HIV/AIDS knowledge and practices of traditional health practitioners in Tutume sub district: Implications for collaboration in HIV/AIDs care in Botswana

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Abstract

The aim of the study was to determine HIV/AIDS knowledge and practice of traditional health practitioners (THPs) and their views on collaboration with biomedicine health practitioners (BHPs). A cross sectional survey was conducted with a sample of 39 THPs using semi structured interviews. THPs were drawn from communities in Tutume sub district in Botswana, using snowball sampling. The mean age of THPs was 58.2 years, majority 25 (64.1%) were males, and almost half 18 (46.2%) had no education. THPs had a positive attitude towards BHPs, and viewed them as colleagues they would share knowledge with, refer patients to, and were eager to learn biomedical skills. THPs had misconceptions and low knowledge on the causes and diagnosis of HIV but believed that antiretroviral therapy (ART) can treat HIV/AIDS. THP's willingness to learn biomedical skills and share knowledge on traditional healing with BHPs has positive implications for collaboration in the sub district.

Key Words: Biomedicine practitioners, traditional medicine, healing, referral, HIV prevention, HIV/AIDS knowledge, collaboration

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Introduction

The World Health Organization (WHO) advocate for the inclusion of traditional health practitioners (THPS) in National AIDS programmes since the early 1990s (UNAIDS, 2002; WHO, 1990). The call for collaboration was motivated by a shortage of biomedical health practitioners (BHPs) and was aimed at increasing their role in the provision of primary health care (Kaboru et al., 2006; WHO, 1978). According to Peltzer and Mngqundaniso (2008) the HIV epidemic has brought the idea of collaboration very much to the forefront again. The continuous spread of HIV and the poor state of health care systems in most of sub-Saharan Africa are compelling reasons to involve THPs in the fight against HIV (King et al., 2004).

The current debate for involving THPs in HIV/AIDS care represents a unique opportunity to increase community access to HIV services in a culturally appropriate and economically sustainable way. Moreover, in the context of HIV treatment in many countries in Africa, patients often choose traditional healing systems as their primary care (Mills et al., 2006). THPs represent an available health care resource that could strengthen and expand existing HIV prevention and care services in sub-Saharan Africa (Homsy et al., 2004; Kaboru et al., 2006; Mills et al., 2006; Peltzer & Mngqundaniso, 2008). Evidence from previous studies and programs show that THPs made significant impact in HIV/AIDS and awareness and prevention through collaboration with BHPs (Liverpool et al., 2004). To date, collaborative HIV/AIDS programs have been established in many African countries, including Malawi, Mozambique, Uganda, Senegal, South Africa, Swaziland, Zambia, and Zimbabwe (Bodeker, Carter, Burford, & Dvorak-Little, 2006).

In the context of HIV/AIDS, King et al (2004) argue that despite the increasing availability of antiretroviral treatment (ART), only a small proportion of those in need and eligible have benefited from ART services. The vast majority of African people continue to use traditional medicine (TM) for the treatment of HIV related conditions. The high cost and unavailability of ART to people living with HIV/AIDS (PLWHA) in poor resource countries lead many to turn to TM for HIV care (Bodeker et al., 2006). In sub-Saharan Africa, the ratio of THPs to the population is 1:500, while medical doctors are in the ratio of 1:40,000. This indicates that THPs are serving a large portion of the population (Green, Zokwe, & Dupree, 1995; King & Homsy, 1997). Given the widespread availability of THPs and TM and the reliance of the population on these services, it is inevitable that PLWHA will turn to THPs for treatment (Bodeker et al., 2006). Moreover, data show that up to 90% of PLWHA consult THPs before visiting BHPs (Peltzer & Mngqundaniso, 2008). According to Homsy, King, Balaba, & Kabatesi (2004), the majority of PLWHA depend on and choose THPs and TM not only because they are more available and accessible to their communities than BHPs and ART, but because the majority believe in the usefulness and power of TM. This is because TM is accessible, affordable, culturally and socially acceptable to most populations in Africa (Agbor & Naidoo, 2011; Kusimba et al., 2003). An appropriate and effective response to the HIV/AIDS epidemic in sub Saharan Africa requires reconsideration of the collaboration between THPs and BHPs (Bodeker, Kabatesi, King, & Homsy, 2000; Homsy & King, 1996; Homsy et al., 2004; Kaboru et al., 2006). The genuine interest and enthusiasm of THPs to collaborate with BHPs (UNAIDS, 2002) represents a unique opportunity for collaboration.

