 million general practitioner appointments each year, making this disease a health concern worldwide. Dermatologists are medical practitioners who are qualified to diagnose and treat acne vulgaris. In the province of KwaZulu-Natal patients suffering from acne vulgaris frequently consult homoeopathic as well as izinyanga traditional health practitioners for the alleviation of their skin ailments. However, little is known about the conceptual understanding together with the management of acne vulgaris amongst registered homoeopaths and izinyanga in KwaZulu-Natal.

AIM

The aim of this study was to explore and compare the conceptual understanding as well as the practice and management methods of homoeopaths and izinyanga in the treatment of patients with acne vulgaris in order to fully understand their conceptual understanding and management of acne vulgaris.

METHODOLOGY

An exploratory study using qualitative research techniques together with inductive reasoning processes was employed to collect data from six registered homoeopathic practitioners and six registered izinyanga traditional health practitioners in KwaZulu-Natal selected by means of judgemental sampling and snowball sampling respectively. Semi-structured interviews in a face-to-face situation were utilised to collect the primary data. The collected data was then transcribed and analysed using framework analysis.

RESULTS

The results showed that the homoeopath and izinyanga respondents shared similar ideas in terms of their conceptual understanding and management of acne vulgaris. Both groups of practitioners held that acne vulgaris on its own was not purely a disease but was rather a symptom of a deeper underlying cause. Furthermore, both of them prescribed their treatment based on individualisation. Homoeopaths understood the disorder as an outer expression of an inner underlying pathology that presented itself outwardly via visible signs and symptoms. Suppression of the sycotic miasm together with hormonal imbalances were the two main underlying pathologies that they believed were the cause of acne vulgaris. Homoeopaths made their medical diagnosis based on physical examinations together with the past medical history medical history of the patient. Lastly, homoeopaths managed their patients through detailed case taking, constitutional and similimum remedies.

Izinyanga described acne vulgaris as *isichito* (a human made curse to ruin ones skin or to break up a relationship), that was placed by *abathakathi* (witch doctors) or jealous individuals with the intention of ruining one's face or with the aim of separating a couple. Izinyanga used *ukuhlola* (the use of ancestral powers to diagnose patients). Lastly their treatment regime consisted of a combination of herbs and natural elements (collectively known as *uMuthi*) together with *ukugquma* (i.e. steaming, where one exposes the face for several minutes to steam coming from a very hot pot while covering the head with a blanket draped over the pot) and *ukuphalaza* (to vomit or to clear the stomach through induced emesis).

There were, however, a few differences between these two medical systems. Homoeopaths believed that in addition to the prescribed treatment patients should undergo counselling. The izinyanga did not share this idea. In addition, the izinyanga believed that witchcraft was a barrier to treating acne vulgaris patients while the homoeopaths did not mention this in their responses.

CONCLUSION

The conceptual understanding and management of acne vulgaris amongst the homoeopaths and izinyanga interviewed appeared to be similar despite a few differences in their treatment regime. Additionally, considering the fact that acne vulgaris is a chronic disease that affects the majority of the adolescent population at large and that many of these affected individuals consult either homoeopaths or izinyanga for the alleviation of their skin ailments, a co-operative practice between these two health practitioners is paramount. Furthermore, more awareness about the treatment methods offered by homoeopaths and izinyanga should be promoted within the healthcare system.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

GLOSSARY

Allied Health Practitioners Council of South Africa (AHPCSA): is a statutory health body and juristic person established in terms of the Allied Health Professions Act, 63 of 1982 (the Act) in order to regulate certain allied health professions, or, according to international terminology, complementary healthcare professions (Allied Health Professions Council of South Africa 2014).

Allopathic medicine: Mainstream medicine. The term allopathic medicine was largely used in the 19th century to differentiate itself from homoeopathic medicine (Farlex Dictionary 2019).

Holistic: Pertains to an organism as a whole. In recent years, there has been a growing interest in the concept of holistic health and the notion that the physical, mental, social, and spiritual aspects of a person's life must be viewed as an integrated whole. This leads to a broader concept of patient/client care in which emotional and social needs are dealt with as well as physical needs (Farlex Dictionary 2019).

Complementary and Alternative Medicine (CAM): A general term for therapeutic methods that cover a heterogeneous spectrum of ancient to new-age approaches that aim to prevent or treat disease. Examples of complementary practices include acupuncture, chiropractic, osteopathy, homoeopathy to name a few (Barnes and Bloom 2008).

Constitutional remedy: A remedy that best fits a patient based on mental, emotional and the physical symptoms together with their medical and family history. It also looks at how an individual reacts to life and their surroundings (Greensmith 2018).

Homoeopathic Association of South Africa (HSA): is a voluntary association recognised by the Allied Health Professions Council of South Africa (AHPCSA) as the official representative of the homoeopathic profession in South Africa. The HSA represents and promotes the homoeopathic practitioner, the profession and its

interests including related education matters, for the better health and well-being of all South Africans (Homoeopathic Association of South Africa 2016).

Homoeopathy: is a medical term derived from the Greek words "*homoios*" (similar or same) and "*pathos*" (suffering). It is an application of complementary and integrative medicine based on the idea of "*similia similibus curentur*" which in English means "let like be cured by like". Homoeopathy uses highly diluted substances to cure a wide range of disorders (Senel 2019).

Interim Traditional Health Practitioners Council of South Africa (ITHPCSA): a council of traditional health practitioners (THPs) that was inaugurated in February 2013 that gives THPs registered with it the authority to issue medical certificates in line with the provisions of the Basic Conditions of Employment Act (Tshehla 2015).

Inyanga (herbalist): herbalists that have a good knowledge of many natural substances which have a real effect when used as a remedy (Conco 1972).

***Isichitho*:** *Isichitho* is a human made curse to ruin one's skin or to break up a relationship. Mainly used by *abathakathi* (witch doctors) and females against each other. It is very common amongst the African community. When one has *isichitho*, people become irritated when they look or think about you (Matic Society 2018).

Miasm: Invisible substance that overpowers the vital force and creates a weakness in the patient and a tendency to suffer from particular diseases. If not eradicated with anti-miasmatic treatment, they persist throughout life and are transmitted to subsequent generations (Schuett 2010)

Primary health care: a basic level of health care that includes programmes directed at the promotion of health, early diagnosis of disease or disability, and prevention of disease. Primary health care is provided in an ambulatory facility to limited numbers of people, often those living in a particular geographic area. It includes continuing health care, as provided by a family nurse practitioner (Farlex Dictionary 2019).

Remedy: Homoeopathic remedies are medicinal applications, or treatments that relieve or cure a disease. They are prepared from plants, minerals and animal

products, and administered as pills, powders, granules, tablets and/or liquid (Shealy 1998).

Similimum remedy: is the best remedy suited for the case and covers the totality of the presenting symptoms. The word itself is the superlative of simile – that which is similar as compared to another. Based on the principle that “Like cures Like”, finding the best remedy for the case should be as easy as finding the rubrics and giving the remedy that covers the totality (Resonance School of Homoeopathy Forum 2008).

Snowball sampling: is where one participant is identified and then used to refer others in his or her social network (Tongco 2007; Patton 2015: 180).

Traditional Medicine (TM): refers to the knowledge, skills and practices based on the theories, beliefs and experiences that are native to different cultures. TM is used in the prevention, diagnosis, treatment of physical and mental illness together with the overall maintenance of health. Herbal treatments are the general form of TM used in primary health care (World Health Organization [WHO] 2017).

Traditional health practitioner (THP): represents a broad spectrum of practitioners that either serve as diviner- diagnosticians (medium), herbalists (*izinyanga* or *amaxhwele*), traditional surgeons (*iingcibi*) who mainly do circumcisions, and traditional birth attendants (*ababelethisi* or *abazalisi*) (Peltzer 2009).

***Ukuchatha* (administer an enema):** is a traditional way of administering medicines (izimbiza) or to evacuate the bowel contents via the anal canal (Doke *et al.* 2001).

***Ukugcaba* (make skin incisions):** means to cut small incisions in the skin for tribal, ornamental, or medicinal purposes. A razor is used to make the incisions (Doke *et al*. 2001).

***Ukuhlola* (divine):** This means to divine or diagnose. In this method ancestral powers are used by THPs to diagnose patients where they consult their ancestors who in turn reveal to them what is wrong with the patient (Doke *et al.* 2001).

***Ukuphalaza* (Induced emesis):** *Ukuphalaza* means vomiting or to clear the stomach by inducing vomiting by taking an emetic for health purposes (Doke *et al.* 2001).

***Ukugquma* (steaming):** means to steam where one lets steam absorb into their face for several minutes while covering the face with a blanket over a very hot pot (Farlex Dictionary 2019).

***Umthakathi* (witch doctor):** The witch doctor is a person who practices witchcraft; witch, wizard or warlock. *Umthakathi* can also mean a very skilful person or the emerging teeth during teething (Doke *et al*. 2001).

***uMuthi* (medicine):** medicinal substances that is used by THP's. The word '*uMuthi*' has three meanings, namely: tree, bark or medicine. It is made from natural indigenous substances that occur naturally in nature such as the bark of certain trees or leaves of certain plants and various animal parts and minerals (Ancient Origins 2013).

Vital force: The organising energy that is responsible for one's health. Vital force is analogous to chi (qi) of Chinese medicine and prana in ayurvedic medicine, but philosophically differs regarding disease management. Whereas Chinese and ayurvedic medicine aim to reverse the forces that result in disharmony, homoeopathy regards the vital force as powerful enough to allow the body to shake off the symptoms and pathogenic influences itself (Farlex Dictionary 2019).

ACRONYMS

Acronyms	Full Word
AHPCSA	Allied Health Professionals Council of South Africa
CAM	Complementary and Alternative Medicine
HSA	Homoeopathic Association of South Africa
ITHPCSA	Interim Traditional Health Practitioners Council of South Africa
KZN	KwaZulu-Natal
THP	Traditional Health Practitioner
TM	Traditional Medicine
WHO	World Health Organization

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

In developing countries like South Africa, skin diseases are not only a major public health problem but also pose significant disfigurement and a decrease in the quality of patient`s daily lives. Amongst these skin diseases acne vulgaris is the most common chronic skin condition that dermatologists and other medical practitioners treat daily, mostly during adolescence or puberty (Aboobaker 2012: 6-9; Tausk 2010).

Acne vulgaris (commonly known as 'acne') is a chronic condition of the pilosebaceous gland that is characterised by inflamed papules, comedones, nodules and superficial pus-filled cysts (Purdy and de Berker 2011).

In the continent of Africa, traditional medicine (TM), seems to be more prevalent compared to conventional, Western medicine in terms of the treatment of skin diseases (Ancient Origins 2013). The World Health Organization (WHO) (World Health Organization [WHO] 2011, has estimated that roughly 80% of the population in developing countries still depend on TM for their primary health care needs. Homoeopaths and izinyanga are amongst the highest users of indigenous herbs in KwaZulu-Natal (KZN).

Homoeopathy is a system of natural health care that treats each person as a unique individual with the aim of stimulating their own healing ability (School of Homoeopathy 2017). Banu and Humnekar (2011) stated that homoeopathic practitioners have been treating acne vulgaris for many centuries, however, very little research has been conducted to investigate their treatment regime for acne vulgaris.

In KZN there are two main types of traditional health practitioners (THPs) who dominate in the majority of communities. These include: diviners commonly known as isangoma and the herbalists commonly known as izinyanga (Tshehla 2015).

Izinyanga are herbalists and are regarded as doctors in the Zulu culture who treat various physical ailments using herbs only (van Bogaert 2007).

Ryan and Willcox (2011) claim that in many African countries patients use TM to treat skin diseases such as acne vulgaris before seeking help at other healthcare practitioners. THPs are consulted by approximately 60% of the South African population, usually in conjunction with modern biomedical services. It is estimated that there are 200 000 indigenous THPs in South Africa compared to 25 000 Western-trained doctors (WHO 2011). Gqaleni *et al*. (2007: 178), stated that there are approximately 15 000 THPs practising in the province of KZN and these THPs play a vital role in the health care of the majority of the South African population and elsewhere on the African continent (Zuma *et al.* 2016).

Ryan and Willcox (2011) stated that good skin care management provided by all systems of medicine, including THPs is essential as most severe complications of other secondary diseases originates from skin problems. However, very little information has been published on the conceptual understanding and treatment of acne vulgaris amongst izinyanga in KZN hence the study aims to gain insight into the understanding and management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN.

1.2 BACKGROUND OF THE STUDY

The skin is a versatile part of the human body (Jablonski 2013), the largest organ and an active living tissue that serves as a tough but flexible barrier to keep harmful microbes, chemicals or strong rays of light away from more sensitive inner tissues (Hulick 2016). The skin also maintains a safe internal environment conducive to normal physiological function (Dlova 2014). The skin occupies one to two metres of the human surface area and makes up 12% to 15% of body weight (Richard 2016).

Skin diseases are one of the most common conditions that affects individuals from various ages and cultures, yet despite this profound impact, skin diseases continue to receive relatively little attention in the national or global health debate (Hay *et al.* 2014). According to the Marshall (1963), the main factors that influence the prevalence of skin diseases in South Africa and Africa as a whole are race, climate,

nutrition, migration, way of life, occupation and a lack of medication in rural areas. Teshima *et al.* (1982) further discovered that emotional stress has a massive influence on the immune system which later manifests in the form of skin disease.

Acne vulgaris is one of the most common skin diseases treated by physicians worldwide (Mosam *et al.* 2005) and, according to Dlova (2014), acne vulgaris is among the five most common skin diseases in South Africa.

Cordian *et al*. (2002) noted acne vulgaris as a universal disease that affects 79% to 95% of the adolescent population in Westernized societies. Mahto (2017), stated that acne vulgaris accounts for more than 3.5 million general practitioners appointments per year. Research studies further showed that more than 85% of adolescents suffer from acne vulgaris with only two-thirds of adults aged 18 and older being affected (Barnes *et al*. 2012). A population study in Germany that was conducted by Williams, Dellavalle and Garner (2012) found that 64% of those aged between 20 to 29 years and 43% of those aged between 30 to 39 years had visible acne. Another study of more than 2000 adults showed that 3% of men and 5% of women still had definite mild acne at the age of 40 to 49 years.

Dermatologists are skin care doctors who specialise in the care, diagnosis and treatment of the diseases of the skin, hair and nails and are the practitioners who treat acne vulgaris. As suggested by Dawson and Dellavalle (2013), the medical approach to acne vulgaris by dermatologists targets precursor and active inflammatory lesions. Milder cases of acne vulgaris are managed best with topical regimens. More severe cases are managed with systemic drugs. However, according to Katsambas (1998), more than 10% to 15% of people undergoing treatment for acne vulgaris do not respond as satisfactorily as expected to the prescribed medication. In the continent of Africa TM seems to be more prevalent compared to conventional, Western medicine in terms of the treatment of skin diseases (Ancient Origins 2013). A large proportion of the population in KZN still believe in and follow traditional cultural activities (van Niekerk 2012), which explains the high usage of TM in this province. Homoeopathic practitioners and izinyanga are amongst the practitioners that use TM in KZN.

1.3 PROBLEM STATEMENT

Skin diseases pose a significant public health problem in Africa and the developing world in general (Dlova *et al*. 2014). Of these skin diseases acne vulgaris which is a disorder of the pilosebaceous gland that commonly affects the face, chest and the back is the most common skin disorder that dermatologists and other healthcare providers worldwide diagnose and treat on a daily basis (Zulu *et al*. 2017). Twin studies by Dellavalle *et al*. (2016: 13-25) revealed that the concordance rate for the prevalence and severity of acne is extremely high and he further stated that the prevalence of acne vulgaris exhibits a global distribution which continues to grow each year. This continued growth suggests an unmet dermatologic need worldwide for management of this disorder and potential opportunities for improved access and delivery of dermatologic care. Lynn *et al.* (2016) mention that despite previous epidemiologic patterns of acne vulgaris in various ethnicities and regions, adequate knowledge of the understanding of acne vulgaris as a skin condition remains lacking. Tan, Vasey and Fung (2001: 439-445) concur that there is a paucity of information on the knowledge and understanding of acne amongst patients regarding their condition. The statistics further expose that more than 85% of adolescents aged between the ages of 12 to 24 years are affected with acne vulgaris which often results in low self-esteem and an increased risk for depression and suicidality in affected individuals making acne vulgaris a primary healthcare concern worldwide (Barnes *et al*. 2012). South Africa is one of the underdeveloped countries that faces the challenge of having a shortage of practising dermatologists. Therefore, dermatological issues still remain a high concern in South Africa (Mars *et al*. (2016). According to Dlova *et al*. (2017) within the public health sector there are only 220 dermatologists who practice in South Africa, with a ratio of one dermatologist to 216 000 people. Walters, Mars and Scott (2016) found that the dermatologist to population ratio is 1:310 000 versus the ideal estimate of 1:50 000.

In the province of KZN which has the second largest population in South Africa, with roughly 11.07 million people (KwaZulu-Natal Provincial Government 2016), acne vulgaris has been documented as the second most common skin disorder that affects the population at large (Zulu *et al*. 2017). Based on studies conducted by the World Health Organization (WHO 2002), 80% of the population in rural KZN are

dependent on TM and complementary alternative medicine (CAM) as a source of primary health care. The rationale for the high usage of TM and CAM as opposed to dermatological services in KZN has been attributed to several factors which include: access, affordability, cultural views of the disease, and traditional healing methods (Nkosi 2017). Yarnell and Abascal (2006) stated that natural treatments for acne vulgaris in industrialised societies, had much to offer despite the lack of clinical studies that were done on this particular topic. Healey (2016) further suggested that there is a gap between mainstream (allopathic) and alternative medicine regardless of the increasingly number of people who turn to these professionals for treatment ranging from minor conditions to life threatening illnesses. Even though a high number of people consult either an izinyanga or a homoeopaths' in KZN for TM or CAM treatment for patients suffering from acne vulgaris, little research has been published in terms of their conceptual understanding and management of acne vulgaris. This study therefore employed the qualitative research technique using semi-structured interviews together with inductive reasoning processes to understand the problem and fill the gap in the knowledge base that exists regarding the conceptual understanding and management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN.

1.4 SIGNIFICANCE OF THE STUDY

Alharithy (2011) stated that acne vulgaris is the most common disturbing skin disease and affects majority of adolescents worldwide. Cordian *et al.* (2002) and Clark (2009) postulated that acne vulgaris affects 79% to 95% of the adolescent population with cosmetic, and social consequences for the affected sufferers. Stathakis, Kilkenny and Marks (1997) noted that the clinical characteristics of acne remain undistinguishable and uncertain in many studies. This study aims to benefit not only adolescents, but all individuals affected by acne vulgaris. This study can also propose and develop a co-operative practice framework amongst registered homoeopaths and izinyanga in the treatment of patients with acne vulgaris in KZN. This co-operative practice will benefit patients with acne vulgaris in exercising their right to consult any health practitioner of their choice with proper guidance. The results generated from the study can promote clear understanding of the clinical

definition of acne vulgaris as well as to create and to form practices amongst registered homoeopaths and izinyanga in the treatment of acne vulgaris. In addition, the results can assist to establish protocols for the treatment of acne vulgaris using TM and natural substances. The results gathered from the study can also concurrently bring awareness and attention to the professions of homoeopathy and TM.

As suggested by Nkosi (2017) the outcome of this study will contribute to the pool of knowledge on traditional healing done by Izinyanga and Homoeopaths in KZN. This study can also help to identify what training the izinyanga and Homoeopaths require in order to effectively treat patients with acne vulgaris. Lastly this study can establish rules to be followed in the co-operative practices between the Homoeopaths and the Izinyanga in the treatment of patients with acne vulgaris.

1.5 AIM OF THE STUDY

To determine the conceptual understanding and management of acne vulgaris amongst Homoeopaths and Izinyanga in KZN.

1.6 RESEARCH QUESTION

The study was guided by the following questions:

Main research question:

How do homoeopaths and izinyanga manage acne vulgaris in KZN?

Sub-questions:

1) How does your medical system understand the concept of health and disease?
2) Based on the above understanding, how is acne vulgaris understood by your medical system?
3) Describe how you diagnose acne vulgaris?
4) Describe how you differentiate acne vulgaris from other skin conditions?
5) What does your treatment of acne vulgaris entail?
6) How do you manage this condition apart from the medication prescribed?

7) In your view, what are the limitations to treating acne vulgaris as a chronic condition?

1.7 OBJECTIVES OF THE STUDY

a. To gain knowledge of the conceptual understanding as well as the management of acne vulgaris.
b. To compare and contrast the conceptual understanding of acne vulgaris amongst registered homoeopaths and izinyanga in KwaZulu-Natal.
c. To assess the how registered homoeopaths and izinyanga manage acne vulgaris in KZN.
d. To propose a co-operative practice between registered homoeopaths and izinyanga in KZN for the treatment of acne vulgaris.
e. To purposefully bring additive awareness and considerations to the profession of homoeopathy and traditional healers (izinyanga).

1.8 THEORETICAL FRAMEWORK

Frameworks in research studies help to produce research questions that will be used in the analysis. Frameworks also help to guide the analysis of all types of institutional arrangements by identifying the relationship that exist among elements (Richardson 2004). As suggested by the Northcentral University Library (2019), the theoretical framework provides a specific perspective through which to examine a research topic. Grant and Osanloo (2014), defined the theoretical framework as the blueprint for the entire dissertation inquiry that serves as the guide on which to support and build the research study. Lastly the theoretical framework provides the structure as to how to philosophically, epistemologically, methodologically, and analytically approach the dissertation as a whole. The theoretical framework has many different perspectives which can be used to define concepts as well as explain different phenomena (Northcentral University Library 2019).

Maree and van der Westhuizen (2009: 23) stated that while a theoretical framework is a viewpoint on events and exists in the context of competing theories, a conceptual framework on the other hand is a less developed explanation of events.

Jabareen (2009) defined the term conceptual framework as a network, or “a plane,” of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena. Svinicki (2010) posited that the conceptual framework is an interconnected set of ideas (theories) about how a particular phenomenon functions or is related to its parts. The framework serves as the basis for understanding the causal or correlational patterns of interconnections across events, ideas, observations, concepts, knowledge, interpretations and other components of experience. Scholars argue that a conceptual framework always underlies a research study, even if the framework is not articulated. This may seem incongruous, because many research problems originate from practical educational or clinical activities (McGaghie, Bordage and Shea 2001). Grant and Osanloo (2014) stated that the conceptual framework offers a logical structure of connected concepts that help provide a picture or visual display of how ideas in a study relate to one another within the theoretical framework. Lastly Adom, Hussein and Agyem (2018) concluded that both the theoretical and conceptual framework assist in stimulating research while ensuring the extension of knowledge by providing both direction and impetus to the research inquiry. These frameworks also enhance the empiricism and rigour of a research.

The conceptual framework guiding this study is Andersen’s (1995) behavioural model of health services and access to care (Figure 1.1). According to this model, people’s use of health services is a result of their beliefs, socio-economic status, environment and their need for care. Jahangir, Irazola and Rubinstein (2012) noted that health care utilisation was an imperative step in the disease management process together with the prevention and treatment of disease. According to Jahangir, Irazola and Rubinstein (2012), Andersen’s Behavioral Model of Health Care Utilisation was initially developed in the late 1960s. The model suggests that people’s use of health services is a function of their predisposition to use services (factors which enable or impede use) and their need for care. For this model, use of services was defined as a function of three main elements: need, enabling, and predisposing factors. In line with the framework, patients with acne vulgaris need relief from their skin condition they therefore consult either homoeopaths or izinyanga for help. The availability of health care services enables acne sufferers to

seek medical treatment at various health outlets which include: general practitioners, clinics, homoeopaths and izinyanga. Predisposing factors such as beliefs, social economic status, cultural practices, environment, awareness and availability of resources determine the use of homoeopaths and izinyanga in the treatment of acne vulgaris. This theoretical framework is in line with the research objectives which were to firstly gain knowledge of the conceptual understanding as well as the management of acne vulgaris, secondly to compare and contrast the conceptual understanding of acne vulgaris and thirdly to assess how registered homoeopaths and izinyanga manage acne vulgaris in KZN. Babitsch, Gohl and von Lengerke's (2012) suggested that the Andersen's Behavioural Model should be used in studies to investigate the use of health services and the manner in which they treat their patients. Thus, this study adopted Andersen's behavioural model of health services and access to explore the conceptual understanding together with the treatment protocol for acne vulgaris within the health care system offered by homoeopaths and izinyanga in KZN.

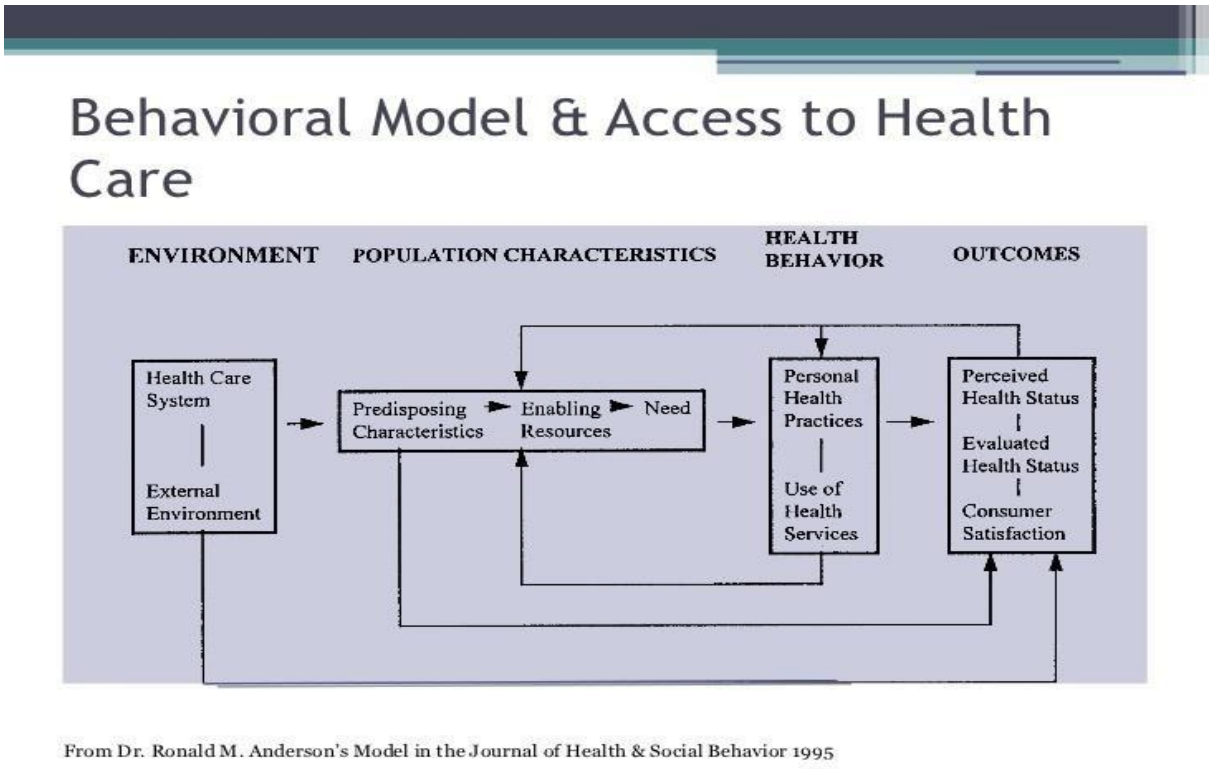

Figure 1.1: **Andersen's behavioural model of health services and access to care** Source: Andersen (1995)

1.9 OVERVIEW OF THE RESEARCH METHODOLOGY

This research employed the qualitative research methodology to obtain the desired objective. Astalin (2013: 118) defined qualitative methodology as a systematic scientific inquiry which seeks to build a holistic and largely narrative description to inform the researcher's understanding of a social or cultural phenomenon. Brink van der Walt and van Rensburg (2012: 2) had previously defined qualitative methodology as research that focuses on qualitative aspects of meaning, experience and understanding. Qualitative research is used to study the human experience, understanding and viewpoints of the research participants in the context in which the action takes place. Creswell (2014) further stated that qualitative methods establish a different approach to scholarly inquiry that rely on text and image data and also have unique steps in data analysis and draw on diverse designs.

Semi-structured interviews and observations were used in the study to obtain data from the willing research participants. According to Qu and Dumay (2011), interviews in research are one of the most important qualitative data collection methods and have been widely used in conducting field studies and ethnographic research. Cohen and Crabtree (2006) add that semi-structured interviews not only provide reliable and comparable qualitative data but also give research participants the freedom to express their views in their own terms. Judgemental sampling was used to recruit six homoeopaths who were registered with the Allied Health Professions Council of South Africa (AHPCSA) and who had been in practice for more than five years and who practised in the KZN area. Judgemental sampling allowed the researcher to handpick the sample of homoeopaths based on their knowledge of the phenomena under study. Snowball sampling (also referred to as chain referral sampling) was employed to recruit six izinyanga who were registered with the Traditional Health Practitioners Council of South Africa (ITHPCSA) and who had been in practice for more than five years and who practiced in the KZN area. The qualitative framework analysis that was developed by Jane Ritchie and Liz Spencer in the late 1980s was used to analyse the collected data.

