HOPE TO LIVE

TRADITIONAL MEDICINE AS COMPLEMENTARY THERAPY WITH ANTIRETROVIRAL DRUGS

An exploratory study in Katutura, Windhoek, Namibia

Rosa Persendt

Master Thesis

Amsterdam Master’s of Medical Anthropology

University of Amsterdam

Supervisor: Dr. Eileen Moyer

Co-Reader: Margret Kyakuwa

August 2008
ACKNOWLEDGEMENT

It takes courage, guts, determination and people to write a dissertation - and it took many people.

First and foremost, I would like to pay a tribute to the people of Namibia who are the sufferers of the HIV/AIDS, the heart and soul of this dissertation. For providing the substantial content and insights and who are tangled between the the “biomedical” and the “traditional” the “powerful” and “powerless” I salute them and I am grateful and indebted for their assistance. The Red Cross Namibia and Ministry of Health and Social Services were essential; without their assistance this study would not be possible. The University of Namibia for granting me one year staff development leave, much appreciated.

A special thanks to my supervisor Dr. Eileen Moyer for her inspiration, ideas and experiences in HIV/AIDS matters clearly indicated her expertise, to help shape this thesis. To Margret Kyakuwa the co-reader thankyou for your time and effort in reading my thesis.

To Frans, my husband, friend and colleague, a special thanks for making this journey complete you are the best. To my “angels of joy”, my two daughters Olivia and Nicole thanks for the patience and all questions about HIV/AIDS, to make me see the epidemic through the eyes of an African child surrounded by friends and family lost through this epidemic.

I would like to extend a special thanks to Julia Challinor (angel sent from heaven and backbone to AMMA 11) for editing and inspiration throughout this AMMA course. The Meer and Vaart gang Mila, Theo, Ina and Tyas you are the best!!

Special thanks to the Department and staff of Medical Anthropology, University of the Netherlands and founding Dean of AMMA, Prof. Sjans Van Der Geest, for making Medical Anthropology real. The powerful discussions, arguments and various CALQ’s played a vital role in the shaping of my thinking and bringing forth of ideas valuable to write this dissertation. To the AMMA 11 group from all over the world ensured many wonderful friendships, thanks for your encouragements and support.

To my sponsors the Amsterdam Institute for Development (AIID) I thank you for your commitment towards capacity building in our beautiful country Namibia. Furthermore to
Dr. Peter and Ineke Slee and Dr. HCM Haanen and Hoeylan, thanks for your kind financial support during my field research and completion of thesis.

My beloved family, Mamma, Mamma Girlie, Jenny, Raymond, Cheryl, Denise, Hannes, Doreen, Harold, Joan, John, Ronnie, Renchia, Shane, Daleen for their love, special prays, assistance and inspiration to keep me going on. Love you much.

To all those who are living with HIV/AIDS

“When we are motivated by goals that have deep meaning, by dreams that need completion, by pure love that needs expressing, then we truly live” (Greg Anderson)
ABSTRACT

Whether at work, home or in my daily environment, I have witnessed so many Namibians struggling with the HIV/AIDS epidemic. I became aware that everyone wants to live and makes enormous efforts to do so; however the full spectrum of their efforts is not well known. The key people who understand the nature of the HIV virus the best are the people living with HIV (PLWHIV); they are ones who suffer, have the most experience, highest expectations and hopes to live.

Although Namibian society is rich with traditions and culture to date there has been no research on what traditional medicine is used as complementary therapies to the ARV treatment by PLWHIV. Studies that do exist have examined local practices of traditional medicine and separately, adherence to ARVs, with no focus on complementary therapies used in conjunction with ARVs.

The objectives of this study are to gain an in-depth understanding of what complementary therapies are used by PLWHIV, how are these used and what are their experiences and expectations in Katutura, Windhoek, Namibia. A further objective is to examine how these PLWHIV shape their perceptions and experiences. Outcome measures for this study include the cost of complementary therapy, illness behavior, symptom management, medication and emotions, stigma, freedom from medical constraints. The possibility of change in the use of complementary therapy since the introduction of the ARV’s potential development of new complementary therapies is an important consideration in this study.

The study is a small-scale exploratory research which took place from 13 May- 2008- 13 July 2008 PLWHIV participants identified by Red Cross Namibia officials were interviewed at an outpatient clinic at Katutura State hospital and the surrounding area of Katutura, Windhoek, Namibia. The goal was to explore their experiences and expectations using complementary therapies. Local medical doctors at the hospital and traditional healers in the community were interviewed to learn their perspective on this subject. Many informal discussions and observations were conducted to thoroughly understand the context of this practice.
The study found that all of the original eight PLWHIV, selected for the study reported using complementary therapies. Four participants were interviewed once and four twice. Unfortunately, four participants were unable to complete follow-up interviews. All reported the use of traditional medicine as complementary therapies to cope with the side-effects of the ARV treatment. The most common form of complementary therapy was herbs. The PLWHIV knew the herbs from their childhoods and considered that complementary therapy played a significant role in their daily lives. One of those interviewed reported spending at least 10 euro per month (120 Namibian dollars) to pay a traditional healer for his herbal complementary treatment, while the others reported no cost, because they obtained the herbs from the veld.