Despite advocacy for collaboration by WHO and the growing needs and opportunities for collaboration, the number of studies on the use of TM and HIV/AIDS and collaboration between THPs and BHPs have not increased significantly (King et al., 2004). Current data show that there are still few collaborative efforts between BHPs and THPs for HIV/AIDS prevention or care. Many African governments still have contradictory attitudes towards TM for HIV/AIDS, discouraging it within ART programmes (Chinsembu, 2009). Consequently, in many countries, THPs have not been actively involved in the primary health care activities as recommended by WHO (Addis, Abebe, Genebo, & Urga, 2002; Chinsembu, 2009; Chipfakacha, 1997; King & Homsy, 1997; WHO, 1990). More than a decade after the call for collaboration, relationships between BHPs and THPs are still often characterized by indifference, suspicion, and mutual rejection (King et al., 2004).

Similar to other African countries, documented collaboration activities in Botswana are limited. This is despite the government having a policy actively promoting collaboration between BHPs and THPs (Botswana, 1995). Documented collaborative activities include seminars on AIDS to sensitize THPs on AIDS and to coordinate THPs activities with district health teams, as well as implementing the Botswana Dingaka AIDS awareness and training project. The Botswana Dingaka project was implemented between 1991 -1993 and created HIV/AIDS awareness among THPs, trained THPs as core-trainers to train others, and promoted collaboration for health services (WHO, 1990). Studies conducted in the country to evaluate collaboration found little collaboration between the two groups (Lejowa, 1993; Motswagole, 1993). There are limited studies assessing THP's HIV/AIDS knowledge and practice, considering that HIV/AIDS training is one of the collaborative approaches in the country. The aim of the study was to determine HIV/AIDS knowledge and practice of TPHs and their views on collaboration with BHPs.

Methodology

Study design

A cross-sectional survey was conducted with a sample of 39 THPs using semi structured interviews during October 2006. THPs were drawn from communities in the Tutume sub district using snowball sampling. Tutume is one of the sub districts of the central district in Botswana with a population size of about 123,514 people (Census, 2001). A semi structured questionnaire with open and close ended questions was developed using literature on collaboration between BHPs and THPs. The questionnaire was developed in English and translated to Setswana the first language of the THPs in the district. The questionnaire was pretested and revised prior to the start of data collection to ensure quality of the data. The questionnaire obtained information on the socio-demographic profile of THPs, the types of traditional healing practices, documentation of healing practices, willingness to collaborate with BHPs, preferences of collaboration approaches and HIV/AIDS knowledge and practices. A trained field worker administered the questionnaire during face to face interviews with THPs. The interviews were conducted in the home of the THPs.

Data was analysed using Stata version 10.0. Descriptive statistics were carried out to describe the socio-demographic variables in frequency, percentage mean and standard deviation. Responses to open-ended questions were quantified and also analysed using Stata, and results were summarised as frequencies and percentages.

Ethics

The School of Public Health Research, Ethics, and Publication Committee of the University of Limpopo granted ethical clearance for the study. Permission to conduct the study was obtained from the Botswana Ministry of Health. An informed consent was obtained from the participants prior to the interview.