1.10 CONCLUSION

Acne vulgaris was described as a chronic condition of the pilosebaceous gland (Purdy and de Berker 2011), that affects 80% to 90% of the adolescent population. This chapter also noted the background as well as the rationale of carrying out the study. The aim together with six objectives and seven research questions were proposed to guide the research. The stated research questions were kept within the constraints of knowledge as well as the treatment protocol of acne vulgaris amongst homoeopaths and izinyanga in KZN. The significance of the study focused on exploring the conceptual understanding as well as providing alternative management for acne vulgaris. The following chapter gives a detailed review of the relevant literature that is related to acne vulgaris, homoeopaths and izinyanga.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

A literature review identifies and critically evaluates the existing knowledge of completed and recorded work produced by researchers, scholars and practitioners (Fink 2013: 3). The aim of the literature review is to provide the context and background regarding current knowledge of the topic at hand (Machi and McEvoy 2012). A constructive literature review creates a firm foundation for advancing knowledge and facilitates the development of theories as well as reveals areas where research is needed (Watson and Webster 2002:1). The purpose of the literature review as suggested by Creswell (2014:59) is to provide a framework for establishing the significance of the research under study as well as to provide a benchmark for comparing the results of the current study with other studies. Lastly the literature review helps to identify the relationship between ideas and practice as well as to help identify the main methodologies and data collection tools that can be used to conduct research (Hart 2018).

The literature review identifies the gap that exists in the literature (Creswell 2014). The gap that exists in the literature is the conceptual understanding and management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN. The following concepts will be explored in this chapter: the history of acne vulgaris, definition of what acne vulgaris is, the conceptual understanding of the pathogenesis of acne vulgaris from a dermatological point of view, homoeopathic practice and understanding of disease and lastly izinyanga practice and understanding of disease.

2.1.1 BRIEF EXPLANATION OF IMPORTANT CONCEPTS

Homoeopathy is a holistic practice of medicine that aims to treat the person in totality; the word “totality” incorporates symptoms, pathology, personality, trauma, inherited tendencies and individual tendencies (van Wyk 2009). Homoeopathy was developed by the German Physician and Chemist Samuel Hahnemann (1755-1843) in 1796 based on the Law of Similars ‘Like cures like’ which states that in order to

cure a disease, one must look for medicinal substances that can create similar symptomatology in a healthy body (Vithoulkas 2009). The homoeopathic medications work by stimulating the body ‘s inherent ability to heal itself (School of Homoeopathy 2017; Trivieri 2001).

A homoeopathic consultation is a gentle yet thorough exploration of physical and emotional make-up or constitution of the individual and endeavours to build a well-rounded picture of a patient (De Schepper 2001). During the time of the explanation of the main complaint by the patient, the homoeopathic practitioner ask questions related to the main complaint using the following guidelines (De Schepper 2001):

- Concomitant: are there any other symptoms that arise with the original symptoms?
- Location: where is it painful/ where is the pain?
- Aetiology: the underlying cause of the disharmony.
- Modalities: symptoms relating to what makes a person better or worse.
- Sensation: how does it feel?
- Intensity: the intensity of the pain using a scale of 1-10.
- Timing: what time of the day are symptoms worse.

Traditional health practice is defined as the performance of a function, process, activity or service that is based on a traditional philosophy that makes use of indigenous African beliefs and principles (Peltzer 2009: 956-957). Traditional health practitioners represents a broad spectrum of practitioners that either serve as divine diagnosticians (medium), herbalists (izinyanga), traditional surgeons (*iingcibi*) who mainly do circumcisions, and traditional birth attendants (*ababelethisi* or *abazalisi*) (Peltzer 2009).

Izinyanga are defined as herbalists who have a good knowledge of many natural substances, which have real remedial effect. The source of the medicinal substances of izinyanga come from natural indigenous substances such as the bark of certain trees or leaves of certain plants and various animal parts and minerals. One major difference between conventional, Western medicine and izinyanga, is their way of viewing illnesses and their treatments
(Ancient Origins 2013).

Acne vulgaris, commonly known as ‘acne’, is a chronic condition of the pilosebaceous gland that is characterised by inflamed papules, comedones, nodules and superficial pus-filled cysts (Purdy and de Berker 2011).

Acne vulgaris affects the majority of adolescents worldwide (Cordain *et al*. 2002). Acne vulgaris has been documented as the second most common skin disease that affects the population KZN (Zulu *et al*. 2017) and 60% of the population use TM (Sobieck 2012).

2.2 HISTORY OF ACNE VULGARIS

Acne vulgaris has been well known since ancient times and is suggested to have had affected people even before humans could write (Coan 2005). Although acne vulgaris is not a serious disease that can lead to death, it has a nuisance value out of all its proportion to seriousness as it significantly affects young people at a vulnerable age where they are most sensitive to any disfigurement (Grant 1951). The origin or root of acne vulgaris can be traced back to three well known ancient civilisations, namely, the Egyptians, Greeks and Romans. The earliest description of acne vulgaris appeared in the ancient Greek writings of the Byzantine physician Aetius Amidenus in the 1800’s BC. The word acne originates from the Greek word ‘acme’ which means ‘point or spot’. The ancient Greeks also believed acne vulgaris to be ‘tovoot’, the meaning of this word in the singular implies ‘the first growth of the beard’ hence acne vulgaris was therefore associated with puberty, in contrast to that, the ancient Egyptians in the 3rd century BC had many superstitious beliefs regarding the cause, clinical presentation and treatment of acne breakouts; these breakouts were said to be cured with magic, spells and charms (Tabasum *et al.* 2013). King Tutankhamun, an Egyptian pharaoh (1355-1337 BC), had unmistakable acne scars. To preserve his purity in the afterlife his tomb contained a variety of medications to treat his skin (Plewig and Kligman 2000).

The ancient Romans were the first to develop a guide for the treatment of acne; they treated acne with baths as they believed that the pores of the skin would be opened and cleaned by a mixture of sulphur in the mineral baths. Lastly Aetius, emperor Justinian’s physician, used the word acne for the first time after asserting that ‘acme’ was a misprinting (Tabasum *et al*. 2013).

In 1931 Bruno Bloch, after examining 4000 girls and boys in Zurich Switzerland pointed out that acne vulgaris in the form of comedones could be regarded as a physiological manifestation of puberty after observing that this disorder was so frequent in these young persons (Plewig and Kligman 2000a). Cosmetic chemist Mark Broussard argued that acne vulgaris is fundamentally genetic in nature and that individuals with acne vulgaris over produce androgen hormones which causes an overproduction of sebum (the oily substance secreted by the sebaceous glands) that later on leads to the development of acne vulgaris (Carusillo 2019).

2.3 WHAT IS ACNE VULGARIS?

From the first description of acne vulgaris in the 6th century BC dermatologists proposed that acne vulgaris was a disease of the pilosebaceous follicle (Tilles 2014). During the 20th century, dermatologists hypothesised that key factors such as follicular keratosis, seborrhoea and microorganisms could be individually responsible for causing acne vulgaris. Acne vulgaris commonly known as ‘acne’ is a common and chronic condition of the pilosebaceous gland and is characterised by inflamed papules, comedones, nodules and superficial pus-filled cysts. Acne vulgaris belongs to the family mammalian target of rapamycin complex (mTORC) diseases of civilisation (Melnik 2018).

Dawson and Dellavalle (2013: 33) defined acne vulgaris as a common inflammatory skin disease that affects nearly 90% of the adolescent population. Williams, Dellavalle and Garner (2012) added that acne vulgaris is an inflammatory disease of the pilosebaceous unit that results from androgen-induced increased sebum production, altered keratinisation, inflammation, and bacterial colonisation of hair follicles on the face, neck, chest, and back by *Propionibacterium acnes (P. acnes)*. Mahto (2017) proposed that acne vulgaris is a skin condition that is caused by a blockage or inflammation of the hair follicles and their associated sebaceous glands.

Malahlela and Motswaledi (2013) wrote that the development of acne vulgaris typically begins during adolescence and resolves by the mid-twenties. However, in some individuals acne vulgaris persists up until the age of 40. Solman and Layton (2019: 89) explained that expert consensus classifies acne vulgaris into five subtypes based on the time of onset of acne vulgaris in the affected individual.

These subtypes include: neonatal, infantile, mid-childhood, preadolescent and adolescent. Solman and Layton (2019: 85) further explained that the distinction between pre-adolescent and adolescent by age poses numerous challenges as previous epidemiological studies have revealed that acne vulgaris now develops earlier in boys and girls than before.

The clinical features of acne include seborrhoea (excess grease), non-inflammatory lesions (open and closed comedones), inflammatory lesions (papules and pustules), and various degrees of scarring. The distribution of acne corresponds to the highest density of pilosebaceous units (face, neck, upper chest, shoulders, and back). Nodules and cysts comprise severe nodulocystic acne (Williams, Dellavalle and Garner 2012).

2.4 EPIDEMIOLOGY AND INCIDENCE OF ACNE VULGARIS

Bhate and Williams (2012: 474-85) noted that despite acne vulgaris being a universal condition that affects many adolescents, relatively little is known about its epidemiology. Webster (2019) defined the term epidemiology as a branch of medical science that deals with the distribution, incidence and control of disease within a population. Coggin, Rose and Barker (1997) concur that epidemiology is the study of how and why diseases occur in different groups of people. These authors further explain that epidemiological information is used to plan and evaluate strategies to prevent illness as well as guide the management of patients in whom the disease has already developed. Ghodsi, Orawa and Zouboulis (2009: 2136) wrote that data of population-based epidemiologic studies are important in quantifying disabilities, use, and cost of health services. They can also be used as a guide to find out whether there is a need for specific education of those affected and for health providers offering care for them. Despite these facts, data based on community-based samples including an actual dermatological examination of acne patients are scarce.

A large study within the United Kingdom, France, and the United States of America revealed that acne vulgaris is consistently represented in the top three most prevalent skin conditions amongst the general population (Lynn *et al*. 2016). Cordain *et al.* (2002: 1584) observe that in Westernized societies, acne vulgaris is

a universal skin disease that affects 79% to 95% of the adolescent population. Epidemiological evidence further suggests that the incidence rate of acne vulgaris is considerably lower in non-Westernised societies (Cordain *et al.* 2002: 158). Stathakis, Kilkenny and Marks (1997) reported that the prevalence of acne varies from 35% to over 90% amongst adolescents. Cordain *et al* (2002: 2867) argue that although acne mainly affects adolescents, it is also presents in children and adults. Stathakis, Kilkenny and Marks (1997) stated that the prevalence of acne varies between sexes and age groups. A study by Ghodsi, Orawa and Zouboulis (2009: 2136-2141) revealed that pupils with a family history of acne exhibited a higher prevalence of moderate/severe acne than those who did not have a family history of acne vulgaris.

Acne vulgaris appears earlier in females than in males, possibly due to the fact that females enter puberty earlier than males. However, there is a greater severity of acne in males than in females in the late teens, which is compatible with androgens being a potent stimulus to sebum secretion. The prevalence of acne at a given age has been shown to be highly dependent on the degree of sexual maturity. Acne commonly shows a premenstrual increase in women. Some studies have detected seasonal variability in acne vulgaris, with the colder months associated with exacerbation and the warmer months showing improvement. Other studies have not confirmed these findings. Several studies that have investigated the psychosocial impact of acne have had conflicting results. The prevalence of severe acne has decreased over the past 20 years due to improved treatment. The general prevalence figure for acne may be confounded by treatment and this factor needs to be accounted for when collecting data. According to Health24 (2017), the life span of acne vulgaris in adolescents is roughly six to fourteen years or longer, depending on the hereditary and genetic make-up of the individual.

2.5 CLINICAL FEATURES OF ACNE VULGARIS

The symptoms of acne begin with a blocked pore which then causes a lesion on the skin. This can range from non-inflamed bumps and blackheads to inflamed, red pimples and pustules. The most severe symptoms are seen in cystic acne, which can lead to scarring (Palmer 2018). Clark (2009: 163) wrote that the clinical features

of acne vulgaris vary from a few mild lesions on the face to inflamed widespread lesions that affect the face, chest and upper back. According to the American Skin Association (2012) there are several different types of acne lesions. Each individual person may have predominantly one form, or a combination of acne lesions present at one time. The American Skin Association (2012) continued to describe the clinical lesions of acne vulgaris as laid out below.

Comedones — are considered non-inflammatory acne lesions and may be open or closed. Closed comedones or whiteheads are small blocked follicles, the contents of which are not exposed to the skin. Open comedones or blackheads are small follicles with dilated openings to the skin allowing oxidation of the debris within the follicle leading to the black colour. Though many believe these lesions represent dirt, they cannot be washed away and are not representative of poor hygiene (Figure 2.1 and Figure 2.2).

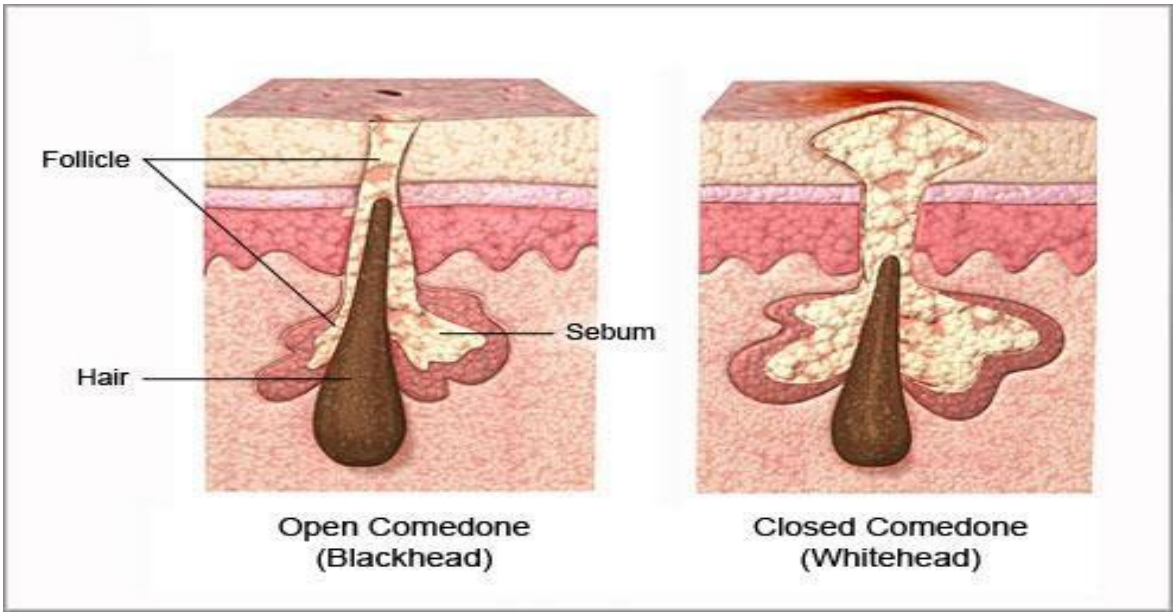

Figure 2.1: Skin structure of open and closed comedones
Source: Shutterstock (2003)

Figure 2.2: a): Open comedones **b) Closed comedones**
Source: Oakley *et al*. (2014) Source: Oakley *et al*. (2014)

Inflammatory acne — When lesions become red and/or tender bumps they are termed papules. These can fill with purulent material forming pus bumps or pustules. Papules and pustules represent inflammatory acne lesions, which originate as comedones (Figure 2.3).

Figure 2.3: Inflammatory acne
Source: Palmer (2018)

Nodular acne — As lesions progress to become larger and more tender, they are termed nodules (Figure 2.4).

Figure 2.4: Nodular acne
Source: Shutterstock (2003)

Nodulocystic acne — Cysts are deep, fluid-filled lesions and when these occur along with nodules, the term nodulocystic acne is use (Figure 2.5).

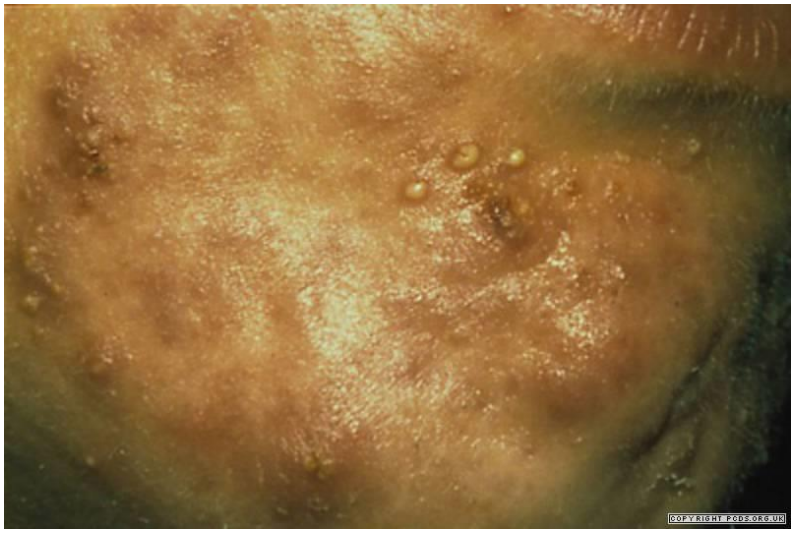

Figure 2.5: Nodulocystic acne
Source: Oakley *et al*. (2014)

From the American Skin Association (2012) description of acne vulgaris, Mahto (2017: 386-389) further classified the characteristics of acne vulgaris into three categories, namely:

1) Mild acne consisting of open and closed comedones and few inflammatory lesions;

2) Moderate acne consisting of comedones with occasional inflammatory papules and pustules that are confined to the face; many comedones with small and large inflammatory papules and pustules; more extensive; and
3) Severe acne consisting of many comedones and inflammatory lesions with nodules and cysts tending to coalesce; face and truncal involvement; evidence of scarring.

2.6 FACTORS THAT CONTRIBUTE TO THE DEVELOPMENT OF ACNE VULGARIS

Degitz *et al*. (2007: 316) wrote that there is a genetic predisposition to acne vulgaris and that the concordance rate of acne vulgaris is high among identical twins. Degitz *et al*. (2007: 318) further stated that relatively little is known about the specific hereditary mechanisms that cause acne vulgaris. All authors speculate that several factors are involved in the predisposition for acne vulgaris. Kumar *et al.* (2016: 67) explained that the accumulation of sebum and dead skin cells within the sebaceous follicle which enhance the microbial load and thereafter disrupt the follicular wall are key factors that contribute to the development of acne. Kumar *et al.* (2016: 69) further stated that sebum production and hormonal changes are endogenous factors that cause acne vulgaris.

Palmer (2018) proposed that there are three major factors that cause acne to develop: overactive sebaceous (or oil) glands, abnormal shedding of dead skin cells, and a proliferation of acne-causing bacteria. None of these factors have to do with skin care or lack thereof, and they all must be present for acne to occur. The tendency to develop acne has more to do with genetics than anything, meaning that one develops acne because one's skin has the propensity to develop acne – it is nothing that one does or does not do. The American Skin Association (2012)

proposes that there are four main factors which contribute to the development of acne vulgaris:

1) Plugging of the follicles by debris from skin cells;
2) Inflammation in the skin surrounding the follicles;
3) Increased production of sebum (oily secretions) by the sebaceous glands; and

4) The presence of the bacteria *P. acnes* within the follicle.

Mayo Clinic (2018) concur that there are four main factors that cause acne vulgaris: excess oil production, hair follicles clogged by oil and dead skin cells, bacteria, and excess activity of a type of hormone (androgens). The Mayo Clinic (2018) added that in addition to the above listed causes of acne vulgaris, certain medications trigger or aggravate acne. Hormonal changes related to pregnancy and the use of oral contraceptives can also affect sebum production. Low amounts of androgens circulate in the blood of women can worsen acne. Certain medications containing corticosteroids, testosterone or lithium can trigger or aggravate acne.

Melnik (2018) argued that the high prevalence rate of adolescent acne cannot be explained by the predominance of genetic factors alone but should include the influence of a Western diet that over stimulates the key conductor of metabolism, the nutrient- and growth factor-sensitive kinase mTORC1. Melnik (2018) continued to say that increased mTORC1 activity has been detected in lesional skin and sebaceous glands of acne patients compared with acne-free controls. Increased mTORC1 signalling is a characteristic feature of insulin resistance, obesity, type 2 diabetes mellitus, cancer, and neurodegenerative disease.

Melnik (2018) further explained that studies indicate that certain dietary factors, including skim milk and carbohydrate-rich foods such as bread, bagels and chips may worsen acne. High sugar and carbohydrates in commercial chocolate bars that increase blood sugar and impact insulin resistance have been suspected to aggravate acne vulgaris. A small study of 14 men with acne showed that eating any chocolate was related to a worsening of symptoms. Further study is needed to examine why this happens and whether people with acne would benefit from following specific dietary restrictions.

The American Skin Association (2012) concluded that in each individual, these factors mentioned above may contribute in varying degrees to the onset and duration of acne as well as the type of acne that predominates in a given person.

2.7 DIAGNOSIS OF ACNE VULGARIS

Mahto (2017: 386) highlights that patients with acne vulgaris usually present with a history of spots, most of which affect the face, back, chest and shoulders. Symptoms are often absent, but the patient may describe local symptoms of pain, erythema or tenderness. Additionally, acne can have a psychological impact, regardless of the severity of disease. Mahto (2017: 389) further adds that when taking a patient's history, it is important for physicians to enquire about the duration of symptoms, aggravating factors, any over-the-counter preparations that have been tried, and the psychosocial impact of the disease, particularly at work or school. In female patients, consider whether acne could be secondary to hyperandrogenism, and enquire about irregular menstrual cycles, hirsutism, androgenic alopecia, premenstrual flaring of acne lesions or sudden-onset severe acne. This complex of symptoms is seen in polycystic ovarian syndrome which in turn is relieved by a low carbohydrate/Ketogenic diet and or by treatment with anti-diabetic drugs e.g. Metformin. Psychosocial factors are often overlooked but must not be taken lightly.

Acne can have a severe negative impact on a person's life and is often underestimated by healthcare professionals. Validated quality-of-life scoring systems such as the Cardiff Acne Disability Index can be used to monitor psychological states. Individuals in whom acne is having a marked psychosocial impact may need more aggressive treatment or early referral to a specialist.

Physical examination of acne vulgaris reveals atrophic or pitted scars, post-inflammatory erythema or hyperpigmentation, and keloids. The latter two are more common with darker skin. When making a clinical assessment, an attempt should be made to categorise disease severity. There are multiple acne severity grading systems, largely developed for use in clinical trials that may not be entirely suitable for daily clinical practice. However, expert opinion is that separating disease status into mild, moderate and severe categories can help to judge efficacy of treatment (Mahto 2017: 389).

2.8 GAP IN CONCEPTUAL UNDERSTANDING AND MANAGEMENT OF ACNE VULGARIS

A study conducted by Brajac *et al*. (2004) revealed a gap in the literature that exists around the understanding and treatment of acne vulgaris. The aim of the study was to evaluate health beliefs and the level of knowledge about the causes, natural course and therapy of acne vulgaris. The study included 100 patients and 120 family physicians from the outpatient services of the Department of Dermatovenereology, University Hospital Centre, Novi Sad, Serbia. The results obtained from the study showed that both patients and the physicians had major gaps in their knowledge of acne vulgaris. Misconceptions also existed regarding factors that cause acne, its natural projection and treatment. Results further showed that although acne vulgaris was rarely misdiagnosed by physicians it was often inadequately treated.

Poli *et al.* (2011) observe that most people have misguided beliefs and misunderstandings concerning acne vulgaris. A study carried out by Allayali *et al*. (2017) further pointed out that the lack of knowledge about acne vulgaris was widespread among Saudi medical students and patients. Gallo *et al.* (2018: 10) found that although acne vulgaris is a very common disease, little time is spent on it in medical curricula, even within dermatology modules. In fact, dermatology education as a whole is lacking in the teaching of medicine in some countries. In the United States of America medical schools have no undergraduate dermatology programmes, and more than half of American medical schools teach only 10 hours of dermatology. Bhate and Williams (2012) wrote that relatively little is known about the epidemiology of acne vulgaris despite this skin condition being a universal disease that affects the majority of the adolescent population worldwide. Darwish and Al-Rubaya (2013) concluded that despite the high prevalence of acne vulgaris amongst adolescents there were still too many wrong misconceptions regarding the beliefs and general knowledge of acne vulgaris. Darwish and Al-Rubaya (2013) further suggested that more effort regarding health education in general and selective patient education in particular is needed to improve patients' knowledge about acne and its modalities of treatment, and to encourage early medical consultation behaviour and improve patient adherence to treatment.

According to Dellavalle *et al*. (2016), acne vulgaris is the most common skin condition affecting late adolescence across the globe. Although prior studies have evaluated epidemiologic patterns of acne vulgaris in various ethnicities and regions, adequate understanding of the worldwide burden of disease associated with patients in their late adolescence (15–19-year olds) remains lacking (Lynn *et al.* 2016). An article by Dlova *et al*. (2014) stated that acne vulgaris and acne rosacea were the third most common skin diseases that were identified in five public referral hospitals in the province of KZN which has the second largest population in South Africa. Furthermore 71% of the adolescent patients who consulted in these hospitals presented with acne vulgaris in this province (Dlova *et al*. 2014). This high epidemiology and prevalence of acne vulgaris worldwide suggests a gap in the conceptual understanding and management of this skin disease that needs to be addressed.

2.9 CONCEPTUAL UNDERSTANDING OF ACNE VULGARIS FROM A DERMATOLOGICAL POINT OF VIEW

It was previously hypothesised that the lesions of acne vulgaris developed from an increase in either sebum production, ductal hypercornification or *P. acnes* which all came together with local inflammatory processes to facilitate the pathogenesis of acne vulgaris. However, Zouboulis *et al.* (2005:103-105) stated that “the exact sequence, choreography of pathogenic events and precise interdependence of acne vulgaris still remained unclear”. Bellew, Thiboutot and Del Rosso (2011: 582) stated that the pathogenesis of acne is complex and multifactorial. The authors further posit that there continues to be an influx of new information that increases the understanding of this chronic skin disease. Tan, Vasey and Fung (2001: 439) concur that the pathogenesis of acne is multifactorial and involves androgenic stimulation, sebaceous hypersecretion, follicular obstruction, *P. acnes* and lastly inflammatory mediators. Grech (2014) concurs that pathogenesis of acne is a multifactorial process and that dietary habits, genetic factors, hormonal disturbances and alterations of the normal skin flora contribute to the development of moderate to severe disease. Grech (2014) added that colonisation of the skin by *P. acnes* is largely recognised as a salient factor in the pathogenesis of acne. *P. acnes* is a Gram-positive anaerobic rod that stimulates keratinocytes for the

production of proinflammatory mediators resulting in the development of inflammatory macules and pustules of acne. To this end, long-term antibiotic treatment either with topical preparations or with orally administered antimicrobials is part of the therapy of moderate to severe acne. Tan, Vasey and Fung (2001) further concluded that the tendency to severe acne may be inherited.

According to dermatologists there are eight key factors that contribute to the development or pathogenesis of acne vulgaris which in turn play a crucial role in its pathogenesis. These factors are as follows: sebaceous gland biology, hormonal influences, hyperkeratinisation, bacteria, sebum, nutrition, toll-like receptors and lastly cytokines. Amongst these factors the sebaceous gland plays a very important role as it is active in the natural defence system of the skin. The sebaceous gland also produces neuropeptides, removes antimicrobial peptides and shows or displays characteristics of stem cells (Kurokawa *et al*. 2009). During the development of the pathogenesis, androgens affect sebocytes (cells of the sebaceous gland) and infundibular keratinocytes in a complex way causing cell differentiation, proliferation, lipogenesis and comedogenesis. These events later lead to the following: increased sebum production, perifollicular hyperkeratinisation, colonisation with *P. acnes* and finally the release of enzymes which induce humoral and cell mediated inflammation (Nguyen and Su 2011:119). Foods such as milk which have a high glycaemic load may cause an increase in the tissue levels of 5alphadihydrotestosterone which is an endogenous androgen, sex steroid and hormone (Kurokawa *et al*. 2009).