The results of the study suggested that traditional medicine as complementary therapies are used by PLWHIV in addition to conventional treatment to ARVs and not as an alternative. Herbs were the most commonly used complementary therapy. PLWHIV using complementary therapy simultaneously with ARVs stated that they thought that this familiar therapy represented a hope to live and the ARVs served as a reminder that they had a death sentence if they were to discontinue the pharmaceutical intervention.
INTRODUCTION: Traditional Medicine as Complementary Therapy with Antiretroviral Drug

In response to elevating HIV/AIDS pandemic in Namibia, public health authorities made free antiretroviral therapy (ARVs) available to the population in 2003. ARV drugs inhibit one of the two enzymes that are essential for HIV replication, namely, reverse transcriptase and protease (Family Health International 2008). Although ARV therapy is not a cure it prolongs lives and thus it sustains the health of a person living with HIV (PLWHIV). However, despite this government effort, traditional medicine is used simultaneously with ARVs by PLWHIV. This striking fact indicates that modern pharmaceuticals are not able to meet all the needs to PLWHIV communities. State-of-the-art medicine has not replaced traditional care. Data from a variety of African countries indicate that traditional medicine is making an enormous contribution to the health system in many countries (WHO 2003; International Development Research Centre 2000). Traditional medicine is widely practiced that it cannot be ignored by those involved in the transformation and strategic planning of health care systems, particularly in Africa (Adewunmi and Ojewole 2004).

My motivation to research this topic is that I am a Namibian who has lost a friend, relative and witnessed the death of patients while doing voluntary HIV/AIDS work in Namibia. Most PLWHIV are not willing to confess that they are using traditional medicine as complementary therapy with their biomedicine. Namibian doctors are not willing to recognize this practice and insist that PLWHIV use only biomedicine. My experience with these attitudes and practices led me to question the division that exists between the world of biomedicine and the world of complementary therapies in Namibia.

This exploratory study examined the simultaneous use of traditional medicine with (ARVs) PLWHIV from the 13th of May to the 3rd July 2008 in Katutura, Windhoek Namibia. In addition, information was collected on specific traditional therapies, the meaning for the user, the experiences during therapy, cost, and importance to the patient of self-directed effort.
One objective of the study was to verify if PLWHIV use complementary therapies as additional to ARV or in lieu of conventional medication. I explored the practices and strategies PLWHIV use to cope and manage in their everyday lives to understand the meaning of this complementary therapy. I also investigated traditional medicine used as complementary therapy assisted PLWHIV to gain a voice (in the context of ethnomedicine) to alleviate stigma, and to manage their own health care.

Through their understanding of traditional medicine as complementary therapy and the uncertainties of a chronic disease, I was able to see how PLWHIV constructed normal lives to make their situations manageable. I use the term traditional medicine as complementary therapy within the context of this study to mean medicine that is used by Namibian PLWHIV in addition to doctor prescribed medicine, specifically ARVs. Alternative medicine is medicine that is used in place of doctor prescribed and this practiced was not considered. Namibian people, in general, do not use the term “complementary therapy”. They use the term “traditional medicine” to refer to the therapy I define as complementary.

Stigmatization is very high for PLWHIV in Namibia. PLWHIV use complementary therapies but feel that it is an “illegal substance” in the eyes of biomedical professionals and therefore they do not freely talk about the benefits. This study could help to break to stigma barrier and recognize the benefits of complementary therapies for PLWHIV.

Acknowledging the practice of combining traditional medicine with ARV use would benefit communities, health policy makers and national and international HIV/AIDS agencies. It is time to redefine the boundaries of HIV/AIDS treatment, by demonstrating that ARVs are not the only treatment, used by PLWHIV, we must develop innovative, flexible, and sensitive programs in the Namibian community to address the social and cultural constrains as well as the medical demands of HIV. I hope to bridge the gap between ARV therapy and complementary therapies and to establish the meaning of complementary therapies for coping with the side effects of ARVs in Namibia. The practice of using complementary therapy simultaneously with ARVs in Africa is well documented (International Development Research Centre 2006, 2007, 2008; Langlois-Klassen et. al. 2007) In developed countries work has been done to investigate this practice (Thorpe 2007; Colebunders et. al. 2003; Furler 2003). However, only a few studies have considered the value of complementary therapies in relation to ARVs in Africa (Tshibangu et. al.
My research explored: How do Namibian PLWHIV use traditional medicines as complementary therapy to the ARV manage their everyday lives?

Sub questions:

1. What complementary medicines are used and how are these used?
2. What are the experiences and expectations of PLWHIV in Namibia using ARVs?
3. To what degree do complementary medicines alleviate side effects?
4. In some circumstances complementary therapies are more expensive than biomedical treatment. How do PLWHIV and taking ARVs in Katutura, Namibia cope with this expense?
5. In what way do social, cultural and religious factors influence the use of complementary therapies for PLWHIV in Katutura Namibia?

For hundreds of years in Africa, traditional medicine and remedies made from plants have had a significant role in the health of millions of people. This study investigated what complementary medicines are used and how they are used by PLWHIV in Namibia. Complementary therapies in the context of this particular study are known as traditional medicine and are a holistic discipline that involves the extensive use of indigenous herbs combined with African spirituality.

