

**GUIDELINES FOR DISCLOSURE OF TRADITIONAL
MEDICINE USE TO ALLOPATHIC MEDICINE
PRACTITIONERS BY PATIENTS WHO USE BOTH
TRADITIONAL AND ALLOPATHIC MEDICINES AT
SELECTED HOSPITALS IN GAUTENG, SOUTH AFRICA**

Lindiwe Gumede (21649326)

Thesis submitted in fulfilment of the requirements for the Philosophiae Doctor
in Health Sciences in the Faculty of Health Sciences at the Durban University
of Technology

Supervisor : Dr P.B. Nkosi

Co-supervisor : Prof M.N. Sibiya

Date : 06 November 2022

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work is entirely my own and not of any other person unless explicitly acknowledged (including citation of published and unpublished sources).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 any other institution for assessment or any other purpose.

06 April 2023

Signature of student

Date

Approved for final submission.

_07 April 2023__

Dr P.B. Nkosi

Date

PhD: Health Sciences

7 April 2023

Prof M.N. Sibiyi

Date

RN, RM, DTech: Nursing

Abstract

Background

Within the South African context, the concurrent use of traditional medicine (TM) and allopathic medicine (AM) is often not disclosed to allopathic medicine practitioners (AMPs) during a consultation. It is quite common for patients to consult with traditional health practitioners (THPs) prior to reaching out to AMPs for further assistance. When compared to AM, TM used by patients who use both TM and AM has on many occasions been perceived as a sub-standard treatment option. Non-disclosure of TM use by patients who use both TM and AM may render the AM prescribed by the AMPs ineffective if not detected in a timely manner. While there is literature that identifies the reasons why patients who use both TM and AM do not disclose this to AMPs during a consultation, no guidelines have been developed to focus on facilitating disclosure by these patients.

Aim

The aim of the research was to explore and describe the perceptions of AMPs regarding disclosure of TM use to AMPs by patients who use both TM and AM and ultimately to develop guidelines for disclosure of TM use to AMPs at selected hospitals in Gauteng.

Methodology

An exploratory, descriptive, qualitative research design was employed. The opinions of AMPs who met the non-probability, purposive sampling inclusion criteria were explored and described. Data was gathered through one-on-one, masked semi-structured interviews and qualitative observations of AMPs in their natural environment. The findings were triangulated and integrated with Petronio's communication privacy management (CPM) theory as a theoretical framework informing the study to help delineate correspondence concerning the phenomenon.

Findings

The findings of the one-on-one, semi-structured interviews reveal that the practice of AMPs in Gauteng regarding the concurrent use of TM and AM by patients they consult with is limited by their knowledge of the TM used by these patients. Secondary elements of non-disclosure include stigma, AMP attitudes, AMP training, belief systems, lack of knowledge, lack of communication skills, scoffing at TM and prejudice. The research findings prompted the development of guidelines and recommendations for stakeholders involved in patient care and management in Gauteng.

Key words: Allopathic medicine practitioners, disclosure of TM use, Gauteng, guidelines, traditional health practitioners, traditional medicine, South Africa

Dedication

This study is dedicated to my family. This had to be the most stressful period of my life. I know it wasn't easy for any of us, but I couldn't have done it without the unwavering love and support of my husband and three children. Your words of encouragement never went unnoticed. I would not have gotten this far on my own. I hope that one day you will understand how grateful I am to have reached this point in my life with all of you present.

Acknowledgements

- I would like to thank God (Umvelinqangi) and my ancestors. I am sure that where my strength ended, you carried me.
- My grandmother Pumla Victoria (Papu) Nkwanyana, thank you for being the epitome of a woman that can survive through all odds.
- To my loving husband Mangaliso Gumede, God could not have chosen a better person to walk this journey of life with.
- My parents Mbongeleni Thabethe and Thoko Thabethe, I will never be too old to need you. With your support, everything seems better.
- My eldest son Bonginkosi Gumede, this journey intensified at a time when I thought you needed me the most because you were in your matric year. I hope the support that I was able to provide counts well into your future. Thank you for your support.
- To my daughter, Mbalenhle Gumede, thank you for being my mirror. I look at you and I see so much of myself; I appreciate the effort that you put into everything you do; I hope you shine in everything you put your heart in.
- To my youngest son Sanele Gumede, a young man with a big heart. When you used to ask “Mama, are you ok?” I would know that I looked like hell due to long hours in front of the laptop screen.
- My supervisor Dr Busisiwe Nkosi, you are a true mentor and a mother to me. Your presence during my development, both career-wise and academically, fills me with so much gratitude.
- My co-supervisor Prof Nokuthula Sibiyi, thank you for sharing your expertise and work ethic. You have been an inspiration throughout my journey.
- To the Gauteng research committees, thank you for the confidence in the concept of my research.
- To all the CEOs and clinical managers of all my research sites, thank you for permitting me to conduct the study in your hospitals.

- To all my participants, thank you for allowing me to conduct the interviews. The time that you took is highly appreciated.
- To the University of Johannesburg, thank you for funding me for the duration of my study.
- Thank you to the DUT for approving my concept and allowing me to pursue the dream of obtaining my PhD.

Table of contents

	Page
Declaration	i
Abstract	ii
Dedication	iv
Acknowledgements	v
List of appendices	xiii
List of tables	xiv
List of figures	xv
Glossary of terms	xvi
List of abbreviations and acronyms	xvii
CHAPTER 1: OVERVIEW OF THE STUDY	1
1.1 INTRODUCTION AND BACKGROUND TO THE STUDY	1
1.2 PROBLEM STATEMENT	4
1.3 AIM OF THE STUDY	5
1.4 RESEARCH QUESTIONS	5
1.5 SIGNIFICANCE OF THE STUDY	6
1.6 STRUCTURE OF THE THESIS	8
1.7 SUMMARY OF THE CHAPTER	9
CHAPTER 2: LITERATURE REVIEW	10
2.1 INTRODUCTION	10
2.2 LITERATURE SEARCH	10
2.3 HISTORICAL PERSPECTIVE OF TM AND AM USE	13
2.4 RELEVANCE OF TM IN SOCIETY	15
2.5 SOUTH AFRICAN LEGISLATION ON TM USE	16
2.6 GLOBAL, AFRICAN AND SOUTH AFRICAN VIEW OF NON-DISCLOSURE TO AMPs BY PATIENTS USING TM AND AM	17
2.7 BARRIERS TO FACILITATION OF DISCLOSURE TO AMPs BY PATIENTS USING BOTH TM AND AM	19
2.8 ISSUES OF INTERACTION BETWEEN AM AND TM	21

2.9 AMPs AS LEADERS OF THE ENQUIRY DURING CONSULTATION	22
2.10 STRATEGIES TO FACILITATE DISCLOSURE	24
2.11 SUMMARY OF THE CHAPTER	25
CHAPTER 3: THEORETICAL FRAMEWORK GUIDING THE STUDY	26
3.1 INTRODUCTION	26
3.2 ESTABLISHING THE NEED FOR DISCLOSURE GUIDELINES	27
3.3 SELECTION OF THE THEORETICAL FRAMEWORK TO GUIDE THE STUDY	29
3.4 PETRONIO'S COMMUNICATION PRIVACY MANAGEMENT THEORY	30
3.4.1 Communication privacy management theory in health	34
3.4.2 Non-disclosure as a mechanism to conceal a denounced status	35
3.4.3 How Petronio's CPM theory guided this study	35
3.5 SUMMARY OF THE CHAPTER	37
CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY	38
4.1 INTRODUCTION	38
4.2 RESEARCH DESIGN	38
4.2.1 Qualitative research	38
4.2.2 Explorative research	39
4.2.3 Descriptive research	39
4.3 RESEARCH PARADIGM	41
4.4 STUDY AREA	42
4.5 IDENTIFICATION OF DATA COLLECTION SITES	44
4.5.1 Inclusion criteria for the study area	44
4.5.2 Exclusion criteria for the study area	44
4.6 STUDY POPULATION	44
4.7 SAMPLING PROCESS	45
4.7.1 Inclusion criteria for the study population	45
4.7.2 Exclusion criteria for the study population	46
4.8 SAMPLE SIZE	46

4.9 PRE-TESTING OF DATA COLLECTION TOOL	46
4.10 DATA COLLECTION PROCESS	47
4.11 DATA ANALYSIS	49
4.12 TRIANGULATION OF DATA	51
4.13 RESEARCH TRUSTWORTHINESS	52
4.13.1 Credibility	52
4.13.2 Transferability	52
4.13.3 Dependability	53
4.13.4 Confirmability	53
4.14 ETHICAL CONSIDERATIONS	53
4.14.1 Respect	54
4.14.2 Beneficence and non-maleficence	55
4.14.3 Justice	55
4.15 SUMMARY OF THE CHAPTER	56
CHAPTER 5: PRESENTATION OF THE FINDINGS OF THE STUDY	57
5.1 INTRODUCTION	57
5.2 DEMOGRAPHIC DATA OF THE PARTICIPANTS	57
5.3 DATA OBSERVATIONS	58
5.4 CONCEPTUALISATION OF NON-DISCLOSURE OF TM USE BY PATIENTS WHO USE BOTH TM AND AM	59
5.4.1 Theme 1: AMPs' perceptions of non-disclosure of TM use by patients who use both TM and AM	60
5.4.1.1 Lack of scientific evidence for TM	61
5.4.1.2 Unspecified dosage of TM	62
5.4.1.3 Non-adherence to the AMPs' treatment plan	63
5.4.1.4 Complications because of interaction between AM and TM	64
5.4.2 Theme 2: Practices of AMPs when consulting with patients who use both TM and AM without disclosing	67
5.4.2.1 AMPs' bedside manner	67
5.4.2.2 Stigmatising TM use	68
5.4.2.3 Individual belief system	70
5.4.3 Theme 3: Facilitating disclosure of TM use to AMPs	72

5.4.3.1 Creating a conducive environment for disclosure of TM use	72
5.4.3.2 Encouraging patients to disclose TM use to AMPs	74
5.4.3.3 Patient autonomy	75
5.4.3.4 Training of AMPs to understand TM	77
5.4.4 Theme 4: Procedures to encourage disclosure of TM use to AMPs by patients who use both TM and AM	78
5.4.4.1 Collaboration of THPs and AMPs	79
5.4.4.2 Acknowledgement of traditional health practice	80
5.5 REFLEXIVITY	82
5.6 SUMMARY OF THE CHAPTER	85
CHAPTER 6: DISCUSSION OF FINDINGS OF THE STUDY	86
6.1 INTRODUCTION	86
6.2 DEMOGRAPHIC PROFILE OF AMPs IN THE STUDY	86
6.3 APPLICATION OF CPM THEORY TO THE FINDINGS	87
6.4 THEME 1: AMPs' PERCEPTIONS OF NON-DISCLOSURE OF TM USE BY PATIENTS WHO USE BOTH TM AND AM	87
6.4.1 Lack of scientific evidence for TM	88
6.4.2 Unspecified dosage of TM	89
6.4.3 Non-adherence to the AMPs' treatment plan	91
6.4.4 Complications because of interaction between AM and TM	92
6.5 THEME 2: PRACTICE OF AMPs WHEN CONSULTING WITH PATIENTS WHO USE BOTH TM AND AM WITHOUT DISCLOSING	95
6.5.1 AMPs bedside manner	95
6.5.2 Stigmatising TM use	97
6.5.3 Individual belief system	99
6.6 THEME 3: FACILITATING DISCLOSURE OF TM USE TO AMPs	101
6.6.1 Creating a conducive environment for disclosure	101
6.6.2 Encouraging patients to disclose TM use	103
6.6.3 Patient autonomy	105
6.6.4 Training of AMPs	107
6.7 THEME 4: PROCEDURES TO ENCOURAGE DISCLOSURE OF TM USE TO AMPs BY PATIENTS WHO USE BOTH TM AND AM	108

6.7.1 Collaboration of THPs and AMPs	109
6.7.2 Acknowledgement of TM practices	111
6.8 FINDINGS CONCERNING THE AIM OF THE STUDY	113
6.9 SUMMARY OF THE CHAPTER	114
CHAPTER 7: DEVELOPMENT OF GUIDELINES	116
7.1 INTRODUCTION	116
7.2 PROCESS OF DEVELOPING GUIDELINES	116
7.3 PURPOSE OF THE DEVELOPED GUIDELINES	118
7.4 RATIONALE OF THE DEVELOPED GUIDELINES	118
7.5 SCOPE OF THE GUIDELINES	119
7.6 RECOMMENDATIONS FOR DEVELOPING GUIDELINES FOR STAKEHOLDERS	120
7.6.1 Recommendations for developing guidelines for policymakers at the Gauteng Department of Health	120
7.6.2 Recommendations for developing guidelines for clinical managers in Gauteng district hospitals	120
7.6.3 Recommendations for developing guidelines for AMPs in Gauteng	121
7.6.4 Recommendations for developing guidelines for patients who use TM in Gauteng	122
7.7 DEVELOPED GUIDELINES	122
7.7.1 Guideline A: Guideline for policymakers at the Gauteng Department of Health	123
7.7.2 Guideline B: Guidelines for hospitals in Gauteng	124
7.7.3 Guideline C: Guidelines for AMPs in Gauteng	128
7.7.4 Guideline D: Guidelines for patients who use TM in Gauteng	130
7.8 SUMMARY OF DEVELOPED GUIDELINES	132
7.9 APPRAISAL OF THE DEVELOPED GUIDELINES	135
7.10 DISSEMINATION OF THE DEVELOPED GUIDELINES	137
7.11 SUMMARY OF THE CHAPTER	137
CHAPTER 8: SUMMARY, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS OF THE STUDY	138
8.1 INTRODUCTION	138
8.2 SUMMARY OF THE STUDY FINDINGS	138

8.2.1 Realisation of study aim and objectives	138
8.2.2 Maximisation of trustworthiness in the study	139
8.2.3 Significance of the guidelines	139
8.3 CONCLUSION OF THE STUDY	140
8.4 LIMITATIONS OF THE STUDY	141
8.5 RECOMMENDATIONS OF THE STUDY	142
8.5.1 Recommendations for use of the developed guidelines within Gauteng	142
8.5.2 Recommendations for future research	143
8.6 CONTRIBUTION OF THE RESEARCH STUDY TO THE BODY OF KNOWLEDGE	144
8.7 SUMMARY OF THE CHAPTER	145
REFERENCES	146
APPENDICES	174

List of appendices

Appendix	Page
Appendix 1: University ethics clearance	175
Appendix 2a: Letter of request for permission to the Chief Director of Johannesburg Health District	176
Appendix 2b: Approval letter from the Chief Director of Johannesburg Health District	177
Appendix 3a: Letter of request for permission to the Chief Director of Tshwane Health District	179
Appendix 3b: Approval letter from the Chief Director of Tshwane Health District	180
Appendix 4a Letter of request for permission to the Chief Director of Ekurhuleni Health District	181
Appendix 4b: Approval letter from the Chief Director of Ekurhuleni Health District	182
Appendix 5a: Letter of request for permission to the CEO of Thelle Mogoerane Regional Hospital	183
Appendix 5b: Approval letter from the CEO of Thelle Mogoerane Regional Hospital	184
Appendix 6a: Letter of request for permission to the CEO of Jubilee District Hospital	185
Appendix 6b: Approval letter from the CEO of Jubilee District Hospital	186
Appendix 7a: Letter of request for permission to the CEO of Bheki Mlangeni District hospital	187
Appendix 7b: Approval letter from the CEO of Bheki Mlangeni District Hospital	188
Appendix 8a: Letter of request for permission to the CEO of South Rand District Hospital	189
Appendix 8b: Approval letter from the CEO of South Rand District Hospital	190
Appendix 9: Letter of information	191
Appendix 10: Consent	194
Appendix 11a: Demographic data for allopathic medicine practitioners	195
Appendix 11b: Interview guide for AMPs	196
Appendix 12: Sample of an interview transcript	197
Appendix 13: Data management using ATLAS.ti 9 Windows software	203
Appendix 14: Certificate of a professional editor	206
Appendix 15: Turnitin report	207

List of tables

Tables	Page
Table 4.1: Applying various stages of content analysis in ATLAS.ti	51
Table 5.1: Demographic data of the AMPs	59
Table 5.2: Themes and subthemes	60
Table 7.1: Developed guidelines	123
Table 7.2: Summary of developed guidelines for the integration of themes, subthemes and categories	134
Table 7.3: AGREE II unique domains and items for guideline quality	136

List of figures

Figures	Page
Figure 1.1: Outline of thesis chapters	9
Figure 3.1: Schematic diagram displaying process in CPM theory	33
Figure 4.1: Qualitative research process for the current study	40
Figure 4.2: A map of Gauteng showing district hospitals	43

Glossary of terms

Boundaries: Something that indicates a limit (*Merriam-Webster Dictionary* 2022a). In this study, boundaries are defined as a rule-based management system that controls the level of access to private information of patients.

Disclosure: The act or instance of disclosing (*Merriam-Webster Dictionary* 2022b). In this study, disclosure refers to the process through which patients that use both traditional medicine and allopathic medicine reveal private information to allopathic medicine practitioners.

Facilitation: The act of helping other people to deal with a process or reach an agreement without getting directly involved in the process (*Cambridge Dictionary* 2022). In this study, facilitation refers to allopathic medicine practitioners' advice given to patients who use both traditional and allopathic medicine to encourage them to disclose without feeling obligated.

Guidelines: Rules or instructions that are given by an official organisation telling you how to do something, especially something difficult (*Oxford Learner's Dictionary* 2022). Guidelines in this study refer to a developed and recommended reference guide for stakeholders to use to facilitate disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional medicine and allopathic medicine.

Mandate: To direct or require someone to do something (*Merriam-Webster Dictionary* 2022c). In this study, mandate refers to the responsibility given to hospitals to carry out official government orders.

List of abbreviations and acronyms

Acronym	Term
AIDS	Acquired immune deficiency syndrome
AMP	Allopathic medicine practitioner
AM	Allopathic medicine
CPM	Communication privacy management
DUT	Durban University of Technology
HIV	Human immunodeficiency virus
SA	South Africa
SADC	Southern African Development Community
THP	Traditional health practitioner
TM	Traditional medicine
WHO	World Health Organization

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Archives of systematic observations that support the use of traditional medicine back up the use of traditional medicine. (WHO 2000: 41). The World Health Organization (WHO) estimates that traditional medicine (TM) is used by 60% to 80% of the world's population, with some countries incorporating it into their public health system (WHO 2000: 41; WHO 2002: 1). Traditional medicine is instrumental in sustaining health in some communities (Zank and Hanazaki 2017: 13). Despite the popular use of TM, patients do not always inform their allopathic medicine practitioners (AMPs) of their TM use. Approximately 9.6% of patients disclose to the AMPs (Johny, Cheah and Safii 2017: 7). There is evidence that most patients use both types of medicine without disclosing them to AMPs in the hospital setting (Marais, Steenkamp and DuPlooy 2017: 36). Robinson and McGrail (2004: 96) report non-disclosure to be the result of pessimistic critical responses received from AMPs.

Over the last 25 years, there has been a strong global trend to promote the incorporation of TM use and personal care approaches into accepted allopathic practices (Melchart 2018:76). Universally, AMPs often regard TM use as a practice that has no significant contribution while if TM use still exists simply because of a shortage of healthcare facilities (Habtom 2018: 11). Despite this debate, most patients who use TM also use AM, and the same patients who rely on TM visit AMPs on a regular basis (Adams, Sibbritt and Young 2007:957). An article by Reid *et al.* (2016:20) provides a comprehensive review of the nature of TM use in Australia and concludes that TM use is still widespread in that country. However, this suggests that all key players in the healthcare system need to be aware of TM use, especially when it is used simultaneously with AM and in consultation with AMPs.

AMPs include physicians, nurses, optometrists, pharmacists, dentists, psychologists, public health professionals, podiatrists, veterinarians and other allied professionals (Kreitzer, Kliger and Meeker 2009: 212). For this study, AMPs are regarded as physicians. According to Von Pressentin *et al.* (2018: 14), in South Africa, a physician must carry out six fundamental roles, namely care provider, consultant, capacity builder, clinical trainer, clinical governance leader and champion of community-oriented primary care. When fulfilling these fundamental roles, the AMPs should be conscious of the fact that their patients might be using TM and therefore, disclosure of TM use must be encouraged and facilitated during a consultation as routine (Frenkel and Cohen 2014: 13; Stub *et al.* 2017: 2). Most studies have focused on TM use, its effects, and the attitude towards collaboration (Marais, Steenkamp and DuPlooy 2017: 36; Nemutandani, Hendricks and Mulaudzi 2016: 6; Gyasi *et al.* 2011: 46). The failure of AMPs to recognise traditional health practitioners (THPs) emanates from years of perceived intimidation of AMPs by THPs (Nemutandani, Hendricks and Mulaudzi 2016: 1). Regardless of this perception, the AMPs' responsibility is to understand the attributes of patients who may or may not disclose the use of TM and to trace and record any negative interactions detected (Chang, Chang and Siren 2013: 2).

According to Ekor (2014: 4), AMPs receive hardly any training on how TM influences the treatment they provide to patients. He further elaborates that AMPs are not knowledgeable regarding the types of TM and their uses. Some TM use may result in reactions. For example, garlic is believed to alleviate hypertension but usually results in some side effects such as burning in the gastrointestinal tract, nausea, dyspnoea and light-headedness. Therefore, AMPs need to show commitment to understanding the use of TM. This can be done by merely asking relevant questions when they are in consultation with patients that may be using TM.

Therefore, disclosure of TM use to AMPs must be encouraged for safe and effective patient care (Foley *et al.* 2019: 1; Chung *et al.* 2021: np). When AMPs fail to enquire about TM use, patients perceive this as detachment from the

issue and therefore conclude that disclosure of TM use is insignificant to the AMPs (Robinson and McGrail 2004: 95). A study by Warriner, Bryan and Brown (2014: 139), which aimed to analyse women's attitudes towards the use of TM in pregnancy, revealed that patients' perception of TM use was positive because there were no strict instructions to follow. The authors further elaborate that this sense of authority regarding their well-being influenced patients' non-disclosure as they felt disclosing would shift the authority to the AMPs (Warriner, Bryan and Brown 2014: 139).

Non-disclosure of TM used by patients using both TM and AM results in fragmented care of patients. Kew *et al.* (2015: 91) conducted a study aimed at investigating the prevalence of TM use, treatment preference and substitution of AM in the study population with cardiovascular risk factors. The study results reveal that the absence of proper communication between patients using TM and AMPs is the main influence on fragmented patient care and ultimately results in poor patient management.

These results are consistent with those presented in a review paper of policies and peer-reviewed English journals which employed four settings, i.e., England, South Africa, Kenya and Jordan (Stuttaford *et al.* 2014: np). The results show that there is a gap in research on the right of patients who choose to use both TM and AM simultaneously. This review further elaborates that research on the interaction of TM and AM, consent and respect for the patient's own choice of treatment is vital. Research of this calibre will enhance the relationship between patients and AMPs because it will improve healthcare delivery by establishing a balance between the two treatments.

The current study assists in understanding the disclosure procedures to AMPs for TM use by patients who use both TM and AM. This research, therefore, addresses the gap that is viewed as non-disclosure of patients using both TM and AM at selected hospitals. This concept builds upon the various insights that have been revealed by other researchers in health and social sciences to facilitate collaboration between THPs and AMPs and improve patients'

treatment outcomes. Therefore, the findings of this study assisted the researcher in developing guidelines to facilitate disclosure of TM use to AMPs by patients who use both TM and AM at the selected hospitals in Gauteng.

1.2 PROBLEM STATEMENT

Patient disclosure of TM use to AMPs should be part of hospital work ethics to reduce side effects during treatment (Marais, Steenkamp and DuPlooy 2017: 36). Johny, Cheah and Safii (2017: 9) found that patients' disclosure of the use of TM to AMPs is an important area for inquiry and suggest that to better understand the broader perspective of the relationship between AMPs and patients with regards to TM use, more qualitative studies are necessary to ascertain AMPs' outlook on the subject. Due to the increase in TM use globally, the health system is faced with recognition of increasing issues surrounding the safety of TM use (Ekor 2014: 1). In sub-Saharan Africa the use of TM remains common because it is considered a cultural component (Amaroyi 2016: 6) as well as a family tradition (Welz, Emberger-Klein and Menrad 2019: 8). However, the main concern is that most AMPs do not enquire about the use of TM during a consultation (Kretchy, Owusu-Daaku and Daquah 2014: 8). AMPs need information about these patients because non-disclosure may seemingly promote unnecessary interaction between the two treatments (Stub *et al.* 2016: 2; Johny, Cheah and Safii 2017: 9).

According to Robinson and McGrail (2004: 96), the reason for non-disclosure may emanate from the pessimistic critical responses received from THPs. There is a paucity of in-depth research on the disclosure of the use of TM and AM (Foley *et al.* 2019: 12). According to Foley *et al.* (2019: 12) and Stuttford *et al.* (2014: np), more research into the nature of prevalent communication patterns, including differences in disclosure behaviours among populations of different demographics, as well as clarification about state obligations concerning the right to information, is required. Non-disclosure by patients using both TM and AM forms contributes to the fragmented healthcare system and therefore affects the efficacy of the health system. Humble openness to

disclosure is an essential component for the successful integration of TM and AM to encourage a positive healthcare system (Mothibe and Sibanda 2019: 10). This study fills this gap by addressing the issue of non-disclosure of TM used by patients using both TM and AM.

1.3 AIM OF THE STUDY

This study aimed to explore and describe the perceptions of AMPs regarding the disclosure of TM use to AMPs by patients who use both TM and AM and ultimately to develop guidelines for disclosure of TM use to AMPs at selected hospitals in Gauteng.

1.4 RESEARCH QUESTIONS

The main research question is as follows:

- What are the guidelines for disclosure of TM use to AMPs by patients who use both TM and AM in Gauteng?

The following research questions were used to guide the study:

- What are the perceptions of AMPs regarding the disclosure of TM use by patients who use both TM and AM?
- During a consultation, what are the practices of AMPs regarding disclosure of TM use by patients who use both TM and AM?
- How will AMPs encourage patients who use both TM and AM to disclose TM use?
- What procedures should be followed to encourage disclosure of TM use to AMPs by patients who use both TM and AM?

1.5 SIGNIFICANCE OF THE STUDY

Traditional healing is gaining acceptance all over the world because it is affordable and uncomplicated and shows evidence of growing profits (WHO 2002: 19). According to the 2002 WHO Strategy on TM, alternative healing practices should be integrated into national health systems (WHO 2002: 29).

Furthermore, one of the key objectives of the WHO strategy 2014 – 2023 is based on the WHO strategy of 2002-2005 and calls for the execution of national TM policies in those member states, of which South Africa is one, where the integration seems viable (WHO 2013: 11).

In South Africa, recommendations have been made on the cooperation of AMPs and THPs concerning attitude, communication and empowerment (van Rooyen *et al.* 2015: 9). However, the belief system of most AMPs seemingly conflicts with traditional African cosmology comprising confluent explanations of existence and natural occurrences, of life, religion, health, disease, healing and death (de Roubaix 2016: 159). AMPs' perceptions of TM are seemingly aligned with Western methods and this mindset may need to be decolonised to alter their attitudes (Nemutandani, Hendricks and Mulaudzi 2016: 1) because these attitudes and beliefs may ultimately influence health and patient care (Sundarmurthy, Devarashetty and Reddy 2017: 1996). The lack of knowledge of TM, coupled with prominence based on Western teachings, gives rise to discrimination against THPs and their patients (Krah, De Kruijf and Ragno 2018: 159). Subsequently, these factors affect the communication between the patients and the AMPs. Research into the nature of communications, including disclosure etiquette of patients, is therefore required.

Poor communication between patients and AMPs, lack of awareness of possible interaction between TM and AM, as well as AMPs judging the use of TM incorrectly may result in non-disclosure by patients using both TM and AM (Agarwal 2020: 130). The lack of proper communication increases the possibility of AMPs missing serious health issues that may result from the negative interaction of TM and AM, as well as the collapse in the connection between the patients (who use both TM and AM) and AMPs (Bauer and Guerra 2014: 2). Ultimately these call for research to explore the relationship between non-disclosure and treatment outcomes to clearly understand how this impacts the patient care given to these patients by AMPs (Foley *et al.* 2019:12).

Johny, Cheah and Safii 2017 (2017: 5) state that barriers to disclosure arise from the patient's loss of trust in the AMPs. Robinson and McGrail (2004: 93) indicate that most studies seem to present similar results regarding the grounds for non-disclosure, stating that these grounds are classified into three areas: the negative response of AMPs, the patient's perception that there is no need for AMPs to know about the TM use and the AMPs not asking about TM use. These revelations show how important it is that AMPs be urged to enquire about the patient's use of TM (Frenkel and Cohen 2014: 12).

It is very unlikely that patients will take part in a conversation when they feel disregarded and offended during a consultation (Fischer and Ereaut 2012: 40). Most studies show why patients do not disclose, but information on why AMPs do not try to probe these patients is lacking (Foley *et al.* 2019:13; Johny, Cheah and Safii 2017: 9; Bello, Winit-Watjana and Macgarry 2012: 133). The choice of AMPs as the only participants in this study were based on the perspective of AMPs being the leader of the enquiry during a consultation (Rocque and Leanza 2015:11) because they are required to initiate the session and be able to explore issues of the patient (Dennes 2013:595). Fischer and Ereaut (2012: 47) presented an idea for developing a consultation model in their report, which they describe as an occasion where the AMP and the patient are engaged in a dance, but only the AMP knows the steps and can hear the music. It was therefore anticipated that this choice would benefit the study outcome, which was to ultimately develop guidelines for disclosure of TM use to AMPs.

The necessity for disclosure demands that AMPs have methods which they can use to encourage disclosure from this group of patients. Thus, hospitals that apply the recommended guidelines from the results of this study could yield better health outcomes for their patients. The AMPs will be guided on what should be emphasised during a consultation with the patients that may be using both TM and AM. For the researcher, the study uncovers critical areas in the disclosure process that many researchers have not been able to explore. Thus, a set of guidelines for disclosure of TM use to AMPs by patients who use both TM and AM may be developed.

This study will benefit AMPs, THPs and patients using both TM and AM in that the AMPs may even discover simple ways to engage with these patients. The researcher proposes the developed guidelines to be implemented in hospitals in Gauteng which will benefit especially if they have been experiencing unexplained reactions by patients using both forms of medicine. Further to this, the researcher proposes that the efficacy of the implemented guidelines be assessed. Finally, the study will benefit THPs whose patients will be informed in line with their disclosure history. Fragmentation is not only of concern from an equity perspective but also concerning health system efficiency and affordability. Focusing on the patients' interaction with AMPs can help develop better relations between the AMPs and the THPs, as well as potentially inform future policy objectives. Therefore, the findings of this study will benefit the healthcare system, considering that non-disclosure by patients using both TM and AM may affect how the patient is managed.

1.6 STRUCTURE OF THE THESIS

Chapter 1 provides an overview of the study. Chapter 2 contextualises the study in the relevant literature. The theoretical framework that guided the study is discussed in Chapter 3. Chapter 4 is an account of the research methodology and methods applied in the study. The results are presented in Chapter 5. Chapter 6 deals with the analysis of the acquired data. Chapter 7 presents a detailed discussion of the development of guidelines. Finally, the summary, limitations, conclusion and recommendations of the study are covered in Chapter 8. The outline of the thesis chapters is illustrated in Figure 1.1 below:

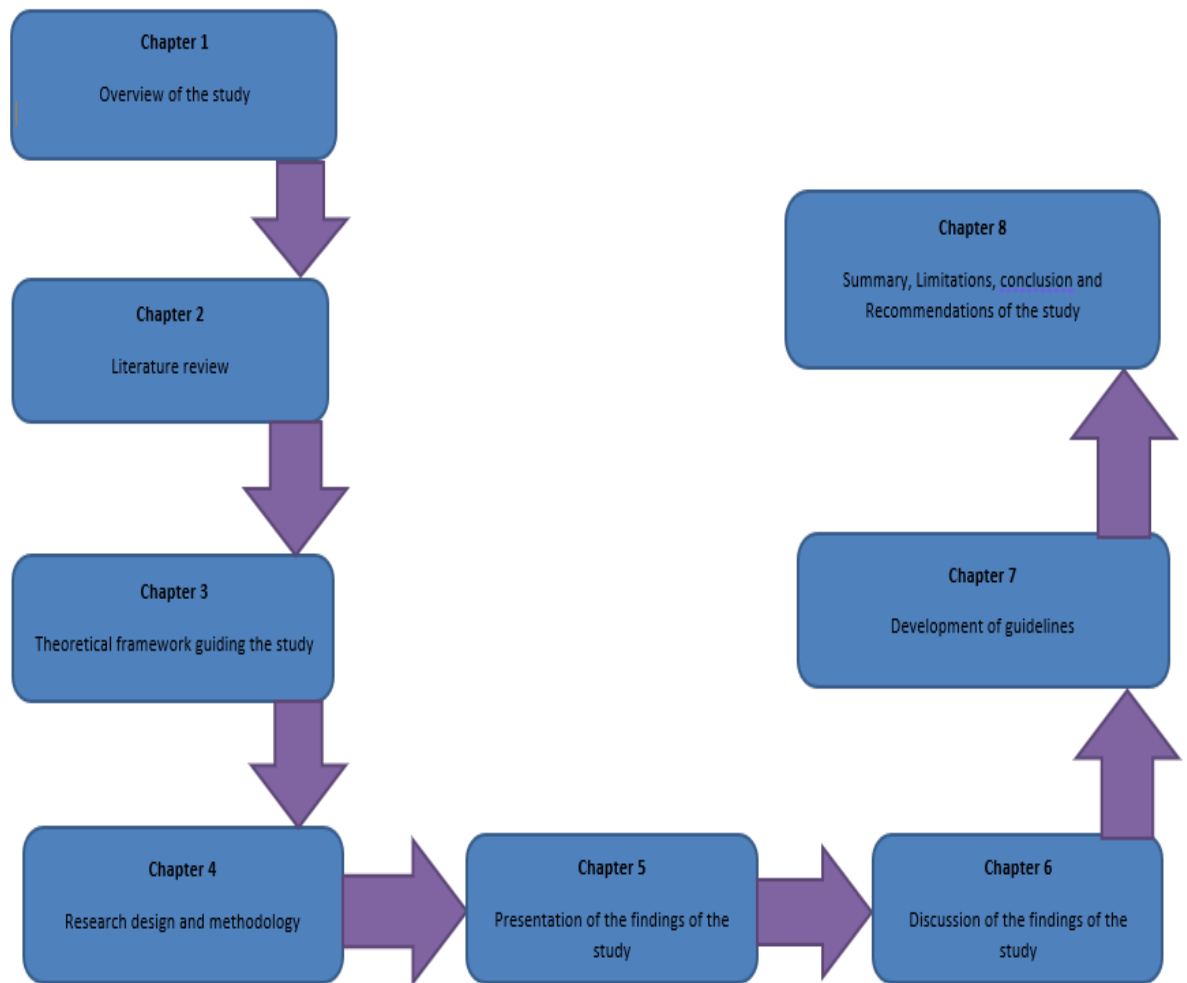


Figure 1.1: Outline of thesis chapters

1.7 SUMMARY OF THE CHAPTER

This chapter outlined the development of the researcher's interest in the disclosure of the use of TM and AM by patients, particularly to AMPs. Background information was given on the prevalence of non-disclosure by patients using both TM and AM. The problem statement and the significance of the study illustrate how the study was contextualised within the literature. The literature related to this study is reviewed in the next chapter.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 focused on the background and rationale of this study and a brief outline was provided of all the chapters. This chapter provides further background on literature related to disclosure to AMPs by patients using both AM and TM. The literature related to the study's purpose is reviewed in this chapter. The purpose of this chapter is to present the reader with a detailed background of what was known and not known about the research problem before data collection and what was useful in regulating the data for the focus of this study (Gray, Grove and Sutherland 2017: 929). The focus of this study was on exploring and describing the experiences of AMPs on non-disclosure by patients using both TM and AM. Although there is a paucity of literature related to the focus of the study, some identified literature communicates primary opinion which assisted the researcher in identifying the existing gaps in knowledge relating to the topic. This literature review assisted the researcher in developing guidelines that will facilitate disclosure to AMPs by patients using both AM and TM at selected hospitals in Gauteng.

2.2 LITERATURE SEARCH

This literature search was done according to the procedure clarification for writing a literature review for a thesis (Galvan and Galvan 2017:12) and was initiated in March 2020. Helpful leads for keywords as well as basic data context relating to the research question were found through Google. The keywords used to search were: 'traditional medicine', 'complementary medicine', 'allopathic medicine', 'integration', 'drug-herb interaction', 'physicians', 'health care system' and 'patient-provider relationship'. Literature to support the study and to identify the gaps from studies done on a similar topic was reviewed using search engines such as Science Direct, Google Scholar, ResearchGate and PubMed to search for scholarly peer-reviewed journal articles and books. Most

of the research studies considered in the research were recent and performed within the last decade. The sources that were used in this literature review provided a solid foundation upon which the rationale for the study was built and the findings on this under-researched topic and disclosure phenomenon were interpreted.

Although the reasons for non-disclosure to AMPs by patients using both AM and TM have been researched extensively, there are not many studies that show why AMPs are not trying to probe these patients during consultation about their TM usage. The paucity of literature on perceptions of AMPs regarding disclosure of TM use to AMPs by patients who use both TM and AM has been highlighted by several researchers (Bello, Winit-Watjana and Macgarry 2012: 130; Chang *et al.* 2013:7; Stub *et al.* 2017: 312; Foley *et al.* 2019: 12; Johny, Cheah and Safii 2017:9). Bello, Winit-Watjana and Macgarry (2012: 130) state that “there was little evidence of in-patients revealing their applications of CAM [complementary alternative medicine] during a hospital stay in the UK and abroad, and few studies mainly focused on the CAM disclosure to medical doctors and nurses”. Chang, Chang and Siren (2013: 7) state that “research on the factors predicting the disclosure of using natural products to conventional healthcare professionals is limited and, consequently, there is a lack of knowledge on factors influencing the decision to disclose and not to disclose”. Stub *et al.* (2017: 312) point out that AMPs have called for more research and guidelines on TM and the training of THPs. The lack of policies concerning communication between AMPs and patients was also highlighted in recent research (Foley *et al.* 2019: 12; Johny, Cheah and Safii 2017: 9). Foley *et al.* (2019:12) propose that “research exploring the relationship between communication and treatment outcomes is warranted to provide a richer, deeper understanding of the impact of patient care dynamics”. The same authors went on to say, “Such understanding could arguably provide the scaffolding for robust, effective, efficient public health policy and practice guidelines”. Johny, Cheah and Safii (2017: 9) suggest that more qualitative studies are needed together with quantitative findings from the healthcare provider’s perspective concerning the disclosure of traditional and

complementary medicine context “to help better understand the big picture of the patient-doctor relationship”.

Certainly, the well-being of this group of patients is dependent on a discussion of their use of TM with the AMPs. Therefore, apart from targeting to decrease the risks of interaction between TM and AM through discussion, this process could also inspire an increase in disclosure during the consultation as trust is established (Wardle, Sibbritt and Adams 2018: 252). Considering the lack of relevant literature, the search was broadened. The researcher found literature that included research on adverse reactions and the integration of TM and AM. Studies that were excluded dealt with TM and AM diagnoses of patients as well as studies that discussed the benefits of TM and AM use as individual medicines. The reference lists of core sources were perused to identify other relevant sources. Therefore, both refereed and non-peer-refereed articles and online material were considered for a thorough review of accessible research and resources. In the case of uncertainty, all literature abstracts were reviewed to ascertain relevance to the focus of the current study and all literature complementing this research was selected. The Gauteng Department of Health website was visited to assess different documents, policies and guidelines related to the focus of the study. After scrutinising, the researcher was able to develop the sections listed below:

- Historical perspective of TM and AM use
- Relevance of TM in Society
- South African legislation on THPs
- Global, African and South African views on non-disclosure to AMPs by patients using TM and AM
- Barriers to the facilitation of disclosure to AMPs by patients using both TM and AM
- Issues of interaction between AM and TM
- AMPs as leaders of the enquiry during a consultation
- Strategies to facilitate disclosure

The literature review that follows shows the significance of probing patients using both TM and AM by AMPs and the guidelines to facilitate disclosure by these specific patients. The role of the AMPs as the main facilitators of the disclosure conversation during a patient consultation is also assessed.

2.3 HISTORICAL PERSPECTIVE OF TM AND AM USE

TM use is generally recognised in countries in sub-Saharan Africa, but most research is evident in countries such as Nigeria, South Africa, Ghana and Uganda (James *et al.* 2018: 12). Mahomoodally (2013: 2) describes Africa as a biodiverse continent containing between 40 000 and 45 000 species of plants, 5 000 of which are used in medicine. The evolution of TM use has a historical context that corresponds to the Stone Age (Ozioma and Chinwe 2019: 191

TM was used globally for the treatment of various diseases long before the arrival of AM and is still being used by most of the population for their healthcare needs (Mothibe and Sibanda 2019: 1). Despite this, according to Macfarlane (2015: 60), TM was rejected by the European settlers in South Africa based on a lack of knowledge and threat to their command over the development of the continent. This had devastating effects on community livelihood and cultural recognition (Abbott 2014: 14). However, with the progression to democracy in most countries, TM was normalised in a bid to preserve the heritage even though most Africans were already accustomed to AM (Macfarlane 2015: 60). TM has been reported to have magnificent benefits for the economy (Abdullahi 2011: 119).

