

University of KwaZulu-Natal

**The practices of traditional healers in the fight
against HIV/AIDS in the Roma Valley, Lesotho**

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Declaration

This dissertation represents original work by the author and has not been submitted in any other form to another University. Where use has been made of the work of other people, it has been duly acknowledged and referenced in the text.

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ACRONYMS

AIDS	Acquired immunodeficiency Syndrome
ANC	Ante-Natal Clinic
ARVs	Antiretrovirals
CBOs	Community Based Organisations
CHWs	Community Health Workers
CHAL	Christian Health Association in Lesotho
DOTS	Directly Observed Therapy for TB
GoL	Government of Lesotho
HIV	Human Immunodeficiency Virus
LANFE	Lesotho Association on Non Formal Education
MoHSW	Ministry of Health and Social Welfare
MTCT	Mother-To-Child Transmission
NAC	National AIDS Commission
NGOs	Non Governmental Organizations
PHC	Primary Health Care
PROMETRA	Association for the Promotion of Traditional Medicine
STIs	Sexually Transmitted Infections
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
TBAs	Traditional Birth Attendants
THs	Traditional Healers
THETA	Traditional and Modern Health Practitioners Together
against	AIDS
THPs	Traditional Health Practitioners
TM	Traditional Medicine
VCT	Voluntary Counselling and Testing
UNAIDS	United Nations Programme on AIDS
WHA	World Health Assembly
WHO	World Health Organisation

Abstract

Historically colonizers made several attempts to diminish traditional healers and their practices. This was done despite the fact that before the arrival of colonizers, in many African communities, traditional healers were the sole health care providers. This yielded negative attitudes towards traditional healers that still persist today. However, traditional healers and their practices never ceased. People continued to consult traditional healers for various ailments. Even today, in this era of HIV/AIDS traditional healers continue to play a vital role in health care. Even though there are major advancements in the biomedical health care, traditional healers still provide care to people living with HIV/AIDS.

In chapter two, the study discusses the role of traditional healers in the primary health care in most African communities. Traditional healers are largely involved in the prevention of diseases as well as illnesses. Recently traditional healers are also involved in the prevention and care of HIV/AIDS, despite the fact that they feel that they are largely excluded in most HIV/AIDS activities. Chapter two also highlights International resolutions that have been adopted regarding traditional healers and traditional medicine. This marks the importance of formally recognizing traditional healers as public health care providers at an International level as well as regionally after the Alma Ata International Conference in 1976 on Primary Health Care.

The study was conducted in two areas in Lesotho, Roma and Teyateyaneng. Twenty respondents were interviewed in these areas. The study found out that there are different types of traditional healers in Lesotho who use various methods in diagnosing and treating various illnesses including HIV/AIDS. Diviners use divining bones, herbalists use herbs, faith healers use prayer as well as water. The study found out that traditional healers had different views about HIV/AIDS, particularly the definition of HIV/AIDS and its causes, Witchcraft was strongly recognised as the causal agent of HIV/AIDS. A change in one's sexual behaviour was reckoned as the major preventative measure. Hence they strongly advocated behavioural change. However they had misconceptions about condoms.

Traditional healers also provide care for people living with HIV/AIDS. In some instances, they provide home-based care, refer patients to hospitals and also encourage their patients to eat healthy.

The study concluded that some of the traditional healers' practices have positive and negative aspects. Some of the positive features include their advice to reduce sexual partners, sex abstinence particularly among young people. While negative aspects include delay in referring their patients to the hospitals. Traditional healers are not well collaborate, as a result there is no mutual trust amongst them.

Key words:

Traditional healers, HIV/AIDS, Prevention, Care.

CHAPTER 1

INTRODUCTION

1.1 THE PURPOSE OF THE STUDY

The primary purpose of this study is to examine the practices of traditional healers¹ (THs) in the prevention and care of HIV/AIDS in Lesotho. The terms “traditional health practitioners” (THPs) and “indigenous healers” will be used interchangeably with THs as they are sometimes referred to as such. The study will explore how THs’ practices are utilised in the effort to extend HIV/AIDS prevention and treatment in the country. The study will also consider whether these practices are sufficient and suitable in the prevention of HIV/AIDS in the country. In many African countries THs play a significant role in health promotion especially in areas where the population has limited access to modern biomedical services (Quaye and Kinpanda 2003).

About eighty percent of the population living in Africa use traditional medicine for their health care (Elujoba et al 2005:46, Maja 2001:2, Ndulo 2001:529, UNAIDS 2002:7, WHO 2001:2). The South African Department of Health (2004:1) states:

“Although modern medicine may be available in most countries, herbal medicines have often maintained popularity for historical and cultural reasons. Traditional medicine also continues to play a significant role in the treatment and management of life-threatening diseases such as malaria, tuberculosis and AIDS in the developing world, though no adequate scientific evidence has been documented in these specific areas”.

In addition, given the current HIV/AIDS situation in most countries in the region, there has been strong support for mobilising both biomedical and traditional health practitioners to address the complex psychosocial and physical nature of HIV infection and AIDS related illness.

¹ “A person who is recognised by the community in which he/she lives to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of diseases and disability” (WHO 1978:9)

1.2 A BRIEF OVERVIEW OF LESOTHO

Lesotho is a small mountainous country, landlocked by its neighbour the Republic of South Africa, and it covers an area of 30,355 square kilometres (Maseribane 2003:10 Moleko 2003:1)². Known as the Mountain Kingdom, Lesotho is situated between 5,000 and 11,425 feet above sea level (Moleko 2003:1). The population is approximately 2.2 million and is predominantly rural with over seventy-five percent of its population living in the rural areas (Bureau of Statistics- Lesotho 1998: 12). Lesotho is made up of ten administrative districts: Butha-Buthe, Berea, Leribe, Mafeteng, Maseru, Mohale's Hoek, Mokhotlong, Thaba-Tseka, Qacha's Nek and Quthing. It is divided into four ecological zones (see figure 1) namely: the lowlands, the highlands, the foothills, and the Senqu (Orange) River Valley (Bureau of Statistics Lesotho 2000:2). The mountains occupy about fifty nine percent of the country, and are characterized by steep topographical features and thin soils. Mountain climate is harsh with cool summers and cold winters, often accompanied by snow (Bureau of Statistics Lesotho 2000:2-3):

“The lowlands consist of areas below 1,800 metres above sea level and cover approximately seventeen percent of Lesotho's surface areas. Summers are warm in the lowlands, with occasional rain and the land is suitable for agriculture. The foothills lie at an altitude between 1,800 and 2,000 metres. They lie between the lowlands and the Maluti Mountains. They form a narrow strip that makes up about fifteen percent of the surface of Lesotho. The Senqu River Valley is a zone that penetrates deep into the Maluti Mountains and comprises about nine percent of the land area”.

² See Appendix 1

[illegible]

For a long time Lesotho's major assets were its migrant workers, but this has changed as many migrants working in South African mines have been retrenched (Ministry of Health and Social Welfare [MoHSW] 2004:1). There are however other resources utilised to boost the country's economy. According to Wilson (2001:9), Lesotho has started harnessing its other major resource, which is water, through the Highlands Water project, for export to South Africa. Since the mid-1990s which saw significant laying-off of Basotho employed in South Africa, Lesotho's incomes and remittances from migrants have been greatly reduced (UNDP 2007:56). As a result the Southern African Customs Union (SACU) has become another major income earner for the country (MoHSW 2004:1). According to Lesotho Revenue Authority (LRA) (2004: 4) Lesotho collects the customs duties for imported goods into a common revenue pool. LRA (2004:4) further states that, at the end of every year, shares are allocated to each member state according to the level of imports and exports of each. Annual intra SACU trade data import values determine each member state's share of the pooled customs duties.

Migration has a huge impact on household composition, and on food production, particularly in rural areas, poverty, as well as the spread of HIV/AIDS. Murray (1981) points out that migration separates a family: a woman has to stay at home whilst her husband is at work in the mines.

“Migration deprives the rural areas of labour and impacts negatively on production, then it is likely to increase the food security of the rural population. In most instances, migrant male household head return from an urban area ill, eventually the household experience the death of the male household head. The most vulnerable households on the other hand are likely to lose their homesteads, destitution and also the possible breakup of the household unit...If there is a remaining widow, she is likely to be weakened if she has contracted HIV from her husband” (Crush et al 2006:29).

Agriculture has been the traditional form of sustenance, but this is not sufficiently developed to make a significant contribution to economic development (MoHSW 2004:1). In recent years, Lesotho has been prone to humanitarian crises such as drought, food shortage, malnutrition, illness and unemployment (MoHSW 2004:4). According to UNDP (2007: 55) topography plays a critical role in the challenge to address food insecurity. More than eighty percent of the population live in the rural areas and depend to a large extent on agriculture for their subsistence. Rural dwellers are vulnerable in terms of their access to food, given the topography which does not favour farming. According to UNDP (2007) only nine percent of Lesotho’s land is suitable for arable agriculture and over eighty percent of this land is found in the lowlands, where it is not used for agriculture but for other purposes such as housing. HIV is one of the factors contributing to chronic food insecurity in Lesotho and other southern African countries (UNDP 2007:7). HIV/AIDS is likely to prolong or even increase poverty, in particular, at household level (Brummer 2002:6). Within HIV-affected households, there is increased risk of food insecurity and malnutrition as sick members are unable to work, incomes decline, expenditure on health care and care-giving burdens increases (Crush et al 2006:24).

The Government of Lesotho has attempted to address problems brought about by an imbalance between population and economic growth, coupled with economic inequality between groups. These measures include a five-year National Development Plan introduced in 1970, the National Population Policy 1994 and 2003, a Primary Health Care (PHC) policy adopted in 1979 which targets maternal and child health, a Poverty Reduction Strategy 2002, and Vision 2020.

In this study only the health sector development will be discussed. The Lesotho MoHSW (2004:4) reckoned that there were major improvements as far as the health sector was concerned, but all have been eroded over the last fifteen years due to HIV/AIDS and economic decline. The MoHSW (2004:4) elaborates:

There are 5,000-7,000 active community health workers providing community-based health services throughout Lesotho's rural villages (Global Primary Care 2009). There is agreement on the potential of CHW programmes to improve access to and coverage of communities with basic health services (Hermann et al 2009:2). However the supervision, re-training, and financial incentives are said to be virtually non-existent for these dedicated volunteers, although they are critical to providing healthcare in Lesotho (Quattlebaum 2009:3), which has a limited number of trained doctors and nurses: the ratio is one doctor to seventeen thousand patients (1:17,000) (Mokete 2008:3). There is some evidence, however, that although they can improve health outcomes under certain conditions, many CHW programmes have not been successful. Berman et al 1987:443, WHO 1989:10 have shown that large-scale and national CHW programmes have been beset by problems affecting their sustainability and the quality of services they provide. Many CHWs in Lesotho face obstacles in delivering care to their patients, such as insufficient educational and material resources, arduous travel and their own inadequacies (Quattlebaum 2009:3).

1.3 HIV/AIDS: GLOBAL OVERVIEW

HIV/AIDS is perhaps the most devastating disease humankind has ever faced. There is no continent left untouched by this disease. WHO (2003:44) states:

“AIDS was first described in 1981, when previously healthy young adults, mainly men living in the urban areas of the United States, began falling ill with opportunistic infections previously unknown among this age group. Similar infections were soon described in Africa, the Caribbean and Europe. AIDS was clearly an epidemic disease”.

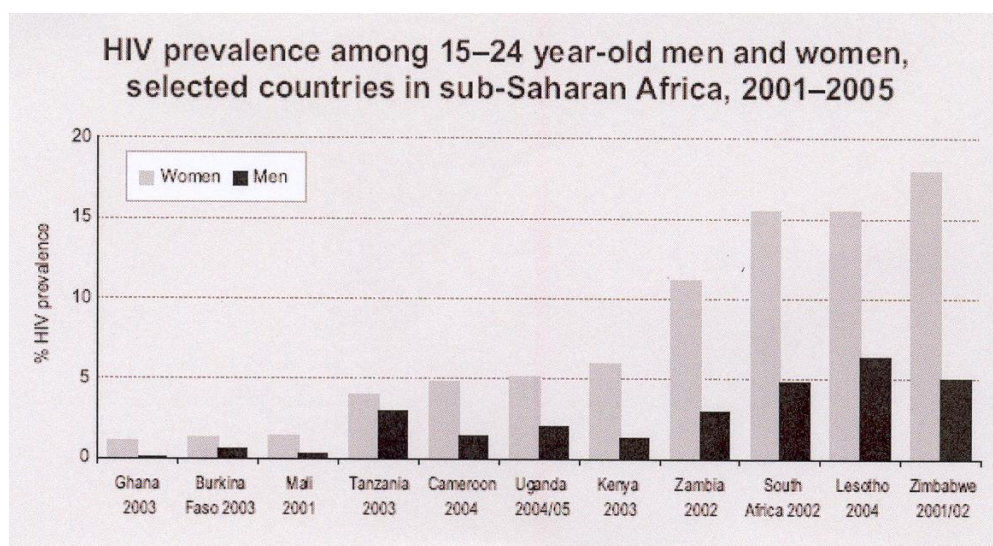
WHO (2003:44) reports that in spite of scientific achievements in the development of inexpensive diagnostics by mid-1980s, the sequencing of the entire HIV genome less than fifteen years later and the development of effective antiretrovirals by 1995, the virus continues to spread. Since the beginning of the HIV epidemic, large numbers of people have been infected with HIV (Gayle 2003:3) (see Figure 2). UNAIDS (2006:8) reports “...an estimated 38.6 million people worldwide were living with HIV in 2005. An estimated 4.1 million became newly infected with HIV and an estimated 2.8 million lost their lives to AIDS”.

Ninety-five percent of new HIV infections are found among people in developing countries due to factors “which include widespread poverty, gender inequality and health systems weakened by pressures such as large external debt loads of the individual States” (WHO 2003:45).

In Sub-Saharan Africa HIV/AIDS is spreading throughout the general population rather than being confined to specific populations which are at higher risk, such as sex workers and their clientele, men who have sex with other men and injecting drug users.

In most communities in southern Africa, women do not have the same power or control over their life choices as their male counterparts do, even in matters concerning their sex lives. Consequently men determine when to have sex or to use a condom or not. Violence against women makes them more at risk of HIV infection, as they are subjected to rape in which condoms are rarely used. UNDP (2007:53) asserts that due to minority status of Basotho women, religious and/or cultural beliefs as well as adverse economic conditions impact negatively on their health. According to Figure 2 below, HIV prevalence is greater amongst women than amongst men in Zimbabwe, Lesotho, South Africa and Zambia.

Figure 2: HIV/AIDS prevalence among 15-24 year-old men and women in selected Sub-Saharan Africa countries.



Source: UNAIDS 2005:9

There are several factors contributing to the widespread incidence of HIV/AIDS in the Sub-Saharan Africa including Lesotho, gender inequity and inequality being critical:

“In the context of gender inequality male attitudes and behaviours are currently the crux of the HIV/AIDS problem. As clients of sex workers demanding skin to skin or as husbands with the same expectation, as dominant partner in most sexual interactions and the main initiators of sexual activity, many men put personal pleasure first and

responsibility, respect and restraint a poor second. Essentially, the widespread stereotype of masculinity “machismo” and what it means to be a “real man” encourages male dominance over women, risk taking and promiscuous sex. In many cultures, ideals of manhood include strength, courage and dominance and critically accept men as having an uncontrollable sex drive that lets them off responsibility” (Jackson 2002:87).

Despite the efforts of national government and Non-Governmental Organisations (NGOs), southern African populations have been slow to adopt safer sex practices (Wilson 2001:13). But the reasons for insufficient level of behaviour change are complex. In addition, sex and sexuality are not openly discussed in many southern African countries, including Lesotho:

“In Lesotho, the reluctance of the older and more traditional Basotho to discuss sex and sexuality exacerbates the difficulty of reaching the youth through such formal channels as the public health system, churches or schools. Effective mechanisms are still lacking within these institutions to inform and encourage sexual behaviour changes among Basotho youths” (Government of Lesotho [GoL] 2002:6).

1.3.1 THE HIV/AIDS SITUATION IN LESOTHO

The first AIDS case in Lesotho was reported in 1986. Since then the disease has spread rapidly throughout the Lesotho Population (GoL 2002:24). Adult HIV prevalence has risen from around four percent in 1993 to twenty-five percent in 1999 to thirty-one percent in 2002 (Kimaryo et al 2004:67). The percentage of adults living with HIV/AIDS at the end of the year 2005 in Lesotho was twenty-three percent (UNAIDS 2006:506). Estimates of HIV prevalence in Lesotho are mainly obtained from tests done among women attending antenatal clinics and from various surveys of selected groups such as mine workers, sex workers and factory workers (Wilson 2001:10). HIV/AIDS prevalence among these groups seems to be increasing, particularly amongst pregnant women observed at

antenatal clinics (ANC) as well as among sexually transmitted infections (STIs) clinic attendants. The GoL (2002:4) states:

“HIV prevalence among the antenatal care and sexually transmitted infections of clinic attendants has increased over time in the country. From a range of 4.8%-7.1% in 1991 to a range of 34.9 %-63.5% among STI attendants while for ANC it has increased from 5.5% in 1991 to 42% in 2000”. It is estimated that every year an average of seven thousand babies are infected during pregnancy, labour and delivery as well as breastfeeding”.

Kimaryo et al (2004:69) report:

“...the majority of Basotho infected with HIV are between 15-49 years old, the most sexually active population. It is estimated that one out of three Basotho in this age group is living with HIV/AIDS. By June 1999, over 80 percent of AIDS deaths came from this age group”.

According to UNAIDS (2006:507) about 18,000 Basotho children between 0-14 years old were living with HIV/AIDS at the end of 2005 and 140,000 women aged fifteen and above were living with HIV/AIDS at the end of 2003. 9% of all new HIV/AIDS cases in 2001 were among children less than 4 years of age 4, who had contracted the virus through mother-to-child-transmission (MTCT) and also affected by the loss of a parents to AIDS. HIV/AIDS is disproportionately concentrated in urban areas: in Maseru it increased from 5.5 percent in 1991 to 42 percent in 2000, whereas in the Quthing district, the comparable figures are 0.7 percent and 23 percent (Kimaryo et al 2004:70). Hence more commercial sex workers and more people migrant from their rural homes to Maseru due to work related issues were infected. Mineworkers, migrant labourers, factory workers, their spouses, as well as young people are at risk of being infected. Sub-section 1.3.1.1 outlines some of the contributing factors as to why Lesotho is experiencing such an alarming increase in HIV prevalence.

HIV/AIDS has had a devastating impact in the country, affecting individuals, families and children and is also highly stigmatised in the country. Lebaka (2002) found that after revealing HIV status publicly, individuals in Lesotho tend to experience some form of hatred and discrimination from friends, sexual partners, people they served and family members. Some of the respondents reported that their friends no longer wanted to be in their company, while their families only allowed them to sweep or work in the garden and did not allow them to handle or cook food. Friends and neighbours laughed at them and used provocative names when referring to them such as *seja menate* (fun liker)³ (Lebaka 2002:39). Those who were in business experienced economic decline as the result of stigma. One respondent reported that she had been selling fruit, vegetables, eggs and chickens: her best customers were mainly neighbours, who stopped buying from her once they found out that she was HIV positive.

Many children in the country have been and are being orphaned by HIV/AIDS. In 2006 there were 97,000 orphans due to HIV/AIDS in Lesotho younger than seventeen years (UNAIDS 2006:392). Orphans are often rejected by their extended families and have nowhere to live (GoL 2002:10). Grandmothers or aunts may take in orphans, despite having insufficient support to meet their basic needs.

According to GoL (2002:10), “HIV/AIDS affects the most productive members of the family. It is more devastating in households specifically when the person affected by the disease in the family is the income generator”. Because HIV/AIDS is diminishing Lesotho’s human resources, it threatens its survival as a nation (Kimaryo et al 2004:20). The table below shows Lesotho death rate due to HIV/AIDS from 2003 to 2009.

³ Fun-liker refers to a person who loves parties and is most of the time at parties or at the bars.

Table 1: Lesotho Death Rate from 2003 to 2009

Year	HIV/AIDS deaths
2003	25,000
2004	29,000
2005	29,000
2006	29,000
2007	29,000
2008	29,000
2009	18,000

Source: CIA 2009:1

HIV/AIDS related deaths decreased in the country as ART coverage was scaled up as stipulated in table 2. According to Avert (2011:4) by December 2007 only 29,000 people were able to access treatment. A total of 104 sites were providing antiretroviral therapy, which included sites in remote parts of the country. In recent years Lesotho has made significant progress in treatment scale-up. By the end of 2010, the number of people receiving antiretroviral drugs was double that of 2007. In 2010, an estimated 76,487 people were receiving treatment (Avert 2011: 6).

1.3.1.1. Factors contributing to the HIV/AIDS epidemic in Lesotho.

Factors contributing to the HIV/AIDS situation in the country include high population mobility, patterns of sexual behaviour, poverty and unemployment. Cultural practices such as wife inheritance and the taking of mistresses are likely to expose partners to contracting the virus (GoL 2002:8). Moreover, there is a tendency in recent years for older men to date young women and vice versa. This puts young people at greater risk of contracting HIV/AIDS from people who have been sexually active for longer periods.

GoL (2002:8) indicates that traditional practices, such as scarification, rituals of head-shaving at funerals and mass circumcision in traditional initiation schools, if practiced without the necessary precautions, may be occasions for transmission of the virus. The most common contributory factor however to the rapid spread of the

disease is undoubtedly unprotected sex. Unemployment has led to people seeking other means of survival, such as commercial sex work, which places them at high risk of contracting HIV/AIDS.

Migrancy is another prominent contributing factor in Lesotho, especially to South African mines, and its effects arguably go beyond the economic sphere and permeate every aspect of Basotho life (Romero-Daza 1994:193). For many years men in several Southern Africa Development Community (SADC) countries have been working in the mines outside their countries of origin, particularly in South Africa. Wilson (2001:10) asserts, "...virtually every country in the SADC has migrants who work in South African mines. Lesotho, Swaziland, Mozambique and Botswana have been the longstanding sources of these migrants". These workers leave their families, probably for a year or more and live in squalid single sex hostels, where they are more likely to have other sexual partners at their work places and are therefore at higher risk of contracting the disease (UNDP 2007:54). Upon their return home, they are likely to infect their spouses. The long term separation of migrant men from their wives and families along with the dangers of mining work, and high risk behaviours help to foster aggressive masculinities and sexualities among migrant labourers (Walker et al 2004:64). All these factors have contributed to the rapid spread of HIV/AIDS both in South Africa as well as in their countries of origin.

In recent years, women are said to be migrating more than men, both internally and externally (Matobo 2002:18). UNDP (2007: 54) reports that women migrate because they are compelled by poverty. UNDP (2007:54) further indicates that people living in poverty are denied opportunities for earning regular income to cover necessities such as food, shelter and clothing. UNDP (2007: 54) explains that extreme poverty dehumanizes the individual to a point where issues of self-esteem become secondary. Many young Basotho girls are forced into commercial sex work due to poverty, which compromises the ability of households and communities to withstand the onslaught of HIV, with the burden falling disproportionately on women and girls. Romero-Daza (1994: 200) also observed

in Mokhotlong that even though women are engaged in income-generating activities such as brewing of sorghum (*joala*) or selling fruits, vegetables, and articles of clothing, their earnings are insufficient for their basic needs. Hence it is not surprising to find that multiple partner relationships constitute a viable alternative for women's economic survival (Romero-Daza 1994: 200).

A large number of female migrants from rural areas seek work in the newly developed urban industries (Kimaryo et al 2004: 71, Matobo 2002:18, for the most part in Maseru and Maputsoe in the Leribe District. Women working in the factories in Lesotho earn low wages of around five hundred Maloti (M500) (Matobo 2002:19). They have to share this amount with their children, pay rent, transport and other necessities out of this amount. This financial struggle may force women to resort to other strategies:

“Because of this low wage, they end up resorting to cohabitation with men who could support them financially. This results in broken marriages and contraction of diseases. Women move to towns to work in factories during the day and engage in commercial sex work at night. This they do as a survival strategy. With those who migrate internationally particularly those who are less educated are viewed as pervers, whose job is to go and collect diseases including HIV/AIDS and distribute them locally” (Matobo 2002:18).