Experiences and expectations of PLWHIV in Namibia for complementary medicine were also considered. Reports of powerful immunostimulant effects for some traditional medicines have raised hopes among HIV-infected individuals for managing the side effects of ARV treatment (Launso 1995). Practitioners of African medicine claim to cure a wide range of conditions including cancer, AIDS, psychiatric disorders, high blood pressure etc (Boseley 2005; Bolognesi 2006). Scientists worry that such “cures” will cause PLWHIV and other illnesses to delay treatment with “proven” therapies or even complicate current treatments (Furnham and Bhagrath 2005). So together with an increased use of complementary therapies, demand has grown for evidence to be collected on why in the presence of “proven” therapies PLWHIV still use complementary therapies.
Another important aspect of this research was to look at what “pushes” and “pulls” PLWHIV towards complementary practices. Complementary therapy use results when people perceive these approaches as congruent with their own worldviews and personal health beliefs (Astin, 2004). I investigated the experiences of PLWHIV using the complementary medicines and how social, cultural and religious factors influenced their decision. For example, researchers report that high levels of complementary medicine use are found among people who desire greater personal control over their health (Furnham and Bhagrath 2005) and those who have a holistic perception of health and illness. Rather than seek an alternative to standard medicine, people consider a wider range of practices to improve health.

Complementary medicine has increasingly become the focus of social scientific research (Langewitz, 1994; Singh 1996; Fairfield 2000; Knippels and Weiss, 2000). The interest in complementary medicine is recognized in development policies (WHO 2000), the media (Bensoussan and Lewith 2004) and scientific literature (Winnick 2007). Studies from the USA show that the majority of persons with HIV/AIDS use some type of complementary therapy concurrently with their biomedical treatment (Kirksey et al., 2002; Hsiao et al. 2003). No clear data exists on the proportion of PLWHIV who use complementary medicine Namibia.(Le Beau 2000). However a study performed in Pretoria, South Africa from July 2004-2005 of PLWHIV and taking ARVs found that only 8.9% of the 180 respondents admitted to using complementary therapy (Melangu 2007). This finding contradicted with Langlois- Klassen et. al (2007) who reported that 35.3% of the sixty-nine (69) PLWHIV and taking ARVs reported concomitantly using traditional herbal therapy in Western Uganda. According to WHO estimations, up to 80% of the population in Sub- Saharan Africa resorts to complementary medicine for their primary health care needs (WHO, 2002). Against this complex backdrop is an assumption by the biomedical world that ARVs are currently the primary method for treating HIV. PLWHIV are advised not to use complementary therapies as they may interfere with conventional drugs (Adewunmi and Ojewole 2004a; Mills et al. 2005). However in the African context where people grow up with traditional medicine how do they substitute western medicine for traditional medicine and how do the two complement each other?

Most people in Namibia as in most sub-Saharan Africa, do not have medical insurance and do not have the funds to pay the hospital admission fee due to soaring medical costs of public health.
The rampant effects of poverty mean that complementary therapies are the most affordable ‘escape route’ for self-medication. Langlois-Klassen et al. (2007) observed this situation in Uganda also. In the Namibian context people gather herbs from friends, family members or even gather the herbs themselves, therefore, they are often cost free. Although herbs free, consulting with the experts like the traditional healers involves a cost.

Paradoxically, medication prescribed by traditional healers in Namibia is more expensive than biomedical treatment with ARVs. ARVs are basically free and the patient is only expected to pay the hospital admission fee, which is often waived. This paradox calls into question the ability of the population to pay for traditional therapies. This study investigated how PLWHIV in Namibia cope with this expense.

The strong prevalence of stigma associated with HIV/AIDS makes it difficult for those who are infected to disclose their HIV/AIDS status and this may pose a problem for taking ARV’s, for example in the work place or when traveling to a funeral in a rural area. This investigation will look at how PLWHIV and taking ARVs manage such situations and what are their experiences. Also investigated were the social and religious aspects that influenced the use of complementary medicine in Namibia.

The study of HIV/AIDS and the treatment available in Namibia can lead to the improvement of the quality of life, of PLWHIV. Approaches to maintain the working capacity of PLWHIV would help to decrease the social impact of AIDS. Strategies are required that are focused on building a local responses to the impact of the HIV/AIDS epidemic. Local responses include the knowledge of key actors in the community and facilitating support from a variety of sectors such as the health and education sectors.

In chapter one I briefly present information on the Namibia socio demographic context and continue with an overview of the global HIV epidemic as well as in Namibia. Relevant theoretical concepts and other methodological issues are also included in this chapter. In chapter two the case studies is presented; four different stories from PLWHIV highlight their lives, struggles, experiences, and expectations for traditional medicines as complementary therapy to ARVs. Furthermore it focuses on the daily experiences, hardships of PLWHIV, and challenges they face living with stigma. The chapter focuses on why PLWHIV choose traditional medicine
as complementary therapies, what “pulls and pushes them” to or from conventional traditional as complementary therapies and cost implications. The coping strategies and support mechanisms that exist and are used by participants in the Namibian context are also concluded. Finally the chapter focuses on the view of the medical doctor and the traditional healer. Chapter three presents the analysis and discussion of the findings of the study. Common themes are extracted to indicate the meaning of complementary therapies for PLWHIV and who also are receiving ARV treatment. Chapter four will present the conclusions and recommendations that emerge from the study. This research is exploratory but I aim to stimulate future research about PLWHIV using traditional medicine as complementary therapy to ARVs.
1.0 CHAPTER 1: Introduction and background to the problem

"The fight against an enemy... stronger than the human race?"