Traditional, complementary, and alternative medicine's economic impact in South Africa was estimated to be R2,9 billion in 2007 (Mander *et al.* 2007: 190). Furthermore, according to the 2008 WHO Report, annual revenues from herbal treatments alone reached \$5 billion in Western Europe in 2003-2004. The then Health Minister Dr Manto Tshabalala-Msimang said in 2007 that TM should be protected and the implementation of continental initiatives focusing on TM

research and development should be accelerated (Tshabalala-Msimang 2007). As a result, it is critical to discuss issues concerning indigenous knowledge system protection. Despite this, tensions continue to dominate the landscape of research and policy debates on the role and practices of TM, particularly concerning historical injustices, gaps in scientific evidence, mistrust on the part of AMPs and toxicity of TM (Moshabela, Zuma and Gaede 2016: 83).

Most patients decide to use TM as a result of dissatisfaction with AM, negative attitude of AMPs towards cultural TM healthcare methods, drug availability, long distance to and inequity in accessing health facilities as well as long waiting times (Diaz *et al.* 2016: 7; Olisa and Oyelola 2009: 104; Mwaka, Okello and Orach 2015: 510). A study by Ahlberg (2017: 8) set in Central Kenya noted that people continue to use TM and AM together to meet their health-perceived needs, but those traditional healers are often consulted because they deal with health, social and psychological problems simultaneously.

Non-disclosure of TM use to AMPs is listed as an integral point of research considering the increase in the use of TM in sub-Saharan Africa (James *et al.* 2018: 2). Furthermore, the feedback from research on the topic is important as it may highlight to policymakers, researchers and AMPs those implementations that will promote the health and safety of patients using TM. In a study by Zank and Hanazaki (2017: 13), the low cost of TM was cited as the most prominent reason for using TM despite the possible effects. The study also reported the co-existence of TM and AM use where TM was used to treat problems of the digestive system, respiratory system and general pains. Sobiecki (2014: 3) explains that genuine THPs are pivotal in any healthcare system where people consider the human entity to be one with nature and that TM influences the levels of an individual's physical, psychological and spiritual components.

The purpose of the Traditional Health Practitioners Act 22 of 2007 (Republic of South Africa 2008: 2) is "To establish the Interim THP Council of South Africa; to provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for the management and control

over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners profession; and to provide for matters connected therewith". However, in South African society none of the THPs has been registered even after legislation was put in place over a decade ago (Abrams *et al.* 2020: np). Therefore, the WHO suggests that it may be unnecessary, and perhaps worthless, to seek to harness TM when there is clear evidence that the population prefers AM (Oyebode *et al.* 2016: 984).

Tran *et al.* (2016:2) did a study aiming to assess preference and awareness of TM use as well as satisfaction with TM services among people in rural Vietnam. They observed that the population was more likely to choose TM over AM. Some research indicates that TM is still widely used in Africa regardless of the lack of data about the actual patients and the reason for use (Shewamene, Dune and Smith 2017:14). According to the WHO, several Asian countries show significant use of TM despite AM being accessible (WHO 2002: 11). For example, TM use is frequent in China, Ghana, Mexico, Russia and South Africa and much less frequent than commonly reported in India (Oyebode *et al.* 2016: 988).

2.4 RELEVANCE OF TM IN SOCIETY

Ozioma and Chinwe (2019: 193) state that in the African traditional setting, diseases are often linked to an explanation, and most conditions are believed to be related to bad spirits, witchcraft or even angered spirits. These conditions include hypertension, sickle-cell anaemia, cardiomyopathies and diabetes, which are thought to be well-understood by AMPs. According to traditional African beliefs, a living person is a human characterised by physical, spiritual, moral and social aspects and any imbalance would result in ill health (Ozioma and Chinwe 2019: 193). This means that the treatment of an ill person requires consideration of the body and other components such as the spiritual, moral and social components.

According to Abbott (2014: 5), there has been a renewed global comeback in the use of TM in the last two decades, although there has been significant use of TM in the developing world. While there is evidence that a recognisable number of patients still use both medicines, they do not necessarily disclose them in the hospital setting (Marais, Steenkamp and DuPlooy 2017: 36). James *et al.* (2018: 11) conducted a review which indicated that TM was used simultaneously with AM and that TM was not a substitute for AM, but rather a supportive therapy. Lemonnier *et al.* (2017: 12) argue that the knowledge base of TM practices may still be useful in future to add an element of consideration for the prevention of disease as well as the general wellness of patients during treatment. Although the issue of poor knowledge of TM by AMPs and communication breakdown between AMPs and patients using TM persists, there seems to be an interest in AMPs to learn more about TM (Thandar *et al.* 2017: 27).

2.5 SOUTH AFRICAN LEGISLATION ON TM USE

A recent article by South African authors Abrams *et al.* (2020: np) mapped and analysed legislation on THPs in the Southern African Development Community (SADC) which comprises 14 countries, including South Africa. Their analysis reveals that South Africa was the only country with information that was up-to-date and reasonably accessible (Abrams *et al.* 2020: np). However, it has been evident from previous years that most of the funding from both state and private sectors was infused into AM practices compared to TM; this has in turn elevated the cost of AM (Rautenbach 2007: 520). The South African government took the initiative to incorporate TM into the health system by setting up a Directorate of Traditional Medicine in 2006, which was given the authority to manage the resourcefulness of TM in the Department of Health and validate the Traditional Health Practitioners Act (Republic of South Africa 2008: 2). According to Abrams *et al.* (2020:np), the South African THP Bill was presented in Parliament in 2003 but only publicised later in 2004. Despite the hurdles that the Act had to overcome in the beginning, it was later approved by the

legislature with very minimum change from the 2004 draft (Abrams *et al.* 2020:np).

This Act ultimately lays out the validation of the earliest favoured healthcare system (Street 2016: 326). In 2008, the South African government published a notice about a draft policy on African TM for South Africa (South African Department of Health 2008: 1). This draft policy marked a historical event for African TM in South Africa, which came at a time when the public healthcare system needed to consider the diversity in health disciplines used by South Africans for their healthcare needs (South African Department of Health 2008: 3).

Rautenbach (2011:45) highlights an important fact, stating that the South African government has realised that healing is intertwined culturally and spiritually into the lives of many South Africans and therefore the application of international guidelines related to TM should be integrated into the public healthcare system in South Africa. Recent data shows without a doubt that the argument is no longer about the case of TM being integrated, but rather how this integration can be achieved (Rautenbach 2011: 30). The South African government and public organisations such as the South African Healers Association and the Traditional Health Organization recognise the necessity for accessibility of both TM and AM for patients.

2.6 GLOBAL, AFRICAN AND SOUTH AFRICAN VIEW OF NON-DISCLOSURE TO AMPs BY PATIENTS USING TM AND AM

Globally, the use of TM in the treatment of any disease has been increasingly welcome (Ekor 2014: 4; Abdullahi 2011: 120). A review by Foley *et al.* (2019: 2) aimed to describe the prevalence and characteristics of disclosure of TM use to AMPs. Their analysis reveals that there has hardly been any observable development in the rate of disclosure in the past decade. The outcome of previous reviews has shown that disclosure rates vary (Foley *et al.* 2019: 6), depending on population demographics and the classification of TM (Robinson

and McGrail 2004: 96). Therefore, AMPs can play a part in boosting the rate of disclosure by probing patients about TM use. Foley *et al.* (2019: 12) reiterate the importance of further research on the topic, especially concerning AMPs' involvement as the key gatekeepers in general awareness of their patient's health (Foley *et al.* 2019: 13). Ensuring patient safety calls for intense exploration of patients' disclosure of TM use and the basis for non-disclosure (Bello, Winit-Watjana and Macgarry 2012: 126).

Non-disclosure by patients using TM is difficult for AMPs because it prevents them from giving the best patient care and promotes the risk of herb-drug interaction (McIntyre *et al.* 2016: 9; Zingela, van Wyk and Pieterse 2019: 147). A study by Johny, Cheah and Safii (2017: 1) found that patients are responsible for disclosure of the use of TM owing to the increase in the use of TM, which threatens the possibility of patients substituting the use of AM over time. However, the results showed a low rate of disclosure by patients, which led the researchers to assume that the patients may consider it unimportant to disclose to AMPs because they are unaware of possible adverse effects and also the AMPs usually do not ask about the use of TM. Most of the participants in the same study revealed that they were aware of the main benefits of disclosure of TM use to AMPs, which were health benefits and the platform to carry on with TM use, as they could get clarity before deciding to continue with the use of both TM and AM (Johny, Cheah and Safii 2017: 7). Similar results were seen in a study by Agyei-Baffour *et al.* (2017: 5), which revealed that the participants believed in the significance of disclosure of TM for ensuring the effectiveness of their treatment, even though none of them had ever considered disclosing.

A study in Australia by Wardle, Sibbritt and Adams (2018: 252) highlights that those AMPs who are against the use of TM with no room for discussion should be made aware of the critical dangers of non-disclosure. Furthermore, this can lead to awareness of the significance of the need to look into ways to address the strain of non-disclosure between AMPs and patients. Patients do not disclose because the AMPs do not ask about the use of TM, and the patients consider that it is not important to disclose their use to the AMPs (Ahmed *et al.*

2020: np). Abdullahi (2011: 120) believes that to some extent, “colonialism, Western religion and education as well as globalisation phenomenon have negatively affected the perception about TM in Africa, usually among the educated elites”. AMPs in South Africa attend to patients with diverse cultural backgrounds (Zingela, van Wyk and Pieterse 2019: 147) and different education levels and occupations (Sobiecki 2014: 1). Further to this, the use of TM in South Africa also varies between physical and spiritual uses concerning health (Sobiecki 2014: 2). Therefore, the TM system is mostly regarded as a community-level system that is complex, yet easily adjustable (Zank, Araujo and Hanazaki 2019: 1).

2.7 BARRIERS TO FACILITATION OF DISCLOSURE TO AMPs BY PATIENTS USING BOTH TM AND AM

Mothibe and Sibanda (2019: 9) suggest that both patients themselves and AMPs have various reasons for non-disclosure. Patients are not necessarily forthcoming about their history of TM use when consulting their AMPs, thus suggesting that doubt still exists that prevents the collaboration of the two entities (Mothibe and Sibanda 2019: 9). Non-disclosure of TM use in the hospital setting is an important occurrence that needs to be investigated and attended to. Chang, Chang and Siren (2013: 2), in a study aimed at exploring the decision for the use of TM by out-patients, found that the rationale for the lack of communication between the AMPs and patients was less explored. These researchers suggest remodelling the medical model into an integrated one that would cater for TM and AM in-patient treatment strategies.

Amirudin *et al.* (2021: 281) identify patient barriers to disclosure in the use of TM to treat diabetes. The participants revealed the following possible factors for their failure to disclose:

- Fear that the AMPs would scold them
- A belief that the AMPs would also disapprove of their TM usage
- Lack of enquiry by AMPs about TM usage during a consultation
- Choice of not disclosing until probed

- Some revealed having disclosed but were subsequently reluctant to do so because they had a bad experience after the disclosure

Foley *et al.* (2019: 6) also identify several factors related to the communication between AMPs and patients about TM use: a modern person-centred healthcare model, the type of communication approach, the barriers of discussion during a consultation as a result of AMPs' perceived knowledge of TM as well as the disclosure is made after a direct enquiry about TM use by the AMPs. Peprah *et al.* (2019: 72) found that the main reason for non-disclosure of TM use to AMPs by patients using both TM and AM is that patients believe that TM use is safe and that disclosure may cause them to lose authority over their health resolutions. Furthermore, these patients believe that they may be victimised and coerced to stop using TM.

Gall *et al.* (2019: 4) conducted a study aiming to explore AMPs' views on the usage and disclosure/non-disclosure of TM by native cancer patients. The study identified six key themes:

- Concern about risks such as hospitalisation as a result of drug-herb interaction (Marais, Steenkamp and DuPlooy 2017:36) when using TM
- No 'real' benefits of TM use
- Has no scientific base
- Patients' choice is twofold since they may choose to disclose or not to disclose
- AMP's lack of knowledge of TM

The findings of their study were that the perceptions of AMPs about TM and AM are opposing rather than supportive due to their knowledge and outlook about TM (Gall *et al.* 2019:8). AMPs usually consider only the success of the TM that they have accessed; however, other aspects of individual treatments such as "risk, alignment with medical principles, and openness to exploring new avenues of treatment where others have failed" are just as critical when AMPs shape their perception of TM (Wardle, Sibbritt and Adams 2018: 253). Mwaka, Abbo and Kinengyere (2020: 3703) cite the following reasons for non-disclosure: AMPs not probing patients, rebuking patients for using TM and

lacking knowledge of TM, resulting in no need to share issues of the use of TM with them.

2.8 ISSUES OF INTERACTION BETWEEN AM AND TM

Johny, Cheah and Safii (2017: 2) maintain that while TM may be useful in certain aspects of the patient's well-being, some treatments may have adverse effects and may interact with the prescribed AM. Abbott (2014:5) notes that the use of TM is subject to several disputes within the health system. Kim *et al.* (2020: 1077) state that TM generally yields negative outcomes but also that some research has indicated otherwise. AM is defined as a treatment system based on Western healing methods and AMPs in this regard focus on disease presentation and not much so on the root cause. Therefore, AM usually aims to restore health without dealing with the origin of the disease (More 2016:4). There is a paucity of research related to various TM and AM negative interactions and effects (Oliveira, Piva and Lund 2015: 5).

Luckyx *et al.* (2004: 50) conducted a study several years ago on adverse effects associated with the use of South African TM. The study was based on a large sample of the population who were admitted to the hospital due to negative reactions to TM, occasionally resulting in loss of life. About 76% of the patients in the study presented with renal dysfunction, 48% with liver dysfunction and the recorded mortality rate was 34%. The conclusion was that people who use TM believe in the safety and efficacy of TM, but the belief is based on a lack of knowledge and not on data. Considering this outcome, it may be assumed that even TM which is deemed the safest may result in negative interactions when used concurrently with AM (Fong 2002: 290). Similarly, Kim *et al.* (2020: 1078) indicate that there are challenges with TM use, such as untimely deaths, incorrect use of TM and treatment delays. However, they suggest that rather than condemning the use of TM altogether, it would be wise to investigate the principal cause of those effects to be knowledgeable about the issue.

Ekor (2014: 1) conducted a review of the dangers of TM use and called attention to the challenges related to safety observation. Garlic, for instance, is known for its use in food but it is also used to control hypertension (Ekor 2014: 6). Crushing garlic changes its chemical composition and negative reactions such as “burning sensation in the gastrointestinal tract, nausea, diaphoresis, and light-headedness” have been reported. The same study reveals that ginkgo can obstruct platelet-activating factors, thus affecting bleeding times (Ekor 2014: 4). Furthermore, even though the extracts of this TM are considered safe, headache, dizziness, restlessness, nausea, vomiting, diarrhoea and dermal sensitivity are the most observed reactions.

In light of the above, it is clear that research into TM use is still necessary due to the issues that need to be addressed in future, such as the vague methods of the use of TM mixtures which may exhibit complementary effects (Yuan *et al.* 2016:13). In the case of patients using both TM and AM concurrently, non-disclosure to the AMPs poses the highest risk to patients, including side effects and drug-herb interactions (Mwaka *et al.* 2020: 3710).

2.9 AMPs AS LEADERS OF THE ENQUIRY DURING CONSULTATION

AMPs must be made aware of all the pertinent issues associated with non-disclosure of TM use during the consultation to be more considerate of their patient's beliefs and perceptions in a supportive clinical setting (Johny, Cheah and Safii 2017: 8). Robinson and McGrail (2004: 96) report non-disclosure to be the result of pessimistic critical responses received from AMPs. Non-disclosure of TM use by patients is worsened by this lack of proper communication with the AMPs (James *et al.* 2018: 11). Despite the lack of communication, the AMPs still bear the responsibility to understand and recognise the attributes of patients who may or may not disclose the use of TM to trace and record any negative interactions detected (Chang, Chang and Siren 2013: 9). Lewis, Matheson and Brimacombe (2011: 503) encourage AMPs to act as situational change agents during interactions with patients and

their traits and note that the way they relate to the patient can determine the patient's choice regarding disclosure.

Currently, the existing communication between patients and AMPs does not allow the AMPs to link TM and AM in practice; therefore, the development of workable methods to guide the process is required (Wardle, Sibbritt and Adams 2018: 252). Results from a study by Jou and Johnson (2016: 545) reveal that non-disclosure was the result of AMPs not probing their patients, coupled with AMPs' knowledge of TM, contrary to prior studies which showed that non-disclosure could be attributed to AMPs' rejection of TM use by patients. Thandar *et al.* (2017: 27) yielded similar results which showed that most participants were of the view that AMPs should ask all patients about TM use and stress the importance of AMPs knowing notable TM treatments. In support, Zingela, van Wyk and Pieterse (2019: 147) state that the use of TM is common in South Africa and therefore AMPs need to be knowledgeable to better manage their patients.

According to Ekor (2014: 4), AMPs have hardly any training on how TM influences the treatment they provide to patients. This contributes to the lack of knowledge of the types of TM and their uses. AMPs should be aware of non-medical meanings and effects of medicines to avoid ignoring the issues surrounding various medicines (van der Geest and Hardon 2006: 4). Therefore, AMPs need to show commitment to understanding the use of TM. This can be done by merely asking relevant questions when they are in consultation with patients that may be using TM (van der Geest and Hardon 2006: 4). It is therefore important to create ways to train AMPs to work under conditions that complement TM and to respect the different forms of knowledge to pursue a higher quality of healthcare for all patients (Zank and Hanazaki 2017:14; Kim *et al.* 2020:1079).

There is a paucity of research concerning the non-disclosure of the use of TM and AM (Foley *et al.* 2019: 12). Foley *et al.* (2019: 12) and Stuttaford *et al.* (2014: np) encourage more research into the nature of prevailing

communication patterns, including differences in disclosure behaviours between populations of different demographics as well as clarification about state obligations regarding the right to information. Based on the explored literature, it can be concluded that focusing on the patients' interaction with the AMPs, establishing a knowledge base for identifying these patients and exploring the current procedures employed when a negative interaction between TM and AM is identified can help develop guidelines, thus potentially informing future policy objectives. There are few studies on TM use disclosure issues in a hospital setting in Gauteng, South Africa.

2.10 STRATEGIES TO FACILITATE DISCLOSURE

The WHO TM Strategy 2014 – 2023 aims to support member states that are driven to implement systems that will strengthen the role of TM in healthcare (WHO 2013: 7). Ahmed *et al.* (2020: np) conducted a study aimed at examining the characteristics and potential predictors of TM use among pregnant women in Nepal. This study revealed that at least 60.3% used TM during their previous pregnancy. Considering this revelation, the researchers reflect that regular antenatal care visits might have assisted these patients in building mutual trust. They further suggest that combining antenatal check-ups with a combination of questions about TM use would facilitate the disclosure of TM use during pregnancy. Furthermore, the development of public education and awareness programmes on the safe use of TM was suggested to encourage pregnant women's disclosure of TM use.

Writing on traditional medicine in modern healthcare, Berube (2015) notes that learning more about the holistic benefits of TM and ceremonies, as well as becoming more knowledgeable in both practices may result in a greater level of respect and understanding for each discipline, realising the significance of recognising the co-existence of both systems. James *et al.* (2018: 11) propose that all policies and guidelines related to TM must integrate teachings about cultural differences, specifying the significance of patient disclosure of TM use to the AMPs. This optimistic outlook may further be encouraged by prospects

of an improved patient-provider relationship due to balanced quality care (Stuttaford *et al.* 2014:np).

Chung *et al.* (2021: 1) summarised evidence of the possible use of TM to promote healthy ageing by considering population preference, available clinical evidence, community empowerment strategies and the importance of regulating TM. Through their review, the combination of opinions from mature people led Chung *et al.* (2021:7) to conclude that policymakers require facilitating communication and collaboration between THPs and AMPs, regulatory bodies, community organisations and the public. Furthermore, the development of guidelines could also encourage uniform care, thus ensuring that all patients experience the same patient care for similar clinical presentations regardless of the hospital or attending AMP (Lim *et al.* 2008: 29).

2.11 SUMMARY OF THE CHAPTER

This chapter presented the findings of the literature reviewed to support the study's aim. Several sources and findings to support and prove the need for this study were mentioned and used to generate relevant arguments related to this research. In the context of this study, disclosure was presented as communication between the patients and AMPs concerning the use of TM. The discussion was also based on establishing a knowledge base for identifying patients that use both TM and AM as treatment options and exploring the current procedures employed when a negative interaction between TM and AM is identified to inform future strategies to facilitate disclosure. Most of the research reviewed concentrated on patient perceptions of disclosure to AMPs but did not investigate the reasons AMPs fail to probe patients using TM during consultation. Some studies advocate for policies and guidelines to ensure improved communication between patients using TM and AMPs.

In Chapter 3, the theoretical framework which was adopted to guide the current study will be presented.

CHAPTER 3: THEORETICAL FRAMEWORK GUIDING THE STUDY

3.1 INTRODUCTION

Chapter 2 revealed that non-disclosure of TM by patients using both TM and AM may have negative consequences in the overall management of the patient. Regarding communication between patients and AMPs, studies recommend that AMPs probe patients to encourage disclosure (van der Geest and Hardon 2006: 4; Thandar *et al.* 2017: 27; Foley *et al.* 2019: 12). Guidelines are therefore fundamental to help facilitate conversations during consultation between AMPs and patients using both TM and AM. A theoretical framework which is based on an existing theory would help the researcher to develop guidelines concerning the research aim of this study. Gray, Grove and Sutherland (2017: 234) describe a framework as an abstract, well-reasoned structure of meaning that guides the development of a study, thus enabling the researcher to link the study outcome to literature. According to Kumar (2011: 190), the theoretical framework emerges from the existing body of knowledge established in empirical evidence. Polit and Beck (2017: 225, 358) describe a framework as the general conceptual underpinnings of a theory-based study and warn that taking up research without a guiding theory may be condemned for suggesting cause and effect due to the lack of thoroughness of the outcome recommendations. Therefore, for any qualitative study, the combination of research and theory is necessary as the absence of a theory may limit the overall quality of the research (Bradbury-Jones, Taylor and Herber 2014: 136). Based on the research problem, it was assumed that privacy is not a simple concept, and therefore the researcher selected Petronio's communication privacy management (CPM) theory (2000: 1) to allow the concept of disclosure to be fully explored. This chapter outlines how this theory applies to the current research.

3.2 ESTABLISHING THE NEED FOR DISCLOSURE GUIDELINES

According to O'Dowd (2004: 39), the consideration of communication skills as part of medical training is uncommon. Literature shows that the application of guidelines for disclosure by patients using both TM and AM to AMPs during consultation has always been recommended (James *et al.* 2018: 11; Foley *et al.* 2019: 12). For instance, Stuttaford *et al.* (2014: np) assert that research is lacking on human rights and guidelines related to the right to health. Research has shown why patients fail to disclose (Ahmed *et al.* 2020:np) and why AMPs fail to probe (Gall *et al.* 2019: 8); however, their perception of non-disclosure by patients using TM remains an identified gap. This is despite several studies showing non-disclosure factors as being largely dependent on direct enquiry by AMPs (Foley *et al.* 2019: 6; Amirudin *et al.* 2021: 281).

Barriers to communication between the AMP and the patient using both TM and AM have been largely based on cultural differences which may be related to language use and belief systems (Fowler 2009: 43). AMPs who probe may be able to acquire actual information to allow them to give a precise diagnosis with suitable recommendations, thus increasing the chances of improved patient management wellbeing (The American College of Obstetricians and Gynecologists 2014: 389). Disclosure is not merely about the patient telling the AMPs what they need to know to be treated. When a person discloses information, it puts their mind at ease (Barach and Cantor 2007:79). There is already a notable knowledge base showing that patient perceptions of their AMPs have a lot to do with their choice not to disclose (Khan, Hassali and Al-Haddad 2011: 253; Gall *et al.* 2019:8). Patients deserve a partnership and clarity of suggested treatment as well as alternative treatment options regarding their care (O'Dowd 2004: 39).

Robinson and McGrail (2004:96) found that non-disclosure of TM use by patients that had a previous negative experience was based on their impulse to avoid conflict during consultation. Establishing a safety net that includes standard operating procedures to guide conversations between AMPs and

patients using both TM and AM is therefore essential to ensure that AMPs can protect patients from perceived negative effects resulting from the use of TM (Shelley *et al.* 2009: 145). Several studies have indicated that the overall management of the patient is dependent on disclosure of the use of TM, since the patients may not be aware of the harmfulness and possible interactions between TM and AM. Furthermore, the AMPs misjudge the use of TM (Agarwal 2020: 130). Therefore, the exposure of a patient to a negative incident with the AMP can adversely affect whether they decide to disclose or not to the AMPs for fear of their reaction (Jou and Johnson 2016:545; Gyasi, Siaw and Mensah 2015: 139). Consequently, this may result in the possible death of patients due to undetected reactions from combining the two treatments (Gyasi, Siaw and Mensah 2015: 138). This is significant with the advent of policies that encourage THPs to register their practice (Republic of South Africa 2008: 1). Proper disclosure may open access to both AMPs and THPs to allow for a more collaborative treatment plan even if the two practitioners never physically meet.

The absence of disclosure guidelines has a major effect on the interaction between TM and AM (Johny, Cheah and Safii 2017:8). Disclosure in this regard is significant as it is primary for AMPs involved in extensive management and care of patients since they are leaders during a consultation (Foley *et al.* 2019: 14). Both TM and AM used simultaneously are usually at odds with each other and thus more research should be encouraged to establish the potency and safety of TM (Ahlberg 2017: 8; Agarwal 2020: 131). Therefore, ensuring awareness of both individuals and AMPs about the risks of the use of TM is essential (Ekor 2014: 1). In addition, exploring the reasons patients and AMPs are not comfortable talking about TM is vital, as this could assist in understanding what can prompt patients to disclose and what can encourage AMPs to pay attention (Shelley *et al.* 2009: 146). This will assist in keeping track of any negative interactions between the two treatments to ensure better patient outcomes as the AMPs can make informed decisions regarding patient management. AMPs should make efforts to create a culture of safety for patients using both TM and AM, one in which all AMPs are willing to communicate in detail with patients as this is an important element for

disclosure (Johny, Cheah and Safii 2017: 8). In this way, the concept of proper communication between AMPs and patients using both TM and AM should also gain acceptance and further encouragement and prominence in Africa (Liwa *et al.* 2017: 8).

Therefore, to develop guidelines for facilitating disclosure to alleviate possible interactions between TM and AM, it was important to identify a useful theoretical framework for this study. Several authors have contended that qualitative researchers should consider using the theoretical frameworks of distinguished theorists in disciplines rather than aiming to construct a new theory, to build on the existing knowledge (Kivunja 2018: 46; Denzin and Lincoln 2018: 1245). On the condition that the researcher acknowledges the significance of a theoretical framework, the descriptions will be clear and validating (Anfara and Mertz 2015: 27). Non-disclosure by patients using TM to AMPs arises from a variety of barriers such as unwillingness and fear of rejection by AMPs, AMPs lacking TM knowledge associated with patients' misconceptions regarding AM, and ignorance of AMPs regarding non-disclosure (Gall *et al.* 2019: 5). Petronio's CPM theory was therefore employed in this study to allow the perceptions of AMPs towards disclosure by patients using both TM and AM with regard to barriers for disclosure to be adequately explored and described. CPM is an important component of disclosure because "managing privacy and confidentiality mean navigating between the need for autonomy and the need for connectedness with others" (Petronio, Dicorcia and Duggan 2012: 41).

3.3 SELECTION OF THE THEORETICAL FRAMEWORK TO GUIDE THE STUDY

A theoretical framework may be identified through a literature review to support the findings of a study (Trent and Cho 2014: 655). A theoretical framework is regarded as a description of the way things work (Collins and Stockton 2018: 1). Kivunja (2018: 46) describes a theoretical framework as the organised concepts and theories established by theorists that the researcher integrates and employs in developing a theoretical background or rationale for findings

contained in the data collected. In general, a theory is a systematic design that provides a detailed description of numerous ideas (Collins and Stockton 2018: 2). Kivunja (2018: 45) states that ideas, declarations and links claimed by the theory form a knowledge base for future research. and that theory assumptions develop the layout for future research with a limited knowledge base, thereby helping the researcher ascertain the key to understanding participants' perceptions. Furthermore, a theory can be used in descriptions of behaviour and to solve pertinent issues depending on the theory presumption as well as how the researcher understands the context of the topic. This research aimed to explore and describe the perceptions of AMPs towards disclosure of TM use to AMPs by patients who use both TM and AM and ultimately to develop guidelines for disclosure of TM use to AMPs. In this regard, Collins and Stockton (2018:2) describe the meaning of a theoretical framework very well by stating that it is the convergence of:

- Existing knowledge and previously formed ideas about complex phenomena
- The researcher's epistemological dispositions
- A lens and a methodically analytic approach.

Collins and Stockton (2018) further explain that a theoretical framework is the actual employment of a theory in research that demonstrates extensive merit while laying out the connections of how the study will cite new knowledge on the topic under research. The selection of the research theory for this study was based on the aim and research questions of the study. The theory that guided this study was Petronio's communication privacy management (CPM) theory.

3.4 PETRONIO'S COMMUNICATION PRIVACY MANAGEMENT THEORY

According to Margulis (2003: 411), privacy is dependent on consideration of the basic principles underpinning the concept of privacy. Philosophers such as Westin and Altman have shared ideas that have stood the test of time since the late 1960s and early 1970s. Westin's theory of privacy sparked a flurry of research into privacy states and functions, and other researchers conducted

systematic and empirical studies based on factor analysis and the function of privacy (Margulis 2003: 413).

Westin (1967:7) asserts that individuals have the right to choose what they want to disclose based on the context to which they are exposed. The actual conditions and justification of privacy are the focus of Westin's theory of privacy. Altman's theory of privacy (1975:24) focuses on privacy as a means of controlling access to oneself. The difference between these two theories stems from the emphasis of Altman's theory on social relationships, which leads to a more expansive view of privacy (Rizza *et al.* 2011: 9). As a result, Petronio (2004:194) supports Altman's privacy presentation, claiming that his research revealed that the lack of proper construction in information about disclosure could be remedied by conducting additional research on the opinions surrounding privacy in the structure of non-disclosure. According to Petronio and Child (2020: 76), Altman's foray into privacy laid the groundwork for a theoretical and functional CPM theory that could be used to better understand privacy in the future. Even though Westin's and Altman's theories have demonstrated shortcomings in approaches to privacy by discussing individuals' privacy management, they were not chosen for the current study because of a recent modification emphasising private disclosure as the theory's main thrust.

Petronio's CPM theory was used to guide this study since this study aimed to encourage openness about the use of AM and TM. The main objective of the chosen theory is to ensure that decisions made benefit the well-being of various interpersonal relationships (Petronio 2016: 1). This theory developed to allow clarity in the process of concealment as well as disclosure of private information (Bylund, Peterson and Cameron 2012:261). CPM theory was developed to investigate personal relationships; however, it also applies to the relationship between AMPs and patients because it advocates for the establishment of both personal and common boundaries using information that is considered private (Bylund, Peterson and Cameron 2012: 261). As a result, this theory is concerned with how people clarify and later disclose private information (Petronio 2016: 1). This theory was relevant for disclosure issues that are

confronted by AMPs and patients using both TM and AM. When Petronio developed this theory in 1991, it was called boundary management. In 2002 she decided to rename it CPM theory. Petronio's CPM theory is governed by five fundamental concepts (Masaviru 2016: 44):

- Most individuals are convinced that they hold the authority to disclose their information, giving them a chance and choice as to who they disclose to.
- Individuals avoid disclosure through personal privacy rules which create boundaries.
- As soon as the information is disclosed, it is no longer theirs alone and the next person is like a confidant.
- Collaboration with the person receiving the disclosure is necessary to ensure that the disclosure is accepted and protected.
- Should the collaboration fail, barriers to disclosure will result.

The theory presumes that disclosure and privacy should exist in collaboration, thus proposing that privacy attitudes rely on rules that regulate disclosure (Lewis, Matheson and Brimacombe 2011:503). Therefore, a study of how the AMP's role as a confidant is interpreted may reveal related issues concerned with the patient's ultimate choice regarding disclosure through this theory. Furthermore, in the confines of the current study, areas of possible challenge in privacy negotiations are discussed in terms of how the relationship between the AMPs and the patients blend with disclosing TM and AM use to the AMPs, ultimately articulating the logic for employing CPM theory as the most suitable theoretical framework. More importantly, CPM theory continues to develop as a functional method to regulate the disclosure of private information between individuals (Petronio 2016: 7). Therefore, it was critical to identify communication skills that AMPs with varying levels of probing could negotiate through non-disclosure in an encouraging approach that yields an interchangeable outcome that both the patients and AMPs are willing to maintain.

In 2017, Samens conducted research to examine the decision-making process leading toward disclosure. Samens (2017: 10) points out that the various parts

of the disclosure are critical in a relationship, health status is distinctive due to the extensive association, and the level of disease may shift during the relationship. She further argues that CPM theory is a relevant solution since there is a need for persistent negotiation of boundaries concerning private information between individuals. That study revealed how patients perceive themselves in a relationship due to the distinct nature of health issues, boundaries and disclosure as they integrate different forms of logic before deciding to disclose. This research acknowledges the fact that disclosure is not the initial alternative for individuals; it remains a principal implement in assisting interpersonal and work relationships (Samens 2017: 57). After disclosure, boundaries become interchangeable, which necessitates negotiation. Disclosure can be regarded as a course of action that applies control over an individual's privacy (Xiao *et al.* 2015: 79). Figure 3.1 depicts the process in CPM theory:

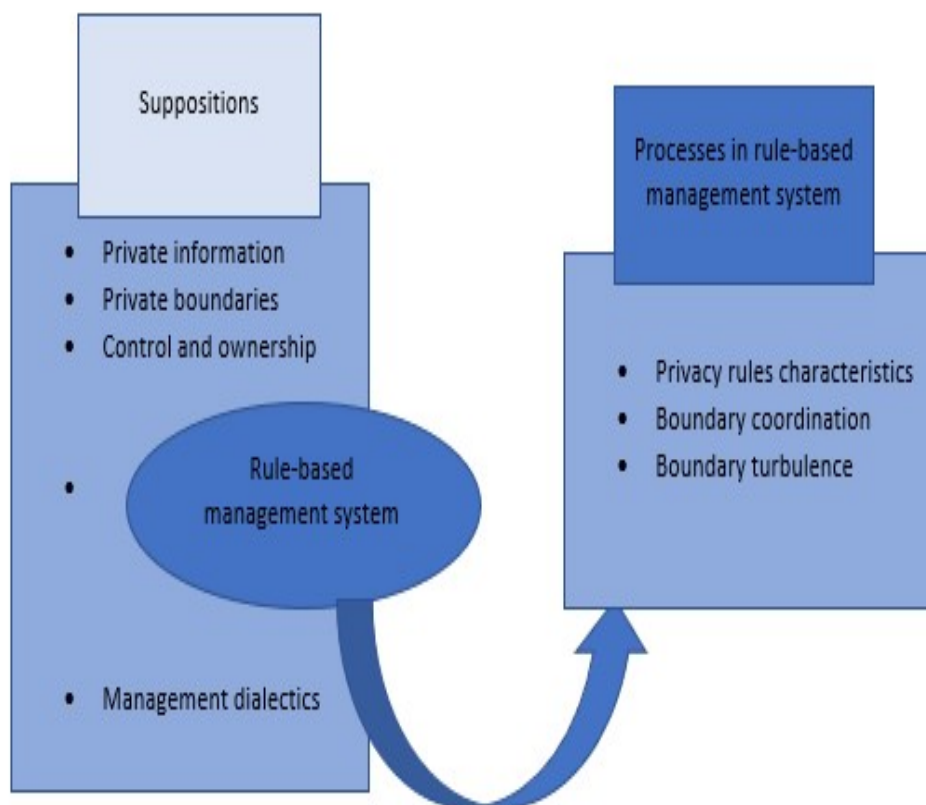


Figure 3.1: Schematic diagram displaying process in CPM theory (Adapted from Petronio 2002:4)

3.4.1 Communication privacy management theory in health

The extent to which CPM theory can be applied in research shows its significance concerning privacy in daily living (Petronio and Child 2020: 76). CPM theory has previously been used to apply logic in health communication encounters (Hudak 2015: 44). Whether patients use TM and AM concurrently is not an apparent fact to AMPs that they may consult daily. In this instance, if a patient is using both TM and AM concurrently, they must state this without any vagueness to their AMP during consultation. Patients must be comfortable disclosing in the environment of consultation with AMPs. Disclosure in this regard can help the AMPs to determine what advice they may need to give to the patient, especially when there are incidents where treatment is not working as expected. Without proper disclosure, AMPs may recommend substandard diagnosis and treatment choices to patients using both TM and AM. According to Bylund, Peterson and Cameron (2012: 261), the encounter between AMPs and patients is generally regarded as interpersonal communication. They further state that theory in healthcare communication studies is employed to acknowledge and anticipate “health beliefs, attitudes, intentions, and behaviours of individuals and populations” (Bylund, Peterson and Cameron 2012: 261).

The use of TM depends primarily on an individual’s cultural context. According to Petronio (2016: 7), CPM theory identifies those cultural beliefs forming the foundation for evolving the regulations to determine ways to approach a privacy boundary. Within the context of this study, the link between the AMPs and the patients from the CPM point of view is that AMPs have two barriers that they control with patients (Petronio, Dicorcia and Duggan 2012: 41). These barriers are firstly the AMP's judgement and boundaries regarding instances where disclosures are made to patients and secondly the AMPs being regarded as the co-owners of their patient's private information, thus including them within the bounds that surround that information. So, patients can withhold or change information depending on the subject. Therefore, findings from the use of this theory have the potential to improve communication interventions both for

patients using TM and AM and AMPs. This study can provide a new outlook on CPM by focusing on how AMPs discuss privacy management with their patients.

3.4.2 Non-disclosure as a mechanism to conceal a denounced status

TM use could be regarded as private information by patients using both TM and AM because of the doubt that surrounds its efficacy in treating ailments. Therefore, based on the risk surrounding the disclosure of the use of TM, CPM theory was relevant for this study. The issue of non-disclosure of TM use to AMPs is distinctive due to its extensive association with patient management. CPM theory explores the coordination process of private information disclosure (Wilbur 2018: 73). However, the choice to disclose is dependent on how the AMPs will respond after receiving the information. Petronio argues that research using CPM in health privacy issues is growing, framing everything from patient care, confidentiality, and stigma to e-health.

3.4.3 How Petronio's CPM theory guided this study

According to Bylund, Peterson and Cameron (2012: 265), CPM theory was developed to encourage acknowledgement of the activities in non-disclosure and disclosure of knowledge relevant to AMPs and patient associations. Therefore, the communication between the patient and the AMP is a significant circumstance in which non-disclosure may be questioned, hence the need for CPM theory application. Concerning this study, CPM suggests that AMPs, the patients and the shared boundaries result from non-disclosure. Bylund, Peterson and Cameron (2012: 265) maintain that CPM theory is one of the theories that could be used in established relationships such as constant consultations between patients and AMPs. Petronio (2004: 195) suggests focusing on non-disclosure rather than personalising information, thus allowing researchers to understand the type of information they want to acknowledge.

The medical environment must allow disclosure by patients using both TM and AM. This is critical during patient consultation to ensure proper patient

management procedures for all patients. During this time the AMPs are obligated to assist all patients that come for their services. Therefore, how the AMPs' attributes encourage disclosure during a consultation need to be considered (Lewis, Matheson and Brimacombe 2011: 509). While non-disclosure is a reality, patients are aware that they may need to share as much information with the AMP as possible during a consultation to receive the best results. Based on the research problem, the AMPs were identified as individuals that could help patients by treating whatever condition they present with.

The researcher adopted the application of the theory from Lewis, Matheson and Brimacombe (2011: 509). CPM theory suggests that AMPs become co-owners of the information as soon as the patients decide to disclose it. The initial component within the process of CPM theory is that if the patient senses that the dialogue aligns with the conversation they are having with the AMP, then they may disclose private information. The next component to consider is the private boundaries which may change depending on how critical the information is to the situation. Control and ownership are therefore dependent on the beliefs as they are closely related to stigma where the patient may feel their well-being and dignity could be at risk of attack. The component of rule-based management may require both the AMP and the patient to consider the commitment made during disclosure. Lastly, the component of management of the dialectics is led by what transpires after the decision to disclose has been made based on the initial decision of the disclosure or non-disclosure (Lewis, Matheson and Brimacombe 2011: 503).