This is what Hunter (2002:101) refers to as “transactional sex”, which takes place against the background of gendered economic discourses (Hunter 2001: 110):

“The privileged economic position of men, rooted in their access to the most lucrative segments of the formal and informal economy as well as to resources such as housing. These inequalities provide a material basis for transactional sex.” (Hunter 2002:101).

Due to such survival strategies, more Basotho people are becoming vulnerable to HIV infection, now generalised in the population (as opposed to being confined to

specific high risk groups). Furthermore, people tend to worry about the immediate problems rather than worrying what will happen, as illustrated by the saying in Lesotho that “by the time one dies of AIDS, at least one would have provided one’s family with basic needs such as food, clothes and shelter”. (*“Mohlang ke shoang ke AIDS, ke tla be ke ile ka fa lapa la ka lijo, liphahlo esita le ntlo.”*)

1.3.1.2 The response to HIV/AIDS in Lesotho

The Government of Lesotho is committed to strengthening its efforts against major health problems including that of HIV. In December 2005, a “know your status” campaign was launched for universal access to voluntary counselling and testing (VCT) (GoL 2005:20). In addressing infection through mother to child transmission (MTCT), the Government has integrated interventions such as VCT and management of HIV positive pregnant women in maternity health services (GoL 2004:1). In 2007 Lesotho Government with the help of UNICEF and other development partners designed a minimum package for expectant mothers which included ARV drugs and antibiotics needed to keep them and their children healthy (UNAIDS 2010:1). According to UNAIDS (2010) the coverage of prevention of mother to child transmission (PMTCT) programmes has increased from an estimated 5% in 2005 to 42% in the first quarter of 2009. Antiretroviral (ARVs) plans were developed with the assistance of the WHO country office in 2004. The Ministry of Health and Social Welfare through STI/HIV/AIDS Directorate is responsible for distributing ARVs to all ARVs centres throughout the country (see Table 2).

Table 2: Centres distributing ARVs in Lesotho

Centre	District
May 2004	
Maluti Hospital	Berea
Sankatana ARVs centre	Maseru
December 2004	
Tšepong Clinic (Motebang Hospital)	Leribe
Bophelong Clinic (Queen Elizabeth II Hospital)	Maseru
Karabong Clinic (Mafeteng Hospital)	Mafeteng
Katlehong Clinic (Ntšekhe Hospital)	Mohale's Hoek
Makoanyane Military Hospital	Maseru
January – June 2005	
Paballong clinic (Butha-Buthe Hospital)	Butha- Buthe
Machabeng Hospital	Qacha's Nek
Mokhotlong Hospital	Mokhotlong
Seboche Hospital	Butha- Buthe
Lesotho College of Education	Maseru

These centres have been established with support from the Global Fund, WHO and the Stephen Lewis Foundation. Other institutions such as Lesotho Red Cross, First Lady's Office, World Vision Lesotho, Christian Health Association in Lesotho (CHAL), Lesotho Association on Non Formal Education (LANFE) as well as other community based organisation (CBOs) in partnership with MOHSW have held home based training programmes throughout the country (GoL 2005:2). According to GoL (2005:3) people have been made aware of the provision of ARVs in the country. Mass information about HIV/AIDS has been put on billboards of which in each district there are at least two.

HIV/AIDS prevention campaigns such as "Know your status" are reckoned not to be fruitful in most African communities. Ulin (1992) argues that most of these campaigns have not yet taken into account the cultural, social and economic constraints of African communities. Varga (1997:47) observes that "for many people unsafe sex is a rational choice which is perceived to result in and safeguard benefits such as emotional intimacy, trust, legitimacy and even economic

stability”. Varga (1997:57) also observes that there is a tendency amongst KwaZulu-Natal youth where his study took place to avoid direct communication with partners about the conditions under which intercourse would take place, as the dynamic within the relationship is guided by male partners. It will not be easy, therefore, particularly for females, to encourage their male partners to know their HIV status.

1.4 STATEMENT OF THE PROBLEM

Traditionally, Basotho have always used the services of traditional healers for various health problems. Even now, traditional healers in Lesotho continue to treat illnesses and diseases, including HIV/AIDS, which is one of the major health threats in the country. As a result, the Government of Lesotho (GoL) saw a need to cooperate with some of the traditional healers in dealing with critical health issues such as tuberculosis, HIV/AIDS and condom distribution (GoL 2004:25). Questions stand out: “What do traditional healers understand about HIV/AIDS? How do they perceive condoms?” It is important to establish the degree of knowledge of traditional healers concerning HIV/AIDS. GoL (2004) states that it aims to streamline and regulate the practices of traditional healers. Which practices are traditional healers using against HIV/AIDS? In addition it needs to be established which practices of traditional healers need streamlining and regulation, and why.

1.5 OBJECTIVES

- To investigate traditional healers’ practices in the prevention and care of HIV/AIDS Lesotho.
- To explore traditional healers’ knowledge of HIV/AIDS.
- What practices are they engaging in so far as prevention and care are concerned?
- To explore whether these practices are contributing to preventative and care initiatives.

1.6 SIGNIFICANCE OF THE STUDY

The Lesotho Government as well as United Nations (UN) agencies in the country realise that traditional healers play a role in the fight against HIV/AIDS in the country. Kimaryo et al (2004:24) point out that “traditional healers have a high potential to play a catalytic role in making every Mosotho HIV/AIDS competent”. Probably this is due to the fact that most Basotho still consult traditional healers (Kimaryo2004: 25). It is widely believed that traditional healers in Lesotho are best suited for treating some diseases. They also play an active role in caring for HIV/AIDS patients. The Bureau of Statistics Lesotho (2002:20) affirms “traditional healers are among other institutions which provide home-based care for chronically HIV/AIDS ill persons, especially in the rural areas of the country”.

In recent years Lesotho has been experiencing a massive brain drain of medical personnel. More than half of serving medical doctors in Lesotho are drawn from outside the country (Mokete 2008:3). Most Basotho medical doctors train in South Africa or in other African countries as Lesotho does not have training institutions. There are four nursing institutions that serve the entire country. These are National Health Training Centre, Roma College of Nursing Maluti Adventist Nursing College, and the National University of Lesotho. In addition a community health workers’ programme was established in Lesotho to meet health care needs of people particularly in the rural areas. However the difficult terrain makes access a challenge (Kethusegile et al 2000:217).

The intention of this study is to outline what traditional healers are doing in the era of HIV/AIDS. It further explores traditional healers’ knowledge of HIV/AIDS. Most importantly, traditional healers’ practices as far as prevention and care of HIV/AIDS are outlined. Are these practices effectively contributing to preventative and care initiatives in the communities they serve?

1.7 CONCEPTUAL FRAMEWORK

The study prioritizes the influence that culture has over health and health-seeking behaviour. Why do we look to the influence of culture in society's health seeking behaviour? Geertz (1973:5) explains that culture is composed of psychological structures by means of which individuals or groups of individuals guide their behaviour, including health seeking behaviour. Culture is important in determining the aetiology and treatment of diseases (Lehmann et al 1985: 236). This is because culture is not a power, something to which social events, behaviour, institutions, or processes can be causally attributed; it is a context, something within which they can be intelligibly described (Geertz 1973:6). Just as humans beings have always suffered from diseases, they have always responded to them in particular ways. According to Hughes (1985:240) "in a number of societies, regardless of how small or technologically advanced they may be" the outbreak of any disease with unknown cure or origin may be linked with an offence against one's spirit, the ancestors or the gods or an omission of duty on the part of an infected person (Awusab-Asare et al 1997:244, Lehmann 1985:236).

Views on causes of diseases and illness vary amongst communities. Some individuals and communities understand disease to be caused by magical and spiritual forces, while others draw on scientific reasoning and many apply both models (Walker et al 2004:90). Communities, which rely on traditional medicines and therapeutic practices usually relate to supernatural theories (Hughes 1985:242).

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses relevant literature on the role of THs in the prevention and care of HIV/AIDS in the African continent, using secondary data from studies done in other African countries as well as in Lesotho. The chapter first discusses the role of THs in the primary health care system, and then proceeds to their role in the prevention and care of HIV/AIDS more specifically.

The chapter also looks at international and regional resolutions as well as at national policies on THs and traditional medicine. This allows us to evaluate how much THs and their practices are recognized at a policy level, particularly by international agencies such as the WHO.

Attempts were made by the colonial authorities to discourage the use of THs (Pitt 1996:200, UNAIDS 2000:10,). However, they continued to play a role within their communities and still do today in caring and treating a variety of psychosocial problems that arise from conflicting expectations in changing societies (UNAIDS 2000:10).

The arrival of Christian missionaries in what is now South Africa and Lesotho in 1833 marked the beginning of Western attempts to discourage the use of THs and their medicines (Khoboko 1982:19, Leclerc-Madlala 2002:62,).

Education was used as the major weapon against traditional healing and other ways of life, which were not approved of by the missionaries. The traditional healers, once known as “witch doctors” were then referred to as the “greatest evil” in Africa by General Smuts at the opening of the medical association in Pretoria in 1948 (Beck 1979:3). But three decades later we see a change of attitude towards THs and their practices. The African Expert Committee on traditional medicine in Africa meeting

held in Brazzaville in 1976 emphasized the profoundly original nature of the basic ideas underlying Traditional Medicine (Beck 1979:3).

One suggestion is that this change of attitude towards traditional healers is due to problems encountered in the biomedical health service. Health care delivery faces many challenges in most countries particularly on the African continent:

“The absence of hospitals and clinics in many regions (particularly in rural areas) and understaffed and overcrowded health facilities (where they do exist) partly account for widespread reliance on traditional healers in many Southern African countries” (Walker et al 2004:92).

As a result, some health planners have proposed that the most effective way to expand modern primary health care would be for western trained practitioners to collaborate with traditional healers. Traditional healers tend to be the entry point for health care in many African communities, “even more so for the complex HIV-related disease that frequently jolt family dynamics and shake community’s stability” (UNAIDS 2002:5). Traditional healers operate within a shared cultural framework, which is familiar and understood by many Africans as both powerful and effective (Walker et al 2004: 92).

Beck (1979:3) points out that when colonisers took over many African countries, much of their concern lay in the continuation of a functioning administration which included medical department and other departments in urban centres. In order for the colonisers to function well in the African countries, where they were unfamiliar with the local conditions, they largely depended on the good will and cooperation of the local populations. They were unable to reach out to the more isolated and distant sections of the country and African traditional healers were left to do much of the work in those remote areas. Beck (1979:4) further points out that in recent years, traditional healers and their medicines have been experiencing a renaissance.

Some authors such as Morgan (2000) conclude that societies are built upon the re-emergence of traditional healing practices. These traditional healing practices it

seems are not static and have adapted to socioeconomic, religious and most importantly western medical influences within their communities (Ingstad 1990:31).

The rebirth of respectability for traditional healers and their healing practices in most African countries began with the plan to extend medical care beyond the consulting hospital (Beck 1979:4). Medical care in the rural areas was given first priority, but the training of manpower in the rural areas could not be done fast enough. In this process traditional healers became very useful.

But most importantly in recent years, the AIDS pandemic has been an important additional pressure or burden on the health care sector. According to Pitt (1996:201) western and traditional health concepts have common ground in a community orientation. It is argued that AIDS is inevitably a community problem involving as it does the necessity for education and awareness, social support, coping mechanisms as well as appropriate caring procedures.

WHO also advocated for the reversal of culturally biased notions that viewed THPs as quacks and charlatans (South African Department of Health et al 2004: 22). UNAIDS (2000:9) affirms:

“With growing interest and increasing need for expanded health care in the past twenty years, the governing bodies of WHO have adopted a series of resolutions. Policies regarding collaboration with traditional medicines have been shifting since the late 1970s”.

Several countries in the African continent have initiatives in which THs are incorporated in the HIV/AIDS strategy. Some African countries have initiated collaborative projects with THs for prevention and care of HIV/AIDS, while others have provided traditional healers with training.

2.2 TYPES OF TRADITIONAL HEALERS IN SUB- SAHARAN AFRICA.

In Africa, traditional health practice covers a wide range of activities and diverse types of THs (Chipfakacha 1997:423, Pitt 1996:197, UNAIDS 2000:9) singly or in combination to maintain wellbeing as well as to treat or prevent illnesses (Pitt 1996:197, WHO 2002:1). Traditional healers utilize methods from herbal treatment to throwing of bones, and many other means of consulting the spiritual world (Jackson 2002:252) as well as mineral based medicine, manual techniques and exercise (WHO 2002:1). Below are different types of traditional healers in Africa.

The most known type of traditional healer is herbalists (*inyanga* in Zulu in singular, and *izinyanga* in plural, *ixwele* in Xhosa in singular and *amaxwela* in plural, and *mganga* in Swahili). Different herbalists use different methods of healing (Berglund 1976:310). According to Berglund (1976:309) “the herbalists manipulates the power embedded in materia on the basis of his knowledge of the properties and capacity of the materia”. Berglund (1976:310) points out that the herbalists’ knowledge is acquired partly from the tutor in the use of medicines, partly by either exchanging secret information with other herbalists or buying it from them. “Herbalists specialise in the use of herbal medicines because they possess an extensive knowledge of curative herbs, natural treatments and medical mixtures of animal origin” (Abdool–Karim et al 1994:7) which are mostly used to ward off evil, partly to restore health once a person has been stricken by *ubuthakathi*⁴ (Berglund 1976:310).

Herbalists also immunize people against *ubuthakathi* (Berglund 1976:311). The herbalist are also said to give *isilambalala* a prophylactic particularly against *idliso* (sorcery in the form of poisoning).

Another prominent type of traditional healers is diviners or spiritual healers (*izangoma* in Zulu) who possess two to three or more spirits, which guide and assist

⁴ Social influences in Zulu dreaming (Berglund 1976:191).

them in their healing practice. Diviners represented a source of authority independent of the colonial administration. In times of social stress they could assume a political function (Jolles et al 2000:236). According to Jolles et al (2000:236) diviners were very influential in their communities: even the acts of King Shaka on coming to power were to break their influence. Writing about diviners in Swaziland, Green et al (1984:1072) elaborate:

“Diviners describe a division of labour between the spirits whereby each tends to have a specialized function ranging from guidance in diagnosis to help in collecting overdue patient fees. Most diviners also treat patients with herbal and other traditional medicines, but it is their special cultivated relationship with spirits and their attributed divinatory power that distinguishes them from herbalists”.

The instruments used during divination vary from one community to another and between different diviners.

There are also faith healers (*Baprofita* in Sesotho and Tswana, *Umthandazi* in Zulu), who are usually part of a church, usually of African Independent Churches. Faith healers use a synergetic combination of imported and local beliefs, where cure is affected through prayer (Pitt 1996:198) and by laying hands on the patient (Abdool-Karim et al 1994:7). Faith healers usually belong to one of the missions of African independent churches (Abdool-Karim et al 1994:7). Faith healers believe that their healing power comes directly from God. Faith healers also often invoke treatment over items used by the affected person such as clothing (Devenish 2003:6). Faith healers use a combination of herbs and holy water in their treatment.

There are also traditional birth attendants (TBAs) or midwives whose work primarily involves pregnancy and childbirth. TBAs attend a pregnant woman from the early months of pregnancy and handle all labour complications (Iwu 1993:336). Some TBAs also treat sterility.

2.2.1 Lesotho

Traditional healers of various types have always existed in Lesotho. Historically Basotho traditional healers were very influential in their communities and engaged in various important activities of the community such as diagnosing and treating diseases, helping people with their personal problems and preventing misfortunes from happening (World Travel 2006:14). Khoboko (1982: 35) reports that many traditional healers known as *ngaka* had expert knowledge of the medical qualities of local herbs. The *selaoli* on the other hand threw bones and depending on their position, decided what had caused the illness and how to treat it (World travel 2006:14). According to World Travel (2006:14) this approach necessitated the use of magic and making contact with the spirits. A *senohe* was honoured as a person who was able to see what others could not and this gift enabled him or her to establish the cause of illness to foretell future events (World Travel 2006 :14).

However, the most important type of healer traditionally in Lesotho is the initiation healer. The traditional healer was centrally involved in the preparation and at the start of the initiation ceremony. His work was to see to it that the boys were not tampered with by the people who had bad intention towards them in the initiation lodge. This began while still at home and continued in the mountains when the healer would cleanse the initiation lodge and all its surrounding for the protection of the boys during their stay there.

War doctors were also regarded as equally important in Basotho society:

“Basotho also used a war healer very much. The responsibility of this type was to see to it that the warriors were well protected during the attacks or when the enemy attacked them. The medicine that the healer used was called *mame*. This medicine was believed to make the enemy weak in power and gave confidence when Basotho were attacked or attacked. In most of the wars that Basotho fought, this medicine had been used” (Khoboko 1982:37). ”.

Great Basotho leaders had and relied on traditional healers in their activities. Khoboko (1982:37) states:

“Mokhachane, Moshoeshoe’s father had a war doctor called Mobe. It was firmly held that the fortunes of the chieftdom as a whole depended on the medicines, which were kept by Mobe. Moshoeshoe also had his own doctor who was called Tsapi. Moshoeshoe depended on Tsapi to weigh the power and strength of the enemy when he attacked or was attacked and as a result, Moshoeshoe was always victorious in all his wars”.

Traditional healers have historically been trusted and accepted among Basotho.

2.3 THE ROLE OF TRADITIONAL HEALERS IN PRIMARY HEALTH CARE

THs play a crucial role in the primary health care⁵ of communities due to particular attributes they have, such as communications skills, persuasion, as well as their preventative skills in health related problems (Pitt 1996:203). According to Ayers (2002:15) THs in KwaZulu-Natal fulfil the first three objectives of primary health care: accessibility, acceptability and affordability. THs are considered accessible because they speak the same language in which their clients are fluent and comfortable with, the language in which the clients can express their pain in detail. In Lesotho there are substitute words or expressions used to refer to the body, especially to reproductive organs and bodily excretions instead of the actual words, which are regarded as offensive. Thus THs can easily receive the message and understand what their clients are referring to.

THs can also use the same words with the patients without feeling embarrassed or embarrassing the patient. Allopathic doctors on the other hand, may have to use translators, especially if the doctors do not speak the same language as their patients,

⁵ The Alma Ata Conference defines Primary Health Care as “essential *health care* based on practical, scientifically sound and socially acceptable methods and technology made universally, accessible to individuals and families in the community by means of acceptable to them, through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country’s health system, of which it is the central function and the main focus and of the overall social and economic development of the community.” (WHO et al 1978:1)

which is usually the case in Lesotho's formal health care services where most doctors are expatriates. Miscommunication in such situations is likely to occur. This can affect the patient's willingness to comply with medical instructions, the information may not be well understood when it is first communicated or not accurately recalled (Ayers 2002:16). As a result crucial information may get lost when translated. Another advantage is that THs live in the same communities as their patients and are easily accessible to them.

Hewson (1998 1033) points out traditional healers prevent and protect people from problems, determine the causes of these problems and the eventual elimination of them. For example, according to Ayers (2002: 15), in KwaZulu-Natal, South Africa, THs' work is concerned with prevention first rather than waiting for diseases or illnesses to strike and then treating them. For instance, in order to survive prevailing environmental dangers, everyone must be frequently strengthened to develop and maintain resistance. This is due to the fact that some people are considered much more vulnerable to the environmental dangers than others (Ngubane 1977, in Makhathini 2003:64). Specific protection is provided by the ancestors as well as by the prescription of preventative charms. For example, there are various types of charms worn to prevent diseases (Gelfand 1985, in Makhathini 2003:65). Normally these are worn around the waist, neck, wrists and ankles. It is apparent that traditional healers have a long experience in diagnosing and managing various common diseases in the primary health care level (Elujoba et al 2005:48, Pitt 1996:203,) in most African communities. As a result traditional healers have become trusted sources of health information and treatment. There is also an overlap in advice given in primary health care between traditional and biomedical practitioners. Both advocate preventative measures such as boiling water before drinking it in order to avoid water-borne diseases.

Diseases which are commonly treated by traditional healers in Africa include malaria, arthritis and inflammatory disorders, sexually transmitted diseases such as gonorrhoea and syphilis, gastrointestinal disorders, snake bites, psychiatric and psychosomatic disorders, coughs, skin diseases as well as cutaneous infections (Iwu

1993:304). A study done in Uganda found out that THs also treat such diseases as infertility, bewitching, madness, ectopic pregnancies and other complicated pregnancies, asthma, dry cough, skin infections, fever and bone fractures, epilepsy, severe headache, syphilis, ulcers, heart problems, body swellings, cough, pneumonia, herpes zoster, mental cases and impotence (Quaye et al 2003). These diseases are also treated by biomedical doctors. Most people tend to use traditional and biomedicine simultaneously, or when they believe that the other is not so effective.

Most importantly, indigenous healers pay particular attention to the prevention and treatment of STDs, because they are commonly attributed to a transgression of cultural taboos and thus are seen to represent a threat to social stability (Ayers 2002:25). In most African communities it was widely believed that if a person had STDs, one must have committed adultery or had sex before marriage. Hence STDs were interpreted as a form of moral punishment. It is not surprising therefore that HIV/AIDS is considered an indigenous rather than modern disease that cannot be cured by biomedical health practitioners (Pitt 1996: 202). According to Ayers (2002:25) the underlying cause of STDs and HIV/AIDS in the view of many healers is the transgression of existing sexual taboos.

An understanding of the causation of these diseases is based on communities' belief systems. According to Pitt (1996:203) some of these diseases were thought to arise from some improper conduct of behaviour or polluting activity, which incurred supernatural wrath or revenge. In Liberia for instance, gonorrhoea is believed to be caused by sex with a person with the disease or an unclean person, a stranger or prostitute. It may also result from strenuous sex (Green 1992:1460). Hence in most communities, there are extensive and complex taboos regulating sexual behaviours and traditional healers are often the custodians of this knowledge (Pitt 1996:203). Sexual taboos in most cases are designed to restrict promiscuous behaviour.

THs are believed to have in-depth knowledge of plant materials and their curative powers hence they use herbs for preventing, managing and diagnosing these diseases. Traditional healers use various herbal dosage forms such as concoctions, decoctions,

infusions, dried powders and ointments which are found within the community (Elujoba et al 2005:48). The herbal mixtures are normally made from seeds, stems, barks or roots. Animal parts and minerals are also used. By way of illustration Table 2 below shows some of the medical plants used in treating some of the diseases in Rwanda and Burundi (Ramathal et al 2001:132-137).

Table 3: African medicinal plants used to treat diseases.

Plant	Parts Used	Use
<i>Hygrophila spiciformis</i>	Fresh leaves Leaf decoction	Gonorrhoea Hepatic disease
<i>Thurnbergia alata</i>	Leaf juice	Relief of pain after childbirth
<i>Cyathula cylindrical</i>	Fresh leaves crushed and boiled	Gonorrhoea
<i>Cyathula spathulifolia</i>	Stem, fruits and seeds	Ointment for leprosy cure
<i>Rhus vulgris</i>		Diarrhoea, wounds, gonorrhoea, infertility, and ease pain during child delivery
<i>Markhamia Lutea</i>	Fresh or dried herb decoction	Kidney disease
<i>Blumea Brevipes</i>	Fresh leaves crushed	Skin diseases and burns
<i>Conyza aegyptiaca</i>	Fresh herbs crushed and boiled	Intestinal worm infestations
<i>Crassocephalum vitellium</i>	Leaves and roots Roots	Sores in infants
<i>Guitzotia scabia</i>	Fresh leaves boiled	Sores in the mouth in adults
<i>Vernonia miambicola</i>	Decoctions of fresh leaves	Liver disease, intestinal worms and diarrhoea
<i>Vernonia schreb</i>		Chest infections Pneumonia

Source: Ramathal et al 2001:132

2.3.1 COLLABORATION BETWEEN TRADITIONAL HEALERS AND BIOMEDICAL PRACTITIONERS

The integration of traditional healers into the biomedical model of primary health care has never occurred. There has always been tension between biomedical services and traditional medicine due to different approaches to disease, bases of knowledge as well as issues pertaining to progress and change. Western medicine believes in progress and change while traditional medicine does not. Technology plays a very crucial role in achieving progress and change within Western medicine. Mokaila (2001) indicates “western medicine continuously comes up with new drugs for many different diseases such as the invention of ARVs for HIV/AIDS”. According to Mokaila (2001) “the knowledge that traditional medicine practitioners possess about medicine is a complicated concept that reflects more complex set of socio-culturally

related and spiritual factors”. This knowledge refers to the integrated expression of collective values and customs that guide interactions between people and nature.