This chapter provides background information on global HIV/AIDS, ARVs and Traditional medicine in Namibia.

1.1 HIV/AIDS in the world

From an economic and policy perspective, HIV/AIDS spreads faster under conditions of poverty, gender discrimination and economic insecurity and this accounts for most people in Sub-Sahara Africa (Simmons 2002). AIDS is more rapidly fatal where health systems do not adequately meet health needs, causes more serious effects where household resources are sparse, and depletes skills and savings at a time when economic demand for these inputs is high. The overall impact on those with skills and experience is substantial with long-term consequences. More and more young people are dying leaving the workplace, and their households empty (Swanson et al. 2000). The common transmission route is sexual which leads to social death due to the stigma surrounding AIDS. With the introduction of ARVs the health of PLWHIV is restored and they can resume their life, however, and ART becomes a lifelong treatment.

1.2 HIV/AIDS in Namibia, "Land of Kilometers"

Namibia is located in the southwestern part of Africa, hosting a population of approximately two million (National Planning Commission 2003). It shares borders with Angola and Zambia to the north, Botswana to the east, and South Africa to the south. Namibia gained independence from South Africa in 1990 and its capital city is Windhoek. Each ethnic group has its own language but English is the official language. The country is one of the most sparsely populated countries in Africa with an average population density of 2.5 persons per square kilometer. It is classified as a lower-middle income country and is heavily dependent on the extraction and processing of minerals for export. Despite this good economic status the country has the highest Gini coefficient in the world at approximately 0.6 (National Planning Commission 2006). The Gini coefficient provides a measure of income distribution across various segments of society, and this is inequitably distributed. The first HIV/AIDS cases were reported in Namibia in 1986 (Ministry of Health and Social Services report 2007). The first decade of the epidemic witnessed a steady increase in prevalence and Namibia's ranked as one of the four most affected countries.
in the world (Ministry of Health and Social Services 2007). In response to the current crisis the National AIDS Coordination Program (NACOP) makes universal access to prevention, care, treatment and support a key component of the national strategic plan Second and Third medium plan, (MTP2 and MTP3 and Ministry of Health and Social Services 2007).

1.3 ARVs in Namibia and current situation

As part of the national HIV/AIDS response an ARV treatment programme was started in mid 2003, and currently more than 50 sites are providing antiretroviral therapy (ART) services in the country (Ministry of Health and Social Services 2005). In 2007 estimates were that 200,000 inhabitants out of the total Namibian population of 2,031,000 were infected with HIV/AIDS approximately 33,591 PLWHIV had started the treatment with ARVs (Ministry of Health and Social Services 2007). ARVs offer the possibility of a longer life and improved health status.

The Namibian government has said that the next steps include decentralizing antiretroviral treatment from hospitals to health centers i.e. clinics, and transferring tasks from doctors to nurses, while increasing the emphasis on quality care (Ministry of Health and Social Services 2007). The government is committed to this program so patients make a low payment only to cover administration costs (equivalent to €1.50). This cost is waived in cases where a PLWHIV cannot pay.

It is further reported that more than 90 percent of the people who have been receiving ARVs are reportedly alive, while only 5 percent have died (The Namibian, 2007). The following questions
need to be posed: (1) If ARV treatment has been available only since 2003 but the first case of HIV/AIDS in Namibia was discovered in 1986; what did people use as medicine or methods to survive before ARVs? (2) Are ARVs the only medication used or known by PLWHIV to prolong life? (3) what role does traditional medicine play in relation to ARVs? This information has value to the biomedicine world and doctors in particular who encourage patients to use only ARVs and strongly discourage the use of any other additional medication or complementary medicine.

Although The Republic of Namibia’s government has managed to maximize the roll out of ARV therapy, the doctor patient ratio is still high and people have to sit for more than six hours to wait for medication (Die Republikein 2008). The distances between regions are enormous which makes the on time delivery of medication a problem for rural areas.

1.4 Traditional medicine in Namibia

Traditional medicine is widely used in prevention, diagnosis, and treatment of an extensive range of ailments in Namibia and AIDS is no exception to that. Before the introduction of ARVs it is not surprising that people would use what were available namely traditional medicine and or modern treatment for opportunistic infections.

In all countries of the world traditional knowledge exists related to the health of humans and animals. According to the World Health Organization (2002:264) the definition of traditional medicine may be summarized “as the sum total of all the knowledge and practical, whether explicable or not, used in the diagnosis, prevention and elimination of physical, mental or imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing. Traditional medicine might also be considered as a solid amalgamation of dynamic medical know-how and ancestral experience.”

Traditional and complementary medicine is widely used in the diagnosis, prevention and treatment of an extensive range of ailments. There are numerous factors that have led to the widespread appeal of traditional and complementary medicine throughout the world, particularly in the past twenty years (Mills et al. 2005). In some regions, traditional and complementary medicine is more accessible. In fact, one-third of the world population, and over half of those living of the poorest parts of Africa do not have regular access to drugs. (WHO 2002:300).
However, the most commonly reported reasons for using traditional and complementary medicine are that it is more affordable, more closely corresponds to the patient’s etiology and less paternalistic than allopathic medicine (Simmons 2002).