This theory was applied during data collection from the AMPs to explore and describe the perceptions of AMPs regarding patients who use both TM and AM. With CPM theory, this study was able to assist the researcher in developing guidelines to facilitate the disclosure of TM use in both TM and AM use to AMPs.

3.5 SUMMARY OF THE CHAPTER

Research related to the disclosure of the use of TM by patients using both TM and AM has been conducted largely from a negative perspective. The responsibility of AMPs to probe these patients for an improved patient management system has been overlooked. Literature, however, shows that probing of these patients by AMPs can influence non-disclosure to ensure that disclosure rates increase. CPM theory was therefore selected as a guide for the exploration of the topic. The next chapter presents the research design and methods which were employed to elicit data that would enable feasible guidelines to be developed.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

Petronio's CPM theory was adopted as described in the previous chapter as the suitable theory that guided the study. This chapter focuses on the research methodology, steps and processes that were used to collect data.

4.2 RESEARCH DESIGN

An exploratory, descriptive, qualitative research design was undertaken to conduct the study.

4.2.1 Qualitative research

According to Hammarberg, Kirkman and Lacey (2016: 499), qualitative research entails an organised collection, coordination, description and interpretation of written, and verbal data. Qualitative studies are naturalistic and interpretive and are therefore deemed to have a compound focus of gaining insight into a phenomenon according to the individuals' lived experience (Gray, Grove and Sutherland 2017: 67; Aspers and Corte 2019: 142). This allowed the participants in this study to describe their perceptions of consulting with patients that use both TM and AM to elicit information-rich data. Focusing on the meaning of data in context also allowed the researcher to capture the setting in which the AMPs consult with these patients, thus obtaining a comprehensive concept of their perceptions. Attributes of qualitative research design are discipline dependent, thus focusing on a particular inquiry. However, some design attributes usually apply across disciplines (Merriam and Tisdell 2016:2). This design was appropriate for this study because the research question was restricted to AMPs who consulted with patients in the district hospitals in Gauteng. Qualitative research is useful in exploring a phenomenon that has not been explored and interpreted (Corbin and Strauss 2015: 5). There is currently no research available that provides an understanding of how disclosure of patients who use both TM and AM is facilitated during a consultation with AMPs.

This then enabled the researcher to explore the phenomenon of non-disclosure to develop guidelines to facilitate disclosure during a consultation.

4.2.2 Explorative research

Polit and Beck (2017: 53) explain that exploratory research is an innovation of a phenomenon by generating different plans through which it is presented and the associated fundamental operations. There is a paucity of evidence related to the regulations necessary to facilitate disclosure to AMPs by patients using both TM and AM during hospital consultations in Gauteng. The researcher identified and explored this gap to acknowledge the pertinent issue of non-disclosure to AMPs by patients using both TM and AM and the incapacity of the AMPs to probe these patients during hospital consultations in Gauteng. The data collected from the AMPs were mandatory in developing guidelines to facilitate non-disclosure to AMPs by patients using both TM and AM during patient consultation in Gauteng.

4.2.3 Descriptive research

Neuman (2014: 38) explains that descriptive research begins with a clear question aiming to devise a precise description from the collected data. Polit and Beck (2017: 379) elucidate that descriptive research is significant in keeping a record of various details related to a phenomenon and is critical in the development of practical interventions. The researcher described and analysed the factors that influence non-disclosure to AMPs by patients using both TM and AM during patient consultation in Gauteng. This fact-based information was collected from the participants in their natural setting which were convenient and comfortable for the individual participants.

In this research, the perspectives of AMPs regarding non-disclosure by patients using both TM and AM during patient consultation in Gauteng were explored. The researcher collected data from the AMPs using one-on-one semi-structured interviews and observations to allow the researcher to get a good scope of the inquiry. This design was selected because the researcher wanted

to triangulate by collecting data through semi-structured interviews and detailed observations and analysing both sets of data through content analysis and interpreting the findings. Both data collection approaches played a vital role in addressing the research problem. The researcher used the findings from the two sources of data to develop the guidelines that will facilitate disclosure to AMPs by patients using both TM and AM during patient consultation in Gauteng. Figure 4.1 illustrates the qualitative research process of the current study.

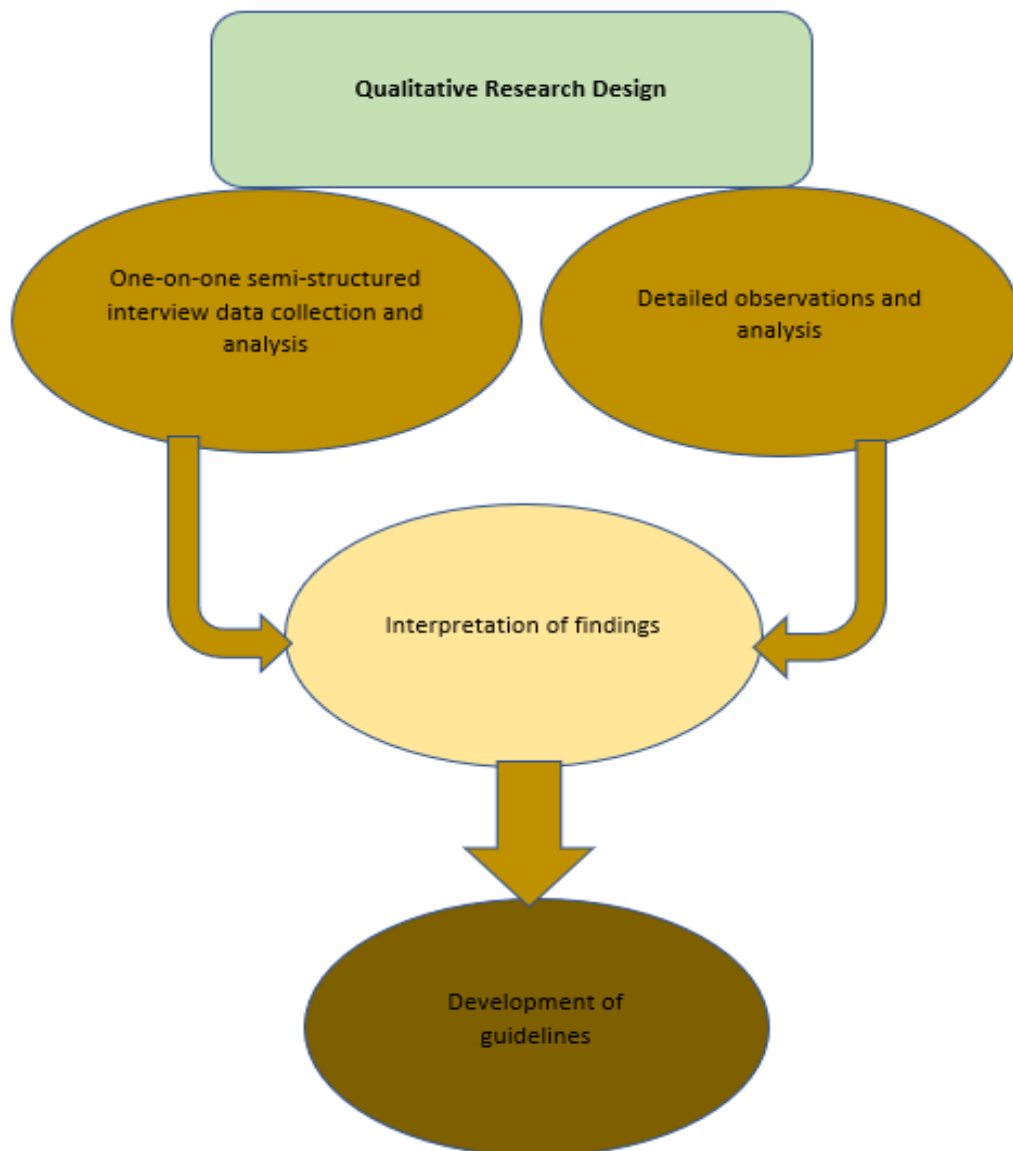


Figure 4.1: Qualitative research process for the current study

4.3 RESEARCH PARADIGM

A paradigm refers to a specific way of viewing phenomena that include a set of theoretical expectations and guides the approach to the research (Gray, Grove and Sutherland 2017: 1075). Wahyuni (2012: 70) shares the following fundamental elements of paradigms: ontology (the position of nature of reality), epistemology (the view on what constitutes acceptable knowledge), axiology (ethical requirement and researcher's perspective) and research methodology (the theory behind the research process):

- **Ontology:** Deals with the external, multiple views chosen to best answer the research question. The reality in this study was that patients who use both TM and AM do not disclose their TM use to AMPs due to the AMP's perceptions and attitudes toward TM use.
- **Epistemology:** Entails either or both observable phenomena and subjective meanings that can provide acceptable knowledge dependent upon the research inquiry. In this study, the researcher conducted one-on-one semi-structured interviews with the AMPs. AMPs were selected because they were knowledgeable about and experienced with various types of patients, including those that do not disclose the use of TM and AM.
- **Axiology:** Refers to the ethical issues that need to be considered. In this study, the researcher ensured the confidentiality and anonymity of the participants by assigning codes to each participant to ensure that no personal information was revealed. Furthermore, all potential participants willing to participate signed informed consent before taking part in the study.

Based on these philosophical groundings, the theoretical expectations that guided the current study were contextualised using CPM theory. Social constructivism was the best approach for this study as it allowed the participants to describe their views during the one-on-one semi-structured interviews, which facilitated understanding of their interpretations that were

similar to their experiences (Creswell 2013: 27). Yin (2011: 308) delineates constructivism as a relative perspective that is subjective to the researcher who is the observer of the phenomenon that was created by the nature of the external conditions. These perspectives are diverse and require the researcher to consider their compound nature instead of attempting to reduce the explanations into lesser categories. Social constructivism was adopted in this study because it focuses on the lived experiences of participants (Taylor, Bogdan and Devault 2016:12).

4.4 STUDY AREA

The setting includes detail about the environment in which data was collected. Qualitative researchers explore phenomena in their natural setting and context, avoiding intrusion (Traianou 2014: 68). In the current study, data were collected from participants in selected district hospitals around Gauteng. Gauteng contains the highest portion of South Africa's population (Statistics South Africa 2020). Gauteng is divided into three metropolitan municipalities: City of Johannesburg Metropolitan Municipality, Ekurhuleni Metropolitan Municipality, and Tshwane Metropolitan Municipality, as well as two district municipalities, which are further subdivided into six local municipalities (Gauteng Municipalities 2022). This research was carried out in all three metropolitan municipalities. The Gauteng City-Region Observatory (GCRO) shows that the areas included in this study are the most densely populated and are situated close to core business areas in Gauteng (Parker and Hamann 2020).

This study was conducted in the context of the diversity of the surrounding areas of the selected hospitals. According to the National Health Act 61 of 2003 (Republic of South Africa 2003: 4), all public sector hospitals in Gauteng are classified into different levels of healthcare; thus, district hospitals are classified as level 1 hospitals, and these are the primary locations for the selected AMPs (physicians). District hospitals were chosen for this study because they play an important role in supporting primary healthcare on one hand and being a gateway to more specialist care, on the other. Most patients with chronic

conditions and possibly using TM and AM are managed within these hospitals. The selected hospitals included two large district hospitals and two medium district hospitals, situated in City of Johannesburg Metropolitan Municipality, Ekurhuleni Metropolitan Municipality, and Tshwane Metropolitan Municipality. Figure 4.2 shows a map of all the district hospitals in Gauteng.



Figure 4.2: A map of Gauteng showing district hospitals (Municipalities of South Africa 2022)

4.5 IDENTIFICATION OF DATA COLLECTION SITES

The study was conducted in the Gauteng province. Only three districts in Gauteng, namely the City of Johannesburg Metropolitan District, Ekurhuleni Metropolitan Municipality and Tshwane Metropolitan Municipality, were used in the study. The sites of the study were four hospitals from the three identified districts. A total of 12 out of 33 hospitals in Gauteng are district hospitals with outpatient departments. All 11 district hospitals provide outpatient care and accept referrals from public health clinics in the surrounding areas. These hospitals were chosen on the basis that they are situated within the districts with the largest population in Gauteng. This was done to ensure adequate representation of the population within the study area.

4.5.1 Inclusion criteria for the study area

- Districts with the largest population
- District hospitals that provide an out-patient service

4.5.2 Exclusion criterion for the study area

- All other district hospitals in Gauteng

4.6 STUDY POPULATION

Polit and Beck (2017: 121) define the population as a complete group of people with similar traits, from whom the information will be collected (Kumar 2011: 58). The population of this research study consisted of AMPs from the selected hospitals providing out-patient services. For this study, the term **allopathic medicine practitioner (AMP)** is used for the physicians that were involved in the consultation with patients in the outpatient departments of the selected hospitals.

4.7 SAMPLING PROCESS

Sampling is a significant aspect of all research studies. Due to time constraints and the cost to examine a large population, the researcher used a sampling technique to reduce the number of prospective participants (Taherdoost 2016: 18). Non-probability, purposive sampling was adopted for this study. After the researcher has been granted IREC clearance certificate, IREC 016/21 (Appendix 1), the researcher selected and interviewed 14 participants from the five selected hospitals. According to Polit and Beck (2017: 476), after obtaining permission from the institution, the researcher initiates the recruitment process. The researcher sought permission and obtained approval from the three Chief Directors of the Health Districts, namely: Johannesburg, Tshwane and Ekurhuleni (Appendix 2a, 2b; 3a, 3b; and 4a, 4b) and the hospital four CEOs of the selected hospitals, namely: (Appendix 5a, 5b; 6a, 6b; 7a, 7b; and 8a, 8b), respectively. The researcher then accessed the out-patient department of the chosen hospitals to approach the AMPs to gain cooperation face to face (with masks). The information letter and consent form (Appendices 9 and 10) were shared with all eligible participants to take home for further consideration. Thereafter, appointments were made with the participants to conduct the interviews at their convenience at the selected hospitals. This afforded each participant enough time to make an informed decision whether to participate or not in the study without being coerced. All willing and consenting participants signed the consent form to complete the recruitment process. To ensure representativeness, the researcher recruited samples from multiple sites (Polit and Beck 2017: 609).

4.7.1 Inclusion criteria for the study population

- AMPs were in selected hospitals and registered with HPCSA.
- AMPs worked in the out-patient department in the selected hospitals.
- The age range was between 25 years and 70 years.
- Both male and female AMPs were included.

- AMPs had to have a minimum of 1 year of experience in general patient management.

4.7.2 Exclusion criteria for the study population

- Non-registered AMPs.
- Registrars.
- Retired AMPs.
- AMPs on community service.

4.8 SAMPLE SIZE

Qualitative research studies do not require a specific sample size. Dworkin (2012: 1319) suggests that 5 to 50 participants are an adequate sample in qualitative research. Malterud, Siersma and Guassora (2016: 1758) explain that data saturation may be identified when the researcher is no longer presented with new data to add to the information collected from previous interviews. In this study, purposive sampling size was determined by data saturation during the one-on-one semi-structured interviews conducted with the AMPs in the selected hospitals. The researcher conducted face-to-face semi-structured interviews with 12 AMPs and a further 2 interviews to ensure that data saturation was reached. Data saturation was reached when the researcher received the same information from the participants per selected study site.

4.9 PRE-TESTING OF DATA COLLECTION TOOL

Pre-testing of the data collection tool was done before the main study to consider the feasibility of the questions on the interview guide. The pre-testing of the data collection tool was also done to illuminate challenges that could arise during the actual study interviews to maximise the outcome from the interview guide. In support, Gray, Grove and Sutherland (2017: 628) explain that pre-testing the interview tool is crucial in identifying possible issues with the outline and order of questions, thus clarifying how the responses can be recorded. Majid *et al.* (2017: 1073) agree that pre-testing the interview guide is important to assess and familiarise the researcher with the interview process.

Therefore, the researcher can never underestimate the value of pre-testing the data collecting tool due to the uncertainty of things that may be hoped for. The same methods for sampling and data collection set for the main study were applied during this process. Two AMPs were interviewed using a semi-structured interview guide and observations were made. The interview was initiated by the researcher, who introduced herself and explained the aim of the study. The researcher then used the questions in the interview guide to facilitate the interview. Probing questions used were guided by participants' responses during the interviews. All interviews were audio-recorded and field notes from the observations were also recorded in a diary. This was to ensure that the researcher did not miss critical information, including behaviour activities and any attributes of the research setting that needed to be clarified in the interview guide before the main study. The results from the pilot study are not included in the presentation of results in this study.

4.10 DATA COLLECTION PROCESS

Data collection commenced only after permission was granted by gatekeepers. Two qualitative approaches to data collection were employed in this study. Data was collected from AMPs who met the inclusion criteria through one-on-one, face-to-face semi-structured interviews to explore and describe the perceptions of AMPs regarding non-disclosure by patients using both TM and AM consulting in the selected hospitals in Gauteng, as well as qualitative observations of the AMPs in their natural setting. A semi-structured interview guide was developed by the researcher based on the aim and the research question, which were confirmed by supervisors who have doctoral degrees. The researcher reviewed the literature to identify key points that assisted in the development of the interview guide.

All interviews were scheduled at the convenience of the participants and took place at the selected hospitals, thus ensuring uncomplicated access to the targeted participants. The researcher collected both data sets from the interviews and observations during which participants were observed in the

interview session. The use of both data collection methods in one session with the individual participants helped the researcher to integrate auxiliary data from the observations with the semi-structured interviews.

Data for this study were collected by using both deduction and induction. This assisted the researcher in analysing the data according to the theoretical framework discussed in Chapter 3, as well as the data collected during the one-on-one in-depth semi-structured interviews with the participants and observation of them (Kennedy and Thornburg 2018: 50-51). The data analysis and interpretation took place concurrently with the data collection to develop the guidelines to facilitate disclosure to AMPs by patients using both TM and AM during patient consultation in Gauteng hospitals.

Data collection consisted of using one-on-one in-depth semi-structured interviews with the participants and observation of them. Jamshed (2014: 87 and 88) suggests that most health professionals use semi-structured in-depth interviews in their research in the form of pre-set open-ended questions posed to the participants, whereas qualitative observations are usually integrated as additional data to the semi-structured interviews. The information letter given to the participants during recruitment clarified the methods that would be applied in the study, including confidentiality issues and anonymity procedures for participants, and the option to withdraw at any time if they so wished. All participants were assigned codes to ensure anonymity. A private room was organised at each study site to use for the interviews to ensure that the interviews were conducted in a suitable environment that facilitated the participants expressing themselves freely.

The researcher used a self-developed interview guide based on the research questions to elicit information from the participants (Appendix 11b). The qualitative data was collected through a masked one-on-one and semi-structured interview using open-ended questions. Each interview was initiated with the general purpose of the study being explained by the researcher as to how the study would benefit the hospitals by minimising undetected interactions

between TM and AM and thus improving patient management. The researcher collected demographic data (Appendix 11a). All the interviews were audio-recorded and none of the participants disagreed with the recording. Each interview was planned to last 30-45 minutes, and data collection proceeded until data saturation was reached. In line with the Protection of Personal Information (POPI) Act 4 of 2013, all data collected was kept confidential and private. The researcher achieved this by storing all the data in a computer which requires password access. Only the researcher knows the password. All the data collected from the interviews were transcribed verbatim before the analysis (Appendix 12). The researcher conducted all interviews and made all observations during her visit to the five selected hospitals.

4.11 DATA ANALYSIS

Qualitative content analysis was used to analyse the data. Miles, Huberman and Saldana (2014:56) describe qualitative content analysis as a method that allows the researcher to systematically analyse the collected data by taking into consideration the frequency and sequences of the words and concepts in the data. The analysis began with the coding of the data which was facilitated by Computer-Assisted Qualitative Data Analysis Software (CAQDAS) (Brinkmann, Jacobsen and Kristiansen 2014:37). All audio data was initially transcribed into written data using Microsoft Office 365. According to Bengtsson (2016: 11-12), qualitative data analysis using content analysis includes:

- Decontextualisation.
- Recontextualisation.
- Categorisation.
- Compilation.

Data collection and data analysis were conducted simultaneously with masked semi-structured interviews and observations. This was achieved by the researcher initiating the data analysis process for each transcription on the day of the interview. To decontextualise the data, the researcher carefully considered the manuscripts to break the data into sections. This was significant

as it enabled the researcher to reflect on both the transcribed data and observations while details were still fresh in her mind. The researcher used ATLAS.ti 9 to code the data by highlighting certain excerpts from the transcripts. This is an advanced data analysis platform which allows easy access and management of data.

The researcher opened the Hermeneutic Unit, which is regarded as the project container in ATLAS.ti, to create a project and gave it a name (PhD research 2022). Once a project had been created, all 14 transcripts were loaded and grouped according to research sites in 'My library' for single-user projects as this was not a team project. This helped the researcher to set the stage for data analysis following the steps in content data analysis. The transcripts were initially assigned descriptive codes and prepared in a folder on the researcher's desktop to allow for easy location and transfer. Deductive and inductive coding was applied using the theoretical framework described in Chapter 3, as well as the information obtained from listening and observing during the interviews to gain insight into the disclosure to AMPs by those patients who use both TM and AM. At this point, the researcher had a plan for how the text would be coded before the process in ATLAS. ti 9. She used a code list in which the codes were brief for uncomplicated and structured reference. At this point, the researcher had a list of coded quotations and started unlinking codes from data segments. To check for any unnecessary codes, the coding analyser was used. Then the codes were merged. However, the researcher had some difficulty reversing merges, only to discover that saving the Hermeneutic Unit first was useful in case the code merger needed to be reversed. The researcher also linked the codes to comments for reference. Colour codes were applied to the mergers which were later used to form categories from which themes emerged. The researcher then created code groups which allowed the merged codes to be linked to the themes that emerged (Appendix 13). The researcher then viewed the codes in network views to appreciate the data visually. As a final step, a report of all the analysed data on specific themes was extracted. Table 4.1 below, adapted from Soratto, De Pires and Frieze (2020: 4), summarises the application of various stages of content analysis in ATLAS.ti.

Table 4.1: Applying various stages of content analysis in ATLAS.ti (Soratto, De Pires and Frieze 2020: 4)

Stages in content analysis	Steps in ATLAS.ti
Decontextualisation.	<ul style="list-style-type: none"> • Creating the project. • Adding transcripts. • Grouping transcripts under document groups. • Writing first memos on the overall aim of the study, including research questions.
Recontextualisation.	<ul style="list-style-type: none"> • Reading the data, selecting data segments and creating quotations. • Creating and applying codes. • Writing memos and comments. • Linking codes and memos
Categorisation.	<ul style="list-style-type: none"> • Exploring the coded data using the code analyser. • Coding mergers for reference. • Colour coding mergers to form categories. • Generating network views (visual data).
Compilation.	<ul style="list-style-type: none"> • Extracting reports (specific themes).

4.12 TRIANGULATION OF DATA

All collected data were triangulated. Triangulation is a method of improving data accuracy by considering ideas from multiple perspectives (Neuman 2014: 166). Triangulation was used in the current study to enhance the quality of the results and to ensure the trustworthiness of the data collected. The researcher decided to employ triangulation as a method of validating the data collected during the interviews and observations (Taylor *et al.* 2016: 93). In the current study, data was collected from various sites that met the inclusion criteria and dealt with the AMPs' work. Data was collected from AMPs using observations and one-on-one semi-structured interviews to explore and describe the phenomenon to gain a deeper and clearer understanding of the setting and participants being researched. The themes that emerged from data analysis were triangulated to identify the correspondence between the semi-structured interviews and the observations of participants' behaviour during the interview sessions. This was

pivotal in guiding the researcher to develop guidelines to facilitate disclosure to AMPs by patients using both TM and AM during patient consultation in Gauteng.

4.13 RESEARCH TRUSTWORTHINESS

In qualitative research, trustworthiness refers to the research procedures that a researcher follows while conducting a study to ensure that the results do not contradict reality (Stahl and King 2020:26). Lincoln and Guba (1985: 301) present steps meant to ensure rigour and trustworthiness in a qualitative inquiry; these steps are credibility, transferability, dependability and confirmability.

4.13.1 Credibility

According to Polit and Beck (2017: 90), credibility is the truthfulness of the data collected and its interpretation. The researcher was guided by a plan of action to ensure that credibility was maintained; this was to ensure that the data and its interpretation can be trusted. Triangulation was used in this regard to facilitate this plan of action. Firstly, the researcher avoided untimely termination of the interview sessions to establish prolonged engagement with the participants; this assisted the researcher in forming a bond with the participants, which encouraged detailed engagement with the inquiry. Secondly, detailed observations were applied so that the researcher could get a good scope of the inquiry. Lastly, member checking was used during the actual interview sessions and after data analysis had been completed (Polit and Beck 2017: 90). This was achieved through the researcher's summarised accounts of the interview which were shared with the participants upon completion of the interview. Usually, this results in richer data being shared as a reaction to the summaries.

4.13.2 Transferability

The general assumption is that qualitative researchers tend to want to create awareness rather than produce generalised data (Polit and Beck 2017: 303;

Stahl and King 2020: 27). Transferability is therefore the probability of the data collected being transferable to another setting. The researcher achieved this by ensuring that the data from the study had enough descriptive information to provide a clear context of the research. Therefore, the findings of this research will not have a direct consequence on all AMPs as a result of the qualitative nature of this study.

4.13.3 Dependability

According to Polit and Beck (2017: 981), dependability is a term that was refined from the concept of auditability. Therefore, dependability may be defined as stability over time and circumstances (Polit and Beck 2017:982). To ensure dependability, the researcher performed a pilot study to pre-test the data collecting tool. The interviews were all recorded. All observation notes from the interview sessions were audited and saved in case they were required for verification.

4.13.4 Confirmability

Confirmability is regarded as the impartiality reflected by the data and interpretations (Polit and Beck 2017: 1004). The participants' opinions and circumstances attached to the study must be reflected, not the biases of the researcher. This will allow possible compatibility between individuals regarding the relevance of data. The researcher kept a record of the procedures as an audit trail. Reflexivity was also applied to allow the researcher to examine herself and the relationships within the study (Polit and Beck 2017: 1002).

4.14 ETHICAL CONSIDERATIONS

According to Fleming and Zegwaard (2018: 209), considering that the core principles of ethical research involving humans is paramount, approval should be sought and obtained before the research begins. Approval to conduct this study was sought and obtained from the Institutional Research Ethics Committee (Ethical Clearance Number IREC 016/21) (Appendix 1). The

researcher also sought permission from the metropolitan district health managers/research committees (Appendix 2a, 3a and 4a) and the CEOs of the selected hospitals (Appendix 5a, 6a, 7a and 8a). Once the Directors have granted permissions (Appendix 2b, 3b and 4b) and upon approval by the hospital CEOs (Appendix 5b, 6b, 7b and 8b), all potential participants were provided with a letter of information and consent (Appendices 9 and 10) to consider and sign once they agreed to participate. During the interviews and throughout the study the researcher considered the fundamental ethical principles to circumvent any omission to the accepted protocol, such as insufficient informed consent, subjecting participants to harm (psychological or physical), and negligence concerning participant anonymity and confidentiality. The Belmont Report (United States National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978: 4-8) cites three fundamental ethical principles which were applied to the study: respect, beneficence and justice, which are described below:

4.14.1 Respect

The researcher must show respect for human beings from the moment they decide on a specific population. This will ensure that they adhere to ethical considerations. This was upheld in this research by ensuring that the participants in the study retained their human dignity and were not exposed to any risk to their health (Polit and Beck 2017: 260). All participants had full autonomy which allowed them to make a reasonable judgement regarding their participation. An information letter accompanied by a consent form (Appendices 9 and 10) was offered to fully inform the participants about the conditions of the study and they consented to participate by signing the consent form. Therefore, the researcher ensured that everyone who participated in this study did so willingly without being coerced into participating. The participants were allowed to make the researcher aware as soon as they wished to withdraw once the study had commenced. No reason was expected to be given before withdrawal.

4.14.2 Beneficence and non-maleficence

According to Polit and Beck (2017: 258,259), the researcher must be aware of any potential risks throughout the research to maintain the balance with the potential benefits to the participants in the study. This was achieved by the researcher not asking questions that could result in emotional harm to the participants. The researcher did not anticipate any physical harm that could occur during the study. Although discussing a contentious topic could cause emotional harm, the interviews were conducted in the research sites (hospitals). Therefore, counsellors were available in the hospital should the participants need assistance. The researcher also limited asking sensitive questions to avoid emotional triggers during the interviews.

Mann (2016: 237) says that it is common for researchers to use pseudonyms to conceal the identity of the participants in a study. However, there is sometimes reasonable information that could identify both the setting and participants. Therefore, due to the nature of qualitative research being face-to-face, total anonymity could not be achieved in the current study. Despite this, confidentiality was maintained throughout the study by safeguarding the information and limiting who had access to it. If any of the information is to be used publicly or requested by a court of law, the researcher will seek permission from the participants. Furthermore, the researcher used codes for all the research sites and participants in the write-up. The participants were made aware that they had no direct benefit from this research. The developed guidelines could, however, help the AMPs and benefit treatment outcomes for patients.

4.14.3 Justice

Polit and Beck (2017: 262) state that fairness and the absence of bias are important to consider, ensuring that all participants are represented equally. The Belmont Report (United States National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978: 8) states that

there is a necessity to demonstrate “fairness in distribution” based on the burdens and benefits of the research. In terms of the report, the researcher considered the following to ensure justice:

- To each person an equal share.
- To each person according to individual needs.
- To each person according to individual effort.
- To each person according to societal contribution.
- To each person according to merit.

Throughout the research, honesty was maintained by making an effort to listen to those participants who were not the most vocal, because they were all individuals who deserved an equal opportunity to express their opinions.

4.15 SUMMARY OF THE CHAPTER

This chapter presented a detailed description of and justification for the methodology and processes that were used in this study. The plan and execution of the current research were based on the rationale of the study. In Chapter 5, the findings of the study are presented.

CHAPTER 5: PRESENTATION OF THE FINDINGS OF THE STUDY

5.1 INTRODUCTION

In this chapter, the findings of the one-on-one, masked semi-structured interviews with 14 AMPs from the selected hospitals are deliberated. The qualitative data provided by the AMPs was used to realise the aim of the study and provide answers to the research questions. The demographic information of the participants, data observations and emergent themes are presented. Themes and subthemes were generated from the data collected from the semi-structured interviews. To support these themes, excerpts from the AMPs' statements have been used.

5.2 DEMOGRAPHIC DATA OF THE PARTICIPANTS

The semi-structured, masked one-on-one interviews were conducted at different locations at the convenience and comfort of the individual participants. Three district hospitals from the City of Johannesburg and the City of Tshwane districts and one regional hospital from Ekurhuleni district were the study sites. The hospitals were coded DH1 (n = 1), DH2 (n = 4), DH3 (n = 5) and RH (n = 4). Ten AMPs were selected from the three district hospitals and four from one regional hospital.

Table 5.1 below depicts the demographic information of participants according to gender, age, race, marital status, highest qualification and work experience in a number of years. There were 7 male and 7 female participants. Their ages ranged from 29 to 68 years. Most participants were aged 41 - 50 (n = 6), 51-68 (n = 5) and three were aged 28 - 40. Most participants (n = 11) were of African origin and only one was Indian. Out of the 14 participants, 4 were single and 10 were married. Thirteen participants had undergraduate qualifications and one had a postgraduate qualification. The participants had work experience ranging

from 3 years to 36 years: 3-5 years (n = 2), 6-11 years (n = 2), 12-15 years (n = 4), 16-20 years (n = 3), 21-30 years (n = 1) and 30 plus years (n = 2).

5.3 DATA OBSERVATIONS

Throughout the interview process, the following was observed: the majority of the participants had a modern way of reasoning, and the research topic was contentious for them. Most of the participants were positive individuals and were eager to be interviewed. They also presented with open-body postures. All the interviews were conducted in English, but some of the detailed descriptions were clarified using Zulu words. Some of the responses provided by the participants during the interview were short but provided in-depth information. The AMPs provided authoritative responses with examples from personal experiences with patient cases. Most of the participants were very quick to respond to the questions and seemed comfortable during the interviews.

It was pertinent for the aim of this study that participants only referred to AMPs consultations with patients who used both TM and AM. The participants indicated various notions in their responses which showed the lack of a uniform approach applied when consulting with these patients. The data demonstrated a generally modern outlook regarding the use of TM by patients consulting with the AMPs. The participants' responses hinted that they based their perceptions either on their belief structure or their profession alone without considering the two at the same time. Specifically, the data showed that there was a need to add TM knowledge to the training of AMPs.

Table 5.1: Demographic data of the AMPs

AMP number	Gender		Age (years)			Race		Marital status		Qualification		Work experience (years)					
	M	F	28-40	41-50	51-68	African	Indian	Single	Married	UG	PG	3 - 5	6 - 11	12- 15	16- 20	21- 30	30+
1.		✓		✓		✓			✓		✓			✓			
2.	✓				✓	✓			✓	✓							✓
3.		✓	✓			✓		✓		✓		✓					
4.		✓			✓	✓			✓	✓							✓
5.	✓			✓		✓			✓	✓					✓		
6.		✓		✓		✓			✓	✓				✓			
7.	✓			✓		✓			✓	✓					✓		
8.	✓			✓			✓		✓	✓						✓	
9.	✓				✓	✓			✓	✓				✓			
10.		✓			✓	✓			✓	✓			✓				
11.		✓		✓		✓		✓		✓					✓		
12.		✓			✓	✓			✓	✓			✓				
13.	✓		✓			✓		✓		✓		✓					
14.	✓		✓			✓		✓		✓				✓			

Key

AMP = Allopathic medicine practitioners

UG = Undergraduate

PG = Postgraduate

M = Male

F = Female

5.4 CONCEPTUALISATION OF NON-DISCLOSURE OF TM USE BY PATIENTS WHO USE BOTH TM AND AM

Four major themes emerged from the masked semi-structured interviews with the AMPs:

- Theme 1: AMPs' perceptions of non-disclosure of TM use by patients who use both TM and AM

- Theme 2: Practice of AMPs when consulting with patients who use both TM and AM without disclosing
- Theme 3: Facilitating disclosure of TM use to AMPs
- Theme 4: Procedures to encourage disclosure of TM use to AMPs by patients who use both TM and AM

In the following section, each theme and the subthemes depicted in Table 5.2 are discussed. To reflect strong patterns in data, quotations from the transcribed masked interviews are used.

Table 5.2: Themes and subthemes

THEMES	SUBTHEMES
AMPs' perceptions of non-disclosure of TM use by patients who use both TM and AM	Lack of scientific evidence for TM. Unspecified dosage of TM. Non-adherence to the AMPs' treatment plan. Complications because of interaction between AM and TM.
Practices of AMPs when consulting with patients who use both TM and AM without disclosing	AMPs' bedside manner. Stigmatising TM use. Individual belief system.
Facilitating disclosure of TM use to AMPs	Creating a conducive environment for disclosure. Encouraging patients to disclose TM use to AMPs. Patient autonomy. Training of AMPs.
Procedures to encourage disclosure of TM use to AMPs by patients who use both TM and AM	Collaboration of THPs and AMPs. Acknowledgement of TM practices.

5.4.1 Theme 1: AMPs' perceptions of non-disclosure of TM use by patients who use both TM and AM

When participants were asked for their opinion regarding the disclosure of TM use by patients who use both TM and AM, they indicated that disclosure was uncommon during a consultation with these patients. They mentioned that this practice posed challenges when treating those patients. In their opinions, those challenges were associated with 1) lack of scientific evidence for TM use, 2)

unspecified dosage of TM, 3) non-adherence to the AMPs' treatment plan and 4) complications because of interaction between AM and TM. These are described next as subthemes.

5.4.1.1 Lack of scientific evidence for TM

Most AMPs stated that the lack of scientific evidence related to TM was a challenge when it came to knowing exactly what was in the medicines they prescribed to their patients. Furthermore, there was no evidence of how it is decided which herbs cure which condition. Their opinions were that patients were rarely able to share what they were taking as they also did not know themselves. The AMPs stated that TM was viewed as a lesser equivalent for patient treatment. This was noted in the following quotes:

"... there is little understanding of what happens on the other side. I believe there are two doctors in the district who are both doctors and traditional leaders who do not want to initiate conversation, so it is difficult to ask them what they do because it comes across as intrusive and rude." AMP1

".... Usually, doctors just laugh. I'm not sure why, but I know for a fact that doctors would dismiss traditional medicine because we aren't trained in it. We don't know how traditional medicine works, and it's difficult to say that this one can't be used with a certain drug." AMP2

".... uhm, also because the patients, to be honest, don't know what they're taking in terms of traditional medicine, they're given whatever they're given, and even they can't explain what they're taking." AMP3

"You know even though I find it in health stores, especially when it comes to herbs because you don't know much about them it's also difficult to make that decision that this one you can't use it with a certain drug." AMP5

Some participants were concerned about the initiation procedures undertaken by some of the THPs as they stated that this left questions regarding genuine THPs. This was evident in these responses:

".... I believe it is due to the lack of uhm... What can I say? There is still a significant gap between traditional and Western medicine. Traditional medicine is still undervalued and regarded as far inferior by Western medicine practitioners." AMP6

"Patients who use traditional medicine I believe it is a part of what we see daily and is a part of South African life. It depends, I believe. Certain things we don't know the harm of because they haven't been scientifically investigated, so we don't know if they are more harmful or beneficial to the patient." AMP14

5.4.1.2 Unspecified dosage of TM

There were quite a few responses that verbalised the dosage of TM, but the AMPs stated that most of the TM used by those patients who use both TM and AM either has no specific dose or the patients themselves disregard what is stipulated by the THPs. The quotes below support this:

".... All I know is that I haven't used it [referring to TM], and I'm not sure if the strength and dose of the medication that the patients are taking are calculated correctly or not. I will only treat the patient based on the condition that I discover the patient to be in." AMP12

".... I recall having a patient when I was still at the hospital" [referring to another public hospital]. As a result of an overdose of some herbal drug, the child was unconscious and intoxicated. The mother had no idea how much of this TM had been given and prescribed." AMP1

".... to treat such a patient [referring to a patient who uses TM], you simply try to determine if there are any dosage issues, but I am unsure about the dosage

of herbal medicine and the dose for that patient, and then see how it affects the patient's management in the modern setting, in modern medicine.” AMP7

“.... for example, I know that in the case of a kidney or liver problem, the dosage is usually reduced. We don't give the standard dosage to someone who already has such complications, and it's the same when the patient tells me that I'm also on traditional medication. I tell them that it's fine, but your condition prevents you from combining both currently.” AMP4

5.4.1.3 Non-adherence to the AMPs' treatment plan

It became evident in the responses from the AMPs that using both treatments at the same time without disclosing was more of an issue, and therefore they would advise these patients to use only the AM until the condition improved. This would then ensure better treatment outcomes from the prescribed AM. Most AMPs did not support the use of TM and AM concurrently. The following narratives illustrate this:

“.... certain things are dependent on the patient's condition. If the patient has an infection, I will have a problem using traditional medicine because antibiotics are required. I'm honest with the patient and usually say OK, I understand they're on medication (referring to the TM). However, I have no idea how this medication works. It's best not to combine the two.” AMP1

“Uh, yes, it is. It will depend on whether I see that the traditional medication will worsen the outcome I want to achieve. I'll explain to the patient why he must first complete my treatment.” AMP4

"Normally, I try to figure out why they're taking. Both and, um, I don't know much about it, so I inquire as to what they are taking. In terms of contraindications, if the person has liver or kidney problems, I usually ask them to discontinue their herbs until they finish our treatment.” AMP5

The same participant clarified by stating:

"...and the only time if it's antibiotics, yeah, I usually ask them to stop the herbs if they're taking antibiotics." AMP5

"... there are many patients who are not disclosing; that is my point; the more they are encouraged to disclose, the better because we rely on the information they provide. We lose if they say they are not using traditional medicines. We end up using more expensive treatment methods. Also, we're going to end up investigating and investigating and investigating." AMP9

"The only thing I would advise the patient is that if she has been taking traditional medication, I will give her my medicine if she can just stop using that so that we can see if the condition improves or not, but I have nothing, Uhm..., against traditional medication." AMP12

5.4.1.4 Complications because of interaction between AM and TM

The AMPs were concerned about the cases of unconfirmed interactions that are only discovered through blood tests. Their main concern was the delay in finding the right solution in time due to non-disclosure which promotes adverse implications. They stated that sometimes even in severe cases where the AMPs needed to know what the patient had been given in order to know which antitoxin would help, they still did not get full disclosure to help the patient appropriately. Most of the AMPs expressed concern regarding the complications usually associated with cases of TM use by these patients. However, some AMPs believed that if the two medications did not interact with each other, they would not advise the patient otherwise. The following excerpts support this:

"I don't have a problem if there is no negative interaction between traditional medicines and our allopathic medicine. Unfortunately, because the medication

is not labelled, you would not know what the patient is taking. We know the medications for the specific conditions, so I'd be biased toward my field." AMP2

"When we get these patients from traditional healers, they usually present to us with complications of whatever disease they've been treated for, and we find that at some point they already have organs that are failing due to the traditional medicine." AMP6

The same participant elaborated:

"... the majority of drugs we use, including traditional medicine, are metabolized in the liver and excreted in the kidneys." So, when we perform their renal function and liver function tests, we can detect herbal intoxication. As a result, I usually discourage patients from using traditional medicine until I am finished treating them." AMP6

"...Well, if a patient is using traditional medicine. Unless they are on ARVs or have an infection, I will not tell them what to do. Otherwise, I don't get involved too much, especially when it comes to chronic conditions like hypertension or diabetes. Remember that medicine has a psychological benefit as well. Patients do not give you all the information about TM use and the concern is the interactions, adverse reactions, and the AM not working when the patient uses TM and AM at the same time." AMP1

"...Um, I'd discourage the patient from using traditional medicine, because I do not know of the interaction between traditional and allopathic medicine. So, I will discourage the patient from using traditional medicine until I am finished treating whatever disease I am treating." AMP2

"Because we are concerned about adverse reactions, it would be safe for them to make us aware of the conditions they think we are unable to treat. Tell us they did and took the traditional route." AMP3

".... a desperate patient will reveal everything they are currently taking" (referring to all medication). If they take both at the same time. They can even seek counsel. Since they are consulting with you at the time, they may even ask your opinion. In that case, I can offer advice. Some patients disclose that they require assistance if they see that they can rely on you. They put their trust in you, so they will tell you everything." AMP4

".... if patients understand that whatever drugs or tablets, we use to interact with herbs because the interaction can sometimes be a problem. The medicine can hinder each other, or you the patient can develop complications. So, if patients understand that they must tell us everything for us to know what to prescribe. However, I find that in health, particularly when it comes to herbs because we don't know much about them, it's difficult to make the decision that this one can't be used with a certain drug." AMP5

".... we must explain the situation to the patient. Particularly for conditions that cannot be treated with conventional medicine. Conditions that require hospitalization, as well as the fact that traditional medicines interact with some drugs. Drugs and traditional medicine can interact with chronic medication. These are significant factors because, uhm..." AMP9

".... I'll just explain to them why we need to know what they're using because some traditional treatments cause organ dysfunction on our side, so we need to beg them and explain so that they understand why they must disclose those traditional medicines." AMP10

".... when I find someone, who is using both traditional medicine and our medicine, I just check to see if there is no Uhm..., an unfavourable interaction, and if there is no problem where the patient might be taking some traditional medicine and it affects the organs. I will tell the patient that it is not good for them... But if it is not affecting anything and is not interfering with the medication that I'm giving, the patient can continue." AMP11

"... ok, so we ask them (patients) why they use the traditional medicine. What effect does the allopathic treatment have on their bodies, and the effect to the conditions they are experiencing in a positive or negative way? If they aware of any interactions between the allopathic treatment and the other treatment?"
AMP13

5.4.2 Theme 2: Practice of AMPs when consulting with patients who use both TM and AM without disclosing

When participants were asked about how they dealt with patients that presented with views that were different from theirs regarding medical treatment, they identified several factors that influenced their practice. Their opinions were based on the approach and attitude of AMPs towards these patients resulting in barriers to disclosure. They indicated that even though they sometimes tried to encourage disclosure, those patients using both TM and AM were still reluctant due to fear of being judged. They highlighted that non-disclosure could be the result of the stigma attached to the use of TM. The AMPs believed that once a patient opened up to disclosure and later felt that they were judged, they would not feel comfortable going through the same process again. Three subthemes emerged: 1) AMPs' bedside manner, 2) individual belief system and 3) stigmatising TM use.