Mokaila (2001) states “western medicine uses empiricism as a basis for knowledge believing that observational experience is essential to understand diseases”. In other words in order to make any claims about diseases, thorough examination must be made. Traditional medicine is based on cultural beliefs and practices handed down from generation to generation.

Though traditional healers were not drawn into primary health care they can still play a role in combating Africa’s major diseases. THs were involved in TB programme in the Hlabisa district of KwaZulu/Natal, where they were trained as supervisors of Directly Observed Therapy for TB (DOTS) (Colvin et al 2001:1). According to Colvin et al (2001:1) “Illnesses such as TB can be easily cured if patients take their medication every day and complete the course. But with the treatment lasting between six and eight months, many drop out of the treatment programme”. However, an innovative partnership between medical and traditional practitioners helped reduce the spread through a course that trained healers to supervise and record the doses taken by each patient to ensure proper compliance.

In some communities, traditional healing emphasizes the importance of support groups in the treatment of certain illnesses such as mental illness. For instance:

“In West Africa support groups may be supplied by religious cults, secret societies or by elaborate discharge ceremonies that ritualize the patient cleansing of illness, death and rebirth into a new life. Elsewhere the patient may receive support by moving from one area and social network to another” (Edgerton 1985:259).

Within traditional African healing systems, counselling commonly exists. Many people within the community, including traditional healers, depending on the situation and circumstances, offer counselling informally. Counselling forms part of the holistic approach to health and well-being of a person. In traditional counselling,

THs are said to listen to their clients, ask questions and check for understanding. According to Homsy et al (1996:3) “traditional healers deal with their patients’ anxieties by extracting a story from them and then consulting for insights and advice”. Traditional counselling is largely dependent on a spiritual medium who influences the treatment choice whether it be herbal, psychological or spiritual. In countries like Uganda counselling is an old concept. “Traditional healers and other groups in the country such as elders, parents and religious leaders have all been traditionally giving counselling, regarding cultural values and expectations” (Homsy et al 1996:3). It is apparent that this valuable component of health care needs to be enhanced at grassroots level.

2.4 THE ROLE OF THS IN THE PREVENTION AND CARE OF HIV/AIDS.

2.4.1 INTRODUCTION

Traditional healers have been largely excluded in HIV/AIDS initiatives in most African countries. The reasons for this exclusion are the same reasons why they have been excluded in primary health care (see section 2.3). However, some countries, such as Uganda, have tried to work together with traditional healers while other countries have actually trained the healers on HIV/AIDS issues (see section 2.6). In addition most programmes on HIV/AIDS in Africa exclude traditional healers. In most instances, invitations to THs are restricted to workshops or seminars where they exchange views and information with health educators, researchers, nurses and doctors (Green et al 1994: 1073, Curtis 2007). Indeed most countries have carried out such seminars or workshops for traditional healers with the aim of training them on HIV/AIDS issues. Although these seminars are meant to bring positive benefits to the healers and the communities, Curtis (2007) claims that in most instances the information within these seminars is a narrowly focused, scientific view promoted by the trainers with little real input from traditional healers. Curtis (2007) also argues that traditional healers need to be actively involved in designing the training material, in order for that training to be sustainable and effective.

James (1996) agrees that traditional healers feel that they have not been invited on equal basis to forums or conferences to discuss the issues of the world medicine or AIDS in particular.

In some countries such as Botswana, which introduced large-scale provision of antiretroviral treatment free of cost, traditional healers have been largely excluded from the implementation of the programme (Motsumi 2002) despite the fact that people who are taking antiretroviral treatment still continue to consult traditional healers. Tjoa (2005:6) observed that financial benefits geared towards traditional medicine in order to conduct research and come up with substantial development are very limited as compared to those given to biomedical medicine. Through ample financial support biomedical medicine was able to conduct research and experiments until antiretroviral treatment was developed.

2.4.2 PREVENTION

THs can be of value in the control of AIDS, especially in its prevention, management and treatment areas. The reasons for this are to do with access, their position in the community, knowledge and communication, and innovation. Firstly, the ratio of traditional healers to patients is more favourable than that of doctors to patients (see table 3). They are potentially able to reach a greater number of patients due to these more favourable ratios.

Table 4: Ratio of doctors and traditional healers in some Sub-Saharan African countries

Country	Doctor: patient	Traditional medicine Practitioners
Botswana	-	Estimated 2000 in 1990
Eritrea	Estimated 120 doctors in 1995	-
Ethiopia	1:33,0000	1:987 urban areas
Kenya	1:7,142	1:1,833 urban Mathare
Lesotho	-	Licensed traditional medicine practitioners, estimated at 8,579 in 1991
Madagascar	1:8,333	-
Malawi	1:50,000	1:138
Mozambique	1:50,000	1:200
Namibia	-	1:1000 Katutura
Tanzania	1:33,000	1:350-450
Uganda	1:2,500	1:708
Zimbabwe	1:5,250	1:234 urban 1:956 rural

Source CAI 2004:2

Secondly, they live among the population and are able see their patients in their own home environment, which often is also the home environment of the patient. Living in the same community with the people, they can persuade people to adhere to practices that enhance good health as advised by THs. THs are able to check on the their patients frequently as they do not require costly resources such as transport or accommodation to do their work. This is because they live and operate in the same communities. Western trained doctors are mostly based in hospitals or clinics which are rather far from the communities. In most cases patients have to travel long distances to get to hospitals or clinics.

THs can be (or have the potential to become) knowledgeable about disease prevention measures. They may also advocate measures against HIV/AIDS such as limiting the number of sexual partners, and enforce taboos restricting certain behaviours, (Ayers 2002:26). Healers who have been trained in HIV/AIDS prevention have devised ways of discussing safer sex practices with their clients,

distributed condoms and demonstrated condom use (Manci 1993, in Ayers 2002:26). For instance, in Uganda, in a project with THETA⁶ traditional healers encouraged their patients to use condoms. Indeed it was found out that condom use and frequency of use increased over time by women who said they had received counselling from their healers (Homsy et al 1996:4). It is not clear whether they were given equipment after training in order to demonstrate to their clients how condoms are used in order to achieve maximum and effective results they are aimed to bring, or whether THs conceptions and views about sex education were included.

Information, education and communication are very crucial in AIDS prevention strategies in any given country. THs can be an important source of information for HIV/AIDS prevention because they can assist in education training awareness programmes, situated as they are in the health care sector but only if they are provided with necessary and relevant information. This information would guide them in making informed decisions in promoting social and cultural support for those practices that spell good health, while modifying or abandoning those practices that expose them and their clients to the risks of HIV infection and other public health hazards (Kimario et al 2004:24, WHO 1990:22,).

For instance, THs are usually involved in scarification practices in Lesotho and other African communities associated with traditional rites. Although the frequency of activities may have declined in the general process of cultural change, activities involving blood contact are still common to mark identification with particular social group or in rites of passage. These scarification rituals involve a number of different body parts, for example tattooing, piercing (including ear and sexual organs), circumcision, and cliterodectomy. In Lesotho, traditional healers run most of the initiation schools. Matšela et al (2002:8) also adds that this group, that is young men who go to initiation school, stand a high risk of HIV/AIDS infection as a result of lack of scientific information.

⁶ Traditional and Modern Health Practitioners Together Against AIDS.

Initiation schools are also an excellent opportunity for teaching young men about responsible sexual behaviour, safe sex, the value of introducing and observing the practice of “one man and one blade”, HIV/AIDS awareness because they are already being taught about sexuality and responsible manhood (Kimaryo et al 2004:195). If initiation schools include intensive HIV/AIDS education and information, young men passing through these schools would be more knowledgeable about HIV/AIDS. The argument is that if should this happen, more Basotho men would receive HIV/AIDS training while in these schools. It would therefore be unnecessary for Basotho women to worry about negotiating safe sex since their men would already be in the forefront of promoting safe sex and responsible sexual behaviour (Kimaryo et al 2004:195). Education provided to young men at initiation school would be of great importance in promoting safe sexual practices such as using condoms and limiting sexual partners. Condom use is not unproblematic however. Though condoms offer considerable protection against sexual transmission of AIDS, many Africans who are at risk of infection reject condoms as "unnatural" (Schoepf 1992:225). In addition condom use is a very sensitive issue in many African communities inclusive of traditional healers.

Chipfakacha (1997) feels that basic hygiene education should be given to THs. Hygiene practices are important and key factors in the prevention of communicable diseases. This includes washing hands, sterilization of utensils and avoiding bodily fluids and soiled utensils as well as clothes. It is likely that THs have their own hygiene practices which should be noted and enhanced.

In addition, THs can also inform and educate their communities about HIV/AIDS infection and other diseases. WHO (1990:22) states that this could be effective, especially when messages are translated and adapted to local language and cultures. Health messages must be written in a language well understood by the people. THs' communication skills in health and social issues are a vital resource that can be utilized in a variety of crucial area of AIDS prevention (Chipfakacha 1997: 418).

Moreover, THs have useful health knowledge and often closely guarded secrets onto which incoming information must be consolidated if it is to be absorbed into the local consciousness (Pitt 1996: 205). There is evidence suggesting that many programmes have failed in African countries because they have lacked cultural sensitivity. There are also several kinds of misfit between message and medium of message. There may be inappropriate use of audiovisual media, for example radio or TV. Gbodossou (2000:1) asserts:

“Many of the preventative methods used in Africa are unsuitable and inefficient. Many rely upon newspapers, radios and televisions. In many African countries radios often times do not educate, television is a luxury and the majority of the population is illiterate. African traditional healers provide health education and treatment for majority of the population and have a great level of respect within their communities. Thus, they are perfect conduit to serve as information, education and communication (IEC) agents in the prevention of HIV/AIDS throughout Africa”.

Increased level of HIV/AIDS awareness through the use of media has been achieved for those who have access to media, but misunderstandings still exist (Ayers 2002:24). Misunderstandings may exist because people do not have the opportunity to ask questions to clarify issues which are not clear to them. As a result interpersonal channels of communication to reach all the people are advocated in order to generate in-depth understanding (Laver 1988 in Ayers 2002:25). On the other hand, some forms of media are not easily available to many people, particularly those in the rural areas who cannot afford food, let alone a radio and batteries. Most people may not have radios for a number of reasons, and in countries such as Lesotho the mountainous terrain makes it extremely difficult for people in the rural areas to have access to radio networks. A study done in Lesotho in 2001 showed that not every household has access to radio. Bureau of Statistics Lesotho (2001:43) shows that just over four in ten households possessed a working radio⁷ In the mountainous areas, 28.7 percent possessed a working radio while in the other two

⁷ A radio which has batteries in order to function.

ecological zones, the foothills and the Senqu River, only one in three households possessed a working radio.

There are other methods used in getting HIV/AIDS message across such as billboards (see Chapter 4) and public gatherings by the Government and Non-Governmental Organisations.

THs can be useful not only in being the recipients of health messages but also the originators of more innovative and effective campaigns. THs can be largely used in areas such as these to inform people about diseases and how to control them especially in areas where there are few trained health personnel. WHO (1995:40) explains:

“Traditional health practitioners can be utilised in the promotion of education concerning prevailing health problems and methods of preventing and controlling them, including; information about local prevailing health problems, methods of preventing and controlling these problems and use of posters and other simple health education material; promoting improved food supplies and proper nutrition, including; how to obtain a balanced diet, proper diet for mother and child (i.e. breast feeding and proper weaning foods) and growing vegetables and fruits in kitchen gardens; promoting prevention and control of locally endemic diseases, including how to recognise symptoms of dangerous diseases such as diarrhoea, TB, leprosy, malaria, malnutrition and to refer for treatment”.

Pitt (1996:208) reports that education, training and awareness must be coupled with promoting community participation in the AIDS programmes as well as other programmes vital to the community's welfare and wellbeing. In this regard THs, including traditional birth attendants (TBAs), can be vital brokers between the outside world and the grassroots because of their intimate knowledge and links with traditional cultures. THs as informal community health workers are seen as valuable, influential and strategic in channelling educational messages to the community

(Ayers 2002:25). Educational messages should be specifically designed to reinforce and not to contradict or fight traditional concepts of diseases and illnesses.

2.4.3: THE ROLE OF TRADITIONAL HEALERS IN CARE AND TREATMENT

Long before the AIDS epidemic, THs throughout Africa were known for their efficacy in the diagnosis and treatment a variety of illnesses including STDs and other conditions (Giarelli et al 2003:39, Homsy et al 2004:905). Most importantly at the present time, when the modern medicine system has little to offer many Africans to cure or halt further spread of HIV infection, particularly in terms of cure (Chipfakacha 1997:417), many HIV/AIDS patients regard traditional healers' treatment as effective and advantageous (UNAIDS 2000:10). However, modern medicine should be applauded for the invention of ARVs which are benefiting people living with HIV/AIDS.

In most African countries, if not all, many people believe that there are certain types of illnesses that are due to forces that are beyond the comprehension of modern medicine. There is a strong belief among most African communities and traditional healers themselves that traditional treatment can cure HIV/AIDS. Their greater availability in the communities (Nina et al 1996 in Ayers 2002:26) is also an asset. Fear of stigma keeps individuals away from TB and HIV/AIDS clinics. Confidentiality offered to patients themselves does not inspire confidence. Patients tend to consult doctors when traditional medicine has failed them.

In treating patients, traditional healers usually see their patients in the presence of other family members (Chipfakacha 1997:420, Oja and Steen 1996:186). This sets the stage for effective and family counselling and it can also assist in reducing stigma and discrimination against people with HIV/AIDS at least within the family. This is similar to counselling within biomedical system. Family counselling also encourages very active involvement of a family from pre-test counselling, testing, to post test-counselling. Family counselling also strongly advocates for family support for an HIV positive person within the family. A study done in Uganda found that THs can

transfer basic counselling skills and facts about AIDS to clients, enable peer-support and self-reliance to take root among people with AIDS (Lattu et al 1994:31). In addition, the introduction of support groups in Uganda was through the THs' initiative, which was viewed as a significant approach that fills the gap remaining in the people living with HIV/AIDS's (PWA) lives in the treatment-biased health care system. Enthusiastic responses by THs, PWAs and community members suggested that support groups could be an invaluable community-based service (Lattu et al 1994). This shows that both traditional healers and biomedical practitioners could work together, counselling at grassroots level.

Traditional healers also provide home-based care for chronically ill patients. THs home-based care provides psychosocial support, emotional nurturing and religious succour (Ayers 2002: 22).

2. 5 RESOLUTIONS ON TRADITIONAL HEALERS AND TRADITIONAL MEDICINE INTERNATIONALLY AND ON THE AFRICAN CONTINENT

2 5.1 INTERNATIONAL RESOLUTIONS AND TRADITIONAL MEDICINE

Since THs are used for prevention, diagnosis, and treatment of an extensive range of ailments and recognizing the widespread use of traditional medicines, it is important to ensure that the health care provided by THs and their medicines are safe and reliable. It is also crucial to ensure that standards for the safety, efficacy, and quality control of herbal products and TM therapies are established and upheld, that practitioners hold qualifications, and claims made for products and practices are valid. These issues have become important concerns for both health authorities and the public. Policies are a key part of addressing these concerns. This includes international, regional as well as national policies and declarations (WHO 2002:3).

In recognition of the role that traditional medicine practitioners play in the development of health systems and services as well as the achievement of "Health for All" WHO governing bodies at global and regional levels have adopted several resolutions on traditional medicine (Green 1992:1125, Kasilo et al 2003:2, UNAIDS

2000:10, WHO 1995: 3,). The Alma Ata declaration in 1976 appears to have brought change in attitudes towards traditional healers and their medicines. This resolution acknowledged the potential value of traditional medicine in expanding health services by calling attention to the manpower reserve constituted by traditional health practitioners. There were also other resolutions such as 1977 resolution, “Health for all” which urged countries to utilize their traditional system of medicine. The 1978 resolution “Primary Health Care”, on the other hand recognised that primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of a country's health system, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (WHO 1978:2). Member states therefore called upon countries to develop a comprehensive approach to the subject of medical plants (WHO 1990:3).

It is clear that international organizations are committed to THs and their practices and medicines in health care. There is now a recognition that each and every society needs to make valuable use of traditional health services in their communities. Arguably, the HIV/AIDS pandemic could be brought under control if there is good collaboration and good relations between THs and modern medical practitioners. Collaboration refers to increased dialogue and communication between the two health sectors as well as various joint activities aimed at improving community health education and patient care and support (Koburu et al 2006:2).

One could argue that since attempts made to suppress THs and their practices in most African countries have failed, and as people continue to consult traditional healers for ill health and other reasons, therefore the only option available is to collaborate with them. WHO 1989 resolution, “Health Promotion, Public Information and

Education for Health”, provided a fresh mandate for the future action in promoting effective collaboration between traditional and modern health care sectors within WHO’s Member States⁸ (WHO 1990:3). It is possible that WHO realized that most people in developing worlds, particularly those in the African region use both health systems simultaneously. As a result the WHO saw the need to establish harmonious relations between the two systems.

2.5.2 DECLARATIONS ADOPTED FOR AFRICA

As early as 1974 the WHO Regional Committee for Africa discussed traditional medicine and its role in the development of health services in Africa (UNAIDS 2000:9). Three years later the World Health Assembly (WHA) adopted a resolution promoting and training and research related to traditional medicine. In 1990, in Botswana, the WHO traditional medicine programme and the WHO global programme on AIDS met to consider ways to involve traditional health practitioners (THPs) more actively in measures to prevent HIV infection and AIDS in African communities. At this forum, recommendations were made on the policy and legislation, education and training, research and involvement of traditional health practitioners in national AIDS programmes (WHO 1990:15).

Resolution AFR/RC50/R3, “*Promoting the role traditional medicine in healthy systems: A strategy for the African Region*”, was adopted at the fiftieth session of the WHO Regional Committee for Africa held in Burkina Faso in 2000 (Kasilo et al 2003:2, WHO 2002:29). This resolution recognized the importance and potential of traditional medicine for the achievement of “Health for All” in the African Region and recommended accelerated development of local production of traditional medicine. The resolution further urged Member States to translate the strategy into realistic national traditional medicine policies, backed up with appropriate legislation and plans for specific interventions at national and local levels, and to collaborate actively with all partners in its implementation and evaluation (WHO 2002:29).

⁸ The term “Member States” refers to all individual countries affiliated to the WHO.

Africa also held its first international conference on traditional medicine and HIV/AIDS in 1999 in Senegal (PROMETRA⁹ 2003). It was recommended that all traditional practitioners be empowered to take an active role as information, education and communication (IEC) agents. The conference also recommended creation of local structures to facilitate people's access to health care services; inclusion of THPs in biomedical research; as well as the creation of a regional office for the identification, promotion, and protection of traditional medical knowledge (PROMETRA 2003).

Another declaration was adopted in Kenya in the 13th ICASA in a workshop entitled "Traditional Healers Workshop, Sharing knowledge, Experience and challenges in providing treatment and care to HIV/AIDS patients". PROMETRA (2003) indicated that this conference was of great importance because in-depth knowledge of traditional healers that can be used to fight the AIDS pandemic was discussed. This is due to the fact that traditional healers live in countries where communities are affected by HIV/AIDS. It was recommended that traditional healers and organizations supervising the activities of traditional healers in the prevention of HIV/AIDS be involved. It was further recommended that traditional healers collaborate in research into the identification of therapeutic solutions for HIV/AIDS; and that traditional medicine must be legalised in all countries and healers participate in biomedical research (PROMETRA 2003).

Homsy et al (2004:905) point out that the idea of a regional initiative on traditional medicine and AIDS in Eastern and Southern Africa was spearheaded by THETA in 2001, in Kampala, Uganda. A regional consultation that took place in May 2003 defined standards of practice around six predefined themes regarding the involvement of THs and TM in HIV/AIDS prevention, care and treatment. These are as follows:

"Evaluation of traditional medicine: evaluation of traditional medicine should be preceded and guided by information gathering on purported

⁹ PROMETRA - The Association for the Promotion of Traditional Medicine.

efficacy and safety and observational studies should be conducted to generate further information on safety and assess preliminary indicative efficacy. Spiritual healing: Spiritual healing should be accepted by the community, should not have negative or physical connotations and should be provided free of charge; community/clients only make voluntary contributions. Prevention and care: Traditional healers and biomedical health practitioners should be trained/empowered in cultural beliefs and practices, basic and updated information on prevention and care for sexually transmitted diseases (STDs) HIV/AIDS and tuberculosis. Standardisation, processing and packaging of herbal medicine: There should be proper selection and botanical identification of raw material.” (Homsy et al 2004:906”).

A number of countries within the WHO African Region have made important strides in the area of TM in relation to policies and regulations (DoH et al 2004:19, WHO 2001:4). A national law or regulation exists in the following countries:

Benin, Burundi, Botswana, Burkina Faso, Cameroon, Côte d’Ivoire, Central African Republic, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Gambia, Ghana, Kenya, Guinea, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Namibia, Nigeria, Senegal, Sierra Leone, Swaziland, Togo and Zimbabwe. (WHO 2001:4, Kasilo et al 2003:8).

Lesotho has two statutes that regulate the practice of traditional medicine and limit it to registered practitioners. These are Natural Therapeutic Practitioners Act of 1976 (35) and the Lesotho Universal Medicinemen and Herbalists Council Act of 1978 (36) (WHO 2001:19). The Natural Therapeutic Practitioners Act defines natural therapeutics as the provision of services for the purpose of preventing, healing, or alleviating sickness or disease or alleviating, preventing, or curing pain “by any means other than those normally recognized by the medical profession”. Natural therapeutics includes methods commonly employed by homeopaths, naturopaths, osteopaths, chiropractors, and acupuncturists. The Medicinemen and Herbalists Act

provided for the establishment of a Medicinemen¹⁰ and Herbalists council. The council has to promote and control the activities of traditional medicine practitioners, to provide facilities for the improvement of skills of traditional medicine practitioners, and to bring together all traditional medicine practitioners into one associated group.

According to this Act, the Council has to ensure that every medicineman and herbalist has a valid license to practice. Membership is open to every medicineman and herbalist who pays a subscription fee as determined by the constitution and whom Council recommends for membership. According to this Act, the council has the responsibility of promoting and controlling the activities of medicinemen and herbalists so as to provide facilities for the improvement of skills of medicinemen and herbalists. The Act is very outdated and appears to be ineffective for Basotho medicinemen and herbalists. Much has changed since its enactment. The focus of the Act is mainly on the council.

Though the title of the Lesotho Universal Medicinemen and Herbalists Council Act seem not to be inclusive of other types of traditional healers, it recognises other types of traditional medicine practitioners and it aims to bring all the types of traditional medicine practitioners under one association (WHO 2001: 20). In South Africa the South African Traditional Health Practitioners Act 2004 does not accommodate the current practices of different types of traditional healers that exist in the country. The South African Traditional Health Practitioners Act outlines detailed objectives and functions of the council, the funds of the council and the steps needed to lay a charge against a traditional health practitioner as well as inquiries into charges of misconduct.

