

## Traditional healers as caregivers to HIV/AIDS clients and other terminally challenged persons in Kanye community home-based care programme (CHBC), Botswana

Simon Murote Kang'ethe

### Abstract

The research study done at the Kanye village of Botswana was qualitative in design and exploratory in nature. While the broad goal aimed at assessing the contributions of caregivers in the Kanye CHBC programme, this article aims at evaluating the traditional healers' contribution as providers of care to HIV/AIDS patients and other chronically ill persons. The study conveniently involved all the 140 registered caregivers in the Kanye programme, but with only 82 caregivers turning up for focus group discussions. The caregivers were grouped in 10 focus group discussions, and all of the 5 CHBC nurses were subjected to one-on-one interviews. Both the focus group discussions and one-on-one interviews with the nurses used two slightly different interview schedules as data collection instruments. The study findings revealed that traditional healers are important players in caregiving of persons with various ailments but their role, position and contribution in the battle against HIV/AIDS is fast waning with time. The government has been challenged to map out strategies of collaboration between the two systems as traditional healers can complement the services of biomedical practitioners in this era of HIV/AIDS.

**Keywords:** *Traditional healers, biomedical practitioners, community home-based care programme (CHBC), people living with HIV/AIDS (PLWHA), CHBC nurses.*

### Résumé

La recherche menée au village de Kanye au Botswana était conceptuellement qualitative et de l'ordre de l'exploratoire. Alors que le but général était de rendre compte de la contribution des travailleurs sociaux dans le cadre du programme SCD à Kanye, cet article vise à évaluer la contribution faite par les guérisseurs traditionnels en tant que fournisseur de soins aux patients souffrant du VIH/SIDA et aux autres personnes souffrant de maladies chroniques. L'étude impliquait commodément les 140 travailleurs sociaux agréés au programme Kanye, seulement 82 travailleurs sociaux s'étant présentés pour les discussions en panel. Les travailleurs sociaux ont été groupés en dix groupes de discussions; et les 5 infirmières SCD ont dû passer des entretiens individuels. Aussi bien les panels de discussions que les entretiens individuels avec les infirmières ont utilisé deux grilles d'entretien comme instruments marginalement différents l'un de l'autre pour rassembler les données. Les résultats de l'étude ont démontré que les guérisseurs traditionnels jouaient un rôle important quant à l'administration de soins dans le cas de différentes maladies, mais leur rôle, position et contribution dans la lutte contre le VIH/SIDA décroissait rapidement avec le temps. Face à ces données, le gouvernement doit élaborer des stratégies de collaboration entre les deux systèmes puisqu'il est clair que les guérisseurs traditionnels peuvent suppléer aux services des praticiens biomédicaux dans le contexte de l'ère du VIH/SIDA.

**Mots clés:** *Guérisseurs traditionnels, praticiens biomédicaux, programme de soins communautaires à domicile (SCD), personnes vivants avec VIH/SIDA (PVVIH), infirmières SCD.*

Dr SM Kang'ethe is an HIV/AIDS/ gender practitioner. He has authored articles in more than 20 international journals and is currently a part-time lecturer in the Bachelor of Business Administration Degree course, Centre for Continuous Education (CCE), University of Botswana. He teaches Politics of Gender. He has also authored several book chapters and Botswana secondary school books.

Correspondence to: smkangethe@yahoo.com

## Introduction

With high levels of the HIV/AIDS epidemic still ravaging the developing world, the country of Botswana, notwithstanding wide-ranging social, cultural, environmental and economic advances, needs to adapt and explore possible solutions to the devastating effects of the HIV/AIDS pandemic. Collaboration with and incorporation and integration of traditional healers as important players alongside biomedical practitioners needs to be expedited and improved through provision of a fruitful and conducive environment (UNAIDS, 2000; Pinky, 2001; Jackson, 2002; UNAIDS, 2005). Operationally and for the sake of this article, the term 'traditional healers' refers to either herbalists, spiritualists, or to those (the great majority of healers) involved in both practices.

Since the late 1970s, many countries have found it imperative to include traditional healers in primary health care (WHO, 1978; UNAIDS, 2000; Pinky, 2001). This is because of the inability of the health ministries to adequately cater for the health care services. Additionally, African healers are accessible, affordable, acceptable and culturally appropriate, thereby fulfilling the major criteria for low-cost and effective health care service delivery necessary in sub-Saharan African settings. This is coupled with the fact that traditional medicine is deeply rooted in the beliefs, values, social organisation and customary behaviour patterns of each community (Fabrega, 1974; UNAIDS, 2000).

With empirical evidence suggesting that despite the pervasiveness of modern medicine in Africa, a high number of Africans rely on traditional medicines for their health care needs. Therefore, traditional healers fill an acceptable and special niche in the HIV/AIDS arena (Pinky, 2001; Jackson, 2002). The World Health Organization (WHO) estimates that at least a third of people in Africa do not have access to essential medicines and thus no access to treatment and care, and consequently a large population in some countries depend on traditional medicines, whose safety and effectiveness has not been well documented (UNAIDS, 2000; Muchiru, 2001; Jackson, 2002).