5.4.2.1 AMPs' bedside manner

Some AMPs were of the view that the attitude of most AMPs resulted in patients holding back on the information they were supposed to share. They stated that their attitude when consulting with patients could be the cause of most patients opting to share only what would be acceptable to the AMPs. The following quotes illustrate this:

"...Non-disclosure by traditional medicine patients is due to our attitude as doctors. We do not pay attention to what patients have to say. This is especially true for very traditional work." AMP2

".... I believe patient disclosure of traditional medicine use is influenced by your bedside manner as a doctor. How do you interact with a patient when he or she enters the room?" AMP7

"How doctors communicate with their patients, good communication skills are essential. We must show the patient respect and treat the patient as if he or she were your brother or sister. And be sure to explain your point of view thoroughly. When we undermine traditional medicine's use due to preconceived notions. We make our patients unable to disclose, and their lives will impede the healing process and cause unnecessary investigating." AMP9

".... The way the patient should be approached. How the doctor simply asks the patient questions, how the doctor opens up to the patient, and how the patient opens up to you. That, I believe, is how the patient will reveal that they are using traditional medicine... Our attitude toward them as medical professionals leads to non-disclosure, while you have no idea how traditional medicine works." AMP12

5.4.2.2 Stigmatising TM use

Some AMPs reported that stigma was one of the factors that discouraged patients from disclosing their use of TM to AMPs. According to their narratives, they believed that incorporating TM into healthcare treatment would help reduce the dread associated with the use of the medicine. The AMPs expressed that those patients using both TM and AM usually felt blamed for using TM and were subjected to stigmatisation. The AMPs also indicated that when the patients presented late, they would not disclose because they were afraid of being judged for making an unacceptable choice that is sometimes associated with witchcraft. The following quotes support this:

"Technically, if we are to be exposed to say, health care workers, we must spend a week visiting traditional healers to see what they do. The stigma would be reduced as a result, right? We as health care workers need to be exposed

to traditional healers or alternatives now that the other stigma has been lifted."
AMP1

"... Patients do not disclose primarily due to responses from healthcare workers. And they are most afraid of being judged. They believe they will face legal consequences for their decision to use traditional medication." AMP3

".... uhm, I think the most common reason patients do not disclose their use of traditional medicine is uhm... Perhaps they are afraid that health care providers will not understand why they are using it (referring to TM), as well as the stigma that most people do not want to disclose that they are using traditional medicine or other forms of herbs, or where they use herbal medicine." AMP5

"I believe the stigma associated with using traditional medicines will be the first factor in patients' refusal to disclose their use of traditional medicine." AMP6

"The reason patients won't admit to using traditional medicine... Yes, they may fear being blamed for taking those medications. To be held accountable by the doctor or the medical staff. They will be asked why they travel to Sangoma (THP). Why did you decide to use traditional medicine? If they are afraid, they will not reveal." AMP8

"When patients fail to disclose... Mm... Most of the time, I believe it is fear of the unknown. Perhaps they are afraid of the severity of the already done damage and would rather not tell the doctor. Don't tell me about it (referring to the TM). They then conceal the information from me (the AMP). They (the patient) would rather not know the extent of the damage done." AMP10

"Usually, they expect you (the AMP) to be angry because you are a doctor. You don't want them to use anything else but what you're giving them, and they think you think it's evil or something. So, won't disclose, they think you'll interpret it as if they're using witchcraft or something shady, and they'll make you angry when they tell you." AMP11

5.4.2.3 Individual belief system

The AMPs indicated that their reaction and response toward patients who use both TM and AM during the consultation were mostly the results of either limited knowledge of how the TM works or no confidence in the TM use. They shared that cultural upbringing had a major impact on how they responded to those patients that use both TM and AM. They felt that there was not a great deal they could do to change the patient's mindset regarding the use of TM, but they usually provided clarity even though the patients might not agree with stopping the use of TM at the time. They also highlighted that some patients used TM because of cultural and ethnic customs, which should not be undermined. The following quotes illustrate this:

".... Traditional medication is trusted and relied on by most patients. You know, if they've used it before and it worked, they wouldn't be shy about disclosing it. They will say, Now, that I'm using it [the TM], I know it works, and I can continue to use your medical treatment [AM]." AMP3

".... I have no objections to that [patients using traditional medicine]. It also depends on each person's belief that it can help them. We are here to assist the patient." AMP4

".... If the practitioner has prejudices against cultural beliefs and says something about the culture in general and what he believes should be done, the bedside manner or how the practitioner interacts. That patient may feel criticized. Makes the patient believe that, yes, the practitioner has a belief system that contradicts what they believe, or if a practitioner fails to drop to a humane level for a few moments. The practitioner must forget that they are the doctor in the equation and simply interact with the patient as you [AMP] would normally." AMP7

"In my opinion, the patient must disclose. I encourage it, and once I discover that they are using traditional medicine, I tell them, but I also come from that background, because as Africans, we used to use this traditional medicine. I

explain my position, and where I'm coming from, without prejudice, undermining, or implying that traditional medicine practitioners don't know what they're doing because, unfortunately, we can't get rid of them as Africans. Because that is the most important thing, we must accept that traditional medicine will continue to play an important role. It (TM) is not something we can eradicate right now. We must not destabilize them (TM)." AMP9

"... [big sigh] That's a tough one! When I discover that my patient is using traditional medicine, I am unable to do anything as a doctor. You cannot make the patient stop taking this type of medicine (TM) if they still believe it helps them. You [AMP] are not with them at home. But the only thing I will do is give the patient advice and explain why I don't agree with them taking them both." AMP10

"Discovering that the patient uses both traditional and our medicine... Eh... Usually, I try to understand their point of view and where they're coming from. If they believe in traditional medicine, I will simply give them guiding advice and all the side effects of whatever they're taking, but I will never discourage them." AMP11

".... if we want the patient to disclose, we should examine our attitude, how we address it, how we ask questions, and how we politely address the treatment that we will give the patient. As for me, I don't think there's anything wrong with people who use traditional medicines because I don't even know how they work." AMP12

".... uh, the other one would be stigma, especially from healthcare workers, because of different religious and healthcare practices. As a result, you may find that among us healthcare workers, others are Christians who do not believe in traditional medicines, so patients are reluctant to disclose because of the stigma." AMP13

"I believe traditional medicine is simply a South African way of life, and many South Africans truly believe in traditional medicine, and they will always see a traditional first before coming to see us... I would simply educate them to be cautious of traditional medicine. Because if it is someone's belief, it is pointless to discourage them" AMP14

5.4.3 Theme 3: Facilitating disclosure of TM use to AMPs

When participants were asked about what would make a patient who uses both TM and AM disclose TM use, they stated that good communication between AMPs and these patients played a significant role in consultations with patients. Most AMPs said that they were aware that the responsibility lay within themselves to ensure that the environment was conducive for patients to feel welcome. They further cited that if the patient did not feel welcome within the space, patients would not be open to disclosing anything other than what they felt was enough to get help at that time. Most AMPs indicated that a safe environment would instil within the patient some sense of trust towards the person they were interacting with. According to the AMPs, disclosure of TM use to AMPs can be facilitated by factors such as 1) creating a conducive environment for disclosure of TM use, 2) encouraging patients to disclose TM use to AMPs, 3) patient autonomy and 4) training of AMPs.

5.4.3.1 Creating a conducive environment for disclosure of TM use

The AMPs expressed their awareness regarding the responsibility that lay with them to ensure that the environment was conducive for all patients to feel welcome. The participants displayed an eagerness to make sure that patients felt welcome so that they would be open to disclosing. The AMPs stated that having a standard method of approach for all patients would assist in ensuring that patients that use TM could disclose regardless of the AMPs' stance concerning TM use. The following narratives illustrate this:

"Uhm, I believe if a patient discloses in a safe environment. It is our responsibility as healthcare providers to create a safe environment in which

patients can disclose anything, even if it is not traditional medicine. However, whatever adjuvant treatment they are receiving, we must create a safe environment." AMP3

"Patients, in my opinion, should be required to disclose. I believe that practitioners must keep an open mind and be able to create an environment in which the patient can speak. So, does the practitioner have to create an environment?... First, the environment must be clear and conducive, and trust must be established by you (the AMP). It is the practitioner's responsibility to create that platform to clarify the implications of the patient's illness and treatment. Practitioners must foster an environment in which patients are encouraged to disclose." AMP7

"... OK. First, when I consult with a patient, I want the patient to feel safe and confident; when the patient is with me, I want the patient to trust me because I'm here to help, not to harm; and once the patient trusts you (the AMP), I believe it will be easy for the patient to disclose." AMP4

"Uh, we'd like patients to fully disclose because we don't want them to be hiding anything from us. So, we'd like to provide an environment in which a patient feels very safe to disclose and is not judged by whatever treatment they're using, but ultimately, we'd like patients to give us full disclosure about what they're using, because it affects how we manage them further." AMP13

5.4.3.2 Encouraging patients to disclose TM use to AMPs

The AMPs believed that through proper communication and with the proper tools being applied, patients could be motivated to disclose. They stated that if patients could see that there was awareness of TM use, they would easily disclose it during consultation. They indicated that patients needed to be reassured that they could approach and trust that the AMPs would receive the disclosure well even if the patient denied being responsible for their situation. The quotes below support this:

"... However, if you ask the patient directly, they will not disclose unless they believe you [the AMP] are receptive. If I'm curious, I'll tell the patient that most of my patients take traditional medications. So, when they suspect that they are not the only ones using traditional medicine, they reveal it. But if I simply asked, they would not reveal." AMP1

"We (the AMPs) should not judge patients for their own choices in order to allow the patient to disclose. We must recognize that patients have rights. We should also inform patients that their rights entail responsibilities. We [the AMPs] also have a responsibility to protect patients." AMP3

"... In my opinion, I want the patient to disclose because I want to know everything about the patient when I'm treating him or her. As a result, if the patient discloses, we should always inquire as to how long this has been going on. Is there anything else wrong with them? And what other medications are they taking? You'll discover that some medication could be the source of the patient's symptoms?" AMP4

"Some other people (referring to AMPs) are easier to talk to than others, so some health care workers may discover that patients believe it's difficult for them because they aren't free to talk about everything." AMP5

".... I would engage the patient to encourage disclosure. I'd like to know why. Just try to figure out why the patients made the decisions they did. That is important to me, and I try to be accommodating in terms of background so that the relationship I have with that patient is maintained." AMP7

"In order for the patient to disclose, I usually ask the patient. I ask the patient to tell me the truth, and when I discover they are using traditional medicine, I don't dismiss them; instead, I speak appropriately. I show them that traditional medicines in this condition are not to be used because they will all harm your kidneys." AMP9

".... The thing that will make them [the patients] disclose is when you explain to them that you understand and acknowledge that you know about their traditional medicine and that you know it can help with some diseases. Then, if they know you know and you admit that another medication is different from what you (the AMP) are giving, they will reveal." AMP11

".... I will be delighted if all patients who come to us can tell us when we ask, 'Have you ever taken any traditional medication?' I'd be delighted to work on them." AMP12

"OK, so they would disclose, one, if they are aware of information that would benefit them. So, having explained the preceding point. They should be allowed to fully express themselves. That they should be aware of the impact of their treatment plans on their condition, as well as the interaction of their treatment plans with other treatments that they may be using. As a result, if they are aware of such information, it will be easier for them to disclose." AMP13

5.4.3.3 Patient autonomy

In terms of the autonomy of patients who use both TM and AM, the AMPs stated that these patients could not be obligated to use only AM if they believed the TM was working for them. They felt that they had to allow the patients the autonomy to choose their treatment options based on their preferences. Some AMPs were of the view that if enough information were made available to these patients, it would enable them to make informed decisions regarding the use of TM. The following quotes support this:

".... I don't mind if there are no negative interactions between traditional medicines and our allopathic medicine." AMP2

"Uhm...We [AMPs] have a responsibility to make sure that we are always constant, and the patient autonomy is respected." AMP3

"I used to be autocratic before I went to get my speciality, but not anymore. I no longer use that method; instead, I simply allow the patient to make their own decision because, at the end of the day, it is the patient's choice. I can't make the patient do anything." AMP1

"We should not pass judgment on patients based on their own choices." We must recognize that patients have the right to choose their treatments. We should also remind patients that their rights come with responsibilities. On the other hand, we have a responsibility to protect the patients and maintain our commitment to patient autonomy." AMP3

"...The patient must consider the outcomes. However, it is ultimately the patient's choice. I can't force it." AMP4

"For example, in traditional medicine, let's say a patient comes in for an acute illness and they don't necessarily have any chronic conditions, and I have no reason to suspect any other chronic illnesses." I don't usually have a problem with that (referring to the use of TM)." AMP5

"I always keep an open mind when dealing with patients who have different perspectives on medical treatment. So, if a patient has a different point of view. I'm always willing to sit down with a patient and talk about it [the TM use]." AMP7

"Yeah, well, we should talk properly. They [the patients] are of legal drinking age. They have the right to make their own decisions. They have the right to know as well. The more information we provide, the clearer their decisions will be." AMP9

"... I believe that if it [the TM] is working for them and isn't causing any problems, they should continue using both, as long as it doesn't interfere with the medication that we're giving." AMP11

"Um, we can't refuse patients who are taking their regular medication. The only thing that will help us is if they can just tell us what kind of medication they used and why so that when we [the AMP] treat that patient, we know where to look and how to deal with the patient's problem..." AMP12

"So, when patients come to us, uh [AMPs]. Uh, I'd usually ask them that, but I'd also give them information about our treatment plan, and they'd decide which plan they wanted to go with on their own." AMP13

5.4.3.4 Training of AMPs to understand TM

When referring to AMP training, the participants stated that AMPs were trained to consider other complementary methods of treating the patient. However, they also mentioned that TM was not considered an alternative to AM, except in instances where the individual AMP had previous exposure to TM use. They also mentioned that THPs could also benefit from health education as this could encourage their visibility as people who are involved in patient treatment. The following quotes illustrate this:

"But our medical training does not prepare us for this type of scenario [referring to patients who use TM], because you are always told to do what is best for the patient, but this is not always the case... However, during their undergraduate training, doctors are exposed to technology that does not allow us to know what they [THPs] are doing; we simply assume they throw bones [a method of checking with the ancestors to determine what problems the patient may be experiencing] and then [showing a gesture of bare hands]. There is very little understanding of what occurs on the other side." AMP1

".... It is our training that will make us opposed to the use of traditional medicine." AMP2

".... Your [as an AMP] training, usually uhm, tends to direct your thoughts and your experiences in life, so mina [Zulu reference to self] coming from a family

where there are traditional healers. So, I think I'm more inclined to understand why they are using them. So hence I try and work somewhere in between if I can" AMP5

".... if I find out the patient is using traditional medicine, as a medical practitioner, I don't have a clue about traditional medicine." AMP12

"...We [AMPs] were primarily trained in the use of a medical treatment" [AM]. So, our approach would be for the patient to use what we recommended. As a result, my opinion strongly supports what I know about the medical treatment aspect. As a result, we usually advise patients to use medical treatment rather than other treatment options about which we are unsure." AMP13

5.4.4 Theme 4: Procedures to encourage disclosure of TM use to AMPs by patients who use both TM and AM

When participants were asked to provide recommendations that would encourage the disclosure of TM use to AMPs by patients who use both TM and AM, they made various suggestions. The AMPs highlighted that unnecessary costs were incurred by the healthcare system because of complications resulting from mixing treatment plans. Communication entails exchanging information and for the AMPs and patients using both TM and AM, this seems to be important. The AMPs suggested that THPs could be regulated to enable them to refer patients as soon as they notice complications. Some of the participants said that they had had an experience where a patient decided to disclose only because they had no other option. They said that patients using TM usually disclosed when they saw a decline in their condition. They also emphasised the collaboration of both AMPs and THPs to allow better communication with the patient. Two themes emerged: 1) collaboration of THPs and AMPs and 2) acknowledgement of TM practices.

5.4.4.1 Collaboration of THPs and AMPs

The process of THPs referring patients to AMPs was initiated but has since stopped. AMPs wanted this process to be initiated again as it would help greatly in encouraging dialogue between the two types of health practitioners. They also said the THPs should encourage patients to disclose the use of TM when they consult the AMPs. The following quotes support this:

"...My recommendation is that the department tries to bring traditional healers closer to the healthcare system. Because there was a time when they said they were going to train them [THPs] to be lay counsellors. Because, technically, they are an option we cannot dismiss, and we know patients are going there [to THPs]." AMP1

"My recommendation, in my opinion, is public health education, training and involvement of traditional healers is required. The Department of Health must involve, regulate, and train traditional medicine practitioners while also training them on when to refer patients to nearby clinics if they believe the patient is too sick for them to handle. THPs and clinics or hospitals must have open lines of communication. Because they serve as patients' first point of contact with the actual treatment. " AMP6

".... I keep an open mind because it provides an opportunity for me to learn something new as well. Then I'm certainly open to collaborating with whoever is administering this medication [TM] to figure out how they're able to determine dosage for that patient and then see how it affects patient management in modern medicine." AMP7

"They [THPs] must learn from us, and we must learn from them, in order for healthcare to be united. Healthcare is not just for western-trained doctors; THPs are also a part of our healthcare system." AMP9

"The first point of call for help, especially for medical treatment, would be traditional healers. As a result, traditional healers are the first point of contact. So, if we work together and collaborate, we can teach them some things and they can teach us some things. Then we can identify them and inform them that if they notice certain symptoms, they must immediately take the patient to the hospital. They [THPs] can treat because there are some things that we cannot treat and that only traditional people can treat." AMP11

"Other recommendations include management putting in place protocols that can address issues surrounding allopathic and traditional medicine use. There should be an interaction between the two groups of healthcare providers who use different types of treatment. Traditionalists should also be discussing how they will manage patients of certain ages or conditions together for the benefit of the patients." AMP13

5.4.4.2 Acknowledgement of traditional health practice

To encourage disclosure by patients who use both TM and AM, AMPs said they needed to reach out to the THPs and communicate with the THPs to support the common goal of treating the patient. The AMPs also mentioned that if they encouraged disclosure, it would assist in the acknowledgement of TM practices by the Department of Health, AMPs, communities and AMP conferences. The following statements illustrate this:

"I would recommend health education about what we [AMPs] offer and how far the treatment can go. Because there are specific resolution medications, particularly for pregnant women. We can only get to a certain point and then we are unable to treat certain things because of their pregnancy and we are afraid of adverse reactions." AMP3

"When a patient comes here [AMP] or goes there [THP], it is because they want help, and we can only help them if we understand their condition and the solutions. I believe the patient will feel comfortable disclosing and explaining to you what other medications they are taking." AMP4

"... Asking direct questions, and perhaps from the other side, herbal and homoeopathic if they can also encourage patients that if they can find out if they're taking any medication and they also encourage them to disclose on their side [referring to the AMP]. So, let them [AMPs] know if they [THPs] assist and encourage the patient if you go to the clinic. So, I believe that information gleaned from both sides' interrogation would aid in the disclosure." AMP5

"My recommendation is information because I believe we need to start a campaign in which we inform patients that if they use traditional medicines out there, they must disclose. They can approach medical practitioners to disclose using these aids [TM] ... But I also believe that in our public hospitals, information should be posted [on posters] to say, 'Look, if you happen to be using traditional medicine, feel free to disclose to the practitioner and don't hold back...' So, if they will know you [the AMP] acknowledge the existence of such a thing [TM]." AMP7

"As a recommendation, I believe, uhm, we should use the media to explain that there is a risk of using traditional medicine, and I encourage patients to use medical [AMP] first." AMP8

"They [THPs] are the first point of contact for patients. We can't just say, 'You know, we have to invalidate some of their findings.' They assist us, and at times we must inform them. We must also educate them. We must allow them to attend our meetings. We must attend their conferences in order to learn from one another." AMP9

"My recommendation is, to begin with, Primary Health. The Community must be informed. Primary healthcare exists for such purposes so that the community is aware of what traditional medicine can do for them. That will be extremely beneficial... Churches can also be used at times. There are also stages for doctors in churches and schools to address such issues [referring to the use of traditional medicine]." AMP10

"The thing that will make them, disclose is when you explain to them that you understand that you know about their traditional medicine and you acknowledge that and that you know it's helpful in some diseases. Then if they know that you know and you acknowledge that another medication is different from what you are giving like there are other treatments, they will disclose it. We are checking also this Moringa and Lingana (traditional herb) and other things that they're taking." AMP11

"I propose that we develop a tool, in a form of a pamphlet that patients could read. It could take the form of a board written on the door or even on the patient's file, and when they come in, specific questions [related to TM use] may be asked of you. The patient will come freely, knowing that I will ask these questions, and I believe the patient will open up in telling me what I see them. Unlike when you [the AMP] simply bombard them with questions when they arrive [for consultation]." AMP12

"All right, a recommendation to healthcare providers. They should be aware of the people they serve. They should be aware of the situation. Traditional methods have been used and taught to people as curative treatments. So, when approaching such a patient, they should be sensitive, understanding that there are various options. Patients have the right to exercise and access." AMP13

"Recommendations? ... I believe. If patients use traditional medicine, we should simply ask standard questions when they come to the hospital. To elaborate, ask when they last used it, how frequently they use it, and why they would choose it over allopathic medicine." AMP14

5.5 REFLEXIVITY

Research history shows that qualitative researchers have evolved to be more transparent about their research procedures (Creswell and Poth 2018: 366).

This transparency is achieved through reflexivity, which is a method that allows qualitative researchers to prevent prejudice against that which could affect data collection and interpretation (Polit and Beck 2017: 304). Therefore, describing the convergence of the individual participants, the determined setting and the researcher increases the credibility of the findings in the study, to ensure an in-depth understanding of the phenomenon under study (Dogson 2019: 220).

During the study, the researcher maintained a strong sense of reflexivity to ensure that all aspects of the data were represented without bias from the researcher's theoretical assumptions. The researcher and supervisor were attracted to topics related to exploring and developing relationships between AMPs, THPs and patients who use both TM and AM. At the beginning of the PhD concept, the researcher was considering exploring new methods of improving work ethics to guide disclosure procedures between AMPs and patients who use both AM and TM. During the process of refining the concept, the topic evolved as the researcher was exposed to various literature sources and immense guidance from the supervisor. In the final topic for her PhD, the researcher explored the non-disclosure of patients who use both TM and AM.

The researcher has 16 years of work experience as a radiographer. This has given her a perspective of the hospital setting and the procedure that is applied. Additionally, the researcher has more than 10 years of experience as a practising THP, allowing her to have a perspective of the setting and procedures applied by some THPs. During her tenure as a radiographer, the researcher noticed that patients were being evasive when it came to suspected cases of TM use during treatment in the hospital setting. In addition, she experienced the opposite with patients she consulted within her capacity as a THP. This led to an interest in the current topic. The researcher believes that AMPs as health professionals responsible for treating and managing various patients' conditions could provide a solution to the issue of disclosure.

An exploratory, descriptive approach was used as it enabled the contextualisation of how the AMPs perceived disclosure and their role within

the context of the study. Regarding accessing the AMPs from the various research sites, the researcher came across some challenges as she was familiar with all but one of these departments. Ethical clearance was obtained from the DUT Research Ethics Committee as well as the CEOs/clinical managers of the selected research sites. In an email communication on 1 September 2021 the Research Manager at the Gauteng Department of Health indicated that once the research site had granted permission to the researcher, the study could proceed as the province only approved clinical trials.

To ensure thoroughness in the data analysis, the researcher attended training on how to use ATLAS.ti to ensure that data was managed appropriately. Data analysis was initiated by first considering and analysing the data manually through careful consideration of all the transcribed data. The documents of how the data analysis was developed were later shared with the supervisors so that they could validate if the data analysis had been done correctly as they had extensive experience in qualitative research. CPM theory was also revised by applying the findings accordingly to the various associated suppositions so that the findings during data analysis and interpretation could be merged into a theoretical narrative. This also allowed an audit trail from the data collected to the finding by including quotations.

To ensure the trustworthiness of the study, the initial audio interviews and transcripts were shared with the supervisors. This helped the researcher to improve where necessary with subsequent interviews as per advice. The supervisors were also given the outline of the theory that was discussed in Chapter 3 and the transcripts of the recorded interview. This was important to confirm if the findings were correctly presented in Chapter 5. The researcher was concerned about the length of some of the interviews which did not lead to the desired prolonged engagement with the participants. However, the supervisor clarified that this sometimes happens as the flow of the interviews is determined primarily by the participants' responses.

5.6 SUMMARY OF THE CHAPTER

This chapter presented the pertinent findings as themes and subthemes that emerged from the interview data analysis in the study. Disclosure of TM use is an important factor in communication between AMPs and patients who use both TM and AM. The perceptions of AMPs regarding the disclosure of TM use by patients who use both AM and TM were explored. A further discussion of the findings will be presented in the next chapter.

CHAPTER 6: DISCUSSION OF FINDINGS OF THE STUDY

6.1 INTRODUCTION

The aim of this study included exploring and describing the perceptions of AMPs regarding the disclosure of TM use to AMPs by patients who use both TM and AM at selected hospitals in Gauteng. This aim was achieved, as seen in the findings presented in Chapter 5 which reveal the significant variations in perceptions of the AMPs regarding disclosure of TM use by patients that use both TM and AM in the study context. In Chapter 5 the themes, subthemes and categories that emerged were discussed and supported by direct quotations from AMPs' responses. In this chapter, the findings are discussed and interpreted. These findings will be discussed, triangulated and contextualised through CPM theory, which is the theory that guided this study. Various conclusions can be drawn from the findings which concern CPM theory. The research findings also helped the researcher to identify several immediate issues that result in non-disclosure to AMPs by those patients that use both TM and AM.

6.2 DEMOGRAPHIC PROFILE OF AMPs IN THE STUDY

The AMPs who took part in this study were healthcare professionals who supported the primary healthcare needs of patients in Gauteng. The 14 AMPs consulted with patients who either presented themselves or were referred by primary healthcare facilities from areas surrounding the respective hospitals. Their ages ranged from 28 to 68 years and their work experience as AMPs ranged from 3 to 36 years. Through these descriptions, it could be seen that work experience in years was closely related to the grouping of the participants' ages. Most of the AMPs working in the selected hospitals were African (13) and only one was Indian. The researcher noted that there was an obvious shortage of AMPs in the departments that took part in the study. There were more medical officers (13) and only one family physician. According to Mash *et al.* (2015: 56), the family physician is regarded as the consultant AMP to lower-

ranking members of the team such as interns, community service medical officers and clinical associates, as they have postgraduate qualification training, whereas medical officers do not have any postgraduate training.

6.3 APPLICATION OF CPM THEORY TO THE FINDINGS

How the AMPs interact with patients who use both AM and TM to disclose the use of TM seemed to be influenced by individual experiences. CPM theory was applied through the five notions and three privacy rules management processes used in Petronio's CPM theory. Bylund, Peterson and Cameron (2012: 269) emphasize that CPM theory necessitates deliberation to recognize that individuals believe they own private information and that all boundaries are established around this information. In this study, the major players in CPM theory were the AMPs and the patients since they play a significant role in the disclosure process. The application of CPM theory during AMPs' consultation with patients will be discussed next. The theme categories were derived from CPM theory elements and will be elaborated on in the context of the study findings.

6.4 THEME 1: AMPs' PERCEPTIONS OF NON-DISCLOSURE OF TM USE BY PATIENTS WHO USE BOTH TM AND AM

Regarding private information, for AMPs to be able to properly dispense patient care and management, they should be entrusted with co-ownership of the TM information of their patients (Petronio, Dicorcia and Duggan 2012: 41). Therefore, if the patient feels that the information is not pertinent to the treatment given by AM, it results in non-disclosure (Gall *et al.* 2019: 9). In this study the AMPs aligned their perceptions of non-disclosure with the prevention of sharing of information that is necessary for treatment planning. This was evident in the participants' responses which revealed that AMPs end up treating patients without fully knowing the underlying cause of complications during AM treatment. Non-disclosure in this regard has negative implications, thus reducing the possibility of positive outcomes.

6.4.1 Lack of scientific evidence for TM

The lack of knowledge means that the AMPs do not have enough information about TM and therefore do not understand how TM works. Similarly, Hilal and Hilal (2017: 331) found that AMPs who participated in their study had a limited understanding of TM and therefore were not able to provide patients with appropriate advice regarding TM. Foley *et al.* (2019: 6) agree with these findings, stating that a perceived lack of TM knowledge is regarded as an obstacle that could hinder open communication during patient consultations. In the current study, some AMPs indicated that they tried to find common ground even though they were not knowledgeable about how TM works.

AMPs believed that because the information is abstract, it results in TM being mocked. These findings are consistent with those from a study conducted in Tanzania by Stanifer *et al.* (2015: 1) aimed at characterising the extent of and reasons for the use of TM among the community to illuminate public health efforts in the region. They deduced that TM practices are regarded as out of date because of insufficient scientific evidence to confirm dosage and methods of diagnosis (Stanifer *et al.* 2015: 13). However, it has been shown that there is a paucity of research on the topic, thus showing a clear division between the humanities and the AM research of TM used in the African context (Sobiecki 2014: 3). Therefore, the issue with current research in phytopharmacology is the limited data relating to perceived knowledge of TM (Sobiecki 2014: 3).

The AMPs indicated that due to the absence of confirmed knowledge regarding TM treatments, TM is then viewed as a lesser counterpart to in-patient treatment. This is in line with Mothibe and Sibanda (2019: 9) who found that AMPs did not view TM as an equivalent concerning scientific evidence available and felt that allowing such patients into the healthcare system would jeopardise patient management in the hospitals. On the contrary, an earlier study by Sobiecki (2014: 2) investigated common samples of TM used for spiritual purposes in South Africa to show facts related to divination through the integration of phytopharmacological research and anthropological fieldwork

procedures. This researcher discovered that the popular examples used in the research revealed that there was indeed existing scientific evidence to support TM use in Africa (Sobiecki 2014: 7). A study by Yuan *et al.* (2014: 17) presented a positive outlook regarding knowledge of TM, citing that there was immense potential for future revelations from plants and other common items; this, in turn, offers extensive potential in inferring valuable data about novel chemical structures and their unused medicinal development.

However, the researcher in this current study noted that the prominent issue among most AMPs is that even the patients that use TM do not have any details of the TM that they are using. The AMPs also confirmed that they occasionally did not consider TM due to the lack of details usually provided by these patients. Therefore, they ended up questioning the validity of the training of the THPs that dispense the TM to these patients. The current study findings are consistent with those of Mutola, Pemunta and Ngo (2021: 1) who explored the reasons for the slow progress of the integration of TM with the AM healthcare system in Qokolweni in the Eastern Cape, South Africa. They found that one shortcoming of THPs is the lack of standard working strategies such as record-keeping type/name, amount of TM given to the patients, recurrence, the length of time that the medicine is effective and adverse effects associated with the TM (Mutola *et al.* 2021: 2). AMPs indicated having reservations about the THP training to legitimise their practice. Logiel *et al.* (2021: 1416) shared similar findings, stating that most ailments are not legitimately analysed, which could result in incorrect treatment being prescribed by THPs and thus TM may negate the impact of or delay AM treatment, which could be lethal.

6.4.2 Unspecified dosage of TM

The AMPs indicated that they had no information regarding the dosage and strength of the TM used by their patients since the patients also did not know about the TM they were using. They stated that this lack of information made it difficult to manage cases of toxicity as they needed to know the details of the medicine that the patient took. AMPs shared instances where TM overdose was

suspected but patients still did not feel that disclosure would solve their problem. However, one of the AMPs shared how a mother of a child who presented with herbal intoxication only disclosed when the child was well and survived the ordeal. AMPs acknowledged that not being able to confirm the severity of the issues associated with the dosage of TM used by patients severely impacts the overall management of the patient. Furthermore, the AMPs in the current study also raised questions regarding how the actual dose given to a patient is calculated by the THPs. The absence of correct dosing is an issue associated with TM use by patients (Ahwinahwi and Chukwudi 2016: 100). Therefore, dealing with dosage issues will help AMPs identify cases of TM intoxication in time.

AMPs argued that they knew when to increase or decrease the AM dose given to the patient according to the patient's needs, even in cases where the AM might be causing problems in the organs. Therefore, similarly, TM should be standardised and graded for safety (Kamsu-Foguem and Foguem 2014: 127). Fokunang *et al.* (2011: 288) and Zhang *et al.* (2015:1) agree that initiating safety standards for TM dosage should help avoid safety issues associated with overdosage of TM and could be recommended for organ safety. Another study recently conducted in Kenya to identify important traditional and modern governance practices that regulate the TM sector in Western Kenya (Chebii, Muthee and Kiemo 2020: 1) found that constraints of information on healing effects in the expanding TM industry are accompanied by numerous health and safety concerns. AMPs in this current study indicated that the unavailability of the dosage of TM used by patients made it difficult for them to make any necessary adjustments to the AM treatment. Gyasi *et al.* (2016: 7) reveal that even the TM bought in pharmacies and from street vendors poses a risk because they do not have any dose indications and expiration dates. Despite this, AMPs are expected to provide the necessary advice that is relevant to the condition the patient is currently suffering from to avoid any adverse consequences related to overdosage.

6.4.3 Non-adherence to the AMPs' treatment plan

AMPs generally understood that the patient's outlook is key to providing the best healthcare advice. However, some AMPs indicated that they did not know how TM works and therefore had to ask patients to stop using TM while on AM treatment so that they could follow up on patient improvement with AM only. Mokhesi and Modjadji (2022: 8) concur that using TM and AM concurrently may render the AM ineffective as the use of TM is connected to toxicity and patients not complying with the prescription. An earlier study by Sobiecki (2014: 5) disputes this, saying that notions that regulatory standards on AM are a preventative measure of toxicity are incorrect. Well-known administrative research statistics show that there is an increasing tendency of mortality and harm related to AM treatment. Similarly, a recent study by Zingela, van Wyk and Pieterse (2019: 146, 149) was conducted in the Nelson Mandela Metropole in South Africa on the pattern of use of TM and THPs among psychiatric patients. These researchers found that there is a need for AMPs to acknowledge that the adequacy of medications proposed to patients may have critical implications for treatment adherence.

Some AMPs mentioned that they did not encourage using TM with antibiotics as this may worsen the patient's condition, which is usually an infection. AMPs indicated that while managing the patient, they recommended that the patients stop using TM when using AM until they had completed their AM treatment and the condition had improved according to their general health. They argued that TM used by patients was not properly identified and therefore tended to be biased towards their own prescribed AM. According to a study by Puoane *et al.* (2012: 495) aimed at exploring the perceptions, knowledge and attitudes of patients, AMPs and THPs about the use of TM and antiretrovirals, patients did not disclose their use of TM because AMPs had a pessimistic and demoralising opinion about the harmful consequence of TM (Puoane *et al.* 2012: 501). The researcher noted that this may then act as a deterrent to those patients who would want to disclose.

Non-disclosure suggests that patients do not recognise the significance of disclosure of their care by AMPs (Petronio, Dicorcia and Duggan 2012: 41). The AMPs indicated that they depended on the information that the patient was willing to provide to manage them properly. They claimed that examinations done to confirm what may be wrong with the patient were prolonged in the absence of correct and complete disclosure by patients and by the time the patient reached out to the AMPs, there was already irreversible damage to organs. AMPs expressed concern about having to resort to other costly options to achieve proper treatment because patients chose not to disclose pertinent information. On the other hand, patients opted to supplement their treatment with TM because AM treatment bears a high cost compared to TM (Fokunang *et al.* 2011: 286; Hughes *et al.* 2013: 38). The patient has ultimate control over this information as they are regarded as the information owner (Petronio and Child 2020: 76). The researcher noted that this is what leads to problems for AMPs and the patient in achieving the common goal of positive results.

6.4.4 Complications because of interaction between AM and TM

Complications related to the concurrent use of TM and AM are a major problem. The AMPs are confronted with the task of saving patients with limited information. The AMPs pointed out that these patients presented themselves very late, usually when there was extensive organ damage. The AMPs believed that if these patients did not disclose, the AMPs would lose and that those patients who were experiencing complications should disclose without any persuasion as they needed help urgently. In line with CPM theory, for the AMPs to be able to properly dispense patient care and management, they should be entrusted with co-ownership of the information by their patients (Petronio, Dicorcia and Duggan 2012: 41). This would then help the AMPs to explain to the patients any contraindications of using TM with the AM treatment prescribed for their condition.

The response relating to AMPs' reaction when they find that a patient is using TM differs from that of most AMPs based on their efforts to gain the trust of the

patient. Some AMPs indicated that they were not in support of using both TM and AM together, and others indicated that they were reluctant to discourage patients from using TM and would rather explain the implications of the two medications interacting. The researcher noted that this uncertainty could be changed if healthcare organisations implement motivational strategies to ease the disclosure of TM used by patients so that patient care and outcomes can be improved. Mutola *et al.* (2021:3) argue that the limitations of TM perceived by those opposed to TM integration in the healthcare system should be viewed as opportunities for improvement rather than impediments. This may be because a good number of individuals believe that because TM is natural, it is safe, has no negative reactions and can therefore be used concurrently with AM (Johny, Cheah and Safii 2017: 2; Ozioma and Chinwe 2019: 207). Ekor (2014: 7) and Mothibe and Sibanda (2019: 7) argue that the terms 'safety' and 'natural' should not be considered synonyms and therefore all medicines should be approved with regulations applicable globally.

