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Perspectives on the use and integration of traditional medicine in maternal healthcare: Experiences of traditional practitioners, midwives, and community health workers in Lesotho

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Authors:
Lisemelo L. Chesetsi[1]
Andrew Ross[2]

Affiliations:
[1]School of Nursing and Public Health, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa

[2]Department of Family Medicine, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa

Corresponding author:
Lisemelo Chesetsi,
lydia.chesetsi@yahoo.com

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With limited healthcare facilities in sub-Saharan Africa, many females rely on traditional medicines (TM) to address their maternal health needs. The World Health Organization (WHO) has advocated for the integration of TM into the National Healthcare System to improve health outcomes. This study explored the perspectives of traditional healers, midwives, and community healthcare workers on the integration of TM into maternal healthcare in Lesotho to understand the pathways and barriers to integration. The study was conducted in three villages in Lesotho: (1) Ha-Shalabeng (urban), (2) Ha-Molengoane (peri-urban), and (3) Ha-Setoko (rural). The study employed an exploratory qualitative design. The 10 participants were selected purposively and qualitative data were collected through semi-structured interviews and analysed using a thematic analysis. The following three main themes were identified: (1) factors influencing the use of TM during pregnancy; (2) stakeholders' perceptions of the integration of TM into maternal healthcare; and (3) challenges to successful integration. The findings indicated that TM plays a crucial role in maternal healthcare, with various factors influencing its utilisation. The integration of TM into maternal healthcare has been impeded by multiple factors that need to be addressed.

Contribution: Achieving successful integration will require collaborative efforts and active engagement with all relevant stakeholders.

Keywords: healthcare system; integration; Lesotho; public health; traditional medicine.

Introduction

Traditional medicine (TM) is defined as 'the use of plants, animal parts, minerals, as well as spiritual therapies and techniques for treating, diagnosing, preventing disease, or maintaining overall well-being' (Poli et al. 2025:2). Traditional medicine continues to play a significant role in maternal healthcare, particularly among pregnant females in both developing and developed countries (Siatwiko & Nkhata 2025). The continued use of TM in maternal healthcare is particularly evident in sub-Saharan African countries, where challenges such as limited access to maternal healthcare services, inadequate healthcare infrastructure, and a shortage of healthcare personnel persist, particularly in rural communities (Qwabi et al. 2025).

These factors have contributed to the sustained reliance on TM, and given its widespread utilisation, there has been a growing need to integrate TM into the formal healthcare system to enhance access to quality care (World Health Organization [WHO] 2023).

The integration of TM into primary healthcare has increasingly been recognised as an important strategy for advancing Universal healthcare coverage and improving equitable access to healthcare services, particularly in rural and peri-urban communities (Wang 2025). The integration of TM into national healthcare systems will strengthen relations between traditional practitioners (TPs) and biomedical practitioners through improved communication and cooperation (WHO 2023). In Lesotho, TM and biomedical healthcare coexist, and females commonly access both systems during pregnancy and childbirth (Mokhesi & Modjadji 2022; Mugomeri et al. 2015). Despite this pluralistic healthcare context, the integration of TM into maternal healthcare remains limited, underscoring the need to explore approaches that support coordinated, contextually appropriate healthcare delivery (Kithinji et al. 2025). This study explored the perspectives of traditional healers, midwives, and community healthcare workers on the integration of TM into

maternal healthcare in Lesotho to understand the pathways and barriers to this integration.

Traditional medicine and maternal healthcare in Lesotho

Traditional medicine remains an important component of primary healthcare globally (Obu 2025). An estimated 80% of the world's population relies on TM for health maintenance and the management of various illnesses, with pregnant females considered the primary users (Obu 2025; Xiong et al. 2023). During pregnancy, childbirth, and the postpartum period, females use various TM to manage pregnancy-related symptoms, promote maternal well-being, and support postnatal recovery (Tumuhais et al. 2021; Zulu et al. 2025). In sub-Saharan Africa, the use of TM during pregnancy is influenced by a complex interplay of factors, including social, cultural, and healthcare access factors (Sichalwe et al. 2026). Traditional practitioners and indigenous practices continue to play a significant role, particularly in rural communities where formal healthcare facilities may be geographically inaccessible, and community members still have deeply rooted beliefs in traditional healing (Zulu et al. 2025). Traditional practitioners often provide care that is culturally congruent, aligning with beliefs and practices surrounding pregnancy, childbirth and postpartum (Thipanyane et al. 2022).