Despite the multitude of health challenges affecting the people of Africa, and with traditional healers outnumbering biomedical doctors by 100 to 1 or more in most African countries and providing a large accessible, available, affordable trained human resource pool, very little has been done to actually work with healers (UNAIDS, 2000). However, the WHO has recognised the importance of traditional medicine to primary health care, and of the need to include healers in national health strategies and policies (WHO, 1977, 1978, 1991; UNAIDS, 2000). Though considerable prejudice still remains ingrained among many biomedical health practitioners about the justification, validity and integrity of traditional medical practices and practitioners,

the continent of Africa carves a fertile niche for collaboration between traditional and biomedical health care. This is because of its dearth in health resources and the fact that it is hugely affected by HIV/AIDS (Fako, 1989; UNAIDS, 2000).

Available historical data seem to support suggestions that indigenous healing strategies, especially in the developing world, are not bound to decline with the increasing pace of westernisation, urbanisation, modernisation and globalisation. Additionally, many patients in some developing countries have continued to prefer to be treated by a traditional doctor instead of, or in addition to, a Western trained physician (Fako, 1989). This has therefore led to the survival of traditional medicine and hence the sustainability of their services. However, survival of traditional healing is not a phenomenon limited to Botswana or a few African countries only. Traditional medicine continues to exist because Western health care is not established in many African countries, largely due to lack of resources and personnel. Traditional healers are often the only source of health care in rural areas. Although the situation is different today, by 1977 at least 2.3 billion people, or 56% of the world's population, continued to rely on local indigenous health care services for treatment of a wide variety of physical and mental illnesses. In the Philippines, for instance, either because of the unavailability or high cost of antiretroviral drugs (ARVs), the AIDS clients are turning to alternative and complementary therapies like herbal massage and herbal sauna (Good, 1977; Pinky, 2001; <http://cc.msnsnscache.com/cache.aspx>).

Although in some settings traditional African medicine compared with biomedical medicine has been despised and people conjure up images of witchcraft and barbarism, empirical research has proved the usefulness of traditional African medicine from both a medical and a public health point of view. Traditional medicine is useful because it attempts to give illness a social and cultural meaning rather than a purely biomedical one. Some herbal medications show evidence of healing an array of diseases and complications, like sexually transmitted diseases, with an overwhelming success (Green, 1994). That notwithstanding, traditional healers in many countries have continued to be the subject of negative publicity campaigns and advocacy against their practices, making them feel despised and estranged, with their services under attack from, especially, the contemporary biomedical health practitioners (Mburu, 1983; Green, 1994; UNAIDS, 2000; Kang'ethe, 2006).

The government of Botswana has for a long time had a policy of promoting co-operation between modern and traditional medicine (Stuagaard, 1985; WHO, 1991). The Ministry of Health (MOH) has held activities for traditional healers including seminars on AIDS, and has implemented the Botswana Dingaka

AIDS Awareness Training Project. This project, for instance, took place in 1991 and 1993 with the objective of training traditional healers as trainers who would pass and snowball AIDS information to other traditional healers in selected pilot areas, further promoting co-operation and collaboration between traditional and biomedical health services. In line with respect for the Botswana African culture and 'going back to the roots' as advised by Joy Phumaphi, former Botswana Health Minister (1999 - 2002), traditional healers are the practitioners people have known and have had confidence in from time immemorial. Although their knowledge systems and practices are different from those of modern medical practices and some remedies and concoctions they use remain untested (and according to some other players ineffective), it is high time societies and especially the modern medical practitioners look at them as complementary and partners, and not unhealthy competitors (Fako, 1989 ; UNAIDS, 2000; Pinky, 2001; WHO, 2002).

### Study aims and objectives

Whereas the wider study's broader objective from which this article is derived was to assess the contribution of caregivers in community care programmes, this article aims at evaluating the contribution of traditional healers in caregiving; and assessing the challenges involved in HIV/AIDS clients using the two medical systems together. The two medical systems are also compared.

### Research settings and methods

The study was qualitative in design and explorative in nature and involved all the 140 registered caregivers in the Kanye CHBC programme, but only 82 primary caregivers actively participated. The sampling frame, therefore, constituted all the registered primary caregivers in the register. The 82 primary caregivers formed ten focus group discussions conducted using an interview schedule as a data collection instrument. All four CHBC nurses in the programme and their co-ordinator, who were also the caregivers' supervisors, were interviewed on a one-on-one basis, still using an interview schedule that differed only slightly with the one for focus group discussions. The role of the CHBC nurses was to corroborate, cross-check and confirm the responses of the caregivers. The focus group discussions were held to collect qualitative data on the views, attitudes and thinking of the caregivers pertaining to contributions of caregivers in the programme and other players like traditional healers. While participant observation was used, secondary data have also been widely used. The primary caregiver, therefore, formed the unit of analysis (Creswell, 1994; Neuman, 1997, 2000; Merriam, 1998; Rubin & Babbie, 1997).