In addition, some AMPs in the current study suggested that they would discourage the use of TM since they did not know the interaction between what they prescribed to the patient and the TM they might be using. This may be linked to the notion that THPs have no restrictions regarding what they can cure, due to ignorance about AM and TM interactions which results in poor treatment outcomes (Fokunang *et al.* 2011: 289). The researcher observed that the perceived views of TM by AMPs are a contributing factor to considerations of safety and risks related to TM use. Most of the AMPs did not support the use of both TM and AM, with their main concern being organ damage since all medication is metabolised in the liver. Any damage is picked up mainly through liver function tests which may indicate herbal intoxication. This is in line with previous literature which states that interactions between TM and AM may hinder metabolising enzymes as well as alter the effect of AM in the blood (Hussain 2011: 153; Chen *et al.* 2012: 645; Bhadra, Ravakhah and Ghosh 2015: 316). AMPs in the current study also indicated that there are instances where the TM and AM do not hinder each other in the process of patient management and if that was the case, they sometimes allowed the patient to

continue with both treatments. The researcher noted that this was contradictory since the only way AMPs could confirm the absence of interaction is through laboratory tests of both medicines. In support of this view, research performed in Brazil by Moreira *et al.* (2014: 254) to assess the traditional use and safety of herbal medicines highlights that the toxicity of medicine must be assessed clinically to ascertain the pros and cons that are not likely to be revealed through formal research. Furthermore, the researcher noted that AMPs ought to have a good understanding of TM and AM side effects, despite not being of the same traditions.

It became evident from the AMPs' responses that they feared any interactions between TM and AM and therefore they needed to ensure that they kept all the records of any apparent clinical features to refer to in case of complications. This finding is consistent with suggestions made by James *et al.* (2018: 11), who emphasise that exploration of interactions between medicines in sub-Saharan Africa is important as the knowledge can be used by AMPs to guide consultations with these patients and ultimately improve the AM treatment outcomes. Similarly, Hughes *et al.* (2013: 43) maintain that for AMPs to be able to render adequate healthcare guidance to patients regarding interactions between TM and AM, they must observe the significant growth in the number of patients using TM. The AMPs indicated that patients need to understand that using both TM and AM at the same time is bound to obstruct the proper management of their condition, thus resulting in complications. All TM comprises various active components which increase the likelihood of interactions between TM and AM (Zhang *et al.* 2015: 2).

The AMPs revealed that the use of TM was most significant for those patients suffering from chronic illnesses such as HIV and on antiretroviral medication. The AMPs, during the interview, suggested that it was important to explain to the patients that there are conditions that TM cannot treat, such as tuberculosis and HIV. Most patients who suffer from chronic illnesses are the ones that commonly use TM and AM concurrently (Zhang *et al.* 2015: 20). A study performed by Fokunang *et al.* (2011: 289), aimed at coordinating collaboration

between THPs and AMPs in Cameroon, highlights the continuing complications of TM and AM interaction as an issue that is abstract to THPs, thus prompting the need for awareness of possible interactions between TM and AM. Therefore, a study is necessary to determine the awareness of THPs regarding the interactions between the concurrent use of TM and AM.

6.5 THEME 2: PRACTICE OF AMPS WHEN CONSULTING WITH PATIENTS WHO USE BOTH TM AND AM WITHOUT DISCLOSING

The practice of AMPs in the context of disclosure requires proper management of non-disclosure (privacy) and its boundaries. According to Petronio *et al.* (2012: 41), CPM theory illustrates that AMPs inherently manage two non-disclosure boundaries with the patient within the relationship between the AMP and the patient. CPM theory declares that privacy management can be influenced by numerous errors in communication since we live in a flawed world (Petronio and Child 2020: 77). This notion was observed during the interviews with AMPs as the researcher noted through the AMP responses that they drew the boundaries and considered that these could change over time, depending on the patient encounter during consultation. Regarding privacy management, AMPs in the study understood that they had to make the best effort to engage these patients acceptably.

6.5.1 AMPs' bedside manner

The bedside manner of AMPs is a major part of proper AM practice. Apart from being co-owners of patients' information, AMPs also serve as guardians of the AM management of patients (Petronio, Dicorcia and Duggan 2012:42). The AMPs said their approach to patients using TM was negative as most of them did not want to hear anything about TM use by their patients. This finding is in line with several studies in South Africa which reveal that patients are convinced that disclosing to AMPs may negatively affect their consultation with the AMP, thus resulting in substandard patient care service (Hughes *et al.* 2012: 472; Puoane *et al.* 2012: 499). A recent study conducted in Zambia by Hajj *et al.* (2020) to explore the perceptions, motivations and experiences of Zambian

women concerning their use of TM during pregnancy showed that disclosure was a rare phenomenon among the AMPs in their study. Several authors argue that AMPs need to enhance their integration with patients since their negative responses are the main drivers of the fear the patients have for them (Hajj *et al.* 2020: 6; Amirudin *et al.* 2021: 285). This was also confirmed by AMPs in the current study who indicated that the boundaries can also be shared in the sense that the attitude of the AMPs towards patients who use both TM and AM instils fear of judgement by the AMPs in patients.

Good communication skills by AMPs are important during the consultation with patients to be able to openly outline their opinion as an AMP to help the patient understand their illness. Some AMPs in the current study stated that they were aware that patients communicated a lot easier with them if they had established that they were approachable. James *et al.* (2018: 11) explain that to enhance the communication between AMPs and patients regarding TM use, it is important for AMPs to consider the probability of their patients being users of TM and to be unbiased in their interaction with these patients during consultation. The current study reveals that proper communication between the AMP and the patient can determine whether the patient will disclose or not because the patient might be feeling self-blame when they come for the consultation. A recent study was conducted in Lesotho by Mokhesi and Modjadi (2022: 1) to determine the prevalence of traditional and complementary alternative medicine usage and associated factors among patients receiving healthcare in a health facility in Lesotho. These researchers cited motives for non-disclosure of TM use by patients in their study as being a lack of proper engagement and fear of AMPs as they were against the use of TM.

The researcher noted that the AMPs were aware of the need for proper interaction when engaging patients during consultation. AMPs stated that they sometimes referred to previous encounters with other patients that use both TM and AM to ensure that the patient understood that they were not the isolated case without making them feel dominated. Similarly, Johny, Cheah and Safii 2017 (2017: 9) identify interpersonal and communication characteristics of

AMPs regarding the conscious treatment of patients, tuning in mindfully, and respecting patients' privacy as essential elements of the disclosure. With regards to the barriers that hinder open communication between the AMPs and the patients who use TM, the AMPs that were interviewed said the attitudes towards these patients had been a major reason for the patients not being open to them. AMPs indicated that in most cases they were dismissive of the subject of TM. This is in line with Mokhesi and Modjadji (2021: 8), who suggest that those reasons for non-disclosure may be outright dismissal of TM use, fear of AMPs and poor communication.

Furthermore, the AMPs in this study acknowledged that all patients should be treated fairly without prejudice, the same way a family member would be treated with respect, as this could also encourage the patient to open up during the consultation. The basic issues and communication during a consultation, therefore, form a significant component of perceptive patient care (Stanifer *et al.* 2015: 6). The AMPs also suggested that asking questions directly and being open to the patient would put the patient at ease and allow them to disclose freely. A recent review study by Samuels and Ben-Arye (2020) addressed the prevalence and expectations of oncology patients from TM, as well as evidence of the beneficial or harmful effects of this practice (potential and actual), especially when the TM is used in conjunction with anticancer agents. In this review, the researchers assert that the endeavours of AMPs (in this case oncologists), pharmacists and THPs could be more successful if a list of questions was employed when enquiring about the patient's use of TM. AMPs should always display a manner that is kind, understanding and supportive to the patient. They should reassure these patients that they can be trusted and explain the importance of disclosure.

6.5.2 Stigmatising TM use

Saputra, Rafsanjani and Usman (2021: 3270) describe stigma as a “sign” stamped by a community on somebody. The AMPs pointed out that they may need to explore how THPs work, which could reduce the stigma attached to TM

use by patients. Most AMPs are critical and therefore patients dread being punished for opting to use TM. A prior study in South Africa reports that another cause for the non-disclosure of TM use was the AMPs' poor attitude, perceived lack of assistance and perception that leads to distrust and stigmatisation by AMPs (Peltzer *et al.* 2010: 112; James *et al.* 2018: 9). Additional recent studies confirm the detrimental effects emanating from the bad experience of patients with AMPs (Logiel *et al.* 2021: 1416; Amirudin *et al.* 2021: 285). Logiel *et al.* (2021: 1416) indicate that patients who have had bad encounters where they have been abused by AMPs would not effectively need to return to the same facility for any benefit and would go for TM, which is ordinarily managed by a near family member or relative. Amirudin *et al.* (2021: 285) concur by adding that such encounters lead to the patients feeling pitiful, frightened and demoralised at the same time. AMPs should strive to ensure that these patients' experiences during consultations are non-judgemental.

The AMPs in this study suggested that the patients would rather stay uninformed than know about the extent of complications at the time that they present themselves to the hospital. The AMPs stated that the patients usually had a sense of self-blame for their condition and just wanted to be treated. The AMPs in the current study further indicated that patients will not disclose because they might feel that the AMPs will not appreciate the fact that they are using other forms of medicine. In this regard, the patient might feel that they are at fault for consulting THPs and therefore opt for non-disclosure. Another vital point that should be beyond any doubt is that AMPs display more negative attitudes toward TM (Metin, Karadas and Ozdemir 2019: 155). Puoane *et al.* (2012: 501) argue that the reality is that AMPs are concerned about the use of both TM and most AMPs in their study had patients infected with HIV/AIDS who felt that they did not need to disclose. These researchers share that consulting THPs was perceived as more private than the hospital setting where they would feel the need to disclose issues stigmatised in their community (Puoane *et al.* 2012: 501).

Some AMPs argued that the prejudiced approach which undermines TM use results in non-disclosure. This in turn impedes the proper healthcare management of the patient, resulting in unnecessary exploration through tests. Jansen *et al.* (2021: 10) share a slightly different outlook stating that, to a certain degree, the integration of TM with AM offers representative, affordable, open and successful symptomatic management. At worst, it reveals well-being gaps and condemns the destitute to ineffectual care.

The AMPs confirmed that they knew that patients could also fear annoying the AMPs since the use of TM is sometimes associated with witchcraft. The notion of witchcraft being associated with TM is reported by several researchers, who indicate how witchcraft suppression laws have prohibited TM practices and encouraged a more negative outlook in the progression of TM (de Lange 2017: 2; Chebii *et al.* 2020: 18; Sifuna 2022: 193). Witchcraft is a synonym for TM practice in most African countries and THPs are commonly referred to as witchdoctors since they were perceived to own forbidden charms; however, to date, knowledgeable individuals still use TM (Chebii *et al.* 2020: 4; Geiselhart 2018: 170).

6.5.3 Individual belief system

AMPs acknowledged that some patients who use both TM and AM relate the use of TM to their cultural beliefs' connection to their ethnicity. This is consistent with studies that have found that the use of TM is timeless and has formed a significant part of the healthcare system in Africa long before AM was established (Mahomoodally 2013: 9; Mothibe and Sibanda 2019: 1). The AMPs in the current study claimed that if TM use forms a firm part of the patient's belief system, AMPs cannot just order them to stop using TM, but they need to give clear guidance to the patient as to why they may oppose the use of TM at the time. This is particularly observed in the older generation as TM has cultural importance for them (Mokhesi and Modjadji 2022: np). This is further corroboration by Metin *et al.* (2019: 155) who assert that AMPs should consider the individual characteristics of patients, including the individual-level

evaluation for integrated patient healthcare. Some AMPs acknowledged that TM cannot just be eliminated overnight as its use has a long history in the African context. This is in line with Hasan *et al.* (2012: 100) who found that most of the AMPs in their study believed that beliefs and TM incorporated beliefs and practices that could benefit AM practice.

The AMPs in this study indicated that some patients have a certain level of confidence in relying on TM due to previous positive outcomes. This is in line with Gyasi *et al.* (2016: 10), who indicate that the choice of TM has a strong link with health beliefs other than the attitudes of AMPs. The current study also found that AMPs encountered patients who firmly believed there was no problem in using both TM and AM concurrently. Stanifer *et al.* (2015: 13) assert that the validity of TM is affected by variables intertwined with social convictions. Furthermore, they reveal that the AMPs in their study communicated the need for logical legitimacy, suitable dosing, instruction and direction among THPs, but many of those same AMPs still held solid social convictions in TM and used them personally (Stanifer *et al.* 2015: 12).

AMPs generally should avoid outright discouragement of TM use by the patient by not imposing their principles and beliefs on them while they try to appreciate the patient's opinion as individuals. This supports the argument that the effect of conviction frameworks and particular reasons for TM use among people has progressed in well-being care and spatio-medical writing (Gyasi *et al.* 2016: 1). Furthermore, this is corroborated by the findings of this study which indicate that some AMPs did not have any problem with patients they were assisting who used TM if it formed part of their belief system. The researcher found that AMPs considered that certain judgemental comments against cultural beliefs may make the patient feel judged and therefore advised that AMPs be compassionate while consulting with the patient to facilitate discussion about the patient's condition. Zingela, van Wyk and Pieterse (2019: 160) share similar findings in that the most noteworthy impact on choosing a health practitioner in their study was a social and devout conviction, following the influence of family or companions. Furthermore, it could be expected that AMPs that were

exposed to a culture of traditional beliefs when growing up would be open to TM practice (Lampiao, Chisaka and Clement 2019: 4). This is true in the context of the current study as some AMPs indicated that they also grew up using TM for certain ailments as part of family beliefs and customs.

6.6 THEME 3: FACILITATING DISCLOSURE OF TM USE TO AMPs

When patients disclose to AMPs, they will naturally want to be comfortable knowing that their information is safe and will be well-received (Petronio, Dicorcia and Duggan 2012: 42). This notion implies that there is some risk and benefit attributed to sharing information. Patients using TM do not disclose it because they feel that this may change how the AMPs treat them. Based on CPM theory, this would normally fall under the notion of control that leads to ownership but based on the data and what the AMPs stated, control in CPM theory reflects facilitation. The researcher's feeling is that an individual cannot own something that they are controlled by, but, in this case, the ownership is facilitated by the AMPs gently persuading the patient to get to a point where they can recognise that they are disclosing at their own will without being controlled. Ultimately the patient can own their behaviour because someone who is controlled may not be able to do so and therefore will not be able to take responsibility for it, nor will they feel accountable for any consequences. Therefore, patients could disclose in a conducive environment where they can discuss choices.

6.6.1 Creating a conducive environment for disclosure

The AMPs in this study felt that their responsibility as caregivers included ensuring that consultations with all patients were conducted in a welcoming environment where the patient would be able to disclose any secondary information that could assist in the treatment planning. Gall *et al.* (2019:1) conducted a study to explore AMPs' experiences and perspectives relating to the use, disclosure and non-disclosure of TM and complementary medicine by indigenous cancer patients. They shared a similar opinion that open communication may be accomplished by showing empathy and preparing a

safe environment for the patient, which could encourage the potential for disclosure (Gall *et al.* 2019: 7).

Allen *et al.* (2020) analysed special and inventive home-grown organisations in Canada, taking into consideration the advantages that such associations could hold for AMPs, local communities and general society in Canada. In their analysis, they provided suggestions for AMPs, managers and researchers for future practice in an indigenous-led collaboration related to context and necessary resources (Allen *et al.* 2020: E215). These suggestions included the provision of a safe environment within the health facility with input from the knowledgeable THPs to impart cultural knowledge to the AMPs. These results are consistent with the researchers' observations which reveal that for the patient consultation environment to be deemed safe for disclosure, the AMP must encourage open conversation with mutual understanding. This will then alleviate resistance to disclosing to the AMPs.

Furthermore, the AMPs indicated that they must be neutral and be able to create a safe environment to allow the patient to freely disclose because there are very few patients who will freely do so if they are uncomfortable in the environment. Redvers and Blondin (2020: 1, 14) conducted a study in North America, finding that there was a need to provide a better understanding of TM in the context of the existing healthcare delivery and future policies for AMPs, researchers and the general public. The researchers, through their literature review, noted the prevalence of non-disclosure to AMPs among individuals who use TM. They regarded this as an indication of the need to develop an inclusive healthcare system facilitated by AMPs who can communicate with various patient types. The AMPs in the current study argued that the patient must be assured that they can trust the AMP with confidence by not being made vulnerable during consultation. This can be achieved through research to create a well-coordinated and organised healthcare system that could encourage the development of policies to inform practice, especially in sub-Saharan Africa (James *et al.* 2018:13). From these results the researcher assumes that this

study has the potential to inform current practice employed by AMPs to facilitate voluntary disclosure by patients.

6.6.2 Encouraging patients to disclose TM use

With regard to the barriers that hinder open communication between the AMPs and the patients who use TM, the AMPs that were interviewed said the attitudes towards these patients were a major reason for the patients not being open to them. Additionally, the AMPs acknowledged that patients may think that some of them are not approachable compared to others and therefore suggested that they needed to make it easy to talk to all patients to freely engage with them during consultation. A study exploring perceptions and approaches toward integrating TM in Ghana by examining and interpreting proposals made by traditional healers, biomedical practitioners and healthcare consumers was conducted by Kwame (2021). The researcher reveals that merely incorporating TM into the mainstream healthcare system is seen by patients as an opportunity to freely disclose the use of TM when asked by AMPs (Kwame 2021: 1853).

The AMPs indicated that they wanted the patients to be motivated to disclose so that they had enough information about the duration of the condition, the various medications and other medical conditions that they might have. In addition, AMPs have the responsibility to protect patients and not judge them for their choices, as they have rights. Hajj *et al.* (2020: 6) argue that due to the prevalence of non-disclosure, talking about TM use in a non-prejudiced manner initiates trust with patients and incorporates safe and trustworthy TM treatments into patients' care.

The researcher noted that AMPs may need to be forthright in their quest for honesty. They must help the patient to understand the implications of TM in their given condition without compromising the appropriateness of the conversation. The AMPs in this study indicated that they wanted patients to trust them, as their main intent was not to harm, thus facilitating disclosure. To achieve this, the AMPs need to identify the boundaries that result in non-

disclosure as well as to strive to improve interaction with these patients (Mokhesi and Modjadji 2022: 8). Institutions should work on being less critical regarding TM use so that they can encourage these patients to disclose, thus allowing the AMPs to give the necessary advice regarding incompatibility between the prescribed AM and TM they might be consuming at the time (Mokhesi and Modjadji 2022: 8).

The AMPs suggested that making information available through posters could also encourage patients to disclose if they realise that there is awareness of TM use in the hospital space. The researcher noted that posters are still the recommended method when there is a need to disseminate information. Findings from a study in Ghana by Appiah *et al.* (2018: 290) support this finding of the study as media and posters were suggested as the appropriate platforms through which awareness regarding the integration of TM and AM practice could be disseminated.

AMPs stated that they should take the initiative to ask the patients about treatments other than AM that they might be receiving. Furthermore, some AMPs were of the view that engaging with patients would foster a cooperative relationship between themselves and patients. Furthermore, this would also help them find out more details regarding the circumstances of their patients' choices. Patients usually share positive experiences regarding consultations with THPs because they have well-defined characteristics that include empathy and patient autonomy; therefore, the constant mention of these components could encourage AMPs to adopt more patient-centred care (Foley and Steel 2017: 221). The researcher noted that AMPs must be cognisant of how they are characterised by these patients. The researcher believes that this could assist in encouraging the AMPs to work on their communication skills to provide proper support for these patients.

For AMPs to be able to share their sentiments about the use of TM, they must have good communication skills and treat patients with respect as they would treat other people they interact with in their daily life. The researcher noted that

most AMPs would be happy to attend to patients who are forthcoming when asked questions that are specific to the use of TM, but this would need time and patience during their consultations. Contrary to this finding, Amirudin *et al.* (2021: 285) presented slightly different findings which highlighted that chronic patients in their study confirmed that AMPs never enquired about the TM they used but continued to prescribe the AM and only raised the alarm when they noticed a change in blood results.

A recent study conducted by Foley *et al.* (2021: 11) was the first to examine the disclosure of both TM and AM use by patients with chronic conditions across a range of TM and AM contexts. The researchers found that communication between patients and the respective practitioners varied distinctly in consultation times. Their study indicated that the TM clinical setting facilitated longer engagement with patients in addition to empathic, individual-centred approaches that are characteristic of THPs, whereas the AM clinical setting was restricted by shorter engagements with patients, limited progressive care and less individual-centred care by AMPs (Foley *et al.* 2021: 12). The researcher noticed that most of the out-patient departments chosen for the study served many patients with fewer AMPs attending to them. This would imply that the amount of time spent with each patient would be extremely limited. The researcher noted that the issue of non-disclosure is pervasive and requires immediate attention. Most of the recent literature on the disclosure of TM use agrees that non-disclosure of TM use by patients who use both TM and AM does more harm than good for the overall patients' treatment outcome (Agarwal 2018: 2; Samuels and Ben-Arye 2020: 2).

6.6.3 Patient autonomy

A study conducted across Singapore by Lee *et al.* (2019:397, 402) sought to evaluate the prevalence of discussion of TM use in AM consultations and identify factors influencing communication between AMPs and patients regarding TM use. The study revealed that almost one-third of the AMPs tailored treatment to accommodate the use of both TM and AM but with careful

regard to AM treatment. This is partly in line with the current study as AMPs were of the view that they should be consistent in respecting patient autonomy during consultation. However, the AMPs indicated that this autonomy comes with responsibility for the patient. To make this decision, patients should have access to details of the TM they use, which is necessary to guarantee the quality of TM as this is a pertinent issue globally (Kamsu-Foguem and Foguem 2014: 128).

AMPs argued that when patients make their decision, they should consider that the TM they use could affect the AM being given even if the TM is working for them. Moreover, the AMPs cannot prevent the patient from using TM. Lee *et al.* (2019: 402) suggest that the awareness of both patients and AMPs around TM and interactions between TM and AM could be raised, and AMPs could be empowered to be more straightforward with their prescriptions and include patients in their healthcare.

During the interviews, one of the AMPs indicated that most of their peers were autocratic during the consultation which prevents the patient from making decisions on their own. In contrast, TM allows patients uncomplicated access to treatment, enabling them to collaborate in making their own health choice and resulting in greater patient autonomy (James *et al.* 2018: 11). In support of this prior finding, some AMPs in the current study suggested that each patient's case is unique and therefore should be treated as such. For instance, an agreement can be reached with the patient in terms of their condition concerning the AM treatment. AMPs must consider that patients are adults and are allowed fair choice and access to knowledge as this can facilitate intelligible decisions regarding their treatment. In his 2018 dissertation, Gonzales (2018: 133) notes how a participant in his study was firm about the need for AMPs to respect their choices because they did not appreciate being shouted at and judged. AMPs in this study advised that they had to be open to discuss any available options with the patient as they were also individuals with different opinions. The researcher believes that this practice could allow the AMPs to

acquire more information about the types of TM used by these patients to assist in establishing data regarding the practicality of concurrent use of TM and AM.

6.6.4 Training of AMPs

AMPs consider doing what is best for the patient since their training does not prepare them for scenarios with patients who use TM and AM concurrently. Some AMPs acknowledged the need for exposure to TM practices so that they could align them with their practice; for example, how alternatives such as acupuncture are recognised. Jou and Johnson (2016: 545) suggest that AMPs should actively enquire about the use of TM, but this can only be achieved through the inclusion of TM education in the AM curricula to develop the AMPs' ability to initiate the discussion of TM use during the consultation.

The AMPs indicated that their undergraduate training provided them with very little understanding of how THPs make decisions on patient treatment after throwing bones. Similar findings were revealed by Sobiecki (2014: 4), who states that the details of diagnostic methods employed by THPs are not acknowledged by AMPs since they focus on noticeable characteristics of TM. Sobiecki (2014) further clarifies that THPs in South Africa commonly employ an established approach of applying frequent monitoring when diagnosing patients to specify TM that would influence replicable effects on similar indications. Furthermore, AMPs in the current study suggested that prior knowledge of TM is vital to include in the training of AMPs. This corroborates the findings of de Roubaix (2016: 160), that THPs ought to be perceived as proficient individuals and suitable module components must be included in the undergraduate medical programme. Other previous studies further confirm these findings (Bhadra, Ravakhah and Ghosh 2015: 317; James *et al.* 2018: 11; Metin *et al.* 2019: 155), which suggests that TM should be integrated into the training programme of AMPs, there should be cross-practice between AMPs and THPs and recommendations for highly regarded TM in health facilities should be made. This is in line with the current researcher's observations, which indicate that the AMPs' training is not supportive of TM use. Therefore, their decisions

during consultations with patients who use TM and AM are guided mainly by the knowledge they receive during training.

Some AMPs added that health education regarding TM was appropriate for them since most of the time the patients first consulted with THPs before presenting to them. It is, however, interesting that a recent review paper compiled by Innocent (2016: 315) shows that several universities in sub-Saharan Africa offer formal TM education. The countries cited by the author include Ghana, Kenya, Sierra Leone, South Africa and Tanzania. Chitindingu, George and Gow (2014: 1) conclude that basic facts show that AM training in South Africa should assess the programme of the curricula to advance TM understanding by AMPs. The authors further allude to the fact that despite the prevalence of the use of TM and mandates by the government, there are still no visible efforts to integrate TM into AMP training. South African institutions are not mandated to provide TM training as they are guided by the content that is accredited by the Health Professionals Council of South Africa (HPCSA) (Chitindingu, George and Gow 2014: 3). In support of this finding, the researcher in the current study did not find any indication of AMPs' knowledge of postgraduate training in TM available in higher education institutions.

6.7 THEME 4: PROCEDURES TO ENCOURAGE DISCLOSURE OF TM USE TO AMPs BY PATIENTS WHO USE BOTH TM AND AM

Individuals have their unique way of disclosing private information during a conversation, considering how the disclosure will be managed which may bring about privacy breakdowns and conflict (Petronio and Child 2020:80). According to Petronio *et al.* (2012: 42), when the patient decides to disclose TM as an alternative medicine, they may need to consider the risks and benefits of doing so. Furthermore, if the disclosure is not received as per the expectation of the patient, the relationship between the AMP and the patient may lead to privacy problems. Privacy rules are commonly characterised by perceptions of the individual's culture, society and community, which create boundaries. The

AMPs may need to devise procedures regarding what the disclosure should entail, which will help in coordinating the boundaries.

6.7.1 Collaboration of THPs and AMPs

Both AMPs and THPs have the same objectives and inspirations in their practices, namely, to serve the patients and advance a healthy community (Lampiao *et al.* 2019: 4). Some AMPs recalled patients bringing in referral letters when coming to consult with them and there was also an intention to train the THPs as lay counsellors for HIV patients at some point. This finding is in line with the study by Nkosi and Sibiya (2021), who explored the practices of THPs and radiation oncologists in cancer treatment and ultimately derived a workable practice framework for these health practitioners in South Africa. Their study indicates that a relationship should be established between THPs and AMPs to facilitate patients' explored referrals (Nkosi and Sibiya 2021: 3). However, the same researchers in a prior study found that the referral system was one-directional since only THPs referred patients to AMPs because they wanted to validate their diagnosis before TM treatment (Nkosi and Sibiya 2018: 120). The researcher noted a similar trend in the current study as the AMPs indicated that THPs needed to recognise in good time when to refer patients to them to avoid the late presentation of patients with complications. This shows that the AMPs had no intention of doing the same with the THPs. The AMPs' responses during the interviews were indicative that the AMPs acknowledged the mandates made by the South African government for the two entities to work together. However, the researcher noted that none of the AMPs was able to indicate that they had referred patients to the THPs for any further treatment.

Contrary to the latter, the researcher in this study found that some AMPs recognised that the THPs are the patient's initial contact before they see them and therefore considered that involvement of THPs could start by initiating health education and training as there is an existing treatment choice for many patients. Jansen *et al.* (2021: 5) in a recent review found that when TM is embraced outside its conventional culture, it is regularly classified as a frame

of alternative medicine, by allopathic medicine organisations and healthcare frameworks. In contrast, an earlier review by James *et al.* (2018: 11) shows that TM is commonly used as a complementary treatment option more than it is used as an alternative to AM. de Roubaix (2016: 159) wrote an article entitled "The decolonization of medicine in South Africa: Threat or opportunity?". In his article, de Roubaix (2016: 161) contends that dialogue encouraging collaboration with THPs should be initiated to provide South Africans with the healthcare system they deserve. Furthermore, space would have to be made for THPs within the existing healthcare system. Additionally, findings in this study show that some AMPs suggested that being open to collaboration could also allow them to gain an understanding of TM in the same way they learned about AM.

All the AMPs in the current study fully recognised that some of the patients that seek consultation with them also consult THPs. According to Zingela, van Wyk and Pieterse (2019: 162), a small number of THPs encouraged their patients to stop taking their AM. This suggests a potential for collaboration between THPs and AMPs in motivating treatment adherence. Similarly, the AMPs in this study suggested that THPs needed to advise patients to disclose their use of TM when they come for a consultation with AMPs. In this way, both THPs and AMPs could learn from each other as they form part of the same healthcare system. This can assist in preparing an environment that could allow an inclusive healthcare system that would in turn encourage the facilitation of research and development of superior TM (Ozioma and Chinwe 2019: 209). According to Kasilo *et al.* (2019:9), other African countries are more advanced in terms of the incorporation of AM and TM into their context, and this might highlight the benefits that could guide health presentation worldwide. Therefore, for AMPs to understand how TM affects AM treatment management in the current context, they have to put more focus on the benefits of integrating the two entities. Incorporating TM and AM would increase the prospects of better consequences within a population (Krah *et al.* 2017: 16).

AMPs also highlighted that collaboration of the two entities can help familiarise THPs with conditions that they can manage and those that need AMPs. A study by Oseni and Shannon (2020:1) explored the relationship between AMPs and THPs in Africa and the implications of this for future collaboration. The main finding was that authority issues are the primary similarity between THPs and AMPs, thus resulting in external components such as distrust, disrespect, rivalry and lack of mutual understanding. Similarly, Lampiao *et al.* (2019: 2) in the findings of their study state that even though there are associations that support TM, very little effort is made to incorporate the practices. The researcher noted that in the current study, very few AMPs supported the idea of incorporating TM practice within the healthcare practice, even though most of them recognised the mandates put forward by the government.

6.7.2 Acknowledgement of TM practices

Traditional medicine has been used utilised since ancient times (Hilal and Hilal 2017: 326). According to the AMPs in this study, information about TM must be communicated to communities through primary healthcare as people need to be aware of the effects of TM. Similarly, Puoane *et al.* (2012: 501) suggest that THPs need to be enlightened about conditions that are within their capacity to allow a timely referral to AMPs as needed. The AMPs also stated that the Department of Health should call for the inclusion of the THPs in the healthcare system through training and regulation so that they can make patient referrals to AMPs. The researcher noted that although the AMPs considered the idea of referral by THPs, they would only do so once THPs had been trained and regulated. James *et al.* (2018: 10) suggest that it is vital for health departments and governments across sub-Saharan Africa to at least consider acknowledging the perspective of the basis of TM in comprehensive healthcare systems.

The AMPs were aware that THPs were the first point of contact for the patients that came to consult with them. They encouraged AMPs to be open to attending each other's conferences so they can gain an understanding of both aspects of

the patients' health caregivers. Similarly, an overview of the application of TM in Africa provided by a South African researcher (Mothibe and Sibanda 2019: 10) shows that integrating TM into the South African healthcare system could be beneficial to those patients who first seek help from THPs before coming to the hospital (Mothibe and Sibanda 2019: 10). During the interviews some AMPs acknowledged that there were known TM that needed to be checked for efficacy, and that AMPs need to acknowledge that TM could be beneficial in some conditions. The AMPs mentioned TM such as moringa and African wormwood (*lingana/mhlonyane*) which are commonly used by South Africans at present. Kasilo *et al.* (2019: 1, 6) highlight multiple ways in which policy, practice and universal health coverage could be invested. They stress that recognising TM as a form of treatment and providing THPs with certificates would alleviate the prevalence of false THPs. One AMP suggested that during their consultations with patients who use both TM and AM, all AMPs should employ a similar strategy, for instance asking the same questions so that all patients could become accustomed to the idea. These findings are supported by the results presented in a review of literature conducted by Foley *et al.* (2019: 12), namely that asking specific questions about the use of TM and other supplements could help improve disclosure rates. Ahmed *et al.* (2020: np) further corroborate this by suggesting the incorporation of questions on TM during patient consultation to encourage open dialogue.

AMPs suggested that the use of posters and media could be ways in which awareness could be created in communities. Some AMPs believed media should be used to warn patients about the dangers of using TM, whereas Appiah *et al.* (2018: 291) suggest that media could be used to promote collaboration between the two entities. The researcher of this current study observed that media could be used to facilitate knowledge about TM in the relevant communities. This could help transmit the necessary information to encourage discourse regarding TM. It is important to note that even though suppositions about TM advancements are restricted, the use of TM for the treatment of ailments is still extensive in Africa (Kasilo *et al.* 2019: 1).

6.8 FINDINGS CONCERNING THE AIM OF THE STUDY

This study aimed to understand the perceptions of AMPs regarding the disclosure of TM use to AMPs by patients who use both TM and AM and ultimately to develop guidelines for disclosure of TM use to AMPs. This aim was achieved by describing the responsibilities and practices of AMPs during the consultation with patients who use both TM and AM, the perceptions of AMPs towards disclosure of TM use by patients who use both TM and AM and the knowledge of AMPs in the management of patients using both TM and AM. Recommendations that could be used to guide disclosure of TM use to AMPs by patients using both TM and AM are made.

The findings concerning the research questions of the study are discussed next. The AMPs responded to the following questions:

1. What are the perceptions of AMPs towards disclosure of TM use by patients who use both TM and AM? Individual AMPs described how they perceived disclosure of TM use by patients who use both TM and AM. The findings reveal that most patients did not disclose their use of TM to the AMPs. The patients were believed to be afraid of the stigma attached to TM use by the THPs.
2. During the consultation, what are the practices of AMPs regarding disclosure of TM use by patients who use both TM and AM? Individual AMPs described their knowledge of TM. The study shows that there is a lack of knowledge among AMPs regarding TM use by their patients. The training of AMPs includes exposure to other complementary medicine options such as acupuncture and homoeopathy, but the exposure to TM has not yet been considered for inclusion in their training. They need to be open-minded when dealing with patients who use TM and AM. They also need to have an open line of communication with THPs whom some regard as peers in the healthcare of patients. They need a basic exposure to and knowledge of the variety of illnesses that THPs usually treat in the same patients. This knowledge can be used when treating patients, thus

reducing the incidence of interactions between TM and AM. They need to take detailed notes during all consultations to ensure a clear reference in cases of suspected TM intoxication.

3. How will AMPs encourage patients who use both TM and AM to disclose TM use? The findings show that the AMPs interviewed were prepared to create a safe environment which would be conducive for patients to freely disclose their use of TM. The AMPs need to be cognizant of their attitudes during the consultation with patients who use both TM and AM. The study shows that AMPs acknowledged the importance of patient autonomy when making treatment choices.
4. What procedures should be followed to encourage disclosure of TM use to AMPs by patients who use both TM and AM? The study found that AMPs need to ask direct questions when consulting with patients who use both TM and AM. The AMPs surveyed believed that information should be made available by using media platforms to inform patients about interactions between TM and AM. The study shows that some AMPs were aware that THPs were at some point writing referral letters for patients to bring with them when consulting with the AMPs. Patients will disclose freely if they know that both the THPs and AMPs communicate with each other, thus encouraging collaboration and better treatment outcomes. Also, the findings show that a standard tool such as a form that could be developed to guide all consultations could alleviate the high number of non-disclosures by patients who use both TM and AM.

6.9 SUMMARY OF THE CHAPTER

In this chapter, the discussion and triangulation of the study findings with the integration of Petronio's CPM theory as a theoretical framework guiding the study were presented. The findings were also discussed and interpreted concerning the responsibilities and practices of AMPs during a consultation with patients who use both TM and AM. The findings in terms of the aim of the study

were discussed. Notwithstanding various studies on AMPs not probing the patients enough, the findings in this study were that AMPs have several opinions regarding what they could do during the consultation with patients who use both TM and AM. Facilitating disclosure of TM use by patients who use both TM and AM is important, considering the risks of adverse reactions that patients are subjected to. The implication of investigating the cause without adequate information for the AMPs is a challenge in the healthcare system in South Africa.

The findings support and contribute to a new outlook for understanding disclosure to AMPs by patients who use both TM and AM. They assisted the researcher in developing guidelines to help facilitate disclosure to AMPs by patients who use both TM and AM. However, these findings cannot be generalised to other communities in South Africa or other methods of treatment in South Africa since the study was conducted in Gauteng. Disclosure to AMPs by patients who use both TM and AM could impact the patients' general treatment outcomes significantly as well as avoid unnecessary adverse interactions due to the mixing of TM and AM treatments. With proper application and adherence to the guidelines, the treatment of patients who use both TM and AM could be improved because South Africa has a vast variety of indigenous plants used in TM. AMPs in this regard could help alleviate the implications of using both TM and AM concurrently for the treatment of illnesses.

CHAPTER 7: DEVELOPMENT OF GUIDELINES

7.1 INTRODUCTION

The purpose of this study was to understand the perceptions of AMPs regarding the disclosure of TM use to AMPs by patients who use both TM and AM and ultimately to develop guidelines for disclosure of TM use to AMPs at selected hospitals in Gauteng. In the previous chapter, the findings of the current study were discussed as guided by Petronio's communication privacy management theory. The development of the guidelines to facilitate disclosure of TM use to AMPs by patients who use both TM and AM at the selected district hospitals in Gauteng is described in this chapter. The development of guidelines is based on the themes and subthemes that emerged from the findings.

7.2 PROCESS OF DEVELOPING GUIDELINES

Chapter 6 presented a discussion of the findings of this study. The findings concerning the theory applied in the study highlight the recommendations to be included in the development of guidelines. Furthermore, the focus of this study in all the information presented thus far arises from the objectives, which were to:

- Explore and describe the perceptions of AMPs regarding the disclosure of TM use by patients who use both TM and AM.
- Explore and describe the practices of AMPs regarding disclosure of TM use by patients who use both TM and AM during consultation.
- Explore and describe how AMPs encourage patients who use both TM and AM to disclose TM use.
- Explore and describe the procedures that should be followed to encourage disclosure of TM use to AMPs by patients who use both TM and AM.

This section focuses on the last objective of the study which is the development of guidelines for the disclosure of TM use to AMPs by patients who use both

TM and AM. The researcher adopted the steps as proposed by Lim *et al.* (2008: 27-29):

1. The research question was formulated, which was “What are the guidelines for disclosure of TM use to AMPs by patients who use both TM and AM in Gauteng?”
2. A systematic search was conducted of the literature to find available evidence. Documents were selected that were relevant to the topic through the exclusion and inclusion criteria stated below:

Inclusion criteria

- A clear patient disclosure process involves stakeholders, in this case, policymakers in the Gauteng Department of Health, AMPs and clinical managers in Gauteng district hospitals that provide a service to patients who use both TM and AM and THPs.
- Thoroughness in the guideline development shows clear links between research evidence about patient disclosure and the recommendations.
- The hospitals and specific knowledge of AMPs and patient communication are clear.

Exclusion criterion

- Literature that did not reflect the degree of reliance that an approximate of the effect is accurate.
3. Through the critical appraisal of study quality and grading of the sources, all recommendations could be analysed and captured, and they were linked to the literature.
 4. The evidence, which was based on the participants’ concerns shared during the one-on-one masked interviews, ideas expressed about their recommendations that will encourage the disclosure of TM use to AMPs by patients who use both TM and AM, and subsequent evidence gathered from the literature were summarised, and guidelines were developed that could be used during consultation with patients.

The ideas that were supported the most by the literature were considered and listed as guidelines. The recommendations from the interviews with AMPs were consolidated during data triangulation to develop the guidelines as per the study aim. The guidelines for disclosure will improve the effectiveness and efficiency of treatments given to patients and the ergonomics of AMPs, while at the same time saving the patients from dangerous interactions between TM and AM.

7.3 PURPOSE OF THE DEVELOPED GUIDELINES

The purpose of developing guidelines was to guide the AMPs concerning the possible ways to alleviate non-disclosure of TM use by patients who use both TM and AM at hospitals in Gauteng. The guidelines are intended for policymakers in the Gauteng Department of Health, AMPs and clinical managers in Gauteng district hospitals that provide a service to patients who use both TM and AM and THPs. These stakeholders are responsible for the organisation, implementation and evaluation of patient disclosure of TM use during consultation within Gauteng. The purpose of the guidelines is to aid AMPs to prompt their patients to disclose the necessary information for adequate treatment planning. The developed guidelines could be supportive for stakeholders to facilitate disclosure of TM use to avert possible complications and alleviate non-disclosure of TM use. The developed guidelines are not mandatory but are recommended as a guide to facilitate disclosure of TM use during the consultation, particularly by patients who use both TM and AM.

7.4 RATIONALE OF THE DEVELOPED GUIDELINES

This chapter focuses on the last objective of the study which is the description of guidelines that will facilitate the disclosure of TM use to AMPs by patients who use both TM and AM. Guidelines are developed to establish a routine for the best patient care and management, to ensure consistent patient treatment outcomes. According to Young *et al.* (2020: np), years of experience of various stakeholders in South Africa can be used to develop clinical practice guidelines. One of the starting points for efforts to enhance healthcare is guidelines (Woolf *et al.* 2012: 1). Guidelines in patient care and management require the

facilitation of disclosure of TM use by AMPs during the consultation with those patients who use both TM and AM. In this study, the facilitation of disclosure is the responsibility of the AMPs who were interviewed in this study.