Chronic inflammatory acne cannot be defined as an infectious disease, since the bacteria are normally present on the skin of a vast majority of individuals, irrespective of the presence of acne lesions. *P. acnes* apparently only triggers the disease when it meets favourable derma physiological terrain; *P. acnes* colonisation of the skin is therefore necessary but not sufficient for the establishment of the pathology. The four major recognised pathophysiological features of acne include androgen stimulated seborrhea, hyperkeratinisation and obstruction of the follicular epithelium, proliferation of *P. acnes*, and inflammation (Bhatia, Maisonneuve and Persing 2004).

All these events stimulate the infra infundibular inflammatory process, follicular rupture, and perifollicular abscess formation, which stimulate the wound healing process. Injury to the skin initiates a cascade of wound healing events. Wound healing is one of the most complex biological processes and involves soluble chemical mediators, extracellular matrix components, parenchymal resident cells such as keratinocytes, fibroblasts, endothelial cells, nerve cells, and infiltrating blood cells like lymphocytes, monocytes, and neutrophils, collectively known as immunoinflammatory cells. Scars originate in the site of tissue injury and may be atrophic or hypertrophic. The wound healing process progresses through 3 stages: (1) inflammation, (2) granulation tissue formation, and (3) matrix remodelling (Fabbrocini *et al*. 2010: 34).

Holland *et al*. (2004), found that the inflammatory reaction at the pilosebaceous gland was stronger and had a longer duration in patients with scars versus those without; in addition, the inflammatory reaction was slower in those with scars versus patients who did not develop scars. The authors showed a strong relationship between severity and duration of inflammation and the development of scarring, suggesting that treating early inflammation in acne lesions may be the best approach to prevent acne scarring. Figure 2.6 and Figure 2.7 show normal skin and the pathogenesis of acne.

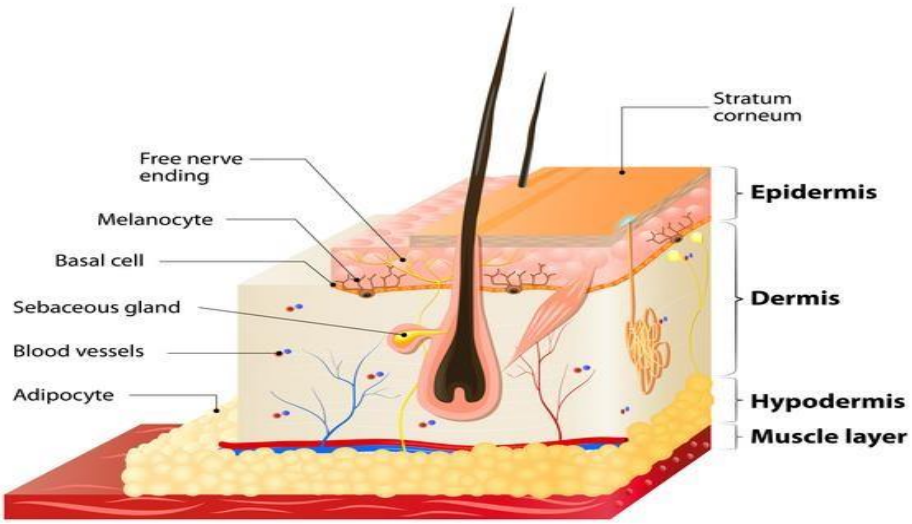

Figure 2.6: Normal skin, acne free
Source: Ash *et al.* (2015)

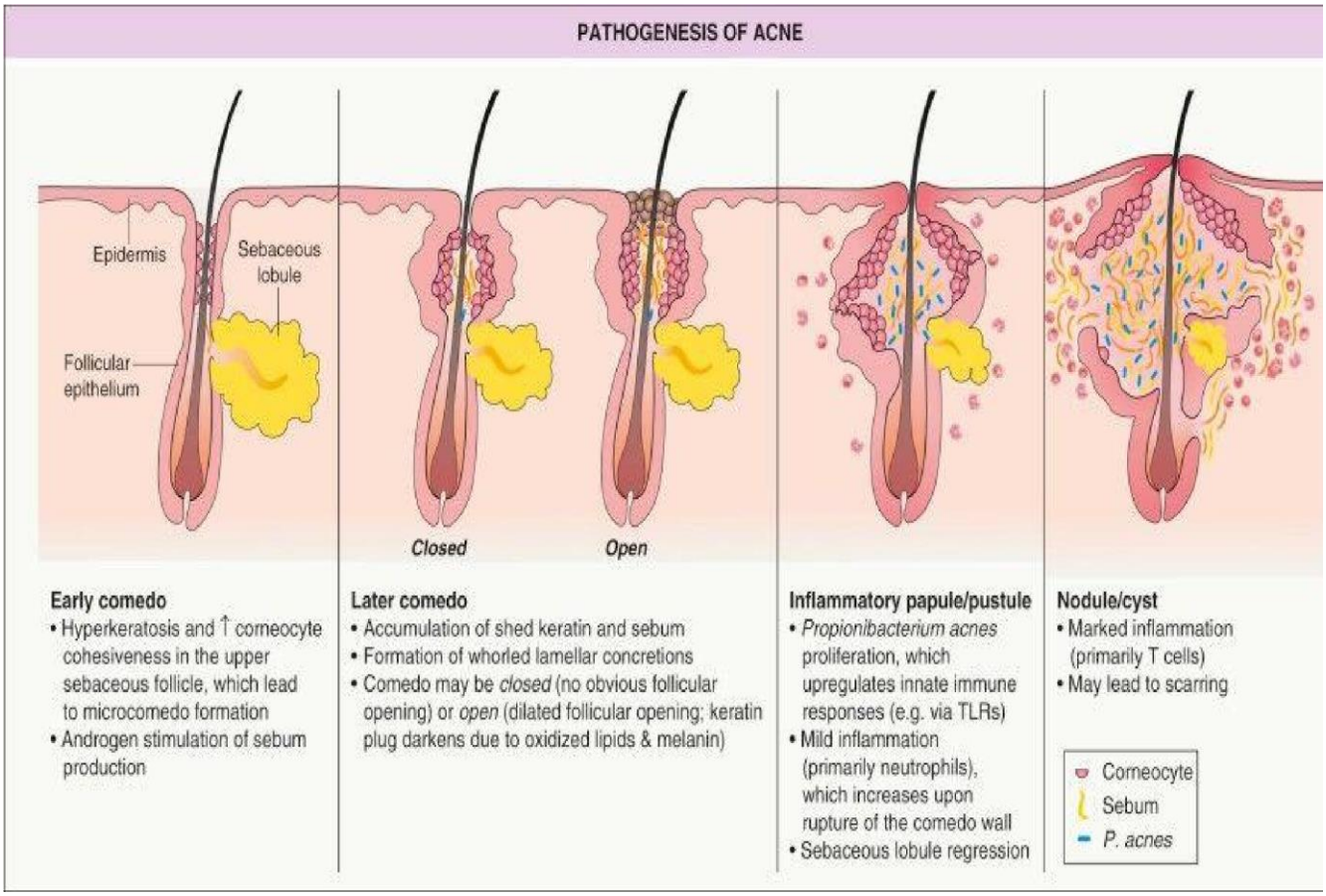

Figure 2.7: Pathogenesis of acne vulgaris Source: Ash *et al*. (2015)

2.10 HOMOEOPATHIC PRACTICE AND UNDERSTANDING OF DISEASE

Kane (2004) wrote that the use of CAM has increased dramatically over the last decade. In addition to the increased popularity of CAM amongst patients, there has been an increase in the number of health practitioners who practice complementary therapies as either their primary discipline or as a complement to their own discipline. According to the Homoeopathic Association of South Africa (HSA) (2016), homoeopathy is fast becoming the preferred mode of CAM around the world. Caulfield and DeBow (2005) concur that homoeopathy is one of the most widespread and most controversial forms of CAM. Senel (2019) has stated that homoeopathy is a popular complementary therapy today and more than 200 million people take homoeopathy drugs worldwide on a daily basis. Caulfield and DeBow (2005) further argue that although the popularity of homoeopathy as a form of CAM in the public sector is reflected in the scientific community, a systematic review of how homoeopathy is represented in conventional and CAM peer reviewed journals

suggests that there is a publication bias against homoeopathy in existing mainstream journals. This could be due to the fact that homoeopathy remains one of the most controversial subjects in therapeutics (Ernst 2002: 577).

Senel (2019) explained that homoeopathy is a medicinal term derived from the Greek words "*homoios*" (similar or same) and "*pathos*" (suffering). It is an important application of complementary and integrative medicine based on the idea of "*similia similibus curentur*" meaning "let like be cured by like". Homoeopathy uses highly diluted and dynamised substances to cure a wide range of disorders.

According to Science Based Medicine (2013), homoeopathy is a holistic system of medicine that was developed by the late German physician and chemist, Doctor Samuel Hahnemann (1755-1843). Hahnemann lived in a time before the rudiments of modern medicine had been developed, before the germ theory of infectious disease, before the first antibiotic, before systematic testing of drugs for safety and efficacy, before surgical procedures were performed with anaesthesia or sterile technique. For many years Hahnemann's search was unsuccessful, until he stumbled upon what he thought was an amazing observation: he took a small amount of cinchona bark, which contains quinine, a drug used to treat malaria, and developed the symptoms of malaria. From this observation he developed homoeopathy's first law, "similia similibus curentur". In other words, drugs which cause specific symptoms can be used to cure diseases which cause the same symptoms. As homoeopathy evolved, other "laws" were also discovered. The law of infinitesimal doses was actually a late development by Hahnemann, but today is often thought of as the primary characteristic of homoeopathy. This law states that when drugs are diluted in either water or alcohol, they actually increase in therapeutic potency. Today, serial dilutions of 1:100 repeated 6 or 30 times are commonly used. Between each dilution the substance is violently shaken, which is thought to be necessary to activate the properties of the drug.

Hahnemann also developed his own theory of disease called the miasm theory. According to this theory there are three miasms which are responsible for all human disease, and homoeopathic remedies are directed towards treating these offending miasms. The goal of a homoeopathic consultation is to find the "totality of

symptoms," physical, mental, and spiritual. Homoeopaths accomplish this goal by taking a "homoeopathic history" which includes questions such as: do you feel sad when you hear piano music, are you excessively tidy, do you have a chilly personality? This information is combined with the patient's symptoms and their physical "constitution," which may depend on such facts as hair colour. The homoeopath then decides on what single remedy will treat the patient's "totality." The remedy is then prescribed and is usually given in either a single dose or only a few doses (Science Based Medicine 2013).

O'Reilly (1997) explained that Hahnemann's book The Organon of Medicine is the cornerstone of Homoeopathic principles and practice and is used by homoeopathy students and practitioners alike. The Organon developed slowly out of Hahnemann's research and experimentation over a period of time (School of Homoeopathy 2017). As cited by O'Reilly (1997), Hahnemann described the term 'disease' as a deviation of the internal vital force from a state of health to a diseased state. The vital force is the internal spirit-like energy or dynamis that maintains and directs life and enables all living organisms to heal themselves and it preserves life by directing the body's system to function as a harmonious whole. A 'diseased state' that arises as a result of a deviation of the internal vital force is expressed through visible signs and symptoms. Hahnemann went on to say that this deranged vital force can only be cured through a change from the diseased state back to the state of health using the correctly selected remedy or medicine in the appropriate dose which possesses the power to act upon the level of the deranged vital force and alter or change the way an individual feels and functions (Kunzli, Naude, and Pendleton 1983: 9). In aphorism 78 of the Organon Hahnemann defined natural chronic disease as diseases that originate from a chronic miasm that when left alone without treatment with a suitable remedy continue to worsen and torment the patient with ever great suffering up until the end of the patient's life. In aphorism 74 of the Organon Hahnemann said that amongst naturally occurring chronic diseases there are widespread illnesses that are artificially created by continuous and prolonged use of strong and harmful allopathic treatments. Such treatments common in his day, and usually taken in high and strong doses, include calomel, bloodletting, mercurial ointment, iodine and its ointments, opium, valerian, Quinine and sulphuric

acid. These treatments or drugs singlehandedly weaken the vital force of an individual and progressively change it, each in its own characteristic way. Lastly in aphorism 77 Hahnemann speaks of the so-called pseudo chronic diseases which we now call lifestyle diseases. The above mentioned are caused primarily by habitual indulgence in harmful food or drink which includes industrial/processed carbohydrates such as pastas, pastries, bread and cakes, carbonated drinks, and processed/industrial oils found in foods such as potato crisps. All the above-mentioned foods have a huge impact on the body, mainly on the skin where they can cause skin conditions such as acne vulgaris or else worsen existing conditions such as polycystic ovarian syndrome. The worsening of polycystic ovarian syndrome has a negative effect on acne vulgaris by causing jawline acne in affected women. Polycystic ovarian syndrome is the most common endocrine disorder affecting women of reproductive age and is associated with obesity, hyperinsulinemia, and insulin resistance. A pilot study conducted in 2005 on the effects of a low-carbohydrate, ketogenic diet on the polycystic ovary syndrome results showed that 6 out of the 11 women who took part in the study lost 12% of their body weight which reduced their insulin resistance by 54% which in turn decreased the severity of polycystic Ovarian syndrome over 24 weeks (Mavropoulos *et al.* 2005). Aphorism 77 goes on to say that the deprivation of things necessary to life (such as water, food, happiness, joy or peace), unhealthy places especially swampy regions, lack of exercise and continuing emotional stress all contribute to the development of chronic disease (Kunzli, Naude and Pendleton 1983).

Prinsloo (2010) observes that homoeopathy in South Africa was first introduced by missionaries from England, Europe and Germany in the late 1820s. In the year 1857 Hugh Eaton became the first homoeopath to set up practice in Cape Town. By the year 1931 there was only one medical doctor practising allopathic medicine in Transvaal while there were 15 chemists carrying homoeopathic remedies. Most locals therefore had to treat themselves and homoeopathy became the most appropriate or practical form of self-medication. The Homoeopathic Society of South Africa (now referred to as the Homoeopathic Association of South Africa), was first started in 1949 by Barbara MacFarland who studied homoeopathy in England. The HSA is the official representative of the homoeopathic profession. The Association

actively engages Government, the Department of Health, the AHPCSA and other organisations and structures that influence the profession of homoeopathy (Homoeopathic Association of South Africa 2016). According to the HSA (2016), currently there are approximately 600 homoeopaths that are registered with this council and practice homoeopathy. Miglani and Manchanda (2014: 203) state that "Homoeopathy is often used in the treatment of acne vulgaris and there are about 227 medicines mentioned in the literature for the treatment of acne vulgaris''.

2.11 IZINYANGA PRACTICE AND UNDERSTANDING OF DISEASE

Reid *et al*. (2018: 1) wrote that TM is an important foundation on which modern medicine has been built. In these traditional practices, plants have been a crucial resource, owing to their abundance since the dawn of humankind. In modern times, synthetic drugs have become a lucrative alternative; however, plants remain an indispensable resource from which even synthetic alternatives are derived. The use of TM is growing and emerging as an issue of public healthcare importance. The global prevalence of use is up to 80% of the population which varies among countries due to different socio-economic and cultural backgrounds. Wada *et al*. (2019: 56) explained that in Nigeria, over 80% of the general population use some form of TM. The authors further stated that the acceptance and predominant use of TM by the majority of the public was directly related to the availability, accessibility, self-administration, and the perception that TM is safe and efficacious.

Globally, and in South Africa, there has been an increased demand for consulting both traditional and allopathic health practitioners. As both health practitioners are working within the same communities, their respective practices could complement or undermine the health of consumers using both health services. Professional collaboration between traditional and allopathic health practitioners is therefore desirable and requires collaboration between the systems, which is currently legislated by the Traditional Health Practitioners Act (Act 22 of 2007) (Republic of South Africa 2007). However, in the Eastern Cape, no evidence-based recommendations were found that facilitated the collaborative relationship between the two health practitioner groups (van Rooyen *et al*. 2017: 291).

Peltzer (2009) explained that patients see no conflict in seeking both allopathic and traditional African healing for their ailments, as doctors diagnose and treat the pathology while traditional healers establish what is wrong with the body-mind complex and importantly who or what (mostly harmful spirits) made the person ill (done mainly by sangomas). Ensink and Robertson (1999) found that most African patients and their families interpret mental health problems in terms of a combination of indigenous, psychosocial, and other causes. Traditional health practice is about ameliorating the cause and identifying who might have placed a bad spell or caused an illness or accident. This is why the two systems can coexist so easily but is also part of the tension between the two systems. An example of this is demonstrated in an article by Kahn and Kelly (2001) who explored how psychiatric nurses manage apparent incompatibilities between their practice of Western psychiatry and the use of traditional healing services. The article showed that these two systems coexist pluralistically. However, when questioned about possible cooperation between these systems, the respondents gave views inconsistent with their pluralistic world-view and promoted psychiatry's hegemony.

Traditional health practice is defined as the performance of a function, process, activity or service that is based on a traditional philosophy that makes use of indigenous African beliefs and principals (Peltzer 2009: 956). Research studies show that the use of THPs has always been a long-standing component of health care practice which contributes to the primary health care needs of the people not only in South Africa but throughout the world. In west Africa, for instance, it has been estimated that between 70% to 80% of the population rely on TM. Such figures, however, are not unique to that part of Africa alone, but may be applied to the whole continent. The WHO particularly estimates that in Africa 60% to 80% of people rely on TM for their primary health care (Peltzer 2009: 958).

Street *et al.* (2018: 5) noted that THPs often play an integral role in communities making them well positioned to support a range of diseases. In South Africa, THPs are an existing healthcare resource and their profession is currently regulated under the national Department of Health. As with conventional or ‘mainstream’ practitioners, THPs are required to follow nationally developed policies as well as to abide by the legal and statutory requirements regulating the profession. Although

the South African government is committed to the development and empowerment of THPs in playing a meaningful and significant role in healthcare service delivery, there is little to no evidence showing a move towards cooperation (mutual connections), collaboration (equal partners), and integration (joint efforts) within the national health system.

In South Africa there are about 200 000 traditional healers and about 60% of South Africans consult these traditional healers in addition to modern medical practitioners African. TM is one of the oldest and perhaps the most diverse of all medical systems. However, the various, often regional systems, are poorly described, scantily recorded and not well understood (Mdima 2011). In South Africa, traditional healers are now recognised by the constitution as they now have licences to practise but very little groundwork has been done to integrate Westernized medicine with traditional healing (Lin, Puckree and Mvelase (2002). The practice of THPs in South Africa was previously restricted by means of the Witchcraft Suppression act of 1957 and the Witchcraft Amendment Act of 1970. These acts were put into place by the apartheid government to restrict THPs performance of any kind of medical practices (Street *et al*. 2018). In the year 1994 the South African government started to look at the prospect and feasibility of formally integrating traditional health care into the public health system (Nkosi 2017). However, it was only in 2004 that the South African government passed the THPs Act which set the parameters for official recognition of THPs under the state (Devenish 2005: 243-284).

The term ‘traditional health practitioner’ represents a broad spectrum of practitioners that either serve as divine-diagnosticians (isangoma) (Figure 2.8), herbalists (izinyanga or amaxhwele) (Figure 2.9), traditional surgeons (iingcibi) who mainly do circumcisions (Figure 2.10), and traditional birth attendants (ababelethisi or abazalisi) (Figure 2.11) (Peltzer 2009: 956). This research study focused on izinyanga who are herbalists that have a good knowledge of many natural substances which have a real effect when used as a remedy (Conco 1972: 322) In my view the inyanga is a "physician-seer" or "Iatromantis" of "Early Greek Primitive Medicine". He/she practises as a physician and also as a "priest", "soothsayer", "diviner" etc. or as a "sangoma". These physician-seers are the masters of the healing art, combining their wide empirical knowledge of medicines with their astute

insight into the psychological makeup of the community of which their patients are a part. They are the basic custodians of the doctrine or theory of African medicine, and their commitment to it shows a very high degree of coherence, stability, depth, conventionality and explicitness.

Figure 2.8: Isangoma
Source: Siyafila Wordpress (2012)

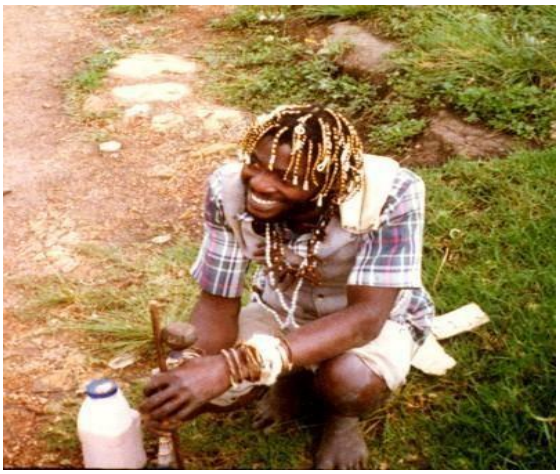

Figure 2.9: Herbalist or inyanga
Source: Brotherhood of Blessed Gérard (2016)

Figure 2.10: Ingcibi
Source: Saul (2016)

Figure 2.11: *Ababelethisi* or *abazalisi*
Source: Saul (2016)

Mabona and Van Vuuren (2013) noted that TM had not only gained popularity and approval but was sometimes the only system available in many rural areas. Medicinal plants have always played an important role in therapy within the traditional health care system in South Africa. It is estimated that between 12 and 15 million South Africans still use traditional remedies from as many as 700 indigenous plant species (Grierson and Afolayan 1999). According to the WHO (2011), about 70% to 95% of the world's population in developing countries relies mainly on plants for their primary health care. In KZN there are three kinds of

traditional healers that are mainly found namely being: isangoma (diviner), inyanga (one who focuses on traditional medical remedies) and umthandazi (faith healer). This research study focuses on izinyanga who are defined as herbalists who have a good knowledge of many natural substances which have a real effect when used as a remedy (Zuma *et al*. 2016).

Izinyanga as THPs play a very important role in the healthcare of the majority of not only the population in South Africa but on the continent of Africa as a whole. However, many studies and authorities challenge the practice of izinyanga in healthcare. According to Zuma *et al*. (2016: 3), concerns raised by authorities are due to the rationale, safety and effectiveness of traditional health practises and the methods izinyanga use, as well as what informs them in the way they heal their patients. Despite the criticism izinyanga face, their main objective within the healthcare system is to act as primary healthcare providers that aim to heal, cure and restore life from disease to health.

Izinyanga use medicinal substances which in isiZulu are known as '*uMuthi*'. *uMuthi* has three meanings, namely, tree, bark and medicine. The source of the medicinal substances of izinyanga comes from indigenous substances that occur naturally in nature such as the bark of certain trees or leaves of certain plants and various animal parts and minerals. One major difference between conventional, Western medicine and traditional African medicine utilised by izinyanga, is the way of viewing illnesses and their treatments. Unlike its Western counterpart, traditional African medicine is said to take a holistic approach, which is based on the premise of interconnectedness, and often includes indigenous herbalism in its treatment (Ancient Origins 2013).

2.12 CONCLUSION

Devenish (2005) stated that THPs play a vital role in the health care of the majority of the South African population and elsewhere on the African continent. The author further stated that a broad view of the literature and research on traditional healing in South Africa indicates that TM is in a process of change, which is reshaping its relationship with biomedicine as well as fashioning new possibilities for traditional healers to engage in health care and the wellbeing of communities. Kane (2004)

stated that CAM has increased dramatically over the last decade and is rapidly becoming preferred. WHO (2002) stated that majority of the population in rural KZN still depend on TM and CAM as a source of primary health care. This study aimed to contribute to an understanding of the clinical features of acne vulgaris (since the clinical characteristics of the disease are still uncertain), and to develop a cooperative practice framework between registered homoeopaths and izinyanga in the treatment of acne vulgaris, and to purposefully increase awareness and consideration of the professions of homoeopathy and traditional healing utilised by izinyanga.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Methodology refers to theoretical and systemic analysis of methods that are applied to a field of study (Rajasekar, Philominathan and Chinnathambi 2013). Taylor, Bogdan and de Vault (2015) defined methodology as the science of how research is to be carried out and how research problems can be approached. Jackson, Drummond and Camara (2007) offered a simplified definition of the term methodology, namely, the identification and utilisation of the best approach for addressing a theoretical or practical problem. Taylor, Bogdan and de Vault (2015) pointed out that assumptions, interests and purposes shape the methodology to be used.

As suggested by Maree (2007: 47), a key component of the research methodology is the research paradigm. A paradigm is a set of beliefs or assumptions about a vital aspect of reality which give rise to a particular worldview. A paradigm also addresses vital assumptions regarding beliefs about the nature of reality. Paradigms therefore serve as an organising principle by which reality is interpreted (Maree 2007).

This chapter discusses the research methodology and paradigm adopted by the study, including the research design, study site, study population, sampling process, data collection and method of data analysis. A qualitative research approach was used to obtain the desired objectives.

3.2 RESEARCH DESIGN

Research design can be understood in one of two ways. Some scholars define the research design as being a standard or fixed arrangement of research methods that have their own logic and rationality to answer the research questions. Other scholars propose the research design as a logical progression of stages that begin from problem formulation to the generation of conclusions or theories that are essential in planning or carrying out a study (Maxwell 2005: 214). de Vaus (2001)

and Trochim (2006) concur with the first suggestion and they further defined research design as being the overall strategy that the researcher chooses to integrate the different components of the study in a coherent and logical way, thereby, ensuring that he or she will effectively address the research problem. Mitchell and Jolley (2012: 64) wrote that the research design constitutes the blueprint for the collection, measurement, and analysis of data. Frankfort-Nachmias and Nachmias (2000: 88) noted two purposes of the research design. Firstly, it suggests and outlines the necessary observations that the researcher needs to make to provide answers to the research question, and, secondly, the research design identifies the analytical and statistical procedures the researcher will need to use when analysing the data. A major purpose of research is to establish whether the independent and dependent variables are causally related. Frankfort-Nachmias and Nachmias (2000: 89) proposed four components of a research design that are necessary to establish causation: comparison, manipulation, control and the ability to generalise findings.

Creswell (2014) explained the research design as being plans and procedures for research that shape the steps of research starting from a wide range of assumptions and arriving at detailed methods of data collection, analysis and interpretations. This simplified explanation was therefore adopted by the researcher. A qualitative research methodology together with the constructivist research paradigm was employed by the researcher in order to meet the desired objectives of this research.

Maree (2007: 52) proposed that qualitative research as a research methodology is concerned with understanding the social and cultural contexts together with the processes that motivate various behavioural patterns. Holloway and Wheeler (2010) wrote that qualitative research focuses on the meaning and interpretations of people or systems by interacting with them and observing them in their natural environment. DeFranzo (2011:1) wrote that qualitative research is primarily exploratory research. Rossman and Rollis (2012: 4) agree that the approach to qualitative research is exploratory and go on to say that this approach makes use of observations, interviews and content analysis to provide understanding and insight. Patton and Cochran (2002: 2) pointed out that qualitative research in general generates words, rather than numbers, for data analysis. According to Creswell (2014: 233), the

following characteristics define qualitative research: the natural setting, the researcher as key instrument, multiple sources of data, inductive and deductive data analysis, emergent design and lastly holistic account.

InterQ Research (2019) highlighted that through the incorporation of in-depth interviews, focus groups and ethnographic project in qualitative research, the researcher is able to seek the opinions, motivations, and drivers behind people's behaviour and purchasing habits. Mack *et al.* (2005: 3) reasoned that the strength of qualitative research lies in its ability to provide complex textual descriptions of how people experience a given research issue. The authors further stated that the key difference between quantitative and qualitative methods lies in their flexibility. Qualitative methods allow greater spontaneity and adaptation of the interaction between the researcher and the study participant while quantitative methods restrict participants through limited range questions that do not allow interaction between the researcher and the study participant. Rossman and Rollis (2012: 5) added that in qualitative research the researcher is the main instrument through which the study is conducted.

Based on the above literature, a qualitative research design using the constructivist research paradigm was appropriate to compare the conceptual understanding and management of acne vulgaris amongst homoeopaths and izinyanga in KZN.

3.3 STUDY SETTING

This study was carried out in Durban, Mtubatuba, Melmoth, and Ladysmith in the province of KZN South Africa.

3.4 STUDY POPULATION

The research population for this study comprised of twelve registered health practitioners who resided in the province of KZN, six of whom were registered homoeopaths and six of whom were registered izinyanga.

3.5 STUDY SAMPLE

The researcher selected two sample groups within the province of KZN.

3.5.1 SAMPLING PROCESS

In qualitative research, the topic under investigation together with the selected research methodology determines the type of sampling process to be employed by the researcher (Higginbottom 2014).

Showkat and Parveen (2017: 3) stated that in research there are two main types of sampling techniques, namely, probability and nonprobability sampling. Surbhi (2016) stated that probability sampling is a sampling technique, in which the subjects of the population get an equal opportunity to be selected as a representative sample. The results obtained from this sampling method can be generalised from the surveyed sample to the target population. Surbhi (2016) added that there are four methods of probability sampling: simple random sampling, stratified sampling, cluster sampling, and systematic sampling.