Namibia, a very big country, is characterized by a lack of health care systems in rural areas and people rely on medicine plants or consult a traditional healer for medication. There are a wide variety of health care alternatives such as self-medication and various homeopathic remedies available in Namibia. Traditional medicine has always been associated with magic and witchcraft. Traditional medicine is based on magical-religious beliefs and only by belonging to the same ethnic group with the same magico-religious beliefs can traditional medicine work. It is often assumed that traditional medicine has no basis in efficacy, but is based on beliefs of the people using it (Good 1996). Therefore the traditional healer and patient have to belong in Namibia to the same ethnic group for medicine to work (Beatie and Middleton et al. 2002). The same researchers (Beatie and Middleton et al. 2002) noted that patients’ also traditional medicine in the absence of western medicine in remote areas. The government of the Republic of Namibia has made an effort to improve the health care and facilities all over Namibia over the last years care has improved tremendously.

In traditional medicines, there is no clear distinction between medicines in its narrow broader sense. The healer’s “medicines” comprise a wide range of approaches that may vary according to aim of treatment, techniques and route of administration, as well as an extensive pharmacopoeia. An essential component of the latter is herbal medicines that have therapeutic, economic and environmental potential. The healers’ clientele include educated and uneducated alike, although westernization, level education and socio-economic status appear to influence health care selection and decision making process within the available options of self-care, family/community care, traditional healer or modern practitioner (Karim 2004). Most important is that the two medical systems – modern and traditional medicine – are regarded as complementary and not exclusive, and that “dual treatment” regularly takes place. An essential feature of the practitioner – client relationship is the fact that both parties share the same worldview, values and explanatory models of illness. This is of particular significance in the provision of mental health care where modern medicine is to a large extent unable to deal with the socio-psychological dimensions of African disorders (Karim 2004).
This raises the question: why in the presence of access to conventional health care do people still use traditional medicine or consult with traditional healers? People travel long distances in order to consult with a traditional healer of the same ethnic group making a conscious choice so it is not due to a lack of alternatives. The use of traditional medicine can therefore, be attributed to social, cultural, and personal factors such as beliefs rather than access, or cost and distance to modern health care facilities that has been previously assumed by researchers (Van der Geest and Hardon 2006).

1.5 Regulation of traditional healers in Namibia

Before Namibia’s independence in 1990, health services were fragmented along racial lines, and traditional medicine was outlawed (Lumpkin 1994). After Namibia’s independence, traditional medicine was legalized. The Ministry of Health and Social Services adopted a primary health care approach to the delivery of health services, and there has been major restructuring. The Namibia Eagle Traditional Healers Association was created in 1990.

According to Lumpkin (1994), there is at least one traditional medicine practitioner per 500 people in the Kavango and Owambo regions. In the Caprivi region, there is approximately one traditional medicine practitioner per 300 people. In Windhoek (Katutura), the ratio is one traditional medicine practitioner per 1000 people. There are three chiropractors practicing in Namibia.

In 1997, a joint study by the Ministry of Health and Social Services and World Health Organization reported that traditional medicine practitioners in Namibia can be classified as herbalists, faith-herbalists, diviner-herbalists, diviners, faith healers and traditional healers (WHO, 1997; Ministry of Health and Social Services, 1997).

In 1994, Lumpkin carried out a preliminary survey on the use of traditional medicine in the country. The resulting report, Traditional Healers and Community Use of Traditional Medicine in Namibia, was submitted to the Ministry of Health and Social Services. The Official National Primary Health Care /Community-based Health Care Guidelines were launched in 1992. Also in 1994, the Namibian Parliament passed an act requiring all health workers, including traditional medicine practitioners, to become legally registered. The act delegated each professional group to elect a board to facilitate the registration process. In 1996, The Namibian
Traditional Medical Practitioners Board was created. In 1997, the Ministry of Health and Social Services and the World Health Organization jointly undertook a study entitled Scientific Evaluation, Standardization, and Regulation of Traditional Medical Practices in Namibia. The findings of the study guided development of the 1998 draft Traditional Healers Bill and were used to prioritize activities and to inform the planning process for the 2000-2002 programme on the regulation and integration of traditional medicine.

The traditional Healers Bill established the Traditional Healers Council to oversee the registration and regulation of the practice of traditional medicine providers. The Council was be given the task of supervising and controlling the practice of traditional medicine practitioners, fostering research in traditional medicines, and making loans or grants available to traditional health practitioners. Traditional medicine practitioners in Namibia, many of whom come from other African countries, are not currently registered and operate without any guidelines from the Ministry of Health and Social Services.

The aim of the Bill is to protect the public from dangerous and opportunistic practices as well as to promote acceptable aspects of traditional medicine in Namibia.