The theoretical framework described in Chapter 3 used notions for understanding the non-disclosure of TM use during consultations with AMPs and was based on Petronio's CPM theory. The findings of the study reveal areas that are barriers to disclosure as well as areas that require collaborative intervention. The ultimate objective of guidelines for disclosure of TM use would be to ensure that those patients that use both TM and AM are provided with the best patient care without any complications and adverse reactions to AM treatment. Therefore, employing evidence in clinical practice is necessary for optimum patient care (Lim *et al.* 2008: 26).

7.5 SCOPE OF THE GUIDELINES

The guidelines are targeted at policymakers in the Gauteng Department of Health, AMPs and clinical managers in Gauteng district hospitals that provide a service to patients who use both TM and AM. These stakeholders are entrusted with the planning, implementation and facilitation of the disclosure process within Gauteng. In this study, an evidence-based technique was used to develop the guidelines. Cruse *et al.* (2002: np) used formal instruments to evaluate the quality of guidelines and found that evidence-based guidelines had considerably superior results compared to consensus-based guidelines. This is because evidence-based guidelines require discernment to ensure consistency with fundamental evidence, whereas consensus-based guidelines do not (Djulgovic and Guyatt 2019: np). According to Lim *et al.* (2008: 26), guidelines based solely on consensus or expert opinion are becoming less acceptable, except in clinical settings where evidence is limited.

7.6 RECOMMENDATIONS FOR DEVELOPING GUIDELINES FOR STAKEHOLDERS

Chapter 6 of this study highlighted the recommendations made by the participants. The developed guidelines should be implemented by the stakeholders who are involved in consultation with the patients who use TM to ensure that they are encouraged to disclose when consulting at district hospitals in Gauteng. The suggestions for guidelines are presented below:

7.6.1 Recommendations for developing guidelines for policymakers at the Gauteng Department of Health

The Gauteng Department of Health renders general healthcare services to the population in Gauteng and develops policies that guide how these services are rendered. The health minister forms part of the national Cabinet for the Department of Health, which is accountable for the conceptualisation and administration of the national health policy and public health administration nationally. The Minister of Health must ensure that the national health policy and standards are implemented provincially. The National Health Act 61 of 2003 constitutes a unique national health system considering national, provincial and local governments. Furthermore, the Cabinet of the Department of Health promulgated the Traditional Health Practitioners Act 22 of 2007 to regulate all practising THPs in South Africa (Republic of South Africa 2008: 2). The guidelines are therefore developed as a recommendation to policymakers at the Gauteng Department of Health.

7.6.2 Recommendations for developing guidelines for clinical managers in Gauteng district hospitals

According to the National Health Act 61 of 2003, district hospitals support primary healthcare and provide a 24-hour service to surrounding communities (Republic of South Africa 2003). Hospitals are responsible for implementing a mandate directed by the Member of the Executive Council of Gauteng Province Health. Hospitals in Gauteng do not have an existing protocol which guides the

follow-up of patients who use TM and AM concurrently. Clinical managers must encourage a culture of non-prejudice where the patient will not be blamed when presenting with complications. This is because there is no referral system for AMPs working in these hospitals and THPs to assist in the discussion on the complications associated with interactions between TM and AM. The hospital management should ensure that there is health education to inform both AMPs and THPs about the reasons the patients choose to consult both health professionals. This will ensure that pertinent information about TM is filtered to the community of Gauteng through the hospitals. The developed guidelines are suggested in line with the required compliance with the National Health Act.

7.6.3 Recommendations for developing guidelines for AMPs in Gauteng

The practice of AMPs in Gauteng is guided by the Health Professionals Council of South Africa (HPCSA). According to the Health Professions Act 56 of 1974, all practising health professionals must be registered with a professional board in line with ministerial policies. During the consultation with patients who use both TM and AM, AMPs are required to probe these patients to enable them to provide the best available treatment. During data collection, it was evident that the AMPs had challenges with meeting their objective to provide the best treatment with little or no information about the TM the patients might be using at the time of consultation. AMPs should recognise the need to create a two-way referral system that will allow the patients to use their treatment of choice and also to have discussions with THPs. Effective communication strategies should be employed to ensure that patients can disclose willingly to enable AMPs to identify any presence of adverse interactions. Therefore, the development of these guidelines is intended to assist AMPs in facilitating full disclosure by patients who use both TM and AM. The implementation of these guidelines will further assist in ensuring better treatment outcomes for these patients.

7.6.4 Recommendations for developing guidelines for patients who use TM in Gauteng

The purpose of disclosure of TM use would ensure that AMPs can perform all necessary examinations in good time to provide the patient with proper guidance. Non-disclosure has led to many patients being subjected to numerous tests and examinations before AMPs can decide on the appropriate treatment option. The findings of this study have indicated areas that need both attention and improvement to eliminate the cost associated with non-disclosure which delays the diagnosis of the patient. Timely disclosure regarding TM used by patients consulting AMPs in Gauteng is necessary to ensure that AMPs can treat these patients effectively. In this context, the developed guidelines will assist patients in being open to disclosing the TM they are taking, thus building a trusting relationship between the patient and AMP.

7.7 DEVELOPED GUIDELINES

The guidelines presented in Table 7.1 are intended to provide recommendations that would aid health policymakers and stakeholders to encourage disclosure to AMPs by patients who use both TM and AM. The guidelines also highlight collaborative strategies that would enable integrated treatment by both AMPs and THPs.

Table 7.1: Developed guidelines

Guideline	Targeted Stakeholders	Focus Area
Guideline A	Policymakers at the Gauteng Department of Health	1. Integrating THP knowledge for AMPs to effectively manage patients who use both TM and AM
Guideline B	Hospitals in Gauteng	1. Developing effective communication skills for AMPs to interact with patients that use both TM and AM 2. Developing effective interventions for stigmatisation through information and references from patients that use both TM and AM 3. Incorporating cultural responsiveness in the consultations of patients that use both TM and AM
Guideline C	AMPs in Gauteng	1. Developing proper support without prejudice for patients that use both TM and AM 2. Maintaining disclosure through follow-up procedures
Guideline D	Patients who use TM in Gauteng	1. Giving access to information and advice to inform choices between TM and AM 2. Advising on the patient's responsibility to comply with prescribed AM treatment

7.7.1 Guideline A: Guideline for policymakers at the Gauteng Department of Health

A1: Integrating THP knowledge for AMPs to effectively manage patients who use both TM and AM

Rendering an excellent healthcare service at Gauteng general healthcare institutions is paramount. Policy administrators should integrate THP knowledge for AMPs to manage patients who use both TM and AM into the Gauteng Department of Health policies.

Rationale for the implementation of the developed guidelines

The patients in Gauteng come from various cultural backgrounds. The policy administrators in Gauteng are obligated to provide services to patients, regardless of AMPs' perceptions of TM. The inclusion and implementation of the recommended guideline in the Gauteng Department of Health policies will guide the filtration of TM knowledge in the outpatient departments.

Recommendation for implementation of this guideline

The recommendations below should be taken into consideration by policymakers in Gauteng:

- Implement a policy which integrates knowledge from both THPs and AMPs.
- Consider a policy which considers the complexities of TM in the treatment of patients by AMPs serving in Gauteng health institutions.
- Incorporate TM awareness in the curriculum of AMP training to ensure that AMPs are trained about the complex cultures that prescribe the decisions made by patients who use TM and AM.
- Make it mandatory to implement a policy that is responsive to the culture of patients who use TM at Gauteng health institutions.
- Incorporate TM practice into mainstream health practice in Gauteng health institutions to promote the need for disclosure of concurrent use of TM and AM by patients.

7.7.2 Guideline B: Guidelines for hospitals in Gauteng

B1: Developing effective communication skills for AMPs to interact with patients that use both TM and AM

AMPs that are employed in outpatient departments at hospitals in Gauteng are supporting primary healthcare. According to the National Health Act of 2003, the district hospitals are mandated to provide a 24-hour service that includes out-patient care, in-patient care and emergency services. It is therefore

important for district hospitals to motivate the advancement of communication skills employed by AMPs during a consultation with patients who use both TM and AM in facilitating disclosure to assist them in achieving their treatment objectives. The developed guideline in this context is designed to enable the AMPs to facilitate the disclosure of TM use by patients during consultation.

Rationale for the implementation of the developed guidelines

The training of AMPs includes exposure to other alternative or complementary methods of treatment that may be considered by patients, such as acupuncture and homoeopathy. This prepares the AMPs to be able to integrate the patient's treatment options with other disciplines. However, AMPs are not taught about TM during their training. Therefore, communication skills could allow informative discussions between these patients and AMPs. The inclusion of a TM programme that will focus on AMPs' exposure to TM used by their patients is therefore necessary.

Recommendations for implementation of this guideline

The recommendations below should be taken into consideration during the design of training for AMPs:

- Design a programme to educate AMPs about the various uses of TM and to provide them with knowledge about TM.
- Involve the relevant stakeholders in the implementation of the training programme about TM to ensure that the programme is implemented correctly in all the district hospitals in Gauteng.
- Involve THPs in the process of educating the AMPs about TM to promote informed consultations with patients that use both TM and AM.
- Encourage patients to disclose any concerns regarding the unpredictability of the TM they use.
- Assess the influence of the inclusion of the programme in the communication of AMPs with patients who use both TM and AM after the programme is implemented.

B2: Developing effective interventions for stigmatisation through information and references from patients who use TM

A programme must be developed that will alleviate the stigmatisation of patients who use both TM and AM. Patients who use both TM and AM must be treated fairly without discrimination. The programme will facilitate the management of the stigmatisation of AMPs as a key component in encouraging adherence to AM treatment. Creative ways must be found to manage stigmatisation and adherence issues.

Rationale for the implementation of the developed guideline

A patient who uses both TM and AM may conceal this fact to secure their consultation with an AMP. Stigmatisation is a key motive for non-disclosure during a consultation with patients who use both TM and AM. The stigmatisation of patients who use both TM and AM may lead other AMPs to assume that TM is substandard based on assumptions made by the consulting AMP. TM treatment discussions must be integrated into all consultations with patients who use TM and AM to alleviate stigmatisation and ensure the disclosure of TM.

Recommendations for implementation of this guideline

Significantly, interventions to mitigate the stigmatisation of patients that use TM are considered for consultation with these patients.

- AMPS must develop skills to provide patients who use both TM and AM with information and knowledge about their concerns regarding the current use of both medicines.
- It is in the best interest of the patient for the AMPs to facilitate the psychosocial function of the patient by providing a therapeutic discussion during consultation.
- AMPs should avoid translating TM use to witchcraft based on social relations.

- AMPs should assess the effectiveness of integrating TM discussions in their consultation with patients who use both TM and AM and give feedback to the hospital management for improvement of protocols.
- Patients who use both TM and AM should be encouraged to give feedback to the hospital management regarding consultations with AMPs to aid in the improvement of the skills to mitigate stigmatisation.

B3: Incorporating cultural responsiveness in the consultations of patients that use both TM and AM

The researcher noticed that the attitudes of AMPs regarding the non-disclosure by patients who use both TM and AM were associated with culture and wide-ranging social factors. Non-disclosure has seemingly been the norm in most consultation scenarios because of the attitude of AMPs. This was confirmed by the participants during this study, who attested that their cultural stance influenced the non-disclosure of pertinent information about TM use to AMPs. Therefore, clinical managers at district hospitals are pivotal in ensuring that AMPs working in district hospitals are socially aware of the circumstances of their patients.

Rationale for the implementation of the developed guidelines

Cultural responsiveness is important in the context of consultations involving TM use by patients in district hospitals in Gauteng. Clinical managers must encourage the AMPs to be socially aware of TM use by patients, as this could help them gain an understanding of the reasons the patients use TM. The inability of AMPs to obtain full disclosure exacerbates the risk of interactions between TM and AM, thus compromising the treatment outcomes.

Recommendations for implementation of this guideline

Clinical managers should consider the following recommendations for the implementation of the developed guideline:

- Clinical managers should find out information about the cultural views of the communities that the AMPs are consulting with.
- Clinical managers should encourage the inclusion of THPs as part of their consultation structure for patients who use both TM and AM. This will allow patients to freely disclose if they see that TM is accepted as alternative medicine.
- Clinical managers should encourage discussions with AMPs regarding suspected and undisclosed TM use that hinders the proper management of patients who use both TM and AM.
- AMPs should initiate the discussion with patients who use TM regarding their choice to ascertain what determines their decision-making.
- AMPs must be empathetic to their patients' situations, as this will assist in ensuring that the patient is comfortable disclosing.

7.7.3 Guideline C: Guidelines for AMPs in Gauteng

C1: Developing proper support without prejudice for patients who use TM and AM

Providing proper support without prejudice is vital for patients who use both TM and AM. Prejudice towards these patients may lead to feelings of judgement and therefore hinder any chance of full disclosure by the patient. The developed guideline to allow AMPs to encourage disclosure is therefore important.

Rationale for the implementation of the developed guidelines

Creating a conducive environment with proper support will allow a continuum of patient care and reduce the prevalence of non-disclosure by patients who use both TM and AM. A safe and supportive environment will enable the AMPs to establish a good rapport with the patient. This will assist in instilling confidence in the patient and promote positive treatment outcomes.

Recommendations for implementation of this guideline

- Develop a programme to improve the knowledge and skills of AMPs to manage the disclosure process.
- Assist AMPs in creating a safe environment within the hospital where they consult with the patients. This will help create trust between the patients and the AMP.
- AMPs should acknowledge patients' opinions without judgement.
- Involve AMPs consulting with patients who use both TM and AM in protocol development regarding policies that will inform practice. This progression will allow AMPs to engage the hospital management regarding their concerns about TM.

C2: Maintaining disclosure through follow-up procedures

AMPs need to be entrusted to maintain the disclosure of information about TM. Patients are more likely to continue disclosing if the AMP was approachable during the initial encounter. Patients will interact with AMPs willingly if the platform for clarification and implications of using both TM and AM are explored through an amicable discussion. AMPs attested to this during data collection by stating that if the patient would like to explore other treatment options, they would be open to discussing the pros and cons of the concurrent use of TM and AM.

Rationale for the implementation of the developed guidelines

During the consultation with patients that use both TM and AM, the AMPs need to build an understanding over several consultations. This will also encourage the patient to be comfortable in sharing information about the TM they are using. AMPs need to be provided with the necessary resources and tools to ensure that the consultations are consistent for all encounters with patients who use both TM and AM so that their treatment objectives are attained. Furthermore, the consultations conducted by AMPs will be more welcoming to the patients.

Recommendations for implementation of this guideline

- AMPs should ask direct questions during the consultation to create a conducive environment in which patients who use both TM and AM can freely disclose without prejudice.
- The protocol should be developed to help the AMPs to manage and direct the consultation with patients who use both TM and AM.
- AMPs must evaluate the patient's adherence to AM treatment. This would help the AMPs to appreciate the effects of medication suggested to the patients who use both TM and AM.
- AMPs must appreciate and commend patients for adherence to prescribed AM treatment. This would help the patients to recognise the importance of full disclosure of TM use to the AMPs.

7.7.4 Guideline D: Guidelines for patients who use TM in Gauteng

D1: Giving access to information and advice to inform choices between TM and AM

Patients who use both TM and AM consult in the district hospitals in Gauteng for medical treatment and advice. The study findings confirm the threats and dilemmas the AMPs encounter when patients present quite late into their complications when consulting with AMPs. Hence the developed guideline to ensure that patients acknowledge the nature of their situation during a consultation with AMPs.

Rationale for the implementation of the developed guidelines

Dissemination of information to patients regarding interactions of concurrent TM and AM use will provide patients with the knowledge to consider when consulting with AMPs. This information will help the patients change their conduct regarding non-disclosure of TM to AMPs during consultations. This will aid patients to understand the implication of non-disclosure of concurrent use of TM and AM for their treatment. This will help prevent adverse reactions linked to the concurrent use of TM and AM by patients.

Recommendations for implementation of this guideline

- AMPs must explain the implications of the prescribed AM when taken with TM to assist the patient in making an informed choice regarding their healthcare.
- AMPs should be assisted in developing TM and AM informative posters that will help create awareness of TM use by patients who consult with the AMPs. This will help disseminate information about the significance of the disclosure of TM use.
- Media must be used as a platform by relevant stakeholders in the Gauteng Department of Health for the dissemination of pertinent information regarding TM and AM practice to allow impartial access to knowledge regarding available treatment options.
- The relevant stakeholders in the Gauteng Department of Health must initiate campaigns to promote discussions regarding the use of TM and AM. This will raise awareness about the subject matter and influence the patient's decision-making.
- AMPs must strive for longer engagements during consultations with patients who use both TM and AM to promote patient-centred care which will enable patients to be forthcoming about the details of their choice.

D2: Advising on patient's responsibility to comply with prescribed AM treatment

Encouraging patients to adhere to the prescribed AM treatment is crucial for the treatment management and care of patients who use both TM and AM. Considering patients' preferences for treatment enables them to be knowledgeable about their treatment as they adapt to it, and this can allow AMPs to understand how patients perceive non-adherence. This will improve their conduct to avoid complications (Tu *et al.* 2021: 9). The developed guideline will empower patients with informed decision-making.

Rationale for the implementation of the developed guidelines

Responsible use of prescribed AM will reduce the incidence of non-adherence complications related to concurrent use of TM and AM by patients. Acknowledgement of the impact of non-adherence to prescribed AM treatment will enable the patients to be informed when making choices about the use of TM. This will prevent unnecessary interactions between TM and AM and promote positive outcomes for patient treatment management and care objectives by AMPs.

Recommendations for implementation of this guideline

- AMPs must provide patients with information that is relevant to their condition and treatment. This will empower the patient to deliberate before using both TM and AM, thus ensuring compliance with the prescribed treatment.
- AMPs must avoid being autocratic during consultations with patients that use both TM and AM. This will enable the patients to take responsibility for their treatment without coercion by the AMP.
- Patients who use both TM and AM should be supported by the AMPs to ensure that they develop the confidence to ask questions or provide input regarding the prescribed treatment.
- Addressing issues of non-adherence should be handled with care and empathy to counteract the delay in treatment.
- Acknowledgement of proper adherence to the prescribed AM by patients who use both TM and AM should be considered by AMPs to improve the patient's reliance on AM.

7.8 SUMMARY OF DEVELOPED GUIDELINES

During the development of the above guidelines, the researcher identified several recommendations that can assist in alleviating the major drivers of non-disclosure, thus providing a comfortable environment for patients who use both TM and AM to disclose information about TM in Gauteng. The guidelines were

also supported by selected literature that was relevant to the topic of disclosure of TM use by patients who use both TM and AM. The researcher further integrated the developed guidelines into the themes, subthemes and categories presented in Chapter 5. Table 7.2 presents this integration.

Table 7.2: Summary of developed guidelines for the integration of themes, subthemes and categories

Themes	Subthemes	Categories	Guideline
Theme 1: AMPs' perceptions of non-disclosure of TM use by patients who use both TM and AM	Lack of scientific evidence for TM	Lack of knowledge and understanding Scoffing of traditional medicine	Guideline A1: Integrating THP knowledge for AMPs to effectively manage patients who use both TM and AM
	Unspecified dosage of TM	Questionable strength and dose of TM	Guideline B1: Developing effective communication skills for AMPs to interact with patients that use both TM and AM
	Non-adherence to the AMPs' treatment plan	Treatment outcomes are dependent on disclosure Patient management	Guideline B2: Developing effective interventions for stigmatisation through information and references from patients that use both TM and AM
	Complications because of interaction between AM and TM	Safety and risks of TM Clarity on interactions of TM and AM	Guideline B3: Incorporating cultural responsiveness in the consultations of patients that use both TM and AM
Theme 2: Practice of AMPs when consulting with patients who use both TM and AM without disclosing	AMPs' bedside manner	The attitude of AMPs Lack of AMP and patient communication skills Manner of approach	Guideline B1: Developing effective communication skills for AMPs to interact with patients that use both TM and AM
	Stigmatising TM use	Alleviating the stigma Negative AMP responses Witchcraft and TM use	Guideline B2: Developing effective interventions for stigmatisation through information and references from patients that use both TM and AM
	Individual belief system	Patients trust TM Prejudices against cultural belief	Guideline B3: Incorporating cultural responsiveness in the consultations of patients that use both TM and AM
Theme 3: Facilitating disclosure of TM use to AMPs	Creating a conducive environment for disclosure	A safe environment to disclose Free and comfortable disclosure	Guideline C1: Developing proper support without prejudice for patients that use both TM and AM
	Encouraging patients to disclose TM use	Asking non-prejudiced direct questions Provision of information to the patient AMP's communication skills	
	Patient autonomy	Facilitating patient autonomy Patients' right to choose treatments of their choice	Guideline D2: Advising on patient's responsibility to comply with prescribed AM treatment
	Training of allopathic medicine practitioners	Trained mainly on the use of AM	
Theme 4: Procedures to encourage disclosure of TM use to AMPs by patients who use both TM and AM	Collaboration of THPs and AMPs	Incorporate THPs into the healthcare system Benefits of collaboration Regulating THPs	Guideline D1: Giving access to information and advice to inform choices between TM and AM
	Acknowledgement of TM practices	Dissemination of information to communities Recognition of TM and THPs	

7.9 APPRAISAL OF THE DEVELOPED GUIDELINES

According to Paniccia *et al.* (2021: 2), Clinical Practice Guidelines (CPGs) could inform future practice and aid patient management, but this is not always possible due to the limitations of using the guidelines. They further indicate that the inclusion of experts in the subject matter is important in the development of evidence-based guidelines (Paniccia *et al.* 2021: 3). The primary aim of this study was to develop guidelines that will be recommended for implementation by stakeholders involved in the consultation with patients who use both TM and AM in district hospitals in Gauteng.

Paniccia *et al.* (2021: 15) suggest that CPGs need to be easy to understand to encourage ease of implementation and application by the target users considering their demographic factors. The authors used the AGREE II tool since it can be employed in several ways including the appraisal of guidelines that are recommended for use in clinical practice (Brouwers *et al.* 2010: E840). Table 7.3 presents a summary of the six unique domains and items for guideline quality.

Table 7.3: AGREE II unique domains and items for guideline quality
(Brouwers *et al.* 2010: E841)

Domain	Items
1. Scope and purpose	The specific question the study sought to answer was: what are the guidelines for disclosure of TM use to AMPs by patients who use both TM and AM in Gauteng? This study aimed to develop guidelines to facilitate disclosure to AMPs. The target population is policymakers, AMPs and clinical managers in district hospitals that provide a service to patients who use both TM and AM and THPs.
2. Stakeholder involvement	The opinions of and recommendations made by the participants were considered together with reviewed literature. The supervisors will review and validate the guidelines as experts in the field before dissemination and implementation. The guidelines will only be piloted once they are approved by relevant stakeholders.
3. Rigour of development	The developed guidelines were strengthened by triangulation of the study findings. Guidelines in this study were developed in a structured and thorough approach to allow the applicability of the recommendations in a similar context and population. Patients' need for autonomy and the AMPs' need to provide the necessary patient care and treatment objectives were taken into consideration to ensure that the developed guidelines were not coercive.
4. Clarity of presentation	To ensure clarity of the guidelines, the guidelines were presented in simple language outlining the rationale and recommendations for their implementation. The guidelines present various options that can encourage disclosure by patients who use both TM and AM.
5. Applicability	The guidelines clearly define the stakeholders involved in the treatment and care of patients who use both TM and AM such as policymakers, AMPs and clinical managers in district hospitals that provide a service to patients who use both TM and AM and THPs. All necessary resources for the implementation of the guidelines are clearly outlined in the recommendations.
6. Editorial independence	The contents and development of these guidelines were not influenced by any funding body. The researcher and supervisors declare no conflict of interest in the guideline development.

7.10 DISSEMINATION OF THE DEVELOPED GUIDELINES

The developed guidelines will most likely be disseminated through various platforms such as the publication of manuscripts in accredited journals of health and medicine, national and international conference presentations and seminars. Soft copies and printed copies of the thesis will be accessible at the DUT library and on the Gauteng Department of Health repository and the National Health Research Database. It is anticipated that the guidelines will be disseminated to general healthcare groups for evaluation, recommendation and implementation. The guidelines will also be disseminated to stakeholders such as the Gauteng Department of Health District hospitals and clinical managers for comment and implementation purposes.

7.11 SUMMARY OF THE CHAPTER

This chapter dealt with the development of guidelines which resulted from the findings of the interviews conducted with the AMPs. Guidelines to facilitate disclosure to AMPs by patients who use both TM and AM are important for the effective treatment and care of patients. Encouraging disclosure by patients who use both TM and AM will ensure that any adverse effects of the concurrent use of TM and AM are identified in good time to improve treatment outcomes. The patient as the key player in providing the relevant information to guide the treatment plan has the responsibility to disclose to the AMPs to enable the provision of the best treatment care for their condition. Collaboration of AMPs and THPs should be adopted to enable more open communication about interactions between TM and AM. The developed guidelines were recommended for implementation by policymakers in the Gauteng Department of Health, AMPs and clinical managers in district hospitals that provide a service to patients who use both TM and AM.

CHAPTER 8: SUMMARY, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS OF THE STUDY

8.1 INTRODUCTION

In this chapter, the findings of this study are concluded and consideration is given to whether the aim was attained. The study aimed to develop guidelines to facilitate the disclosure of TM use to AMPs by patients who use both TM and AM. The summary of findings, limitations encountered during the study, the conclusion of the study and recommendations will be outlined in this chapter. The current study has contributed towards reporting and delineating the opinions of AMPs regarding the pertinent issue of non-disclosure of TM use to AMPs by patients who use both TM and AM in Gauteng South Africa.

8.2 SUMMARY OF THE STUDY FINDINGS

The aim and objectives of the current study are restated in this section. Here, the study's trustworthiness and relevance are established while taking the study's significance into account.

8.2.1 Realisation of study aims and objectives

This study was aimed at understanding and describing the perceptions of AMPs towards disclosure of TM use to AMPs by patients who use both TM and AM and ultimately to develop guidelines for disclosure of TM use to AMPs at selected hospitals in Gauteng. The research questions were answered by interviewing AMPs working in district hospitals in Gauteng. The participants responded to the following questions:

- What are the perceptions of AMPs regarding the disclosure of TM use by patients who use both TM and AM?
- During a consultation, what are the practices of AMPs regarding disclosure of TM use by patients who use both TM and AM?

- How will AMPs encourage patients who use both TM and AM to disclose TM use?
- What procedures should be followed to encourage disclosure of TM use to AMPs by patients who use both TM and AM?

The data obtained from the observations and the interviews with the participants were analysed through qualitative content analysis and ATLAS.ti 9 which assisted the researcher in managing the data. The triangulation of data in the form of themes was extracted from the ATLAS.ti 9 report and integrated with Petronio's CPM theory, which was the theoretical framework which guided the study. This data was then used to develop the guidelines to facilitate the disclosure of TM use to AMPs by patients who use both TM and AM at the district hospitals in Gauteng as delineated in the previous chapter.

8.2.2 Maximisation of trustworthiness in the study

The researcher employed exploratory descriptive qualitative research in this study to enable the exploration of the participants' experiences of disclosure of TM use to AMPs by patients who use both TM and AM to describe the phenomenon of the study. This enabled the study to generate information-rich data concerning a distinct phenomenon. Correspondingly, this meant the study could not be generalised due to its susceptibility to subjectivity and researcher bias. Trustworthiness was employed to manage the methodology application and interpretation of the findings of the study. Chapter 4 provides a summary that is more in-depth regarding the trustworthiness applied in this study.

8.2.3 Significance of the guidelines

The current study found that guidelines are important to facilitate the disclosure of TM use to AMPs by patients who use both TM and AM. In this study, the perceptions of AMPs regarding non-disclosure of TM use to AMPs by patients who use both TM and AM emanate from the lack of knowledge of TM by AMPs. This suggests that equipping the AMPs with relevant information regarding TM could influence open communication between the AMPs and the patients who

use both TM and AM. Arguably the most prominent element of this study is the practice of AMPs during the consultation with patients who use both TM and AM. This has been identified to be the outcome of AMP training which does not include TM knowledge as part of the alternative medicine curriculum for AMPs.

The issue of non-disclosure of TM use by patients who use both TM and AM remains contentious in Gauteng. Given the number of patients that present with suspected interactions possibly from the concurrent use of both TM and AM, facilitation of disclosure of TM use to AMPs by patients who use both TM and AM could alleviate the burden of examinations required to confirm toxicity. The WHO supports the implementation of various TM policies. It is therefore important to advance from discussions to execution.

AMPs are facing major challenges resulting from their lack of knowledge of TM used by their patients. The patients consult THPs and THPs refer patients to AMPs, but AMPs do not refer their patients to THPs. Future actions should be to facilitate a two-way referral system between the AMPs and the THPs. It may be possible to implement interventions and foster dialogue by starting the process with a conversation between AMPs and THPs about the best course of therapy, the appropriate dosage and the potential side effects of TM and AM. AMPs should openly discuss their reluctance to refer patients to THPs. This could be achieved through encouragement by the government so that AMPs can start referring patients to THPs for cases that are known to be treatable by TM.

8.3 CONCLUSION OF THE STUDY

The study was conducted using an exploratory, descriptive, qualitative research design. Masked one-on-one interviews were conducted to collect data from AMPs working at selected district hospitals in Gauteng. The study was guided by CPM theory, due to its relevance to the nature of the study. Recommendations were identified and guidelines to facilitate disclosure of TM use to AMPs by patients who use both TM and AM were developed. Numerous

components that could facilitate disclosure of TM use to AMPs by patients who use both TM and AM in the district hospitals in Gauteng were identified from the opinions of the AMPs who participated in the study. These components, incorporated with the evidence from the literature, were used to develop guidelines to facilitate the disclosure of TM use by patients who use both TM and AM in district hospitals in Gauteng. The guidelines are purposefully developed for use by AMPs who consult with patients that use both TM and AM, district hospitals, policymakers in the Gauteng Health Department and patients who use both TM and AM.

8.4 LIMITATIONS OF THE STUDY

The following limitations were identified in this study:

- The COVID-19 pandemic limited the study in terms of prolonged engagement with the participants. Furthermore, it was cited as one of the reasons for a research site denying access for the research to be conducted.
- A qualitative descriptive and explorative design was used to expound on the meaning of the phenomenon from a limited sample size; the findings may have been different if a quantitative element had been incorporated into the study. This enabled the researcher to achieve objectivity and thus statistically significant findings.
- The study was based on AMPs only; thus, the study findings may have been different if THPs and patients had participated in this study.
- The participants purposely selected for the study were AMPs. The study could yield different findings if THPs, policymakers at the Gauteng Department of Health, patients, hospital managers and clinical managers were included in the sample.
- The credibility of the study findings may have been affected by participants who opted not to take part in the research as their participation may have provided diverse responses.
- The study was conducted in the Gauteng province; the study findings may have been different if the study settings were broadened to other

provinces in South Africa. This was not necessary for the current study due to its context in nature.

- AMPs who participated in this study were employed at Gauteng district hospitals. The inclusion of AMPs working at the Gauteng district hospitals may have influenced the findings of the study.
- Several stakeholders, whose information could have enriched the findings of the study, such as clinical managers, interns and patients who use both TM and AM, were not included.

8.5 RECOMMENDATIONS OF THE STUDY

The background for the recommendations presented in this study is justified by the findings from the analysed data through which the development of guidelines arose to facilitate disclosure of TM use to AMPs by patients who use both TM and AM at Gauteng district hospitals. Below are the recommendations of the study.

8.5.1 Recommendations for use of the developed guidelines within Gauteng

The developed guidelines are recommended for all relevant stakeholders involved in patient care and management in Gauteng for the following resolutions:

- To be considered by the policymakers in Gauteng, during their policy review period, for possible integration into the training policies of AMPs in this province.
- To be disseminated by the Gauteng Department of Health to their respective professional bodies, for incorporation of the developed guidelines in the AMPs' training policies.
- The policy, with integrated developed guidelines, is to be mandated as a patient consultation disclosure policy document in the district hospitals within Gauteng.

- To be implemented by hospital managers in collaboration with clinical managers when appointing AMPs in the district hospitals to facilitate the feasibility of the disclosure guidelines.
- To be taken into consideration by clinical managers when allocating and distributing AMPs in the district hospitals' outpatient departments to ensure non-prejudice during the consultation with patients who use both TM and AM.
- The Gauteng Department of Health to implement the developed guidelines in the current training of AMPs.
- To be incorporated into the curriculum design of AMPs' training programmes by the HPCSA in preparation for AMP qualifications that include TM knowledge.
- To be implemented by AMPs at the Gauteng district hospitals that cater for communities that recognise TM as an alternative treatment.
- To be assessed and suggested for review to guarantee their efficacy in the district hospitals of Gauteng.
- To be made available to AMPs as a referral document during their consultations with patients who use both TM and AM at Gauteng district hospitals.

8.5.2 Recommendations for future research

The current research showed various gaps in knowledge regarding the TM training of AMPs who consult with patients that use both TM and AM in the district hospitals in Gauteng. The following areas are recommended for future research:

- There is still a considerable amount of research that is required in this sphere to enhance the disclosure procedures employed by AMPs during the consultation with patients who use both TM and AM.
- The study was conducted in Gauteng province district hospitals which provide out-patient treatment to patients who use both TM and AM. It is recommended that the study be extended to other provinces.

- The focus of the study was AMPs who work at the district hospitals where patients who use both TM and AM consult for AMP treatment. It is recommended that a duplicate of the current study be conducted at larger hospitals such as tertiary hospitals which is where the district hospitals refer patients.
- The study identified tradition and culture as one of the factors that influenced AMPs' acceptance of TM use by patients who use both TM and AM. This warrants further study involving THPs to explore their opinion regarding the referral system of a patient who uses both TM and AM.
- The current study revealed the need to investigate *why* and *what* affects the timing of TM disclosure and to create a conducive environment for patients using TM to disclose.
- A broader study, including several other stakeholders that are involved in the training of AMPs such as the HPCSA, Gauteng Department of Health and South African universities is also recommended.
- The findings of the current study also require the Gauteng Department of Health policies regarding appointments to be reviewed to ensure that the social components of the community being served are considered.
- Future incorporation of TM knowledge as part of the curriculum for the training of AMPs would enable a better understanding of the TM used by patients who use both TM and AM while consulting with the AMPs.

8.6 CONTRIBUTION OF THE RESEARCH STUDY TO THE BODY OF KNOWLEDGE

This study is in line with current clinical practice applied by AMPs in the district hospitals in Gauteng. The literature evidence and research methods used in the study show that AMP training specifically related to TM used by patients, in general, is a challenge. The study findings also confirm that the attitudes of AMPs in Gauteng district hospitals need to be evaluated to avoid non-disclosure by patients consulting with the AMPs while using both TM and AM. Policymakers in the Gauteng Department of Health, Gauteng district hospitals

and clinical managers in their assigned hospitals in the province of Gauteng could promote change by putting the guidelines into practice. The researcher maintains that this is the first study that has researched and developed guidelines for the disclosure of TM use to AMPs. The study contributes both current general information about the phenomenon and the creation of TM knowledge training for AMPs.

8.7 SUMMARY OF THE CHAPTER

Chapter 8 shows that the aim of the current study has been achieved, which was to develop guidelines to facilitate disclosure of TM use to AMPs by patients who use both TM and AM. These guidelines are straightforward and practical, guiding patients who use both TM and AM to disclose information in a way that promotes open discussion about TM use while consulting with AMPs. AMPs should employ these guidelines as a way of encouraging disclosure of TM use to promote better treatment outcomes for patients who use both TM and AM. The researcher believes that if these guidelines are implemented, they could influence the current referral system from the one-way system (THP to AMP) to a two-way referral system which will enable AMPs to also refer patients to THPs. Notwithstanding the various limitations of this study encountered during the research process of data collection and findings, the researcher was able to achieve the aim of the study. Finally, the reference to Petronio's CPM theory helped the researcher comprehend disclosure to understand patients' decisions on non-disclosure.

REFERENCES

- Abbott, R. 2014. Documenting traditional knowledge. *World Intellectual Property Organization*, 1-48.
- Abdullahi, A.A. 2011. Trends and challenges of traditional medicine in Africa. *African Journal of Traditional and Complementary and Alternative Medicine*, 8(S): 115-123.
- Abrams, A.L., Falkenberg, T., Rautenbach, C., Moshabela, M., Shezi, B., van Ellewee, S. and Street, R. 2020. Legislative landscape for traditional health practitioners in Southern African development community countries: A scoping review. *British Medical Journal Open*, 10: 1-11.
- Adams, J., Sibbritt, D. and Young, A.F. 2007. Consultations with a naturopath or herbalist: The prevalence of use and profile of users amongst mid-aged women in Australia. *Public Health*, 121(12): 954-957.
- Agarwal, V. 2018. Complementary and alternative medicine provider knowledge discourse on holistic health. *Frontiers in Communication*, 3(15): 1-12.
- Agarwal, V. 2020. The semi-structured interviewing method in a qualitative study examining complementary and alternative medicine providers' knowledge discourse. *SAGE Research Methods Cases: Medicine and Health*. SAGE Publications, Ltd.
- Agyei-Baffour, P., Kudolo, A., Quansah, D.Y. and Boateng, D. 2017. Integrating herbal medicine into mainstream healthcare in Ghana: Clients' acceptability, perceptions and disclosure of use. *BioMed Central Complementary and Alternative Medicine*, 17(513):1-9.

Ahlberg, M.N. 2017. Integrated health care systems and indigenous medicine: Reflections from the sub-Saharan African region. *Frontiers in Sociology*, 2(3): 1-10.

Ahmed, M., Im, H.B, Hwang, J.H. and Han, D. 2020. Disclosure of herbal medicine use to health care providers among pregnant women in Nepal: A cross-sectional study. *BioMed Central Complementary Medicine and Therapies*, 20 (339): 1 - 9.

Ahwinahwi, U.S. and Chukwudi, K. 2016. Perception and use of complementary and alternative medicine (CAM) among undergraduate students in a Nigerian University. *Journal of Applied Pharmaceutical Science*, 6(06): 96-101.

Allen, L., Hatala, A., Ijaz, S., Hon, E.D.C. and Bushie E.B. 2020. Indigenous-led health care partnerships in Canada. *Canadian Medical Journal Association*, 192(9): E208-E216.

Altman, I. 1975. *The environment and social behavior: Privacy, personal space, territory, and crowding*. Monterey: Brooks/Cole.

Amaroyi, A. 2016. Treatment of diarrhoea using traditional medicines: Contemporary research in South Africa and Zimbabwe. *African Journal of Complementary Medicine*, 13(6): 5-10.

Amirudin, N., Panting, A.J., Kassim, R., Ithnain, N. and Krishnan, M. 2021. Disclosure of herbal medicine usage in diabetes management: A qualitative study amongst Type 2 diabetes mellitus patients and health care providers in Negeri Sembilan, Malaysia. *Malaysian Journal of Social Sciences and Humanities*, 6(1): 279-288.

Anfara, V.A. and Mertz, N.T. 2015. *Theoretical frameworks in qualitative research*. 2nd edition. Los Angeles, CA: Sage.

Appiah, B., Amponsah, I.K., Poudyal, A. and Mensal, M.L.K. 2018. Identifying strengths and weaknesses of the integration of biomedical and herbal medicine units in Ghana using the WHO Health Systems Framework: A qualitative study. *BioMed Central Complementary and Alternative Medicine*, 18: 286-293.

Aspers, P. and Corte, U. 2019. What is qualitative in qualitative research. *Qualitative Sociology*, 42: 139-160.

Atlas.ti. 2021. *Qualitative data analysis*. Version 9.0. Berlin, Germany.

Barach, P. and Cantor, M.D. 2007. Adverse event disclosure: benefits and drawbacks for patients and clinicians. In Clarke, S. and Oakley, J (eds.) *Informed Consent and Clinician Accountability: The Ethics of Report Cards on Surgeon Performance*. Cambridge: Cambridge University Press.

Bauer, I. and Guerra J.J. 2014. Physicians' knowledge and communication about traditional, complementary and alternative medicine use among Latino patients at Kaiser Permanente, Oakland CA. *Field Actions Science Reports*, 10: 1-8.

Bello, N., Winit-Watjana, W. and Macgarry, K. 2012. Disclosure and adverse effects of complementary and alternative medicine used by hospitalized patients in the Northeast of England. *Pharmacy Practice*, 10(3): 125-135.

Bengtsson, M. 2016. How to plan and perform a qualitative study using content analysis. *Nursing Plus Open*, 2: 8-14.

Berube, K. 2015. Why traditional healing has a place in modern health care. *The Globe and Mail Canada*. 25 April. (Online). Available: <https://www.theglobeandmail.com/life/health-and-fitness/health/why-traditional-healing-has-a-place-in-modern-health-care/article24126195/> (Accessed 5 May 2021).

Bhadra, R., Ravakhah, K. and Ghosh, R.K. 2015. Herb-drug interaction: The importance of communicating with primary care physicians. *Australasian Medical Journal*, 8(10): 315-319.