Non-probability sampling is a method of sampling wherein there is no probability attached to the unit of the population and selection relies on the subjective judgement of the researcher. Therefore, the conclusions drawn from the sample cannot be inferred from the sample to the whole population. The methods of nonprobability sampling are as follows: convenience sampling, quota sampling, judgement or purposive sampling, and snowball sampling. Etikan, Musa and Alkassim (2016:1) explained that the key difference between probability and nonprobability sampling is that in probability sampling each element in the population has a known non-zero chance of being selected through the use of a random selection procedure, while non-probability sampling makes use of subjective methods to decide which elements will be included in the sample.

Maree (2007: 79) and Sunday (2014: 10) elaborated that sampling in qualitative research is mostly purposive. Taherdoost (2016: 18) stated that purposive (also termed judgemental) sampling is a strategy in which particular settings, persons or events are selected deliberately in order to provide important information that cannot be obtained from other choices. Sunday (2014: 10) explained that the aim of purposive sampling is to seek conceptual applicability rather than quantitative representativeness. This type of sampling method also seeks to capture the range of experiences, pursue saturation of data and as well as to draw theories from data.

The aim of the study was to compare the conceptual understanding and management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN province. To meet the objectives of the study the researcher employed purposive and snowball sampling methods and data collection until saturation (Manatsa 2018). The sample was divided into two groups: **Sample 1** consisted of six registered homoeopaths selected by means of the purposive method and **Sample 2** consisted of six registered Izinyanga selected by means of the snowball method.

3.5.2 SAMPLING METHOD

Judgemental sampling is a non-probability sampling technique which allows the researcher to select a group of people based on the judgement of the researcher. This sampling method was appropriate to handpick the sample of homoeopaths based on the participant's knowledge of the phenomena under study (Brink, van der Walt and van Rensburg 2012). The six homoeopaths were registered with the AHPCSA and had been in practice for more than five years and practised in the KZN area. Snowball sampling (also referred to as chain referral sampling), was employed by the researcher to recruit six Izinyanga who were registered with the ITHPCSA and had been in practice for more than five years and who practised in the KZN area. Snowball sampling is where one participant is identified and then used to refer others in his or her social network (Tongco 2007; Patton 2015: 180). Three izinyanga were selected from rural areas and three from urban areas. Data collection took place up until the point where data saturation was reached. The total point of data saturation was determined by the supervisor and co-supervisor in charge (Holloway and Wheeler 2010).

3.5.3 INCLUSION CRITERIA

The inclusion criteria of the study were the same for both groups. Participants needed to be:

- Registered with their professional councils (AHPCSA and ITHPCSA);
- Have been practising for at least five year
- Be practising in the KZN area;
- Have experience of treating acne vulgaris;

- Be English or isiZulu speaking; and
- Has experience of treating acne vulgaris

3.5.4 EXCLUSION CRITERIA

- The exclusion criteria for the study was the same for both groups:
- Not registered with their professional council;
- In practice for less than five years;
- Did not practice in KZN;
- Not English or isiZulu speaking; and
- Had no experience of treating acne vulgaris.

3.6 DATA COLLECTION METHODS

Harrell and Bradley (2009: 10) wrote that primary data collection is an important component of research projects, therefore it is imperative that the researcher uses the proper techniques to ensure that the qualitative data is collected in a scientific and consistent manner. Creswell (2014: 239) stated that observations, interviews, documents and lastly audio material are the four basic types of data collection methods in qualitative research. and qualitative research data collection ends when the categories or themes under study are saturated. For this study the researcher made use of observations, interviews and lastly audio recordings to collect the data. During the data collection process semi-structured interviews took place in a real life or face-to-face situation with the aim of obtaining participants' conceptual understanding and management of acne vulgaris.

Harrell and Bradley (2009: 14) described the term "interview" as a discussion between an interviewer (researcher) and an interviewee (research participant) that is meant to gather information on a specific set of topics. Walsh (2001: 88) wrote that data collection methods such as in-depth interviews and participant observation allow less control over the range and type of information the research participants give.) According to Kvale (2006) the main aim of conducting interviews is to understand the meaning of what the interviewees understand about a certain topic under study. McNamara (1999) concur that interviews are particularly useful for getting the story behind a participant's experiences. Wisker (2009: 130) added that interviews allow face-to-face discussion with research participants which aids the

researcher in exploring participants thoughts and understanding regarding a certain phenomenon under study. Packer (2011: 44) pointed out that interviews should adopt an attitude of neutrality and avoid any evaluation of the responses to the research questions.

Harrell and Bradley (2009: 33) stated that qualitative research interviews can be categorised on a continuum of structure, ranging from unstructured to highly structured. In order to fully explore as well as thoroughly understand the conceptual understanding and management of acne vulgaris in a non-restrictive manner, the researcher chose to employ semi-structured interviews. According to Wisker (2009:133), a semi-structured interview is a series of set questions that are not directive but permit the interviewee to explore their ideas and perspectives around a set of research questions which provides the researcher with a broader understanding of the topic in question. Packer (2011: 43) stated that in semi-structured interviews the researcher should have a general plan for the topic in question but must not abide by a fixed order of questions in order to give the interviewee freedom in answering the research questions.

3.6.1 INTERVIEW SETTING

The interviews were carried out in Mtubatuba, Ladysmith, Melmoth and Durban in KZN. Harrell and Bradley (2009: 81) wrote that the location selected for the interview is very important and that ideally interviews should be conducted in a private, quiet space with no distractions. Creswell (2014: 234) elaborated that the data in qualitative research is collected in the natural setting where the participants experience the problem under study. All the interviews took place at the research participants natural setting where the research participants made their living. The researcher ensured that the chosen setting provided both confidentiality and comfort before conducting the semi-structured interviews.

3.6.2 INTERVIEW PROCESS

The researcher contacted potential research participants via emails and phone calls. After agreeing to participate each participant was asked for their convenient day and time for the interview. The researcher maintained punctuality during all designated

interview sessions. Before the interviews commenced the potential participants were asked which language they felt comfortable using. The indicated language for the study was either English or IsiZulu. All the participants opted for their native language. All participants were given a letter of information about the study to read though so they could understand what the study was about. Each participant was then requested to sign a consent form and then were given the interview guide to read through which contained seven research questions about the phenomena under study. Before the interviews with the inyanga commenced each inyanga was required to show their certification of registration with the ITHPCSA. The interviews were carried out using open ended semi-structured interview questions and the interviews were audio recorded. Newcomer, Hatry and Wholey (2015:494) wrote that semi-structured interviews are well suited for a number of valuable tasks particularly when more than a few of the open-ended questions require follow-up queries. The total duration of each interview was 30 minutes. This set time period allowed all research participants to fully express their understanding of acne vulgaris. In addition to that the verbal information, the researcher noted the research participants facial expressions and nonverbal communication through observations in order to fully obtain their full perspective on acne vulgaris (Brink, van der Walt and van Rensburg 2012: 2).

3.7 DATA CAPTURING AND ANALYSIS

Leedy and Ormrod (2015) wrote that in qualitative research the collected data is closely examined to find the main themes and categories that emerge. They further stated that in qualitative designs, data analysis and data interpretation are closely intertwined and occur sequentially. Dudovskiy (2018) explained that qualitative data refers to non-numeric information such as interview transcripts, notes, video and audio recordings, images and text documents. Walsh (2001: 89) wrote that audio recording is the main strategy that is employed in qualitative research for data capturing during interviews, ensuring that the researcher obtains a verbatim record of the data. Bloor and Wood (2006: 4) observed that audio tape recorders have been a significant development within qualitative research and have replaced researchers' handwritten notes. In standard qualitative research, transcription and analysis of the tape-recorded data proceed as soon as possible after the interviews

(Packer 2011: 57). Nigatu (2009) noted summaries, self-memos and lastly diary entry as tools for aiding the analytical process.

Qualitative data analysis refers to the range of processes and procedures whereby the researcher moves from the qualitative data collected to the formation and development of explanations, understandings and theories about a specific phenomenon under study (Sunday 2014: 18). Leedy and Ormrod (2015) added that qualitative data relies greatly on inductive reasoning processes. Sunday (2014: 20) wrote that inductive reasoning uses emergent framework to group the data and then look for relationships thereafter. He also further mentioned that the inductive approach is used when qualitative research is a major design of the inquiry. In order to achieve the objectives of the study the researcher employed inductive reasoning processes together with qualitative framework analysis to understand the context at hand with the aim of filling the gap in the knowledge basis that exists around the conceptual understanding and management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN.

Gale *et al.* (2013: 117) observed that qualitative framework analysis has increasingly become a popular approach for the management and analysis of qualitative data in health research. Qualitative framework analysis was developed by the researchers Jane Ritchie and Liz Spencer in 1994. This method of data analysis is closely related to the broad family of analysis methods often termed thematic analysis or qualitative content analysis. Srivastava and Thomson (2009: 2) noted that framework analysis is well adapted to research that has specific questions, a limited time frame, a pre-designed sample and prior issues that need attendance. Gale *et al.* (2013: 117) defined framework analysis as a systematic and flexible approach for analysing qualitative data. Srivastava and Thomson (2009: 5) concur that framework analysis is flexible during the analysis process and allows the researcher to either collect all the data and then analyse it or do data analysis during the collection process. In the analysis stage the gathered data is sifted, charted and sorted in accordance with key issues and themes. This involves a five step process namely being: familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation. Gale *et al.* (2013) concluded that framework analysis together with its closely related broad family of analysis methods collectively help to identify

the similarities and differences in qualitative data before focusing on relationships between different parts of the data, thereby seeking to draw descriptive or explanatory conclusions clustered around themes.

Qualitative framework analysis fulfilled the aim of this study. Qualitative framework analysis was utilised by the researcher to identify a thematic framework using numerical or textual codes to identify specific pieces of data which correspond to different themes, search for patterns, associations, concepts and explanations in the data, and to transcribe and read the data (Sunday 2014), in order to compare and contrast the conceptual understanding and management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN.

3.8 STORAGE OF RESEARCH DATA

Given (2012: 1) stressed that the collected research data should be stored in a safe and secure place during the research process, utilising both digital and nondigital data storage methods. The researcher stored all the audio recorded data in a safe place at the Department of Homoeopathy in password protected filing. The hard copy notes, and transcriptions were placed in a locked cupboard where only the researcher and the supervisors had access to the collected data. This collected data will remain stored at the Department of Homoeopathy for a five-year period. After five years the collected data will be disposed of in accordance with the Durban University records management policy. The digital data will be deleted. All the research participants personal information was kept confidential throughout the study.

3.9 TRUSTWORTHINESS

In order for research to be considered worthwhile, it should contain: consistency, truth value, neutrality and lastly applicability. These are all aspects of trustworthiness (Guba and Lincoln 1981). Trustworthiness in quantitative research refers to validity and reliability, but trustworthiness in qualitative studies is more obscure because established differently (Shenton 2004: 63). Unlike quantitative research, qualitative research does not make use of instruments with established metrics regarding validity and reliability, therefore it is vital for the researcher to

establish that the research study's findings are credible, transferable, confirmable, and lastly dependable. (Statistics Solutions 2019; Lincoln and Guba 1985). These four concepts were further explored in the following section.

3.9.1 CREDIBILITY

Credibility in qualitative research is defined as the confidence of the data. The techniques for establishing credibility, as identified by Lincoln and Guba (1985), are: prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy, and member-checking. To ensure credibility in the research study, the researcher employed the data triangulation method. Triangulation is the use of various methods to collect data in order to ensure credibility (Brink, van der Walt and van Rensburg 2012: 6; Cohen and Crabtree 2006) A single method can never adequately shed light on a phenomenon, therefore the use of multiple methods can help facilitate deeper understanding of the phenomenon under study (Cohen and Crabtree 2006). Triangulation methods include observation, focus groups and individual interviews, which form the major data collection strategies for much qualitative research. While focus groups and individual interviews suffer from some common methodological shortcomings since both are interviews of a kind, their distinct characteristics also result in individual strengths Shenton (2004: 75). The instruments used to ensure triangulation in this research were: semi-structured interviews, observations and questionnaires.

3.9.2 TRANSFERABILITY

Transferability in qualitative research can be defined as the degree to which the results obtained from a research study can be applied or transferred beyond the duration of the research. Transferability further implies that the results of the research study can be applicable to similar situations or individuals. Lincoln and Guba (1985) wrote that transferability in research could be facilitated through thick description. Lincoln and Guba (1985) defined thick description as a way of achieving a type of external validity. Cohen and Crabtree (2006) further posit that thick description refers to the detailed account of field experiences in which the researcher makes explicit the patterns of cultural and social relationships and puts them in context. To ensure transferability the researcher described the phenomenon

under study in sufficient detail by interviewing six registered homoeopaths and six registered izinyanga with various understandings to allow comparisons to be made.

3.9.3 CONFIRMABILITY

Confirmability in qualitative research means the degree to which the outcomes of the study can be confirmed or corroborated by other people. The main concept of confirmability is the qualitative researcher's concern to avoid bias. To establish confirmability in qualitative research, Lincoln and Guba (1985) suggest confirmability audit, audit trail, triangulation, and reflexivity. An audit trail is a transparent description and record of the research steps taken from the start of a research project to the development and reporting of findings. To achieve confirmability the researcher conducted in-depth interviews and generated thick descriptions. The in-depth interviews and generated thick descriptions further ensured that the study findings were the results of the lived experiences that emerged from homoeopaths and Izinyanga who treat acne vulgaris.

3.9.4 DEPENDABILITY

Dependability in qualitative research can be defined as the stability or consistency of the inquiry processes that is used over time. Essentially, dependability is concerned with addressing the issue of reliability to show that, if the study was to be repeated in the same context, with the same methods and with the same participants, similar results would be obtained (Lincoln and Guba 1985: 129).

Lincoln and Guba (1985) further stress that there is a close relationship between credibility and dependability. Therefore, these two aspects need to be interlinked in research. This may be achieved through the use of overlapping methods such as the focus group and individual interview. The researcher employed semi-structured interviews in order to ensure dependability in the research. Shenton (2004) further highlighted that, in order to address the dependability issue more directly, the processes within the study should be reported in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results. Thus, the research design may be viewed as a prototype model. Such in-depth coverage also

allows the reader to assess the extent to which proper research practices have been followed.

3.10 ETHICAL CONSIDERATIONS

Ethical considerations in research are critical. Ethics are the norms or standards for conduct that distinguish between right and wrong. Ethics help to determine the difference between acceptable and unacceptable behaviours on the part of the researcher (Centre for Innovation in Research and Teaching 2018). The Centre for Innovation in Research and Teaching (2018) further stated that in qualitative research, ethical principles are primarily centred on protecting research participants and the guiding foundation of "do no harm". The following is a list of core ethical principles that are important in qualitative research:

- Respect for persons: respect the autonomy, decision-making and dignity of participants.
- Beneficence: minimising the risks physically, psychologically and socially; and maximising the benefits to research participants justice.
- Respect for communities: to protect and respect the values and interests of the community as a whole and protect the community from harm.

Sanjari *et al*. (2014: 14) wrote that in qualitative research the researcher and research participants are personally involved in different stages of the study, making the interaction between the researcher and research participants ethically challenging. Therefore, formulation of specific ethical guidelines in this respect are essential. The Centre for Innovation in Research and Teaching (2018) posited that one of the most important ethical considerations in qualitative research is the use of human subjects. To address these considerations, most institutions and organisations have developed an Institutional Review Board (IRB) in one form or another. An IRB is a panel of people who help to ensure the safety of human subjects in research and who assist in making sure that human rights are not violated. They review the research methodology in grant proposals to assure that ethical practices are being utilised. The use of an IRB also helps to protect the institution and the researchers against potential legal implications from any behaviour that may be deemed unethical. Sanjari *et al.* (2014: 4) further educated

that health care providers who conduct qualitative research have an immense responsibility. As there is no statistical analysis in qualitative studies, the researcher has to both evaluate what he or she observes and to interpret it.

Sanjari *et al*. (2014: 14) concluded that by providing researchers with the necessary skills and applying stringent supervision this could lead to better extraction of reliable information from qualitative studies. In this study, before the interviews were conducted with the willing research participants, the necessary procedures were followed, and all documentation first went through the ethics committee for approval. The research participants contact details were in the public domain therefore no permission from gatekeepers was required for the study. The names of the research participants were not mentioned at any point during the data collection, analysis or in the final dissertation. Furthermore, all participants information was kept confidential throughout the research study. Prior to the actual research process all participants were required to fill in a written consent form in order to take part in the study. Research participants were allowed to withdraw from the study at any point during the conduction of the study with no negative consequences. Finally, there was no coercion, the data of the study was non-sensitive therefore minimal ethical consideration was required.

3.11 ANONYMITY AND CONFIDENTIALITY

Kaiser (2009: 1632) stressed that maintaining confidentiality in qualitative research while presenting rich, detailed accounts of social life presents unique challenges. Sieber (2007) explained that confidentiality in research is highly important and refers to information about the person that has been revealed to the researcher; especially in medical research. Sieber (2007) further added that in medical research the researcher is in a position of responsibility and deals with a great volume of very personal information that their participants have willingly disclosed making confidentiality a great responsibility. According to the IRB of the Virginia Polytechnic Institute and State University (2019), maintaining confidentiality of information collected from research participants means that only the researcher and the research supervisors can identify the responses of individual subjects; however, the researcher must make every effort to prevent anyone outside of the project from

connecting individual subjects with their responses. Explorable (2019) further noted that science depends on research participants to volunteer information regarding individual beliefs and actions on a host of topics. A participant or subject is more likely to provide honest responses when their identity is not going to be exposed. Data collection instruments must not contain information that could readily identify participants (i.e., identifying information) which can be accomplished by using study codes (IRB 2019).

Safeguarding this information is a key part of the relationship of trust and respect that exists between the researcher and the participant. Depending on the type of study, personal identifiers such as names, birthdates, places of residence etc. may or may not have to be collected. In situations where these data are collected, researchers may take several steps to ensure the confidentiality of their participants' information, including using the participant's first name only (or an alias) when recording or publishing interview data. Most of the time, an alias will suffice, and is especially important to protect the participant if the published data includes other identifiers such as age, gender, community affiliations, or place of residence.

Based on the above understanding, the researcher maintained anonymity and confidentiality throughout the study. The names of the research participants together with their personal information was not at any time mentioned in the study. Participants were given codes based on their demographic profiles and thereafter referred to by their applicable codes e.g. (H2-F) stood for homoeopath number 2, female. The same was true for Izinyanga e.g. (I1-M) stood for Inyanga number 1, male. All the audio recorded information that was derived from the interviews together with the transcribed transcripts were kept in a safe place in the Department of Homoeopathy where only the researcher and the research supervisors had access to them.

3.12 LIMITATIONS

The research noted sample size as one of the limitations. The research sample consisted of six homoeopaths and six izinyanga which made it difficult to generalise the results to the population of KZN. However, Glaser and Strauss (1997) explained that qualitative analyses typically required a smaller sample size than quantitative

analyses. Glaser and Strauss (1997) further mentioned that the qualitative sample size should be large enough in order to sufficiently describe the phenomenon of interest and address the research questions. This study was in line with Glaser and Strauss (1997), as the sample for this study was sufficiently large to describe the conceptual understanding together with the management of acne vulgaris amongst homoeopaths and izinyanga in KZN. Furthermore, the study was limited to the KZN area which side-lined other potential participants from other provinces. Lastly the inclusion criteria for the study included only participants who were registered with their respective councils and who had been in practice for more than five years. This excluded keen participants who had only been in practice for less than five years.

3.13 CONCLUSION

The study was guided by the research problem, thereafter the data was collected and analysed produce text. Lastly the data was interpreted to give meaning to the data which led to the resolution of the problem, thus providing answers to the research question. The outcome of the study was to gain knowledge of the conceptual understanding as well as the management of acne vulgaris. Also, to compare and contrast the conceptual understanding of acne vulgaris amongst registered homoeopaths and izinyanga in KwaZulu-Natal and lastly to assess how registered homoeopaths and izinyanga manage acne vulgaris in KZN. This chapter discussed the research methodology which was utilised to guide the study. Furthermore, the sample and the sampling procedure was explained in detail. Lastly the data collection and analysis methods were described in detail. The following chapter presents and discusses the collected data.

CHAPTER 4: ANALYSIS AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This chapter presents, analyses and discusses the data that was collected from the participants. The aim of this study was to compare the conceptual understanding together with the management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN. Additionally, this study aimed to propose a co-operative practice between registered homoeopaths and izinyanga in KZN for the treatment of acne vulgaris and raise awareness regarding the professions of homoeopathy and traditional healers (izinyanga). The research participants were clustered into two sample groups. Group one consisted to six registered homoeopaths and group two consisted of six registered izinyanga.

Open ended semi-structured interviews were used to gather data. Thereafter, the interviews were transcribed, and isiZulu texts were translated into English. The interview data was then analysed for its relevance to the research questions using framework analysis. This chapter presents the results of this study as themes and sub-themes that emerged from the data analysis.

The responses to the listed questions in the interview guide for the semi-structured interviews provided knowledge and understanding of what acne vulgaris is and how to manage it in relation to its treatment and prevention.

4.2 DESCRIPTION OF THE RESEARCH PARTICIPANTS

The sample group for this study comprised twelve health practitioners who treat patients with acne vulgaris in KZN – six homoeopaths and six izinyanga. All practitioners were registered with their respective councils and had been in practice for more than five years, further implying that they had comprehensive experience and knowledge of acne vulgaris. The following demographic information of the practitioners was analysed: age, gender, race, language of communication and lastly number of years in practice. The demographic profile of the physicians is presented below.

4.2.1 AGE

In this study the age of the homoeopaths ranged from 29 to 49 years, the izinyanga from 50 to 60 years. Semenya and Potgieter (2014) wrote that most traditional healers are between the ages of 41 and 60 years. This concurs with this study since all the izinyanga were above the age of 40. Furthermore, a study conducted by Ndawonde (2006) reported that the age of traditional healers in KZN ranged from 45 to 54 years. Nzue (2009) stated that the majority of male and female Xhosa healers residing in the Western Cape Province of South Africa are between 41 and 50 years, while in this study which was carried out in KZN province, the izinyanga were between the ages of 50 to 60 years. While looking for participants in this study the researcher did not find any izinyanga who were below the age of 40. The above findings suggest that izinyanga are usually older people between the ages of 50 to 60 years.

4.2.2 GENDER

There was a noticeable difference between the genders that took part in the study (Table 4.1). The homoeopaths comprised five female practitioners and one male practitioner. Couchman (2011) conducted a study with 93 practising homoeopaths. Of these 53 were females (63.1%) and 31 were males (36.9%), supporting the finding of this study that there are more females than males practising as homoeopaths. On the other hand, the izinyanga included five male practitioners together with one female practitioner. The researcher noted that there seemed to be more males who practised as izinyanga than females. Kale (1995) wrote that 90% of the population of izinyanga are male. A study conducted by Semenya and Potgieter (2014) on Bapedi traditional healers in the Limpopo province, South Africa, showed that males constituted nearly two-thirds (62%) of the participants while only one third (38%) of the participants were females. Bereda (2002) also noted the dominance of males in traditional healing in the Vhembe district located in the Limpopo province areas. Moeng and Potgieter (2011) further reported that male healers dominated the trade in medicinal plants in the Capricorn, Sekhukhune and Waterberg districts.

4.2.3 RACE

There was a significant difference amongst the ethnic groups that took part in the study. The Homoeopaths consisted of two Africans, one Indian and three white practitioners, which implied that there were more white practising homoeopaths in KZN compared to other ethnic groups. A study by Couchman (2011) showed that the racial distribution of homoeopaths consisted of 89% of white, 8.5% of Indian and 1.2% of African practitioners, which supports the idea that majority of the practising homoeopaths in KZN are white. The izinyanga in this study comprised African practitioners only. Van Wyk and Wink (2004) wrote that amongst traditional practitioners, particularly izinyanga, the philosophy and the knowledge of remedies is passed from one generation to the next. The above literature explains why all the izinyanga in this study were from the African ethnic group.

4.2.4 LANGUAGE OF COMMUNICATION

English was the first language for the majority of homoeopath participants while IsiZulu was the first language for all of the izinyanga participants. The fact that the majority of the homoeopaths spoke English could be a barrier for them to communicate with patients that are not English speaking. The same is true for Izinyanga who speak only isiZulu. Non-isiZulu speakers will not be able to effectively communicate with them. Meuter *et al*. (2015: 371) stated that the differences in language between patients and practitioners was a barrier to effective and equitable healthcare. Meuter *et al*. (2015: 371) further stressed that miscommunication in the healthcare sector could be life-threatening for patients due to the fact that when patients cannot communicate in their own language with trained health professionals they rely on medically inexperienced bilingual relatives or non-medical staff for help which compromises the quality of care and worsens health outcomes.

4.2.5 NUMBER OF YEARS IN PRACTICE

The researcher noted that izinyanga had been in practice for a greater number of years on average than the homoeopaths (Table 4.1). The total number of years in practice for the izinyanga ranged from six to thirty years while for homoeopaths the total number of years in practice ranged from six to twenty years. These results

implied that izinyanga started practice at a younger age than Homoeopaths. A study by Semenya and Potgieter (2014) found that both male and female traditional healers started their traditional healing profession in their early teenage years. Koning (1998) explained that within the community of traditional healers, indigenous knowledge of medicinal plant utilisation was transferred from parents to children within a family. Cheikhyoussef *et al*. (2010) found that 48% of male traditional medical practitioners became healers through the mentoring of another healer. The above literature shows that izinyanga begin practising at an early age due to indigenous knowledge of medicinal plant utilisation being passed down, which therefore contributes to their number of years in practice.

4.2.6 DEMOGRAPHIC PROFILES

Table 4.1: Demographic profile

Pseudonym	Sex	Participant number (≠)	Years of Practice	Total number of participants
Sample 1 Homoeopathic Practitioners(**H**)	Females(H≠-F)	1 3 4 5 6	18 20 6 6 15	6
	Males (H≠-M)	2	6	
Sample 2 Izinyanga THPs **(I)**	Females (I≠-F)	6	20	6
	Males (I≠-M)	1 2 3 4 5	15 25 20 6 30	

4.3 INTERVIEW GUIDE

To help guide the interviews the researcher employed an interview guide that consisted of seven questions around the topic under study. These open-ended questions allowed the research participants to fully express their knowledge, views, understanding as well as experience of treating acne vulgaris. Below is a detailed presentation of the research questions.

4.2.7 INTERVIEW GUIDE FOR THE SEMI-STRUCTURED INTERVIEWS

1. How does your medical system understand the concept of health and disease?
2. Based on the above understanding, how is acne vulgaris understood by your medical system?
3. Describe how you diagnose acne vulgaris.
4. Describe how you differentiate acne vulgaris from other skin conditions.
5. What does your treatment of acne vulgaris entail?
6. How do you manage this condition apart from medication prescribed?
7. What in your view are the limitations to treating acne vulgaris as a chronic condition?

4.2.8 THE PROCESS ON ANALYZING THE RESEARCH INTERVIEWS

The researcher analysed the interview transcripts based on the qualitative framework analysis method. Bryman and Burgess (2002) posited that there were two main approaches to qualitative data analysis that could be found in texts. Firstly, a discussion of the main general frameworks then, secondly, provision of the main emphasis of qualitative data analysis. They continued to say that these two approaches could be further be described as general strategies and general processes. Srivastava and Thomson (2009) stated that in framework analysis, data is sifted, charted and sorted in accordance with key issues and themes using five steps: familiarisation, identifying a thematic framework, indexing, charting, mapping and interpretation.

4.2.9 DATA ANALYSIS AND FINDINGS

This section focused on analysing the findings which were derived from the data. The presented themes were derived from the responses of participants who took part in the in-depth semi-structured interviews. The researcher gave the excerpts codes according to the participant's demographic profile, e.g. (H1-F) means Homoeopath 1-Female and (I1-M) means Inyanga 1-Male. The themes, subthemes and subsequent categories that were derived from analysing the interviews are listed below in Table 4.2.