The caregivers' interview grouping selection criterion was based on the clinic that served them, with some clinics having more than one focus group discussion. Selection grouping was done irrespective of caregivers' age and gender, while the nurses' selection criterion was based on their supervision role of the caregivers. However, there were no minors who turned up for the focus group discussion. All appropriate ethical issues were taken into consideration: informed consent, maintenance of confidentiality, adequate debriefings before data collection commencement, no coercion, and treating the respondents with all due respect to maintain their integrity and their human rights (Creswell, 1994; Neuman, 1997; Salkind, 2000). The researcher had complied with all the application procedures of the research permit from the Department of the Research and Development Committee Board and was therefore given a research permit. The researcher had then to write a letter to the Southern District Council (SDC) asking for authority to enter into the field to collect data, which was attended to by the SDC matron. The matron then wrote letters to all the Kanye heads of clinics requesting them to co-operate and help the researcher to successfully pursue the data collection exercise.

The membership of the focus group discussions ranged from 5 to 10 members. While only 82 caregivers responded to focus group discussions, all the CHBC nurses responded to the interviews (Kang'ethe, 2006). The Kanye village in the Southern District, with a population of 40 628 persons, formed the research setting or domain (CSO, 2001). The village has adequate health facilities comprising of the Seventh Day Adventist (SDA) hospital, which is used as a district referral hospital, 5 clinics and 2 health posts. The Kanye programme was one of the best-organised in the country, with most of the necessary staff on the ground. The programme was also experiencing a high HIV prevalence rate of 25.8% (NACA, 2005) and many deaths, prompting the researcher to carry out the research there. Again, the researcher had worked in the district for 5 years as head of HIV/AIDS activities and it was good for him to document the experience.

As a measure to reduce data and result bias, there was double translation of the instruments, that is translation from English to Setswana and then from Setswana to English by two independent translators, the two parties coming together to settle any differences. To further strengthen data reliability and validity, the two interview guides or the instruments used only differed slightly, and the two sets of responses confirmed, corroborated and cross-checked each other.

With regards to data analysis, the collected data from focus group discussions and interviews were taped and thereafter transcribed. The analysis took the form of examining, sorting,

coding, categorising, evaluating, comparing, synthesising, and contemplating the coded data as well as reviewing the raw and recorded data (Neuman, 1997). The researcher used memo-writing techniques, words, diagrams, charts, quotes, themes, tables as the main tools for data analysis.

### Brief comparison between traditional and biomedical practitioners

Some traditional healers do understand the biomedical concern regarding contagion in relation to some serious diseases, including AIDS and other STDs and are aware that the contagion could include invasion of the body by dangerous micro-organisms, pollution or environmental dangers (Green, 1999). Just like the belief of biomedical practitioners, traditional beliefs about prevention of STDs or HIV/AIDS follow the logic of transmission and causation, and include limiting the number of sexual partners, wearing protective charms or tattoos, using condoms to reduce the risk of 'pollution', or undergoing a 'traditional vaccination' consisting of introducing herbs in skin incisions (Green, 1992; Schoepf, 1992; Green *et al.*, 1993; Nzima *et al.*, 1996).

Despite the fact that Western medicine is a product of a sophisticated, collaborative group of highly trained scientists, its global and well-publicised curative emphasis has made it expensive and especially inaccessible to poor communities. Moreover, modern medicine has to embrace challenging accusations that Western European medicine was used as an imperialist tool and imposed as part of a larger strategy in which African society was to be changed by replacing African ways with European ways. This has proved to be true because, according to Feierman (1984), once colonial conquest was finalised and securely sealed, healers in most places in Africa were denied their public professional recognition and ability to operate. The overthrow of African medical authority was a self-protecting, defensive and conservative capitalistic strategy which enabled Europeans to impose their medical systems effectively. The proliferation and pervasiveness of the Western medical profession throughout the world has been in a large measure due to the ability of dominating classes to perpetuate their own interests on a worldwide scale, rather than due to proven efficiency and superior results (Carlson, 1975; Fako, 1989).

The following points explain positive aspects and negative aspects of traditional healers.