Bradbury-Jones, C., Taylor, J. and Herber, O. 2014. How theory is used and articulated in qualitative research: Development of a new typology. *Social Science and Medicine Journal*, 120: 135-141.

Brinkmann, S., Jacobsen, M.H. and Kristiansen, S. 2014. Historical overview of qualitative research in social sciences. In Leavy, P. (ed.). *The Oxford handbook of qualitative research*. Oxford: Oxford University Press.

Brouwers, M.C., Kho, M.E., Browman, G.P., Burgers, J.S., Cluzeau, F., Feder, G., Fervers, B., Graham, I.D., Grimshaw, G., Hanna, S.E., Littlejohns, P., Makarski, J. and Zitzelsberger, L. 2010. AGREE II: Advancing guideline development, reporting and evaluation in health care. *Canadian Medical Association Journal*, 182(18): E839-E842.

Bylund, C.L., Peterson, E.B. and Cameron, K.A. 2012. A practitioner's guide to interpersonal communication theory: An overview and exploration of selected theories. *Patient Education and Counselling*, 87: 261-267.

Cambridge Dictionary. 2022. s.v. "facilitation". (Online). Available: <https://dictionary.cambridge.org/dictionary/english/facilitation> (Accessed 18 October 2022).

Chang, H., Chang, H. and Siren, B. 2013. Exploring the decision to disclose the use of natural products among outpatients: A mixed-method study. *BioMed Central Complementary and Alternative Medicine*, 13 (319):1-10.

Chebii, W.K., Muthee, J.K. and Kiemo, K. 2020. The governance of traditional medicine and herbal remedies in the selected local markets of Western Kenya. *Journal of Ethnobiology and Ethnomedicine*, 16(39): 1-24.

Chen, X.W., Sneed, K.B., Pan, S.Y., Cao, C., Kanwar, J.R., Chew, H. and Zhou, S.F. 2012. Herb-drug interactions and mechanistic and clinical considerations. *Current Drug Metabolism*, 13(5): 640-651.

Chitindingu, E., George, G. and Gow, J. 2014. A review of the integration of traditional, complementary and alternative medicine into the curriculum of South African medical schools. *BioMed Central Medical Education*, 14(40): 1-5.

Chung, V.C.H., Wong, C.H.L., Zhong, C.C.W., Tjioe, Y.Y., Leung, T.H. and Griffiths, S.M. 2021. Traditional and complementary medicine for promoting healthy ageing in WHO Western Pacific Region: Policy implications from utilization patterns and current evidence. *Integrative Medicine Research*, 10(1): 1-9.

Collins, C.S. and Stockton, C.M. 2018. The central role of theory in qualitative research. *International Journal of Qualitative Methods*, 17: 1-10.

Corbin, J. and Strauss, A. 2015. *Basics of qualitative research: Techniques and procedures for developing grounded theory*. 4th edition. Thousand Oaks: Sage.

Creswell, J.W. 2013. *Qualitative inquiry and research design: Choosing among the five approaches*. Thousand Oaks: Sage.

Creswell, J.W. and Poth, C.N. 2018. *Qualitative inquiry and research design choosing among five approaches*. 4th edition. Thousand Oaks: Sage.

Cruse, H., Winiarek, M., Marshburn, J., Clark, O. and Djulbegovic, B. 2002. Quality and methods of developing practice guidelines. *BioMed Central Health Services Research*, 2(1): 1-7.

de Lange, R.W. 2017. Allopathic and traditional health practitioners: A reply to Nemutandani, Hendricks and Mulaudzi. *African Journal of Primary Health Care and Family Medicine*, 9(1): 1-4.

Dennes, C. 2013. What are consultation models for? *InnovAiT*, 6(9): 592-599.

Denzin, N.K. and Lincoln, Y.S. 2018. *The Sage handbook of qualitative research*. 5th edition. Los Angeles: Sage.

de Roubaix, M. 2016. The decolonialisation of medicine in South Africa: Threat or opportunity? *South African Medical Journal*, 106(2): 159-161.

Diaz, T., George, A.S., Rao, S.R., Bangura, P.S., Baimba, J.B., Macmahon, S.A. and Kabano, A. 2013. Healthcare seeking for diarrhoea, malaria and pneumonia among children in four poor rural districts in Sierra Leone in the context of free health care: Results of a cross-sectional survey. *BioMed Central Public Health*, 13(157): 1-12.

Djulgovic, B. and Guyatt, G. 2019. Evidence vs consensus in clinical practice guidelines. *Journal of the American Medical Association*, 322(8): 725-726.

Dogson, J.E. 2019. Reflexivity in qualitative research. *Journal of Human Lactation*. 35(2): 220-222.

Dworkin, S.L. 2012. Sample size policy for qualitative studies using in-depth interviews. *Arch Sex Behaviour*, 41: 1319-1320.

Ekor, M. 2014. The growing use of herbal medicines: Issues relating to adverse reactions and challenges in monitoring safety. *Frontiers in Pharmacology*, 4(177): 1-10.

Fischer, M. and Ereaut, G. 2012. When doctors and patients talk making sense of the consultation. *The Health Foundation: London*.

Fleming, J. and Zegwaard, K.E. 2018. Methodologies, methods and ethical considerations for conducting research in work-integrated learning. *International Journal of Work-Integrated Learning*, 19(3): 205-213.

Fokunang, C.N., Ndikum, V., Tabi, O.Y., Jiofack, R.B., Ngameni, B., Guedje, N.M., Tembe-Fokunang, E.A., Tomkins, P., Barkwan, S., Kechia, F., Asongalem, E., Ngoupayou, J., Torimiro, N.J., Gonsu, K.H., Sielinou, V., Ngadjui, B.T., Angwafor, III F., Nkongmeneck, A., Abena, O.M., Ngogang, J., Asonganyi, T., Colizzi, V., Lohoue, J. and Kamsu-Kom. 2011. Traditional medicine: Past, present and future research and development prospects and integration in the national health system of Cameroon. *African Journal of Traditional and Complementary Alternative Medicine*, 8(3): 284-295.

Foley, H. and Steel, A. 2017. Patient perceptions of clinical care in complementary medicine: A systematic review of the consultation experience. *Patient Education and Counselling*, 100: 212-223.

Foley, H., Steel, A., Cramer, H., Wardle, J. and Adams, J. 2019. Disclosure of complementary medicine use to medical providers: A systematic review and meta-analysis. *Scientific Reports*, 9(1573): 1-17.

Foley, H., Steel, A., McIntyre, E., Harnett, J., Sibbritt, D. and Adams, J. 2021. Disclosure of conventional and complementary medicine use to medical doctors and complementary medicine practitioners: A survey of rates and reasons amongst those with chronic conditions. *PLoS ONE*, 16(11): 1-16.

Fong, H.H.S. 2002. Integration of herbal medicine into modern medical practices: Issues and prospects. *Herbal Medicine in Modern Medical Practices*, 1(3): 287-293.

Fowler, J.D. 2009. Cultural and structural barriers that affect the doctor-patient relationship: A Bolivian perspective. Honors Baccalaureate of Science in Biology (Honors Associate) and Honors Baccalaureate of Arts in International

Studies in Biology (Honors Associate). Oregon State University. Available: <https://ir.library.oregonstate.edu/downloads/tx31qp52n> (Accessed 26 February 2021).

Frenkel, M. and Cohen, L. 2014. Effective communication about the use of complementary and integrative medicine in cancer care. *The Journal of Alternative Complementary Medicine*, 20(1): 12-18.

Gall, A., Anderson, K., Adams, J., Matthews, V. and Garvey, G. 2019. An exploration of healthcare providers' experiences and perspectives of traditional and complementary medicine usage and disclosure by indigenous cancer patients. *BioMed Central Complementary and Alternative Medicine*, 19(259): 1-9.

Galvan, J.L. and Galvan, M.C. 2017. *Writing literature reviews: A guide for students of the social and behavioral sciences*. 3rd edition. Glendale, CA: Pyrczak.

Geiselhart, K. 2018. WHO guidelines challenged in Botswana: Traditional medicine between healing, politics and witchcraft. *Journal of Political Ecology*, 25(1): 169-185.

Gonzales, S.A. 2018. Communication barriers between patients and healthcare providers regarding disclosure of herbal product use. Doctoral Program in Interdisciplinary Health Sciences. University of Texas at El Paso. Available: https://scholarworks.utep.edu/open_etd/1440/ (Accessed 24 May 2022).

Gray, J.R., Grove, S.K. and Sutherland, S. 2017. *Burns and Grove's the practice of nursing research: Appraisal, synthesis, and generation of evidence*. 8th edition. Elsevier: St. Louis.

Gyasi, R.M., Asante, F., Yeboah, J.Y., Abass, K., Mensah, C.M. and Siaw, L.P. 2016. Pulled in or pushed out? Understanding the complexities of motivation

for alternative therapies use in Ghana. *International Journal of Qualitative Studies Health Well-Being*, 11: 1-12.

Gyasi, R.M., Mensah, C.M., Adjei, P.O. and Agyemang, S. 2011. Public perceptions of the role of TRM in the health care delivery system in Ghana. *Global Journal of Health Science*, 3(2): 40-49.

Gyasi, R.M., Siaw, L.P. and Mensah, C.M. 2015. Prevalence and pattern of traditional medical therapy utilisation in Kumasi Metropolis and Sekyere South District, Ghana. *Journal of Ethnopharmacology*, 161: 138-146.

Habtom, G.K. 2018. Perceptions and attitudes of modern and traditional medical practitioners about traditional medical practice in Eritrea. *International Journal of Complementary and Alternative Medicine*, 11(1): 6-19.

Hajj, E.M, Sitali, D.C, Vwalika, B. and Holst, L. 2020. "Back to Eden": An explorative qualitative study on traditional medicine use during pregnancy among selected women in Lusaka Province, Zambia. *Complementary Therapies in Clinical Practice*, 40: 1-7.

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

Hasan, S.S., Yong, C.S. Babar, G.M., Naing, C.M., Hameed. A., Baig, M.R, Iqbal, S.M. and Kairuz. T. 2011. Understanding, perceptions and self-use of complementary and alternative medicine (CAM) among Malaysian Pharmacy students. *BioMed Central Complementary and Alternative Medicine*, 11: 95-107.

Hilal, M. and Hilal, S. 2017. Knowledge, attitude, and utilization of herbal medicines by physicians in the Kingdom of Bahrain: A cross-sectional study. *Journal of the Association of Arab Universities for Basic and Applied Sciences*, 24: 325-333.

Hudak, N. 2015. Identity disclosure in lesbian, gay, and bisexual patient-provider communication. M.A., James Madison University. (Online). Available: <https://commons.lib.jmu.edu/master201019/26> (Accessed 20 December 2020).

Hughes, G.D., Aboyade, O.M., Clark, B.L. and Puoane, T.R. 2013. The prevalence of traditional herbal medicine use among hypertensives living in South African communities. *BioMed Central Complementary and Alternative Medicine*, 13: 38-45.

Hughes, G.D., Puoane, T.R., Clark, B.L. Wonwossen, T.L. Johnson, Q. and Folk, W. 2012. Prevalence and predictors of traditional medicine utilization among persons living with AIDS (PLWA) on antiretroviral (ARV) and prophylaxis treatment in both rural and urban areas in South Africa. *African Journal of Traditional Complementary Alternative Medicine*, 9(4): 470-484.

Hussain, M.S. 2011. Patient counselling about herbal-drug interactions. *African Journal of Traditional Complementary Alternative Medicine*, 8(5 Supple): 152-63.

Innocent, E. 2016. Trends and challenges toward integration of traditional medicine in formal health-care system: Historical perspectives and appraisal of education curricula in sub-Saharan Africa. *Journal of Intercultural Ethnopharmacology*, 5(3): 312-316.

James, P.B., Wardle, J., Steel, A. and Adams, J. 2018. Traditional, complementary and alternative medicine use in sub-Saharan Africa: A systematic review. *British Medical Journal Global Health*, 3(5): 1-18.

Jamshed, S. 2014. Qualitative research method - interviewing and observation. *Journal of Basic and Clinical Pharmacy*, 5(4): 87-88.

Jansen, C., Baker, J.D., Kodaira, E., Ang, L., Bacani, A.J., Aldan, J.T., Shimoda, L.M.N., Salameh, M., Small-Howard, A.L., Strokes, A.J., Turner, H. and Adra, C.N. 2021. Medicine in motion: Opportunities, challenges and data analytics-based solutions for traditional medicine integration into western medical practice. *Journal of Ethnopharmacology*, 267: 1-12.

Johny, A.K., Cheah, W.L. and Safii, S. 2017. Disclosure of traditional and complementary medicine use and its associated factors to medical doctor in primary care clinics in Kuching Division, Sarawak. Malaysia. *Evidence Based Complementary and Alternative Medicine*, 2017: 1-10.

Jou, J. and Johnson, P.J. 2016. Nondisclosure of complementary and alternative medicine use to primary care physicians: Findings from the 2012 National Health Interview Survey. *Journal of the American Medical Association International Medicine*, 176(4): 545-546.

Kamsu-Foguem, B. and Foguem, C. 2014. Adverse drug reactions in some African herbal medicine: Literature review and stakeholders' interview. *Integrative Medicine Research*, 3(3): 126-132.

Kasilo, O.M.J., Wambebe, C., Nikiema, J. and Nabyonga-Orem, J. 2019. Towards universal health coverage: Advancing the development and use of traditional medicines in Africa. *British Medical Journal Global Health*, 4(Suppl 9): 1-11.

Kennedy, B.C. and Thornberg, R. 2018. Deduction, induction, and abduction. In Flick, U. (ed.). *The Sage handbook of qualitative data collection*. Los Angeles: Sage.

Kew, Y., Chia, Y.L., Lai, S.M., Chong, K.Y., Ho, X.L., Liew, D.W., Moy, F.M. and Selvarajah, S. 2015. Traditional and complementary medicine (TCM) among study population with cardiovascular risk; use and substitution for

conventional medicine in Pahang, Malaysia. *Medical Journal of Malaysia*, 70(2): 86-92.

Khan, T.M., Hassali, M.A. and Al-Haddad, M. 2011. Patient-physician communication barrier: A pilot study evaluating patient experiences. *Journal of Young Pharmacists*, 3(3): 250-255.

Kim, J.K., Kim, K.H., Shin, Y.C., Jang, B. and Ko, S. 2020. Utilization of traditional medicine in primary health care in low- and middle-income countries: A systematic review. *Health Policy and Planning*, 35(8): 1070-1083.

Kivunja, C. 2018. Distinguishing between theory, theoretical framework, and conceptual framework: A systematic review of lessons from the field. *International Journal of Higher Education*. 7(6): 44-53.

Krah, E., De Kruijf, J. and Ragno, L. 2017. Integrating traditional healers into the health care system: Challenges and opportunities in rural Northern Ghana. *Journal of Community Health*, 43(1): 157-163.

Kreitzer, M.J., Kliger, B. and Meeker, W.C. 2009. Health professions and integrative healthcare. *Explore*, 5(4): 212-227.

Kretchy, I.A., Owusu-Daaku, F. and Daquah, S. 2014. Patterns and determinants of the use of complementary and alternative medicine: A cross sectional study of hypertensive patients in Ghana. *BioMed Central complementary and Alternative Medicine*, 14(44): 1-9.

Kumar, R. 2011. *Research methodology: A step by step for beginners*. 3rd edition. Los Angeles: Sage.

Kwame, A. 2021. Integrating traditional medicine and healing into the Ghanaian mainstream health system: Voices from within. *SAGE: Qualitative Health Research*, 31(10): 1847-1860.

Lampiao, F., Chisaka, J. and Clements, C. 2019. Communication between traditional medical practitioners and western medical professionals. *Frontiers in Sociology*, 4(37): 1-6.

Lee, W.Q., Teoh, J., Lee, P.Z.K., Low, Z.X.G., Sim, X., Chong F.F.M. and Wagner, N.L. 2019. Factors influencing communication of traditional Chinese medicine use between patients and doctors: A multisite cross-sectional study. *Journal of Integrative Medicine*, 17(6): 396-403.

Lemonnier, N., Zhou, G.Z., Prasher, B., Mukerji, M., Chen, Z.C., Brahmachari S.K., Noble, D., Auffray, C. and Sagner, M. 2017. Traditional knowledge-based medicine: A review of history, principles, and relevance in the present context of P4 Systems Medicine. *Progress in Preventive Medicine*, 2(7): 1-14.

Lewis, C.C., Matheson, D.H. and Brimacombe, C.A.E. 2011. Factors influencing patient disclosure to physicians in birth control clinics: An application of the communication privacy management theory. *Health Communication*, 26(6): 502-511.

Lim, W., Arnold, D.M., Bachanova, V., Haspel, R.L., Rosovsky, P.R., Shustov, A.R. and Crowther, M.A. 2008. Evidence-based guidelines: An introduction. *Journal of American Society of Hematology*, 1: 26-30.

Lincoln, Y.S. and Guba, E.G. 1985. *Naturalistic inquiry*. San Francisco: SAGE.

Liwa, A., Roediger, R., Jaka, H., Bougaila, A., Smart, L., Langwick, S. and Peck, R. 2017. Herbal and alternative medicine use in Tanzanian adults admitted with hypertension-related diseases: A mixed-methods study. *Hindawi International Journal of Hypertension*, 1-9.

Logiel, A., Jors, E., Akugizibwe, P. and Ahnfeldt-Mollerup, P. 2021. Prevalence and socio-economic factors affecting the use of traditional medicine among

adults of Katikékile Subcounty, Moroto District, Uganda. *African Health Sciences*, 21(3): 1410-1417.

Luckyx, V.A., Steenkamp, V., Rubel, J.R. and Stewart, M.J. 2004. Adverse effects associated with the use of South African traditional folk remedies. *Central African Journal of Medicine*, 50(5-6): 46-51.

MacFarlane, C. 2015. South Africa: The Rise of Traditional Medicine. *Insight on Africa*, 7(1), 60-70.

Mahomoodally, M.F. 2013. Traditional medicines in Africa: An appraisal of ten potent African medicinal plants. *Evidence-Based Complementary and Alternative Medicine*, 2013(617459): 1-14.

Majid, A.A.A., Othman, M., Mohamad, S.F., Lim, S.A.H. and Yusof, A. 2017. Piloting for interviews in qualitative research: Operationalization and lessons learnt. *International Journal of Academic Research in Business and Social Sciences*, 7(4): 1073-1080.

Malterud, K., Siersma, V.D. and Guassora, A.D. 2016. Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13): 1753-1760.

Mander, M., Ntuli, L., Diederichs, N. and Mavundla., K. 2007. Economics of the traditional medicine trade in South Africa: Health care delivery. *South African Health Review*, 2007: 189-96.

Mann, S. 2016. *The research interview: Reflective practice and reflexivity in research processes*. London: Palgrave Macmillan.

Marais, A., Steenkamp, V. and Du Plooy, W.J. 2017. Conditions frequently self-treated with herbal remedies by patients visiting a tertiary hospital in Gauteng, South Africa. *Professional Nursing Today*, 21(4): 36-40.

Margulis, S.T. 2003. On the status and contribution of Westin's and Altman's theories of privacy. *Journal of Social Issues*, 59(2): 411 - 429.

Masaviru, M. 2016. Self-Disclosure: Theories and Model Review. *Journal of Culture, Society and Development*, 18: 43-47.

Mash, R., Ogunbanjo, G., Naidoo, S.S. and Hellenberg, D. 2015. The contribution of family physicians to district health services: A national position paper for South Africa: Forum. *South African Family Practice*, 57(3): 54-61.

McIntyre, E., Saliba, A.J., Wiener, K.K. and Sarris, J. 2016. Herbal medicine use behaviour in Australian adults who experience anxiety: A descriptive study. *BioMed Central Complementary and Alternative Medicine*, 16(60): 1-12.

Melchart, D. 2018. From Complementary to Integrative Medicine and Health: Do We Need a Change in Nomenclature? *Complementary Medicine Research*, 25(2): 76–78.

Merriam, S.H. and Tisdell, E.J. 2016. *Qualitative research: A guide to design and implementation*. 4th edition. San Francisco: Jossey-Bass.

Merriam-Webster dictionary. 2022a. s.v. "boundaries". (Online). Available: <https://www.merriam-webster.com/dictionary/boundary> (Accessed 18 October 2022).

Merriam-Webster dictionary. 2022b. s.v. "disclosure". (Online). Available: <https://www.merriam-webster.com/dictionary/disclosure> (Accessed 18 October 2022).

Merriam-Webster dictionary. 2022c. s.v. "mandate". (Online). Available: <https://www.merriam-webster.com/dictionary/mandate> (Accessed 18 October 2022).

Metin, Z.G., Karadas, C. and Ozdemir, L. 2019. Usage and attitudes related to complementary and alternative medicine among Turkish academicians on the basis of the five-factor model of personality: A multi-centered study. *Complementary Therapies in Medicine*, 44: 151-156.

Miles, M.B., Huberman, A.M. and Saladana, J. 2014. *Qualitative data analysis: A method sourcebook*. 3rd edition. Los Angeles: Sage.

Mokhesi, T. and Modjadji, P. 2022. Usage of Traditional, complementary and alternative medicine and related factors among patients receiving healthcare in Lesotho. *The Open Public Health Journal*, 15 (1): 1-12.

More, B. 2016. Overview of medicine: Its importance and impact. *DJ International Journal of Medical Research*, 1(1): 1-8.

Moreira, D.L., Teixeira, S.S, Monteiro, M.H.D., De-Oliveira, A.C.A.X. and Paumgarten, F.J.R. 2014. Traditional use and safety of herbal medicines 1. *Revista Brasileira de Farmacognosia*, 24(2): 248-257.

Moshabela, M., Zuma, T. and Gaede, B. 2016. Bridging the gap between biomedical and traditional health practitioners in South Africa. *South African Health Review*, 83-92.

Mothibe, M.E. and Sibanda, M. 2019. African traditional medicine: South African perspective. *Traditional and complementary medicine, Intech Open, London*.

Municipalities of South Africa. 2022. *Gauteng Municipalities*. Available: <https://municipalities.co.za/provinces/view/3/gauteng> (Accessed 24 March 2020).

Mutola, S., Pemunta, N.V. and Ngo, N.V. 2021. Utilization of traditional medicine and its integration into the healthcare system in Qokolweni, South Africa; prospects for enhanced universal health coverage. *Complementary Therapies in Clinical Practice*, 43: 1-4.

Mwaka, A.D., Abbo, C. and Kinengiyere, A.A. 2020. Traditional and complementary medicine use among adult cancer patients undergoing conventional treatment in sub-Saharan Africa: A scoping review on the use, safety, and risks. *Cancer Management and Research*, 12: 3699-3712.

Mwaka, A.D., Okello, E.S. and Orach C.G. 2015. Barriers to biomedical care and use of traditional medicines for treatment of cervical cancer: An exploratory qualitative study in northern Uganda. *European Journal of Cancer Care*, 24: 503-513.

Nemutandani, S.M., Hendricks, S.J. and Mulaudzi, M.F. 2016. Perceptions of experiences of allopathic health practitioners on collaboration with traditional health practitioners in post-apartheid South Africa. *African Journal of Primary Health Care and Family Medicine*, 8(2): 1-8.

Neuman, W.L. 2014. *Social research methods: Qualitative and quantitative approaches*. 7th edition. United Kingdom: Pearson Education.

Nkosi, P.B. and Sibiya, M.N. 2018. Perceptions of traditional health practitioners and radiation oncologists regarding referral of cancer patients in a cooperative practice in KwaZulu Natal province, South Africa. *International Journal of Africa Nursing Sciences*, 8: 117-121.

Nkosi, P.B. and Sibiya, M.N. 2021. A practice framework for the cooperative treatment of cancer between traditional health practitioners and radiation oncologists in KwaZulu-Natal province, South Africa. *Health SA Gesondheid*, 26: 1-7.

Nyeko, R., Tumwesigye, N.M. and Halage, A.A. 2016. Prevalence and factors associated with use of herbal medicines during pregnancy among women attending postnatal clinics in Gulu district, Northern Uganda. *BioMed Central Pregnancy and Childbirth*, 16(296): 1-12.

O'Dowd, G.V.G. 2004. Doctor-patient communication: An introduction for medical students. 18: 39-52.

Olisa, N.S, Oyelola, F.T. 2009. Evaluation of use of herbal medicines among ambulatory hypertensive patients attending a secondary health care facility in Nigeria. *International Journal of Pharmacy Practice*, 17(2):101-105.

Oliveira, S.G.D, Piva, E. and Lund, R.G. 2015. The possibility of interactions between medicinal herbs and allopathic medicines used by patients attended at basic care units of the Brazilian unified health system. *Natural Products Chemistry and Research*, 3(2): 1-7.

Oseni, Z. and Shannon, G. 2020. The relationship between indigenous and allopathic health practitioners in Africa and its implications for collaboration: A qualitative synthesis. *Global Health Action*, 13(1): 1-13.

Oxford Learner's Dictionary. 2022. s.v. "guidelines". (Online). Available: <https://www.oxfordlearnersdictionaries.com/definition/english/guideline> (Accessed 18 October)

Oyebode, O., Kandala, N., Chilton, P.J. and Lilford, R.J. 2016. Use of traditional medicine in middle-income countries: A WHO-SAGE study. *Health Policy and Planning*, 31: 984-991

Ozioma, F.J. and Chinwe, O.A.N. 2019. Herbal medicines in African traditional medicine. in P. F. Builders (ed.). *Herbal Medicine, Intech Open, London*.

Paniccia, M., Provvidenza, C., Kingsnorth, S., Ippolito, C., Zemek, R. and Reed, N. 2021. Engaging target users to appraise and refine clinical practice guidelines in pediatric concussion: An integrated knowledge translation approach. *Journal of Concussion*, 5: 1-16.

Parker, A. and Hamann, C. 2020. The most densely populated areas of Gauteng. GCRO Map of the Month, Gauteng City-Region Observatory, April 2020. (Online). Available: <https://doi.org/https://doi.org/10.36634/FMLV8486> (Accessed 17 May 2020).

Peltzer, K., Friend-du Preez, N., Ramlagan, S. and Anderson, J. 2010. Antiretroviral treatment adherence among HIV patients in KwaZulu-Natal, South Africa. *BioMed Central Public Health*, 10: 111-120.

Peprah, P., Agyemang-Duah, W., Arthur-Holmes, F., Budu, H.I., Abalo, E.M., Okwei, R. and Nyonyo, J. 2019. 'We are nothing without herbs': A story of herbal remedies used during pregnancy in rural Ghana. *BioMed Central Complementary and Alternative Medicine*, 19: 65-76.

Petronio, S. 2002. *Boundaries of privacy*. Albany, New York: State University of New York.

Petronio, S. 2016. Communication privacy management theory: The international. In Berger, C.R. and Roloff, M.E. (eds). *Encyclopedia of interpersonal communication*. New Jersey: Wiley and Sons.

Petronio, S. and Child, J.T. 2020. Conceptualization and operationalization: Utility of communication privacy management theory. *Current Opinion in Psychology*, 31: 76-82.

Petronio, S., Dicorcia, M. and Duggan, A. 2012. Navigating ethics of physician-patient confidentiality: A communication privacy management analysis. *Perm Journal*, 16(4): 41-45.

Polit, D.F. and Beck, C.T. 2017. *Nursing research: Generating and assessing evidence for nursing practice*. 10th edition. Philadelphia: Wolters Kluwer.

Puoane, T.R., Hughes, G.D., Uwimana, J., Johnson, Q. and Folk, R. 2012. Why HIV positive patients on antiretroviral treatment and/or cotrimoxazole prophylaxis use traditional medicine: Perceptions of health workers, traditional healers and patients: A study in two provinces of South Africa. *African Journal of Traditional Complementary Alternative Medicine*, 9(4): 495-502.

Rautenbach, C. 2007. Review on a new legislative framework for traditional healers in South Africa. *Obiter*, 28: 218-535.

Rautenbach, C. 2011. Institutionalisation of African traditional medicine in South Africa: Healing powers of the law? *Journal of Contemporary Roman-Dutch Law*, 74(1): 28-46.

Redvers, N. and Blondin, B. 2020. Traditional indigenous medicine in North America: A scoping review. *PLoS ONE*, 15(8): 1-21.

Reid, R., Steel, A., Wardle, J., Trubody, A. and Adams, J. 2016. Complementary medicine use by the Australian population: A critical mixed studies systematic review of utilisation, perceptions and factors associated with use. *BioMed Central Complementary Alternative Medicine*, 16(176): 1-23.

Republic of South Africa. 1974. *Health Professions Act 56 of 1974*. (Online). Available:

https://www.hpcsa.co.za/Uploads/Legal/legislation/health_professions_ct_56_1974.pdf (Accessed 22 June 2022).

Republic of South Africa. 2003. *National Health Act 61 of 2003*. (Online).

Available: https://www.gov.za/sites/default/files/gcis_document/201409/a61-03.pdf (Accessed 24 March 2020).

Republic of South Africa. 2003. National Health Act 61 of 2003. Available: <https://www.knowledgehub.org.za/system/files/elibdownloads/2019-07/Hospital%2520Regulations%25202012.pdf> (Accessed 24 March 2020).

Republic of South Africa. 2008. *Traditional Health Practitioners Act 22 of 2007*. (Online). Available: <https://www.gov.za/documents/traditional-health-practitioners-act> (Accessed 13 March 2021).

Republic of South Africa. 2013. *Protection of Personal Information Act 4 of 2013*. (Online). Available: <https://www.gov.za/documents/protection-personal-information-act> (Accessed 3 March 2022).

Rizza, C., Curvelo, P., Crespo, I., Chiaramello, M., Ghezzi, A. and Pereira, A.G. 2011. Interrogating privacy in the digital society: Media narratives after 2 cases. *Journal of Information Ethics*, 16(12): 6-17.

Robinson, A. and McGrail, M.R. 2004. Disclosure of CAM use to medical practitioners: A review of qualitative and quantitative studies. *Complementary Therapies in Medicine*, 12: 90-98.

Rocque, R. and Leanza, Y. 2015. A systematic review of patients' experiences in communicating with primary care physicians: Intercultural encounters and a balance between vulnerability and integrity. *PLoS ONE* 10(10): 1-31.

Samens, J.M. 2017. How individuals disclose health information: A study examining the choices made when sharing health information. PhD, University of Winkonsin-Milwaukee. (Online). Available: <https://dc.uwm.edu/etd/1690> (Accessed 26 February 2022).

Samuels, N. and Ben-Arye, E. 2020. Exploring herbal medicine use during palliative cancer care: The integrative physician as a facilitator of pharmacist–patient–oncologist communication. *Pharmaceuticals*, 13(12): 1-14.

Saputra, I., Rafsanjani, T.M. and Usman, S. 2021. Mixed methods analysis: Traditional medication, stigma, and leper's family support roles in level II leprosy disability. *Indian Journal of Forensic Medicine and Toxicology*, 15(3): 3266-3272.

Shelley, B.M., Sussman, A.L., William, R.L., Segal, A.R. and Crabtree, B.F. 2009. 'They don't ask me so I don't tell them': Patient-clinician communication about traditional, complementary, and alternative medicine. *Annals of Family Medicine*, 7: 139-147.

Shewamene, Z., Dune, T. and Smith, C.A. 2017. The use of traditional medicine in maternity care among African women in Africa and the diaspora: A systematic review. *BioMed Central Complementary Alternative Medicine*, 17(382): 1-16.

Sifuna, N. 2022. Configuring a model framework statute on traditional medicine for Kenya: To be called "The Traditional Medicine Coordination Act". *Beijing Law Review*, 13: 183-203.

Sobiecki, J. 2014. The intersection of culture and science in South African traditional medicine. *Indo-Pacific Journal of Phenomenology*, 14(1): 1-11.

Soratto, J., de Pires, D.E.P. and Friese, S. 2020. Thematic content analysis using Atlas.ti software: Potentialities for research in health. *Revista Brasileira de Enfermagem*, 73(3): 1-5.

South African Department of Health. 2008. *Draft Policy on African Traditional Medicine for South Africa*. Notice 9060f 2008. (Online). Available: <https://tradmed.ukzn.ac.za/wp-content/uploads/2018/05/Draft-Policy-on-African-Traditional-Healers.pdf> (Accessed 26 January 2021).

Stahl, N.A. and King, J.R. 2020. Expanding approaches to research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education*, 44: 26-28.

Stanifer, J.W., Patel, U.D., Karia, F., Thielman, N., Maro, V., Shimbi, D., Kilaweh, H., Lazaro, M., Matemu, O., Omolo, J. and Boyd, D. 2015. The determinants of traditional medicine use in Northern Tanzania: A mixed-methods study. *PLoS ONE*, 10(4): 1-17.

Statistics South Africa. 2020. *2020 Mid-year population estimates*. (Online). Available:
<https://www.statssa.gov.za/?p=13453#:~:text=Gauteng%20continues%20to%20record%20the,been%20recorded%20in%20KwaZulu%2DNatal> (Accessed 20 December 2020).

Street, R.A. 2016. Unpacking the new proposed regulations for South African traditional health practitioners. *The South African Medical Journal*, 106(4): 325-326.

Stub, T., Quandt, S.A., Arcury, T.A., Sandberg, J.C. and Kristoffersen, A.E. 2017. Complementary and conventional providers in cancer care: Experience of communication with patients and steps to improve communication with other providers. *BioMed Central Complementary and Alternative Medicine*, 17(1): 1-14.

Stub, T., Quandt, S.A., Arcury, T.A., Sandberg, J.C., Kristoffersen, A.E., Musial, F. and Salamonsen, A. 2016. Perception of risk and communication among conventional and complementary health care providers involving cancer patients' use of complementary therapies: A literature review. *BioMed Central Complementary and alternative Medicine*, 16(1): 1-14. (Online). Available: <https://pubmed.ncbi.nlm.nih.gov/27609097/> (Accessed 10 December 2020).

Stuttaford, M., Makhamreh, S.A.I., Coomans, F., Harrington, J., Himonga, C. and Hundt, G.L. 2014. The right to traditional, complementary, and alternative health care. *Global Health Action*, 7: 1-8.

Sundarmurthy, D., Devarashetty, V. and Reddy, S.N. 2017 Complementary and alternative medicine: Practice and perspective of allopathic doctors at a tertiary care hospital. *International Journal of Basic and Clinical Pharmacology*, [S.I.], 5(5):1995-2000.

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.

Taylor, S.J., Bogdan, R. and Devault, M.L. 2016 *Introduction to qualitative research: A guidebook and resource*. 4th edition. New Jersey: Wiley and Sons.

Thandar, Y., Botha, J., Sartorius, B. and Mosam, A. 2017. Knowledge, attitude and practices of South African healthcare professionals towards complementary and alternative medicine use for atopic eczema – A descriptive survey. *South African Family Practice*, 59(1): 22-28.

The American College of Obstetricians and Gynecologists. 2014. Committee Opinion Number 587. Effective patient–physician communication. *Women’s Health Care Physicians*, 123(2): 389-393.

Traianou, A. 2014. The centrality of ethics in qualitative research. In Leavy, P. (ed.). *The Oxford handbook of qualitative research*. Oxford: University Press.

Tran, B.X., Nguyen, N.K., Nguyen, L.P., Nguyen, C.T., Nong, V.M. and Nguyen, L.H. 2016. Preference and willingness to pay for traditional medicine services in rural ethnic minority community in Vietnam. *British Medicine Journal Complementary and Alternative Medicine*, 16(48): 1-8.

Trent, A. and Cho, J. 2014. Interpretation strategies: Appropriate concepts. In Leavy, P. (ed.). *The Oxford handbook of qualitative research*. Oxford: Oxford University Press.

Tshabalala-Msimang, M. 2007. Press statement. (Online). Available: <https://www.gov.za/m-tshabalala-msimang-african-traditional-medicine> (Accessed 13 December 2020).

Tu, P., Smith, D., Clark, R., Bayzle, L., Tu, R. and Lin, C. 2021. Patients' characterization of medication, emotions, and incongruent perceptions around adherence. *Journal of Personalised Medicine*, 11(10): 1-12.

United States National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1978. The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, report, Bethesda, Maryland. (Online). (<https://digital.library.unt.edu/ark:/67531/metadc1213679/>) (Accessed 16 October 2022).

van der Geest, S. and Hardon, A. 2006. Social and cultural efficacies of complications for antiretroviral therapy. *Journal of Ethnobiology and Ethnomedicine*, 2(48): 1-5.

van Rooyen, D., Pretorius, B., Tembani, N.M. and Ten Ham, W. 2015. Allopathic and traditional health practitioners' collaboration. *Curationis*, 38(2), 1-10.

von Pressentin, K.B., Mash, R.J., Baldwin-Ragaven, L., Botha R.P.G., Govender, I. and Steinberg, W.J. 2018. The bird's-eye perspective: How do district health managers experience the impact of family physicians within the South African district health system? A qualitative study. *South African Family Practice*, 60(1): 13-20

Wahyuni, D.2012. The research design maze: Understanding paradigms, cases, methods and methodologies. *Journal of Applied Management Accounting Research*, 10(1): 69-80.

Wardle, J.L., Sibbritt, D.W. and Adams, J. 2018. Primary care practitioner perceptions and attitudes of complementary medicine: A content analysis of free-text responses from a survey of non-metropolitan Australian general practitioners. *Primary Health Care Research and Development*, 19(3), 246-255.

Warriner, S., Bryan, K. and Brown, A.M. 2014. Women's attitude towards the use of complementary and alternative medicines (CAM) in pregnancy. *Midwifery*, 30: 138-143.

Welz, A.N., Emberger-Klein, A. and Menrad, K. 2019. What motivates new, established and long-term users of herbal medicine: Is there more than push and pull? *BioMed Central Complementary and Alternative Medicine*, 19(170): 1-9.

Westin, A. 1967. *Privacy and freedom*. New York: Athenaeum.

Wilbur, D.S. 2018. Have you shot anyone? How combat veterans manage privacy with family and friends. *Psychology of Language and Communication*, 22(1): 71-89.

Woolf, S., Schoenemann, H.J., Eccles, M.P., Grimshaw, J.M. and Shekelle, P. 2012. Developing clinical practice guidelines: Types of evidence and outcomes; values and economics, synthesis, grading, and presentation and deriving recommendations. *Implementation Science*, 7(1): 61.

World Health Organization (WHO). 2000. *Programme on Traditional Medicine. WHO Traditional Medicine Strategy 2002-2005*. Geneva: WHO.

World Health Organization (WHO). 2002. *WHO Traditional Medicine Strategy 2002–2005*. Geneva, World Health Organization (document reference WHO/EDM/TRM/2002.1). Geneva: WHO.

World Health Organization (WHO). 2008. *Integrated Health Services. What and Why?* Technical brief. Geneva: WHO.

World Health Organization (WHO). 2013. *WHO Traditional Medicine Strategy 2014-2023*. Geneva: WHO.

Xiao, X., Li, X., Qiao, S., Zhou, Y., Shen, Z. and Tang, Z. 2015. Using communication privacy management theory to examine HIV disclosure to sexual partners/spouses among PLHIV in Guangxi. *Acquired Immune DS Care*, 27(1): 73-82.

Yin, R.K. 2011. *Qualitative research from start to finish*. New York: The Guilford Press.

Young, T., Dizon, J., Kredo, T., McCaul, M., Ochodo, E., Grimm1 - er, K. and Louw, Q. 2020. Enhancing capacity for clinical practice guidelines in South Africa. *Pan African Medical Journal*. 36(18):1-11.

Yuan, H., Ma, H., Ye, L. and Piao, G. 2016. The traditional medicine and modern medicine from natural products. *Molecules*, 21(5): 1-18.

Zank, S. and Hanazaki, N. 2017. The coexistence of traditional medicine and biomedicine: A study with local health experts in two Brazilian regions. *PLoS ONE*, 12(4): 1-17.

Zank, S., Araujo, L.C. and Hanazaki, N. 2019. Resilience and adaptability of traditional health systems: A case study of communities in two regions. *Journal of Ecology and Society*, 24(1): 1-13.

Zhang, J., Onakpoya, I.J., Pozaski, P. and Eddousks, M. 2015. The safety of herbal medicine: From prejudice to evidence. *Hindawi Publishing Corporation Evidence-Based Complementary and Alternative Medicine*, 18: 1-3.

Zingela, Z., van Wyk, S. and Pieterse J. 2019. Use of traditional and alternative healers by psychiatric patients: A descriptive study in urban South Africa. *Transcultural Psychiatry*, 56(1): 146-166.

APPENDICES

Appendix 1: University ethics clearance



17 September 2021

Ms L Gumede
01 Def Street
Eden Park
Alberton
1485

Dear Ms Gumede

Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected hospitals in Gauteng, South Africa.

Ethical Clearance number IREC 016/21

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letters.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

✓

Professor J K Adam
Chairperson: IREC

Appendix 2a: Letter of request for permission to the Chief Director of Johannesburg Health District

152 Du Plessis Street
Walkerville Manor
Wakerville
Meyerton
1876
[Date]

The Chief Director
Johannesburg Health District
Cnr of Smith and Klein Streets
Private Bag X21
Johannesburg
2017

Dear Sir

PERMISSION TO CONDUCT RESEARCH

I am currently registered for a PhD: Health Sciences at the Durban University of Technology (DUT). I would like to conduct research towards the completion of my PhD degree at three hospitals in Gauteng, namely: South Rand and Bheki Mlangeni Hospitals.

