

# Indigenous Health Systems and Adolescent Sexual Health in Umguza and Mberengwa Districts of Zimbabwe: Community Key Stakeholders' Perspectives

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**ABSTRACT:** Different stakeholders play varying roles in shaping up adolescent sexual behaviours that, in turn, influence their sexual experiences. In Zimbabwe, it has been reported that adolescents from cultural districts exhibit poor sexual health outcomes as compared to other districts. Therefore, this study sought to explore the role of different key community stakeholders in the indigenous health system and how it impacts on adolescent sexual health issues. The study further explored how the indigenous health system could be integrated into the modern health system. A qualitative cross-sectional survey was conducted on purposively and snowballed respondents in Umguza and Mberengwa districts. Interviews and focus group discussions were used to gather and record data from participants. The recorded data were transcribed verbatim, translated to English, coded and thematically analysed on MAXQDA Analytics Pro 2020. Four superordinate and 12 subordinate themes emerged from the data during analysis. Stakeholders play varied roles in adolescents' upbringing and support though there are contradicting teachings from the indigenous health system and modern health system. It is possible to integrate these two systems though there were foreseen logistical challenges and clashes in the values and belief systems. Participants made suggestions on how these challenges could be overcome. There is a window of opportunity to pursue the suggested ways of integrating indigenous health systems and modern health systems for improved adolescent sexual health outcomes.

**KEYWORDS:** Adolescent, indigenous health systems, sexual health, community, stakeholders, Zimbabwe

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## Background

Adolescent sexual health (ASH) outcomes are a global concern, with many countries struggling to provide adequate services that cater to adolescents.<sup>1–3</sup> Globally, governments have failed to sufficiently meet their goals on devising robust programmes that foster safe sexual behaviours in adolescents and yet at the same time equipping different stakeholders with sufficient skills for proper parental protective actions.<sup>2</sup> Several studies have explored how different country settings include as many ASH management stakeholders and how this impacts adolescent sexual behaviours both positively and negatively.<sup>1,2,4,5</sup> Some programmes implemented have shown varying success or failure rates of ASH programme interventions being influenced by socio-demographic characteristics of parents, guardians, and different stakeholders involved in the adolescents' lives.<sup>1,5–7</sup>

Religion, culture, and political scenarios in different communities in different countries have also been reported to influence adolescents' behaviours, practices and experiences to a certain extent as far as sexual health (SH) are concerned.<sup>2</sup>

Health systems (HSs) that are in place in different country settings also do play significant roles in shaping adolescent sexual behaviours and practices.<sup>8,9</sup>

In Zimbabwe, there are two recognised HSs: the indigenous health system (IHS), which is run by traditional healers, herbalists, traditional attendants, community leaders, and community members.<sup>10</sup> The IHS is readily accessible to community members, particularly those marginalised, therefore commanding a considerable proportion of users in different districts.<sup>10–12</sup> The second system is a modernised HS run by trained personnel such as nurses, doctors, and many more who would go through formal training in their line of work.<sup>11,12</sup> The 2 systems are regulated by boards such as the Health Services Board (HSB) and the Zimbabwe National Traditional Healers Association (ZINATHA).<sup>13</sup> However, these systems run parallel, having minimum collaborative effort in the management of ASH issues.<sup>13</sup>

The abstinence-only before marriage approach is usually preached amongst religious communities in Zimbabwe.<sup>1,5,14</sup>