### Positive aspects of traditional healers

- Clients sometimes have more confidence with healers as far as some diseases are concerned. For instance, most clients prefer traditional healers to handle some diseases like mental illnesses because they believe those illnesses are a result of supernatural forces or vengeance from unappeased ancestral spirits and since traditional healers are known to intervene in those situations, people are open and able to access help.
- Traditional healers, unlike the biomedical practitioners, are easily available, accessible and well understood by clients, especially in rural areas. They outnumber doctors by 100 to 1 or more in most African countries and provide a large accessible, available, affordable trained human-resource pool.
- Traditional healers possess many effective treatments and treatment methods which are not used by modern medical practitioners.
- Traditional healers provide client-centred personalised health care that is culturally appropriate, acceptable, holistic, and tailored to meet the needs and expectations of the patient.
- Traditional healers are culturally close to clients, which facilitates communication about disease and related social issues. This is especially important in the case of STDs and other diseases like AIDS.
- Traditional healers often see their patients in the presence of other family members, which sheds light on the traditional healers' role in promoting social stability and family counselling.
- Traditional healers are respected, occupy a critical niche and play a significant role in African societies and are therefore not likely to disappear. Even with the rapid socio-cultural changes occurring in many African societies, traditional healers will continue to play a crucial role in addressing the variety of psychosocial problems arising from conflicting expectations of changing societies.
- Activities of traditional healers are sustainable as they generate their own source of income. Activities of biomedical practitioners need an external funding process and may not be sustainable.
- Documented traditional healers' enthusiasm for collaborating with biomedical health providers shows that they are ready for positive and stakeholder partnership with other players to fight diseases. (Oja & Steen, 1996; Fako, 1989; UNAIDS, 2000)

### Negative aspects of traditional healers

- Their role is weakened by adverse campaign advocacy, and stigma still abounds with regard to the use of traditional medicine, especially in treating HIV/AIDS compared with the use of modern medicine (Muchiru, 2001).
- The training and licensing of healers is not institutionalised in many developing countries, which makes it difficult to reach and train them regularly in a standardised manner. Quality control of healers is therefore difficult in the absence of officially recognised licensing procedures.
- Lack or absence of monitoring and evaluation methods of the healers' activities renders them not credible and professionally untrustworthy.
- Traditional healers generally lack detailed anatomical and physiological knowledge.
- Promotion and improvement of traditional methods may undermine efforts to increase access to biomedicine, whose impact can be measured, monitored and controlled.
- The effects of combining traditional and biomedical treatments are not known and may be harmful. This is because of the untested methods and treatments of traditional healers. Use of traditional medicine in CHBC, alongside the Western medicine, if it goes unchecked, could interfere with the dosage and confuse patients. Use of the two systems presents a conflict and unethical environment (Kang'ethe, 2006), where for instance some traditional healers forbid patients with compromised immunity and who are in home-based care to eat particular foods such as eggs, chicken, fish and fresh milk, substituting them with less nutritious food.
- There are doubts pertaining to successful intervention in CHBC due to their unethical practices. The absence of hygiene standards and protocols in traditional medicine may lead to patients on home-based care being infected with opportunistic illnesses.
- Research on the potency and efficacy of some herbal concoctions is kept a secret by traditional healers since the incumbents consider the information to be a spiritual divination. Information on new herbs is similarly held a secret because of the traditional healers' mistrust of the medical systems and of other healers.
- Some traditional healers are unwilling to work together with modern medicine in CHBC programme as they consider their remedies superior to the modern system, making them closed to change and

unable to adopt best practices and ethics in CHBC. (Fako, 1989; UNAIDS, 2000; Pinky, 2001; Jackson, 2002)

## Study results

### Profile of the volunteer caregivers

Table 1 indicates ages of the caregivers. Forty-five caregivers (56%) were aged 50 years and older, with 27 of the relatively older people (60 and above years) constituting 34% of the total caregivers. There were 17 that fell between 60 and 69 years, which constituted 21% of the caregivers. While there was only one woman caregiver who was 85 years of age, there were 9 between 70 and 79 years, thus constituting 12% of all the caregivers. The study revealed that most caregivers were women and therefore, especially those above 60 years, were physically not strong enough to deal with the care-giving demands. From observation, they looked weak, frail, poor and apparently needing care themselves.

Findings on gender confirmed that the programme faces a severe gender imbalance with 80 (98%) being women and 2 (2%) men (Kang'ethe, 2006). On literacy level (Table 2), 29 caregivers (35%) had never been to school, while 32 (39%) of the caregivers had only primary education. Seventeen or 21% had secondary education. Only 5% of the caregivers had tertiary education.

### Waning confidence of the traditional healers by the caregivers

Study findings indicated that 54 (66%) of the Kanye caregivers were not comfortable with the services of the healers, with only a few indicating they were comfortable with them (mostly elderly caregivers). The majority indicated that the traditional healers were only interested in money, yet clients did not experience any improvement in their health. The following comments were made by the majority in the focus group discussion room:

*Dingaka tsa seso dibatla madi fela, mme ga didiri sepe.  
(Traditional doctors only want money. They are not effective.)*

The author, being neutral but working with the assumption that traditional healers are easily accepted, culturally appropriate and in demand, was astonished to learn that caregivers in Kanye had little confidence in the traditional healers. However, the majority of the caregivers also indicated that they were aware that a few of the caregivers' clients were visited by their traditional healers, although sometimes clandestinely, to avoid being known by the health officers as the clients still needed their assistance. The caregivers indicated that these clients and their caregivers were not able to cut the connection with the traditional healers because of the strong faith in traditional healing that the clients