4.3 THEMES DERIVED FROM THE IN–DEPTH INTERVIEWS

Table 4.2: Themes derived from the in-depth interviews

Theme	Sub-theme	Category
1. Concept of health and disease	❖ What is health	- State of equilibrium - Harmony - Mental, emotional and physical well being - Homoeostasis
	❖ What is disease	- Deviation from health - Imbalance - Illness
	❖ Cause of disease	- Foreign invasions in the body - Miasm
2.Conceptual understanding of acne vulgaris	❖ Knowledge of acne vulgaris	- Outer expression of inner pathology - Isichitho - Sycotic miasm - Observation, presentation and age
	❖ Differentiation from other disease	
	❖ Diagnosis of acne vulgaris	- Physical exam, medical history, ukuhlola
3. Treatment of acne vulgaris	❖ Methods used to treat the patient	- Constitutional remedies, similimum, organ remedies, uMuthi, steaming, vomiting.
	❖ Side effects	- Skin aggravation, depigmentation
	❖ Duration of treatment	- Dependant on the immunity and susceptibility of the patient together with their responsiveness to the prescribed medication.
4.Naturopathic management of acne vulgaris	❖ Counselling	- Building self-esteem reducing stress
	❖ Diet/lifestyle	- Food, eating plan, Exercise
	❖ Detox	- Organ remedies, lymphatic drainage, liver detox and Ukuchatha.
5. Barriers to treatment of acne vulgaris	❖ Patient compliance ❖ Prolonged duration ❖ Witchcraft	- Not following instructions - Discouraged patients - Witch doctors, jealousy

All the participants who were selected for the study had experience with treating patients with acne vulgaris. They all had a basic understanding of what health and

disease were together with what leads to the development of acne vulgaris. Both sets of health practitioners could critically identify what caused acne vulgaris and how this chronic condition could be differentiated from other diseases, diagnosed and successfully treated. During the explanation of their treatment regime of acne vulgaris it emerged that both medical systems applied complementary therapies in addition to their medical treatment. Lastly both health practitioners identified barriers that caused obstacles to cure when treating patients with acne vulgaris. These concepts around the conceptual understanding of acne vulgaris as a chronic disease together with its management protocol formed the sub-themes which guided the mapping of the data derived from the interviews.

4.3.1 `THEME 1- CONCEPT OF HEALTH AND DISEASE

4.3.1.1 Sub theme 1: What is health?

The distinction between health and disease was initially articulated in 1948 by the WHO. According to the WHO (1948) and Locker (1997), health can be defined as an individual's subjective experience of his or her functional, social and psychological well-being on a mental, physical and emotional sphere. From the responses derived from the interviews, both health professionals understand health and disease differently. However, both of them shared the common understanding that health was a state of balance on a mental, emotional and physical planes. Disease is therefore an imbalance between these three spheres. Homoeopaths explained health as overall wellbeing or a state of homoeostasis, where an organism has a balance on a mental, emotional and physical plane. Similarly, traditional healers explained health as a state of balance on a mental, physical and spiritual plane. Sample 2 further added that God and their ancestors were responsible for guiding health therefore it was imperative for a person to have a good relationship with God and their ancestors in order to be healthy. The following excerpts illustrate this:

<u>Sample 1</u>

> *Health is an overall wellbeing not only on the physical aspect but also on the mental and emotional aspects of an individual and its degrees thereafter … the internal vital*

force which is a spirit-like energy within an organism is responsible to maintain health. (H6-F)

Health is more than taking away physical symptoms, it is treating the organism as a whole where the organism looks better outwardly and inwardly simultaneously and resides in a state of peace and harmony. (H3-F)

Health is a state of homoeostasis where the internal vital force which is a spirit-like energy within an individual is in harmony with the external environment. This vital force is made up of three parts which include the mind, body and soul. All these three parts within an individual need to be in the same frequency or alignment with each other in order to establish a state of health. (H4-F)

Sample 2

Health is when a person is in a state of balance on a mental, physical and spiritual aspect. In the African culture we believe that God and our ancestors are responsible for guiding health therefore it is important for a person to have a good relationship with God and their ancestors in order to be healthy. (I2-M)

For me health is when a person is free from disease and is able to function effectively on a mental, emotional and physical sphere. God and our ancestors protect us from harm and evil, therefore it is important that one has a relationship with both of them in order to be protected and free from disease. (I4-M)

Health is when the mind, body and the spirit are balanced and function collectively as a unit. God and our ancestors are responsible for protecting us, so we constantly have to pray in order to be healthy and free from disease. (I6-F)

The majority of the homoeopaths explained health as overall wellbeing or a state of homoeostasis, where there is a complete balance on all three levels (mental, emotional and physical) within an organism. They also believed that a spirit-like energy called the internal vital force is responsible for maintaining homoeostasis. Correspondingly, izinyanga defined health as a state of balance within a mental, physical and spiritual sphere. Furthermore, they added that God and ancestors play a major role in guiding health. According to them, God and their ancestors were responsible for protecting them from external forces that disrupt health.

Furthermore, the WHO (1948) noted that health is not merely the absence of disease or infirmity, but is rather a state of complete physical, mental and social well-being. Bircher (2005: 335) concurred by stating that health is a dynamic state of wellbeing that is characterised by physical, mental and social potential, which gratifies the needs of an individual commensurate with age, personal responsibility and culture. Carel (2007) argued that rather than focusing on the normal functioning of the body as a biological unit, health should be understood phenomenologically as the experience of being at home in one's lived body. The above excerpts reveal that homoeopaths identified the internal vital force as a state of homoeostasis and a key factor that maintains health. Star (2002) defined homoeostasis as a state of equilibrium or balance in the body with respect to various functions of tissues, fluids and processes through which such bodily equilibrium is maintained. In aphorism 9 of the Organon of Medicine Hahnemann (as cited by Kunzli, Naude and Pendleton 1983) defined the vital force as a spirit-like energy that animates the material human organism and also maintains the sensations and activities of all parts of the living organism in harmony or a state of equilibrium.

White (2015: 7) wrote that the term health for traditional practitioners is associated with mental, physical, spiritual, and emotional stability, and that good health for traditional healers is understood in terms of the relationship with one's ancestors. Iroegbu (2005: 78) explained that health amongst Africans was not based merely on how it affected the living but also the deceased. This was because they have a deep belief in the interaction between the spiritual (ancestral world) and the physical/natural world.

4.3.1.2 Sub theme 2: What is disease?

Star (2002) wrote that disease is a state of imbalance that results from external factors that affect the whole body. While defining the term 'disease' the term 'illness' was also used by the majority of the research participants, suggesting that there is a relationship between these two terms. In explaining what 'disease' is, the majority of homoeopaths and izinyanga stated that disease is a deviation from the normal state of health. They further highlighted that this deviation results when the internal vital force moves from a position of homoeostasis to a state of imbalance. According

to them, this imbalance thereafter reveals itself through mental, physical and emotional symptoms collectively termed as ‘dis-ease’. The following excerpts convey the perceptions of the participants:

Sample 1

> *I view disease or rather illness as an inner weakness, or disposition within an organism that affects the organism on all three spheres causing a certain susceptibility to injury which is collectively termed as disease.* (H1-F)
>
> *Disease for me can be defined as an illness or an imbalance of the internal and the external constitution of an individual. This imbalance is caused by the derangement of the spirit-like energy (vital force) within an individual by an exciting cause which thereafter expresses itself on a mental, emotional and physical sphere as visible symptoms.* (H2-M)
>
> *Disease is disruption of the normal functioning of the human body. In this state of illness, the human body can no longer fight off external influences due to an inner weakness or injury within the mental, emotion and physical sphere.* (H5-F)

Sample 2

> *Within an organism lies a spirit essence or energy that controls the normal functioning of that organism. This spirit or energy maintains the body in a state of equilibrium, where the mind, body and soul function collectively as a unit. However, when this spirit or energy is injured, damaged or interrupted by any external influence this causes an imbalance between the mind, body and soul which we term as disease or illness.* (I3-M)
>
> *Disease is anything that causes a weakness within a previously healthy individual.* (I4-M)
>
> *A disease is an illness that causes a person discomfort or pain on a mental, emotional or physical sphere.* (I6-F)

The information gathered revealed that homoeopaths viewed disease as a state of imbalance within an organism that was caused by the disturbance of the vital force which expressed itself outwardly on a mental, emotional and physical sphere as visible symptoms. Hahnemann, as cited by O’Reilly (1997), and Swayne (2000), described the vital force as the spirit-like life force that balanced the material

organism and kept the body in a state of equilibrium. Similarly, Izinyanga stated that within a healthy organism there was a spirit essence that controlled the normal functioning of the body thus maintaining equilibrium. The above knowledge obtained from both samples showed that disease was considered by them to be a disturbance of the state of equilibrium. Additionally, the vital force was identified as the spirit-like energy that controlled the state of equilibrium within a healthy organism. Furthermore, while defining disease the phrase 'illness' was used by both types of practitioner, pointing out that they both perceived that there was a relationship between disease and illness. Helman (1981) wrote that disease and illness are terms employed by medical practitioners and patients to describe the various types of ill-health. An article by Tikkinen *et al.* (2012) posited that disease and illness were related concepts that transpired interchangeably. Tikkinen *et al*. (2012) explained that patients suffer from 'illnesses' and doctors diagnose and treat 'disease', further inferring that illnesses are regarded as experiences of imbalances or abnormalities in the functioning of the normal state of homoeostasis that are perceived by the affected individual, and disease is the combination of the signs and symptoms associated with this illness.

4.3.1.3 Sub theme 3: Causes of disease

Both the homoeopaths and the izinyanga maintained that disease could be caused by a number of factors such as foreign materials, pathogens, genetic disposition, diet/lifestyle, lack of nutrition, emotional stress, physical trauma or injury and lastly socioeconomic status. They both further mentioned that these factors disrupted the normal functioning of the body and caused disease. The following excerpts illustrate this:

Sample 1

> *Disease can be caused by anything that has the ability to successfully invade the organism and change their normal state of functioning.* (H2-F)

> *For me disease is caused by a dominant miasm or an inner weak disposition that is inherited in one's family bloodline. This miasm remains dominant or stagnant while the body is in a state of equilibrium or homoeostasis. However, when an external influence such as a foreign organism invades the human body this dominant miasm*

is expressed outwardly either on a mental, emotional or physical sphere in the affected individual. (H5-F)

When it comes to disease many factors come into play such as microbes, genetic disposition, lifestyle(diet), socioeconomic status (malnutrition, poor sanitation, drinking water from the river), wars, pharmaceutical drugs (adverse effects) that disrupt the normal state of homoeostasis. (H2-M)

Sample 2

Disease is caused by harmful toxins or substances that interfere with the body's natural defence mechanism leading to mental, emotional and physical disturbances in an otherwise healthy organism. (I4-M)

From an African view point disease can be defined as a state of illness which can be caused by a number of factors which include: diet, lack of nutrition, emotional stress, trauma or injury etc … majority of African people especially those who reside in rural areas believe that disease is a manmade disease that is created via witchcraft that manifests itself outwardly through visible signs and symptoms on a mental, emotional and physical sphere. (I6-F)

Disease can be caused by a number of things, so it is particularly hard to name the specific causes of disease. What these factors all have in common is that they all invade the body's natural defence mechanism causing weakness within the affected individual … this weakness is thereafter expressed outwardly via symptoms. (I2-M)

When mentioning the causes of disease Sample 1 and Sample 2 had different explanations regarding what they believed to be the cause of disease. However, despite the different explanations both samples expressed the same fundamental understanding that disease is caused by foreign materials, substances or pathogens that invade the body and cause a certain weakness or disposition within an organism on a mental, emotional and physical sphere. The Australian Institute of Health and Welfare (2015) together with the WHO (2009) stated that due to the rising demand for healthcare worldwide, it was imperative that society and users of healthcare systems understand the causes and risk factors behind diseases, so that they can actively take part in available cost-effective prevention and treatment programmes thereby decreasing the number of people affected by disease

4.3.2 THEME 2- CONCEPTUAL UNDERSTANDING OF ACNE VULGARIS

4.3.2.1 Sub theme 1: Knowledge of acne vulgaris

Smithard, Glazebrook and Williams (2001) wrote that despite acne vulgaris being a distressing condition that affects a majority of the adolescent population, its pathogenesis is poorly understood. In order to gain the conceptual understanding of what acne vulgaris is the practitioners were asked what they understood about acne vulgaris. The following excerpts convey their responses:

Sample 1

> *Acne vulgaris on its own is not a disease but is rather an outer expression of an internal pathological disturbance, hormonal imbalance or sycotic suppression within an individual that is expressed outwardly on the face, neck and upper back as inflamed pustules or papules.* (H6-F)
>
> *Acne vulgaris is a disorder that is caused by a long-standing suppression of the sycotic miasm that expresses itself outwardly via visible signs and symptoms.* (H2-M)
>
> *Acne vulgaris is not just about the physical symptoms that the patient presents with as this disorder has a deeper cause which could include stress, lymphatic toxicity and hormonal imbalances which is mostly seen in women.* (H4-F)
>
> *As far as Homoeopathy is concerned anything that is produced on the skin is a form of eliminating excess dirt that has overloaded the system. The kidney and the liver are the main organs that are largely involved in the excretion process of the body, when these systems fail to do their job the body tries to get rid of this waste through other means. This could be through the skin in the form of acne. Implying that acne vulgaris is an external expression of inward waste that needs to be expelled outwardly.* (H3-F)

Sample 2

> *Acne vulgaris is understood as Isichitho. Isichitho is a curse break up spell that attacks and affects the face, neck and upper back. This disease is placed in an individual by witch doctors with the aim of ruining the face of the affected individual. (I5-M)*

Acne vulgaris is a skin disease that can be caused either by the changing hormones during puberty or it can be caused by witch doctors with the aim of ruining your skin and image in society. The form of acne vulgaris that is caused by witch doctors is referred to as 'isichitho'. The word isichitho means to remove from an area. By placing this skin disease in a person witch doctors or the person responsible for placing it in the affected individual does so with the aim of removing or separating them from their spouse or simply to ruin their face due to jealousy. (I1-M)

Acne vulgaris is a skin disease isichitho that is caused by witch doctors with the intention of running one's face, so they will not be likeable by others. These witch doctors place uMuthi on the ground where the target individual usually passes. Once they step over the uMuthi, this uMuthi runs along their blood stream and forms eggs on the inside that over time cause scattered dark marks on the skin together with pus filled comedones. (I2-M)

There are two forms of acne vulgaris, one that is caused by hormonal imbalances during puberty and another that is caused by witchdoctors which we term 'isichitho'. In my practice I mostly deal with patients that have isichitho. This form of acne vulgaris is placed by witchdoctors with the aim of ruining one's face and image in society. (I4-M)

The information gathered from both samples revealed that both practitioners understood acne vulgaris in the same way. Homoeopaths described acne vulgaris as an outer expression of an inner underlying pathology that presented itself outwardly via visible signs and symptoms. Suppression of the sycotic miasm together with hormonal imbalances were the two main underlying pathologies that were believed to cause acne vulgaris. A miasm in homoeopathy is understood as a certain predisposition or defect that can be inherited by one generation from another (De Schepper 2001). Degroote (2010) wrote that the sycotic miasm (commonly referred to as the miasm of excess), is a whole energetic disturbance which has its origin in inherited gonorrhoea: the inheritance could have been passed down generations ago. Louch (2012) suggested that acne vulgaris was a hormonally driven condition that affected the pilosebaceous glands.

A study by Szabo and Kemeny (2011) on the genetic predisposition in the pathogenesis of acne vulgaris identified hormonal imbalance as a key contributory

factor in the pathogenesis of acne vulgaris. Similarly, izinyanga held that acne vulgaris was *isichitho* that was placed by witch doctors or jealous individuals with the intention of ruining one's face or for the purpose of separating a couple. White (2015: 7) explained that traditional healers understand disease to be caused by attacks from evil or bad spirits. The responses from both practitioners showed that acne vulgaris on its own is not a disease but rather is an outer expression of an inner cause that displays itself outwardly via visible signs and symptoms.

4.3.2.2 Sub theme 2: Differentiation from other disease

When differentiating acne vulgaris from other diseases both the homoeopaths and the izinyanga highlighted that they distinguished acne vulgaris from other diseases through observation, presenting lesions and the age of the affected individual. The following extracts illustrate this:

Sample 1

> *I think the best way that one can successfully differentiate acne vulgaris from other forms of acne is through presentation of the skin lesions, what you physically see on the face, neck or upper back of the patient … as well as the age of the affected individual.* (H4-F)

> *I usually observe the type of lesions that the patient presents with on their face, neck and back together with the distribution of these lesions. The age of the affected individual is also important when distinguishing acne vulgaris.* (H3-F)

> *I think the only way one can differentiate acne vulgaris form other diseases is through its presentation and history in the patient … so presentation of acne will look different to eczema or psoriasis. And the location and distribution of the skin lesions.* (H6-F)

> *Acne vulgaris has its own distinct features and distribution. If one wants to differentiate acne vulgaris from other skin diseases, one must look at the presentation of the skin lesions, the distribution of these lesions together with the age of the affected individual as this disorder mostly affects adolescents.* (H2-M)

Sample 2

> *Differentiating acne vulgaris from other skin diseases can only be done by looking at the physical presentation of the visible lesions, the distribution of these lesions as well as examining the kind of substance within the comedones and pustules of the affected individual.'* (I1-M)
>
> *I differentiate acne vulgaris from other skin diseases through observation of the lesions, their distribution and the type of lesion present.* (I2-M)
>
> *It is quite simple to set acne vulgaris part from other diseases as it has its own unique lesions which include comedones and papules which are often pus filled and the distribution is usually spread around the face, neck and upper back.* (I4-M)
>
> *By looking at the type of skin lesions present together with the distribution of these skin lesions one can clearly differentiate acne vulgaris from other skin diseases. (*I6-F)

Both the homoeopaths and izinyanga held the same idea that acne vulgaris could be distinguished from other diseases through careful observations where they looked at the presenting symptoms together with the visible skin lesions. They both further noted that the age of the affected individual helped to clarify if the person had the disease or not. This was based on the understanding that acne vulgaris is a disorder that mainly affects adolescent during the beginning of puberty. Plewig and Kligman (2000b) elucidated that acne vulgaris flourishes in adolescent during the beginning of puberty and usually clears off towards the threshold of early adulthood, which supports the statements made by both sets of practitioners.

4.3.2.3 Sub theme 3: Diagnosis of acne vulgaris

From the extracts that were derived from the interviews, the researcher noted that the homoeopaths and the izinyanga employed different methods to diagnose their patients. The homoeopaths explained that they diagnosed acne vulgaris based on physical examination and past medical history medical history of the patient, while the izinyanga said that they used *ukuhlola* which is the use of ancestral powers to diagnose patients; they consult their ancestors who then inform them regarding what is wrong with the patient. The following excerpts illustrate this:

Sample 1

Diagnosis is obviously on physical exam where we look at the pustules and comedones. Also, we take the patient's past medical history into account, so that would be how long they have had the skin lesions, when the acne was triggered and if they have experienced it before. (H1-F)

Acne vulgaris can be diagnosed mainly on its appearance through physical exams. (H3-F)

Firstly, I look at the clinical picture, where I inspect the skin for papules, nodules and comedones. Then I also take into account their previous medical history and medication.' (H5-F)

I diagnose acne vulgaris based on the skin presentation also looking at the duration of the lesions that is how long they have been there together with the presence of scarring. (H6-F)

Sample 2

When a patient comes to me for help the patient does not tell me what is wrong with them, instead I consult with my ancestors (ukuhlola) where they reveal to me what is wrong with the patient, then I inform the patient what is wrong with them. The patient thereafter confirms their diagnosis if it was accurate or not. (I1-M)

The moment a patient walks into my practice my ancestors prophetically reveal to me what is wrong with the patient. It is therefore my duty as an herbalist to tell the patient what is wrong with them. (I2-M)

As an herbalist I consult my ancestors through ukuhlola where they reveal to me what is wrong with the patient, I diagnose my patient thereafter based on what has been revealed to me by the ancestors. (I3-M)

We as herbalists do not diagnose patients on own by relying purely on our ancestors who are the ones that gave us the healing gift to reveal to us what is wrong with the patient through ukuhlola. (I4-M)

I throw the bones then my ancestors reveal to me what is wrong with the patient. I tell the patient what is wrong with them, then I allow them to reveal to me if the diagnosis I stated was accurate or not. (I6-F)

From the information gathered from the interviews homoeopaths and izinyanga utilised different methods to diagnose acne vulgaris. Homoeopaths used physical examinations together with the patient's previous medical history to diagnose their patients while izinyanga utilised *ukuhlola*. According to Africa Shaman Experience (2015), *ukuhlola* is a traditional method of reading what is wrong with the patient. White (2015: 4) explained that *ukuhlola* is to consult the 'spirit world' in order to identify the cause of the disease or to discover whether there has been a violation of an established order from the side of the sick person. Similarly, homoeopaths believe that disease is caused by a disturbance and/or incapacity of the vital force (which is spirit like). Africa Shaman Experience (2015) highlighted that *ukuhlola* involves different methods whereby the practitioners consult their ancestors through throwing bones or praying over water. This enables them to channel the message of what the disease is to their patients. White (2015: 3) added that *ukuhlola* is an integral part of an African traditional way of diagnosing diseases. He further stated that this process is the first step towards successfully treating a patient.

4.3.3 THEME 3- TREATMENT OF ACNE VULGARIS

Benner and Sammons (2013) stated that acne vulgaris is the most common disease that physicians are presented with. This theme looked at the treatment protocol for acne vulgaris that was offered by homoeopaths and izinyanga. The following subthemes elaborate on the treatment of acne vulgaris by the participants.

4.3.3.1 Sub theme 1: Method used to treat the patient

The homoeopaths emphasised that in order to treat their patients they first take a detailed case where they consider the patient as whole or constitutionally on the mental, emotional and physical planes. Thereafter, they proceed to prescribe either the constitutional or a similimum remedy. A constitutional remedy is based on a patient's mental, emotional and the physical symptoms together with their medical and family history. It also looks at how an individual reacts to life and their surroundings (Greensmith 2018). The similimum is a remedy suited for the case and covers the totality of the presenting symptoms. The word itself is the superlative of simile – that which is similar and compared to another. Based on the principle that "Like cures Like" finding the best remedy for the case should be as easy as finding

the rubrics and giving the remedy that covers the totality of symptoms (Resonance School of Homoeopathy Forum 2008). The approach used by the izinyanga was very similar to that employed by the homoeopaths. The majority of the izinyanga explained that they use various herbs and natural elements (often referred to as *uMuthi*) to treat their patients. The selection of these herbs differed for each patient as the *isichitho* presented itself differently in each patient. In addition to that they utilised steaming and induced emesis (*ukuphalaza*). The following excerpts confirm this:

Sample 1

> *In order to treat the patient, I first take the patient's case through the process of case taking where I consider the patient as a whole on a mental, emotional and physical aspect. I thereafter find the similimum remedy that best fits the patient in all three levels … considering that acne vulgaris can be caused by pathologies in other organs e.g. liver problems, I often prescribe organ support remedies together with the indicated similimum.* (H1-F)
>
> *Since acne vulgaris on its own is not a disease but is rather a symptom of a deeper cause, I treat my patients on a mental, emotional and physical level after careful case taking. Then I give them the similimum that fits them perfectly on all three mentioned levels.* (H2-M)
>
> *I treat patients based on constitutional case taking where I look at the totality of their symptoms on a mental, emotional and physical sphere then I prescribe the constitutional remedy of the patient that fits them on all three levels.* (H3-F)
>
> *I personally believe that the constitutional treatment of the patient will go a long way in treating the patient successfully in the long term. Treating the patient constitutionally means firstly taking the case of the patient than treating them on a mental, emotional and physical level than prescribing the indicating constitutional remedy of the patient … in some cases though I do give patients the similimum remedy when their constitutional remedy fails to act.* (H6-F)

Sample 2

> *To treat my patients, I combine different herbs (uMuthi) that are mixed together specifically for that patient. Isichito does not present itself in the same way in each*

person therefore each person is given treatment based on their presenting symptoms. These are always fresh indigenous plants, minerals or natural substances which I collect daily in open fields which is their natural habitat. The patient is than required to boil these mixture of herbs (uMuthi) in an open pot for several hours. After that the patient than steams with this mixture for 20 minutes then they drink and vomit up this mixture (ukuphalaza). This process needs to be done daily for one week, in the morning and in the evening. (I1-M)

There are specific herbs that I used to treat acne vulgaris. These herbs often referred to as 'uMuthi, the selection of these herbs differs for each patient. These herbs are indigenous and are taken freshly from their various natural habitats. The patient is required to steam with this uMuthi for five days in the morning and evening. Also, the patient has to drink and regurgitate (ukuphalaza) this uMuthi for the full five days. (I2-M)

When I have diagnosed a patient with acne vulgaris I combine various herbs that I know have the ability to restore their skin and then I place this mixture (uMuthi) in boiling water. The patient then in my presence steams with this mixture for 20 minutes and then drinks and vomit it up (ukuphalaza). This process is then repeated by the patient in the morning and evening for four days. (I4-M)

I treat patients using uMuthi which they steam with and vomit for a period of four days. (I5-M)

The only way to treat acne vulgaris is through steaming and vomiting for one week during the morning and the evening. (I6-F)

The researcher noted that despite the therapeutic regimes being different, both the types of health practitioners used similar principles to treat their patients. Homoeopaths stated that case taking was the first step in treating a patient. During the process of case taking they looked at the patient as a whole on a mental, emotional and physical level and thereafter, treat them constitutionally or prescribed the correctly indicated similimum remedy. Dubey (2016) wrote that the art of case taking provides an excellent foundation for homoeopathic prescription, allowing a precise similimum to be prescribed. Finding the constitutional remedy together with the indicated similimum remedy through careful case taking is the best way for homoeopaths to treat patients with acne vulgaris. The prescribed remedy will be

different for each patient as each patient is treated individually based on their presenting symptoms.

Izinyanga said that they used *uMuthi* to treat their patients. This *uMuthi* consists of several African herbs and minerals that have the ability to act upon the level of the *Isichitho* in order to successfully remove it from the inside where it was placed. In line with the principle of individualisation employed by homoeopaths, the *uMuthi* prescribed by izinyanga differs for each patient as each patient is given their own unique mixture based on their presenting symptoms. This *uMuthi* was usually boiled in an uncovered pot and then streamed with and vomited via induced emesis for a certain period during the morning and the evening. The above stated prescription method appeared to be similar to that employed by homoeopaths i.e. individualised. This is unlike allopathic medicine that uses the same treatment protocol for each patient.

4.3.3.2 Sub theme 2: Side effects

Both the homoeopaths and the izinyanga explained that a large number of their patients experienced a temporary aggravation of their symptoms in the initial stages of beginning treatment for acne vulgaris. In addition to this izinyanga added that some of their patients experienced skin hyperpigmentation while taking the prescribed treatment, although this soon faded after a few weeks. The following extracts illustrate this:

Sample 1

> *The only side effect that my patients have experienced while taking the treatment for acne vulgaris is a minor aggravation of their skin impurities. This aggravation only took place during the first few weeks of taking the remedy, after that this never occurred again*. (H2-M)

> *I have noticed that patients experience a temporary aggravation of their symptoms after taking the indicated remedy for acne vulgaris. This aggravation is a good sign for us as homoeopaths as it indicates the remedy is acting upon the level of the deranged vital force.* (H3-F)

Aggravation of the skin lesions after the initial stages of taking the treatment is the side effect that most patients often experience. (H4-F)

It is quite rare to experience any side effects using homoeopathic remedies as they are safe to use, however a patient might experience a minor aggravation of their skin symptoms during the initial stages of treatment. (H5-F)

Sample 2

During the treatment of acne vulgaris a patient is required to steam their face. For some steaming causes their skin to become darker or hyperpigmented due to the steam. Others experience severe acne. (I1-M)

Some patients experience hyperpigmentation together with skin aggravation while taking the treatment, but these symptoms fade with the course of continuing the treatment. (I3-M)

It is not likely for patients to experience side effects while taking the treatment, but a few may have hyperpigmentation due to being burnt by the steam during steaming. (I5-M)

According to homoeopaths and the izinyanga patients experience a temporary aggravation of their symptoms during the initial stages of taking the treatment for acne vulgaris. The homoeopaths maintained that this aggravation (homoeopathic aggravation), was an indication that the remedy was working. Das (2016) wrote that when the similimum (the most appropriate remedy that is suitable for the patient) is initially given to the patient there is a temporary intensification of the symptoms. This aggravation he explained was usually mild and lasted only for a short period. In aphorism 158 of the Organon of Medicine Hahnemann (as cited by Kunzli, Naude and Pendleton 1983) stated that a homoeopathic aggravation that may be experienced after the administration of the remedy is merely the reaction of the organism as it responds to the gently stimulating action of the remedy.

Izinyanga further mentioned that the majority of their patients experienced skin hyperpigmentation while taking the prescribed treatment. This they believed to be caused by heat exposure during steaming. Palmer (2018) noted that excessive steaming increases skin redness as well as inflammation which further aggravates the skin. Davis and Callender (2010) wrote that post-inflammatory

hyperpigmentation is an acquired hypermelanosis that occurs after cutaneous inflammation or injury of the skin, with this hyperpigmentation more frequently affecting patients with darker skin than Caucasian skin. Bhate and Williams (2012) found that post inflammatory hyperpigmentation was a common finding in darker skin types. This they attributed to the presence of polymorphonuclear cell infiltrates which were directly caused by the inflammatory process. However, izinyanga explained that this hyperpigmentation faded soon after patients completed their treatment.