## Mberengwa and Umguza Districts Area Map

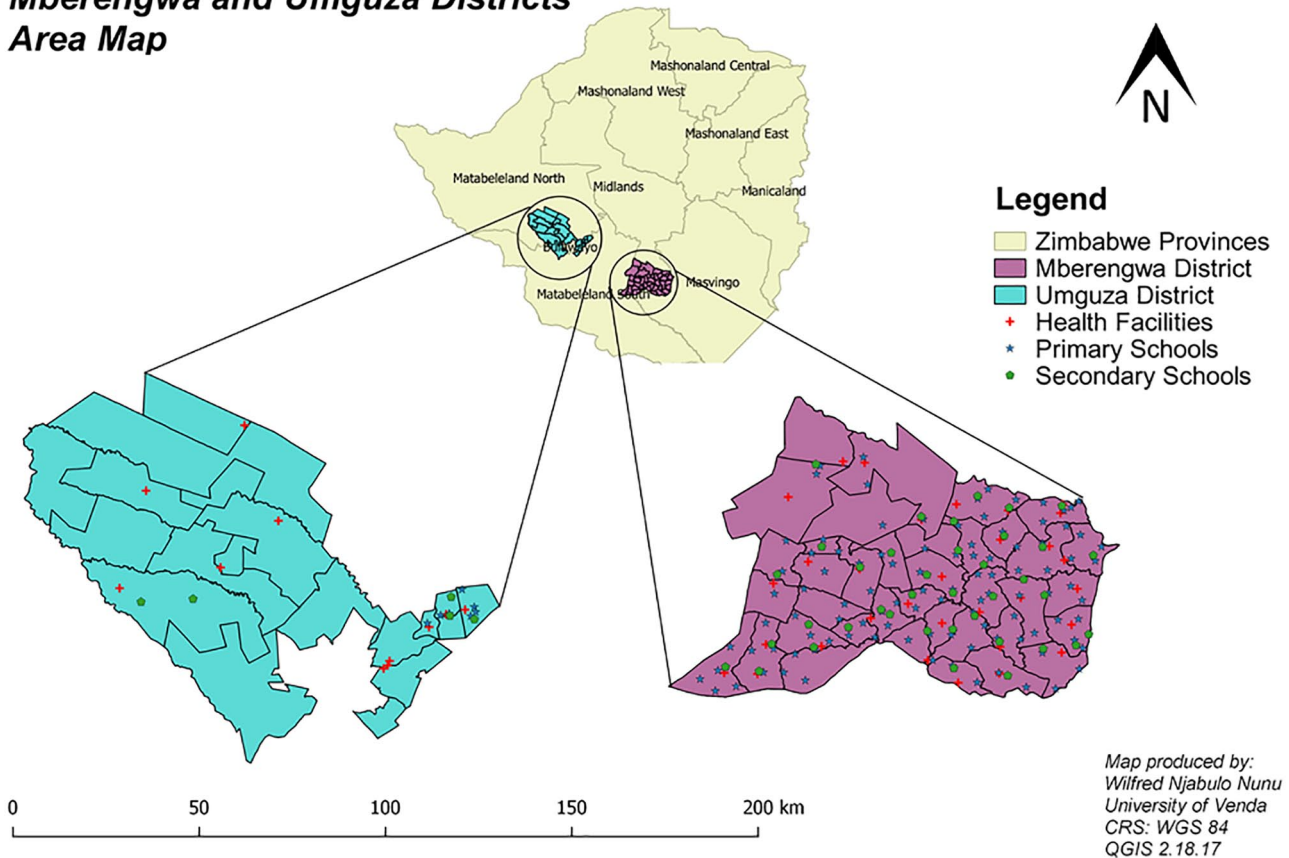


Figure 1. Mberengwa and Umguza districts, Zimbabwe.

However, in some cultures, adolescents' lives and futures are at risk from cultural activities that promote early sexual engagement, such as marrying them early to fulfil cultural obligations.<sup>15,16</sup> Different stakeholders in the communities play a significant role in shaping adolescent sexual behaviours in Zimbabwe.<sup>5,17</sup> Statistics regarding ASH outcomes in Mberengwa and Umguza show that these 2 districts have been fairing badly compared to some communities in the country.<sup>5,15</sup> Adolescents in these two cultural districts have the highest prevalence of teenage pregnancy and a high prevalence of sexually transmitted infections (STIs).<sup>15</sup> This obtaining scenario undermines the progress of attaining Sustainable Development Goals number 3 and 10, which deals with ensuring good health and well-being for all ages and reducing inequalities within the country, respectively.<sup>18</sup>

This study, therefore, sought to explore the role that different key community stakeholders play in the ASH issues. The inquiry further sought to gain insights into what needed to be done to integrate IHSs and modern health systems (MHSs) in managing ASH issues and the foreseen challenges thereof from the critical stakeholders in the communities. The study further solicits critical stakeholders' opinions into what needs to be done to overcome the obstacles they would have mentioned, if any, to improve ASH

outcomes. This study was part of PhD studies guided by a published study protocol.<sup>19</sup>

## Methods

### Study setting

The study area targeted was Mberengwa and Umguza districts that had high prevalence rates of teenage pregnancy and STIs among adolescents (Figure 1).<sup>10,15</sup> The two districts are highly cultural and perform different activities as far as adolescent sexual development is concerned.<sup>6,10,20</sup> In Umguza, there is a cultural activity called *Umguyo*, a celebratory ceremony in recognition of the rite of passage to circumcised adolescents as they graduate to manhood.<sup>21</sup> The Xhosa tribe does this ceremony, and young women/adolescents are also invited to the ceremony to celebrate the young boys' passage from adolescence to manhood.<sup>21</sup> In Mberengwa, cultural initiation is also done following guidance from traditional leaders, traditional healers, herbalists and traditional attendants.<sup>22</sup> This cultural trait is expected in the *Varemba* tribe that are dotted around the District.<sup>10,23</sup> However, the IHS in these 2 districts plays a significant role in ensuring access to health care by different community members regardless of the tribe.<sup>10,21,23</sup> For example, local leaders, the kraal heads, and many more that the