In Lesotho, TM remains a fundamental component of healthcare delivery, particularly in rural and peri-urban communities where access to biomedical services is limited (Schwitters et al. 2022). Its use is deeply rooted in cultural beliefs that emphasise the interconnectedness of natural elements, spiritual forces, and the processes of pregnancy and childbirth (Lekhotsa 2020). The health system is characterised by medical pluralism, with the biomedical and traditional healthcare systems operating alongside one another (Mokhesi & Modjadji 2022; Sefotho 2016). Within this context, many females utilise both systems concurrently, relying on TM to facilitate labour, pain management, and prevent perceived pregnancy complications while also accessing formal maternal healthcare services (Mugomeri et al. 2015). Despite the coexistence of TM and biomedical healthcare in Lesotho, meaningful integration remains limited owing to the absence of a comprehensive TM policy, robust legal and regulatory frameworks, and collaborative efforts (Kithinji et al. 2025). These challenges not only raise concerns about the quality, safety, efficacy, and standardisation of TM but also limit opportunities to develop collaborative approaches that could support its integration into formal maternal healthcare (Nzimande et al. 2021).

As the scholarship on the prevalence and use of TM during pregnancy in Lesotho continues to expand (Chesetsi & Ross 2025; Mugomeri et al. 2015), little attention has been paid to the perspectives and experiences of TPs, midwives, and community healthcare workers regarding the integration of TM into maternal healthcare. As such, this study addresses a critical gap. The findings presented in this study provide evidence-informed recommendations essential for context-specific policies and collaborative strategies that support safe and effective integration.

Theoretical framework

This study is informed by the theory of medical pluralism, a concept rooted in medical anthropology that explains the coexistence and simultaneous use of multiple healthcare systems within society (Ahmad & Ridzwan 2025; Nasrullah et al. 2026). Medical pluralism recognises that individuals often seek care from different therapeutic traditions, including biomedical, traditional and spiritual systems, either sequentially or concurrently, depending on their health needs or socio-cultural context (Ahmad & Ridzwan 2025). Rather than viewing these systems as mutually exclusive, the theory acknowledges their existence and their collective role in shaping healthcare-seeking behaviour (Khalikova 2021). The theory suggests that individuals navigate among these healthcare systems based on multiple considerations, including cultural and religious beliefs, perceived treatment effectiveness, accessibility, and affordability (Nasrullah et al. 2026).

In Lesotho, medical pluralism is deeply embedded in the country's historical, cultural, and social context (Masupha, Thamae & Phaqane 2013; Mugomeri et al. 2015). Traditional healing practices and spiritual beliefs continue to coexist alongside biomedical healthcare services, with each system playing a distinct role in addressing individuals' health needs (Mokhesi & Modjadji 2022). Medical pluralism is particularly pronounced in maternal healthcare, where pregnancy and childbirth are often understood through both biomedical and socio-cultural perspectives, leading females to seek care from TPs alongside or before consulting biomedical practitioners (Chesetsi & Ross 2025; Mosia 2021). Additionally, TPs often serve as a point of care in settings with limited access to healthcare facilities, as they are readily accessible, affordable, and culturally familiar (Sundararajan et al. 2020). Even in urban or peri-urban areas where biomedical services are available, many pregnant females continue to utilise both traditional and conventional healthcare providers, reflecting enduring cultural practices and broader patterns of pluralistic healthcare utilisation (Meihartati et al. 2026).

While medical pluralism may improve access to healthcare and provide culturally acceptable care, it can also pose challenges when communication and collaboration between traditional and biomedical practitioners are limited (Siatwiko & Nkhata 2025). In the context of this study, medical pluralism provides a suitable theoretical framework for examining the perspectives of midwives, community healthcare workers and TPs on the use and integration of traditional practices in maternal care in Lesotho, where multiple healthcare systems coexist and are often used by pregnant females.

Research methods and design

This section outlines the qualitative research design, study setting, participant selection, data collection procedures, data analysis, and the ethical considerations guiding the study.

Study design

This study employed a qualitative exploratory design. According to Pemo, Phillips and Hutchinson (2020), qualitative exploratory design facilitates an in-depth understanding of participants' perceptions, attitudes, beliefs, and experiences, as well as the underlying reasons and motivations associated with a particular phenomenon. This design was considered appropriate for this study because it enabled the researcher to explore participants' perceptions, experiences, and beliefs about the use and integration of TM in maternal healthcare (Dokter 2023).