**Table 1. Caregiving by age and gender**

Age range	Female		Males		Total	
	Number	%	Number	%	Number	%
80 - 89	1	1			1	1
70 - 79	9	11	1	1	10	12
60 - 69	17	21	0	0	17	21
50 - 59	18	22	0		18	22
40 - 49	16	20	1	1	17	21
30 - 39	8	10	0		8	10
20 - 29	9	11	0		9	11
0 - 20	2	2	0		2	2
Total	80	98	2	2	82	100

**Table 2. Caregiving by gender and educational level**

Educational level	Females		Males		Total	
	Number	%	Number	%	Number	%
Never been to school	28	34	1	1	29	35
Primary level	32	39			32	39
Secondary level	16	20	1	1	17	21
Tertiary level	4	5			4	5
Total	80	98	2	2	82	100

and caregivers had held for a long time. This is despite the discouragement and adverse campaign orchestrated by the health officers against the services of the traditional healers.

### Conflict of the traditional and biomedical faith systems

Fifty-five caregivers (67%) indicated they understood that the use of medications from the two systems could be detrimental to the health of the HIV/AIDS clients, and therefore the majority had sided with the government and its health agents. They attributed their bias towards accepting the modern medical treatment as opposed to the services of the healers to the fact that most of their clients, through the CHBC programme, were receiving food baskets and antiretroviral drugs. They echoed the following sentiments:

*Dingaka tsa seso ga dina mosola. Ga di thuse ka sepe.*  
(Services of traditional healers have no value compared with the modern medical services.)

*Dingaka tsa seso di a siesta batho. Nako tse dingwe ga di fodise.*  
(Traditional healers do not heal. They only cheat people.)

They therefore could not see the need to seek the assistance of the healers. The choice of these caregivers widens the gap of mistrust that exists between traditional healers and biomedics.

### Traditional healers' concoctions cheaper and conveniently paid

While the majority did not complain about the prices of the services of the healers compared with the modern medication, a few caregivers in the Kanye programme indicated that some traditional healers were expensive. However, 66% expressed the opinion that traditional healers' payment was negotiable and could be paid in various ways; payment in kind, e.g. chickens, goats or any other acceptable item instead of cash. This, caregivers echoed, was attractive especially in areas where the clinics were far away.

*Dituelo tsa dingaka tsa seso ke tumalano ya bobedi.*  
(Prices of traditional healers' services can be negotiated between the two.)

Furthermore, 25 caregivers (30%) expressed the fact that some caregivers and their clients, especially the elderly ones, have known and used traditional doctors from time immemorial and had confidence in some of them.

### Traditional healers are culturally convenient and acceptable

Almost all the respondents agreed that traditional healers are respected by most people, as their services have both social and cultural value. Their services are especially recommended by

the elderly Batswana, who end up influencing the younger ones. However, respondents agreed that in most parts of the country, especially in the rural areas where clinics tend to be far away and infrastructure weak, traditional healers are highly respected and accepted, with most clients secretly tending to use the two medication systems.

*kwa metseng e leng kwa kgakala le ditoropo, dingaka tsa seso di a tlotliwa thata*

*(In villages far away from urban and towns, traditional healers are much respected.)*

But the respondents also indicated that caregivers and their clients have a tendency to stick to modern medical services, usually in the hospitals, when the clients are seriously sick. However, more than half of the caregivers indicated that the fact that traditional healers' services do not attract bureaucracy such as the queueing that is experienced in the hospitals, and the fact that the healers can keep the treatment services secret, make some clients and their caregivers comfortable with them.

### **Inadequate faith in the biomedical referral system strengthens the tenacity of traditional healers**

Half of the Kanye caregivers indicated that the reason some caregivers and clients go to traditional healers is because of the dissatisfaction with poor service delivery at the clinics, and at the SDA referral hospital. The majority of caregivers complained that at the SDA hospital appointments were not kept by the staff; doctors were scarce, with most treatments being done by trainees. While nurses had protective clothing while handling patients, the caregivers helping clients wash and change clothes and feeding them had to do so without any protection, the scenario presenting a conflicting and a distasteful environment (Kang'ethe, 2006). Asked where they would prefer their clients to be taken care of at homes or in the hospital, the majority of the caregivers said they would opt to have the clients at home, where they would take care of them and show them familial love that would hasten the recovery process. Many echoed their wish that clients would preferably be at home in the hands of their loved ones (NACEP 30, 31, 1996; Sim & Moss, 1991; Ursula, 1991; Fox, 2002). A few caregivers indicated that when clients are taken care of at home the possibility that they might use the services of traditional healers was increased. It was noted that some caregivers did not find good reason why they could discourage traditional healers' visits and collaboration with their clients, despite a strong biased campaign against traditional healers' services (NACP 31, 1996, Kang'ethe, 2006).