¹⁰ A person whose work engages in ritual ceremonial activity and prayer (Hill 2003:9)

2.6. EXPERIENCES OF INTER-SECTORAL COLLABORATIONS IN SELECTED AFRICAN COUNTRIES

HIV/AIDS has had a significant impact on individuals and communities everywhere in the world, particularly in Sub-Saharan Africa. Modern medicine (Richter 2003:8, Chipfakacha 1997:417), therefore attention has been drawn not only to the potential of THs and their medicines but primarily to the major role traditional healers can play in the implementation of national strategies for the prevention and control of HIV infection and amelioration of symptoms caused by opportunistic infections and AIDS (WHO 1990:3). This is not to say that THs have better treatment or a desperately needed cure for HIV/AIDS, there need to work together with them (since most Africans still make great use of their services), rather than discrediting them and their services.

Collaborative health programs involving THs have been advocated by WHO and UNICEF since 1977-78 (Green et al 1995:503, Makhathini 2003:1) and several Sub-Saharan African governments continue to seek ways to incorporate the services of healers within biomedicine in an attempt to deliver health care to the majority of people who have limited access to modern health care. These programmes include community based care, health education, counselling, and the relief of certain symptomatic conditions. In addition to these areas, there is also a potential for involving THPs in providing the community with culture specific information on sexual behaviour and channelling specific health promotional messages (WHO 1990:30).

With the realization that THs could become effective health workers for HIV prevention and given their traditional roles as educators and counsellors in their communities (UNAIDS 2000:14), pilot collaborative programs that focus on primary health care and HIV/AIDS training for THs have been started in Nigeria, Zambia, Ghana, Swaziland, Kenya, Botswana, and Uganda, South Africa and Zimbabwe (Chipfakacha 1997:419, Green et al 1995:503). However, there have been constraints in implementing such collaborative efforts. It is further reported that some of such programs have faltered or been discontinued. Despite a few setbacks in such

programs, there has been a rekindling of interest in THs on the part of African governments and donor organizations concerned with HIV/AIDS prevention (Green et al 1995:504).

2.6.1 BOTSWANA

The Botswana Government has a policy actively promoting cooperation between modern and traditional medicine (UNAIDS 2005:15 WHO 1995:31). Activities of the Ministry of Health and National AIDS programme for traditional healers have included seminars on AIDS and implementing the “Botswana Dingaka AIDS Awareness and Training Project” which took place between 1991 and 1992. According to WHO (1990:44), at these seminars views were exchanged with THPs about the probable aetiology of various diseases, their management, and the prevention of public health problems. In addition, THPs have been successfully involved in the management of diarrhoeal diseases and tuberculosis in Botswana. The traditional healers were also trained as trainers who would pass AIDS information onto other traditional healers in selected pilot areas and promoting cooperation and collaboration between traditional and biomedical health services. Trained healers were then expected to train more healers, obtain condoms from health centres and distribute them to their clients and communities. An assessment was done in 1995 and trained healers reported that they were able to disseminate information in their communities, had referred patients to hospitals when their treatment failed and had no hesitation in distributing condoms or talking to their clients (UNAIDS 2000:15).

2.6.2 MOZAMBIQUE

As early as 1991, the Ministry of Health and Department of Traditional Health initiated a three-year programme with the aim of decreasing the spread of HIV by reducing the incidence of STDs through a collaborative effort with a local healers’ organization (UNAIDS 2000:18). Specifically, a proposed objective was to reduce STD incidence and thereby HIV seropositivity by first modifying the behaviour of THs and through them modifying the behaviour of their clients (Green 1999:34).

This entailed the introduction of new concepts, such as promoting condom use and certain traditional principles (such as discouraging sex outside marriage or promoting sexual abstinence during STD treatment (UNAIDS 2000:18). Based on this strategy, two one day workshops were conducted for thirty healers in two provinces in 1991 and 1994. An assessment workshop was done in 1994, which included seventy trained healers and eight trained patients. The evaluation found that most traditional healers had learned about the sexual transmission of HIV. Seventy-five percent reported condom use as a way to avoid AIDS. However, confusion remained as to the relationship between STDs, HIV and AIDS and about whether AIDS is curable (UNAIDS 2000: 18).

However, it is not mentioned whether traditional healers knew about condoms or not before this training, though preliminary qualitative research on traditional healers' perceptions of STDs and AIDS was done. This pre-training research revealed strong belief by THs that biomedicine personnel "do not understand the true cause of STDs". According to UNAIDS (2000: 18) "the healers had faith in their medicine, advised avoiding biomedicine for STDs and believed a number of illness (but not AIDS) to be sexually transmitted". As a result it is difficult to say whether this training was effective or not.

2.6.3 SOUTH AFRICA

Since the 1970s there have been several attempts at collaboration between traditional healers and biomedical personnel in South Africa. According to Abdool-Karim et al (1994: 11) MEDUNSA conducted an experiment in which African traditional healers participated alongside biomedical personnel. In this experiment, patients were referred by one group to the other and vice versa. Meetings to discuss drugs and other treatments were held. Abdool-Karim et al (1994:11) further report that when herbal medications used by the healers were analysed at MEDUNSA laboratories, therapeutically active ingredients as well as harmful agents were identified. Other institutions such as Valley Trust in KwaZulu- Natal held several professional

meetings and exchanges between traditional healers and biomedical personnel (Abdool-Karim et al 1994:12).

2.6.4 UGANDA

In the early 1990s, two Non-Governmental Organizations (NGOs),¹¹ and the Ministry of Health and the National AIDS commission, launched an initiative known as THETA (UNAIDS 2000:19). The aim of this initiative was to promote a true collaboration between traditional healers and biomedical health providers in the area of treatment, care, support and prevention of STDs and AIDS. In 1992, the first THETA project based in Kampala, attempted a collaborative clinical study to evaluate herbal treatments for HIV/AIDS symptoms for which few or no therapeutic options were available in the region (UNAIDS 2002:31, UNAIDS 2000:19). The first phase aimed at evaluating traditional herbal treatments for specific symptoms and the second tested the effect of empowering THs as STIs/ AIDS educators and counsellors (UNAIDS 2000:31). The project also had a particular focus on the healers' women clients in Kampala where the prevalence had reached around 30% in pregnant women. Healers used skills acquired, for example community education, counselling and facilitating youth or women support groups. Community education by the healers proved to be a very interactive process whereby traditional healers designed their own training materials and developed and used unique approaches such as storytelling, personal testimonies from persons living with HIV/AIDS, music, dance, poetry and drama to convey their messages. A preliminary assessment was conducted a year later, comparing three communities where healers had completed THETA curriculum with one community where healers had not been trained.

Condom knowledge, attitudes and use were found to significantly increase over time among women clients. Within the first year of training three of the trained healers spontaneously initiated the formation of persons living with HIV/AIDS support groups for their clients, some of who achieved local renown for their educational

¹¹ The AIDS support organization (TASO) and Médecins Sans Frontières (MSF)

songs, drama and dance on AIDS. A participatory evaluation of THETA conducted in 1997-1998 showed that 125 traditional healers were trained in the first five districts selected; 60% of trained traditional healers reported distributing condoms to patients; 82% of them (compared to 40% of untrained traditional healers) reported counselling patients (UNAIDS 2002:19). From the above discussion, we can see that the Ugandan example is the only true collaboration which seems to have been successful.

2.6.5 ZIMBABWE

In Zimbabwe, the healers' association, Zimbabwe Traditional Healers Association (ZINATHA), was established immediately after independence. In 1981, the Government enacted the Traditional Medical Practitioners Act, which has assisted the development of traditional medicine in a number of ways. This Act recognized ZINATHA as the official representative of traditional healers in Zimbabwe (WHO 1990: 46). This enabled the traditional healers to organize themselves more openly and effectively. The Act also enabled the traditional healers to form a traditional medical council known as Zimbabwe Traditional Medical Practitioners Council. These developments have facilitated research into traditional medicine in Zimbabwe. ZINATHA joined the fight against HIV/AIDS in 1988, by organizing their own workshops to train their members (Chipkafacka 1997: 419).

Having realised the importance of traditional healers in primary health care, it became apparent that African traditional healers could also be partners in the prevention and care of HIV/AIDS in their communities. Several countries set up programmes in attempts to bring about collaboration between African traditional healers and biomedical personnel. Botswana, Mozambique and Zimbabwe have trained traditional healers in several aspects of the biomedical model of HIV such as its aetiology and management. On the other hand some countries such as South Africa and Uganda have taken a step further by initiating collaboration between biomedical personnel and traditional healers.

2.7 CONCLUSION

Even though traditional healers and their practices were undermined under various colonial regimes, they never disappeared. They continue to exist alongside biomedical systems even today. There are different types of traditional healers in the continent. These include herbalists, diviners, faith healers, traditional birth attendants and visionaries. All these types of healers play a crucial role in the provision of primary health care in most African communities. They are easily accessible and largely accepted by the members of their communities. Their fees are flexible for the benefit of their patients. But most importantly traditional healers speak the same language as their patients, which is crucial in disseminating valuable health information to the communities. Traditional healers treat illnesses such as arthritis, mental health problems, bewitching, ulcers, and heart problems, as well as various STDs such as gonorrhoea, syphilis and HIV/AIDS. In addition to prohibiting certain behaviour, THs prescribe treatments as well as preventative charms in an attempt to prevent illnesses and diseases.

Due to their recognised skill in the provision of primary health care, traditional healers play an active role in the prevention and treatment of HIV/AIDS in many African communities. Traditional healers employ a holistic approach in treating their patients, as both spiritual and physical aspects are looked into in the presence of a patient's family. This paves the way for family counselling and support for the patient. Traditional healers are in a better position to disseminate HIV/AIDS messages in their communities, as they are already involved in health care, especially in areas where there is limited access to other forms of information such as media. In addition traditional healers live in the same communities as their patients and communities and can readily deliver HIV/AIDS information.

Traditional healers are also in a better position to persuade their communities to modify cultural practices which seem detrimental to their health. However, this can only be achieved if the healers have correct and adequate information about HIV/AIDS. Traditional healers have long experience in treating STDs, which are

largely linked with HIV transmission. The healers are consulted to treat STDs because of the general belief that they can effectively treat them, using different medical plants. Some of these plants have also proven to be effective in treating HIV/AIDS symptoms in patients, such as mouth ulcers, oral thrush and thereby improving the quality of a patient's life.

Even though traditional healers appear to be valuable in the prevention and care of HIV/AIDS in most African countries, there is a danger that they contribute to its spread if they transmit negative messages such as attaching witchcraft as the cause of death of a person who had AIDS related symptoms; and if they employ unprotected practices in handling their patients. Further potentially harmful consequences may follow if they delay in referring patients to the hospitals, or attempt to suck blood out of the patients using their mouths.

The WHO has been at the forefront of ensuring that traditional healers are included in national health policies in countries affiliated with the organization. Many African countries also adopted national policies or regulations for traditional healers. Some of the countries in the region have taken the further step of initiating projects whereby biomedical practitioners and traditional health practitioners begin to work together, particularly in Uganda. Other countries have simply provided the healers with HIV/AIDS training. Biomedical personnel are inclined only to share the information they have with THs, not necessarily collaborate with them.

The chapter has focused on traditional healers' positive qualities, which seem to be useful against HIV/AIDS. However, gaps can also be identified. The chapter addresses how THs can contribute in the prevention of HIV/AIDS in their communities on condition that they are given thorough HIV/AIDS training. The preconceptions of THs around HIV/AIDS are important to recognise but not necessarily investigated prior to training. The literature also advocates that traditional healers can be used as a source of HIV/AIDS information in their communities. Are traditional healers confident enough to educate members of their communities about HIV/AIDS issues? In addition, in some countries THs are distributing condoms to

their patients and other members of their communities. Condoms are a foreign entity to the healers. The literature I consulted does not stipulate healers' views and concerns about condoms and their use. Some authors argue that traditional healers should be given hygiene education, as this is the key in the prevention of communicable disease. Do traditional healers have their own basic hygiene measures in order to ensure that diseases do not spread any further?

The literature also clearly shows that traditional healers have been and are still actively involved in treating various diseases in their communities. There is a need to know exactly how traditional healers care for their HIV/AIDS patients other than prescribing herbal medication. In addition it is apparent that traditional healers provide home-based care. How do they provide home-based care? Does it differ from care offered within hospitals? It is also claimed that traditional medicines have proven to be effective in improving the lives of people living with HIV/AIDS. Which are those medicines? Are traditional healers willing to share such valuable medicines with other people as biomedical personnel have done with ARVs? Biomedical personnel have various views about traditional medicines as far as HIV/AIDS is concerned. These views are both negative and positive. The healers' thoughts about the use of their medicines and ARVs are also of value. It is also crucial to know how long healers take to refer their patients to hospitals and under which conditions. Most importantly, do healers encourage their patients to disclose their HIV status? Some of these issues are taken up in the presentation below.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This chapter outlines the steps the researcher took in collecting data for the study. The chapter first provides a brief overview of the area of the study, then discusses the study's design. A section on research design encompasses the methodological paradigm followed, how respondents were selected, tools for the data collection and data analysis procedure. Ethical issues are also highlighted, and finally the limitations of the study are discussed.

3.2 AREA OF STUDY

The study was conducted in the Roma¹² valley, thirty-five kilometres away from Maseru, the capital city. In the valley there are twenty-three villages. The country's only university, the National University of Lesotho (NUL), is situated in the valley. Roma is regarded as the headquarters of Lesotho Roman Catholic Church, which was founded in 1862. It has one hospital that serves the entire valley and the neighbouring villages. According to the 1996 census, the population of the valley was approximately 10,500.

Data was also collected in the District of Berea, in a small town called Teyateyaneng¹³ where the population is approximately 22,806. The data was collected in five villages.

3.3 RESEARCH DESIGN

The study is qualitative, explorative and descriptive, the main objective of this study is to explore and describe the practices of THs in the prevention and care of HIV/AIDS in Lesotho. The intention was to design a study with the capacity to

¹² See Appendix 2

¹³ See Appendix 3

capture emotions, views, opinions, experiences and attitudes of THs as the main actors in this study and to understand the meaning THs attach to their experiences. As a result the study adopted an interpretive approach research design to data collection and analysis. According to Geertz (1973:25) ethnographic study is interpretive because the flow of social discourse and the interpretation involved consists in trying to rescue the “said” of such discourse for perishing occasions and fix it in perusable terms. Geertz (1973:25) explains that an anthropologist has to engage with the informants as persons rather than as objects. The interpretive approach argues that research should explore:

“...socially meaningful behaviour through the detailed observation of people in natural settings in order to arrive at understandings and interpretations of how people create and maintain their social world.”
(Neuman 1997:68 in Kamali 2001:70)”.

This approach was seen as a suitable research design for this study as opposed to a more positivist approach. The interpretive approach research design emerged out of the criticism that the social world cannot be studied using the same techniques used to study the natural world as implied by the positivist approach. The positivist approach argues that the world exists independent of people’s perceptions of it and that science uses objective techniques to establish what exists in the world (Sullivan 2001:47).

More specifically, research design informs which research methods will be used. However research design must not be confused with research methods. Babbie et al (2001:49) state:

“The application of methods and techniques in the research involves a variety of assumptions. They include certain assumptions and values regarding their use under specific circumstances”.

Interpretive research design was chosen because it employs methods which rely on detailed and “thick” verbal descriptions by informants of a particular social context in question. This implies that researchers should explore “...socially meaningful

action through the direct detailed observation of the people in natural settings in order to arrive at understandings and interpretations of how people create and maintain their social world” (Neuman 1997:68). The study used face-to-face interviews to collect data whilst recording interviewees’ responses and their interpretation. The study has provided thick verbal descriptions which traditional healers attach to their healing experiences and HIV/AIDS.

The next section discusses the methodological paradigm adopted in this study based on the research’s design. The term “methodological paradigm” is used to include both the actual methods and techniques that social researchers use as well as the underlying principles and assumptions regarding their use.

3.3.1 METHODOLOGICAL PARADIGM

The three methodological paradigms dominating the scene in recent social science research are the quantitative, qualitative and participatory action paradigms (Babbie and Mouton 2001:49). The study presented here mainly employed the qualitative paradigm:

“Qualitative researchers always attempt to study human action from the insiders’ perspective. The goal of research is defined as describing and understanding rather than the explanation and prediction of human behaviour” (Babbie and Mouton 2001:53)”.

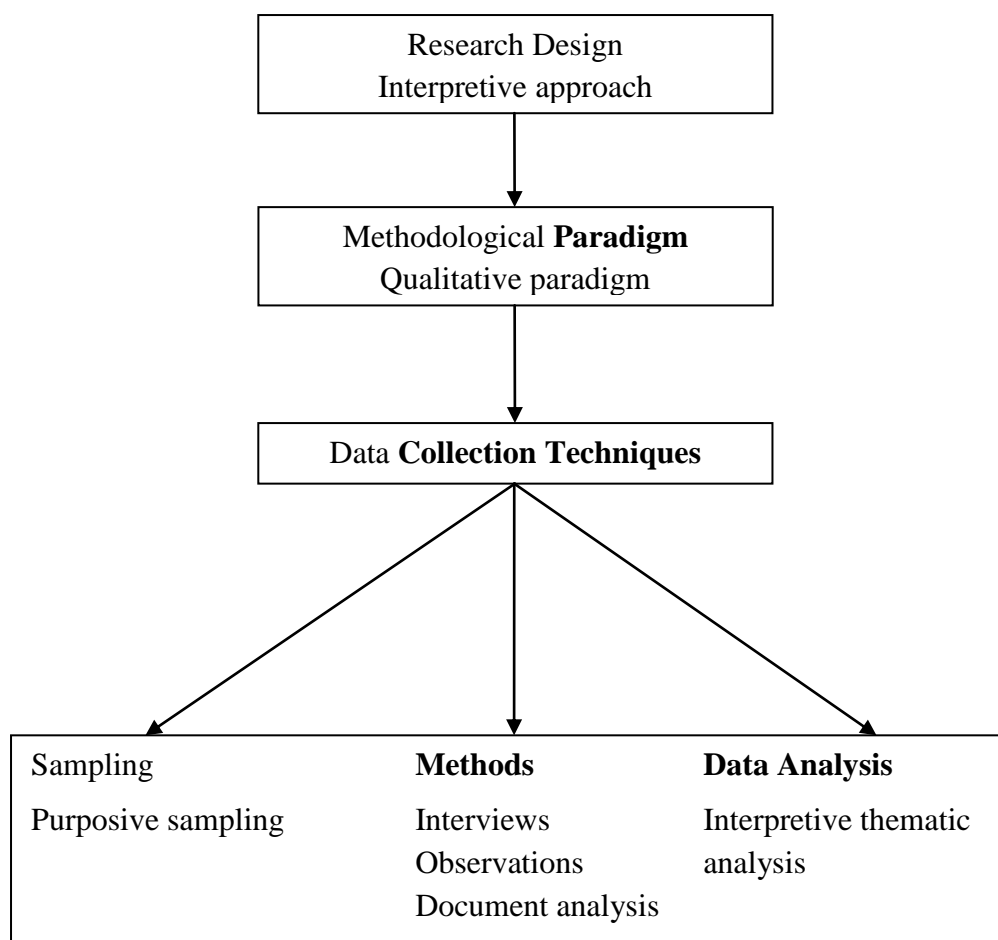
The other two methodological paradigms, that is quantitative and participatory action paradigms, were not suitable for this study. Quantitative paradigm presents people’s views and attitudes towards a topic in question in a numeric form rather than words. Babbie and Mouton (2001:49) state:

“The quantitative researcher believes that the best, or only, way of measuring the properties of phenomena is through quantitative measurement that is assigning numbers to the perceived qualities of things”.

The qualitative methodological paradigm was seen as the most suitable methodological paradigm for this study. Many aspects of THs' practices cannot be quantified, that is in the form of numbers. They need to be described and understood from the healers' point of view. Qualitative methodology allows the research to do this. In addition, the study's objectives suggest that it is an exploratory study. This requires an open-ended qualitative approach.

The research design illustrating the methodological paradigm followed is summarised in Figure 3.

Figure 3: Summary of Research Design and Methodological Paradigm.



Source: The Author

3.3.2 SAMPLING AND DATA COLLECTION PROCEDURE

3.3.2.1 SAMPLING

Sampling is the process of selecting observations (Babbie et al 2001:164). This implies that not everyone can be included to participate in the study, and so a certain number of participants are selected to represent the general population. I used purposive sampling in this study. This kind of sampling is based on prior knowledge, of the populations and also on the nature of the researcher's aims (Babbie 1998:195). Selection of the study's sample, based on the researcher's judgement and prior knowledge, was the method selected to provide the best information (Sullivan 2001:209). I deliberately chose a sample of traditional healers due to the purpose of

the study. The sample reflects the characteristics of the group that the researcher wants to make statements or conclusions about (Smit 2000:103). Twenty respondents were interviewed.

The data collection process took longer than anticipated, stretching to almost five months from March to July 2006. This was due to circumstances beyond my control, as the availability of respondents could not be guaranteed. Respondents sometimes were not available on the day of the interview despite prior arrangements, as they had to attend urgent personal commitments. This means that the appointments had to be rescheduled. Others took longer than expected to respond to my request to see them or to grant permission for me to obtain information from their organizations. Some of the respondents, for example government officials or staff of organisations, were too busy to reschedule an appointment. They were either out attending workshops and meetings or out of the office for several days. Other delays were from my office's commitments, as I had to put data collection on hold for few weeks due to my tight schedule at work, as I am a full time civil servant.

I embarked on the research having not had prior personal contact with THs. When discussing the study with others (including healers) many had reservations about the study, perhaps based on a concern about *boloi* or witchcraft associated with THs.

I initially consulted the traditional healers' council office, which is based in the Ministry of Tourism, Environment and Culture (MTEC) in Maseru. This was to obtain permission from the council to interview its members living at Roma. Dewalt et al (2002:37) affirm, "...gaining permission is the first step in carrying out research." However gaining such access can take time and this was the case in obtaining permission from the council. The key informant was reluctant at first but after posing several questions to me, I was asked to submit my questionnaire for review and comments. The key informant said:

"You will have to give us the questions you want to ask traditional healers in order to have a look at them. This is to see what kind of questions you are going to ask the healers and also give you some

guidance on how to ask some of them as you are dealing with a very sensitive issue. You will have to come in a week's time to get the response”.

I submitted two different sets of questions to the council both written in Sesotho and awaited their response. These were questions that I intended to ask the traditional healers as well as questions for their patients. This was to give the council the opportunity to see what kind of questions I would ask the healers' patients and whether they were acceptable to them. In the meantime, I also tried to schedule interviews with other relevant people in Government and other organizations, but most people were too busy to schedule an appointment or were out of the office. It took about three weeks to get the response from the council. The chairperson was either out of the office or busy with other matters. I myself had to go through a set of questions from the council about myself, such as my age, marital status, whether I was planning to get married, whether I had any children. I guessed that my gender was also in question though it was not asked. I was afraid that some of the questions would not be approved. The key informant said:

“Ausi (a way to address a girl) you are still young and not married, why do you want to know about condoms and sex? You know in our tradition adults do not discuss sexual matters with young people especially when you are not married. Another thing a true traditional healer would never tell you the names of medical plants (lithlare). How do you intend to ask that question”?

I, as the researcher, responded:

“It is not that I want to know about sex, I am just interested on sexual issues healers discuss with their patients in relation to HIV/AIDS”.

The key informant discussed his concerns about HIV/AIDS and healers in the country. He told me that he could not allow me to talk to the healers in his absence: he would be concerned that some healers would feel betrayed that the council had given a person who was not even a healer herself permission to talk to them? The

council informed me that the best way forward was to have a workshop or a meeting with the healers (even though a workshop would not enable me to collect detailed data). Respecting the notion that the potential respondents have the right to have a say in the way in which they are studied and represented (Saukko 2003:20), I was concerned about the quality of data I would collect using this approach. This would also mean disrupting the healers' daily activities, as they had to travel about one hour and thirty minutes to and from Roma.

Conducting a workshop would impose major financial problems on me as I would have to take care of transport expenses and lunch for the identified respondents on the day of the meeting. I was told the Ministry's boardroom could be used for the venue. This approach would have denied me an opportunity to make some observations as to the healers' social setting and other information that might be useful to the study. There were also ethical obligations to observe as well, such as respecting the respondents privacy and confidentiality (discussed in detail in the next section).