4.3.3.3 Sub theme 3: Duration of treatment

Both the homoeopaths and the izinyanga expressed that it was hard for them to state the duration of treatment for acne vulgaris as patients did not all respond in the same way to the treatment. They both agreed that for some patients took a month to fully recover while for others it took several months, depending on the strength of the patient's internal vital force together with their responsiveness to the treatment. The following excerpts affirm this:

Sample 1

> *It is hard to state how long the duration for treating acne vulgaris is because results differ with each patient. For some the duration might be a few weeks while for others it might be a few months … so I can simply say that the duration of treatment depends on how strong one's immune system is together with their internal vital force.* (H2-M)

> *The duration of treatment for acne vulgaris varies based on the responsiveness of the patient.* (H3-F)

> *The duration for acne vulgaris can be a month, or several months. This all depends on how strong a patient is and how their bodies and immune system responds to the treatment.* (H5-F)

> *For some individuals the duration might be a month while for others months to a year, all depending on the patient's responsiveness to the prescribed treatment.* (H6-F)

Sample 2

> *Patients are all unique individuals with different genetic make-up together with different immunity strengths. The duration of treatment for this reason differs for each patient.* (I2-M)
>
> *Because of various immunities the duration of treatment differs for each patient.* (I3M)
>
> *Patients do not all respond in the same way to the treatment so the duration it takes for complete healing to take place differs from one patient to another.* (I5-M)
>
> *Although there is a set period of how long the patient should take the treatment, there is no set or fixed duration of how long the healing process will be as patients respond differently to the treatment.* (I6-F)

The presented information showed that the period of treating of acne vulgaris varied amongst individuals. For some it took a month while for others the duration lasted for several months to years. This all depended on the strength of the patient's vital force together with their overall immunity. Homoeopathy Plus (2019) explained that the vital force was an energy that enabled all living things to self-heal or to preserve life by adapting to environmental changes. In the case of the human body, the vital force directs the different body systems to function as a harmonious whole. However, the manner in which the vital force functions in each organism differs due to individualised genetic makeup. Janssen and Osnas (2005: 93) wrote that the function of the immune system is to maintain the health of the body by protecting it from invasions by harmful pathogens such as bacteria, viruses, fungi, and parasites. Furthermore, immune systems vary among organisms based on their environmental dispositions and overall state of health. The above literature supported the idea that people differ as individuals due to their vital force and immunity therefore the period of healing will differ from one individual to the next.

4.3.4 THEME 4- NATUROPATHIC MANAGEMENT OF ACNE VULGARIS

4.3.4.1 Sub theme 1: Counselling

The homoeopaths stressed that in addition to the medicinal prescription patients with acne vulgaris needed counselling. This they attributed to the fact that acne

vulgaris affected one's self-esteem greatly and subsequently caused insecurities together with emotional disorders, particularly in the young adolescent. The izinyanga did not mention counselling in their responses which implied that only the homoeopaths used it in their treatment regime. The following information derived from the interviews confirms this:

Sample 1

> *Mentally acne vulgaris has a far greater impact than any other type of skin condition given the young age that it affects adolescents … therefore counselling is necessary to build up their self-esteem as well as to help them cope with their skin ailments.* (H1-F)
>
> *Acne vulgaris affects patients greatly both mentally and emotionally. This is particularly true for adolescents who at the time are trying to build their self-esteem together with their self- confidence. Therefore, in addition to the medicinal treatment I advise my patients to go for counselling in conjunction to the treatment. (H2-M)*
>
> *In addition to giving the medicinal prescription for acne vulgaris patients I often advise patients to go for counselling as most patients especially adolescents feel insecure and struggle with insecurities due to the presence of impurities on their skin.* (H5-F)
>
> *The society we live in has a huge impact on how people feel or respond to situations. Patients with acne vulgaris often feel dirty, ugly and imperfect due the social media portraying that in order to be beautiful one needs to have clear skin. Affected individuals as a subsequent consequence suffer from depression due to their skin ailments, which further aggravates their skin severely. I therefore advise counselling in conjunction to the prescribed medication.* (H6-F)

The information gathered from the homoeopaths showed that in addition to the prescribed medication, patient's with acne vulgaris required counselling. This nonmedicinal or naturopathic form of treatment is necessary to deal with the mental as well as the emotional symptoms that were directly associated with acne vulgaris. Suva *et al*. (2014) explained that although acne vulgaris was not a life-threatening disease it had severe mental, emotional, social and psychological effects in affected patients. Tan (2004) wrote that in adolescence acne vulgaris can be associated with developmental issues of body image, sexuality and lastly socialisation. Hosthota,

Bondade and Basavaraja (2016: 124) explained that psychological impact of acne was determined by various factors such as age, sex, personality, grade of disease, scarring, and environmental and ethnic background. Previous studies on the psychosocial impact of acne vulgaris among adolescents has documented dissatisfaction with appearance, embarrassment, self-consciousness, and lack of self-confidence in acne patients (Tan 2004). Williams, Dellavalle and Garner (2012) stressed that health care providers should evaluate patients with acne vulgaris for loss of self-esteem, lack of confidence, and symptoms of depression including suicidal thoughts. Thereafter, patients should be given information about support groups and counselling sessions to prevent detrimental outcomes such as suicide.

4.3.4.2 Sub theme 2: Diet/lifestyle

Both the homoeopaths and the izinyanga mentioned that diet and lifestyle played a great role in managing acne vulgaris. According to them the food that patients ate together with their everyday lifestyle contributed to the pathogenesis of this disorder.

Oily foods together with junk food combined with a lack of physical activity were identified as a hindrance to successfully managing patients. The following excerpts affirm this:

Sample 1

> *Diet plays a huge role in managing acne vulgaris. Acne vulgaris is most commonly caused excess oil production by the sebaceous gland, consuming foods rich in oil and starch can further aggravate the skin. Exercise can also help as when one sweats pores on the skin of the face are opened which helps to clear the skin lesions or impurities.* (H2-M)

> *Lifestyle changes for example an eating plan where one minimises the amount of sugar they take helps to clear the skin of acne patients. The bacteria which causes acne vulgaris feeds on sugar. Eating a lot of sugar therefore further aggravates the skin.* (H4-F)

> *The diet and lifestyle of the patient play a huge role when managing acne vulgaris.* (H5-F)

Diet plays a major role in managing acne vulgaris. Patients who tend to eat healthy foods which contain less oil, starch and sugar tend to recover quicker compared to those that consume junk food. (H6-F)

Sample 2

The food that patient's eat affects acne vulgaris. Foods rich in sugar, oil and starch aggravates further aggravates the skin. Therefore, I advise my patients to eat healthier foods in conjunction to the prescribed treatment. (I1-M)

As traditional healers we do not have a face cream that a patient with acne vulgaris can apply. In additional to the uMuthi I advise patients to get a face product that contains less oil, also I advise patients to exercise and to add for healthier foods in their everyday diet. (I5-M)

In addition to giving my patients uMuthi I advise them to eat healthy food. (I6-F)

The majority of the homoeopaths together with most of the izinyanga mentioned that the diet and the everyday lifestyle of the patient played a significant role in managing acne vulgaris. According to them the type of food a patient ate either acted as a curing agent or a contributing factor to the pathogenesis of the disease. Foods such as oil, starch and sugar were identified as main contributors. Akawi, Nemr, Razzak and Aboosi (2006) posited that, acne vulgaris like other skin diseases might be predisposed by the nutritional status of the patient. They added that the consumption of a diet that was rich in saturated fats and unsaturated acids but low in polyunsaturated fatty acids further aggravated this skin disease. Louch (2012) noted that the association between diet and acne vulgaris could no longer be dismissed due to compelling evidence that showed that high glycaemic (sugar) diets exacerbated and worsened acne. This was a result of insulin metabolism in the human body. Cordain (2005: 88) continued to explain that diet was a well-known modulator of the systemic inflammatory response. He further highlighted that the relative intake of polyunsaturated fatty acids found in oil and starch were one of the most important dietary factors that initiated inflammation which intensified acne vulgaris. Logan (2003: 941) observed that oils (e.g. industrial seed oils such as sunflower, canola and soft margarine spreads) that are high in pro-inflammatory

omega 6 fatty acids as well as other chemical artefacts of the production process induce the pathogenesis of acne vulgaris.

4.3.4.3 Sub theme 3: Detoxification

The homoeopaths and the izinyanga declared that detoxing or the elimination of toxic waste was a useful method of managing acne vulgaris in conjunction with the prescribed medication. The following excerpts explain this:

Sample 1

> *In addition to the constitutional remedy I give patients organ remedies together with lymphatic drainage remedies that help to assist in clearing any toxic waste or substances that might be within the patient suffering from acne vulgaris … organ remedies are particularly important in cleaning the liver, as dysfunctions in the liver aggravate acne vulgaris.* (H1-F)
>
> *The liver performs the important role of excreting waste products together with harmful toxins from the body. Therefore, to help patients further manage acne vulgaris I recommend organs support remedies together with liver detox.* (H2-M)
>
> *In conjunction to the prescribed treatment I recommend lymphatic drainage, liver detox together with homoeopathic adjuncts.* (H5-F)
>
> *Applying organ remedies to support the liver and the kidneys is a method I use to naturally manage acne vulgaris.* (H6-F)

Sample 2

> *Besides the previously mentioned treatment I advise to detox themselves at home through Ukuchatha. Ukuchatha is a traditional way of administering medicines through the anal canal.* (I1-M)
>
> *To help get rid of excess waste within the individual I recommend Ukuchatha to my patient.* (I3-M)
>
> *Acne vulgaris is further aggravated by the presence of toxins and waste within the body. I therefore advise my patients to detox themselves via Ukuchatha in conjunction to the prescribed treatment.* (I4-M)

Detoxing was mentioned by both practitioners as a useful method of maintaining acne vulgaris apart from the prescribed medication. The Farlex Dictionary (2019) explains that detoxification is amongst the most widely used treatments and concepts in alternative medicine. This process is based on the principle that illnesses can be caused by the accumulation of toxic waste (toxins) in the body. Eliminating existing toxins and avoiding new toxins was therefore an essential part of the healing process for patients suffering from chronic diseases and conditions such as acne vulgaris. Homoeopaths shared that they used organ (particularly liver) support remedies together with lymphatic drainage remedies to help detox their patients while izinyanga mentioned that they employed *ukuchatha*. *Ukuchatha* involves the insertion of a combination of mixed herbs into the rectum and colon with the aim of emptying the bowel of harmful toxins and waste materials. This is done to clean the system and purify the blood as a aid to clearing the skin. This process of *ukuchatha* is closely related to enemas. Sissons (2019) clarified that an enema involves the insertion of liquid or gas into the rectum with the aim of emptying the bowels in order to administer medication or to allow for an examination. She further posited that an enema can be effective in treating certain medical conditions.

4.3.5 THEME 5- BARRIERS TO TREATMENT OF ACNE VULGARIS

Rathi (2011: 56) mentioned that there are various topical and systemic drugs that are available to treat acne vulgaris. Both the homoeopaths and the izinyanga stated that despite the numerous available therapies for treating acne vulgaris they faced challenges or limitations when treating their patients. The following sub-themes elucidate their responses in greater detail:

4.3.5.1 Sub theme 1: Patient compliance

Both the homoeopaths and the izinyanga noted patient compliance as being the main barrier to treating acne vulgaris as a chronic skin disease. According to them, patients do not follow the correctly explained instructions on how they should take their prescribed medication. Furthermore, they highlighted that as a result of patient noncompliance patients tended to experience severe acne post treatment. The following excerpts elucidate this:

Sample 1

While taking the prescribed medication patients tend to use other medications simultaneously, this ends up being a barrier to treatment as patients do not take the prescribed medication correctly and adverse effects result from the combination of these medications leading to more severe forms of acne vulgaris. (H1-F)

Patients especially adolescents want to get better now and expect to see results immediately, many of them have a habit of taking the medication incorrectly outside of the prescribed manner which later becomes harmful to them as their acne becomes worse leading to secondary acne and scarring. (H3-F)

In addition to not following the instructions on how to administer their medication, patients don't comply to the lifestyle changes that are required to successfully treat acne vulgaris. Acne vulgaris is one disease that requires a change in lifestyle, especially diet as diet contributes a large percentage in the pathogenesis of this disease. (H4-F)

Patients want to see instant results now but fail to comply with the instructions on how they should take their medication which in turn prolongs the healing process. (H6-F)

Sample 2

It is particularly hard to treat patients who suffer from acne vulgaris as most of them do not follow the instructions on how they should take the indicated medication. For example, I tell patients to steam twice a day for four days using a certain medication however patients only steam once a day and they are not consistent in following the instructions. Majority of the patients that I treat come from poor and disadvantaged areas and cannot afford any other form of treatment, implying that we as Izinyanga are their source of primary health care that is why it is imperative that they follow the given instructions on how to administer their medication. (I3-M)

Most patients tend to be impatient which leads to them not following the correct instructions on how they should take their medication. After two weeks of not seeing any results patients with acne vulgaris tend to stop using the prescribed medication causing severe acne post treatment. Majority of the patients that I treat come from rural areas and cannot afford dermatological services therefore it is important for them to take the medication correctly to avoid any side effects. (I4-M)

Patients do not follow the instructions correctly on how they should administer the prescribed medication which leads to the treatment not working effectively even though it was the correct medication. (I5-M)

The responses from both the homoeopaths and the izinyanga revealed that patient compliance was a major barrier to the treatment of acne vulgaris. Both health professionals stated that a significant number of patients failed to administer their medication correctly, and as a result the duration of treatment was prolonged. Baldwin (2006: 224) stated that since Hippocrates' (Godfather of medicine) time, non-compliance has been recognised as a barrier to effective therapy. Jay (2014) stated that that non-compliance by patients has become a major issue in the world. Jin *et al*. (2008: 269-286) observed that non-compliance was directly associated with poor treatment outcomes. The WHO (2003) further estimated that in developed countries such as Africa only 50% of the patients suffering from chronic diseases follow the recommendations given as part of treatment. The above literature is in line with the responses of the participants that patient compliance was a hindrance to successful treatment. In order to improve compliance, it is recommended that health practitioners provide their patients with counselling on the correct administration methods and how to accurately take their medication.

4.3.5.2 Sub theme 2: Prolonged duration

Participants highlighted that the prolonged duration of treating acne vulgaris was a barrier to successful treatment. According to the participants most patients were discouraged during the treatment period, therefore many of them combine various therapies instead of only using the prescribed treatment. The following excerpts illustrate this:

<u>Sample 1</u>

Treatment of acne vulgaris is a long-term process that takes time to successfully cure due to the fact that the patient has to be treated as a whole on all three levels. The problem with this prolonged duration is that patients are impatient and tend to use multiple therapies which further hinders their healing. (H6-F)

Acne vulgaris is one of those diseases that cannot be cured overnight as many factors come into play to contribute to its pathogenesis. This prolonged duration is

however a barrier to treatment as many patients often get discouraged during the treatment period. (H2-M)

Acne vulgaris really plays havoc on adolescents and their self-esteem. Patients therefore have increased pressure to get rid of their acne quickly however due to the prolonged duration of acne vulgaris this does not necessarily happen. (H3-F)

The problem of acne vulgaris being a chronic condition is that it has a prolonged duration that is often lengthened by complications such as scarring and emotional mayhem. (H1-F)

Sample 2

Acne vulgaris is a chronic disease or disorder therefore it takes a long time to completely heal. For us as practitioners this is a bad thing because patients are impatient and want to see results immediately. (I2-M)

Due to the prolonged duration of acne vulgaris some patients do not stick with the treatment protocol and often stop the treatment before it has completely worked. (I4-M)

It takes quite some time to treat acne vulgaris which is a hindrance to both me and the affected individuals. (I6-F)

The homoeopaths and izinyanga stressed that the prolonged duration of acne vulgaris was a hindrance to the successful treatment of this disease. According to them patients got discouraged during the treatment period and as a subsequent result of impatience the majority of the patients combine different therapies to the prescribed medication which aggravates the existing skin lesions and further delays the duration of the treatment. Gollnick, Finlay and Shear (2008: 279) wrote that acne vulgaris is a chronic disease that continuously changes its distribution and severity, and that the treatment period for this disease varies among individuals.

Sub theme 3: Witchcraft

The word witchcraft was mentioned several times by the izinyanga. According to them witchcraft is a great barrier to treating acne vulgaris. They further mentioned that as soon as their patients recovered from their skin aliments a small number of them relapsed and experienced severe acne several weeks later due to *abathakathi*

(witch doctors) who placed the disease back in them. However, with the aid of *ukugcaba,* these patients were later cured from this disease. The homoeopaths did not mention witchcraft in their responses which implied that they did not view it as a barrier to successful treatment. The information presented in the following excerpts below demonstrates this:

Sample 2

> *One of the challenges that we have when curing acne vulgaris patients is witchcraft done by abathakathi. What happens is a patient comes to me with the disease and I give them the correct medication. After the patient has taken the medication the person who initially caused the disease in them sees them and tries to put the very same disease back again in them. To prevent the patients from getting the disease I usually gcaba [cutting with a razor then applying TM], to protect the patient from any forms of witchcraft.* (I1-M)

> *A number of patients came to me with severe acne vulgaris after taking the treatment. What seemed to happen was when the skin of the patients was clearing the person who initially caused the disease in them placed uMuthi in their yard at home. When the person passed through this uMuthi the uMuthi passed through their bloodstream and caused a severe form of the disease. However, these patients were later successfully cured when I identified what was causing this aggravation in my patients.* (I2-M)

> *Witchcraft used by abathakathi is one barrier that I face when treating acne vulgaris patients. Women tend to be jealous of other women, when a woman who suffers from the disease comes to me I give her the treatment for the disease however along the course of treatment other women become jealous and try to ruin her face that is now clearing up. My job as an Inyanga is to successfully heal my patient to make sure no form of witchcraft affects her.* (I4-M)

> *Witchcraft is a problem that I have experienced while treating patients with acne vulgaris. This is done by abathakathi with the aim of ruining the face of the affected individual.* (I5-M)

Izinyanga mentioned the word ‘witchcraft’ several times throughout the interviews. Witchcraft was further emphasised as a major barrier to successfully treating patients with acne vulgaris. Izinyanga revealed that a large number of their patients

relapsed after completion of treatment. This they reasoned was caused by the influence of *abathakathi* (witch doctors) who placed the disease back in the individuals once their skin ailments disappeared. Middleton and Winter (2009: 1) explained that witchcraft is a mystical and innate power, that was employed by witch doctors to harm other people. Doke (1990) stated that umthakathi is person who practises witchcraft; witch, wizard or warlock. Furthermore, the word *umthakathi* also means izinyanga, very skilful person, or the emerging teeth during teething. Parle and Scorgie (2012: 852) wrote that for more than a century, witchcraft, particularly related to young women and their skin, has been reported in south-eastern Africa, especially in the province of KZN. This bewitchment is supposedly caused by the use of love medicines or evil spells that aims to harm or hinder their progress. This literature, in line with the responses of the participants, shows the impact of witchcraft. Izinyanga stated that they had to *gcaba* their patients to protect them from external stimuluses. Doke (2001) explained that the word *ukugcaba* means to cut small incisions in the skin for tribal, ornamental, or medicinal purposes, using a razor to make the incisions.

4.4 CONCLUSION

This chapter presented the themes and subsequent sub-themes (Table 4.2), that emerged from the semi-structured interviews. Thereafter, the obtained information was discussed in greater detail in the form of excerpts (section 4.3). The following chapter presents the conclusion and recommendations for future research.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The aim of this study was to determine the conceptual understanding as well as the management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN. The collected research data was presented in Chapter 4 as five main themes and fourteen sub-themes which emerged from the in-depth semi-structured interviews. The discussion below summarises the overall findings derived from the themes presented in Chapter 4. This chapter concludes with recommendations, conclusions, limitations and propositions for future research.

5.2 DISCUSSION

From the data collected from the semi-structured interviews, five main themes emerged. The themes were as follows:

- Concept of health and disease.
- Conceptual understanding of acne vulgaris.
- Treatment of acne vulgaris.
- Naturopathic management of acne vulgaris.
- Barriers to treatment of acne vulgaris.

In addition to the to the five main themes, fourteen sub-themes were generated from the results. These were as follows:

- What is health?
- What is disease?
- Cause of disease.
- Knowledge of acne vulgaris.
- Differentiation from other diseases.
- Diagnosis of acne vulgaris.
- Methods used to treat the patient.
- Side effects.
- Duration of treatment.
- Counselling.
- Diet/lifestyle.
- Detoxification

- Patient compliance.
- Prolonged duration.
- Witchcraft.

5.3 CONCLUSION

The purpose of this study was to investigate as well as to compare the conceptual understanding and management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN. Open ended semi-structured interviews were conducted with six homoeopaths and six izinyanga who were registered with their respective councils and had been in practice from more than five years. This implied that both health professions had knowledge of and experience with treating acne vulgaris. The data collected from the study revealed acne vulgaris was understood in similar ways by both the professionals in question. Both the homoeopaths and the izinyanga believed that acne vulgaris on its own is not a disease but is rather an outer expression of an inner underlying pathology that presents itself outwardly via visible signs and symptoms. The homoeopaths expressed that suppression of the sycotic miasm together with hormonal imbalances were the two main underlying pathologies that played a key role in causing acne vulgaris. They diagnosed patients through physical examinations together with the past medical history of the patient. Lastly the homoeopaths highlighted that they treated their patients as unique individuals through detailed case takings, constitutional and similimum remedies.

Likewise, the izinyanga held that acne vulgaris was *isichitho* that was placed by *abathakathi* (witch doctors) or jealous individuals with the intention of ruining their face or for the purpose of separating a couple. They diagnosed their patients through *ukuhlola* which involves them consulting their ancestors who in turn inform them what was wrong with the patient. The treatment for acne vulgaris provided by the izinyanga in this study consisted of *uMuthi*, *ukuphalaza*, *ukugquma* and *ukugcaba*. Each patient was given this *uMuthi* based on their presenting symptoms. The treatment regime for both sets of practitioners appeared to be comparable as in both medical systems treatment for each patient was prescribed based on the totality of their presenting symptoms or individualisation. Additionally, both the homoeopaths and the izinyanga differentiated this condition from other chronic

diseases through observations, presenting lesions and the age of the affected individual. Both participants mentioned that non-medicinal supplementary therapies such as diet, counselling and detoxification were necessary for acne vulgaris patients. Lastly, they both noted that there were barriers to treating acne vulgaris such as prolonged duration of treatment and noncompliance by patients.

From the above it is evident that the conceptual understanding of acne vulgaris together and its management by the homoeopaths and izinyanga who participated in this study is very similar. However, there are a few minor differences that exist between these two professions, related to counselling and witchcraft. The substantial similarities that exist between these two health systems indicates that these two professions could work collaboratively by referring their patients to each other when one system fails to successfully treat a patient. Therefore, a co-operative framework of practice is suggested for these groups of health practitioners where they can work together to manage acne vulgaris patients. Furthermore, awareness regarding the treatment methods offered by homoeopaths and izinyanga should be raised within the healthcare system as little research has been published in terms of their conceptual understanding and the management of acne vulgaris.

5.4 THE IMPACT OF ANDERSEN'S BEHAVIOURAL MODEL OF HEALTH SERVICES AND ACCESS TO CARE ON DEALING WITH ACNE VULGARIS

According to Andersen's behavioural model of health services and access to care (1995), people's use of health services is a result of their beliefs, socio-economic status, environment and their need for care. According to the study, izinyanga explained that most of their patients were from rural areas and shared the cultural belief that acne vulgaris was a form of witchcraft (*isichitho*) that was placed in them by jealous *abathakathi* (witch doctors) with the aim of ruining their skin. Middleton and Winter (2009: 1) explained that witchcraft is a mystical and innate power that is employed by witch doctors to harm other people. Izinyanga further emphasised that witchcraft is a major barrier to successfully treating patients with acne vulgaris. Izinyanga revealed that a large number of their patients relapsed after completion of treatment. This they ascribed to the influence of *abathakathi* (witch doctors) who placed the disease back in the individuals once their skin ailments disappeared.

However, this study could not establish what influenced patients to consult Homoeopaths.

Furthermore, Andersen's theory states that socio economic status is a factor influencing access to health care. The izinyanga in this study were mostly located in rural areas, and they noted that the majority of their patients were from rural areas and could not afford dermatological services. Most of the homoeopaths in this study were located in urban areas with only a few of them residing in rural areas. Hence one can conclude that socio economic status influences the choice of which health practitioner to consult.

The literature review found that that majority of the adolescent population suffers from acne vulgaris. Alharithy (2011) stated that acne vulgaris is the most common disturbing skin disease that affects the majority of the adolescent population worldwide. The KwaZulu-Natal Provincial Government (2016) wrote that the province of KZN has the second largest population in South Africa, with roughly 11.07 million people. Zulu *et al*. (2017) noted that in this province acne vulgaris had been documented as the second most common skin disorder that affected the adolescent population at large. This is in line with Andersen's model which states that people's use of health services is a result of their need for care. In this study care was understood as being the therapeutic treatment of the face, neck and back with the aim of preserving one's self-esteem and self-confidence. The majority of the adolescent population in KZN require skin care for their acne vulgaris. The homoeopaths further stressed that although acne vulgaris is not a life-threatening disease it has severe mental, emotional, social and psychological effects in affected adolescents which emphasises their need for skin care, this being in line with Andersen's model.

The WHO (2002) posited that majority of the population in rural KZN were dependent on TM and CAM as a source of primary health care. The rationale for the high usage of TM and CAM as opposed to dermatological services in KZN can be attributed to several factors including: access, affordability, cultural views of the disease, and traditional healing methods. This in line with Andersen's behavioural model of health services and access to care and explains why the majority of the

population in KZN consult homoeopaths and izinyanga for the treatment of acne vulgaris rather than other medical practitioners (Zulu *et al*. 2017).

5.5 RECOMMENDATIONS

Based on the findings of this study the following recommendations can be made:

1) The sample group of the homoeopaths and the izinyanga in the study was not a reflection of the entire population of homoeopaths and izinyanga within the area of KZN or within South Africa as a whole. Future studies should include a larger sample group as well as incorporate other areas which have reported a high usage of homoeopaths and izinyanga such as Cape Town, Johannesburg, Kwahlabalingane, Dundee, Newcastle and Limpopo.
2) The researcher noted that there were more female than male homoeopaths in the study. Future studies should look at why there is no gender balance amongst practising homoeopaths. The same is true for izinyanga as more male izinyanga took part in the study compared to females.

5.6 LIMITATIONS

This study compared the conceptual understanding and management of acne vulgaris amongst registered homoeopaths and izinyanga in KZN. Despite achieving the aims and objectives of the study, there were certain limitations, which were as follows:

1) The sample of the study consisted of only 12 participants.
2) The study was limited to the province of KZN.
3) The inclusion criteria of the study only included registered practitioners who had been in practice for more than five years.

5.7 FURTHER RESEARCH

The study noted that socio economic income together with the environment of an individual influences the type of health practitioner consulted. Future research should look at the role that these two factors play in determining the physician of choice for healthcare purposes.

REFERENCES

Andersen, R. M. 1995. Revisiting the Behavioral model and access to medical care: does it matter. *Journal of Health and Social Behaviour*, 36: 1-10.

Aboobaker, J. B. 2012. Skin disorders in primary health care in KZN: testing for solutions after assessment of burden of disease, and evaluation of resources. MD University of KwaZulu-Natal. Available: https://researchspace.ukzn.ac.za (Accessed 7March 2019).

Clark, R and Adler, E. S. and 2008. *How it's done: an invitation to social research*. London: Thomson Wadsworth.

Adom, D. Hussein, E. K. and Agyem, A. J. 2018. Theoretical and conceptual framework: mandatory ingredients of a quality research. *International Journal of Scientific Research*, 7(1): 438-439.

Africa Shaman Experience. 2015. Consulting a sangoma – reading, divination and ancestral spirits (online). Available: www.africashamanexperience.com (Accessed 15 May 2019).

Akawi, Z. Nemr, A. L. Razzak, A. and Aboosi, M. 2006. Factors believed by Jordanian acne patients to affect their acne condition. EMHJ - *Eastern Mediterranean Health Journal*, 12 (6), 840-846.

Alharithy. R. 2011. Adolescent's acne: scarring inside out. *Journal of the Saudi Society of Dermatology & Dermatologic Surgery,*15(2): 43-46.