government recognises under the Ministry of Local Governance.<sup>24-27</sup> Different tribes are found in these districts, with the majority of the people surviving through peasant farming.<sup>10,21</sup> The Northern and southern parts of Umguza (such as Nyamandlovu) experience a lot of migration as most breadwinners seek employment in neighbouring countries such as Botswana South Africa.<sup>28,29</sup> There are intense migration activities in these areas as the breadwinners send goods through the services of cross-border transporters, popularly known as *Omalayitsha* in the local language.<sup>30,31</sup> The rate of school drop-outs by adolescents in these districts is high.<sup>29</sup>

### Study design

A qualitative cross-sectional survey was conducted in Umguza and Mberengwa district to answer the stated objectives. A qualitative inquiry was chosen as it enabled the respondents to give as much information as possible and allowed the researcher to probe further and understand issues that were of interest regarding ASH.<sup>32</sup> This design also enabled the identification and follow-up of critical informants that played an essential role in ASH management.<sup>33</sup>

### Study population and sampling

This research targeted key stakeholders that played a role in the upbringing and taking care of adolescents. Therefore the study focussed on all stakeholders in the community who had a role to play in ASH management. This inclusion criterion gave a total of 21 traditional leaders (ie, chiefs; 16 from Mberengwa and 5 from Umguza), herbalists, traditional attendants, parents, and legal guardians of adolescents in these 2 districts. Purposive sampling was used to target and recruit chiefs as they are well known; snowballing was used on traditional healers, herbalists, and traditional attendants. Some are not formally registered, and many are secretive about their operations. Parents and legal guardians were purposively selected; that is, only those that had adolescents under their care qualified to be part of the study.

### Data collection tools

Data was collected from the respondents through interviews with traditional leaders, traditional healers, herbalists and traditional attendants. The interviews were done as guided by the interview guide developed in line with the stated objectives of this research. Interviews were conducted in the language that the respondent was comfortable with English, Ndebele, or Shona, as they are the three main languages spoken in Zimbabwe.<sup>34</sup> The interviews lasted for an average period of between 15 minutes to 1 hour 30 minutes. Ten focus group discussions (FGDs) were also conducted in the two districts: 5 in Umguza and 5 in Mberengwa Districts. These FGDs had a 50-50 percent representation of males and females (so each group would have 5 females and 5 males). The researcher ensured that only 1 parent

from a family was selected to minimise bias and dominance. The FGDs lasted between 45 minutes to roughly 2 hours in cases where respondents were debating. These interviews and FGDs were recorded using a digital tape recorder with prior permission from the participants.

### Data management and analysis

The data collected from the interviews and FGDs were transcribed verbatim and then translated into English and transcripts exported to MAXQDA Analytics Pro 2020 for coding and thematic analysis. Superordinate and subordinate themes were there for identified, developed, and presented as results in line with the background's objectives.

## Results

### Characteristics of participants

Fifty-eight key stakeholders were interviewed. Their ages ranged between 28 and 101 years. The participants' key characteristics are presented in Table 1. All the 10 FGDs were conducted though 1 had 9 participants after 1 female participant withdrew after being notified of a close family member's death during the discussions and had to be excused in Mberengwa.

### Themes that arose from data

Four superordinate themes were obtained as guided by the objectives and the interview guides. Furthermore, 12 subordinate themes were obtained under the 4 superordinate themes as summarised in Table 2. These themes are presented in-depth in the result sections that follow.

*The Role played by stakeholders.* Three subordinate themes emerged under the superordinate theme 'role played by stakeholders in ASH related issues'. These are detailed below.

*Teaching, discipline, and grooming.* A subordinate theme that emerged on the roles of the different stakeholders on ASH-related issues was grooming and disciplining adolescents, hence, as they adopt specific prescribed values that are expected of them by society. Participants explained that they are responsible for grooming, teaching and disciplining the adolescents in the community or family expectations. Under this subordinate theme, participants further cited that though they are meant to ensure they groom adolescents in dignified ways, they have encountered a lot of challenges that hinder them from doing everything to the best of their ability. It also came out that grooming adolescents are torrid since many competing value systems lead to some parents and guardians giving up.

### Participants said:

*'It is our role to ensure these children are taught ways of behaving themselves as they are growing up. They meet a lot of new enticing things that they should be made aware of to make smart decisions'.* Participant 3, Male (87 years), Interview.