Results

Characteristics of traditional healers

A total of 39 THPs participated in the study, 25 (64.1%) were males and 14 (35.9%) females. The mean age of participants was 58.2 years (range 27-88, SD=17.8 years), and more than two thirds 25 (64.1%) were over 50 years. Almost half 18 (46.2%) had no education, 14 (35.9%) had primary education, 5 (12.8%) had a secondary education and only 2 THPs had a senior secondary education.

Table 1: Characteristics of traditional health practitioners

Gender	**Frequency**	**Percent**
Female	14	35.9
Male	25	64.1
Age in years		
20-30	4	10.5
31-40	3	7.9
41-50	6	15.8
51-60	9	23.7
61-70	3	7.9
71-80	9	23.7
81-90	4	10.5
Education status		
No education	18	46.2
Primary	14	35.9
Secondary	5	12.8
Senior secondary	2	5.1
Type of healing practice		
Sangoma diviner)	1	2.6
Traditional healer	6	15.4
Spiritual healers	22	56.4
Prophets	5	12.8
Bone setter	4	10.3
Other (Tsotswa)	1	2.6

More than a third 15 (38.5%) could read and write in Setswana, and slightly more than a quarter 11 (27.5%) reported that they documented their healing activities. Regarding their healing practices, participants consisted of spiritual healers 22 (56.4%), traditional healers 6 (15.4%), prophets 5 (12.8%), bone setters 4 (10.3%), sangoma (diviner) 1 (2.6%) and other 1 (2.6%). Slightly more than half 20 (51.2%) were registered with the Botswana Traditional Healers Association. Table 1 shows the characteristics of THPs.

Attitudes of THPs towards collaboration with BHPs

Table 2 summarizes the THP's views on approaches to collaboration. The majority of the THPs had positive attitudes towards BHPs and were eager to collaborate. Almost all 36 (92.1%) viewed BHPs as colleagues, 33 (84.6%) would share their knowledge with BHPs, and 37 (94.9%) would refer patients to BHPs. Almost all 35 (89.8%) the THPs believed that the biomedical health system is useful in HIV/AIDS treatment and 31 (81.4%) believed that ART can treat HIV/AIDS.

Table 2:Attitudes of traditional health practitioners towards approaches to collaboration (n=39)

Approach to collaboration	Strongly agree/ Agree	Somewhat agree	Strongly disagree/ disagree
Sharing knowledge with BHPs	33 (84.7)	2 (5.1)	4 (10.3)
Sharing knowledge with other THPs	30 (76.9)	2 (5.1)	7 (18)
Learning biomedicine skills	28 (71.8)	1 (2.6)	10 (25.6)
Participate in workshops/seminars	36 (92.3)	0	3 (7.7)
Referring patients to each other	37 (94.9)	0	2 (5.1)

THP's knowledge of HIV/AIDS

THPs responded to an open ended question on the causes of HIV/AIDS, and slightly more than a third 13 (34.2%) correctly mentioned that HIV is sexually transmitted, about a quarter 9 (23.7%) did not know the causes of HIV/AIDS, and 42.1% had misconceptions about the causes of HIV/AIDS, including beliefs that HIV is a punishment from God and that HIV/AIDS is caused by cultural violations of sexual norms. THPs also responded to an open ended question on the curability of HIV/AIDS, two thirds 23 (62.2%) correctly mentioned that HIV/AIDS cannot be cured while more than a quarter 13 (35.1%) believed that HIV/AIDS can be cured. THPs were also asked to describe how they diagnose HIV/AIDS, the majority 32 (78.8%) had misconceptions on how to diagnose HIV/AIDS, and only a few 7 (19.4%) reported that they did not know how to diagnose HIV/AIDS. More than a third 13 (36.1%) said that they used the client's physical signs of deterioration to diagnose HIV/AIDS, and about a quarter 9 (25%) used the bible or bones to diagnose HIV/AIDS. None of the THPs mentioned referring patients for HIV counselling and testing as a way of diagnosing HIV/AIDS. Table 3 summarizes THPs knowledge and misconceptions on HIV/AIDS.