### **Discussions of the findings and recommendations**

The quality of care giving, as the study results suggest, has been affected by the age of the caregivers. In their research in Botswana, Atta & Fidzani (1996) found that over 50% of caregivers in most of the Botswana CHBC programmes are old women who may not be able to follow the hygiene protocol in the care process, while research by Jacques and Stegling (2001) in Kweneng, Botswana, found three clients with caregivers who were not able to fulfil their roles due to old age or disability. This definitely impacts negatively on the quality of caregiving. According to McDonnell et al., (1994), the traditional safety nets providing for caregiving could be stretched enormously beyond its capacity with the resultant inadequate productivity if the caregiving is to be left to the elderly. However, it was apparent that it was usually the elderly caregivers who had confidence with the services of the traditional healers despite the modern medical practitioners' advice against that (Kang'ethe, 2006). Ways and means should be suggested to persuade the relatively young into caregiving to help the ageing caregivers. Changing caregiving policies to allow for giving paid incentives could possibly attract the young, and especially men, into the caregiving occupation. Advocacy education by leaders and civil society bodies is necessary to indicate that caregiving should be a task for all in society.

With regard to gender, other studies indicated the same trend among the caregivers. In a study carried out in Botswana by Munodawafa (1998) all caregivers except one were female in Tutume while in Molepolole, all caregivers were females. This state of affairs does not augur well, especially with feminists who see it as gender exploitation of women. Because of women having to attend to other domestic chores in the homes, caregiving presents an overwhelming experience. This has also been a strong reason driving women to poverty (Walker, 1982; Finch, 1994; UNDP, 1995; Kelesetse, 1998). Societies need to work and persuade men to assist women in the caregiving assignments as the HIV/AIDS epidemic needs the support of all in the community. Advocacy by leaders and civil society bodies could help change the stereotypical idea that caregiving should be done by women.

On the educational level of the caregivers, other studies show more or less the same trend and pattern. In a study by Phorano *et al.* (2005) on caregivers in Maun and Kweneng, 33% had lower-primary education. Therefore it is recommended that to offset the impact of illiteracy, on-the-job training by care managers in collaboration with the government needs to be

carried out within programmes to ensure that the knowledge base and coping capacities of the caregivers are improved (Abbat & Meija, 1988; Petit, 1994).

The waning confidence in the traditional healers' services by the HIV/AIDS caregivers and their clients, forms a departure from current common practice in many African countries, where respective ministries of health are working hard towards the process of integrating and incorporating traditional healers into the mainstream health system and curriculum, with South Africa and Uganda making significant inroads (UNAIDS, 2000; Muchiru, 2001; Kang'ethe, 2006). On the conflict between the modern medical practitioners and the healers, the author, himself an HIV/AIDS practitioner who has worked in the study area for 5 years, provides evidence of the biased campaign orchestrated by the biomedics against the services of the traditional healers. The conflict is justified, especially in this era of antiretroviral drugs (ARVs), where concurrent use of the two healing protocols is detrimental to the health of the clients and therefore the working of the ARVs. However, further diverse literature indicates cases where the traditional healers are prescribing successful treatments and therefore successfully healing some ailments better than the biomedical practitioners. This evidence points to the importance of integration and the need for collaboration between the two medical systems (Green, 1994; Kang'ethe, 2006). On the cost of the traditional healers' services, diverse literature indicates that the cost of traditional medical care has been found to be flexible and varying with the nature of treatment, the type and severity of the ailment and the relative wealth of the client (Porter, 1996; King *et al.*, 1992). Further literature also supports the study findings on the general history of healers' service acceptability.

According to UNAIDS (2000), African healers have been well-known, accessible, affordable, culturally appropriate and acceptable, and could well be trusted by many communities to fill the ever-widening gap in medical circles created by the impact of HIV/AIDS in most sub-Saharan African settings (Jackson, 2002). Collaboration and integration of the two health systems, therefore, could bring new benefits to the HIV/AIDS campaign with each system complementing, augmenting, and supplementing each other (Pinky, 2001). This, therefore, suggests that the biomedical practitioners should stop their campaign against the traditional healers, and instead should seek the support of healers in an endeavour to correct any unethical and unhygienic procedures in their treatment process. Traditional healers, on the other hand need to change their attitudes, stereotypical perceptions, thinking, beliefs and accept the notion of incorporating and integrating the modern medical practices into their service delivery systems. This would be beneficial to

the country suffering from inadequate biomedical practitioners as HIV/AIDS continues to bite harder.

The literature suggests that there are relatively more traditional healers than modern medical practitioners (UNAIDS, 2000; Muchiru, 2001; Pinky, 2001; Jackson, 2002). The government of the day, therefore, needs to map out a strategy where medical practitioners and traditional healers need to accept each other as important partners and necessary players in the HIV/AIDS field and stop negative publicity campaigns and advocacy against each other. The high prevalence of HIV/AIDS in Botswana calls for stakeholder partnership with each stakeholder filling its niche and comparative advantage (NACA, 2005).