The proposed title of the study is: **Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected public hospitals in Gauteng, South Africa**. This will be a qualitative exploratory study. Semi-structured interviews will be employed to collect data from participants who are Allopathic Medicine Practitioners. The study will require a minimum sample size of five participants, one from each hospital. The interview sessions will last for 45-60 minutes.

Copies of the proposal, letter of information, consent, interview guide and provisional ethics clearance are included for perusal. For any queries, please do not hesitate to contact my supervisor Dr P.B. Nkosi 031-373 2509. Her email address is paulinen1@dut.ac.za

Yours sincerely

.....
Ms L. Gumede (PhD: Health Sciences student)
Email: lindiwe.gumede@gmail.com
Tel: 011-559 6847
Cell: 082 568 2035

Appendix 2b: Approval letter from the Chief Director of Johannesburg Health District



Research Committee of Johannesburg Health District

15th July 2021

152 DUPLESSIS STREET
Walkerville Manor
Walkerville
Meyerton
1961

Enquiries: Ms. Busisiwe Sikhosana
Tel: 011 694 3909
Email :Busisiwe.Sikhosana@gauteng.gov.za
Hillbrow CHC: Administration Building,
Cnr Smith Str. & Klein Street
Private Bag X21, Johannesburg,
South Africa, 2017

Email: lindiwe.gumede@gmail.com

Dear: Mrs Lindiwe Gumede

TITLE: *Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected hospitals in Gauteng, South Africa.*

DRC Ref: 2021-02-022

NHRD Ref no: GP_202102_073

OFFICIAL APPROVAL

The Johannesburg Health District Research Committee (DRC) has reviewed your application. This letter serves as approval to access the Districts Health facilities (mentioned below) for the above research.

The following conditions must be observed:

- The facilities in which the research will be conducted are: SOUTH RAND HOSPITAL, BHEKI MLANGENI HOSPITAL
- These facilities will be visited from: 15/07/2021 to 15/07/2022
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit an annual progress report to the District Research Committee.

- Your supervisor and the University Witwatersrand will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.
- You will liaise with the manager/s before initiating the study.

Contact	Sub District	Sub District Manager/ Area Manager	Contact No.	Cell phone
	ABCEF	Ms Lombuso Matlala	011 440 1259	082 307 0267
	D	Ms Maria Mazibuko	011 674 1200	082 781 9919
	G	Mr Peter Mathole	011 213 9603	072 483 6839
	CoJ A	Ms Nelly Shongwe	011 237 8010	082 467 9276
	CoJ B	Ms Zanozuko Mbane	011 718 9656	082 551 5804
	CoJ C	Mr Tebogo Motsepe	011 761 0200	084 655 5420
	CoJ D	Ms Busi Phiri	011 986 0164	082 467 9316
	CoJ E	Mr Vusi Mazibuko	011 582 1504	082 464 9547
	CoJ F	Mr M Monyamane	011 681 8130	082 467 9423
	CoJ G	Ms Olga Kruger	011 211 8936	083 286 0388
X	Southrand	Dr N Maleka	011 681 2002	071 872 6649
x	Bheki Mlangeni	Ms M Makhetha	011 241 5792	079 885 1668

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above. Please feel free to contact us, if you have any further queries.

On behalf of the District Research Committee, we would like to thank you for choosing our District to conduct such an important study.

...

 Prof S. Moosa
 Chairperson: District Research Committee
 Johannesburg Health District
 Date: 15th July 2021

/Mrs M. Morewane
 Chief Director
 Johannesburg Health District
 Date: 19/07/2021

Appendix 3a: Letter of request for permission to the Chief Director of Tshwane Health District

152 Du Plessis Street
Walkerville Manor
Walkerville
Meyerton
1876
[Date]

The Chief Director
Tshwane Health District
Johannesburg
2000

Dear Sir

PERMISSION TO CONDUCT RESEARCH

I am currently registered for a PhD: in Health Sciences at the Durban University of Technology (DUT). I would like to conduct research towards the completion of my PhD degree at Jubilee District Hospital.

The proposed title of the study is **Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected public hospitals in Gauteng, South Africa**. This will be a qualitative exploratory study. Semi-structured interviews will be employed to collect data from participants who are Allopathic Medicine Practitioners. The study will require a minimum sample size of five participants, one from each hospital. The interview sessions will last for 45-60 minutes.

Copies of the proposal, letter of information, consent, interview guide and provisional ethics clearance are included for perusal. For any queries, please do not hesitate to contact my supervisor Dr P.B. Nkosi 031-373 2509. Her email address is paulinen1@dut.ac.za

Yours sincerely

.....
Ms L. Gumede (PhD: Health Sciences student)
Email: lindiwe.gumede@gmail.com
Tel: 011-559 6847
Cell: 082 568 2035

Appendix 3b: Approval letter from the Chief Director of Tshwane Health District



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Manel Letebele-Hartell
Tel: +27 12 451 9036
E-mail: Troy.Mashabela@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 19/03/2021

PROJECT NUMBER: 18/2021

NHRD REFERENCE NUMBER: GP_202102_055

TOPIC: Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected hospitals in Gauteng, South Africa.

Name of the Lead Researcher: Mrs Lindiwe Gumede

Name of the Supervisor: Dr P.B. Nkosi
Prof M.N. Sibiya

Facilities: Jubilee District Hospital

Name of the Department: Durban University of Technology

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

NB: "The time used for interviews should not be within working hours"

DECISION OF THE COMMITTEE: APPROVED

Dr. Mpho Moshime-Shabangu
Deputy Chairperson: Tshwane Research Committee

Date: 19/03/2021

Mr. Mothomōne Pitsi
Chief Director: Tshwane District Health

Date: 20.02.2021

Appendix 4a: Letter of request for permission to the Chief Director of Ekurhuleni Health District

152 Du Plessis Street
Walkerville Manor
Wakerville
Meyerton
1876
20/04/2020

Ekurhuleni Health district
West Wing Street
40 Catlin Street
Germiston
1401

Dear Dr Keleman

PERMISSION TO CONDUCT RESEARCH

I am currently registered for a PhD of Health Sciences in Radiography at the Durban University of Technology (DUT). I would like to conduct research towards the completion of my PhD degree at one of the hospitals in Ekurhuleni Metropolitan District. The selected hospital is Germiston hospital.

The proposed title of the study is: **Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected public hospitals in Gauteng, South Africa.** This will be a qualitative exploratory study. Semi-structured interviews will be employed to collect data from participants who are Allopathic Medicine Practitioners. The study will require a minimum sample size of five participants, one from each hospital. The interview sessions will last for 45-60 minutes.

Copies of the proposal, letter of information, consent, interview guide and provisional ethics clearance are included for perusal. For any queries, please do not hesitate to contact my supervisor Dr P.B. Nkosi 031-373 2509. Her email address is paulinen1@dut.ac.za

Yours sincerely

.....
Ms L. Gumede (PhD: Health Sciences student)
Email: lindiwe.gumede@gmail.com
Tel: 011-559 6847
Cell: 082 568 2035

Appendix 4b: Approval letter from the Chief Director of Ekurhuleni Health District

RE: Re:PROTOCOL FOR MS GUMEDE LINDIWE



Kelleman, Ronel (gphealth) <Ronel.Kelleman@gauteng.gov.za>

To: Gumedé, Lindiwe; johnmusonda82; Manamela, Mpho (GPHealth)

You replied to this message on 2021/05/12 12:31.

CAUTION: This email originated from **outside** of the University of Johannesburg. **DO NOT** click on links or open attachments if the sender is unknown.

Morning

I have send your protocol to Thelle Mogoerane CEO. As we do not give permission for hospitals, you should also follow up with them directly.

Regards,

Dr Ronel Kellerman

Public Health Specialist

DoH Ekurhuleni District

Work:

Email: ronel.kelleman@gauteng.gov.za

Appendix 5a: Letter of request for permission to the CEO of Thelle Mogoerane Regional Hospital

152 Du Plessis Street
Walkerville Manor
Walkerville
Meyerton
1876
[Date]

The Chief Director
Thella Mogoerane Regional Hospital
Johannesburg
2000

Dear Dr Manamela

PERMISSION TO CONDUCT RESEARCH

I am currently registered for a PhD: in Health Sciences at the Durban University of Technology (DUT). I would like to conduct research towards the completion of my PhD degree at Thella Mogoerane Regional Hospital.

The proposed title of the study is **Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected public hospitals in Gauteng, South Africa**. This will be a qualitative exploratory study. Semi-structured interviews will be employed to collect data from participants who are Allopathic Medicine Practitioners. The study will require a minimum sample size of five participants, one from each hospital. The interview sessions will last for 45-60 minutes.

Copies of the proposal, letter of information, consent, interview guide and provisional ethics clearance are included for perusal. For any queries, please do not hesitate to contact my supervisor Dr P.B. Nkosi 031-373 2509. Her email address is paulinen1@dut.ac.za

Yours sincerely

.....
Ms L. Gumede (PhD: Health Sciences student)
Email: lindiwe.gumede@gmail.com
Tel: 011-559 6847
Cell: 082 568 2035

Appendix 5b: Approval letter from the CEO of Thelle Mogoerane Regional Hospital



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: P/N Mabizela/P/N L. Mogosi
Directorate: Staff Development
Telephone number: (011) 8917109
Email: Thandwe.Mabizela@gauteng.gov.za

Date: 27 July 2021

Ms.L.Gumede

Thelle Mogoerane Regional Hospital Management Team is pleased to grant you permission to conduct your research on **Guidelines for disclosure of traditional medicine use to allopathic medicine** at **Thelle Mogoerane Regional Hospital**. Your data will be conducted through obtaining information through "Prospective data collection" in your protocol for which you will obtain the ethics clearance certificate from the Durban University of Technology. The following condition must be adhered to:

- Once the research is finalized the results and recommendations of the research should be submitted to Staff development Department.

11 DT VEFKO HAHWU BLANCÉ
AETLW Chief Executive Officer
Thelle Mogoerane Regional Hospital
Date: 2021/7/27

To be the best provider of quality health care services to the people of Gauteng

Appendix 6a: Letter of request for permission to the CEO of Jubilee District Hospital

152 Du Plessis Street
Walkerville Manor
Walkerville
Meyerton
1876
[Date]

92 Jubilee Road
Temba
0407
Gauteng
South Africa

Dear Dr Modise

PERMISSION TO CONDUCT THE STUDY

I am currently doing my PhD in Health Sciences at the Durban University of Technology. As a partial fulfilment of the award of the degree, I am required to conduct a research study that I chose; therefore, I request to conduct data collection at your hospital's outpatient department. I will also need permission to approach physicians working in those outpatient departments for part of the research.

The proposed title of the study is **Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected public hospitals in Gauteng, South Africa**. This will be a qualitative exploratory study. Semi-structured interviews will be employed to collect data from participants who are Allopathic Medicine Practitioners. The study will require a minimum sample size of five participants, one from each hospital. The interview sessions will last for 45-60 minutes.

Copies of the proposal, letter of information, consent, interview guide and provisional ethics clearance are included for perusal. For any queries, please do not hesitate to contact my supervisor Dr P.B. Nkosi 031-373 2509. Her email address is paulinen1@dut.ac.za

Yours sincerely

.....
Ms L. Gumede (PhD: Health Sciences student)
Email: lindiwe.gumede@gmail.com
Tel: 011-559 6847
Cell: 082 568 2035

Appendix 6b: Approval letter from the CEO of Jubilee District Hospital

Annexure 1	
Declaration of intent from the clinic manager or hospital CEO	
I give preliminary permission to <u>MRS LINDIWE GUMEDE</u> (name of researcher) to do his or her	
research on <u>Guideline for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected Public hospitals in Gauteng, South Africa</u> (research topic)	
_____ (name of clinic) or	
_____ (name of CHC) or	
<u>JUBILEE DISTRICT HOSPITAL</u> (name of hospital).	
I know that the final approval will be from the Tshwane/Metsweding Regional Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.	
Other comments or conditions prescribed by the clinic or CHC manager or hospital CEO:	
<div>Please inform the Hospital about the outcome of your research</div>	
Signature Clinic Manager/CHC Manager/CEO	
Date <u>22/03/04</u>	

Appendix 7a: Letter of request for permission to the CEO of Bheki Mlangeni District Hospital

152 Du Plessis Street
Walkerville Manor
Walkerville
Meyerton
1876
[Date]

Cnr Koma Street and Bolani Road
Jabulani
1868
Soweto, Gauteng
South Africa

Dear Dr Makhetha

PERMISSION TO CONDUCT THE STUDY

I am currently doing my PhD in Health Sciences at the Durban University of Technology. As a partial fulfilment of the award of the degree, I am required to conduct a research study that I chose; therefore, I request to conduct data collection at your hospital's outpatient department. I will also need permission to approach physicians working in those outpatient departments for part of the research.

The proposed title of the study is **Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected public hospitals in Gauteng, South Africa**. This will be a qualitative exploratory study. Semi-structured interviews will be employed to collect data from participants who are Allopathic Medicine Practitioners. The study will require a minimum sample size of five participants, one from each hospital. The interview sessions will last for 45-60 minutes.

Copies of the proposal, letter of information, consent, interview guide and provisional ethics clearance are included for perusal. For any queries, please do not hesitate to contact my supervisor Dr P.B. Nkosi 031-373 2509. Her email address is paulinen1@dut.ac.za

Yours sincerely

.....
Ms L. Gumede (PhD: Health Sciences student)
Email: lindiwe.gumede@gmail.com
Tel: 011-559 6847
Cell: 082 568 2035

Appendix 7b: Approval letter from the CEO of Bheki Mlangeni District Hospital



GAUTENG PROVINCE

HEALTH
REPUBLIC OF SOUTH AFRICA

BHEKI MLANGENI DISTRICT HOSPITAL

Enquiries: Dr. WT. Mngomezulu

Tel: 011 241 5879

Email: Thulani.Mngomezulu2@gauteng.gov.za

To: Ms. Lindiwe Gumede

RE: APPROVAL FOR RESEARCH STUDY: GUIDELINES FOR DISCLOSURE OF TRADITIONAL MEDICINE USE OF ALLOPATHIC MEDICINE PRACTITIONERS BY PATIENTS WHO USE BOTH TRADITIONAL AND ALLOPATHIC MEDICINE AT SELECTED HOSPITALS IN GAUTENG, SOUTH AFRICA.

The above-mentioned study is noted and permission granted. The research may be undertaken at Bheki Mlangeni District Hospital. Bheki Mlangeni District Hospital pledges to provide the required support in terms of access as well as guidance, should it be needed.

Kind regards

Dr. WT. Mngomezulu

Clinical Manager (Bheki Mlangeni District Hospital)

011 241 5879

Date: 22/11/2021

Appendix 8a: Letter of request for permission to the CEO of South Rand District Hospital

152 Du Plessis Street
Walkerville Manor
Walkerville
Meyerton
1876
[Date]

Private Bag X1
Rosettenville
2130
Gauteng

Dear Dr Maleka

PERMISSION TO CONDUCT THE STUDY

I am currently doing my PhD in Health Sciences at the Durban University of Technology. As a partial fulfilment of the award of the degree, I am required to conduct a research study that I chose; therefore, I request to conduct data collection at your hospital's outpatient department. I will also need permission to approach physicians working in those outpatient departments for part of the research.

The proposed title of the study is: **Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected public hospitals in Gauteng, South Africa**. This will be a qualitative exploratory study. Semi-structured interviews will be employed to collect data from participants who are Allopathic Medicine Practitioners. The study will require a minimum sample size of five participants, one from each hospital. The interview sessions will last for 45-60 minutes.

Copies of the proposal, letter of information, consent, interview guide and provisional ethics clearance are included for perusal. For any queries, please do not hesitate to contact my supervisor Dr P.B. Nkosi 031-373 2509. Her email address is paulinen1@dut.ac.za

Yours sincerely

.....
Ms L. Gumede (PhD: Health Sciences student)
Email: lindiwe.gumede@gmail.com
Tel: 011-559 6847
Cell: 082 568 2035

Appendix 8b: Approval letter from the CEO of South Rand District Hospital



SOUTH RAND HOSPITAL
1 Friars Hill Road, Rosettenville, 2149

ENQ: OFFICE OF THE CEO
T: 011 681 2008
M: 072 704 3371
E: Nobantu.Maleka@Gauteng.gov.za

To: Mrs Lindiwe Gumede

**RE: APPROVAL FOR RESEARCH STUDY: GUIDELINES FOR DISCLOSURE OF
TRADITIONAL MEDICINE USE TO ALLOPATHIC MEDICINE PRACTITIONERS
BY PATIENTS WHO USE BOTH TRADITIONAL AND ALLOPATHIC MEDICINE
AT SELECTED HOSPITALS IN GAUTENG, SOUTH AFRICA,**

The above mentioned study is noted and permission granted. The research may be undertaken at South Rand Hospital. South Rand Hospital pledges to provide the required support in terms of access as well as guidance, should it be needed.

Regards,

Dr MN Maleka
CEO, South Rand Hospital
18 October 2021

Appendix 9: Letter of information



Title of the Research Study: Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected hospitals in Gauteng, South Africa.

Principal Investigator/s/researcher: Ms Lindiwe Gumede PhD: Health Sciences

Co-Investigator/s/supervisor/s: Dr P.B. Nkosi, PhD: Health Sciences (Supervisor) and Professor M.N. Sibiya, D Tech: Nursing (Co-Supervisor).

Good day,

I hope you are well.

My name is Lindiwe Gumede; I am registered as a PhD student at DUT for my PhD in Health Sciences. I would like to invite you to participate in the research. Your participation in the study would help to a better understanding regarding the disclosure of the use of both traditional medicine and allopathic medicine use to allopathic medicine practitioners.

Brief Introduction and Purpose of the Study: The aim of this study is to explore and describe the perceptions of AMPs towards disclosure of TM use to AMPs by patients who use both TM and AM and ultimately develop guidelines to facilitate disclosure of TM use to AMPs by patients who use both TM and AM.

What is Research about? This research is about non-disclosure to AMPs by patients who use both TM and AM.

Outline of the Procedures: Should you agree to take part in this study you will be required to sign the consent letter and will also, therefore, be required to answer a few interview questions regarding disclosure of the use of both traditional medicine and allopathic medicine to allopathic medicine practitioners. The choice of venue will consider convenience and comfort for you. All interviews will be conducted through semi-structured, mask-to-mask and one on one interviews using semi-structured open-ended questions. A minimum of five AMPs like you (at least one participant per hospital) will be interviewed and the session will take 45-60 minutes. Your candid responses would be greatly appreciated. Follow-up interviews may be necessary depending on the depth of information acquired from the initial interview

sessions. Once the interview is done the information will be analysed to ascertain and put together the results from all the interviews. If you would like to have access to the outcome of the interviews, please send me your e-mail address.

Risks or Discomforts to the Participant: As far as I know there is no risk to you in sharing experiences. Participants will not be subjected to any invasive procedures. The study merely involves the sharing of information about the disclosure of the use of both traditional medicine and allopathic medicine to allopathic medicine practitioners. You may withdraw from the interview at any time should you feel uncomfortable responding. You may also opt to withdraw at any given time during the study without penalty.

Explain to the participant the reasons he/she may withdraw from the Study: You should make the researcher aware as soon as you wish to withdraw. The reason for withdrawal may be stated but not required. The research may be terminated early in particular circumstances that may not be determined in advance.

Benefits The results from this study may enable better communication between patients and allopathic health practitioners to encourage proper disclosure. Traditional health practitioners may also be encouraged to follow up on details involving their patient's consultation at the hospital. This study will also be beneficial to Allopathic Medicine Practitioners because it will help identify all potential hazards that may hinder the proper management of patients using both traditional and allopathic medicine.

Remuneration: There is no money to be received by you or the researcher.

Costs of the Study: There will be no cost to you.

Confidentiality: Confidentiality will always be maintained. Only people involved in the research such as the researcher, co-researcher and supervisors will have access to the data. All participants will be assigned a special code to ensure anonymity throughout the research. You must rest assured with the knowledge that all information will be kept in a safe place and treated with the utmost confidentiality. The personal details of the participant will not be mentioned anywhere in the dissertation when the results of the study are published.

Results: The proposed guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicine may result in better outcomes in patient treatment and management by both traditional health practitioners and Allopathic health practitioners. The results will be disseminated through writing articles and publishing them in Journals. The researchers will also present the results in seminars and conferences.

Research-related Injury: There are no injuries anticipated because of this research.

Storage of all electronic and hard copies including tape recordings: All data collected will remain confidential and safeguarded. The researcher will achieve this by storing all the

data in the personal workspace (Cloud storage), which requires password access. All the data that will be stored in the researcher's personal computer will be stored under a password-protected folder and will be deleted after 5 years. All the data collected from the interviews will be analysed as soon as possible and all physical notes will be destroyed after 5 years by soaking in water to make them unreadable since the researcher has no access to a shredder.

Persons to contact in the Event of Any Problems or Queries: Please contact the researcher, Ms Lindiwe Gumede (082 568 2035), my Supervisor Dr Nkosi (031-373 2509), my co-supervisor Prof M.N. Sibiya (031-3737 2284) or the Institutional Research Ethics Administrator on 031-373 2375. Complaints can be reported to the Director: of Research and Postgraduate Support Dr L Langaniso at 031 373 2577 or researchdirector@dut.ac.za

Appendix 10: Consent



Statement of Agreement to Participate in the Research Study:

- ☐ I hereby confirm that I have been informed by the researcher, (Name of Researcher), about the nature, conduct, benefits, and risks of this study - Research Ethics 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 computerized 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
Thumbprint**

Date Time Signature / Right

I, _____ (Name of the researcher) herewith 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

Appendix 11a: Demographic data for allopathic medicine practitioners

Participant Code_____

Hospital Code_____

Date of interview_____

SECTION A: DEMOGRAPHIC DATA

1. Gender_____
2. Age_____
3. Race_____
4. Marital status_____
5. Highest qualification_____
6. Work experience (years)_____

Appendix 11b: Interview Guide for AMPs

INTERVIEW QUESTIONS

1. In your own opinion, how do you deal with patients that present with views that are different than yours regarding medical treatment?
2. What is your opinion regarding patients who use both TM and AM?
3. What will you do when you find out that your patient uses both TM and AM?
4. What is your opinion regarding disclosure of TM use by patients who use both TM and AM?
5. In your opinion what will make a patient who use both TM and AM not to disclose TM use?
6. In your opinion what will make a patient who use both TM and AM to disclose TM use?
7. What recommendations will you provide that will encourage the disclosure of TM use to AMPs by patients who use both TM and AM?

Probing questions will be guided by participants' responses during the interview session

Appendix 12: Sample of an interview transcript

Participant Code: AMP3

Hospital Code: DH2

Date of interview: 22/12/2021

Interviewer: Good morning... OH sorry, it is already after 12 so good afternoons. (Chuckle)

Interviewee: (Chuckle) Good afternoon

Interviewer: Thank you for giving me this opportunity to interview you.

Interviewee: You are welcome

Interviewer: As we have gone through the information letter before. This research is about exploring and describing the perceptions of Allopathic Medicine Practitioners (AMPs) towards disclosure of Traditional Medicine (TM) use to Allopathic Medicine (AM) by patients who use both TM and AM and ultimately develop guidelines to facilitate disclosure of TM use to AMPs by patients who use both TM and AM.

Interviewee: Ok.

Interviewer: The first part of the interview requires your demographic information. Please note that the information that I'm collecting today will not be attached to your identity, all the information will be anonymized when published.

Interviewee: Ok.

Interviewer: Please state your gender

Interviewee: female.

Interviewer: And your age.

Interviewee: Twenty-nine

Interviewer: Your race

Interviewee: African black.

Interviewer: Your highest qualification.

Interviewee: MBCHB

Interviewer: Your work experience

Interviewee: In terms of years?

Interviewer: Yes.

Interviewee: Three years

Interviewer: Thank you for the information. Now we will move on to the second part of our interview. For the second section of the interview, feel free to give as much information as possible in terms of the responses.

Interviewee: Ok.

Interviewer: So, the first question is, in your own opinion. How do you deal with patients that present with views that are different than yours regarding medical treatment?

Interviewee: For me, the most important thing is to ensure that they understand the recommended medical treatment. **(Category: provision of information to the patient)** And you know, before I can address the challenges, the first step is to determine what they haven't understood. If I can see that they have an understanding, that they have insights, that means they are making an informed decision **(category AMPs communication skills)** to refuse or have a different opinion. I understand, yes, given that we have explained the complications, as well as the consequences of not following their recommended treatment, and then we respect their rights to autonomy, as well as their right to alternative medical treatment. It is a contract and communication between me and the patient. Yeah, I always must respect the patients, so I always have to acknowledge patients' right to refuse the recommended medication.

Interviewer: OK, I see. So, what is your opinion regarding patients who use both traditional medicine and allopathic medicine?

Interviewee: They must understand that traditional medicine has complications that are not well studied and documented. Right? **(Subtheme 1.1 Lack of scientific evidence)**

Interviewer: Ok, I see. Can you please elaborate on that statement? **(Probing)**

Interviewee: Yes, traditional medicine can lead to serious complications in their pregnancy for instance, especially for maternity patients. And yeah, for maternity patients or complications or the recipient. **(Subtheme 1.4 complications because of interactions between TM and AM)** And yeah, some of them use enhancing medication to enhance labour to enhance contractility. So that may have very serious implications for the baby on the outcome of the pregnancy. So, they must know and understand that. And if they are still taking the traditional medicine that they want to take. It's fine, they must just know that it can harm the baby.

Interviewer: Ok. I see.

Interviewee: For pregnant women, I would not recommend it. I would not recommend traditional medication, especially during pregnancy, because it has not been thoroughly researched. Every pregnancy medication we use here has been studied in both animals and humans. **(Subtheme 1.1 Lack of scientific evidence)** And we are told whether it is safe to use or not. Uhm, for me to say that they can go and safely use traditional medication, I would not recommend it in my professional opinion. A pregnant woman especially should not take any medication unless it has been prescribed by a doctor.

Interviewer: So, in other patients other than pregnant patients, what's your opinion? **(Clarifying question)**

Interviewee: I only deal with pregnancy and maternity obstetrics and gynaecology patients only so. I can't comment on other instances at the moment.

Interviewer: Ok, I see. So, what will you do when you find out that your patient uses both traditional medicine and allopathic medicine?

Interviewee: Well, it still goes back to patient autonomy as well. Do you know?

Interviewer: I see. So, what do you mean by patient autonomy? (Probing question)

Interviewee: A patient's design is a holistic person, so if they choose to use other traditional medications despite their evidence, there isn't much I can do as a professional. (**Category: patients' right to choose treatment of their choice**) If I've documented in the file that the patient is taking other medications, it can help with the clinical features if there are any complications.

Interviewer: So, what is your opinion regarding disclosure of traditional medicine use to AMPs used by patients who use both traditional medicine and allopathic medicine?

Interviewee: So, in my opinion, they need to disclose so that we can understand the clinical outcome. If they don't disclose, it creates problems for us, you know, so we don't know how complications began, how they resulted, how they got to be the way that they are so. Regarding disclosure, they have to disclose. Whether the health practitioner agrees with them or not, disclosure is very important.

Interviewer: OH, I see. So, in your own opinion, what will make patients who use both traditional medicine and allopathic medicine not disclose their use of traditional medicine?

Interviewee: Patients do not disclose primarily due to responses from healthcare workers. And they are most afraid of being judged. They believe they will face legal consequences for their decision to use traditional medication. **Theme 2: Practices of AMPs when consulting with patients who use both TM and AM without disclosing – Subtheme 2.2: Stigmatising TM use – Category: Alleviating the stigma** Uhm, also because they don't know what they are taking to be honest in terms of traditional medicine, they are given whatever it is that they're given, and even they can't explain what is it that they're taking. **Theme 1: Allopathic medicine practitioners' perceptions of non-disclosure of TM use by patients who use both TM and AM – Subtheme: 1.1 Lack of scientific evidence for TM – Category lack of knowledge and understanding**

Interviewer: So, in your own opinion, what will make them disclose, what will make a patient who uses both traditional medicine and allopathic medicine disclose the use of traditional medicine?

Interviewee: Uhm, I believe if a patient discloses in a safe environment. It is our responsibility as healthcare providers to create a safe environment in which patients can disclose anything, even if it is not traditional medicine. However, whatever adjuvant treatment they are receiving, we must create a safe environment. **Theme 3: Facilitating disclosure of TM use to AMPs – Subtheme 3.1: Creating a conducive environment – Category: Free and comfortable disclosure**

Interviewer: OH, I see.

Interviewee: Traditional medication is trusted by most patients, and they rely on it. You know, if they've used it before and it worked, they wouldn't be shy about disclosing it. They will say, Now, that I'm using it (the TM), I know it works, and I can continue to use your medical treatment (AM). **Theme 2: Practices of AMPs when consulting with patients who use both TM and AM without disclosing – Subtheme 2.3: Individual belief system – Category: negative AMP responses**

Interviewer: OK, we are almost at the end of our interview.

Interviewee: OK.

Interviewer: What recommendations will you provide that will encourage the disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional medicine and allopathic medicine?

Interviewee: Uhm, can you please repeat that?

Interviewer: What recommendations, will you provide that will encourage the disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional medicine and allopathic medicine?

Interviewee: I would recommend health education about what we (AMPs) offer and how far the treatment can go. **(Recommendation)** Because there are

specific resolution medications, particularly for pregnant women. We can only get to a certain point and then we are unable to treat certain things because of their pregnancy and we are afraid of adverse reactions. **Theme 4: Procedures to encourage disclosure of TM use to AMPs by patients who use both TM and AM – Subtheme 4.2: Acknowledgement of TM practice – Category: Recognition of TM.** Because we are concerned about adverse reactions, it would be safe for them to make us aware of the conditions they think we are unable to treat. Tell us they did and took the traditional route. As a result, health education about how far our treatment can go can encourage patients to disclose any other adjuvant treatments they're receiving. **Theme 1: Allopathic medicine practitioners' perceptions of non-disclosure of TM use by patients who use both TM and AM – Subtheme: 1.4 Complications because of interactions between TM and AM – Category: Safety and risk of TM**

Interviewer: Ok, I see. So, in terms of the safe environment, can you elaborate on that statement? (Probing question)

Interviewee: We (the AMPs) should not judge patients for their own choices to allow the patient to disclose." We must recognize that patients have rights. We should also inform patients that their rights entail responsibilities. We (the AMPs) also have a responsibility to protect patients. **Theme 3: Facilitating disclosure of TM use to AMPs – Subtheme: Encouraging patients to disclose – Category: Provision of information to the patient.**

Interviewer: OH, I see.

Interviewee: Uhm...We (AMPs) have a responsibility to make sure that we are always constant, and that patient autonomy is respected. **Theme 3: Facilitating disclosure of TM use to AMPs – Subtheme: Patient autonomy – Category: facilitating patient autonomy**

Interviewer: OK, so that was the end of our interview. Thank you so much for the time that you took from your very busy day. I appreciate it.

Interviewee: You're welcome.

Appendix 13: Data management using ATLAS.ti 9 Windows software

Document manager in ATLAS.ti 9 Windows software showing document groups for transcripts and observation notes

The screenshot displays the ATLAS.ti 9 Windows software interface. The top menu bar includes options: File, Home, Search & Code, Analyze, Import & Export, Tools, Help, and Documents. Below the menu is a toolbar with icons for adding documents, creating new groups, searching, and managing documents. The main window is divided into three panes: 'Explore' on the left, 'Document Manager' in the center, and 'Comment' on the right.

The 'Explore' pane shows a list of documents (D 53 to D 67) with their titles and counts. The 'Document Manager' pane shows a table of document groups with columns for ID, Name, Media Type, Location, and Groups. The 'Comment' pane is currently empty, showing a placeholder for a comment.

Document Groups	ID	Name	Media Ty...	Location	Groups
Age: 25-29 (1)	D 40	AMP1 Interview November 2021...	Text	Library	[Age: 40-49] [Ekurhuleni district [Regional] (RH)] [Ger
Age: 40-49 (5)	D 41	AMP2 interview December 2021 f...	Text	Library	[Age: 60-69] [Gender: male] [Highest qualification: Ur
Age: 50-59 (3)	D 42	AMP3 interview December 2021 f...	Text	Library	[Age: 25-29] [Gender: female] [Highest qualification: Ur
Age: 60-69 (3)	D 43	AMP4 interview Jan 2022 final	Text	Library	[Age: 50-59] [Ekurhuleni district [Regional] (RH)] [Ger
Ekurhuleni district [Regional... (10)	D 44	AMP5 interview Jan 2022 Final	Text	Library	[Age: 40-49] [Ekurhuleni district [Regional] (RH)] [Ger
Gender: female (7)	D 45	AMP6 Interview Jan 2022 Final	Text	Library	[Age: 40-49] [Ekurhuleni district [Regional] (RH)] [Ger
Gender: male (5)	D 46	AMP7 Interview Jan 2022 Final	Text	Library	[Age: 40-49] [Gender: male] [Highest qualification: Ur
highest qualification: post gr... (1)	D 47	AMP8 interview Jan 2022 final	Text	Library	[Age: 40-49] [Gender: male] [Highest qualification: Ur
Highest qualification: Under... (11)	D 48	AMP9 interview Jan 2022 final	Text	Library	[Age: 50-59] [Gender: male] [Highest qualification: Ur
Johannesburg district (DH1... (9)	D 49	AMP10 interview Jan 2022 final	Text	Library	[Age: 60-69] [Gender: female] [Highest qualification: Ur
Marital status: married (11)	D 50	AMP11 interview Jan 2022 final	Text	Library	[Age: 50-59] [Gender: female] [Highest qualification: Ur
Marital status: Single (1)	D 51	AMP12 interview January 2022 fi...	Text	Library	[Age: 60-69] [Gender: female] [Highest qualification: Ur
Race: African/ Black (11)					
Race: Indian (1)					
Tshwane district (DH3) (10)					
Work experience : 20-24 years (2)					
Work experience : 35-39 years (1)					
Work experience : 10-14 years (4)					
Work experience : 15-19 years (2)					
Work experience : 30-34 years (1)					
Work experience : 5-9 years (1)					

29 documents

Codes created in ATLAS.ti Windows software

The screenshot shows the ATLAS.ti Windows software interface. The title bar reads 'PHD research 2022 - ATLAS.ti'. The menu bar includes File, Home, Search & Code, Analyze, Import & Export, Tools, and Help. The ribbon contains various icons for document management, search, and analysis. The 'Explore' pane on the left is set to 'Codes' and displays a list of codes with their 'Grounded' and 'Density' values. The main workspace on the right shows the project title 'PHD research 2022' and metadata including creation and editing dates, user information, and the ATLAS.ti Educational License.

Name	Grounded	Density
Marital status: married~	9	0
Mixing TM and AM~	12	1
non adherence to AMP treatment~	12	0
opinion when dealing with patients~	2	0
patient approach by allopathic medicine practitioners	1	0
patient autonomy~	18	0
Patients presenting only when complicating	1	0
Race: Black~	10	0
race: indian	1	0
reasons for disclosure~	3	0
Reasons for using TM	1	0
Recommendation: public health education~	16	0
significance of disclosure~	3	0
stigmatizing TM use~	10	0
TM and AM different~	3	0
TM as the first option~	3	0
Training of AMPs~	11	0
undermining traditional medicine~	5	0
Unspecific Dose of TM~	7	0
work experience: 14 years~	12	0

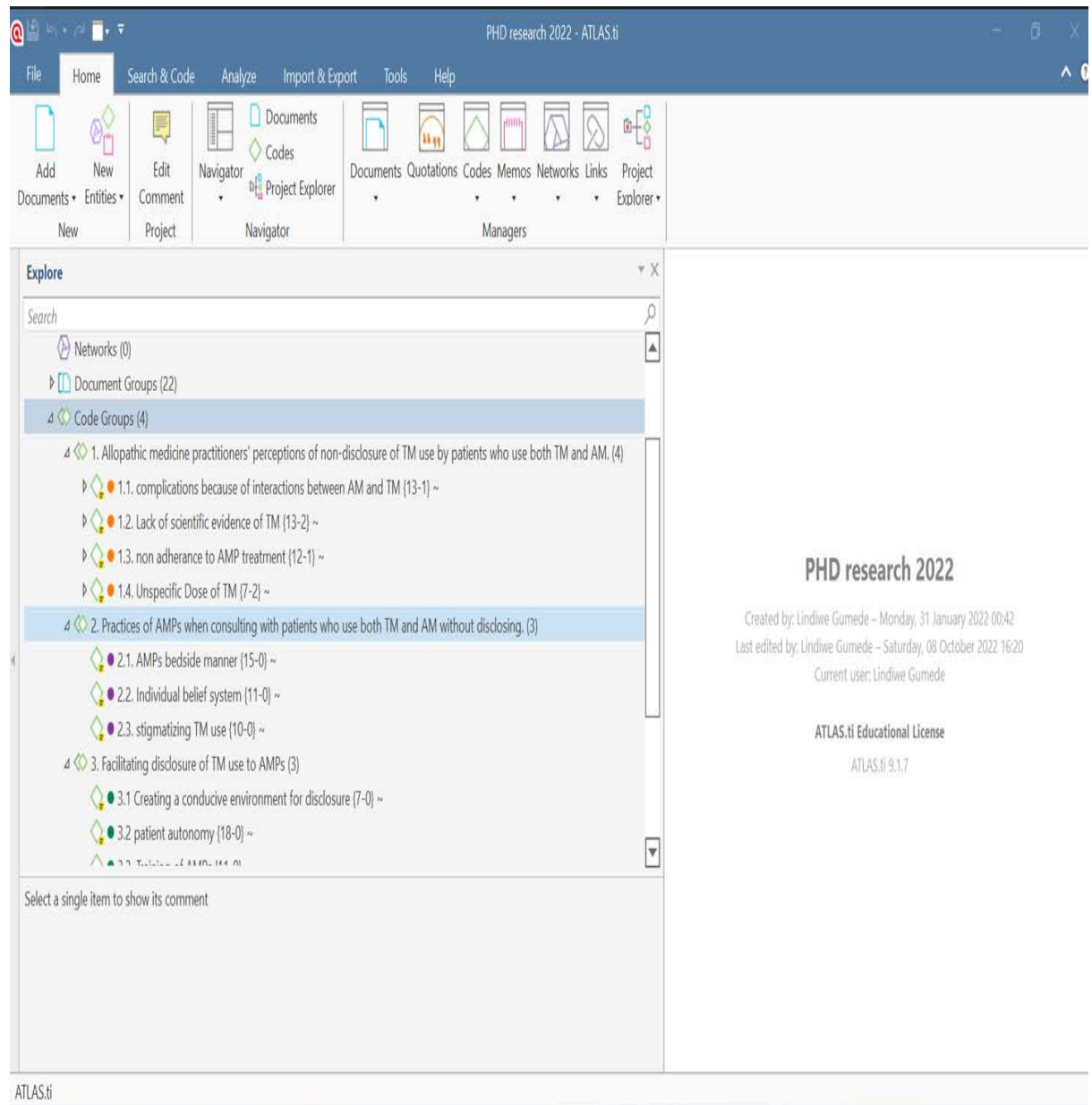
PHD research 2022

Created by: Lindiwe Gumedé - Monday, 31 January 2022 00:42
 Last edited by: Lindiwe Gumedé - Saturday, 08 October 2022 14:28
 Current user: Lindiwe Gumedé

ATLAS.ti Educational License
 ATLAS.ti 9.1.7

ATLAS.ti

Code groups presenting colour-coded themes and subthemes in ATLAS.ti Windows software



Appendix 14: Certificate of a professional editor

October 2022

To whom it may concern

I hereby declare that I have edited the dissertation entitled "Guidelines for disclosure of traditional medicine use to allopathic medicine practitioners by patients who use both traditional and allopathic medicines at selected hospitals in Gauteng, South Africa" written by Lindiwe Gumede for the Philosophiae Doctor in Health Sciences in the Faculty of Health Sciences at the Durban University of Technology.

The onus is, however, on the author to make the changes suggested and to attend to the queries.

Glenda Buncombe

BA(Trans), Rhodes University

Appendix 15: Turnitin report

L Gumede Thesis resubmission			
ORIGINALITY REPORT			
6%	5%	4%	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS
PRIMARY SOURCES			
1	etd.uwc.ac.za Internet Source	<1 %	
2	www.ncbi.nlm.nih.gov Internet Source	<1 %	
3	opus.lib.uts.edu.au Internet Source	<1 %	
4	uir.unisa.ac.za Internet Source	<1 %	
5	vital.seals.ac.za:8080 Internet Source	<1 %	
6	hdl.handle.net Internet Source	<1 %	
7	www.science.gov Internet Source	<1 %	
8	www.scielo.br Internet Source	<1 %	
9	pdfs.semanticscholar.org Internet Source	<1 %	