Allayali, A. Z., Alhunaki, R. N., Algoblan, F. S., Al Nodali, N. I. and Asseri, B. N. a2017. Assessment of prevalence, knowledge, attitude, and psychosocial impact of acne vulgaris among medical students in Saudi Arabia. *Journal of Clinical & Experimental Dermatology Research,* 5(4): 2155-9554.

Ally, S. 2013. The efficacy of a Homoeopathic complex (Kalium Bromatum 9CH, Natrum Muriaticum 9CH, Selenium 9CH, Sulphur 9CH and Thuja Occidentalis 9CH (online). M. Tech, Durban University of Technology. Available: http://ir.dut.ac.za/handle/10321/167 (Accessed 12 March 2018).

American Skin Association. 2012. Acne. Available: www.americanskin.org. (Accessed 14 April 2019).

Ancient Origins. 2013. Traditional African Medicine and its role in healing in a modern world. Available: https://www.ancient-origins.net. (Accessed 9 March 2019).

Ash, C., Harrison, A., Drew, S. and Whittall, R. 2015. A randomised controlled study for the treatment of acne vulgaris using high intensity 414nm solid state diode arrays. *Journal of Cosmetic and Laser Therapy,* 17(4): 1-15.

Astalin, P. R. 2013. Qualitative research designs: a conceptual framework. *International Journal of Social Science & Interdisciplinary Research*, 2(1): 118-119.

Australian Institute of Health and Welfare. 2015. Risk factors to health. Available: http://www.aihw.gov.au/risk-factors. (Accessed 18 May 2019).

Baldwin, H. E. 2006. Tricks for improving compliance with acne therapy. *Dermatological Therapy,* 19(4): 224-236.

Banu, A. and Humnekar, A. 2011. A prospective study to determine the effectiveness of Clindamycin (Allopathy), Berberis Aquifolium (Oregon Grape Homoeopathy) and Azadirachta Indica (Neem-Ayurvedic) medications against the microorganism causing acne vulgaris. *International Journal of Basic Medical Sciences*, 2(2): 78-79.

Barnes, P. M. and Bloom, B. 2008. *Complementary and Alternative Medicine use among adults and children: United States, 2007*. National Health Statistics Reports, Number 12. Hyattsville, MD: National Centre for Health Statistics.

Barnes, E.L., Levender, M.M., Fleischer, A.B. and Feldman, R. 2012. Quality of life Measures for Acne patients. *Dermatologic Clinics,* 30: 293-300.

Bellew, S. Thiboutot, D. and Del Rosso, J. Q. 2011. Pathogenesis of acne vulgaris: what's new, what's interesting and what may be clinically relevant. *Journal of Drugs in Dermatology*, 10(6): 582-585..

Benner, N. and Sammons, D. 2013. Overview of the treatment of acne vulgaris.

Osteopathic Family Physician, 5(5): 185-190.
Bhate, K. and Williams, H. C. 2012. Epidemiology of acne vulgaris. *British Journal of Dermatology*, 168(3): 478-485.

Bhatia, A., Maisonneuve, J. F. and Persing, D. H. 2004. *Propionibacterium acnes* and chronic diseases. The infectious etiology of chronic diseases: defining the relationship, enhancing the research, and mitigating the effects: workshop summary. In: Knobler, S. L., O'Connor, S., Lemon, S. M., et al., eds. *Institute of Medicine (US) Forum on Microbial Threats*. Washington (DC): National Academies Press (US); 2004.

Bircher, J. 2005. Towards a dynamic definition of health and disease. *Medicine, Health Care and Philosophy,* 8(3): 335-341.

Bloor, M and Wood, F. 2006. Keywords in Qualitative Methods: A Vocabulary of Research Concepts. Sage Publications.

Brajac, I., Zulle, B. L., Loncarek, K. and Gruber, F. 2004. Acne vulgaris: myths and misconceptions amongst patients and family physicians. *Patient Education and Counselling,* 55(1) 21-25.

Bereda, J. E. 2002. Traditional healing as a health care delivery system in a transcultural society. M.A. University of South Africa.

Brink, H., van der Walt, C. and van Rensburg, G. 2012. *Fundamentals of research methodology for health care professionals*. 3rd ed. Cape Town: Juta.

Brotherhood of Blessed Gérard. 2016. Traditional healers in Zululand (online). Available: http://bbg.org.za/tradheal.htm. (Accessed 23 April 2019).

Bryman, A. and Burgess, R. G. 2002. *Analyzing qualitative data*. New York, NY: Routledge.

Carel, H., 2007. Can I be ill and happy? *Philosophia*. 35: 95-110.

Carusillo, C. 2019. The history of acne: Modern phenomenon or a centuries old curse? https://www.manrepeller.com/2016/11/history-of-acne.html (Accessed 7 February 2019).

Caulfield, T, and DeBow, S. 2005 A systematic review of how homoeopathy is represented in conventional and CAM peer reviewed journals. *BMC Complementary and Alternative Medicine,* 5: 12.

Centre for Innovation in Research and Teaching. 2018. Ethical considerations. Available: https://cirt.gcu.edu/research/developmentresources/tutorials/ethics (Accessed 16 April 2019).

Cheikhyoussef, A., Shapi, M., Matengu, K. and Ashekele, H. 2010. Ethnobotanical study of indigenous knowledge on medicinal plant use by traditional healers in Oshikoto region, Namibia. *Journal of Ethnobiology and Ethnomedicine*, 7: 10.

Cherry, K. 2018. *Sample types and errors in research*. Available: https://www.verywellmind.com/what-is-a-sample-2795877 (Accessed 26 March 2019).

Clark, C. 2009. Acne causes, and clinical features. *Clinical Pharmacist*, 1: 163-164.

Coan, L. 2005. *History of acne.* Available: http://www.articledashboard.com//2912672Coan. (Accessed 7 February 2019).

Cohen, D, and Crabtree, B. 2006. Qualitative research guidelines project. Available: http://www.qualres.org. (Accessed 16 April 2019).

Conco, W. Z. 1972. The African Bantu traditional practice of medicine: some preliminary observations. *Social Science & Medicine,* 6(3): 283-322.Cordain, L. 2005. Implications for the role of diet in acne vulgaris. *Seminars in Cutaneous Medicine and Surgey*, 24: 84-91.

Cordain, L., Lindeberg, S., Hurtado, M., Hill, K., Eaton, S. B. and Brand-Miller, J 2002. Acne vulgaris: a disease of Western civilization. *JAMA Dermatology*, 138(12): 1584-1590.

Couchman, K. 2011. A survey of the opinions and interventions of registered South African homoeopaths, regarding childhood vaccinations. M. Tech., Durban University of Technology. Available: www.dut.ac.za. (Accessed 25 April 2019).

Creswell, J. W. 2014. *Research design: qualitative, quantitative and mixed method approaches*. 4th ed. Thousand Oaks, CA: Sage.

Darwish, M. A. and Al-Rubaya, A. A. 2013. Knowledge, beliefs, and psychosocial effect of acne vulgaris among Saudi acne patients. *ISRN Dermatol* (online). http://dx.doi.org/10.1155/2013/929340

Das, E. 2016. Homoeopathic aggravation. National Health Portal, India. Available: https://www.nhp.gov.in/homeopathic-aggravation_mtl (Accessed 15 May 2019).

Davis, E. C. and Callender, V. 2010. Postinflammatory hyperpigmentation. *The Journal of Clinical and Aesthetic Dermatology,* 3(7): 20-31. Available: https://www.ncbi.nlm. (Accessed 12 April 2019).

Dawson, A. L. and Dellavalle, R. P. 2013. Acne vulgaris. *British Medical Journal*, 346: 26345.

Degitz, K., Placzek, M., Borelli, C and Plewig, G. 2007. Pathophysiology of acne. *Journal of the German Society of Dermatology*, 5(4): 316-323.

Degroote, F. 2010. Homoeopathic miasms and heredity: the genome and epigenome (online). Available: www.filipdegroote.be.com (Accessed 22 May 2019).

DeFranzo, S. E. 2011. What's the difference between qualitative and quantitative research. Available: https://www.snapsurveys.com/blog/qualitative-vs-quantitativeresearch/ (Accessed 27 March 2019).

De Schepper, L. 2001. *Hahnemann revisited. A textbook of classical homoeopathy for the professional*. New Delhi: B. Jain Publishers.

De Vaus, D. A. 2001. *Research design in social research*. London: Sage.

Devenish, A. 2005. Negotiating healing: understanding the dynamics amongst traditional healers in KZN as they engage with professionalisation. *Social Dynamics*, 31:(2): 243-284.

Dlova, C. N. 2014. Ethnic skin and hair disorders in KZN: A study of the spectrum of ethnic skin and hair disorders, and the composition and use of skin lightening preparations, traditional cosmetics and sunscreen. PhD, University of KwaZulu-

Natal. Durban, South Africa (online). Available: https://researchspace.ukzn.ac.za/xmlui/handle/10413/14185. (Accessed 5 March 2019).

Dlova, N. C., Mankahla, A., Madala, N., Grobler, A. Tsoka-Gwegweni, J., and Hift, R. J. 2014. The spectrum of skin diseases in a black population in Durban, KwaZulu-Natal, South Africa. *International Journal of Dermatology*, 54: 279-285.

Dlova, N. C., Chateau, A., Khoza, N. Skenjane, A., Mkhize, Z., Katibi, O. S., Grobler, A., Gwegwen, J. T. and Mosam, A. 2017. Prevalence of skin diseases treated at public referral hospitals in KwaZulu-Natal, South Africa. *British Journal of Dermatology,* 178(1) 1-2.

Doke, C. M., Malcom, D. M., Sikakana, J. M. A. and Vilakazi, B. W. 2001. *English isiZulu dictionary.* Johannesburg: Wits University Press

Dubey, S. 2016. *Method for arriving at similimum*. Available: https://www.homeobook.com/method-for-arriving-at-similimum/ (Accessed 15 May 2019).

Dudovskiy, J. 2018. The ultimate guide to writing a dissertation in business studies: a step-by-step assistance. Available: https://research-methodology.net/aboutus/ebook/ (Accessed 17 April 2019).

Education Centre. 2006. Sampling in research. The Hillingdon Hospital. Available: (Accessed 8 April 2019).

Ensink, K. and Robertson, B. 1999. Patient and family experiences of psychiatric services and African indigenous healers. Transcultural Psychiatry, 36(1): 23-43.

Ernst, E. 2002. A systematic review of systematic reviews of Homoeopathy. *British Journal of Clinical Pharmacology*, 54(6): 577-582.

Etikan, I., Musa, S. A and Alkassim, R. S. 2016. Comparison of Convenience Sampling and Purposive Sampling. American Journal of Theoretical and Applied Statistics, 5(1):1-4.

Explorable. 2019. Privacy in research–confidentiality. Available: https://explorable.com/privacy-in-research (Accessed 15 April 2019).

Fabbrocini, G., Annunziata, M. C., D'Arco, V., De Vita, V., Lodi, G., Mauriello, M. C., Pastore, F. and Monfrecola, G. 2010. Acne scars: pathogenesis, classification and treatment. *Dermatology Research and Practice*, (online). http://dx.doi.org/10.1155/2010/893080

Farlex Dictionary. 2019. Detoxification. Medical dictionary. Available: https://medical-dictionary.thefreedictionary.com. (Accessed 16 May 2019).

Fink, A. 2013. Conducting Research Literature Reviews, from the internet paper. 4th ed. California: SAGE.

Frankfort-Nachmias, C. and Nachmias, D. 2000. Research methods in the social sciences. 6th ed. New York, NY: Wadsworth

Gale, N. K., Heath, G., Cameron, E., Rashid, S. and Redwood, S. 2013. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13: 117.

Gallo, R. L., Granstein, R. D., Kang, S., Tan, J and Thiboutot, D. Standard classification and pathophysiology of rosacea: The 2017 update by the National Rosacea Society Expert Committee. Journal of the American Academy of Dermatology, 78(1): 148-155. Elsevier.

Ghodsi, S. Z., Orawa, H. and Zouboulis, C. 2009. Prevalence, severity, and severity risk factors of acne in high school pupils: a community-based study. *Journal of Investigative Dermatology*, 129(9): 2136-2141.

Given, L. 2012. Data Storage. *SAGE research methods*. Available: https://methods.sagepub.com. (Accessed 10 April 2019).

Glaser, B. G. and Strauss, A. L. 1997. *The discovery of grounded theory: strategies for qualitative research*. Piscataway, NJ: Transaction.

Gollnick, H. P., Finlay, A. Y. and Shear, N. 2008. Can we define acne as a chronic disease? If so, how and when? *Journal of Clinical Dermatology, 9(5): 279-298.* Available*:* https://www.ncbi.nlm.gov (Accessed 23 April 2019).

Gqaleni, N. Moodley, I. Kruger, H. Ntuli, A and McLeod, H. 2007. South African Health Review - Traditional and complementary medicine care delivery. Sabinet African Journals, 2007(1)175-188. Available: https://journals.co.za. (Accessed 24 April 2019).

Grant, R. N. 1951. Section of history of medicine: the history of acne. *Proceedings of the Royal Society of Medicine*, 44(8): 647-650

Grant, C. and Osanloo, A. 2014. Understanding, selecting and integrating a theoretical framework in dissertation research: creating the blueprint for your "house". *Administrative Issues Journal*, 4(2): 12-13.

Grech, I. 2014. Susceptibility profiles of *Propionibacterium acnes* isolated from patients with acne vulgaris. *Journal of Global Antimicrobial Resistance*, 2(1): 35-38.

Greensmith, M. 2018. What is a constitutional remedy. Available: https://marygreensmith.co.uk (Accessed 2 May 2019).

Grierson, D. S. and Afolayan, A. J. 1999. An ethnobotanical study of plants used for treatment of wounds in the Eastern Cape, South Africa. *Journal of Ethnopharmacology*, 67 (327-332).

Guba, E. G and Lincoln, Y. S. 1981. The Jossey-Bass higher and adult education series and the Jossey-Bass social and behavioral science series. Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches. San Francisco, CA, US: Jossey-Bass.

Harrell, M. C. and Bradley, M. A. 2009. Data collection methods: semi-structured interviews and focus groups. Available: https://www.rand.org/pubs/technical_reports/TR718.html. (Accessed 10 April 2019).

Hart, C. 2018. Doing a literature review: releasing the research imagination. 2nd ed. London: Sage.

Hassan, M. A. 2019. Research population. *Academia education*. Available: https://www.academia.edu.com. (Accessed 8 April 2019).

Hay, R. J., Johns, N. E., Williams, H. C., Bolliger, I. W., Dellavalle, R. P., Margolis, D. J., Marks, R., Naldi, L., Weinstock, M. A., Wulf, S. K., Michaud, C., Murray, C., and Naghavi, M.2014. The global burden of skin disease in 2010: an analysis of the prevalence and impact of skin conditions. *Journal of Investigative Dermatology*, 134: 1527-1534.

Healey, J. 2016. *Complementary and alternative medicine* (eBook). The Spinney Press Available: https://spinneypress.com.au/product/complementary-andalternative-medicine/# (Accessed 12 April 219).

Health24. 2017. Incidence of acne. Available: https://www.health24.com/Medical/Acne/Anatomy-of-acne/Incidence-of-Acne20120721. (Accessed 14 April 2019).

Helman, C. G. 1981. Disease versus illness in general practice. *Journal of the Royal College of General Practitioners* 32(230): 548-555.

Higginbottom, G. M. A. 2014. Sampling issues in qualitative research. *Nurse Researcher*, 12(1): 1-15.

Holland, D. B., Jeremy, A. H. T., Roberts, S. G., Seukeran, D. C., Layton, A. M. and Cunliffe, W. J. 2004. Inflammation in acne scarring: a comparison of the responses in lesions from patients prone and not prone to scar. *British Journal of Dermatology*, 150(1): 72–81.

Holloway, I. and Wheeler, S. 2010. *Qualitative research in nursing and healthcare.* 3rd ed. London: John Wiley & Sons Ltd.

Homoeopathic Association of South Africa. 2016. The official HSA booklet. Available: https://www.homeopathy.org.za/ (Accessed 9 February 2019).

Homoeopathy Plus. 2019. Tutorial 7: The vital force and what it means (online). Available: https://Homoeopathyplus.com (Accessed 2 May 2019).

Hosthota, A., Bondade, S. and Basavaraja, V. 2016. Impact of acne vulgaris on quality of life and self-esteem. *MD Edge Dermatology*, 98(2):121-124..

Hulick, K. 2016. Explainer: what is skin. Available: https://www.sciencenewsforstudents.org/article/explainer-what-skin (Accessed 5 March 2019).

Iroegbu, P. 2005, Healing insanity: skills and expert knowledge of Igbo healers. *African Development*, 30(3): 78-92.

InterQ Research. 2019. What are the primary goals of qualitative research. Available: https://interq-research.com/what-are-the-primary-goals-of-qualitativeresearch/ (Accessed 28 March 2019).

Jabareen, Y. 2009. Building a conceptual framework: philosophy, definitions, and procedure. *International Journal of Qualitative Methods,* 8(4), 49-62..

Jablonski, N. G. 2013. *Skin: a natural history*. Berkeley CA: University of California Press.

Jackson, R. L., Drummond, D. K. and Camara, S. R. 2007. What is qualitative research. *Qualitative Research Reports in Communication*, 8(1): 21-28.

Jahangir, E., Irazola, V. and Rubinstein, A. 2012. Need, enabling, predisposing, and Behavioral determinants of access to preventative care in Argentina: analysis of the national survey of risk factors (Online). Available: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0045053. (Accessed 14 February 2019).

Janssen, M., A and Osnas, E., E. 2005. Adaptive Capacity of Social-Ecological Systems: Lessons from Immune Systems. Eco Health, 2(2): 93-101.

Jay, N. 2014. Difference between adherence and compliance (online). Available: https://www.differencebetween.com/ (Accessed 17 May 2019).

Jin, J., Sklar, G. E., Oh, V. M. and Li, S. 2008. Factors affecting therapeutic compliance: a review from the patient's perspective. *Therapeutics and Clinical Risk Management,* 4(1): 269-286.

Kane, M. 2004. *Research made easy in complementary and alternative medicine*. Edinburgh: Churchill Livingstone.

Kale, R. 1995. South Africa's health: traditional healers in South Africa: a parallel health care system. *British Medical Journal*, 310: (6988): 1182-1185..

Katsambas, A. D. 1998. Why and when the treatment of acne fails. *Dermatology*, 196(1): 158-61.

Kaiser, K. 2009. Protecting Respondent Confidentiality in Qualitative Research. Qualitative Health Research, 19(11): 1632–1641. Sage Journals.

Kahn, M.S and Kelly, K. J. 2001. Cultural tensions in psychiatric nursing: managing the interface between western mental health care and Xhosa traditional healing in South Africa. Transcult Psychiatry,38: 35–50.

Koning, M. 1998. Biodiversity prospecting and the equitable remuneration of ethnobiological knowledge: reconciling industry and indigenous interests. *Intellectual Property Journal*, 11: 185-201.

Kumar, B., Pathak, R., Mary, B., Jha, D., Sardana, K. and Gautam, H. K. 2016. New insights into acne pathogenesis: exploring the role of acne-associated microbial populations. *Dermatologica Sinica,* 34(2): 67-73.

Kunzli, J., Naude, A. and Pendleton, P. 1983. *Samuel Hahnemann - The organon of medicine*. London. Victor Gollancz Ltd.

Kurokawa, I., Danby, F. W., Ju, Q., Wang, X. Xiang, L. F., Xia, L. Chen, W. Nagy, I., Picardo, M., Suh, D. H., Ganceviciene, R., Schagen, S., Tsatsou, F. and Zouboulis, C. C. 2009. New developments in our understanding of acne pathogenesis and treatment *Experimental Dermatology*, 15: 156-267.

Kvale, S. 2006. Dominance through interviews and dialogues. *Qualitative Inquiry*, 12(3): 480-500.

KwaZulu-Natal Provincial Government. 2016. Provincial growth and development strategy, 2035. Building a better future together (online). Available:

http://www.kznppc.gov.za/images/downloads/Reviewed%20Provincial%20Growth%20and%20Development%20Strategy.pdf. (Accessed on 21 May 2018).

Leedy, P. D and Ormrod, J. E. 2015. Practical research. Planning and design. 11th ed. Boston, MA: Pearson.

Lin, J., Puckree, J and Mvelase, P. T. 2002. Anti-diarrhoeal evaluation of some medicinal plants used by Zulu traditional healers. Journal of Ethnopharmacology, 79: 53-56

Lincoln, Y S. and Guba, E. G. 1985. *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Locker, D. 1997. Measuring oral health and quality of life. Proceedings of a conference held June 13-14, 1996, at the University of North Carolina-Chapel Hill, North Carolina. pp. 11-24.

Logan, A. C. 2003. Omega-3 fatty acids and acne. *JAMA Dermatology*, 139(7): 941942.

Louch, C. 2012. Natural treatment options for acne vulgaris. Available: http://www.positivehealth.com/article/herbal-medicine/natural-treatment-optionsfor-acne-vulgaris (Accessed 12 April 2019).

Lynn, D., Umari, T., Dunnick, A. C. and Dellavalle, P. R. 2016. The epidemiology of acne vulgaris in late adolescent. *Adolescent Health, Medicine and Therapeutics*, 7: 13-25.

Mabona, U. and Van Vuuren, S. F. 2013. Southern African medicinal plants used to treat skin diseases. *South African Journal of Botany*, 87(175-193).

Machi, L. A. and McEvoy, B. T. 2012. *The literature review; six steps to success*. 2nd ed. Thousand Oaks, CA: Sage

Mack, N., Woodsong, C., MacQueen, K. M. Guest, G., and Namey, E. 2005. Qualitative research methods: a data collector's field guide. Research Triangle Park, NC: Family Health International. Available:

https://www.fhi360.org/resource/qualitative-research-methods-data-collectorsfield-guide (Accessed 27 March 2019).

Mahto, A. 2017. Acne vulgaris. *Medicine*. 45(6): 386-389.

Malahlela, P. and Motswaledi, H. M. 2013. Management of mild to moderate acne vulgaris. *South African Family Practice*, 55(3): 241-244.

Maree, K and van der Westhuizen, C. 2009. Research Proposals in the Social Sciences. Juta and Company Ltd. Cape Town, South Africa.

Matic Society. 2018. Isichitho: modern women courting system. Blogger (online). Available: https://4maticsociety.blogspot.com (Accessed 2 May 2019).

Marshall, J. 1967. Skin Diseases in South Africa. *Archives of Dermatology,* 87: 419427. Available: https://jamanetwork.com/journals/jamadermatology/articleabstract/527937. (Accessed 23 April 2019).

Mavropoulos. J. C., Yancy, W. S, Hepburn, W. and Westman, C. 2005. The effects of a low-carbohydrate, ketogenic diet on the polycystic ovary syndrome: A pilot study. *Nutrition & Metabolism*, 2: 35.

Maxwell, J. A. 2005. Qualitative *research design: an interactive approach* 2nd ed. Thousand Oaks, CA: Sage.

Mayo Clinic. 2018. Acne. Available: https://www.mayoclinic.org/diseasesconditions/acne/symptoms-causes/syc-20368047 (Accessed 14 April 2019).

McGaghie, W. C., Bordage, G. and Shea, J. A. 2001. Problem statement, conceptual framework, and research question. *Academic medicine*. 76(9): 923-924. Available: https://www.scholars.northwestern.edu/en/publications/problemstatement-conceptual-framework-and-research-question. (Accessed 3 February 2019).

McDavid, G. M. 1994. Homoeopathic treatment of acne. M.Tech, Technikon-Natal. Available: http://ir.dut.ac.za/handle/10321/167 (Accessed 12 March 2017).

McNamara, 1999. General guidelines for conducting interviews. Available: http://managementhelp.org/businessresearch/ interviews.htm (Accessed 2 May 2019).

Mdima, S. V. 2011. A Field-Study of the use and understanding of Umqalothi (Strychnos Henningsii) by Traditional healers in KZN and its relationship to the Homoeopathic proving of the substance. Durban University of Technology. Available: openscholar.dut.ac.za/bitstream/10321/692/1/Mdima_2011. (Accessed 15 April 2019).

Melnik, B. C. 2018. Acne vulgaris: The metabolic syndrome of the pilosebaceous follicle. Clinics in Dermatology, 36(1): 29-40. Elsevier.

Meuter, R. F., Gallois, C., Segalowitz, N. S., Ryder, A. G. and Hocking J. 2015. Overcoming language barriers in healthcare: a protocol for investigating safe and effective communication when patients or clinicians use a second language. *BMC Services Research,* 15: 371.

Middleton, J. and Winter, E. H. 2009. *Witchcraft and sorcery in east Africa*. London: Routledge.

Mifflin, H. 2011. The American Heritage Science Dictionary (online). Available: https://www.dictionary.com. (Accessed 22 March 2019).

Miglani, A. and Manchanda, R. K. 2014. Observational study of *Arctium lappa* in the treatment of acne vulgaris. *Homoeopathy*, 103(3): 203-207.

Mitchell, M. L. and Jolley, J. 2012. *Research design explained*. 8th ed. Belmont, CA: Wadsworth.

Moeng, E. T. and Potgieter, M. J. 2011. The trade of medicinal plants by muthi shops and street vendors in the Limpopo Province, South Africa. *Journal of Medicinal Plants Research, 5*: 558-564.

Mosam, A., Vawda B. N., Gordhan, A. H., Nkwanyana, N. and Aboobaker, J. 2005. Quality of life issues for South Africans with acne vulgaris. *Clinical and Experimental Dermatology,* 30(1): 6-9.

Mugo, F. W. 2002. *Sampling in research*. Available: http://www.indiana.edu/~educy520/sec5982/week_2/mugo02sampling.pdf. (Accessed 26 March 2019).

Murphy, E. 1998. Qualitative research methods in health technology assessment: a review of the literature. *Health Technology Assessment*, 2 (16): 1-274.

Naoum, S. G. 2007. *Dissertation research and writing for construction students*. 2nd ed. Sydney: Elsevier Ltd.

Ndawonde, B. G. 2006. Medicinal plant sales: a case study in northern Zululand M.Sc., University of Zululand.

Newcomer, K. E., Hatry, H. P. and Wholey, J. S. 2015. *Handbook of practical program evaluation*. 4th ed. San Francisco, CA: Jossey-Bass.

Nguyen, R and Su, J. 2011. Treatment of acne vulgaris. Paediatrics and Child Health, 21(3): 119-125. Elsevier.

Nigatu, T. 2009. Qualitative data analysis (online). Slideshare.net. Available at: https://www.slideshare.net/tilahunigatu/qualitative-data-analysis-11895136 (Accessed 4 Apr. 2019).

Nkosi, P. B. 2017. A framework of co-operative practice between radiation oncologists and THP's in the management of patients with cancer in the KwaZulu-Natal province. D. Tech., Durban University of Technology. Available: http://ir.dut.ac.za/handle/10321/167 (Accessed 2 September 2018).

Northcentral University Library. 2019. *Researching theoretical frameworks* (online). Available: https://ncu.libguides.com/researchprocess/theoreticalframeworks (Accessed 17 March 2019).

Nzue, A. P. M. M. 2009. Use and conservation status of medicinal plants in the Cape Peninsula. M.Sc., University of Stellenbosch.

Oakley, A., Ngan, V., Writer, S. and Morrison, C. 2014. Comedonal acne. Available: https://www.dermnetnz.org/topics/comedonal-acne/ (Accessed 16 May 2019).

O'Reilly, W. B. 1997. *Organon of the medical art*. 6th ed. Washington: Birdcage Books.

Packer, M. 2011. *The science of qualitative research*. New York, NY: Cambridge University Press.

Palmer, A. 2018. What causes acne; top 3 factors that cause acne. https://www.verywellhealth.com/the-three-major-causes-of-acne-15503 (Accessed 14 April 2019).

Parle, J. and Scorgie, F. 2012. Bewitching Zulu women: umhayizo, gender, and witchcraft in KwaZulu-Natal. *South African Historical Journal,* 64:4, 852-875.

Patton, M. Q. and Cochran, M. 2002. A guide to using qualitative research methodology. Available: https://evaluation.msf.org/sites/evaluation/files/a_guide_to_using_qualitative_research_methodology.pdf (Accessed 17 March 2017).

Patton, M. Q. 2015. *Qualitative research and evaluation methods: integrating theory and practice*. 4th ed. Thousand Oaks, CA: Sage.

Peltzer. K. 2009. THPs in South Africa. *The Lancet*. 374(94): 956-957. Available: https://doi.org/10.1016/S0140-6736(09)61261-7

Plewig, G. and Kligman, A. M. 2000a. History of acne and rosacea. In: Plewig, G. and Kligman, A. M. *Acne and Rosacea*. 3rd ed. Berlin: Springer.