**Table 1.** Characteristics of respondents.

RESPONDENT TYPE	MBERENGWA	UMGUZA	TOTALS
	MALE (FEMALE)	MALE (FEMALE)	MALE (FEMALE)
Interviewed			
Traditional leaders	10 (0)	2 (0)	10 (2)
Traditional healers	12 (2)	9 (1)	21 (3)
Herbalists (and some of who double up as prophets)	4 (4)	3 (1)	7 (5)
Traditional attendants	2 (4)	3 (1)	5 (5)
Totals	28 (10)	17 (3)	45 (13)
Grand total	58		
Participated in focus group discussions			
Parents/guardians	25 (25)	25 (24)	50 (49)
Totals	50	49	99

**Table 2.** Summary of emerging themes.

SUPERORDINATE THEME	SUBORDINATE THEMES
The role played by stakeholders in ASH related issues	Teaching, discipline, and grooming Upkeep protection and support Treatment of STIs and other conditions
Integrating IHS and MHS	Improvement of management of ASH issues Existing gaps
Foreseen challenges	Mistrust and pride Logistics
Overcoming challenges	Collaborations through establishing committees Aligning programmes and respecting stakeholders Referrals Establishing consultation rooms for indigenous practitioners in health facilities Development of terms of reference

*‘Even though most of our children engage in sexual activities early, at the homes, we try by all means to exercise control in as much as we can to teach them about sex, its associated consequences as well as how they could stay safe. We even have teaching sessions in our churches that emphasise abstinence and give information regarding issues relating to sexual health in general’.* Participant 65, Female (44 years), FGD.

*‘We had our ways culturally of ascertaining whether or not the adolescent had engaged in sexual activities; for instance, the aunts were responsible for checking the girls. Nowadays, it isn’t easy to follow through all these processes as there are now new value systems that differ from our belief systems, such as the new Christian religion. All these things are not permitted there’.* Participant 1, Male (101 years), Interview.

*‘We are blaming this so-called civilisation that you educated people bring in and make the policies. It is difficult now to discipline our children as the laws no longer permit. If you slap a child, you are arrested for child abuse. In our yesteryears, we would be disciplined by our elders,*

*and they would suffer no consequences as they would have been grooming their children’.* Participant 1, Male (101 years), Interview.

*‘Our role of grooming and disciplining our kids has been taken away from us. Isn’t now the children belong to the state? What role then do we play since these kids only belong to us for feeding purposes?’.* Participant 15, Male (88 years), Interview.

*‘We no longer have total control of our children as indigenous people. We are blamed if we fail to groom our children properly but are we allowed to teach them our ways of living?’.* Participant 12, Female (56 years), Interview.

*‘Our children have been polluted by these cultures of civilisation that you are teaching them at your schools. You have ensured they unlearn all the values we instil in them as they grow up and dismiss our indigenous ways as uncivilised. Do you then blame us for them engaging in sexual activities early?’.* Participant 59, Female (46 years), FGD.

*'This task is daunting as most issues are prescribed to us by the government on how we raise our kids with the new things coming up; it is difficult to be an effective parent. Most of us have given up; we teach the kids one thing culturally; at their schools, they are told that what we taught them does not work; it is outdated. What more could we do? Our kids nowadays reach puberty after having sexual intercourse multiple times. They do not have time to mature properly.'* Participant 85, Male (62 years), FGD.

**Upkeep, protection, and support.** It emerged that stakeholders play a significant role in the adolescents' upkeep and do their best to protect them from the social ills that might tempt them to engage in early sexual activities. Participants further cited that most stakeholders fail to ensure they meet their obligations, thus putting the adolescents' sexual health at risk from sexual predators. These predators would use money as bait to lure the adolescents and coerce them into engaging in sexual activities since there are illegal mining activities in those 2 districts. Participants cited that due to poverty, some of the adolescents are forced to fend for themselves, resulting in them being exposed to abuse as their parents or guardians would have less control over their lives and the decisions they make. Participants also cited that due to the generational gaps and advancements in technology, most of the strategies they were using to raise their children were no longer effective. They are viewed as outdated and inappropriate by the children themselves and other members of the societies, making raising children challenging. Participants further cited that adolescents now have access to offensive content in their cellular phones that the elderly cannot monitor properly.

**Participants said:**

*'We are no longer able to take most of our kids to school. Most drop out from school at an early age as the monies we are getting or making is meaningless. In such a situation, what do they spend their days doing except thinking of marrying or engaging in sexual activities.'* Participant 80, Female (38 years), FGD.