Study setting

The study was conducted at three sites located within two of the country's 10 districts, Maseru and Quthing. These areas were purposively selected to ensure representation of urban, semi-urban, and rural settings. This diversity enabled the researcher to capture variations in healthcare access, cultural practices, and use of TM. These differences are crucial for understanding the utilisation of TM and its potential integration into maternal healthcare services.

Ha-Shalabeng is located in Maseru, the capital of Lesotho. As observed by Mokhesi and Modjadji (2022), residents of Maseru have access to at least three hospitals, indicating substantial access and availability of biomedical healthcare services. Despite this access, TM use remains prevalent. Kose, Moteetee and Van Vuuren (2015) reported that TM is widely used in areas such as Ha-Shalabeng, with community members relying on it to manage common health conditions, including infertility and pregnancy complications. Ha-Molengoane is a peri-urban community situated on the outskirts of Maseru. Although residents have access to healthcare services through a local clinic within the village, they continue to maintain strong ties to TM.

Ha-Setoko is a rural area located in the Quthing district. It is among the remote communities in this district, with no local healthcare facilities (Ministry of Local Government and Chieftainship 2008). The nearest hospital is approximately 10 km away, requiring residents to travel for 4h to access medical care (Ministry of Local Government and Chieftainship 2008). In such settings, TM plays an important role in supporting the well-being of rural populations, including those in Ha-Setoko, where access to clinics or hospitals is limited (Kose et al. 2015).

Study population and sampling strategy

Purposive sampling is a non-probability sampling technique that involves the deliberate selection of information-rich participants who possess the relevant knowledge and experience of the phenomenon under investigation (Campbell et al. 2020). In this study, purposive sampling was employed to identify and recruit midwives, TPs, and community healthcare workers with experience and insights into the use and integration of TM in maternal healthcare. Midwives and community healthcare workers were purposively selected based on their knowledge, experience, and expertise in maternal healthcare, while TPs were selected for their recognised role and established reputation in providing traditional maternal care within their communities.

To minimise selection bias, participant recruitment was guided by predefined inclusion and exclusion criteria that were explicitly aligned with the study objectives. The selection criteria were reviewed by the second author to enhance methodological rigour and reduce subjective decision-making. Participant recruitment was facilitated through gatekeepers. The village chiefs assisted in locating community healthcare workers and TPs within their respective villages, while the clinic managers facilitated access to eligible midwives.

In Ha-Shalabeng, three midwives and one traditional healer were interviewed. In Ha-Molengoane, interviews were conducted with two midwives and one community healthcare worker; no traditional healer was available in the village. The community relied on a healer from the neighbouring Ha-Ntsi village, which was not included in the study. In Ha-Setoko, there was no health facility, and no midwives were available to recruit. Instead, two TPs and one community healthcare worker were interviewed. Overall, the study included 10 participants, as presented in Table 1.

The study sample size was guided by the principle of 'information power' proposed by Malterud, Siersma and Guassora (2016), which suggests that smaller samples are adequate when participants possess substantial knowledge and experience relevant to the research topic and can provide rich and meaningful data. Given the focused nature of the research questions and the inclusion of experienced TPs, community healthcare workers, and midwives, a sample of 10 participants was considered sufficient to generate rich, meaningful data (Akkaş & Meydan 2024; ed. Coast 2017).

Data collection

Data were collected from November 2022 to December 2022 using semi-structured interviews. A semi-structured interview is a qualitative data collection method that uses predetermined, open-ended questions to guide discussion while allowing participants to elaborate on their perspectives and experiences (Ilovan & Doroftei 2017). A key advantage of

TABLE 1: Sample size.

Villages	Population	Total sample size
Ha-Shalabeng	Traditional practitioners	1
	Midwives	3
	Community healthcare workers	0
Ha-Molengoane	Traditional practitioners	0
	Midwives	2
	Community healthcare workers	1
Ha-Setoko	Traditional practitioners	2
	Midwives	0
	Community healthcare workers	1

this approach is that it allows the researcher to probe participants' narratives for further clarification and detail (Kallio et al. 2016). This method of interviewing was used because it allowed the researcher to clarify questions, explore emerging issues in greater depth, and generate rich, comprehensive data relevant to the study objectives. The interview guide consisted of four sections: (1) demographic details, (2) factors influencing the use of TM during pregnancy, (3) perceptions regarding integration, and (4) barriers to successful integration. The interview guide content was checked by the second author.