Table 3: TPH's knowledge and misconceptions on HIV/AIDS

Theme	Frequency/Percent
Causes of HIV/AIDS (n-38)	
HIV/AIDS is sexually transmitted	13 (34.2)
Don't know what the cause is	9 (23.7)
It is mixed diseases	8 (21.1)
Is caused by cultural violations of sexual norms	4 (10.5)
It is a punishment from God	2 (5.3)
It is from primates	1 (2.6)
Comes from painful womb	1 (2.6)
Diagnosing HIV/AIDS (n=36)	
Don't know how to diagnose HIV/AIDS	8 (22.1)
Use physical signs of deterioration	13 (36.1)
Use tools of my trade (Bible, bones)	9 (25)
Listen to client's complaints	1 (2.7)
Association of death of close people	1 (2.7)
Irrelevant answers	4 (11.1)
Curability of HIV/AIDS(n=38)	
HIV/AIDS can be cured	9 (24.3)
HIV/AIDS cannot be cured	2 (5.4)
HIV/AIDS can be suppressed	21 (56.8)
Biomedicine health practitioners can cure it	3 (8.1)
Traditional health practitioners can cure it	1 (2.7)
HIV/AIDS can be prevented	1 (2.7)
It is up to the biomedical who came up with it	1 (2.7)

THPs HIV/AIDS practices

With regards to the advice THPs give to their clients to prevent HIV infection, two thirds 24 (63.1%) reported that they advised their clients to follow the ABC approach for prevention, i.e. abstain, be faithful and condomize. Other responses ranged from telling clients to pray, and to reduce the intake of beer. One THP reported that he gives his clients medicine to prevent them from getting infected with HIV.

THPs also responded to an open ended question on what they do after diagnosing HIV/AIDS, and two thirds 23 (62.2%) said they refer their clients to hospital and a small proportion 3 (8.1%) said that they did not know how to help their clients after an HIV/AIDS diagnosis as reported in Table 4.

Table 4: THPs HIV/AIDS practices

Theme	Freq./Percent
Advice on how to prevent HIV/AIDS (n=38)	
To follow the Abstain, Be faithful, Condomise approach	24 (63.1)
To bring own equipment for consultation	2 (5.2)
Take care when looking after infected people	1 (2.6)
Reduce beer intake	1 (2.6)
To pray	1 (2.6)
Don't know what advice to give/ don't know about AIDS	7 (18.4)
Not to have intercourse right after an abortion	1 (2.6)
Give patients medicines not to get infected	1 (2.6)
Advice given to clients after HIV/AIDS diagnosis (n=37)	
Send clients to hospital	23 (62.2)
Give instruction or advice or help clients (unspecified)	6 (16.2)
First help the client then send to hospital	5 (13.5)
Don't know how to help	3 (8.1)

Discussion

This paper discusses THP's knowledge and practices on HIV/AIDs and their views on collaborating with BHPs in HIV care. The study shows that majority (64.1%) of the THPs were over 50 years. The older age of THPs in many countries could be one of the reasons for the popularity of TM because the elderly are respected among local communities (Ragunathan, Tadesse, & Tujuba, 2010). Over 64% of the THPs in the current study were males; this finding is in agreement with previous studies which found more males than females among THPs. However, the gender distribution was not specific to any particular line of traditional healing (Addis et al., 2002; Burnett et al., 1999). Gender roles in traditional healing in African settings are influenced by cultural beliefs and differ with countries and regions (UNAIDS, 2007). Researchers argue that the higher prevalence of males in traditional healing is because TM is a male dominated profession (Agbor & Naidoo, 2011; Gessler et al., 1995).