I had deliberately chosen to conduct this study in my home village as I would be easily understood, and understand my respondents without any difficulties, and I knew my way around. I did not have to hire an escort or translator to assist me. Jackson (1987 in Rapport et al 2000:21) reinforces the view that anthropology has returned home because research there is easier to access, cheaper and faster. However there are some difficulties associated with research conducted at a researcher's home. Hence an anthropologist at home must sometimes work harder not to take things for granted and to make himself view things as a stranger might.

I then requested the council to allow me to conduct the interviews in the respondents' social settings where the respondents would be comfortable. Besides they would not have to travel from their places, and they would be able to carry on with their daily activities. I also explained ethical considerations, which must be strictly observed in conducting research. I asked the chairperson that if it was impossible for me to interview the healers on my own, to have at least a healer based at Roma who would

present/introduce me to the healers. Following a long discussion, verbal permission was granted. After several weeks I was called to the Council's office to meet my escort who was also a healer based at Roma. The escort was the first respondent of the study. I had a list of the villages in Roma and then asked my escort which villages had traditional healers who could be respondents. The villages with traditional healers were identified.

The escort introduced me to all the respondents and thereafter it was all my responsibility to introduce myself and state the purpose of the study. Introductions were done on the days when the escort was not working, mainly on Tuesdays and Thursdays. Those days were just for introducing me and making appointments. I would then take the respondent's contact details in order to confirm before the day of the interview. However, this arrangement was very time consuming, as I had to work according to the escort's schedule. Interviews at Roma were conducted from May to June 2006.

I also interviewed traditional healers in the Berea District. I was invited to talk to healers by the chairperson of the traditional healers in this district. I was promised to have written permission,¹⁴ obtained on the 30th June 2006, which would allow me to interview traditional healers in Berea. The Chairperson from Berea was enthusiastic about my research topic unlike the Chairperson based in Maseru. The Chairperson gave me all necessary and relevant information regarding traditional healers and HIV/AIDS at least within Berea. I was also informed that Berea's THs had submitted a proposal to the National AIDS Commission (NAC) for HIV/AIDS training workshop for Berea District healers, scheduled to take place sometime in September 2006. The chairperson also added some essential questions, and gave me some hints on how to ask certain questions regarding the healers' medicines. My working relationship with Berea chairperson really improved, to the extent that I was invited to a workshop, with the theme of traditional healers and HIV/AIDS.

¹⁴ See Appendix 4

The Chairperson provided relevant information, such as which villages I could visit, the list of healers in the districts and their contact details. I made appointments in person by cell phone. Interviews in Berea were conducted from 3rd July to 23rd July 2006. I did not rely on the escort this time as I was just given written permission that I presented to all the respondents (and directions with contact details of the healers).

3.3.2.2 Data collection

Interviews

The non-schedule, standardized, in-depth interview was used as the main tool to collect primary data for the study. In an interview, an interviewer reads questions to respondents and records their answers (Sullivan 2001:255) and is typically done in a face to face encounter (Babbie 1999:242, Babbie 1998:264). The interviewee is fully engaged in an interview. The non-schedule interview has a specific topic and the same specific questions are asked of all respondents (Sullivan 2001:265). The in-depth interview on the other hand focuses in detail on the life experience and social behaviour of respondents. This kind of interview allows the respondent to describe and explore their experiences and thoughts while the researcher guides them towards a particular area of interest of the research (Power 2002:87).

In this study a questionnaire¹⁵ was used in order to guide the interview. I conducted the interviews personally and the respondents were asked the same open-ended questions from the questionnaire and their response was tape-recorded. Notes were also taken. I purposely chose to use this kind of questioning because it gives the respondents freedom of expression, that is, the respondents were able to give their views and opinions without any restriction. The problem with open-ended questions is that the respondents tend to give information that might not necessarily be relevant. As a result I had to move back and forth with further questions, (probing), in order to keep the respondents on track concerning the study's main theme.

¹⁵ Refer to Appendix 5

Face to face interviews as opposed to self-administered questionnaires was chosen as an appropriate method for this study because interviews give the researcher the opportunity to explain questions that respondents may not understand. This way the number of “don’t knows” and negative answers are minimized (Babbie 1995:264).

Where necessary 6 interviews were done telephonically, where respondents were not available for a face-to-face interview. They were either out of the office or too busy for a longer interview. These were mainly people whom I believed could provide valuable information such as some of the Government’s officials and other people relevant for the study. A telephone interview with them was the only option here. The primary respondents; traditional healers were never interviewed via the telephone.

Other data collection methods: Document analysis

This method was basically used to supplement data collected through interviews. I used this method to generate detailed background information.

Document analysis refers to the collection, review, interrogation and analysis of various forms of primary source of research data (O’Leary 2004:177). However, in this particular study, this method was not used as primary source of data but rather as a way to supplement interviews. The term document includes photographs, works of art and even television programmes.

“Documents suitable for analysis are wide and varied. They can contain numbers, words or pictures” (O’Leary 2004:178).

In this study, document analysis included maps, photographs of plants and videos. These secondary sources proved to be very important informative data in this study. These included maps of the Lesotho, Roma and Teyateyaneng. The documentary videos consisted of information about indigenous plants of Lesotho commonly used by traditional healers.

3.3.3 PROCESSING AND ANALYSIS OF DATA.

3.3.3.1 TRANSCRIPTION

The researcher interviewed Sesotho speaking respondents who were tape-recorded and their responses transcribed. This entails changing the form of the raw data from verbal into textual. This gave me the opportunity of becoming familiar with the raw data. In some instances ambiguous answers were noticed. In cases like this, I went back to the interviewees in order to get clear and specific answers. The tapes were transcribed in full. This is what Miles and Huberman (1994) call data reduction. Data reduction refers to the process of selecting, focusing, simplifying, abstracting and transforming the data that appear in written up field notes or transcriptions (Miles and Huberman 1994:10).

3.3.3.2 Analysis

Data was qualitatively analysed. Qualitative analysis is a procedure whereby data, which is collected, is transformed into a form of explanations or interpretation of people or situations that are being investigated (Lewins et al 2005:1). The process of qualitative data analysis involves two processes, namely writing, and identification of themes. Firstly I transformed the verbal conversation from the tapes into text, based on themes identified from the questionnaires and those which came up during the interview. The data was then presented in a form of findings. The purpose was to report the views of the respondents on the subject in question. Findings were then interpreted.

3.4 LIMITATIONS OF THE STUDY

One of the major limitations of the study arises from the fact that THs' patients are excluded from the study. I had indicated in the study proposal that the healers' patients would also be interviewed so as to find out whether the information regarding HIV/AIDS conveyed to them is suitable. Patients were also originally intended to be included because the literature indicates that some people in the country do get HIV/AIDS information from THs. As a result I had intended to find out what kind of information traditional healers convey to their patients, and whether

the information is appropriate and accurate. The patient interviewees were mainly going to be obtained from the healers themselves. I had hoped that the healer would ask their patients if they would participate in the study. Unfortunately, I failed to get the healers' patients to participate in the study. Most healers were very reluctant to allow me to interview their patients, despite all my efforts to explain that I was mainly interested in anyone who consults a traditional healer regardless of their HIV status and that information given to me would be confidential. I detected from their responses that healers were thinking that only HIV positive patients could participate in the study. One of the healers stated:

*“Talking to my patients is bit difficult, because I am not supposed to give out any information on my patients. If I give out their names, that means I would have broken a contract between us, even though not written down. A true traditional healer has **koma** (deep secret), as patients' information is very confidential”.*

From the above response, it is clear that traditional healers respect the confidentiality of their patient:

*“Besides, since many of you educated people disregard traditional healers and their practices, people who consult traditional healers tend to hide that they consult traditional healers. And more importantly, there is tendency for people who consult **Bo-Nkhekhe** (another way of addressing a traditional healer in Sesotho) to be shamefully spoken about by those who do not recognise our importance. Furthermore, this illness you want to talk about, people who have it are discriminated upon. They tend to lose their friends, and their neighbours stop visiting their families. Actually it is double embarrassment on them, having HIV/AIDS and consulting with traditional healers, as most people dislike us”.*

I could not conceal that the study was related to HIV/AIDS and that the questions, which were going to be asked, related to HIV/AIDS and traditional healers. I was bound by research ethics, which are discussed in detail later in this chapter. However

some promised to ask their patients and I was asked to call later to get the response, but all in vain. It took me almost four months of coaxing all the interviewed healers to ask their patients to participate in the study. When all had failed, other options were tried in order to obtain access to people who consult THs.

When I realized that there was very limited chance of obtaining healers' patients through the healers, I opted to approach organizations, which specifically work with HIV positive people, such as Botšabelo (also known as Sankatane) clinic based in Maseru. This clinic deals with HIV positive people only. It provides pre-test and post-HIV test counselling, HIV/AIDS education and provision of HIV/AIDS treatment such as ARVs. Other organizations consulted were people living openly with HIV/AIDS (PLOWA) and Society of Women and AIDS Africa (SWAA). Initially, these organizations were going to be consulted to provide assistance to patients who were respondents, should they suffer stress during the interview process. However, I also failed to get respondents from these organizations. I was informed that patients were not allowed to use traditional medicines when they are using the clinic's services and for this reason, there would be no one suitable for participation in the study. (These organizations were consulted in the end to find out whether they had support groups for people living with HIV/AIDS).

After being introduced to the patients by the Director of Sankatana clinic I was also given an opportunity to introduce myself and present the purpose of the study. I was given an office from which I could work or at least conduct interviews. Three weeks of being present at the clinic daily yielded no response. In all probability, their reluctance to be interviewed stemmed from possible fear of talking to a stranger about a forbidden activity.

Other organizations such as PLOWA asked me to submit the study proposal as well as the questionnaire, which would be discussed with Board members of those organizations. If the Board approved, then I would be notified. It took a while before I was given a response, which was more or less the same as the one I was given before. One key informant at PLOWA said:

“Patients have reported using traditional medicines particularly herbal products bought at chemists or from hawkers selling raw herbal medicines, not particularly consulting traditional healer”.

I believe that the study’s findings could have been more comprehensive had I employed ethnographic methodology, which entails participant observation as a method in collecting the data. This method entails that the researcher enters into the respondents’ social settings and gets to know people involved in it (Emerson et al 1995:1). Due to time constraints, this method could not be used.

3.5 ETHICAL CONSIDERATIONS

Social inquiry is said to invade people’s lives, because they are expected to reveal to strangers certain aspects of their lives unknown to anyone but themselves. Some of the questions may even make them very uncomfortable. There are therefore crucial ethical obligations that every researcher has to observe every time social enquiry is conducted. Ethical issues in social science research have to do with how researchers treat people being studied (Sullivan 2001:58) and the importance first and foremost of not harming them.

3.5.1 INFORMED CONSENT

I had an introductory page¹⁶ stating my name, degree, research topic and the purpose of the study. This page requested respondents’ permission to ask them questions about the work in relation to HIV/AIDS. This page was written in Sesotho and it was left with the respondents after the interview. The introductory page also had all my contact details, for respondents to call me should there be a need to do so. An important aspect of this introductory page was a request that the respondents sign an informed consent form,¹⁷ after fully understanding the purpose of the study. Informed consent implies telling potential research participants about all aspects of the research that might reasonably influence their decision to participate in the study

¹⁶ See Appendix 6

¹⁷ See Appendix 7

(Sullivan 2001:59, O’Leary 2004:53). The informed consent was issued to respondents to assure them that they had a right to ask me questions, did not have to answer any questions which they were uncomfortable about, and that they could withdraw from the study at any stage of the interview. This introductory page also explained that the response would be anonymous. Nobody except the researcher would be able link any information provided to the respondents to themselves.

3.5.2 VOLUNTARY PARTICIPATION

It is every researcher’s responsibility to inform potential respondents that their participation in the study is completely voluntary. Even though the researcher may be in need of information, respondents should not be forced to participate in the study against their own will. Researchers must respect a respondent’s right to refuse to participate in the study. The surest way of ensuring that people understand that participation is voluntary is to explicitly tell them so (De Vaus 2001:84). My escort introduced me to one of the potential respondents and explained the purpose of our visit. The respondent did not even give me the chance to explain myself.

“People like her always come and ask us question about our work, but we never benefit anything not even the country. After she has acquired her “lengthily” certificates we won’t benefit anything. And at the moment I’m very busy I won’t be able to help her¹⁸”.

3.5.3 ANONYMITY AND CONFIDENTIALITY

Two common methods researchers use to protect participants are anonymity and confidentiality. According Nachmias et al (1996:88) the obligation to protect the anonymity of research participants and to keep data confidential is all inclusive. It should be fulfilled at all costs unless the researcher makes arrangements to the contrary with the participants.

¹⁸ Response from one of the traditional healers

3.5.3.1 Anonymity

It is the duty of researchers to ensure that the participants in any study are anonymous. This is done by separating the identity of individuals from the information they give (Nachmias and Nachmias 1996:88) and from any subsequent report. Participants are considered anonymous when the researcher or other persons cannot identify the participants with information they had provided. Participants in this study were anonymous to all except the researcher. It was necessary to retain the link due to the need to go back to the participants to get more information and clarify answers. Nachmias and Nachmias (1996:89) further report that in analysing data, researchers must also maintain anonymity by separating identifying information from the data itself. The participants were generalised in the data analysis, that is, information provided in the finds and discussion does not reveal the identity of the particular participants.

3.5.3.2 Confidentiality

Participants in social science research are often told that the information they provide will be treated as confidential, that is, even though the researchers are able to identify particular participants information they will reveal it publicly (Nachmias and Nachmias 1996:89). The informed consent form as discussed in the previous section assured the participants that the information they have provided would not be published in the media whatsoever, that is, in the newspapers or in various radio stations in the country.

3.6 OBJECTIVITY OF THE STUDY

This section attempts to explore the objectivity of the study. Objectivity represents a continuum of closeness to an accurate description and understanding of the observable phenomena (Dewalt and Dewalt 2002:94). In social science objectivity is often broken down in two concepts, reliability and validity.

3.6.1 RELIABILITY

Reliability refers to the extent to which research results can be reproduced using the same approach under different circumstances (Dewalt et al 2002:95). Reliability in qualitative research uses dependability. Dependability can be used to examine the process and the product of research for consistency. The process refers to the methods used in collecting the data. According to Golafshani (2003:601) the consistency of data is achieved when steps of the research are verified through examination of raw data, data reduction products and process notes. Reliability in this study was checked through several interviews conducted with the respondents. The respondents were interviewed more than once. Follow-up, interviews were solely to clarify issues, which were initially not clear to me. Respondents provided additional information or clarified accounts provided previously.

3.6.2 VALIDITY

Validity refers to the quality of any type of observation. In other words, it has to do with the extent to which the results of the observations correspond to the presumed underlying reality (Dewalt et al 2002:96). To make sure that the results were valid, I interviewed respondents other than the key informants (traditional healers). In addition I also used different, complementary data such as secondary studies, for example videocassettes, maps and photographs.

CHAPTER 4

FINDINGS

4.1 INTRODUCTION

The chapter presents the results of the study, starting with the demographic description of the sample. Thereafter, the chapter focuses on the healing practices of the respondents, looking at how the respondents became healers, types of traditional healers and how they heal. The number of patients seen and the fees charged are outlined. Illnesses as well as diseases are described along with the medications used. The chapter then proceeds to discuss the core theme of the study; the practices of traditional healers in the prevention and care of HIV/AIDS. This theme explores the respondents' HIV/AIDS knowledge, which encompasses sub themes such as their definition of HIV and AIDS, how HIV/AIDS is transmitted, how it can be prevented, the use of condoms, and care of HIV/AIDS patients. This section also explores traditional healers' communication with their patients and communities about sexual behaviour and HIV/AIDS. Issues such as referring patients and use of antiretroviral (ARVs) are also discussed. Finally the chapter explores their membership of the Lesotho Traditional Medicinemen Practitioners Council (LTMPC) and HIV/AIDS training.

4.2 DEMOGRAPHIC DESCRIPTION OF THE SAMPLE

There were 20 participants in this study who ranged in age from 25 to 64. The majority of the respondents were males (13). Half of the respondents were between 45-54 years of age, and one fifth of the respondents were between 55-64 years old. Two respondents were between 25-34 years old and another two were between 35-44 years old.

The majority of the respondents (19) had had some primary education, though four of them never completed it. Thirteen respondents completed primary education. Eight of them had completed their secondary school education. (Two respondents began, but never completed their high school education). There is no information on

the level of education of one respondent as there was a reluctance to answer this question.

Most of the respondents were married (14) with the exception of one respondent who had divorced but remarried, while five respondents were widowed.

4.3 HEALING PRACTICE

4.3.1 BECOMING A HEALER

The respondents had been working as healers for varying lengths of time. Some of the healers reported that they had been healers since 1965, while others started later (2002).

The majority of the respondents (16) indicated that they had been informed by their ancestors (*balimo*), in their dreams or visions, that they would be traditional healers. The ancestors appeared to be their dead relatives, both close and distant. The respondents further indicated a person is born with the gift of healing. Normally a person who is destined to be a healer is able to speak in an inspired manner with ancestors and this is known as *ho thoasa*:

“In 1980, I was breastfeeding my fourth child who was only six months old by then, when I started getting sick and I would just faint, something I never had before and I could not hold my child. I was taken to hospital but all in vain. I was getting weak every day and was forced to stop breastfeeding my child. My sister in law helped me to take care of the child. One day my grandfather appeared to me in my dream. He said to me, “Maliako”, (not her real name) you are called to be a healer. You are fighting the spirit which is actually calling you to be a healer”. I was informed that if I do not accept this call I would die. I had no choice but answer this call, which initially I did not actually like. I was taken to lefehlong (a place where traditional healers are trained by other experienced healers). I lived there for eight months and at the beginning

of 1981, I went to Mautseng in the Free State for further training and spent the whole year. Thereafter I had to go to initiation school”.

Another respondent reported:

“In 1990, I went to initiation¹⁹ school like any other young Mosotho man would do. But when I was there, my ancestors appeared to me in my dreams and gave me instructions on what to work and how to work, especially gathering of herbs for medication. In most instances, I seemed to be doing what other boys were not doing and as a result my instructors were always annoyed. After my term at initiation school, I went to Lefehlong. I stayed there for also most a year until my ancestors showed me my cow, which, I would use some of its bones to communicate with my ancestors while healing”.

According to the respondents, a trainee has to be at *lefehlong* until their ancestors have shown the trainee a cow hidden at certain place. The *mochonoko* (a trainee) alone has to find this cow. It is only after this process that a trainee can be released from *lefehlong*. This cow is slaughtered and its fat and horns are normally preserved for *lenaka* (medication). Traditional healers’ medication is referred to as *lenaka* due to the fact that the cow’s fat would be stored in the horns of this cow and later be mixed with other herbs a healer might use as medication for patients. Respondents reported that traditionally, Basotho did not have containers or mugs in which to mix traditional medicine. Therefore, horns from cows were predominantly used for such purposes, this is why traditional healers still refer to this cultural practice.

All the respondents except one have gone through initiation (*mophatong/lebolong*) school, either after training as a traditional healer or prior to the training. They stressed that it is very important for every healer to go to initiation school. As one respondent explained:

¹⁹ Initiation – A traditional circumcision school.

“It is very important for a traditional healer to go to initiation school. It is part of our culture. There are certain cultural rituals, which a traditional healer is taught and has to perform while still there”.

“When young men are due to leave for circumcision or initiation school a traditional healer is called in to lance (phatsa) them. A healer normally uses a razor and rubs in their special medicine in the cut in order to protect these young men from witches or evil spirits while in the initiation school”.

The respondents indicated that becoming a traditional healer in most instances is not a personal choice; rather it is a call from God. They reported it is an expression of God’s will to sending them to help and heal other people with their illnesses. Respondents strongly indicated that God sends their ancestors to them, as ancestors are believed to exist as intermediaries between them and God. Only two respondents reported that they had become traditional healers because their parents were also healers. They reported that they used to accompany their parents while going pick herbs used for medication, and learned to identify most of the herbs and their uses in this way. Two respondents reported that they had visions that they would heal people. In their visions they had been shown water and a prayer book they would use as their healing tools.

4.3.2 MODES OF HEALING

There are as many types of traditional healers in Lesotho as there are in other African countries as discussed in chapter two. Apart from types of traditional healers in Lesotho discussed in the previous chapters, the study found other types of healers in the country. These include diviners, herbalists and faith healers. The respondents use various methods to heal. Eleven respondents were diviners. Diviners in Lesotho are known as *lingaka tse linaka* (plural), *ngaka e linaka* (singular). But they are more commonly known as *mathuela* (plural), *lethuela* (singular). *Mathuela* use divining bones known as *litaola*. They normally have beads around their heads, necks, wrists

and ankles. The respondents indicated that they normally start their work with a prayer because it is God who has given them the gift of healing. Thereafter, they use *litaola* (divining bones) to consult the ancestors (see Figure 4). The ancestors also communicate with them through *litaola* about the cause of the patient's illness and the medication to be used. In most instances treatment includes herbal concoctions, which are either taken as a drink or tea to cleanse the digestive system, or they are smeared in ointment all over the body in a case where the patient has skin problems (*lekhopho*). Some herbs are put in the water when taking a bath in order to wash away ill forces causing the patient's illness. They also use pure water, which they pray over in order to do the work it is designated to do.

Figure 4: A female *lethuela* (diviner) using *litaola*



Source: Schwager 2004: 53

Only one informant was a herbalist known as *ngaka-chitja* (singular)/ *lingaka-chitja* (plural) in Lesotho. This kind of healer mainly uses herbs to treat any illnesses presented to them. The patients explain what is ailing them and the healer prescribes medication. The patients pay for the herbs but not for the consultation. These healers do not use divining bones at all.

Razors are also used by the traditional healers (particularly diviners and herbalists) in their treatment. These razors are used to cut and open wounds so that the patients' blood may be sucked out using a tennis ball with a small opening to perform this function. This process is called "*ho qobola*". It is believed that there are harmful objects which have been inserted in the body by witches, and they need to be taken out. The cut is made where the object is positioned and is then sucked out using a tennis ball. The respondents pointed out that patients bring their own razors. The healer only provides the tennis ball and the patient washes the ball before and after use. Herbal medication is also prescribed. This medication is either applied on the small cut made or it is ingested as liquid. Traditional healers in the past used their mouths to suck blood out of their patients, but more recently use tennis balls to perform this task.

Four respondents reported that they mainly use holy water in their healing. These are Christians in one of the independent churches such as the Apostolic Church. Respondents indicated that healing involves vigorous praying for the patient in the healer's house or in the church. The water used is prayed for and it is often referred to as holy water (*metsi a hlohonolofalitsoeng* or *metsi a thapelo*). The patient drinks this water and also uses it to bath in or a small container filled with this water is put under the pillow when sleeping. The water is also sprinkled (*foka*) in and around the patient's household, in order to get rid of evil spirits, which are believed possibly to be the cause of the illness. The respondents added that at times certain herbs such as *lihoasho* (ashes of indigenous tree known as wild olive (*mohloare*)) and bones of animals slaughtered as offerings for the ancestors and salt are used. Salt is mixed with water in a small bowl and the patient drinks the mixture, which thereafter induces vomiting (*K'hapa*). This is done in order to purge any impurities in the

patient's stomach, which are believed to be the cause of ill health. It was also reported that the patient might be taken to a running river or to a deep pond (*letša*) to be cleansed while praying for evil spirits to be washed away by the running water. Healers who perform this kind of healing are known as *bapostola/basione* (faith healers). They normally wear very colourful clothes (see figure 5) which have symbolic importance.

Figure 5: *Bapstola/* (faith healers) at the river

Source: Schwager 2004:52

These Faith Healers are Christians in one of the most famous and biggest church in the country, the Apostolic Church. In conjunction with water, respondents reported that they also use a prayer book called *Ngoana Jesu oa Praque* and their faith healing is supplemented by visionary work:

“As I pray, I get visions of what is the cause of the patient illness. For example if a person has been bewitched, I am able to see the witches. And thus I am able to tell the patient exactly the cause of the problem. Or if witches have put something that causes ill health around the patient's house, I am able to see where it is located. I then give a patient water to use to get rid of the ill causing object”.