Face-to-face interviews were conducted with TPs, midwives, and community healthcare workers in private rooms, using Sesotho, the native language for both the researcher and participants. Audio-recorded interviews lasted approximately 30 min – 40 min. However, two of the three TPs and the three midwives did not consent to audio recording. The TPs stated that traditional healing practices involve sensitive information that should not be publicly disclosed, while the midwives cited privacy concerns and discomfort with being recorded. Consequently, these interviews lasted approximately 60 min to allow the researcher sufficient time to take detailed notes and verify them with participants, ensuring that the notes accurately reflected their accounts. This was done to enhance the accuracy and completeness of the data (Rutakumwa et al. 2020). The researcher also expanded these notes after the interviews, thus providing a detailed description of the participants' statements and her observations. All other interviews were recorded, transcribed verbatim, translated into English by the researcher, and then back-translated into Sesotho to ensure consistency with the participant's response.

Data analysis

The researcher conducted and analysed all interviews in Sesotho, after which they were translated into English and reviewed by a colleague proficient in both languages. The data were analysed using Braun and Clarke's six steps of thematic analysis (Braun & Clarke 2006). The familiarisation step involved repeatedly reading the transcripts to gain a comprehensive understanding of the data. Through repeated engagement with the data, initial codes were generated. Similar codes were grouped to develop potential themes and sub-themes. The themes and sub-themes were reviewed against the coded data set to ensure they accurately reflected participants' views and addressed the study objectives. The final themes and sub-themes were then refined, defined, and named. Lastly, the findings were organised and reported using the final themes and sub-themes.

Measures to ensure trustworthiness

The study's credibility was ensured through prolonged engagement with participants in the field. This sustained interaction allowed the researcher to establish trust and rapport, facilitating deeper access to participants' experiences, behaviours, beliefs, and enabling a more nuanced understanding of the phenomenon (Ahmed 2024).

Reflexivity

According to Berger (2015), reflexivity in qualitative research involves evaluating the researcher's positionality within the research and the potential impact it may have on the setting, participants, data collection, and interpretation processes. Relevant to this is that the primary researcher is a Mosotho female who was born and raised in Lesotho, which offered easier access to the research settings and establishing rapport with participants, due in part to speaking the local language, Sesotho, and being familiar with the Basotho.

Ethical considerations

Ethical approval was obtained from the University of KwaZulu-Natal, Human and Social Science Research Ethics Committee (HSSREC) (NO. HSSREC/00004919/2022), and gatekeepers' permission to access the clinics and interview midwives and community healthcare workers was obtained from the Ministry of Health Research and Ethics Committee (ID28-2021). Authorisation was obtained from the Lesotho Council of Traditional Healers to interview TPs and to access the three locations; the researcher also obtained permission from the village chiefs. Before conducting the interviews, study participants were informed of the study's purpose, that participation was voluntary, and that they were free to decline or withdraw from the study at any time. They were required to sign informed consent forms, which assured confidentiality and anonymity, with pseudonyms used.

Results

This section presents the study's findings. It begins with an overview of the participants' characteristics, followed by the main and sub-themes that emerged from the study.

Participants' characteristics

This section presents participants' characteristics (Table 2). All three TPs were sangomas; two were female, two had completed their junior certificate, and one had completed primary education. The five midwives were all females, aged 20 years – 50 years. Three held a diploma, one had a bachelor's degree, and one had a master's degree. Three midwives were single. Both community health workers had completed primary education and were widowed.

Themes

The following three main themes were identified during thematic analysis: (1) factors influencing the use of TM during pregnancy; (2) stakeholders' perceptions of the integration of TM into maternal healthcare; and (3) challenges to successful integration (Table 3).

Theme 1: Factors influencing the use of traditional medicine

This theme explores participants' perspectives on the factors influencing TM use during pregnancy. Participants identified limited access to healthcare facilities, the accessibility of TM,

TABLE 2: Demographic characteristics.

No.	Gender	Age (years)	Marital status	Education	Location
Traditional practitioners (Sangoma's)					
1	Male	60–70	Married	Junior Certificate	Ha-Shalabeng
2	Female	40–50	Widow	Junior Certificate	Ha-Setoko
3	Female	60–70	Married	Primary	Ha-Setoko
Midwives					
4	Female	40–50	Married	Masters	Ha-Molengoane
5	Female	40–50	Married	Degree	Ha-Molengoane
6	Female	30–39	Single	Diploma	Ha-Shalabeng
7	Female	30–39	Single	Diploma	Ha-Shalabeng
8	Female	20–29	Single	Diploma	Ha-Shalabeng
Community healthcare workers					
9	Female	60–70	Widow	Primary	Ha-Molengoane
10	Female	60–70	Widow	Primary	Ha-Setoko

and deeply rooted cultural beliefs as the main factors influencing its use.