*'How do you protect your adolescent, yet you can't even provide for them? Some even make more money than their parents through illegal mining. Automatically they become our breadwinners at an early age. Can you then tell the breadwinner what to do yet you depend on them?'* Participant 67, Female (52 years), FGD.

*'I am expected to protect my niece, who stays with me. But as you see, I am very old, and she can cheat me. Her parents sent her a cellular phone that I can't even operate. I am not sure who she will be communicating with. But at the end of the day, I have to look after her though there is nothing I can do if she goes astray. I no longer have the energy to run around disciplining her; therefore, I am no longer able to protect her.'* Participant 52, Female (81 years), Interview.

*'I am taking care of my adolescent as well as her child and supporting her. She was emotionally traumatised as she was a victim of an unforeseen circumstance. We have no choice but to provide emotional support as well as financial support for the upkeep of her and my nephew.'* Participant 91, Female (43 years), FGD.

**Treatment of STIs and other conditions.** Another subordinate theme that arose was that most traditional healers and

herbalists were usually involved in ASH-related issues by providing services to treat STIs that would have bedevilled the adolescents. Herbalists also cited that they assist with herbs to alleviate period pains in female adolescents and treat ailments related to the reproduction systems.

**Participants said:**

*'We only get to see most of these adolescents when they come accompanied by their parents or in private to seek treatment of STIs. They will be at advanced stages and rotting with these STIs.'* Participant 4, Male (77 years), Interview.

*'We have ways that we use to treat STIs as the adolescents are given herbs that are meant to act as laxatives as well as clean or wipe off the STIs. However, if not properly done when we approach spring, the STIs would reappear again. We have different types of STIs, so one has to be sure to give appropriate medication in the right doses for each.'* Participant 10, Male (28 years), Interview.

*'During our times, we would not rush to engage in sexual activities, our parents would instil fear in us we would be told that engaging in sexual activities was wrong we would get burnt, so we wouldn't even dare until one is around 20 years old thereabout. Nowadays, we treat even the ten-year-olds, meaning that they would be having on average two to three kids by the time they get married. Nowadays, kids do not have that respect for society or themselves.'* Participant, 13, Male (92 years), Interview.

*'They normally come when they are having period pains (Isilumo); however, I'm not sure what causes it though we have a remedy for those conditions. We also treat ailments relating to the uterus or cervix in women, including these adolescents.'* Participant 50, Female (63 years), Interview.

**Integrating IHS and MHS.** Two subordinate themes emerged under this superordinate theme, and these are described in detail below:

**Improvement of management of ASH issues.** Participants cited a need to integrate the 2 systems as they felt it could improve the management of ASH issues though there were differing views. Participants felt IHS and MHS currently pull in different directions in managing ASH issues, thereby making it challenging to attain the desired ASH outcomes. Participants also cited that safer methods could be adopted due to this integration as most utilised methods, particularly in traditional circumcision, can predispose the adolescents to infections. Participants in the IHS cited that they provide services to those who need them at a charge even though you are attended to if you do not have money.

**Participants said:**

*'I think this integration could do more good than harm. Remember, most traditional circumcision methods are not standardised; we have witnessed many adolescents suffering from infections due to sharps sharing and many more. The procedures are done, yes but are they safe? Through integration, we would work together to ensure that such procedures are done safely and in a safe environment.'* Participant 135, Male (42 years), FGD.

*'The biggest problem is that the MHS looks down upon our traditions and feels that our ways of doing things are uncivilised. What you should*

be aware of is that we have been practising our traditions since time immemorial. We were able to control our kids and even let them marry at an age that is appropriate and marrying into families that have solid reputations that share the same values as us. Nowadays, even our adolescents die at an early age because they are taught about sex very early in the MHS and the schools, thereby corrupting them. We have no problems collaborating with though as long as they would not undermine our traditions'. Participant 1, Male (101 years), Interview.

'Majority of times when they are alright, they think of us traditional healers as witches; we only get to see them when something is wrong with their sexual being'. Participant 7, Male (56 years), Interview.

'As an educated person, you, the researcher would you want to come to consult me instead of going to the health facility? Don't you see me as a witch?'. Participant 40, Male (74 years), Interview.

**Existing gaps.** Participants cited that there are now many gaps that lead to adolescents engaging in sexual activities at an early age due to loopholes in the different systems where adolescents are taught different things. Participants had mixed feelings on this aspect, calling for collaborative efforts between different health systems to align programmes and make them worthwhile. Others argued that the government should relax the regulations to allow the IHS parents and guardians to have a level of control over their adolescents, including permission to discipline them. Participants cited a need to integrate IHS and MHS as this could potentially reduce clashes that are currently existing as there would now be having a common goal after integration and a clear roadmap on how to achieve these goals in as far as management of ASH issues is concerned.