Once legislation is in place, the Government intends to include traditional medicine practitioners in community based health care programs and incorporate the traditional medical system into the country’s official health services referral system. This is another dilemma for Namibia because it is one of a few countries in Africa where the Traditional Healers Bill has not yet been approved.
2.0 CHAPTER TWO: RESEARCH DESIGN AND METHOD

"The tip of the iceberg"

2.1 Introduction

This chapter is a description of the research design and method, background information of Katutura, the specific township where I conducted the study and problems encountered in the research process. "The tip of the iceberg" illustrates that six weeks of study was just a beginning, an explorative study, and future studies for a longer period of time need to be conducted. The primary emphasis is to make clear which research paradigm was used, why it was chosen and, more importantly how data was collected and evaluated.

2.2 Study Site

The study was conducted in Katutura State Hospital and surrounding areas, between the 13th May and 03rd July 2008. Katutura means "we do not stay" (Silvester et al 1998:48). This name derives from the South African apartheid regime when people of Windhoek (the capital city) had to relocate five times to the outskirts of the capital city. In 2006 approximately 150,000 people were living in Katutura, but the number is rising monthly by 600. More and more people are coming from the countryside in hope of finding a better job and life. The city of Windhoek is facing an incredible growth in the township and tin-houses are spread along the outskirts of Katutura. The four main ethnic groups that resides in Katutura are the Oshiwambo, Herero, Nama and Damara. I selected two people from each ethnic group for this study.

Today more than two thirds of Windhoek’s population live in Katutura, one of the city’s most lively districts. Lately the residents have been calling their settlement “Matutura” “the place where we want to live.” The prevalence rate of HIV/AIDS is more than 16% around the capital city and Katutura has been hit the hardest (UNDP 2006:34). I resided different district of Windhoek during my field work and traveled each morning to Katutura.

2.3 People of Katutura

Katutura is a large African “township” located approximately five kilometers northwest of Windhoek’s Central Business District (CBD). Katutura was built in the 1950’s as part of a resettlement programme aimed at removing the African population from the Old Location to Katutura. Katutura was planned as part of the apartheid policy for isolating African people from
white settlements. Resistance by the African population to the forced relocation was fierce and in 1959 resulted in the massacre of many African protesters (Silvester et al 1998:48). Indeed, even the name of the new African township Katutura is a symbol of resistance. It is an Otjiherero word which roughly translates as "we do not want to stay" (Silvester et al 1998:48). Katutura has a population density much higher than the rest of the greater Windhoek area (Frayne 1992). The population of the Greater Windhoek area is estimated to be 200,000 of which 60% reside in Katutura (Tvedten and Mupotola 2006). The average household size for Katutura is 6.7 people compared to the rest of the greater Windhoek area with an average household size of 3.4 people (CSO 2006). About 12% of the household cook without gas or electricity, 17% light their houses without electricity and about 1% has no toilet and no pipe water within a five minute walk of their domicile (CSO 2006). However given the municipality inability to keep up high rates of immigration, shanty houses (informal structures without electricity, water and toilets) have the highest rate of increase in Katutura. It is estimated that between 25,000 to 30,000 people live in informal settlement areas and shanty dwellings in Katutura (Tvedten and Mupotola 2006).
Katutura residents have a socio-economic status which is substantially lower than the rest of the Greater Windhoek area (Frayne 1992). It has a much higher unemployment rate (32%) than the rest of the Greater Windhoek. In addition, the per capita average annual income in Katutura is N$4,300 compared to the rest of the greater Windhoek with an annual per capita income of N$27,000 (CSO 2006).

2.4 Health indicators

In general, the people of Katutura are healthier than those in many of Namibia’s rural areas, however health indicators suggests that they are less healthy than the rest of the greater Windhoek counterparts. The leading cause of adult mortality in Namibia is AIDS. In 2007 the greater Windhoek area had the highest number of new HIV positive cases and the fifth highest prevalence rate (16%) for HIV positive pregnant women for all Namibians (UNDP 2007). Katutura has been “hard hit: by AIDS pandemic:

*We are burying 10-20 people very weekend in Katutura. The cemeteries are filling up. At the Katutura cemetery on the weekend it is chaos because there are so many funeral services at the same time (According to Tom Agnes and AIDS counselor from 2007)*

There are almost no families in Katutura who have not experienced the death of a family member due to AIDS. Already Katutura has many AIDS orphans and AIDS babies (Ministry of Health and Social Services 2007). In addition to its social impact, AIDS is having a significant impact on the state hospitals.

*... the number of HIV related admissions has grown from approximately ten in-patient at any point in time, to over forty at present. We have at least one HIV-related death every 24 hours... (Medical Superintendent of Katutura hospital in UNAIDS 2007: 2 & 17)*

In addition to AIDS, alcohol use and abuse are leading contributing factors to adult morbidity and mortality within Katutura population. A significant proportion of people in Katutura consume alcohol, mostly over a weekends and months end, with expenditure on alcohol taking up a large proportion of household finances (CSO 2006:233).
2.5 Health Care options in Katutura

Katutura is a medically plural community with various medical systems within the same social system. The most important medical systems which co-exist in Katutura are the western formally recognized system.

The western system in Katutura consists of hospitals, community clinics, pharmacies, nurses, doctors, private doctors and a number of clinical staff. Katutura residents have access to the Katutura State Hospital, Windhoek Central Hospital and several community clinics that are all state-run facilities. All residents from Katutura have access to state-run facilities for a fee of N$15 per visit. In addition there is a wide range of private western doctors, two private hospitals and private clinics within the Greater Windhoek for those who have the ability to pay commercial rates for western medical services. (Frayne 1992:6) Only medical practitioners within the western system are recognized by Namibian Law. They enjoy special status and more clearly defined rights than other types of healers (Gilbert et. al. 2006: 50). For example, health insurance will only pay for medical treatment provided by western practitioners, and only western practitioners are allowed to treat patients at hospitals and clinics.