There are similarities between healers found in Lesotho and in other African countries. They tend to use the same mode of treatment such as herbs in treating different health problems.

4.3.3 ILLNESS

Most respondents reported that they treat various illnesses presented to them by their patients, both mental and physical illnesses. Mental illnesses include madness (*bohlaya*) and *liphaephae* (hysteria). Other illnesses are reported to result from ignoring certain cultural practices or rituals (*mafu a meetlo e robiloeng*). Respondents reported that there are a number of illnesses that result from not observing certain traditions. For instance a person must shave his or her head to undo his or her status as an orphan after parents' death (*kutela khutsana*). In doing so, several misfortunes are prevented such as being attacked by other people for no apparent reason, being blameworthy, or being the victim of any other misfortunes that may occur such as losing one's job. If a person does not cut hair it is believed that a person is carrying dirt (*sesila*) around which is the ultimate cause of the misfortunes in their lives. It was reported that a person has to show respect for the deceased (*Ho ila*) and to mourn for them. If this is not done, misfortunes are likely to occur:

"If a husband dies, his wife has to sit on the mattress from the day the death occurred until the deceased is buried. If a woman dies, her husband has to be present and put soil in his wife's grave. If these things are not done, a person might get sick due to mysterious illness that cannot be healed unless a traditional healer is called to perform some of the rituals for that person".

Among problems of ill-health dealt with by the healers are gonorrhea (*seso/mahae*) which affects the sex organs (disease believed to be the punishment of people committing adultery during a time of mourning), syphilis (*mashoa*) which refers to bad sores, which usually occur on the sexual organs, cancer (*mofetše*), infertility in women (*Ha mosali a sitoa ho ima*), period pains (*selomi*), epistaxis or nosebleeds

(*mokola*), necrosis (*maqeba a sa foleng*), heart problems, stroke (*ho shoa lehlakore*), bed-wetting (*ho rota segenyenye/ho sesetsa likobong*), asthma, ulcers, and persistent hiccoughs (*thaabe*). Food poisoned to bring about harm by witches (*Sejeso*) and any other objects which have been inserted into a person to do harm are removed from the patient.

They indicated that recently they have added HIV/AIDS to this list of diseases which they referred to as *koatsi ea bosolla thlapi* literally meaning a foreign disease or *kokoana-hloko ea AIDS* or AIDS virus or *mokakallane oa se-tla-bocha*, meaning disease of young people. Most respondents believed it has always been present within the community but referred to differently. This explanation has been observed in Botswana as well. According to Heald (2002) traditional healers in Botswana interpret HIV/AIDS as a manifestation of an old Tswana disease acquiring new virulence due to increasing disrespect of the mores of traditional culture. Issues relating to Basotho traditional healers' views about HIV/AIDS, its symptoms and treatment are dealt with in sections that follow. However, it must be noted that the general population uses these terms when talking about HIV/AIDS. The healers identify a cluster of symptoms as AIDS. These are further discussed in Section 4.4.3.

4.3.4 MEDICATION

Almost all the respondents did not welcome the questions about medication. Their view is that researchers from developed countries with better technologies take medication belonging to traditional healers out of the country and process them into pills, ointments or herbal teas, which are later sold in the market at a higher cost. At the same time the medication or herbs of traditional healers tend to be discredited by researchers in the biomedical field, especially by biomedical doctors. As proof of this claim I was given the tag from a Buchu herbal water bottle displayed in Figure 6.

Figure 6: Tag from Buchu herbal water bottle



I was informed that this herbal water is sold for M250.00 per 2 litres (R250.00) in most pharmacies in the country and it is imported from RSA. The respondents indicated that this product smells exactly the same as *Lengana* (African wormwood) (see appendix 8). *Lengana* grows wild in the country but some people also grow it in their yards. It is commonly used to treat influenza and indigestion. As a result of such appropriations of their knowledge, the healers do not see an opportunity to work together with biomedical doctors in the future. One claimed:

“Due to this exploitation of our knowledge by biomedicine doctors, we cannot work with them and will never do”.

Other respondents believed outsiders use their information without acknowledging them as the source. For example, they cited an example of a project with a German Technical Cooperation country office, the purpose of which was to compile a detailed document about medical treatments and herbs of Lesotho. This project resulted in the production of a book titled *Medical plants and herbs in Lesotho: A visual guide of 60 species from around the country* (Maliehe et al 1997). Table 4

below lists the names of herbs or plants commonly used by traditional healers and are taken from this book. They further pointed out that the Government through the Ministry of Culture, Environment and Tourism, published a poster (refer to appendix 9) of endangered plants/ species in the countries and all the pictures in this poster are taken from this book, the source was not acknowledged.

As a result of this caution around sharing knowledge with outsiders, very few respondents named specific herbs which they commonly use and even then they did not specify what they are used for. However, all respondents refused to indicate whether any of these herbs are used to treat their HIV/AIDS patients or not.

Table 5: Medicinal plants commonly used by traditional healers in Lesotho.

Plant (in Sesotho)	Plant (In English)	Use
Lesoko	Alepidea Amatymbica	Arthritis, fever
Leshoma	Dicoma Anomala	Diarrhoea, back pain, cleanses stomach, STDs, takes out hookworms, lesokolla.
Khapumpu	Pineapple flower/Eucomis Autumnalis	STDs, boils
Kuena	Mentha Aquatica	Liver problems, low blood pressure, worms in children
Mahorametsa	Plantago Lanceolata	
Khama-khamane	Sheep sorrel/ Rumex Acetosella	Dental problems
Motlapa-Tšunyane	Stachys Hyssoides	
Bobatsi	Stinging nettle /Urtica Urens	Vegetable rich in iron
Lengana	African wormwood/ Artemisia Afra	Common cold, fever
Phefo	Everlasting/ Helichrysum Odoratissimum	Influenza
Mofere-fere/Letapisa	Senecio Asprulus	Sore throats, arthritis

Source: Maliehi et al (1997:6-63)

4.3.5 NUMBER OF PATIENTS SEEN BY THE THS

The total number of patients seen varies from healer to healer. All of the respondents were aware that most of their patients, if not all, use their services in addition to western-based health services. Respondents further reported that most of their

patients still believe in their traditional healing practices even though they have access to western-based health services. Traditional healers probe deeply into the patients' social and psychological well-being and to the history of the present illness. However they stressed that in recent years their services seem more popular because most people feel that Western-based health services are failing them. According to the respondents, their patients had often complained about long queues at health centres while at the same time they had to endure rudeness of the staff members. Most respondents pointed out that that it is possible for them to spend a week or two without seeing any patients at all. Some see patients the whole day, approximately 10 to 20 patients a day. Other respondents indicated that they normally have up to 50 patients per day mainly because they only work on certain days of the week:

“I normally work on Mondays, Wednesday and Fridays from my place. Patients on these days came to my house. On Tuesdays and Thursdays I visit some of them at their houses. If I am not visiting patients on these days, I normally pray and talk to my ancestors in order to gain strength for healing. I do not visit all my patients but only those who were critically ill in the last consultation they had with me”.

Other respondents reported that they work six days a week from their houses. On Sundays they operate from their churches, which are predominantly independent spiritual churches (*kereke tsa moea kapa posetola*). Some of the healers stated they stay with their patients until they recover fully. The stay can be up to six months. This entirely depends on how quickly the patient recovers.

Other respondents reported specifically that they do not want to see more than three patients per day as they do not have sufficient gloves or masks when dealing with patients. They also pointed out that a healer could not have lengthy discussion with a patient if there were too many to be seen on one day. These discussions include the patients' presentation of illness and the healer's work such as diagnosis and instructions about medication. They were especially concerned about hygiene because they mostly operated from their houses, which they share with other family members. It would also for this reason not be advisable to have too many patients at

the same time. Some of their patients have TB, which is air-borne and some patients have the habit of spitting all the time which increases the risk of transmission of the bacteria. The healers felt that too many of these patients in their yards would expose the healers and their family members to infections.

This is the reason why many healers work from a separate hut at the back yard of their homes as illustrated in Figure 7, and keep their medical equipment separate from family members.

Figure 7: A hut used by traditional healers when treating patients.



Picture by the author.

4.3.6 FEES CHARGED BY TRADITIONAL HEALERS

The fees charged by healers differ widely. Fees range from M5.00- M500.00 (R5.00- R500.00). Most of the respondents reported that a patient has to “light” for medicines (*Meriana e ea khantšetsoa*). This means that a patient has to first pay a certain amount of money in order for a healer to start the process of healing. Respondents indicated that this money has to be paid before a healer says anything at all to a patient (*pulo ea molomo*). The respondents reported that their fees are usually regarded as “cows”. The fees are regarded as symbolic of cows because traditionally a cow was used as a means of payment for many things, such as payment to the traditional healer or when a young man has impregnated a girl and has not married

her, or for *lobola* (bride price). Patients pay whatever they have to hand directly to the healer and if there is a remaining balance, it can be brought later. Some of the respondents also indicated that payments could also be in the form of goods.

“At times a patient can bring a goat or sheep as payment. Mostly, patients with animals do this”.

It was further reported that these fees also depend on the severity of illness. The sicker a patient is, the more he or she will pay. The amount paid for an initial consultation is M300 and for a check up M100.

4.4 HEALERS’ KNOWLEDGE OF HIV/AIDS

The healers’ knowledge of HIV/AIDS was compared and contrasted with the definitions internationally agreed on by bodies such as WHO and UNAIDS as well as others working on health issues around the globe. These are standard definitions.

4.4.1 DEFINITIONS OF HIV AND AIDS

Respondents pointed out that they first heard about HIV/AIDS in the late 1980s. They further indicated that it was popularly talked about in the 1990s and more recently as large numbers have died due to the disease. The respondents defined HIV/AIDS differently. However they could not distinguish between HIV and AIDS. About a third of the healers defined HIV and AIDS in terms that corresponded closely with what the following healer said:

“When I first saw a patient with this disease, I was puzzled because I have never heard of it before. I did not even know how I was going to treat it. I then consulted my ancestors to help me. I described the patient’s condition to them. The patient was very weak and from time to time she was vomiting. I was also told the patient had diarrhoea. The ancestors informed me that there are small ants in a patient’s blood, which make blood dirty. This causes a person to get sick with HIV/AIDS”.

Four respondents argued that HIV/AIDS is not a new disease at all in the country. They indicated that it has always been there, it has just been referred to by different names. These respondents said:

“HIV/AIDS is not a new disease as we are made to believe. In our Basotho communities even historically, we have always had STIs (mafu a likobo) such as mahae and mashoa. Traditional healers were managing these illnesses quite well before white people introduced their ways of healing. When biomedicine doctors arrived in our country especially Whites, they defined STIs as gonorrhoea and we still managed to treat gonorrhoea. When it was realized that we able to treat this gonorrhoea, they came with the new term, syphilis, and again we still managed to treat it, now they have introduced HIV/AIDS”.

A key informant in the Council also shared the same sentiments. This informant stressed that culturally AIDS is just STI. The informant further reported that AIDS is not a mystery, it is just about weak immune system, which cannot fight diseases any longer. The respondent said:

“Normally this AIDS starts as normal STD, then proceeds to AIDS because people delay to seek for medical help. It slowly reduces the body’s soldiers. If we can count them, let’s say a person has a total of 100 soldiers; AIDS eats all of them until very few are left and the person starts to get sick”.

Few respondents (4) correctly defined HIV and AIDS. The respondents indicated they had attended a HIV/AIDS training workshop. HIV was defined as:

“A small virus, which causes AIDS (Kokoana hloko a nyeyane haholo e bakang AIDS). A person has AIDS when a body is very weak and body soldiers, which protect us and can no longer fight diseases. As a result, a person gets sick regularly with different illnesses or diseases every time. (AIDS ke ha ‘mele o se o fokola haholo, masole a‘mele a se a sitoa ho itoanela. Ebe motho a se akula khafetsa ke mafu a fapakaneng)”.

The above metaphor, “the body’s soldiers”, is common in Government’s and several HIV and AIDS activists’ HIV information campaigns targeting communities. Only one respondent was able to define HIV as Human Immunodeficiency Virus, and AIDS as Acute Immune Deficiency Syndrome. This particular respondent had attended various workshops and seminars related to traditional healers and traditional medicine both nationally and internationally.

Four healers could not define HIV and AIDS. They stated that they just heard from other people that it is called AIDS. They reported that they just know that HIV/AIDS is linked to promiscuity.

4.4.2 MODE OF TRANSMISSION

All the respondents indicated that a person could be infected through sex. They indicated that in most cases people get infected because they had broken sexual taboos. The respondents believed that currently Basotho do not want to follow and adopt their traditional practices and that AIDS is a consequence of this:

“Diseases such as mashoa and mahae (STIs) occur because people at some stage in their lives do not respect tradition. A woman wearing a black mourning cloth mostly after the death her husband is not supposed to have sex with another man until her husband’s corpse particularly his bile gets rotten in the grave. This normally ranges from six months to ten months. And before she has sex with another man certain rituals must be performed, such as cleansing her with certain herbs at the river. Thereafter her new sexual partner has to be part to the treatment. This is done in order to contain the virus at a certain area only”.

Nine respondents clearly indicated that they blame women for the spread of AIDS in the country. In some instances young women abort a foetus and engage in sex immediately without informing their new sexual partners. The respondents indicated that these women have to be cleansed before engaging in sex. In addition those who have had a genuine miscarriage are supposed to wear a white cloth around their

heads as a sign of mourning for a child for a certain period of time. They too still need to be cleansed. The respondents indicated that nowadays most people do not follow this tradition. The informants stressed that because Basotho have moved away from these traditions they are experiencing devastating diseases such as AIDS.

Other respondents indicated that HIV/AIDS is due to witchcraft, which comes in the form of *sejeso* (food that has been drugged to harm a person while asleep). Respondents reported that certain individuals especially witches (*baloi*), can bewitch another person due to envy or for any reason. It was reported that witches have the ability to make a person swallow the poison in their sleep. Normally when person dreams about eating something, that is when witches are believed to be actually giving a person *sejeso*. Respondents pointed out:

“Sejeso is often something alive which is meant to destroy a person from inside”.

When asked “how can a person know whether he/she is positive or not?”, most of the respondents indicated that they often hear that people can go to hospital or the clinic to get tested. Others reported that they know that a patient has HIV/AIDS when patients present with particular symptoms. They also refer to ancestors who in turn inform them through *litaola* that a patient has HIV (*kooana hloko ea AIDS*).

4.4.3 IDENTIFICATION OF SYMPTOMS

Respondents identified various symptoms associated with HIV/AIDS. The symptoms were mainly observed during consultation with their patients. These include a rash all over the body and in the eyes, causing them to be very red and itchy, *lebanta* (herpes zoster), loss of weight, loss of appetite, excessive diarrhoea, oral thrush and mouth sores, vomiting every time a patient eats, *mashoa* and *mahae* (gonorrhoea and syphilis), which do not heal even when treated. One respondent, who had never attended a workshop, added piles, swollen feet, madness in some patients, weak hair, black patches on the skin and dryness.

4.4.4 HIV/AIDS PREVENTION

All the respondents believed that the only way one could prevent HIV infection is through a change in sexual behaviour. They indicated that HIV/AIDS is due to improper sexual behaviour such as having multiple sexual partners. They further reported that it is against Basotho culture for married people to have sex outside their marriages. They say that it seems to be normal practice currently for Basotho men to have extramarital affairs, especially with younger women. Women are also seen to have extramarital affairs with younger men. According to the respondents a person must have one sexual partner in order to avoid diseases such as HIV/AIDS. In addition respondents placed more emphasis on carrying out correct cultural practices as protection from disease, as discussed earlier in this chapter. With regard to young Basotho people, respondents mostly encouraged total sexual abstinence and avoided certain foods until marriage. They stated:

“Young people should not have sex before marriage whatsoever as it was traditionally practiced. A girl has to wait until she gets married, then she can have sex. Traditionally, young women were not allowed to eat eggs and sheep or cow’s insides (tripe and intestines). These foods make young girls to be very highly fertile, hence they engage in sex at a very early age”.

Other respondents indicated that Basotho have moved away from their culture and have copied other people’s cultures. All the respondents were against the idea of parents talking about sex to their children or sex education at schools. They pointed out that when parents do such, they actually teach or encourage their children to have sex, which is unacceptable in Basotho culture.

4.4.4.1 CONDOMS

When asked “Do you encourage your patients to use condoms?”, none of the respondents indicated that they had, currently or in the past. Respondents did not regard condoms as a protective measure against HIV infection. They had various conceptions about condoms. Most of them believed that condoms are a threat to

people's health. They indicated that they were not sure about the damage caused to females' bodies but were certain that condoms cause havoc in males' bodies:

"Condoms have this oil-like substance, which is extremely dangerous to men's health. This oil tends to eat a man's penis. After a while a man starts complaining about his kidneys. Condoms are so tight and they tend to block the pores (masoba) to excrete whatever needs to be excreted from the body".

Some of the respondents did not just disapprove of condoms; the very word condom horrified them. These were mostly female respondents. They believed that condoms actually provide young people with the freedom to be promiscuous or to engage in sexual activities at a very early age. These respondents reported they would never encourage the use of condoms or distribute them:

"I used to visit our local hospital frequently, one day a nurse gave me a box full of these things and asked me to talk to young people about them and encourage them to use them as they are used to prevent AIDS. I could not say no, I took that box to my house and later in the evening I burned them in that box without opening it. To make sure they all burn, I poured paraffin over the box. I could not give condoms with my own hands because in doing so I would be telling them to have sex. I just could not do that. Besides we see these things thrown all over in the village".

Even the respondents who had been to HIV/AIDS training workshops gave similar responses. In addition these respondents strongly questioned the safety and reliability of condoms, because they had heard that condoms do sometimes break.

4.4.5 CURING HIV/AIDS

The majority of respondents (all except one) responded saying that traditional healers are able to cure HIV/AIDS. Their view was that in any case it seems that even biomedical doctors have not yet come up with the cure for HIV/AIDS. They reported

that AIDS is mostly cured in people who are free of certain ill health problems such as mouth sores, but cannot be cured in those who have them:

“Traditional healers can successfully cure AIDS in people who do not have mouth sores and oral thrush. Patients with these ill health problems must be given medicines, which is not bitter. This is because these medicines can effectively cure AIDS. Medicines that are bitter aggravate the symptoms”.

One respondent reported that he/she does not cure HIV/AIDS, rather he/she treats the symptoms presented at that particular moment. It was reported that a patient may have minor symptoms but it does not necessarily mean they have AIDS. The respondent explained:

“I do not normally treat AIDS but I first take a look at the symptoms a patient has at that particular moment. A person may be positive but have minor symptoms. For instance, a person may be experiencing loss of weight and appetite. This may be due to mal-absorption of food. Since food is not properly absorbed in the body, a person can actually lose weight. I start a wellness programme for such person focusing on their diet. I normally recommend special diet for them, such as food with roughage, lots of vegetables, fruits and proteins. Patients are also given special herbs for cleansing the digestive system. Other herbs are given to patient in order to “modulate” the patient’s systems. At times a patient with oral thrush cannot eat, thus I start treating the condition”.

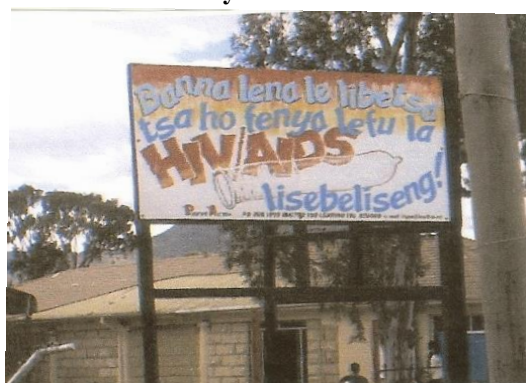
The respondents indicated that by “modulating” the whole body, they actually help it work in a balanced way, with all parts in the system working with equal strength. They pointed out that they are against treatments that boost the body’s energy. They argued that boosting the energy may be harmful to the system as some parts may then work more than others, causing the less efficient parts to be left behind in the process. In other words, there is a need for everything in the system to work in balance.

4.5 HIV/AIDS INFORMATION

All the respondents indicated that the best way information could reach people is through more public gatherings (*lipitso*) such as those held during political rallies. Respondents indicated that they mostly prefer *lipitso*, because they provide an opportunity for people to ask questions about HIV/AIDS. They also indicated that there should be more billboards in the public space with concrete HIV/AIDS messages. Respondents were asked whether there are any billboards with HIV/AIDS educational messages in their communities. They replied that there were none.

I observed that there were very few billboards displaying HIV/AIDS information in Roma. The two that exist are in front of The National University of Lesotho's (NUL) main gate (see Figure 8). Aside from these two below, there are no other billboards in the valley.

Figure 8: Billboards displaying HIV/AIDS messages in front of the main gate of the National University of Lesotho.



“Men, you have weapons to overcome HIV/AIDS disease. Use them!”



“Do you know your HIV status? Test and live longer!!”

Surprisingly, there are no billboards on the main road from Roma to Maseru. Along this road, there are many people's dwellings and where there is a need to see clear HIV/AIDS messages. The first billboards one sees are right in the city near the main traffic circle as shown in Figure 9.

Figure 9: Billboards displaying HIV/AIDS messages near the traffic circle in Maseru.



“Nurse, tell the truth, about what killed the deceased. His soul rest in peace. ... We did receive fair and just consolations.”

These messages are not so appropriate in the prevention and care of HIV/AIDS as they seem to be sending messages to scare people (e.g. Figure 10).

4.6 CARING FOR HIV/AIDS PATIENTS

4.6.1 PHYSICAL CARE

Four respondents reported that they also provide home-based care for their patients. They either have the patient staying at their own houses or care for them at the patient's houses. One particular patient, for example, was never referred to the hospital during her stay at the healer's place:

“I once stayed with a HIV positive patient in my house for ten months. She was very weak when she first came to me for treatment. I had to help her bath. She also had oral thrush. I asked the patient's husband to allow me to stay with her until she recovers. I never took her to hospital during her stay at my house. I only administered various herbs until she recovered, and when she left, I gave her some of the herbs to take daily. Unfortunately a year later I heard that she has passed away”.

The respondent indicated that latex hand gloves were never used when handling the patients and they are never used with any patient. Traditional healers who

use the method of sucking blood out of the patients also said that they did not use protective gloves during this process. They reported that these gloves are not readily available to them. In addition they do not want their patients to feel uncomfortable, and to think that by using gloves the healer shows he is repulsed by them. Very few respondents reported using gloves and some even distribute them to their neighbours as they get them from the hospital.

Twelve respondents indicated they do not physically take care of patients other than seeing them during consultation and prescribing medication. They reported that they do not visit patients at their homes. Four respondents reported that they only visit patients on days when they are not working. When they perform home visits, they reported that they normally take additional medicines for their patients. Other respondents reported that at times they sleep over at patients' place depending on the patients' condition.

Red Cross-Lesotho reported that the programmes the office runs are mainly focused on HIV/AIDS patients. The Office stated that Red Cross help people living with HIV/AIDS in various communities in selected Districts to form support groups. It was further reported that the membership of a support group is solely based on HIV positive status of an individual. The office also indicated that they do not have any programmes lined up for traditional healers specifically. Red Cross and the Government's STI/HIV/AIDS Directorate are responsible for training Community-Based Organisations (CBOs) as well as NGOs in home-based care in the country. The STI/HIV/AIDS Directorate is also training people as lay counsellors in various communities. Lay counsellors provide basic HIV/AIDS counselling, that is, pre and post testing. Under "know your status" campaign the lay counsellors are trained to provide HIV/AIDS test in the communities. This year alone the office trained many community based counsellors in various Districts in the country. For instance, 35 counsellors were trained in Mafeteng, 60 in Qacha's Nek, 32 in Quthing and 28 in Mohale's Hoek. None of these, however, included traditional healers. Traditional healers do not receive this training in their capacity as healers. It was reported that if traditional healers were part of CBOs and NGOs, then they could get training. In

addition, a key informant at Sakatane also reported that at the moment they do not work with traditional healers at all. They only train nurses at the local clinic as patients are later referred to them for medication and check-ups.