**Participants said:**

'They should be teamwork between us the parents, our traditional healers, and leaders as well as the clinics and schools because I feel like what our children are now being taught at school is inappropriate. I have an 11-year-old they now taught about sex because they learnt it at school. Is it not too early to teach them about sex at that age? What would be next is they would want to try it out. If we tell them it is taboo, we cannot talk about it; they will ask you what is taboo and what would happen if I go ahead and do it? When we grew up, we would not challenge our parents or elders what they would say goes'. Participant 55, Male (72 years), Interview.

'I usually refer to some of my patients to the hospital, particularly those I would realise are likely to be HIV positive. I do not want to cheat them and lie to them that they are bewitched if I see that there is a possibility they have HIV and AIDS. Therefore I already have a good working relationship with nearby health facilities as I also go to health facilities sometimes. There are certain conditions that you would see that one needs a health facility, mainly if one is wasted and needs blood or fluids'. Participant 58, Female (72 years), Interview.

'If we are to integrate these two systems as the Indigenous healers would become extinct as we are not properly recognised and are looked down upon by different stakeholders, including our government. I found herbs that could alleviate the symptoms of CORONA, but when I talked about it, I was a laughing stock. How do you collaborate with people who undermine your efforts, yet we are the first port of call when they

are sick? Would we be able to work together? If so, then that would be for the benefit of the adolescents, surely? Participant 5, Male (83 years), Interview.

'What you should note is that we usually provide services at a charge, but we do not turn back those that do have the money. We sometimes take payment in kind, for example, livestock. However, sometimes, even if the resources do not permit, we are a community, and services are provided and payment done later on when the situation improves. This is different from how health facilities operate; consultation fees are required upfront. No payment, no service. This integration provides a window of opportunity for us to address these challenges for the benefit of our adolescent collaboratively'. Participant 42, Male (67 years), Interview.

'This integration could address a lot of issues as all stakeholders are bound to pull in one direction. As it currently stands, we rarely collaborate with the MHS as the IHS'. Participant 50, Female (63 years), Interview.

**Foreseen challenges.** Two subordinate themes arose from the findings under the superordinate theme: foreseen challenges integrating IHS and MHS. These subordinate themes are discussed in-depth below:

**Mistrust and pride.** Different beliefs and values were reported as some of the foreseen challenges that could derail the integration. Some respondents cited that the IHS and MHS are premised on parallel values where there is no trust between the 2 systems' actors. The respondents cited that though they acknowledge these systems' existence, integrating the 2 systems could be hindered by the superiority complex where actors of each system look down upon each other.

**Participants said:**

'It is said that some healthcare providers only come to seek our services as traditional healers at night. They come in the cover of darkness. They do not want to be seen in broad daylight seeking our services. How then can we work together when there is that element of shame? Participant 5, Male (83 years), Interview.

'As someone who runs a surgery and trusted by many locals, why do I have to be seen begging to work with nurses and doctors who are usually in denial that our methods work? They look down upon us, yet their tablets are made from the same components of plant roots and leaves that we use to treat our clients? We are regarded as uneducated and uncivilised'. Participant 1, Male (101 years), Interview.

'I do not see myself leaving my established surgery to go and be humiliated through working with modern health service providers. They do not believe in our ways'. Participant 52, Female (82 years), Interview.

'I would prefer my adolescents to use modern health facilities as there are treated with medicines that have a specific dosage. Our indigenous health systems do not have a specific dose when it comes to their medicines. For example, when one is treated for STIs, you are told sometimes to drink a concoction; you can down three cups of that concoction in a single go. How do you know whether the dose is sufficient or you have overdosed? Would that not lead to some side effects or inadequacy of treatment leading to resistance? This is the biggest challenge with our

traditional ways because the treatment is not standardised'. Participant 104, Female (35 years), FGD.

**Logistics.** Participants cited another challenge that could potentially hinder the collaborative efforts between IHS and MHS as logistically related. Participants had mixed feelings on this issue. Some felt the integration is simple and straightforward without any logistical glitches. In contrast, others thought they could be potential challenges in ensuring the integration is smooth and the transition process accommodative and straightforward.

**Participants said:**

*'Integrating these two systems would ensure that there is effectiveness in how we manage the health of our adolescents in as far as sexual issues are concerned. We will ensure that we have a common way of assisting them, and we complement each other. In the current scenario, if one seeks treatment from HIS and something goes wrong, or you are not completely healed, we do not disclose such information when we seek treatment from the MHS. I, therefore, do not see any problems in integrating these two systems'.* Participants 150, Male (55 years), FGD.