Sub-theme 1.1: Lack of healthcare facilities: This theme is supported by the three participants from Ha-Setoko, who confirmed that there is no formal healthcare facility in this area. Participant 2 stated:

> 'We do not have any clinics or hospitals in this village.' (P2, Traditional practitioner, Female)

Participants further revealed that accessing the nearest healthcare facility, Quthing Hospital, requires walking long distances due to limited transportation and poor road infrastructure. As a result, some individuals who are ill or physically unable to travel such distances often seek assistance from TPs. Participant 10 narrated:

> 'To access medical services, we must travel to Quthing Hospital, which is located far from here and is difficult to reach due to a lack of transportation and poor road conditions. I think that is one of the contributing factors to the high reliance of pregnant [*females*] on TPs.' (P10, Community healthcare worker, Female)

Participant 3 also reported that because of limited healthcare facilities in this area, some pregnant females have experienced pregnancy-related complications:

> 'As you have seen, you have to cross a river to get here. It is not easy for them to get to town, so many complications arise on the way. Some [*females*] have given birth on their way to the hospital.' (P3, Traditional practitioner, Female)

Sub-theme 1.2: Accessibility of traditional medicines and traditional practitioners: Traditional practitioners emphasised their availability and commitment to pregnant females in times of need. Participant 2 said:

> 'We are available day and night to assist, and for us, it is not even about the money but to provide the necessary assistance.' (P2, Traditional practitioner, Female)

The continued relevance and utilisation of TM were attributed to the accessibility and availability of traditional healers. Participant 3 reported:

TABLE 3: Themes and sub-themes.

Main themes	Sub-themes
1. Factors influencing the use of TM	1.1. Lack of healthcare facilities
	1.2. Accessibility of TM and TPs
	1.3. Cultural beliefs
2. Stakeholder's perceptions on integration	2.1. Integration is necessary
	2.2. Lack of two-way referrals
3. Challenges to a successful integration	3.1. Lack of transparency of TPs in their healing practices
	3.2. Negative attitudes of midwives towards TM
	3.3. Limited stakeholder participation in collaborative meetings
	3.4. Lack of education and training

TM, traditional medicine; TP, traditional practitioner.

> 'I live in this village, so they can come see me anytime. My door is always open.' (P3, Traditional practitioner, Female)

One community healthcare worker also revealed that TM is easily accessible and available in most communities, and most pregnant females self-medicate. Participant 10 narrated:

> 'Most traditional medicines are easily accessible and available in our gardens, and it is very easy for pregnant [*females*] to access them.' (P10, Community healthcare worker, Female)

Sub-theme 1.3: Cultural beliefs: This sub-theme was supported by the two participants, who affirmed that deep-rooted Basotho cultural beliefs and practices surrounding pregnancy and childbirth contributed to the continued use of TM during pregnancy. Participant 1 said:

> 'They will continue using traditional medicine because it is our way of doing things. As Basotho, we have longstanding practices and beliefs regarding pregnancy and childbirth, and [*females*] must adhere to them. For instance, wearing selapa, applying letsoku [*red ochre*], and walking barefoot are compulsory for some pregnant [*females*].' (P1, Traditional practitioner, Male)

Some of the participants revealed that certain pregnancy-related complications are associated with spirituality and cultural practices and beliefs of pregnant females. Participant 8 said:

> 'I believe it is because of their cultural beliefs and due to their beliefs, some [*females*] do not come to the hospital, but they seek assistance from traditional healers as they believe that the cause of their illness is spiritual.' (P8, Midwife, Female)

Theme 2: Stakeholders' perceptions on integration

This theme explores the perspectives of traditional healers, midwives, and community healthcare workers on the integration of TM during pregnancy. Three sub-themes emerged.