On the perception of the caregivers that traditional healers professionally cheat for money, Jackson (2002) advises societies to be aware of the traditional healers in African countries who advise those living with the virus to sleep with virgins as an intervention to cure AIDS. This, however, is unethical and has been proved to be without any scientific truth. It is also detrimental to the general HIV/AIDS campaign, which is intended to ensure the uninfected are protected from those already living with the virus.

## Conclusions

The study findings among the Kanye CHBC caregiver respondents indicate that the contribution of traditional healers in the HIV/AIDS campaign is important but waning fast with time. This could be due to strong advocacy against the concurrent use of the two medical systems by the biomedical practitioners. However, not all the caregivers have lost hope with the healers. Some caregivers and their clients are loyal to traditional healers, though clandestinely to avoid being known and therefore losing the assistance of the modern medical practitioners' services. The curative and cultural appropriateness, trust and availability have endeared the healers to some caregivers and their clients. However, with the magnitude of HIV/AIDS in Botswana coupled with an environment of inadequate human resources to face the epidemic, the role of traditional healers needs to be revisited, strengthened through training, mutual consultation and collaboration, with a possibility of integrating their services into the modern health system. The need for integration and collaboration is because of the dangers inherent in clients using the two medical systems concurrently. The traditional healers themselves need to change their mindset, norms, and belief systems and be willing to be partners and collaborators in the war against HIV/AIDS. The war needs the stakeholder partnership of all. The government and health stakeholders need to help put in place a cordial working relationship between biomedics and traditional healers with the possibility of expediting the process

of integration and collaboration between the traditional healers' services and the modern health systems.