Similar to others studies the results revealed low literacy levels among THPs, almost half (46 %) had no formal education although 63% could read and write (Addis et al., 2002; Chipfakacha, 1997; Gessler et al., 1995). As a result, only a third of the THPs documented their healing activities. According to (Gqaleni et al., 2011) THPs are not accustomed to recording their work as the practice of traditional healing has a long oral history. The healing knowledge is passed on from generation to generation through verbal communication with a respectable degree of consistency (Ragunathan et al., 2010; WorldBank, 2001). However, The lack of documentation and the predominantly older age of THPs implies that the legacy of the use of TM is in danger of being lost for ever (Kisangau, Lyaruu, Hosea, & Joseph, 2007).

The majority of the THPs had a positive attitude towards BHPs. Almost all (92.1%) view BHPs as colleagues, were eager to collaborate in patient care, and would share their knowledge on traditional healing with them. The results further showed that most (94.9%) were eager to refer patients to BHPs. Similar findings were reported in other studies (Addis et

al., 2002). Although other studies report mutual respect, recognition and good will among BHPs and THPs, in actual practice, BHPs and THPs may not always reflect their orally expressed commitments (Addis et al., 2002; Ragunathan et al., 2010). THPs in this study were also eager to learn biomedical skills through participation in HIV/AIDs training workshops. Similar findings were reported in other studies (Agbor & Naidoo, 2011; Burnett et al., 1999; Gessler et al., 1995; Kayombo et al., 2007; Kisangau et al., 2007). Other studies in the region also reported that most THPs expressed the need for training and were motivated to learn how to recognize HIV/AIDS and how best to advise their patients in relation to HIV prevention (Addis et al., 2002; Burnett et al., 1999).

The THPs in this study had low knowledge on the causes of HIV, a quarter did not know the causes of HIV, while slightly more than a third correctly stated that HIV was sexually transmitted, but had no knowledge of other transmission routes. Our study findings are in line with those of other studies (Peltzer, Mngqundaniso, & Petros, 2006). Misconceptions regarding the causes of HIV were prevalent, responses included that HIV is a punishment from God, and that HIV is caused by cultural violations of sexual norms. The cultural norms mentioned in this study include instances when cultural rituals of widowhood are violated or having sex with a woman during menstruation. Similarly, half of THPs in a Zambian study mentioned unclean sex as a cause of HIV (Burnett et al., 1999).

More than a third of THPs believed that HIV/AIDS can be cured, about 11% believed that BHPs have a cure for HIV/AIDS, while 3% believe that THPs have a cure for HIV/AIDS. Misconceptions about the cure for HIV/AIDS were also found among THPs in South Africa and Zambia (Burnett et al., 1999; Peltzer et al., 2006). Misconceptions about the diagnosis of HIV/AIDS were also prevalent among THPs in this study, only 19.4% reported that they did not know how to diagnose HIV/AIDS. Most THPs advice their clients to follow the ABC approach for prevention. Two thirds refer their clients to the hospital after diagnosing HIV/AIDS, we assume that TPHs refer patients they suspect of HIV infection or patients with clinical signs of AIDS to biomedical health system.

Conclusion

The findings revealed that HIV/AIDS knowledge of THPs was very low and that none had participated in collaboration workshops in the sub district. The study also revealed that THP's HIV/AIDS practices were characterized by misconceptions. The eagerness of THPs to learn biomedical skills and willingness to share their knowledge on traditional healing with BHPs has positive implications for collaboration in the sub district. Advocates for collaboration argue that THPs abstain from dangerous practices when trained about the risks and are able to adapt their practices to integrate biomedical practices. In line with this view, HIV/AIDS knowledge and practice of THPS can be strengthened through collaboration training programmes in the sub district.

Collaboration is possible but can only be successful if the attitudes between THPs and BHPs are improved and barriers to collaborations are dealt with. The willingness of THPs to learn some biomedical skills suggests that THPs would be receptive to knowledge concerning

HIV/AIDS and represents a unique opportunity for collaboration. More efforts should be taken to strengthen sharing of knowledge through seminars and workshops as stipulated in the National policy on traditional medicine.

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