Sub-theme 2.1: Integration is necessary: Traditional practitioners emphasised the value of integration and expressed support for it. They observed potential benefits of the integration and emphasised that, as healers, they need to work together for the patient's benefit. Participant 1 stated:

'We need each other, and it would be good if we worked together, because there are pregnancy complications that I cannot assist my patients with, but biomedical doctors may have those skills.' (P1, Traditional practitioner, Male)

Participant 3 narrated:

'Pregnant [*females*] have used lipitsa [*Sesotho traditional medicine*] for decades, and it has worked for them. There is no harm in using them with pills they get from clinics. So yes, we can work together with the nurses and community healthcare workers; in fact, I could say I have been working with the nurses and the community healthcare workers because I refer my patients to them.' (P3, Traditional practitioner, Female)

One of the midwives also expressed her support for integration. Participant 6 said:

'I believe we can work together, but there needs to be transparency between us as healers. Through my personal experience, my son was sick, and medically we could not address the condition, and I was assisted by a traditional healer.' (P6, Midwife, Female)

Sub-theme 2.2: Lack of two-way referrals: Participants, particularly traditional healers, emphasised that collaboration is a pathway for effective integration. They indicated that effective collaboration between the two healthcare systems requires clear communication and a functional referral system. Traditional practitioners acknowledged the significance of an effective referral system, reporting that they refer patients to community healthcare workers or the local clinic when conditions fall beyond their scope of practice:

'I do refer patients to the clinic, especially those who need medication for TB and HIV. I cannot provide them with the medication they need, so I refer them to the people who can assist. We need each other, and I believe we're stronger together.' (P2, Traditional practitioner, Female)

'I tell some of my patients to go to the community healthcare worker or the hospital because there are things I cannot do. For instance, I cannot deliver a baby; I can only help during pregnancy and after delivery. We have our Sesotho ways, and they have their Western ways, so we can share our knowledge on certain things for the patient's benefit.' (P3, Traditional practitioner, Female)

However, some midwives and community healthcare workers expressed reluctance to refer patients to traditional healers, stating that they had never done so. Participant 4 stated:

'There will never be a collaboration between TPs and us. Traditional medicines often lead to serious health complications, and TPs lack understanding of how toxic some of these herbs are. That is why I have never referred any of my patients to them.' (P4, Midwife, Female)

Community healthcare workers also reported referring patients to village clinics rather than to traditional healers:

'No, I have never referred my patients to a traditional healer. I refer them to the hospital or to the nearest clinic.' (P10, Community healthcare worker, Female)

'I work with midwives from our local clinics, so I only refer them to the clinic.' (P9, Community health worker, Female)

Theme 3: Challenges to a successful integration

This theme explored participants' perspectives on barriers to integrating the two healthcare systems. Participants identified several challenges, including a lack of transparency in TPs' practices, negative attitudes of midwives and community healthcare workers towards TM, limited stakeholder participation in collaborative meetings, and insufficient education and training as key barriers to successful integration.

Sub-theme 3.1: Lack of transparency of traditional practitioners in their healing practices: Midwives and community healthcare workers explained that their reluctance to refer patients to TPs was because of a perceived lack of research evidence, standardised practices, and scientific proof of TM's efficacy:

'My concern is that patients consume herbal remedies without proper or accurate dosages. Some consume it in larger quantities, and I am saying large quantities because how do we even measure it, and how correct is that dosage? Is it even safe to be consumed?' (P6, Midwife, Female)

'Traditional medicines are not tested for safety and efficacy. So, we cannot be certain whether they are safe for consumption. Before they can be integrated into the maternal healthcare system, their products must undergo scientific testing so that we know the contents of what people are consuming and ensure their safety for public use.' (P5, Midwife, Female)

'The truth is that TPs have so much secrecy. They don't disclose their healing methods. So, it will be challenging to work with people who cannot even disclose their prescriptions.' (P7, Midwife, Female)

Sub-theme 3.2: Negative attitudes of midwives towards traditional medicine: The majority of the participants were not optimistic about integrative healthcare in Lesotho. The TPs found that collaboration with midwives would be difficult, citing a lack of respect for their practices, which they regarded as a barrier to establishing effective, cooperative working relationships:

'We understand and acknowledge that our practices are different, but the disrespect we receive from nurses and medical doctors makes it hard to work with them, because they do not respect us or accept us at all.' (P1, Traditional practitioner, Male)

'Western practices are made superior to our own traditional practices. We are told we do not know what we are doing, and our own healing practices are seen as inferior.' (P2, Traditional practitioner, Female)