*'I foresee a challenge where both these two systems would fail to relate as they are premised on different ideologies and belief systems. How then do they work together? What measures would be put in place for the checks and balances? Who reports to who and who supervises who? These issues might be standardised if this is to be successful'.* Participant 112, Male (42 years), FGD.

**Overcoming challenges.** Five subordinate themes arose under this superordinate theme. Participants felt that there were several ways in which the foreseen challenges stated above could be overcome. These are discussed in-depth below:

**Collaborations through establishing committees.** Participants felt that one way to overcome the foreseen challenges discussed above would be to establish committees that would include different stakeholders (IHS, parents/guardians, representatives from churches, teachers, Non-Governmental Organisations (NGOs) deal with ASH programmes, the local Police and research institutions. Participants felt having such committees that meet at times that are agreed (eg, month, quarterly or bi-yearly) could help tailor and assess issues that affect adolescents and brainstorm on appropriate measures to deal with them.

**Participants said:**

*'Having such committees helps share information and build trust through designing and implementing programs that all stakeholders would support'.* Participant 112, Male (42 years), FGD.

*'We used to have committees in our districts spearheaded by the NGOs that were implementing adolescent-friendly programs that addressed even their sexual issues. However, these committees are usually temporary as they die a natural death after the NGOs pull out of the programs or exhaust funding, or decommission the program. These committees did not have representatives from all the stakeholders; thus, it was usually difficult to comprehensively deal with ASH-related challenges or programs as sometimes we would be ignored as people who run the HIS. Reviving these committees and ensuring there are fully functional, inclusive, and sustainable would be key to prevent the collapse of these ASH programs'.* Participant 98, Female (38 years), FGD.

**Aligning programmes and respecting stakeholders.** Another subordinate theme that arose suggested a need for teamwork based on aligning programmes such that there is a common objective. Participants in the IHS felt that there are not accorded enough respect in decision making regarding health issues by MHS as they are usually seen as uneducated and uncivilised. Yet, they are the ones that stay in the communities where these adolescents are brought up.

**Participants said:**

*'The biggest problem is that we have different belief systems, and several programs implemented by the IHS are different from those implemented by the MHS. We, however, have the same goal at heart; which is trying to ensure we get the best for our adolescents'.* Participant 58, Female (72 years), Interview.

*'One of the key issues that need to be addressed in these communities is the culture of us as the IHS being undermined by the MHS as they claim we are not educated. This integration could bring the hope of working together to achieve a common goal as we are all serving the same populace'.* Participant 3, Male (87 years), Interview.

**Referrals.** Participants cited certain conditions about ASH that they are unable to treat or manage at IHS level. They mentioned that fostering this integration and overcoming challenges is through having a proper referral system. Participants further elaborated that there is no need sometimes to claim you can treat anything as a traditional healer or herbalist. Participants also cited a need to revisit the idea that the government once implemented where traditional healers were given consultation rooms to work in, in their nearest health facilities. It was elaborated that this strategy was just piloted in a few districts and was never followed up. Some respondents, therefore, felt revisiting this strategy and contextualising it could foster this integration.

**Participant said:**

*'I, for one, admit that there are certain conditions that I am not able to manage as a traditional healer. Some people would come to your surgery, claiming that their adolescent has been bewitched or something. After careful assessment through consultations with the ancestors, if I see that the illness's cause is HIV-related, I immediately advise and refer the patient to the local health facility. I immediately call my niece, who is a nurse there, to expect the patient. This has improved my working relationship with the local health facility'.* Participant 50, Female (63 years), Interview.

**Establishing consultation rooms for indigenous practitioners in health facilities.** Participants cited a need to have consultation rooms in health facilities though there were mixed feelings. Some mentioned that it would be difficult to work away from their established facilities at home.

**Participants said:**

*'This provides a good platform for the integration as patients are easily referred and exchanged between the two health system and consultations done through teamwork as well'.* Participant 1, Male (101 years), Interview.

*'I do not support the idea that we need to have a consultation room in health facilities. My ancestors determine and instruct me of where and how I am supposed to work in my line of work. I derive powers from them, and they instructed me to build a place to work here in my home-stead according to their prescribed prescription. If I work from elsewhere, I will lose my powers since that place would be against my ancestors' expectations'.* Participant 1, Male (101 years), Interview.