Plewig, G. and Kligman, A. M. 2000b. Acne Morphogenesis and Treatment. In: Plewig, G. and Kligman, A. M. *Acne and Rosacea*. 3rd ed. Berlin: Springer.

Poli, F., Auffret, N., Beylot, C., Chivot, M. and Faure, M. 2011. Acne as seen by adolescents: results of questionnaire study in 852 French individuals. *Acta Dermato-Venereologica*, 91: 531-536.

Potter, J. and Hepburn, A. 2005. Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology*, 2(4): 281-307

Prinsloo, J. P. 2010. History of homeopathic training in South Africa. Available: www.biocura.co.za (Accessed 5 March 2019.

Purdy, S. and de Berker, D. 2011. Acne vulgaris. *BMJ Clinical Evidence, 1714*.

Qu, Q. S and Dumay, J. 2011. The qualitative research interviews. *Qualitative Research in Accounting & Management,* 8(3): 238-264.

Rajasekar, S., Philominathan, P. and Chinnathambi, V. 2013. Research methodology. Available: https://arxiv.org/pdf/physics/0601009.pdf (Accessed 26 January 2019).

Rathi, S. K. 2011. Acne vulgaris treatment: the current scenario*. Indian Journal of Dermatology*, 2: 79-87.

Reid, A-M., Oosthuizen, C. B., Fibrich, B. D., Twilley, D., Lambrechts, I. A., de Canha, M. N., Rradenab, S and Lall, N. 2018. Traditional medicine: the ancient roots of modern practice. In: Lall, N. ed. *Medicinal plants for holistic health and well-being.* Cambridge, MA: Academic Press. pp 1-11.

Republic of South Africa. 2007. Traditional Health Practitioners Act, 22 of 2007.Pretoria: Government Printer.

Resonance School of Homoeopathy Forum. 2008. Homoeopathy Tips for 8/4/15 The Simillimum. Available: https://robertfield3.wordpress.com (Accessed 2 May 2019).

Richardson, C. R. 2004. A conceptual framework for comparative studies of higher education policy. Available: https://ostromworkshop.indiana.edu/library/node/85414 (Accessed 17 March 2019).

Richard, D. 2016. Cedar of Lebanon-Cedrus Libani. *Polycrest for skin homoeostasis*. An excerpt from Medicinal Embryonic Phytotherapy Encyclopedia, Chapter Materia Medica. Available: https://www.gardebnofeveskincare.com (Accessed 7 April 2019).

Robinson, K. A., Saldanha, I. J. and Mckoy, N. A. 2011. Frameworks for determining research gaps during systematic reviews. *Journal of Clinical Epidemiology*, 64(12): 1325-1330. Available: https://www.ncbi.nlm.nih.gov/pubmed/21937195. (Accessed 15 April 2019).

Rossman, G. B. and Rollis, S. F. 2012. *Learning in the field: an introduction to qualitative research*. 3rd ed. Los Angeles: Sage.

Ryan, T. J and Willcox, M. 2011. Collaboration with traditional health practitioners in the provision of skin care for all in Africa. International Journal of Dermatology, 50(5): 564-570. Available: https://onlinelibrary.wiley.com. (Accessed 24 April 2019).

Sanjari, M., Bahramnezhad, F., Fomani, F. K., Shoghi, M. and Cheragh, M. A. 2014. Ethical challenges of researchers in qualitative studies: the necessity to develop a specific guideline. *Journal of Medical Ethics and History of Medicine*, 7: 14. Available: https://www.ncbi.nlm.nih.gov/pubmed/25512833. (Accessed 13 February 2019).

Saul, P. 2016. Circumcision shortcut disaster. *Daily Sun*, 7 July. Available: https://www.dailysun.co.za/News/National/circumcision-shortcut-disaster20160707. (Accessed 16 May 2019).

Science Based Medicine. 2013. Overview of homeopathy. Available: https://sciencebasedmedicine.org/reference/homeopathy/ (Accssed12 April 2019).

School of Homoeopathy. 2017. What is Homoeopathy. Available: https://www.Homoeopathyschool.com. (Accessed 16 March. 2019).

Schuett, K. 2010. Francisco X. Eizayaga and the layer approach to homoeopathy. Homoeopathy papers. Available: https://hpathy.com/homeopathy-papers/franciscox-eizayaga-and-the-layer-approach-to-homeopathy/ (Accessed 1 April 2019).

Semenya, S. S. and Potgieter, M. J. 2014. Bapedi traditional healers in the Limpopo province, South Africa: their socio-cultural profile and traditional healing practice. *BMC Journal of Ethnobiology and Ethnomedicine*, 10(14).

Senel, E. 2019. Evolution of homoeopathy: a scientometric analysis of global Homoeopathy literature between 1975 and 2017. *Complimentary Therapies in Clinical Practice,* 34:165-173.

Shealy, C. N. 1998. *The illustrated encyclopedia of healing remedies*. London: Element Books.

Shenton, A. K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2): 63-75.

Showkat, N. and Parveen, H. 2017. Non-probability and probability sampling. *Communications Research*. Avaialble: http://www.samplingmethods.communication.research. (Accessed 25 April 2019).

Shutterstock media. 2003. The skin and its appendages. Available: https://api.shutterstock.com/v2/images/search. (Accessed 23 April 2019).

Sieber, J. E. 2007. Privacy and confidentiality: as related to human research in social and behavioral science. Available: https://www.onlineethics.org/cms/17207.aspx (Accessed 15 April 2019).

Sissons, C. 2019. What to know about enemas. Available https://www.medicalnewstoday.com/articles/325086.php (Accessed 17 May 2019).

Siyafila Wordpress. 2012. Isangoma. South Africa, Travel. Available: https://siyafila.wordpress.com/2012/05/04/isangoma/ (Accessed 13 April 2019).

Smithard, A., Glazebrook, C. and Williams, H. C. 2001. Acne prevalence, knowledge about acne and psychological morbidity in mid-adolescent: a community-based study. *British Journal of Dermatology,* 145(2): 274-279.

Sobieck, J. F. 2012. South African TM. *Ethnobotany* (online). Available: www.ethnobotany.co.za. (Accessed 12 March 2019).

Solman, L. and Layton, A. M. 2019. Acne in childhood. *Paediatrics and Child Health,* 29(2): 85-89.

Srivastava, A. and Thomson, B. S. 2009. Framework analysis: a qualitative methodology for applied policy research. *Research Note*, 4(2): 72..

Star, K. M. 2002. The vital force. Available: https://thevitalforce.net (Accessed 4 May 2019).

Stathakis, V., Kilkenny, M. and Marks, R. 1997. Descriptive epidemiology of acne vulgaris in the community. *Australasian Journal of Dermatology*, 38(3): 115-23.

Statistics Solutions. 2019. What is trustworthiness in qualitative research. Available: https://www.statisticssolutions.com/what-is-trustworthiness-in-qualitative-research/ (Accessed 10 April 2019).

Street, A. R., Smith, B., Moshabela, M., Shezi, B., Webster, C. and Falkenberg, T. 2018. Traditional health practitioners and sustainable development: a case study in South Africa. *Public Health,* 165: 1-5.

Sunday, C. E. 2014. Qualitative data analysis. Available: https://www.uwc.ac.za/Students/Postgraduate/Documents/Qualitative%20data%20analysis.pdf. (Accessed 27 November 2018).

Surbhi, S. 2016. Difference between probability and non-probability sampling. *Key Differences.* Available: https://keydifferences.com/difference-between-probabilityand-non-probability-sampling.html (Accessed 10 April 2019).

Suva, M. A., Patel, A. M., Sharma, N., Bhattacharya, C. and Mangi, R. K. 2014. A brief review on acne vulgaris: pathogenesis, diagnosis and treatment. *Research & Reviews: Journal of Pharmacology*, 4(3): 1-3.

Svinicki, D. M. 2010. *A guidebook on conceptual frameworks for research in engineering education*. University of Texas. Available: https://crlte.engin.umich.edu. (Accessed 17 March 2019).

Swayne, J. 2000. *International dictionary of homoeopathy*. Edinburgh: Churchill Livingstone.

Szabo, K. and Kemeny, L. 2011. Studying the genetic predisposing factors in the pathogenesis of acne vulgaris. *Human Immunology*, 72(9): 766-773.

Tabasum, H., Ahmad, T., Anjum, F. and Rehman, H. 2013. The historic panorama of acne vulgaris. *International Journal of Advanced Ayurveda, Yoga, Unani, Siddha and Homeopathy,* 2(1): 99-104.

Taherdoost, H. 2016. Sampling methods in research methodology; how to choose a sampling technique for research. *International Journal of Academic Research in Management*, 5(2): 18-27.

Tan, J. K. L. 2004. Psychosocial impact of acne vulgaris: evaluating the evidence. *Skin Therapy Letter*, 9(7): 1-3.

Tan, J. K., Vasey, K. and Fung, K. Y. 2001. Beliefs and perceptions of patients with acne. *Journal of the American Academy of Dermatology*, 44(3): 439-445.

Tausk, F. A. 2010. Effects of skin diseases on quality of life. *NEJM Journal Watch.* Available: https://www.jwatch.org/jd201011190000003/2010/11/19/effects-skindisease-quality-life (Accessed 7 March 2019).

Taylor, S. J., Bogdan, R, and de Vault, M. 2015. *Introduction to qualitative research methods: a guidebook and resource*. New York: John Wiley & Sons.

Teshima, H., Kubo, C., Kihara, H. Imada, Y. Nagata, S., Ago, Y. and Ikemi, Y. 1982. Psychosomatic aspects of skin diseases from the standpoint of immunology. *Karger Journal*, 37:165-175

Tikkinen, K. A. O., Leinonen, J. S., Guyatt, G. H., Ebrahim, S. and Jarvinen, T. L. N. 2012. What is a disease: perspectives of the public, health professionals and legislators? *Public Health Research*, 2(6): 3-4.

Tilles, G. Acne pathogenesis: history of concepts. Pub Med, 229(1): 1-46. Available: https://www.karger.com/Article/Abstract/364860. (Accessed 17 January 2019).

Tongco, M. D. C. 2007. Purposive sampling as a tool for informant selection. *Ethnobotany Research and Applications*, 5:147-158.

Trivieri, L. 2001. The American Holistic Medical Association Guide to Holistic Health: Healing Therapies for Optimal Wellness. John Wiley & Sons Inc. New York, United States.

Trochim, W. M. K. 2006. Research methods knowledge base. Available: http://www.socialresearchmethods.net/kb/qualapp.Php/ (Accessed 14 August 2017).

Tshehla, B. 2015. THPs and the authority to issue medical certificates. *South African Medical Journal,* 105(4): 34-35.

University of the Witwatersrand Library. 2012. Historical Papers (online). Available: www.historicalpapers.wits.ac.za. (Accessed 17 April 2019).

van Bogaert, D. K. 2007. Ethical considerations in African traditional medicine: a response to Nyika. *Bioethics*. 7(1): 35-40.

van Niekerk, J. P. 2012. Traditional healers formalised? *South African Medical Journal*. 102(3): 105-106.

van Rooyen, R. A., Pretorius, B., Tembani, N. M. and Baloyi, W. H. 2017. Evidence based recommendations to facilitate professional collaboration between allopathic and traditional health practitioners. *Health SA Gesondheid*, 22: 291-299.

van Wyk, B. E. and Wink, M. 2004. *Medicinal plants of the world*. Pretoria: Briza Publications.

Van Wyk, N. C. 2009. Integrative Health Care: A guide to meet the needs of Africa. Juta and Co Ltd, 2009. Cape Town, South Africa.

Virginia Polytechnic Institute and State University. 2019. Institutional Review Board: protecting confidentiality and anonymity. Available: https://www.irb.vt.edu/pages/confidentiality.htm (Accessed 15 April 2019).

Vithoulkas, G. 2009. The Science of Homoeopathy. 5th ed. United State of America.

Wada, A. S., Jatau, A. I., Bala, A. A., Haruna, A., Isa, A. M., Safiyya., A. S. and Sha'abang, A. 2019. Use of traditional medicines among pharmacists in Nigeria. *Complementary Therapies in Clinical Practice*, 35: 53-56.

Walsh, M. 2001. *Research made real; a guide for students*. Oxford: Nelson Thornes Ltd.

Walters, L. E., Mars, M. and Scott, R. E. 2016. A review and critique of Teledermatology in South African public health sector. *Studies in Health Technology and Informatics,* 231: 143-151. Available: https://www.ncbi.nlm.nih.gov/pubmed/27782026. (Accessed 15 January 2019).

Webster, M. 2019. Epidemiology. Available: https://www.merriam-webster.com. (Accessed 14 April 2019).

Webster, J. and Watson, R. T. 2002. Analyzing the past to prepare for the future: writing a literature review. *MIS Quarterly*, 26(2): 1-2.

White, P. 2015. The concept of diseases and health care in African traditional religion in Ghana. *HTS Teologiese Studies/Theological Studies*, 71(3):1-7.

Williams, C. H., Dellavalle, R. P. and Garner, S. 2012. Acne vulgaris. *The Lancet*, 379(9813): 361-372.

Wisker, G. 2009. *The undergraduate research handbook*. New York, NY: Palgrave Macmillan.

World Health Organization (WHO). 1948. Definition of health in preamble to the constitution of the World Health Organization as adopted by the International Health Conference, New York. Geneva: WHO

World Health Organization (WHO). 2003. Adherence to long-term therapies: evidence for action. Geneva: WHO.

World Health Organization (WHO). 2009. Global health risks: mortality and burden of disease attributable to selected major risks. Available: http://www.who.int/healthinfo/global_burden_disease/global_health. (Accessed 18 May 2019).

World Health Organization (WHO). 2011. Integrated Health Services. What and Why? Technical brief. Geneva: World Health Organization.

World Health Organization (WHO). 2017. Traditional Medicine (online). Available: https://afro.who.int (Accessed 2 May 2019).

Yarnell, E. and Abascal, K. 2006. Herbal medicine for acne vulgaris. *Alternative and Complementary Therapies,* 12(6): 303-309. Available: https://www.liebertpub.com/doi/10.1089/act.2006.12.303. (Accessed 24 February 2019).

Zouboulis, C. C., Eady, A., Philpott, M., Goldsmith, L. A., Orfanos, C., Cunliffe, W. C. and Rosenfield, R. 2005. What is the pathogenesis of acne? *Controversies in Experimental Dermatology Section,* 14(3): 143-152.

Zulu, T. P., Mosam, A., Balakrishna, Y., and Dlova, N. C. 2017. Acne in South African black adults: a retrospective study in the private sector. *South African Medical Journal*, 107(12) 1106-1109.

Zuma, T., Wight, D., Rochat, T. and Moshabela, M. 2016. The role of traditional health practitioners in rural KwaZulu-Natal, South Africa: generic or mode specific. BMC Complement & Alternative Medicine, 16(304): 6.

APPENDICES

Appendix A: Letter of Information

LETTER OF INFORMATION

Dear participant, thank you for showing interest in this study.

Title of the Research Study: A comparison of the conceptual understanding and management of acne vulgaris amongst registered Homoeopath sand Izinyanga in KwaZulu-Natal.

Principal Investigator/s/researcher: (Name, qualifications)
Candice Sanelisiwe Cebekhulu- Master's Degree in Technology: Homoeopathy

Co-Investigator/s/supervisor/s: (Name, qualifications)
Supervisor: Dr T.O Wulfsohn- Master's Degree in Technology: Homoeopathy **Co-Supervisor:** Dr N.S Dube - Master's Degree in Technology: Homoeopathy

Brief Introduction and Purpose of the Study:
The purpose of the study is to fill the gap in knowledge that exists in research regarding the conceptual understanding of the pathogenesis and treatment of acne vulgaris by comparing the conceptual understanding and management of acne vulgaris amongst Homoeopaths and Izinyanga in KwaZulu-Natal.

Outline of the Procedures:
Once Six Homoeopath and six Izinyanga are recruited to the study. You will be requested to participate in a 30-minute-long semi-structured interview via telephone call or email or through face to face interviews. There will be seven open ended questions. These interviews will take place at your convenience and preferred location. With your permission, all interviews will be audio recorded for research purposes and stored in safe and password protected computer.

You qualify for the study if:

- You are a Homoeopaths who is registered with the Allied Health Practitioners' Council in South Africa.
- You are a Homoeopath who has been practising for more than five years.
- You are a Homoeopath practising in the KwaZulu-Natal area.
- You are a Homoeopath that treats acne vulgaris or
- You are a Nyanga who has been in practising for more than five years and based in KwaZulu-Natal.
- You are a Nyanga registered with the THP's' Council of South Africa.
- You are a Nyanga who treats acne vulgaris.

If you do not meet the above requirements you will not be included in the study.

Risks or Discomforts to the Participant:
Participation in the study has no risks or discomfort.

Benefits:
As a participant you will get to share your knowledge on the conceptual understanding and management of acne vulgaris with society at large. People who suffer from acne vulgaris will get educated on alternative methods to help cure their skin condition. Society will have a better understanding of Homoeopathy and TM in the treatment of skin diseases. The researcher is doing this research to obtain her master's Degree in Technology at Durban University of Technology.

Reason/s why the Participant May Be Withdrawn from the Study:
The researcher may stop you from taking part in the study at any time if he believes it is in your best interest or if the study stopped. Also, participants may choose to withdraw from the study at any time during the interview process with no adverse consequences for these participants.

Remuneration:
There will not be any payment for taking part in the study.

Costs of the Study:
There is no cost involved for participants taking part in the study.

Confidentiality:
Your personal details will not be disclosed at any stage of the study. The interview documents and audio recordings will be kept secure by the researcher for the duration of the research and then stored in a locked office of research study personnel at Durban University of Technology, Homoeopathy Department and destroyed within 5 years. Only researcher and supervisors will have access this information.

Research-related Injury:

Due to the nature of the research there is no anticipated risk for injury related to research. No compensation will be made for such claims.

Persons to Contact in the Event of Any Problems or Queries:

Supervisor: Dr T.O Wulfsohn (031 373 2514)
Co-Supervisor: Dr N.S Dube (031 373 2514)
Researcher: Candice Cebekhulu (078 408 6686)

Institutional Research Ethics administrator: 031 373 2375
Complaints can be reported to the acting Director: Research and postgraduate Support, Prof C. E Napier, 031 373 2577 or carinn@dut.ac.za

Appendix B: Incwadi Yokubamba Iqhaza

Incwadi Yokubamba Iqhaza

Mubambi weqhaza othandekayo, ngiyabonga ngokubonisa intshisekelo kulolu cwaningo.

Isihloko socwaningo: A comparison of the conceptual understanding and management of acne vulgaris amongst registered Homoeopathsand Izinyanga in KwaZulu-Natal.

Umphenyi oyinhloko: (Igama, Iziqu)
Candice Sanelisiwe Cebekhulu- Bachelor's degree in Technology: Homoeopathy

Umlekeleli womphenyi: (Igama, Iziqu)
Dr T.O Wulfsohn- Master's Degree in
Technology: Homoeopathy

Isingeniso esifushane nenhloso yocwaningo: Inhloso yocwaningo ukugcwalisa igebe ngolwazi olukhona ocwaningweni oluphathelene nokuqonda komqondo we-pathogenesis nokuphathwa kwe-acne vulgaris ngokuqhathanisa ukuqonda nokuqondiswa kwe-acne vulgaris phakathi kwama-Homoeopathsnezinyanga ezizinze esifundazweni saKwaZulu-Natali.

Uhlaka lwezinqubo: Labo ababambe iqhaza bangaphendula ngokuzithandela kwabo emaimeyili kanye nezingcingo ezivela kumcwaningi ukuze babeyingxenye yocwaningo oluthatha isikhathi esiyimizuzu engamashumi amathathu lapho kuzobe kunengxoxompedulwano equkethe imibuzo eyishumi evulekile. Ama-Homoeopath amahlanu kanye nezinyanga ezinhlanu kuphela ezizothathwa ukuze zibe ingxenye yocwaningo. Ukuxoxisana okuhleliwe kuzokwenziwa endaweni eqokwe ilabo ababambe iqhaza. Ngemvume yabazimiseleyo kuyoba nokuqoshwa kwengxoxo leyo.

Ukwelungele ukubamba iqhaza uma:

• Uyi-Homoeopath ebhalisiwe nomkhandlu wezempilo we-Allied eNingizimu Afrika

Appendix

- Uyi-Homoeopath esiqhube iminyaka engaphezu kwemihlanu.
- Uyi-Homoeopath esebenzala esifundazweni saKwaZulu-Natali.
- Uyi-Homoeopath elapha iacne vulgaris.
- Uyi-Nyanga esiqhube iminyaka engaphezu kwemihlanu futhi ezinze KwaZulu-Natali.
- Uyi-Nyanga ebhalisiwe nomkhandlu wabelaphi bendabuko eNingizimu Afrika.
- Uyi-Nyanga elapha iacne vulgaris.

Abantu abangahlangabezani nezidingo ezilotshwe ngenhla ngeke bafakwe kulolu cwaningo.

Ubungozi noma ukungathokozi kulowo obambe iqhaza: Lolucwaningo alubhekeki lungaba nobungozi kulabo abayingxeye kulo.

Izinzuzo: Ukuhlanganyela komhlanganyeli ukwabelana ngolwazi lwabo ekuqondeni komqondo nokuphathwa kwe-acne vulgaris nomphakathi kabanzi. Abantu abahlukunyezwa yi-acne vulgaris bazofunda ngezindlela ezihlukile ukusiza ukuphulukisa isimo sabo sesikhumba. Inhlangano izoba nokuqonda okungcono kwe-Homoeopathy kanye nemithi yokwelapha yendabuko ukuphulukisa izifo zesikhumba. Umcwaningi wenza lolu cwaningo ukuze athole i-Master's Degree Technology kwezobuchwepheshe eThekwini University of Technology

Isizathu esingaholela ekutheni lowo obambe iqhaza akhishwe ocwaningweni: Ukungahambisani, ukugula, ukusabela okubi, njll. Lowo oyingxenye yocwaningo kudingeka kuchazwe kuye ukuthi ngeke kube nemiphumela emibi uma ekhetha ukuhoxa.

Inkokhelo: Ngeke kube khona imali ezokhokhelwa lowo obambe iqhaza ocwaningweni

Izindleko zocwaningo: Lolucwaningo ngeke lubakhokhise labo ababambe iqhaza kulo.

Okuyimfihlo: Ubunikazi kanye nolwazi lwalabo ababambe iqhaza luzogcinwa luyimfihlo. Umcwaningi kanye nabaphathi kuphela abazokwazi ukuthola ukurekhodwa komsindo okuzogcinwa endaweni ephephile. Akukho magama noma ulwazi locwaningo oluzoshicilelwa emqingweni wokugcina wocwaningo.

Ukulimala okuhlobene nocwaningo: Abukho ubungozi nokulimala okusolekayo kulabo abayingxenye yocwaningo

Abantu ongaxhumana nabo uma kukhona izinkinga noma kukhona imibuzo:
Umphathi wezocwaningo: uDkt T. O Wulfsohn (031 373 2514) or uDkt N.S Dube (031 373 2514)
Umcwaningi: Candice Cebekhulu (0784086686)
Umqomdisi womnyango wezokuphenya: (0313732375)
Izikhalazo zingabikwa kuMqondisi osebenzayo: UCwaningo nokuPhasiswa kweziqu zokufunda uProf C. E Napier, 031 373 2577 noma carinn@dut.ac.z

Appendix C: Consent form

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Candice Cebekhulu about the nature, conduct, benefits and risks of this study- Research Ethical Clearance number:
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant	**Date**	**Time**	**Signature**
	/	**Right Thumbprint**	

I Candice Cebekhulu Here with confirm that the above participant has been fully Informed about the nature, conduct and risks of the above study.

Full Name of Researcher	**Date**	**Signature**
Full Name of Witness (If applicable)	**Date**	**Signature**
Full Name of Legal Guardian (If applicable)	**Date**	**Signature**

Appendix D: Ifomu lokuvum

Ifomu lokuvuma

Isitatimende Sesivumelwano Sokubamba iqhaza Esifundweni Sokucwaning Mina lapha ngiyaqinisekisa ukuthi ngitshelwe umcwaningi, ogama lakhe lingu Candice

- Cebekhulu mayelana ngobunjalo, inqubo, izinzuzo kanye nobungozi balolucwaningo. Inombolo egunyaza ucwaningo: _____.
- Ngiphinde ngathola, ngafunda futhi ngayiqonda imininingwane ebhaliwe ngenhla mayelana nocwaningo.
- Ngiyaqaphela ukuthi imiphumela yocwaningo, kufaka phakathi imininingwane yobulili, ubudala, usuku lokuzalwa, namagama alowo obambe iqhaza kanye nokuxilongwa kwakhe kuzobekwa kube imfihlo ngokombiko oveza umphumela wocwaningo.
- Ngenxa yezidingo zocwaningo, ngiyavuma ukuthi idatha eqoqwe phakathi nalolucwaningo ingacubungulwa ohlelweni lwekhompyutha ngumcwaningi.
- Ngingakwazi, nakunoma yisiphi isigaba, ngaphandle kokubandlululwa, ngihoxise imvume yami ekutheni ngibambe iqhaza ocwaningweni.
- Ngibenethuba elanele lokubuza imibuzo futhi ngokuzithandela kwami siqu, ngizibikezele ukuthi ngikulungele ukuba yingxenye yalolucwaningo.
- Ngiyaqonda ukuthi imiphumela emisha engahle ivele mayelana neqhaza engilibambile kulolucwaningo ngiyokwaziswa ngayo.

_____ _____ _____ _____

Amagama aphelele alowo Usuku Isikhathi Isiginesha obambe iqhaza. I-thumbprint

Mina Candice Cebekhulu, lapha ngiyaqinisekisa ukuthi lona obambe iqhaza kulolucwaningo ngimazisile ngobunjalo, ukuziphatha kanye nobungozi obungahle bubekhona ocwaningweni.

_____ _____ _____

_____

Amagama aphelele omcwaningi **Usuku** **Isiginesha**

_____ _____

Amagama aphelele ofakazi (Uma ekhona) Usuku **Isiginesha**

_____

_____

Amagama omgadi ogunyaziwe (Uma ekhona) Usuku **Isiginesha**

Appendix E: Interview Guide for semi-structured interview

Interview Guide for semi-structured interview

Age: _____ **Gender:** ____ **Race:** _____

Question 1: How does your medical system understand the concept of health and disease?

Question 2: Based on the above understanding how acne vulgaris understood by your medical system?

Question 3: Describe how you diagnose acne vulgaris?

Question 4 Describe how you differentiate acne vulgaris from other skin conditions?

Question 5: What does your treatment of acne vulgaris entail?

Question 6: How do manage this condition apart from medication prescribed?

Question 7: What in your views what are the limitations to treating acne vulgaris as a chronic condition?

Appendix F: Umhlahlandlela wengxoxompendulwana ehleliwe

Umhlahlandlela wengxoxompendulwana ehleliwe

Ubudala: _____ **Ubulili:** _____ **Umncintiswano:** _____

Umbuzo 1: Uhlelo lwakho lwezokwelapha luqonda kanjani umqondo wezempilo nempilo?

Umbuzo 2: Ngokusekelwe ngenhla ukuqonda ukuthi ama-acne vulgaris aqondwa kanjani uhlelo lwezokwelapha?

Umbuzo 3: Chaza ukuthi uhlolisisa kanjani i-acne vulgaris?

Umbuzo 4: Chaza ukuthi uhlukanisa kanjani i-acne vulgaris kwezinye izimo zesikhumba?

Umbuzo 5: Ukwelashwa kwakho kwe-acne vulgaris kuhilela kuphi?

Umbuzo 6: Ulawula kanjani lesi simo ngaphandle kwemithi enqunyiwe?

Umbuzo 7: Kuthiwani emibonweni yakho yiziphi izilinganiso zokwelapha iacne vulgaris njengesimo esingapheli?

Appendix G: Editing Certificate

DR RICHARD STEELE
BA, HDE, MTech(Hom)
HOMEOPATH
Registration No. A07309 HM
Practice No. 0807524
Freelance academic editor
Associate member: Professional Editors' Guild, South Africa

110 Cato Road
Glenwood, Durban 4001
031-201-6508/082-928-6208
Fax 031-201-4989
Postal: P.O. Box 30043, Mayville 4058
Email: rsteele201@outlook.com

EDITING CERTIFICATE

Re: **Candice Sanelisiwe Cebekhulu**
Master's dissertation: **A COMPARISON OF THE CONCEPTUAL UNDERSTANDING AND MANAGEMENT OF ACNE VULGARIS AMONGST REGISTERED HOMOEOPATHS AND IZINYANGA IN KZN**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I returned the document to the author with track changes so correct implementation of the changes and clarifications requested in the text and references is the responsibility of the author. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology I supervised numerous Master's degree dissertations.

Dr Richard Steele
24 June 2019
per email