Sub-theme 3.3: Limited stakeholder participation in collaborative meetings: Traditional practitioners disclosed that one contributing factor to the stalling of TM integration into the healthcare system is the lack of participation by concerned stakeholders. They indicated that there were meetings facilitated by the Ministry of Health aimed at enhancing collaboration between TPs and biomedical practitioners, including midwives, but doctors did not attend:

> 'The Ministry of Health held meetings meant to improve the working relationship between healers, but the medical doctors were not present; only nurses were, which was wrong because those are the people we need to collaborate with. How will we work together if they cannot attend meetings that need their input? As hurtful as it was, we had to let go of the matter as the other party was not willing to meet us halfway.' (P1, Traditional practitioner, Male)

Sub-theme 3.4: Lack of education and training: Education about TPs and biomedical practitioners' modalities and practices for all healthcare practitioners was identified as essential for the successful integration of TM into the national healthcare system. The participants felt that most biomedical practitioners showed little interest in being educated about traditional healing practices. Traditional practitioners acknowledged that they had not received formal medical training but expressed a strong interest in acquiring such knowledge:

> 'I do not know anything about the transmission of HIV from mother to unborn child. No one has taught us. Maybe it is because I do not assist in delivering. When it is time for them to deliver, I tell them to go to the hospital in town. But we accept any form of training and education because we believe we are stronger together.' (P2, Traditional practitioner, Female)

> 'We have not received any training on traditional healing practices. However, I think it's very important that TPs receive training in HIV, because some use a single razor blade for incisions on every single patient, thus exposing them to HIV. Those who assist with childbirth do not even use protective clothing during childbirth. I doubt they are trained in PMTCT. They need to be trained because they endanger the lives of unborn children.' (P4, Midwife, Female)

Discussion

This study employed a qualitative approach to explore the perspectives and attitudes of TPs, midwives, and community healthcare workers regarding the integration and use of TM into the maternal healthcare system. The findings indicate that the continued use of TM among pregnant females is driven by limited access to formal maternal healthcare in rural areas, particularly Ha-Setoko, alongside the accessibility of TM and the deeply rooted cultural beliefs surrounding pregnancy and childbirth. These findings reflect the unequal distribution of maternal healthcare services in Lesotho, where geographical isolation, mountainous terrain, long travel distances and poor transport infrastructure limit access to biomedical care (Schwitters et al. 2022). Consequently, TM remains an accessible, affordable and culturally acceptable source of maternal care, with TPs embedded within local communities (Motjotji et al. 2023; Schwitters et al. 2022). Similar findings have been reported in Ethiopia, South Africa, and Uganda, where reliance on TM was associated with limited healthcare access and strong cultural beliefs (Legesse & Babanto 2023; Logiel et al. 2021; Mutola, Pemunta & Ngo 2021). From a medical pluralism perspective, these findings suggest that pregnant females use of TM is shaped by both structural barriers to healthcare access and cultural values that influence maternal health-seeking behaviour (Nasrullah et al. 2026).

Traditional practitioners and some of the midwives support the integration of TM and biomedical healthcare, reflecting recognition of the pluralistic nature of healthcare in Lesotho and the potential for both systems to complement one another in improving maternal health outcomes. Participants viewed collaboration as a practical pathway to integration, enabling communication and reciprocal referral between practitioners. While TPs reported referring patients to health facilities and expected similar referrals, most midwives and community healthcare workers were reluctant to refer pregnant females to TPs because of concerns regarding the safety of TM and its potential association with adverse pregnancy outcomes. Similar findings were reported in Zimbabwe, South Africa, and Rwanda, where support for integration was tempered by differences in professional perspectives and safety concerns (Bazirete et al. 2025; Mudonhi & Nunu 2021; Thipanyane et al. 2022). These findings highlight the coexistence of traditional and biomedical healthcare while demonstrating that the unequal recognition of TM and limited trust between practitioners continue to hinder meaningful collaboration and integration (Rahaman 2023).

Furthermore, midwives viewed the secrecy surrounding traditional healing practices as a barrier to integration, highlighting the importance of trust and transparency in fostering collaboration between traditional and biomedical healthcare systems. Midwives expressed concern that meaningful integration would require greater openness regarding the composition of TM and the practices used by TPs. This need for transparency reflects the biomedical emphasis on evidence and safety. Similar concerns have been reported in countries such as Ethiopia and Kenya (Inyangala et al. 2026; Senbeta et al. 2025). However, the secrecy surrounding traditional healing is often rooted in the need to protect indigenous knowledge, which forms part of traditional healers' livelihoods and cultural identity (Inyangala et al. 2026). Traditional practitioners may therefore be reluctant to disclose their knowledge because of concerns about intellectual property rights, exploitation, or the appropriation of indigenous knowledge without proper recognition or benefit-sharing (Inyangala et al. 2026).