4.6.2 USE OF TRADITIONAL MEDICINES AND ARVS

All respondents indicated that they do not encourage the use of ARVs and traditional medicines simultaneously. Respondents indicated that they basically advise their patients to use one form of medication at a time. The respondents believed that if these two medications are taken simultaneously, the patient's liver could be damaged. Some of the respondents reported that they have heard that ARVs have to be taken at the same time on a daily basis and the patient may encounter problems if medication is not taken at the same time the following day. This information was obtained from the various training workshops which the respondents had attended.

However some of the respondents believe that there are sinister motives around ARVs. Respondents indicated that developed countries benefit from ARVs by selling them to the least developed countries particularly African countries thus impoverishing them further. One of the respondents claimed that:

“Developed countries talk about economic growth and African countries talk about people's lives. Africa is basically a market for Western countries' products including ARVs. African countries will always be poorer and bearer of diseases”.

4.6.3 REFERRAL OF PATIENTS TO A HOSPITAL OR CLINIC

Only one healer refers his/her patients to hospitals or to the clinic immediately once patients present ill health problems. Herbal medication is prescribed and patients are encouraged then to go for tests at the hospital. Eighteen of the respondents indicated that they first treat the patients before referring to the clinic or hospital. For instance, it was reported that patients with TB are treated for at least two months prior to referring them to hospital or clinics. This is because TB is believed to first start as *sejeso*, a sickness well-treated by traditional healers. Respondents indicated that they

treat *sejeso* and leave wounds caused by this treatment for the hospital to treat. They further reported that some do recuperate implying that there is no need to refer them to the clinic or hospital. Other patients are referred only when all methods of treatment have failed. Some are never referred to the hospital because they never return for check-ups. The assumption is they have either been healed or gone to another healer or they have passed away. One respondent reported that he/she does not refer patients to the hospital at all and has never done so in the past. He/she does not refer patients because he/she does not see the need, regarding his/her medication as effective (some of the patients do show progress in due course). Hence he/she does not see a need to refer patients.

Respondents were asked whether clinics or hospitals ever refer patients back to them. They reported that this was never the case. They reported that patients would consult traditional healers of their own accord and would inform them that they were doing so after seeing several clinics or hospitals and not detecting any change in their health. Some of the respondents indicated that patients occasionally come to them when their health has deteriorated. They felt that in these cases traditional healers are seen as their last resort and there is nothing much they are able to do for the patient. Some of the respondents reported that they once proposed working with nurses from their local clinic in the community. They indicated that they had asked for three patients who are at different stages of HIV infection, one who is at the initial stage, mid stage and advanced stage of the disease. But the nurse did not agree to their proposal. Respondents indicated that they wanted to see if, and which stage of the disease they might manage with their traditional medicine.

4.7 HIV DISCUSSION WITH PATIENTS AND COMMUNITY

4.7.1 PATIENTS

All the respondents reported that they do not talk about HIV/AIDS to all of their patients. Rather they only talk about it to patients who specifically consult them about HIV/AIDS, that is, those who are ill because of HIV. The discussion mostly relates to the prescribed medication, and to behavioural change, and also involves

encouraging them to bring their partners for treatment as well. HIV/AIDS is not spontaneously raised as a topic for discussion with patients who do not present AIDS symptoms.

HIV related issues are said to be extremely difficult to discuss with patients because most of them disguise their possible status. A patient might say “I don’t have AIDS”, when asked whether they have ever done HIV tests. Some patients are in denial of their status. Respondents pointed out that the patient might actually suspect that they are positive even before doing an HIV test. They normally present their symptoms as STIs and often attempt to justify why they have them. For instance, respondents stated that a patient could say:

“I had sex with a woman wearing a mourning cloth and I think I have mahae (gonorrhoea) or mashoa (syphilis). I have had them for some time now”.

As a result, the THs often prescribe medication while at the same time recommending that their patients go for laboratory tests. They advise their patients to return with their results. They reported that the tests help them to know which medication and its quantity they give to their patients, and to know the CD4 count of their patients.

Three respondents reported that they do not have time to talk to patients at length because there are too many of them. They reported that they focus on talking to the ancestors to guide them in healing patients. One respondent, on the other hand, reported that he/she specifically encourage patients not to talk about their HIV status to anyone due to discrimination against people living with HIV/AIDS and their families.

Initiating discussions about sexual behaviour with patients is virtually unheard of. Respondents indicated that the health problems patients present to them pave the way for discussion about sexual matters. For instance if a patient presents STI problems, it is only then that they can recommend behaviour change such as total abstinence

until they are completely healed, or encourage the partner to come for treatment. At the same time they are in a position to take the opportunity to encourage patients to change their sexual behaviour.

4.7.2 MEMBERS OF THE COMMUNITY

With regard to discussion about HIV/AIDS with the community, all the respondents reported that they have never held forums for their communities to discuss HIV/AIDS issues in an attempt to educate them. They indicated that if they start talking openly to their communities about HIV, it would appear as if they are advertising their services in order for people to come to them for consultation. Other respondents felt that should they publicly talk about HIV/AIDS, they would be inviting witches to test their powers as traditional healers. As a result, they would have a lot to deal with: people to heal and chasing away of witches attacking them. Other respondents indicated that they cannot talk to their communities about these issues under any circumstances due to existing conflicts they might have with some of their neighbours, which might prompt them to be called witches. One of the respondents reported:

“It could happen that I have a conflict with one of my neighbours, and if it happens that my neighbour experiences catastrophe such as death or any form of sickness after the conflict, obviously I could be blamed for that condition. Consequently my neighbours could actually think that I have actually caused such circumstances just because I am a traditional healer”.

Most of the respondents indicated that this attitude towards them originates from the past when churches were fighting traditional structures. They reported that upon their arrival, missionaries in Lesotho fought against traditional structures such as *chobeliso* (abduction with the aim of marrying), *lebollo* (traditional circumcision) and *bongaka ba meetlo* (traditional healing). It was reported that a woman was forbidden from attending a church when her child went to initiation school or he/she eloped.

However some of the healers felt that people are justified to feel this way about them:

“Traditional healers once had a bad reputation because some people, who make use of traditional healers, use them for totally wrong reasons. It was very common for women to consult a traditional healer in order to kill their husbands while working in the mines (monna a pitloe ke'maene). This was done due to greediness. Women did this in order to receive a huge lump sum of money upon their husbands' death. In some instance, some women use us to break other people's marriages. Some healers prescribe medicines, which make a man to leave his family and live with another woman. Hence people want nothing to do with us. I believe we as traditional healers have contributed in this negative attitude towards us”.

All the respondents also indicated that they have never talked to members of their communities about sexual behaviour. They stated that some people do not have trust in traditional healers and their practices. The respondents added that traditional healers are associated with witchcraft, which is the reason why most of their patients are not from their own communities, but from other communities, contrary to the discussion in chapter two.

A key informant in the healers' council was strongly opposed to discussions on sexuality, STIs, as well as HIV/AIDS. The informant stressed that young people should not be taught about sexuality until the time when they are ready to engage in sex, that is, when they are married.

4.8 TRAINING WORKSHOPS

Fifteen respondents reported that they have never attended any HIV/AIDS training workshop and a council has never invited them to one. Only one respondent had attended workshops at international level as discussed earlier in this chapter. The

traditional healers expressed concern that some organizations exclude them from their training of people in patient care. One respondent reported:

“Red Cross establishes support groups in our villages and train people about home based care and counselling who are not even healers and they leave us out. We also need that training because we are already doing the work”.

The respondent is well informed about HIV/AIDS and the part that traditional healers can play in HIV/AIDS prevention and care. However, this healer pointed out that at the moment it is difficult to share information with other healers because the council would not allow such activity to take place. The respondent reported that the council was not prepared for his input into the council. As a result he has resigned from the council and he is currently not a member. Two respondents reported that they have attended workshops hosted by various Government offices such as MoHSW, Ministry of Gender, Youth and Sports, and other organizations from outside the country such as Transkei AIDS Support Organisation (TRASO). The respondents indicated that some of the workshops were on Basic HIV/AIDS education and counselling, use of condoms, ARVs and home based care strategies for HIV/AIDS patients. These two traditional healers likewise said they have never shared information they have with other healers, as they are not on good terms with the present healers' council. The council confirmed this when I asked the chairperson how they work with other traditional healers.

I was told that:

“Some of the healers are based at Queen Elizabeth II hospital and they fight us because a true traditional healer does not give any information about medicines. So people like those ones at Queen Elizabeth II hospital give this information out. Hence you see medicines made from medical plants being sold in the street, such as “soso” which is not right. Traditional medicines must be freshly prepared and be given to a patient right away. They are not to be sold in the street like soso. Traditional Medicines must be respected and people are not supposed to touch medicines as they lose their value. For

instance a woman wearing a mourning cloth or in her periods (menstruating) are not supposed to touch them or be in the rooms they are kept. So these people give out this information and when we reprimand them, they fight us”.

The two respondents who had attended local workshops reported that they attended those workshops but they felt that they were not appropriate for them. They indicated that they attended the workshop with other people who do not have the same level of understanding as they do. As discussed earlier in this chapter most of the respondents are not educated; they stressed that they mostly attend workshops with people in the formal employment who are more educated than them and who easily understand issues around HIV/AIDS. They further pointed out that they normally felt behind as they tend to ask questions which seem obvious to other people. As a result they felt that they needed their own workshop that is specifically addressing traditional healers. They indicated that they have also been invited to a meeting where the National HIV and AIDS policy was discussed.

Respondents who indicated that they have never attended any workshop expressed an interest in attending HIV/AIDS training workshops in which they could have an opportunity to clear up their uncertainties about HIV/AIDS. They further reported that it is very crucial for them to meet so as to share information for the benefit of their patients. The respondents stressed that it is crucial for them to meet as healers only, in order to have a common ground and understanding. Respondents indicated that if they could frequently meet as traditional healers, the prevailing mistrust amongst them would cease. They also expressed a need to learn from doctors and nurse as well as other people in the field of biomedical health and vice versa:

“At the moment we cannot work together with other people because we as traditional healers we cannot work jointly. There is a lot of mistrust amongst us. For example, if we were to meet to discuss effective medication to treat HIV/AIDS, surely some healers would bring medication which they know that it is not worthwhile. I can argue that this is due to economic reasons, as some healers want to have money more than others rather than to focus on how HIV/AIDS can be treated”.

4.9 MEMBERSHIP

All the respondents had licenses to practice as healers, which prove that they are traditional healers and are registered with the LTPMC (Lesotho Traditional Practitioners and Medicinemen Council). Some of the respondents indicated that they have never renewed their licenses, so they do not know if they still qualify as members or not. However, they are still practising as traditional healers because they have skills. The only time they paid for licenses was when they actually registered as traditional healers. Some of the respondents, who were once active members in the council, pointed out that they resigned from the council because other council members were not interested in their input to improve the calibre of the council. As a result they do not associate themselves with the present Council whatsoever. Unfortunately it seems that the most well informed healers are operating outside the council. As discussed earlier, there is one respondent who has attended various training workshops outside the country.

The Chairperson reported that legally the license should be renewed annually. However, most of the healers do not renew their licences and the Council does not have mechanisms in place to penalise traditional healers who do not renew their licences nor to force every healer to register. Furthermore, the Council does not have offices in every district which means every healer who needs to register has to do it in Maseru. In order to get a license, a trainer writes a letter to the trainee's chief introducing the trainee and confirming the completion of the training. The chief then writes to the Principal Chief of the area or constituency who also writes to the District Administrator (DA). The DA finally writes and convinces the Council to issue a license. A healer fills in a form and attaches a passport size photograph. The fee costs about M120.00 (R120.00).

However most of the respondents indicated that they are not sure what is happening in the Council as they are never called for meetings or any other form of discussion. Other respondents felt that those who have been previously elected into the office are

not improving the Council whatsoever. Hence, they do not associate themselves with the Council.

It was impossible to obtain the number of registered healers from the Council. The fees are paid at the MoHSW accounts office and the receipt is brought to the Council office for issuance of a license. One would think that the Council would keep a record of registered healers, but such information was not available. However, according to a documentary film made about traditional healers in Lesotho, in 2002 there were 12,000 traditional healers in the country (Gibson 2002), whereas in 1991 there were 8579 as shown in table 4.

The Director of Public Health also indicated that it is extremely difficult for the Public Health Office to work with them, as they are not organized at the moment. The Director indicated that the Council even refuses to use the office secured for them within the Ministry. This is why they have office in the Ministry of Tourism, Environment and Culture. The Director also added that healers last had their annual general meeting (AGM) three years back. The AGM that was scheduled early this year in April failed twice because the Council did not prepare for the AGM properly. At the moment there are no structures put in place to monitor them.

In contrast, the chairperson of Berea healers had a record of all registered healers in the District. Registration of healers in this particular District is done after the healer has obtained the license from the National Council. I was informed that there are 3,605 healers in this District alone. Traditional healers in this place have their own association with clearly stipulated rules and regulations. Among other clauses in the principles which are most important are Clauses 3 and 5.

“The chairperson shall ensure that meeting takes place and ensures that they progress accordingly. In those meetings issues around HIV/AIDS must be discussed and healers must share information”. (*Mohokanyi o lokela ho bona hore liphutheho li tsoela pele le hona ho li tamaisa ka*

toka. Ho khothaletsa ka tsebelisana 'moho malebane le HIV/AIDS. Ho thakelana le bongoe. Ho abelena maikutlo) (Clause 3)".

“Hold public gatherings with Chiefs and Principals Chiefs, and various Government’s offices in the Berea District with the aim of educating people about HIV/AIDS as well as bad use of razors and used needles. Ways of taking care of patient who is infected”. (*Ho tsoara lipitso mareneng a libaka le mareneng a sehloho, liofisi tsa Musi oa setereke Berea, sepheo e le ho hlokomelisa sechaba ka lefu la HIV le AIDS. Le tšebeliso e mpe ea mahare moho le mamao(liente) tse sebelitseng. Mokhoa oa ho oka bakuli ba nang le tšoaetso) (Clause 5)".*

The following chapter proceeds to discuss the significance of these findings.

CHAPTER 5

DISCUSSION

5.1 INTRODUCTION

This chapter interprets and discusses the results of the study. Literature sources, as well as the conceptual framework, are used to identify patterns and trends in the data. Selection of the main themes is based on the study's first two objectives, as stipulated in section 1.5. To recap, the main interest of the study was to explore traditional healers' knowledge about HIV/AIDS. The study also explored how traditional healers in Lesotho contribute to the prevention and treatment of HIV/AIDS and whether THs' practices have a positive or negative impact in the prevention of HIV/AIDS in the country. Other questions explored HIV/AIDS messages to the patients and communities by the healers, sexual behaviour and use of condoms and ARVs.

5.2 TRADITIONAL HEALERS IN LESOTHO

There are similar types of traditional healers in Lesotho to other African countries, using similar methods in treating their patients.

The most prominent types are diviners who use divining bones (*litaola*) to diagnosis and treat their patients. Divining bones work as the medium through which healers talk to the ancestors to guide them in determining the cause of illness and the treatment to be executed. There are also herbalists who mostly work with herbs from local medical plants, and faith healers who use prayers in their treatment. In Lesotho as in other countries it was observed that the healers tend to use more than one mode of healing such as prayer, *litaola*, herbs and water simultaneously.

In Lesotho ancestors play a significant role in traditional healers' domains as they do in most African communities, as observed by Van Dyk (2001). Ancestors summon individuals into healing practice as well as determining the duration of the healers' training. In addition, the study supports the observation made by Green (1999) that

heredity factors also play crucial roles in acquiring skills contributing to being a traditional healer.

Traditional healing in Africa rests on a belief system that claims that illness and disease within communities are caused by a supernatural agency. This may include intrusion of disease object, intrusion of a disease causing spirit, and loss of soul. The study found this to be a prevailing situation in Lesotho as well. Basotho traditional healers strongly believe that some illnesses are caused by not adhering to cultural practices. As a result, this non-compliance is seen to provide disease-causing supernatural agencies with the opportunity to invade the body. For instance, traditional healers believe that STDs such as *mashoa* and *mahae* occur because people have not respected certain customs associated with mourning after death. This belief seems to be common in most African communities as illustrated in Section 2.2.

As discussed in chapters 2 and 4, plants play a significant role in African traditional medicine. In treating various ill health problems, Basotho traditional healers make extensive use of medicinal plants to make their medicines, which are regarded as very effective against various ailments. Some plants contain essential minerals such as iron and patients are encouraged to eat them as they are beneficial to their health. The medications are dispensed as herbal drinks or ointments which are applied on affected parts of the body. The diseases treated by traditional healers in Lesotho are similar to those treated by their counterparts in other African countries as discussed in Section 2.2.

As noted earlier there is a great concern amongst traditional healers that their knowledge of indigenous medicines is being exploited (and devalued). This feeling appears to emanate from the knowledge that western-based medicine has borrowed quite a few remedies from traditional herbal medicines, as illustrated in 2.4.2. As a result, they are very reluctant to provide in-depth information about medical plants and their uses to outsiders.

5.3 MAIN THEMES

The critical subject matter of this study is based on the objectives of the study as outlined in 1.5.

5.3.1 HIV/AIDS KNOWLEDGE OF TRADITIONAL HEALERS

Traditional healers had various views about HIV/AIDS, ranging from the definition to causes of HIV/AIDS. This indeed shows that different people understand HIV/AIDS differently even though they may be living in the same society. Traditional healers had a sense of what HIV is, though very few correctly defined it. As one would expect, those who correctly defined HIV/AIDS have attended training workshops on issues related to HIV/AIDS. Even so most traditional healers could not differentiate between HIV and AIDS. Among all the healers, AIDS is regarded as the oldest disease in the country, as something that has always been among communities and effectively dealt with. This belief is also shared by Botswana traditional healers (Heald 2002). A general belief is that AIDS is just like any other STI and that different names are being used to describe it from gonorrhoea to syphilis to AIDS in recent years.

In some instances healers claimed that the ancestors provided them with their understanding of AIDS. AIDS was defined as dirt in the blood or a disease-causing object in the person's body. It is clear that traditional healers in Lesotho have constructed HIV/AIDS in ways that make sense to them. This is seen in the beliefs about the causes of HIV/AIDS in the country, as something for instance caused by supernatural forces when people do not adhere to norms and values stipulated by the society.

The literature review and the study findings show that in most African countries witches are usually blamed as a source of any kind of misfortune that occur in people's lives such as diseases or death. This blaming is probably due to conflict or jealousy which might exist within families or communities. Witches are believed to have supernatural powers and the abilities to cause a person to get sick. But this

belief arises especially when people do not have a definite explanation of the cause of the illness or disease. Van Dyk (2001) affirms that this belief helps most Africans to have meanings for things that happen to them and in their communities, and actually provides answers for problems that modern science cannot resolve. On the other hand suspicions of witchcraft may be used in order for families to avoid stigmatisation of HIV/AIDS (Van Dyk 2001). This is a relief to families as they have explanations for their catastrophe which is believed and easily understood by everyone around them.

According to the findings there is no doubt among healers that HIV/AIDS is transmitted through sexual intercourse under certain conditions which are deemed to be potentially unsafe for a person's health. These results coincide fairly well with an observation made by Burnett et al (1999) in Zambia and Schoepf (1992) in Zaire (now known as Democratic Republic of Congo) in which "unclean" sex is seen to cause HIV/AIDS. According to these authors and the findings "unclean" sex refers to practices in which people are said to be not adhering to their traditions, which prohibit sexual activities under certain conditions. The study found out that for Basotho traditional healers "unclean sex" refers to prohibited sexual activity during certain periods such as when a woman is wearing a mourning cloth or when a woman has had an abortion and engages in sex without being cleansed. The most striking fact is that the respondents of this study appear to be blaming women for the spread of HIV/AIDS in Lesotho. Respondents seem unaware that women do not have complete control over their sexual activities, and that women in Lesotho for a very long time have been treated as minors with men making decisions for them, including those that impact on their sexual health. Women are not able to initiate when to have sex nor are they able to insist on condom use every time they have sex (Kimaryo et al 2004, WHO 2003:3) women cannot be blamed for the spread of HIV/AIDS.

HIV/AIDS symptoms were easily identified by all the respondents. These include rash (herpes zoster), chronic weight loss, and lack of appetite, diarrhoea, oral thrush and sores. STIs which do not heal were also identified as symptoms of HIV/AIDS as

well as black patches on the skin and excessive skin dryness. Traditional healers indeed are aware of the opportunistic infections that arise in people with HIV due to a weakened immune system. They were also conversant with the local terms for HIV within their communities and of the meanings attached to them. This overlap between healers' understanding of HIV and ordinary Basotho understandings of HIV is important because it could facilitate dialogue and communication between traditional healers, biomedical health care providers, and patients. Traditional healers can easily communicate with their patients about the causes and treatment of these diseases. UNAIDS (2005) observed that it is important not to ignore the meanings attributed to HIV held in any given community. If meanings of illnesses or disease are ignored, it is possible that policies or programmes aimed at HIV prevention cannot be effective. Incorrect understandings of HIV in a community can have negative implications for effective HIV intervention, such as referring to HIV/AIDS as a foreign disease (*koatsi ea bosolla tlhapi*).

On the other hand if similar meanings are used within the community, there is greater potential for an effective referral of patients between biomedical personnel and traditional healers.

5.3.2 TRADITIONAL HEALERS' HIV/AIDS PREVENTION PRACTICES

This section focuses on the traditional healers' practices in relation to HIV prevention. The main question to consider is whether these practices comply with the national HIV and AIDS policies as well as what international organizations such as UNAIDS and WHO deem to be necessary for effective prevention of HIV infection. According to UNAIDS (2006:69) "prevention is the mainstay of the response to AIDS, but is seldom implemented on a scale that allows us to turn the tide of the epidemic". UNAIDS (2006) further argues that effective, inexpensive and relatively simple HIV prevention interventions do exist but the pace of the epidemic is clearly outstripping most efforts for effective programming. This is evident as one recalls Figure 2, which shows the escalating estimates of people living with HIV globally and regionally. Lesotho focuses on prevention of HIV transmission as one of the key

strategies likely to significantly impact on the HIV/AIDS epidemic through the reduction in new cases (National AIDS Commission [NAC] 2006:16). This can be achieved through a variety of methods, such as behaviour change communications, advocacy and use of protective implements such as condoms (NAC 2006).

5.3.2.1 Behavioural change

Unprotected vaginal intercourse accounts for the vast majority of HIV infections globally, particularly in Sub-Saharan Africa. According to UNAIDS (2006), effective prevention of sexual transmission of HIV requires a combination of programmatic interventions that promote safer behaviours. Behavioural change includes basic information about the virus and personal risk assessment building skills such as negotiating condom use with sex partners. Other behavioural changes aiming for HIV prevention, according to UNAIDS (2006), include abstinence, delayed sexual debut among young people, monogamy within relationships, reduction of sexual partners, and correct and consistent use of condoms. Noticeable results of this preventative strategy have been observed in Zimbabwe and this has led to shifts in behaviour change (UNAIDS 2006).

Traditional healers in Lesotho, dispense some of the above-mentioned preventative information, which coincides with cultural norms of the society historically. They emphasise the importance of reducing the number of sexual partners and delaying engagement in sex, especially among young people. The respondents also strongly advocated abstinence before marriage for young people to avoid infection. This, according to UNAIDS (2006), is the core component of any HIV prevention programme. And this is in line with the national policy guidelines. According to NAC (2006:17) “behaviour change has been identified as a key to the reduction of HIV and AIDS transmission”. Behavioural change advice is, however, limited to patients who specifically consult traditional healers with HIV/AIDS or any other STIs. However, the policy recognises the limitations of this prevention strategy. The majority of Basotho have not changed in their sexual practices of multiple and concurrent unprotected sexual relationships (NAC 2006).