## References

- Abbat, F.R. & Meija, A. (1988). *Continuing the Education of Health Workers*. Geneva. World Health Organisation.
- Atta, J.K. & Fadzani, N.H. (1996). *Baseline Study for Community Home Based Care Programme for Terminally Ill HIV/AIDS patients in Botswana*. NACP 31. AIDS STD Unit, Gaborone, Botswana.
- Campbell, I.D., Gwyther, L. & Pimentel, D. (2005). Palliative care in resource-constrained settings for people living with HIV/AIDS. <http://cc.msnscache.com/cache.aspx> (Accessed 18 Sept 2005).
- Carlson, R.J. (1975). *The end of medicine*. John Wiley and sons, New York.
- Creswell, J.W. (1994). *Research Design. Qualitative & Quantitative Approaches*. Sage Publications, Inc.
- CSO (2001). Central Statistics Office, Gaborone.
- Fabrega, H. (1974). *Disease and social behaviour: An interdisciplinary perspective*, Chapter 1. Massachusetts: M.I.T Press, Cambridge.
- Fako, T.T. (1989). *Botswana National Health Bulletin, vol.1 3 no. 1*. Gaborone, Botswana: National Health Institute.
- Feierman, S. (1984). *The Shamba Kingdom. A History*. Madison: University of Wisconsin Press.
- Finch, J. (1984). Community Care: Developing non-sexist alternatives. *Critical Social Policy*, 9: 6-18.
- Fox, S. (2002). Integrated Community-based Home Care in South Africa. *The Policy Project*: 1-15.
- Good, C.M. (1977) Traditional medicine: An agenda for medical Geography. *Social Science & Medicine*, 11(14-16): 705-713.
- Green, E. (1992). Sexually transmitted disease, ethno medicine and AIDS in Africa. *Social Science and Medicine*, 35:121-130.
- Green, E., Jurg, A., Dgedge, A. (1993). Sexually transmitted diseases, AIDS and traditional healers in Mozambique. *Medical Anthropology*, 15: 261-281.
- Green, E. (1994). *AIDS and STDs in Africa: bridging the gap between traditional healers and modern medicine*. Boulder, Co. and Oxford, West View Press.
- Green, E. (1999). *Indigenous theories of contagious disease*. Walnut Creek, California, USA: AltaMira Press, a Division of Sage Publication, Inc.
- Jackson, H. (2002). *AIDS AFRICA. Continent in crises*. Harare, Zimbabwe: Safaids.
- Jacques, G. & Stegling, C. (2001). Panacea or Perfidy? Paper presented at the 3rd International Conference on Social Work in Health and Mental Health, 1-5 July, Tampere, Finland.
- Kang'ethe, S.M. (2006). *Contribution of Caregivers in Community Home Based Care Programmes: The case of Kanye, Botswana*. Unpublished PhD Dissertation in Social work, Department of Social Work, Faculty of Social Sciences, University of North West, Mafikeng campus, South Africa.
- Kelesetse, N.M. (1998). *AIDS, Home Based Care and the Status of Women in Botswana: A case study of Mogoditshane*. BA Thesis, University of Botswana, Faculty of Sociology, Gaborone.
- King, R., Homsy, J., Allen, S. (1992). *Traditional medicine vs modern medicine for AIDS*. VIII International Conference on AIDS. Amsterdam, July (abstract P0b 3394).
- Mburu, F.M. (1983) *Professionalization and differentiation of traditional medicine in Kenya*. International African Institute conference on the professionalization of African Medicine, Gaborone, Botswana.
- McDonnel, S., Brennan, M., Burnham, G. & Tarantola, D. (1994). Assessing and planning home based care for persons with AIDS. *Health Policy and Planning*, 9(4): 429-437.
- Merriam, S.B. (1988). *Case Study Research in Education: A Qualitative Approach*. San Francisco: Jossey-Bass.
- Muchiru (2001). *Report of the First Regional (SADC) Community Home based Care Conference*. Boipuso Hall, Gaborone, Botswana, 5-8 March.
- Munodawafa, D. (1998). *Evaluation of the CHBC pilot project (Molepolole and Tutume Sub District*. National AIDS Control Programme (NACP 41) Gaborone, February.
- National AIDS Coordinating Agency (NACA) (2005). *Botswana Second Generation HIV/AIDS Surveillance*. A Technical Report, December.
- National AIDS Control Programme (NACP 30) (1996). *Community Home Based Care for People Living With AIDS in Botswana*. AIDS STD Unit, Gaborone. Revised.
- National AIDS Coordinating Programme (NACP) 31(1996). *Baseline Study for the Community Home Based Care Programmes for Terminally Ill HIV/AIDS Patients in Botswana*. Gaborone, Botswana.
- Neuman, W.L. (1997). *Social Research Methods. Qualitative and Quantitative Approaches*. Boston: Allyn and Bacon.
- Neuman, W.L. (2000). *Social Research Methods. Qualitative and Quantitative Approaches*. Boston, MA: Allyn and Bacon.
- Nzima, M., Romano, K., Anyangwe, S., Wiseman, Macwan'gi, J., Kendall, C., Green, E. (1996). A targeted intervention research on traditional healer perspectives of sexually transmitted illnesses in urban Zambia. *Societies d' Afrique and SIDA*, 13: 7-8.
- Oja, C. & Steen, J. (1996). The traditional health practitioner: a key figure in prevention and control of HIV/AIDS on the community level. In Canberra, C., Pitt, D., Stuagaard, F. (eds). *AIDS and the Grassroots: Problems, Challenges and Opportunities*. Gaborone: Ipelegeng Publishers.
- Petit, P. (1994). Closing the performance gap. *Health Action*, 8: 4.
- Phorano, Nthumang and Ngwenya (2005). *HIV/AIDS Home Based Care and Waste Disposal in Botswana Society* (Ed.) Botswana Notes and Records. *The Botswana Society*. 37: 161-178.
- Pinky, M. (2001). *The Role of Traditional Healers and Doctors, Coping Mechanism of CHBC Patients and the Family*, Published Abstract no.38. on 1st Regional CHBC conference, March, 2001 at Boipuso Hall, Gaborone.
- Porter, L. (1996). *Do traditional healers have a role in the prevention and management of STDS and HIV/AIDS in Africa?* A summary of the issues. Unpublished paper.
- Rubin, A. Babbie, E. (1997). *Research Methods for Social Work*. London: Brooks/Cole.
- Salkind, N.J. (2000). *Exploring Resources*. Upper Saddle River, N.J. Prentice-Hall.
- Schoepf, B.G. (1992). AIDS, sex, and condoms: African healers and the reinvention of tradition in Zaire. *Medical Anthropology* 1992, 14: 225-242.
- Sims, R. & Moss, V. (1991). *Terminal Care for People with AIDS*. London, Melbourne, Auckland.
- Staugaard, F. (1985). *Traditional Healers*. Gaborone, Botswana: Ipelegeng Publishers.
- UNAIDS (2000). *Collaboration with traditional healers in HIV/AIDS prevention and care in Sub-Saharan Africa. A literature Review*. Geneva, Switzerland.
- UNAIDS (2005). *UNAIDS Epidemic Update, December*. Geneva, Switzerland.
- UNDP (1995). *Human Development Report, 1995*. New York, USA.
- Ursula, S. (1991). *Review of Community Based Care Programme in Uganda: Kitovu mobile AIDS home care programme*. Regional workshop report on HIV/AIDS community-based care and control, 6-11 October. Entebbe: Commonwealth Secretariat and WHO.
- Walker, A. (1982). The meaning and social division of community care. In: A. Walker (ed.), *Community Care: The Family, the State and Social Policy*. Oxford: Martin Robertson.
- WHO (1977). *World Health Organization Committee A: Provisional record of the 18th meeting*. 30th World Health Assembly, A30/A/SR/18.
- WHO (1978). *Primary healthcare: Report of the International Conference on Primary Healthcare, Alma Ata, USSR*. Geneva, Switzerland.
- WHO (1991). *Traditional healers as community health workers: a review of projects using traditional healers as community health workers*, 1991. WHO/SHS/DHS/91.6.
- WHO (2002). *Community Home-Based Care in Resource-Limited Settings. A Framework for Action*. Geneva, Switzerland.