Effective integration of TM into the maternal healthcare system depends on mutual respect, trust and active engagement among stakeholders. However, participants perceived a lack of mutual respect between the TPs and biomedical healthcare providers, as well as limited participation in collaborative meetings, which undermined efforts to strengthen collaboration.

Similar findings were reported in a study conducted in Ghana and Ethiopia, where TPs described feeling undervalued and excluded by biomedical professionals (Gyasi et al. 2017; Senbeta et al. 2025). In contrast, Krah,

De Kruijf and Ragno (2018) found greater involvement of biomedical practitioners and stronger support, highlighting the influence of context on integration. These findings reflect the power imbalance and limited institutional engagement that continue to shape relationships between traditional and biomedical healthcare systems in Lesotho. Strengthening mutual respect, inclusive stakeholder participation, and sustained dialogue may therefore be critical for integration.

Participants reported limited knowledge of one another's practices, although TPs expressed a willingness to receive training in biomedical practices. Similar findings were reported in a study conducted in Ghana and Tanzania, where both TPs and nurses expressed an interest in cross-disciplinary learning, despite limited training opportunities (Ampomah et al. 2023; Solera-Deuchar et al. 2020). In medically pluralistic countries, shared learning can help bridge the difference between traditional and biomedical systems, fostering mutual understanding and trust (Sichalwe, Mhinte & Kimaro 2025).

Limitations

A number of factors may have affected the study, including its limited scope, which was confined to only two districts, Maseru and Quthing, making it challenging to generalise the findings to a broader population. The exclusion of medical doctors, who often prescribe treatment and make decisions regarding patient management, limited the study's ability to capture their perspectives on the use and integration of TM within maternal healthcare. The researcher's educational background in biomedical sciences affected the relationship with TPs, as they regarded the researcher as an outsider and were reluctant to share certain aspects of their healing practices. Despite these limitations, the study provided valuable insights into the factors influencing the use of TM and the challenges that need to be addressed to facilitate its integration into maternal healthcare. It highlights the important role that TM continues to play in the health and well-being of communities that remain committed to their cultural beliefs and to providing services in the absence of alternatives, such as clinics.

Recommendations

The study recommends the development of training programmes that integrate the expertise of both traditional and biomedical practitioners to foster collaboration and facilitate mutual knowledge exchange. It further proposes that the government establish institutions and initiatives to support research on TM. Many females have limited awareness of the potential health risks associated with self-medication and excessive use of TM. The study therefore recommends the implementation of educational and awareness initiatives to inform females about the health hazards and adverse consequences associated with self-medicating and overdosing on TM. Lastly, a multistakeholder policy dialogue is also recommended to drive the implementation of the TM policy, which is essential to ensuring the quality, safety, and efficacy of TM.

Conclusion

Traditional medicine continues to play an important role in primary healthcare in Lesotho, particularly in rural areas where people have limited access to healthcare facilities. The findings suggest that integrating TM into the maternal healthcare system would be beneficial for the service users, as it would offer access to a wider range of healthcare services. However, the integration process has been hindered by limited collaboration between the two health modalities, mutual professional mistrust and negative perceptions towards TPs and TM. Addressing these challenges requires efforts from all stakeholders, including TPs and medical practitioners, to ensure that the appropriate policy frameworks are in place to foster collaboration and improve the distribution, breadth and quality of services provided to patients and communities.

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This article is based on data from a larger study. A related article focusing on the usage of TM during pregnancy and the associated factors among Basotho females has been published in the *African Journal of Primary Health Care & Family Medicine*, 17(1), 4936. The present article addresses a distinct research question, focusing on perspectives on the use and integration of TM in maternal healthcare: Experiences of traditional practitioners, midwives and community health workers in Lesotho.

Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

CRediT authorship contribution

Lisemelo L. Chesetsi: Conceptualisation, Formal analysis, Investigation, Methodology, Writing – original draft. Andrew Ross: Supervision, Writing – review & editing. All authors reviewed the article, contributed to the discussion of results, approved the final version for submission and publication, and take responsibility for the integrity of its findings.

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Data availability

The data that support the findings of this study are not openly available and are available from the corresponding author, Lisemelo L. Chesetsi, upon reasonable request.

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