The respondents had a strong belief that HIV/AIDS can be easily prevented if people reinstate specific cultural practices, which prohibit certain behaviours. According to the respondents, if people practice their customs and traditions whole-heartedly, HIV/AIDS cannot be transmitted at all. It seems respondents are unaware of the changes that have occurred in their communities. Will it be possible, in this era, for Basotho communities to reinstate abandoned cultural practices?

5.3.2.2 Use of condoms

The study found out that traditional healers do not encourage their patients to use condoms as another efficient and effective way of preventing HIV/AIDS transmission among sexually active people, despite the fact that international and the national policies regard consistent use of condoms as a vital preventative strategy among sexually active persons. It is apparent that the healers do not fully understand condoms or their use.

Traditional healers interviewed for this study had various misconceptions about condoms. Their disparagement of condoms was based on perceptions of the condoms' chemical makeup. The respondents regarded condoms as harmful to humans as AIDS is. All the respondents also believed that if condom use is encouraged, this will promote promiscuity, as many young people would be encouraged to engage in sexual activities at a very early age. Similar results were also observed by Burnett et al (1999) in Zambia. Since condoms are outside the domain of traditional healers, they do not have a comprehensive understanding of what condoms are, nor do they fully understand their importance in the prevention of HIV infection. Nonetheless, strong and sustained promotion of condoms helps to overcome this kind of resistance (UNAIDS 2006). The Government of Lesotho is willing to work hand in hand with traditional healers to distribute condoms in their communities and amongst their patients. The National AIDS Policy clearly states that the Government of Lesotho shall "ensure availability and access to free condoms for both males and females, and strengthen condom distribution mechanisms" (NAC 2006).

5.3.2.3 Education and information

Effective communication and education strategies are regarded as vital to the introduction of prevention tools or strategies (Global HIV Prevention Working Group 2006). The Government of Lesotho has worked to ensure that information, education and communication (IEC) materials are disseminated nationwide including hard to reach areas (NAC 2006). Most importantly it is understood these messages must be culturally accepted, gender sensitive, age suitable and address issues that drive the epidemic in the country. The study found that respondents preferred to educate only their patients, and did not approve of sex education or HIV/AIDS information being disseminated to young people despite the fact that young people aged 15 years and more are among the most infected population in the country. At this age, most of them are still attending school and definitely they can benefit from such information.

Sexually active young people need comprehensive prevention services such as sexual education and provision of condoms. UNAIDS (2006) argues that young people in particular need protection from HIV infection. UNAIDS (2006) further states that open discussion about sexuality among young people is essential as this provides an effective basis for HIV prevention. According to UNAIDS (2006) hidden discussion about sexuality may inadvertently permit misconceptions about sexual behaviour to persist, which in turn places them at risk of HIV infection. For instance, a belief that anal sex helps to preserve girls' virginity may encourage young people to engage in anal sex, but this can actually put young girls at risk of infection

Even though the respondents do not regard schools as an influential means of teaching young people about HIV/AIDS in an attempt to ensure prevention, school-based HIV prevention programmes play a critical role in the prevention of HIV (UNAIDS 2006, Meyer 2003). Traditionally boys used to sleep in one place known as *thakaneng* in the presence of an older man and girls alike and were taught about different life issues including sexual matters. But schools have taken over this function since the introduction of formal education. Does this mean that traditional healers would prefer Basotho to go back to their past practices such as *thakaneng*,

even though we have seen that this is not possible due to socio-economic changes our society has gone through?

Higher education levels are associated with safer sexual behaviour, delayed sexual debut, also young people within the education system benefit from school based sexuality education and HIV prevention programming. Indeed this kind of education has benefited young people in other African countries. According to UNAIDS (2006), many studies have revealed that school based HIV prevention programmes in the continent have shown significant improvements in young people's HIV/AIDS knowledge and positive behavioural changes. The report further indicates that school based programmes are effective and positively contribute in encouraging young people to delay engaging in sexual activities and also increase condom use. Meyer (2003) also feels that schools and teachers can provide children with knowledge, values and skills with which to make healthy decisions and bring about healthy behaviours. Observations done by other UN organizations such as UNESCO et al (2001) affirm that education, more specifically in schools as well as universities is a key instrument in HIV/AIDS prevention. Schools also provide young people with the opportunity to talk with their peers about sexual behaviour without fear of being judged.

Respondents do not provide any formal HIV/AIDS education to patients and communities. It would be advantageous if traditional healers were given thorough training in sex education. This would provide them with a better understating about sex education in schools. All the patients who consult traditional healers with STIs, including HIV/AIDS, do however benefit from the healers' advice such as the need for changing one's sexual behaviour, reducing sexual partners, as well as their encouragement that their patients need to bring their sexual partners for treatment as well. HIV/AIDS education from the healers is limited to those who present with relevant symptoms

Basotho THs indicated that some people in their communities do not have trust in them or regard them as witches and so they believed that people are not likely to

listen to them. It is apparent that if traditional healers alone are involved in disseminating HIV/AIDS information, some people will not receive the vital information about HIV/AIDS. Hence this will have serious consequences on the efforts geared towards HIV/AIDS prevention and treatment in such communities. Moreover, this will limit on Lesotho policy proposal implementation which intends to use traditional healers in disseminating HIV/AIDS within their communities.

It will be of benefit if traditional healers work together with other influential people within the communities such as teachers, priests and community councillors in order to disseminate HIV/AIDS information. Those who trust traditional healers are those who use their services.

Traditional healers have been accused of accumulating money through false pretences of curing illness such as HIV/AIDS when there is no cure of HIV/AIDS as yet. Richter (2003) observed indeed quite a number of traditional healers have seen a lucrative opportunity in claiming to be curing people living with HIV/AIDS.

5.3.2.4 Other forms of education

This section discusses public messaging in the form of billboards.

The clarity of AIDS messages should not be taken for granted. Some people (especially in the rural areas) might not know what a condom looks like and how it is used. Figure 9 also encourages people to test for HIV/AIDS, but it also scares people by suggesting that if they do not test they will not live long. While figure 9 encourages the use of condoms, it does not specifically say that people should use condoms. The message is talking about “weapons” which is confusing.

The message displayed in Figure 9 is not educational. Nothing is learned from the message and it only succeeds in scaring people even more. Even though there is no cure for HIV/AIDS, these messages do not show any hope for people living with the disease. The second message (Figure 10) illustrates events of the day on the funeral where there is a person who is referred to as a nurse (*mooki*) who explains the cause

of the deceased's death. The message encourages the nurse to tell the truth. Due to stigma still attached to HIV/AIDS in Lesotho, people tend to hide the actual cause of death when it is an HIV related illness that caused the death. Messaging on billboards should be clear and take the whole population into account.

5.3.3 TRADITIONAL HEALERS' TREATMENT AND CARE OF HIV/AIDS

This section discusses HIV/AIDS care and treatment activities of traditional healers in Lesotho. Treatment and care of HIV/AIDS are vital in controlling the progression of the disease. Comprehensive care for people living with HIV/AIDS involves a number of important features in addition to increased provision of antiretrovirals. NAC (2006) also adds diagnosis of the disease, appropriate provision of good nutrition, and community home-based care.

5.3.3.1. Treatment

According to UNAIDS (2006) HIV cannot be effectively treated unless it is diagnosed. Effective HIV/AIDS treatment is preceded by an increase in the use of voluntary HIV counselling and testing. Traditional healers could potentially contribute to this aspect by referring the patients to hospital to be tested for the disease. The study presented here found that very few healers encourage their patients to have laboratory tests performed in order to have a thorough examination. These respondents are aware of HIV/AIDS issues, yet the majority of them do not refer their patients to be tested for HIV/AIDS at all; instead they tend to treat them with their own medicines. Perhaps this is due to the healers' understanding of HIV/AIDS causes and its treatment as referred to earlier.

The healers do not just treat HIV related illnesses, they also claim to cure HIV/AIDS. Traditional healers, particularly diviners, claim to successfully cure HIV/AIDS by administering medicines which are not bitter to the taste. The healers stressed that bitter medicines aggravate the conditions, which can result in a patient dying. In KwaZulu-Natal, South Africa, it was observed that the treatments given to

HIV/AIDS patients by the healers are normally bitter and are taken as drink or tea (Leclerc-Madlala 2002).

Leclerc-Madlala (2002) argues that it is not surprising that in recent years, as HIV/AIDS grows and matures, there are many people claiming to have a cure for HIV/AIDS. In this way, patients are given false hope that HIV/AIDS can be cured by traditional medicines (as was observed in Uganda) whereas there is no cure for HIV/AIDS as yet, only treatments which enable people living with the HIV/AIDS to manage the disease. The same observations were made in Zambia where some of the traditional healers also claimed to have found a cure for HIV/AIDS (Burnett et al 1999).

Some of the respondents stated that there is mistrust amongst them and they do not share effective medical plants amongst themselves.. The respondents further indicated that if they were to meet in any forum to discuss effective medicines for HIV/AIDS related illness and other health problems, some healers would mention medicines which were of doubtful efficacy. It was also observed that among traditional healers in South Africa there is also reluctance to discuss their medicines because they are regarded as secret recipes, which is attractive to patients (Leclerc-Madlala 2002). Traditional healers, like any other therapeutic practitioners, need to be recognised and regarded as powerful in their practices. Each wants to keep useful information to themselves. This mistrust extends to other people outside traditional medicine such as researchers interested in traditional medicine. Only very rarely do traditional healers share information about their practices with other people. The negative experiences they have encountered with biomedical researchers have also added to this mistrust.

Some healers were aware that they could not cure HIV/AIDS but could only treat HIV related ailments. The herbs prescribed help to restore the patient's appetite, clear the symptoms, as well as cleansing the patient's immune system. These healers understand that there is no cure for HIV/AIDS as yet. These healers could play an

important role in informing their patients that there is no cure for HIV/AIDS so as to prevent their pursuing people who make false claims in that regard.

Most importantly, traditional healers recognized that they also deal with TB, which they perceive as *sejeso*. TB is among the leading causes of AIDS deaths, hence its accurate and early diagnosis, prevention and treatment are of overriding importance (UNAIDS 2006). *Sejeso* is diagnosed as TB when the patient is later taken to a hospital. Traditional healers were aware that they cannot fully treat *sejeso* as there are wounds caused by *sejeso*, which they leave for western-based medicine to deal with. *Sejeso* is said to leave unhealed scars on the lungs which are treated better at the hospital. Traditional healers treat *sejeso* for a certain period of time and when it is unsuccessfully dealt with, a patient is taken to hospital. Traditional healers believe that this ailment is caused by a disease-causing object (discussed in detail in 1.6) which has been inserted by witches. They claim that they successfully treat the first aspect of this disease relating to witches then refer patients to hospital for further treatment.

This also applies to the healers' treatment of STIs. They also treat various STIs such as *mashoa* and *mahae*. It is believed that breaching sexual taboos causes these ailments. Therefore healers believe that they can treat them successfully as the origin is closely related to observance of certain cultural behaviours. The healers see their role as one of chastising people for these breaches and convincing them to observe the behaviours in the future. This view has negative consequences for effective treatment of HIV related symptoms and intervening in the speedy progression to full-blown AIDS. The view leads to delays in referring patients to hospital. Biomedical personnel stress the importance of seeking medical help as early as possible in order to delay or prevent advancement of any disease. Hence there will always be tension between traditional healers and biomedical personnel.

5.3.3.2 USE OF ARVS AND TRADITIONAL MEDICINE

Traditional healers were not completely against the use of antiretroviral therapy. However they do not encourage patients to use antiretroviral and traditional

medicines at the same time. They had concerns about the stipulated instruction about taking ARVs at regular times. Their concerns related to a patient forgetting to take their medication by an hour or so. This suggests that there is great need for a better understanding of ARVs by the traditional healers. They also believed that if these two therapies are combined, a patient is likely to develop liver problems. This is not verified by laboratory tests, it is just their belief. Indeed the literature has shown that there are detrimental effects in combining traditional medicines and biomedical drugs. Some respondents felt that ARVs are just another form of exploitation by western countries acting to impoverish African countries by making them buy expensive therapies from the West. Zambian traditional healers also discourage their patients from combining traditional medicine and biomedical therapy in treating some of the STIs (Ndulo 2001). Biomedical practitioners also do not encourage combining traditional medicine and ARVs. They believe that traditional medicine is likely to hamper the effectiveness of ARVs. This response was obtained from the Director of Sankatane who is also a medical doctor. Each system does not regard the other as important and effective in most health related issues. As a result the two systems are not working together for the benefit of people living with HIV/AIDS. This can also be an obstacle in referral between the two. Both systems feel more effective and superior to the other.

However noting the above, the two systems have the potential to complement one another as there are notable similarities between them. Both systems are aware of the effects caused by extreme distress which is likely to result in ill health (Hewson 1998:1032). According to Hewson (1998: 1033) traditional healers provide a healing ritual, that is, a shared experience of healing process. Southern African traditional healers dress in ceremonial clothes when seeing a patient (as seen in figure 5 and 6) and use ceremonial instruments such as divining bones, razors, water and prayer. Biomedical practitioners on the other hand also wear a white coat and use stethoscopes. The act of healing is the cornerstone in both systems. Both traditional healers and biomedical practitioners feel satisfied when a patient is healed.

5.3.3.3 CARE

HOME BASED CARE

Traditional healers, particularly the herbalists, do offer some form of home-based care for their HIV/AIDS patients. The healers, at times, live with their patients at their houses while treating and monitoring their health. Other respondents (faith healers) visit the patients at their own homes and even sleep over. They help patients to bath using holy water, monitor their health as well as chasing the evil spirits inside the patients' homes and around their yards. The healers in the remote areas of the country also provide this essential service to persons chronically ill with HIV/AIDS. Home-based care is significantly important in countries such as Lesotho, which is faced with various challenges in health care delivery for HIV/AIDS patients as seen in the previous chapters. Campbell and Foulis (2004) also state that home-based care plays a vital role in the care of millions of AIDS patients in other Sub Saharan African countries where over-burdened medical and welfare services are overwhelmed by the demands of the epidemic. Traditional healers are able to supplement these services as they are already in the health sector. The National AIDS policy is yet to develop the basic standards for home-based services and train all home-based carers in its use in the country. Both THs and the hospitals offer some form of home based care for their patients, though different in content. Traditional healers do everything themselves while offering home-based care. Home-visiting programmes supported by biomedical hospitals, mobilise volunteers to visit the patients, educating carers and family members about basic care issues, and accompanying patients to medical appointments. Professionally trained staff also educates family members in palliative care and linking them to referral networks of health facilities and welfare agencies, an aspect which is not available in traditional healing practice as observed by Campbell and Foulis (2004).

Campbell and Foulis (2004) further observed that home-based care also provides a useful catalyst for counselling and education about HIV/AIDS amongst local families and communities. This is regarded as highly important in the face of patchy levels of knowledge about HIV/AIDS within communities and the stigma, rejection

and isolation suffered by many people living with HIV/AIDS (Campbell and Foulis 2004) as elaborated in sub-section 1.3.1.

The majority of healers interviewed in this study provide this service without adequate and proper knowledge. They have been excluded from crucial training by relevant offices when training communities on home-based care. Campbell and Foulis (2004) argue that there is a great need for traditional healers to be given appropriate training and support in order to offer adequate rudimentary nursing skills. If this aspect is not taken in to consideration, there can be negative consequences for both traditional healers and their patients even though their intentions may be good, as they do not have nor use the necessary equipment, such as protective hand gloves, to protect themselves as well as their patients. It has been widely documented that if a person has wounds or some form of skin laceration and comes in contact with HIV infected blood that person is likely to be infected. There are other infectious diseases which are likely to spread if proper precautions are not taken. Moreover, the failure by training agencies to specifically target traditional healers and to tailor the training to their needs and skills level has clearly led to gaps in the provision of adequate care. This point is closely related to hygienic measure which needs to be taken into consideration when taking care of a patient.

HYGIENE

According to the findings, the majority of traditional healers have devised their own measures to ensure good hygiene in their practice though under adverse conditions. They operate from a separate room that is situated in their backyard to ensure that their family members are not exposed to infections. The equipment is kept separate from the household. Healers also insist that patients bring their own razors for treatment. These razors are burned after being used. The tennis balls are washed before and after use.

This study found that traditional healers have changed their practice of sucking blood out of patients' body by using their mouths. Instead of using their mouths, they use tennis balls and cut a small hole in them in order to suck out the blood. Some of the

respondents have gone to the extent of limiting the number of patients they see each day. This is done to reduce the risk of other family members contracting diseases from patients. Chipkafacha (1997) noted that hygiene is essential as it plays a crucial role in preventing the spread of disease in any given setting. Though traditional healers seem to be against change and progress, they have adopted new practices, which were not part of their healing practice previously. Progress and change in their practices is therefore possible and has in fact already occurred.

NUTRITION

Few traditional healers are aware of the importance of good nutrition in HIV/AIDS patients. They strongly advise their patients to eat a healthy, well balanced diet daily. They encourage their patients to ensure that they eat food with roughage, fruit and vegetables, and some of the indigenous vegetable such as stinging nettle that is rich in iron.

REFERRAL OF PATIENTS TO A HOSPITAL

There are some cases where traditional healers refer their patients to a hospital. There are also instances where patients are not referred to the hospital at all. According to the respondents, non-response to their prescribed treatment qualifies a patient to be referred to a hospital. Traditional healers delay referring patients mainly because they regard their medicine as effective against most ailments. On the other hand they are also aware of the shortcomings of their therapies as some health problems are not treated completely. Traditional healers are aware that there are some instances where their treatments have limitations.

However there are serious repercussions when a treatment for serious health problems such as TB as well as HIV/AIDS is delayed. Barker et al (2006) reckon that this delay seems a normal practice among most people in the Sub-Saharan Africa who frequently consult traditional healers before reaching western medicine-based centres. This leads to delays in starting effective anti-TB chemotherapy and taking ARVs. It seems to be general practice by THs to delay referring patients to hospitals or clinics. Hatchett et al (2004) observed in Malawi that when healers recognize that

their remedies are not effective for AIDS symptoms, they often tell the patients' families to go to a hospital for help.

5.4 COLLABORATION BETWEEN TRADITIONAL HEALERS AND BIOMEDICAL PERSONNEL.

Traditional healers tend not to cooperate amongst themselves the study shows. However, information sharing is very important as traditional healers who are well informed about HIV/AIDS can share it with those who are not exposed to information as traditional healers in Uganda do (UNAIDS 2002:43). It is also apparent that even though the Government is trying to work with traditional healers, this effort is inadequate because most traditional healers are not invited to participate in some of the HIV/AIDS training workshops which have been undertaken in the country. Traditional healers have been excluded in training, such as basic counselling. As shown in Section 2.6 some African Governments have established a working relationship with the healers to the extent that the healers have been thoroughly trained in issues relating to HIV/AIDS. Some of the healers in the country have shown their eagerness to learn about HIV/AIDS as they have included the HIV/AIDS issues in their mandate at the district level.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

The primary objective of the study is to establish the traditional healers' knowledge of HIV/AIDS, and the practices which traditional healers use in the prevention and treatment of HIV/AIDS in the country. This includes looking at the contribution of traditional healers to HIV/AIDS preventative and care initiatives. Recommendations based on the positive and negative contributions are made thereafter.

The most desirable and most encouraged preventative measure against HIV/AIDS by the healers is behavioural change. Traditional healers regard this preventative measure as the most crucial in the fight against HIV/AIDS. This measure entails observing cultural norms such as not engaging in sexual activities when wearing mourning cloth, and also reduction of one's sexual partners and delay in sexual engagement. The latter needs to be strengthened as it is compatible with the national AIDS policy guideline as well as internationally recognised strategy.

Despite the fact that modern technology has devised some preventative measures such as condoms, traditional healers are strongly against the use of condoms as another means through which HIV/AIDS can be prevented. It is therefore recommended that THs be informed about condoms and their importance in the prevention of HIV/AIDS and further infection of the disease. .

The practices of traditional healers have both positive and negative effects on the prevention and care of HIV/AIDS in the country. Positive aspects include their advice on reducing the number of sexual partners. They strongly advise one sexual partner. They also encourage total abstinence among young people as early debut puts them at risk of infection, and this is supported by international organisations. Positive results have been observed in other African countries where monogamy and

a change sexual behaviour were insisted on. However, this strategy, like any other prevention strategy has limitations to it.

Traditional healers provide home-based care to their patients. They sometimes live with patients in their own homes, where they help them to bath or eat while administering herbal treatments. They also visit their patients at home, a practice that may be seen as positive, as the traditional healer is then able to provide counselling to the whole family. Home-based care is regarded as very useful in many countries such as Lesotho, where there are inadequate health resources.

In addition, some healers are aware that good nutrition is essential for their patients. They encourage their patients to make sure that their daily food in-take conforms to a well balanced diet. They also encourage them to eat some of the indigenous vegetables rich in essential minerals.

Traditional healers have modified some of their practices which were likely to put them and their patients at risk of HIV/AIDS infection, as has been noted earlier. Traditional healers are aware of the risks of coming in contact with contaminated blood. Once a person has the disease caused by *sejeso* or “ants” according to the respondents, it is likely to spread to another person. Hence precautions have to be taken to limit the spread of the disease.

Traditional healers are also eager to learn about all HIV/AIDS related issues so as to have adequate and appropriate information as well as to how to take care of their HIV/AIDS patients properly. They feel that that they can contribute positively in HIV/AIDS education in their communities. They can only perform such role only if they are adequately trained and fully integrated into HIV/AIDS programmes in the country.

However, there are also aspects which can have a negative impact on the efforts geared towards prevention and care of HIV/AIDS in the country. First and foremost, their belief that AIDS is caused by witchcraft is likely to have a negative impact on

communities. Incorrect information, particularly to those who make use of traditional healers' services is likely to be conveyed. It is therefore recommended that THs be given correct HIV/AIDS information in order to pass it to their patients. Traditional healers are also not involved sufficiently in disseminating information related to HIV/AIDS to their patients and communities.

Traditional healers are not only inadequately disseminating HIV/AIDS related information; they are also against educating people, especially young people about sexual issues. They believe that if this is done, it would give young people freedom to engage in sex at a very early age. However, international organizations are working hard to provide guidelines aimed at improving people's health believe that education is vital in the prevention of HIV/AIDS. People need adequate and correct information in order to make informed decisions concerning their sexual choices.

Even though traditional healers treat various ailments using a range of treatments they give their patients false hope that they can successfully cure HIV/AIDS. Some of these treatments include prayers, water (even taking patients to a river to wash away evil spirits which are believed to cause HIV/AIDS). As a result, patients are delayed in referral to a hospital for further treatment. Some are aware that they cannot treat some of the ailments.

As a negative finding it is concluded that traditional healers do not work together at all. Some of the traditional healers have relevant information which can benefit all the healers. But due to lack of trust amongst them, they do not share information amongst themselves. The Lesotho Traditional and Medicinemen Practitioners Council seems not to be interested in HIV/AIDS and related issues. This is supported by the fact that the council does not allow healers who are well informed about HIV/AIDS issues to share such information with other healers (see chapter 4). Also the fact that I was discouraged from interviewing traditional healers about HIV/AIDS because I am not married and had no children at the time, clearly shows that HIV/AIDS conversation is somehow still not welcomed. This is very unfortunate because unity amongst healers in various countries plays an active and important role

in communities. Biomedical personnel likewise do not fully engage traditional healers in training efforts. They make assumptions that if traditional healers are members of various NGOs and CBOs in their communities they have been trained. Furthermore, in decision-making forums, they make assumptions that traditional healers have the same level of understanding. This led healers to express a need for them to meet as traditional healers exclusively.

It is recommended that traditional healers themselves should be more organised in order to have harmonious relationships amongst themselves. This will enable them to share useful information amongst themselves initially and then with others. At the moment communication is haphazard. Some of the healers are eager to learn about HIV/AIDS, while others are already conversant with HIV/AIDS issues. Probably this could bring about trust amongst them, as they would interact more often.

It is also recommended that the present healers' Council encourages all traditional healers to join the council as some of the traditional healers are very informed about HIV/AIDS issues. Traditional healers who do not have adequate information would benefit from those who are better informed.

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