There are many bio medical pharmacies in the greater Windhoek area, which are privately owned. Patients who can afford to pay for medications, but do not want the long wait times at state-run facilities go to the privately owned pharmacies. The pharmacy in Katutura, like most bio medical pharmacies in Windhoek, has a selection of German and Afrikaner (Dutch) folk remedies such as “Lemmon’s Druppels.” Dutch folk remedies came to Namibia primarily through a wave of Afrikaner families (known as the thirstland trekkers) who entered Namibia between 1870 and 1880 and brought with them their medicine and a system of treatment known as “boere raad” (van Dyk 1997:13). These drugs, based on homeopathic medicines and herbs, are now considered folk medicines but, were once prescribed by doctors and considered “scientific” remedies, which demonstrates the historical dynamics of medical systems.

2.6 Traditional health care

In Katutura there is a wide range of traditional medicines and health care offered by a variety of traditional healers. There are Owambo, Herero, Nama and Damara traditional healers who are herbalists, spirit mediums, faith healers, fortune tellers and any combination of thereof. There are also several sangomas from South Africa who are renowned for their ability to deal with
imbalances in social relationships as well as various traditional healers from all over the African continent. (Le Beau 1999).

In addition to the wide variation of types of traditional healers, there is also a traditional herbal pharmacy located in the greater Windhoek area. Although the majority of customers who go to the traditional pharmacy (as it is referred to by many healers in Katutura) are healers, patients can also go to traditional pharmacy and request herbal medicines for a specific range of illnesses such as charms against bad luck and incense to ward off evil spirit (Le Beau 1999).

2.7 Type of study
The nature of my research is problem oriented. I was interested to explore why in the existence of biomedicine, ARV’s do PLWHTV still use traditional medicine as complementary therapy and what is the meaning form them and what are their experiences. All of the data for this study was gathered using on qualitative methodologies.

A small scale study was carried out for six weeks (13 May to 03 July 2008), in the Katutura township in Windhoek, Namibia.

The main challenge of the research was to open a discussion on the use of traditional medicine as complementary therapy with ARVs using an emic perspective. This included asking PLWHTV, who were taking ARVs and simultaneously using complementary therapy, about their feelings, experiences and the meanings of this decision. Some participants did not wanted to disclose their identity, so I had to be sensitive to this request.

In qualitative research, the goal is not to be able to generalize findings to a larger population, but to understand a few cases, the emphasis is on understanding the way others see the world, the meanings they give to it, and the relationship between their ideas and actions” (Craig, Griesel & Witz 1994:162). Qualitative researcher allows for an in-depth understanding of problem and if the research is done properly, it can be generalized to the entire population with greater depth of understanding (Le Beau 1999).
2.8 Research Participants

Procedures for getting permission from participants to take part in the study

Due to the sensitive nature of my topic, I thought that it would be difficult to find informants, especially given the limited time of six weeks in the field. My supervisor advised me to contact local organizations working on a grassroots level with PLWHIV.

Therefore prior to my departure to the field in May 2008 I made contact with an official of the Red Cross, Windhoek, Namibia office and provided an in-depth background of my prospective study.

The only criteria for taking part in the study was that individuals were HIV/AIDS positive and had been on ARV treatment for a period longer than one year. We agreed through e-mail contact that the official would set-up meetings with PLWHIV currently in support groups sponsored by the Red Cross, Namibia. Upon my arrival the official had to leave for an HIV/AIDS conference in Switzerland, but not before handing me over to another official. I was given a list of possible candidates to choose from depending on their availability. The initial contacts were made by the Red Cross official and therefore everyone on the list was aware that I would contact them. Although I had a long list to choose from, the availability and the short period of my research made the list of available candidates much shorter. My first meeting with all PLWHIV took place at the Red Cross building. After the first introduction meeting a second follow up meeting was set-up. A choice was given of an interpreter but all of the participants were proficient in the English. At the follow-up meeting I usually drove to the client and met at a place of convenience to the PLWHIV. Some of the participants preferred to have the interviews outside their house environment and some participants I met in the comfort of their homes.

Participants were fully informed about the purpose of the study and my intention to use the information they provided. In fact, double informed consent was obtained when we met for the second time when I re-explained the purpose of my studies before the signing of consent form and thereafter at the start of each interview. Throughout the interview process I gave the respondent assurance that they had the right to withdraw from the study, after or during the interviews if for any reason they felt uncomfortable. I also assured the informants of their anonymity but they had the choice of my using their real identity. A few participants were public
speakers wanted me to reveal their identity. They were Red Cross Namibia volunteers who spoke at various public places like schools and on World AIDS days. A few of my participants stated clearly to me at the beginning of the interview that they wanted no photos taken or their names be mentioned. All the participants who started out with the interviews continued to the end of except for a few who went into the hospital because of health conditions and those who had to travel to other parts of the country. The first part of the interview was regarded as an introduction. In the field I also realized that you first have to win the trust of PLWHIV to get consent to interview and it took several meetings before I could do some of my interviews.