*'Do remember that there have been efforts in some communities at some point where traditional healers were once given consultation rooms in health facilities. It didn't come to our place, but my question is, why did that arrangement fail? We don't trust each other it is as simple as all that. We, therefore, need to develop that culture of working together, that idea was noble and which could be reoriented and implemented'.* Participant 30, Male (48 years), Interview.

*'Though this did not happen in our district, IHS practitioners were given consultation rooms in health facilities in some districts though that was a trial phase and was never rolled out to the whole country'.* Participant 42, Male (67 years), Interview.

**Development of Terms of Reference.** Participants felt that for most of the challenges to be eliminated, there was a need to have drafted and elaborated Terms of Reference that would guide stakeholders on the role they will play in this integration and how they are expected to conduct themselves.

**Participant said:**

*'There is a need to have clear guidelines that are drafted and agreed upon by all stakeholders to ensure that there are ethical conduct and accountability. We need to know the boundaries of the integration and what we are expected to do and how we would be disciplined if there are acts of misconduct'.* Participant 135, Male (42 years), FGD.

## Discussion

The findings of the study suggest that different stakeholders played varied roles in the management of ASH issues. It was evident that various community members do play different roles in grooming, supporting, teaching, disciplining, and providing treatment services to adolescents. It should be noted that the majority of rural communities rely on the IHS for most of their health needs; therefore, they play a significant role in ensuring that the general populace has access to health facilities.<sup>10</sup> The way these communities are arranged fosters Ubuntu (humanity), where in most cases, parenting and the offering of services are not driven by the availability of resources but rather treat each other with dignity and assist each other.<sup>35</sup> IHS offers diversity, flexibility, accessibility and has been used in several developing countries well before colonialism and has continued to be accepted even in developed countries because of its affordability, low levels of technological input, relative low side effects.<sup>36</sup>

The study's findings also point out that there is a window of opportunity to bridge current existing gaps between IHS and MHS, consider clashes in the 2 systems belief and values, which in turn could see an improvement in ASH outcomes. Different authors have reported in the literature that fragmented programmes or separate HSs usually fail to attain

desired results as there is a duplication of duties, contradicting values, and wastage of resources.<sup>37</sup> These fragmented HSs usually lack continuity and collaborative efforts, which creates many challenges in the management of health-related issues that need consistency in implementation.<sup>38</sup>

Envisaged challenges that could potentially derail the integration of IHS and MHS were reported to be mistrust, pride, and logistics. It was noted that different values and beliefs drove different IHS stakeholders and those in the MHS with the IHS stakeholders feeling looked down upon. It is reported in the literature that those that have enough resources prefer western medicine at the expense of the indigenous or traditional medicine.<sup>39,40</sup> In as much as there is that preference for modern medicine, IHS serves a significant proportion of the population, and the popularity of traditional medicine is gaining popularity globally.<sup>36</sup> Therefore the trust in the IHSs is improving as different uses of the system realise that most of the products do not have side effects though the majority of times, the issue of dosages has not been properly addressed.<sup>41,42</sup>

It was found that several possible ways could be used to overcome the challenges that can derail the integration. Collaborations, establishing committees, aligning programmes, respecting and mutual understanding, and drafting Terms of Reference were cited as critical in aiding this integration. The proposed strategies are consistent with the 10 principles presented by Suter et al<sup>43</sup> (2009) that also class for consideration of some of the respondents' issues in this study.

## Conclusions

There is a window of opportunity to pursue the suggested ways of integrating IHS and MHS for improved ASH outcomes. However, the tasks would need careful consideration of factors that could hinder this activity. IHS has been receiving growing attention by being accessible to the general populace, including adolescents. This system, therefore, plays a significant role in the upbringing of adolescents and the management of ASH-related issues. There is, therefore need to refine the suggested strategies further and brainstorm further on how these could be used to integrate IHS and MHS for the benefit of adolescents.

## Author Contributions

WNN is a PhD in Public Health student at the University of Venda. The author conceptualised the protocol as partial fulfilment of the requirements of the PhD requirements. LM is the Supervisor of these PhD studies, while JTM and RTL are Core Supervisors. The 3 contributed by guiding the PhD student in the conceptualisation, carrying out research, and preparing the paper. All authors read and approved the final paper.

## Ethical Approval and Consent to Participate

Ethical clearance was sought from the University of Venda's Ethics Clearance Committee (Ethics Number: SHS/19/PH/17/2608) and the Medical Research Council of Zimbabwe



(Ethics Clearance number: MRCZ/A/2611). Permission to conduct the study was also sought from the Ministry of Health and Child Care. Permission to conduct the study in the specific districts was sought from traditional leaders (Traditional chiefs and headmen). Written consent was sought from all participants.

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