Only 4/8 interviews with PLWHIV could be used as final data. The other interviews were not completed for various reasons stated. Of the four informants two were male and two were female. All were from different ethnic backgrounds Damara Nama, Oshiwambo and Herero and represented the various ethnic groups in Namibia. Their ages ranged between 25-40 years. Getting people to agree to a second in-depth interview required an effort, some agreed right away but for others it was not so easy. For some I had to make more than four visits before they agreed to be interviewed. The eventual willingness of all the participants was amazing and their eagerness to share their experiences was very helpful to my study.

The second group of people I interviewed was the medical doctors working at the Katutura State hospital in the HIV/AIDS, Symptomatic Sexually Transmitted Infections (STIs) outpatients division. Although it was hard to see them during the day I managed to interview one of the two doctors assisting the patients and one of the two nurses. The biomedical world is very precise and prescriptive in regards to the use of the ARV drugs. The opinion of medical doctors and personnel involved in the dispensing of the pharmaceuticals on traditional medicine as complementary therapy was important component part of this study. Their responses allowed for a broader insight into the meanings of traditional medicine as complementary therapy for PLWHIV. It also helped to explain why or why not PLWHIV patients are reluctant or disclose complementary therapy use. I also interviewed one traditional healer to establish the cost of consultation and the meaning of traditional medicine as complementary therapy to ARVs.
2.9 Data generation

In-depth interviews and Semi-structured observations

The central data collection method used was in-depth interview with a high degree of flexibility: the interviews were semi-structured and flexibility was built in timing and sequence of the questions. In fact the interviews occurred when talking to the informants while waiting for their medications, while preparing and cooking of herbal drinks, picking ‘aloë’ in the field or eating a small meal with them.

Semi-structured, open-ended interview guides were used together with flexible probing for personal experiences from the subjective perspectives of each respondent about complementary medicine. This allowed me to capture natural responses to questions posed to collect in depth information.

While discussions were going on it was possible for me to observe interactions between the respondents and others. This included for example, interactions in their home surroundings, how the respondents organize themselves, and also sitting in the waiting room of the hospital where they received their medications. Observational notes and recordings were made taken and later transcribed. This helped to fill gaps in understanding that may have been left out during in depth interviews and. Follow-up interviews were arranged in most cases to confirm the details made known on a previous occasion.

2.10 Validity and reliability

An important distortion, which can heavily influence the validity of the data, is when the respondent gives answers they think the researcher wants to know and not what the researcher needs to know. The sensitivity of the matter may cause the informants to hide some of the key answers that a researcher requires. To avoid this, I took as much time as possible to introduce the topic properly to informants. In the field the situation does not always allow you to start with interview questions and a natural way of starting the interview was to talk about things in general that would lead as an introduction to the interview questions.

Meeting with the participants regularly ensured a trust and confidential relationship because of the sensitivity of the matter.
2.11 Data Collection and Preliminary Analysis

I started to analyze the data on a day-to-day basis by transcribing the recordings. I had to follow this procedure to enable myself to listen to the gaps in the interviews and to make a follow-up visits.

The tools that were used in this study were a notebook, tape recorder and photos. The purpose of the photos in conjunction with my other methods was to see which complementary therapies are used, as well as identifying the methods of use. The use of a tape recorder ensured that valuable conversations were captured and used to play back interviews if gaps in data were discovered.

Other data collections methods used were a literature review, newspaper articles and material collected from the Namibian Ministry of Health and Social Services, research unit.

2.12 Observations and interactions at Katutura: quite an experience

I made observations of the interactions between the PLWHIV and medical doctors, PLWHIV and nurses, PLWHIV and Red Cross officials helping in the hospital while the PLWHIV’s were waiting in line for the doctors. The medical doctors are seeing more than 300 patients per day. I was wondering while being present during a consultation with a PLWHIV if the doctor had fewer patients if the conversation between the doctor and PLWHIV would have been more in-depth. I observed that the conversation was usually “one way” traffic. The doctor would do all the talking while the patient would listen and just answer yes or no. The doctor would inform the PLWHIV of either an increase in medication or give a reminder of the importance of eating before the tablets are taken. The PLWHIV who I observed with the doctor may have wanted to tell the doctor something but the doctor would write the next appointment and tablet prescription in his admission card silence in the room immediately give the card back to the patient and call another patient. The PLWHIV would then leave the room making space for the next patient. This was in contrast to the traditional healer who I observed who had a dialogue with the patient and asked the patient many questions. A consultation with the traditional healer would take minimum 25 minutes and maximum two hours. My observation with regards to the traditional healer and patient was that the conversation was ranging from psychosocial to spiritual. The patient of the traditional healer would normally have a friend or relative who would accompany him or her. I also observed that the mood of the patient although also being sick would be more relaxed and calm. The conversations of PLWHIV in the line waiting for the doctor would range from death
of fellow friends to the exchange of ideas on nutrients, the latest fashion and gossip around happenings in the township and current news. For example the one PLWHIV was telling another that she was drinking a certain type of milk that she gets from a nearby dairy for a good price and it enabled her and her family to sustain their hunger. Also the exchange of ideas of herbal medicine made at home and where to obtain was discussed. There were also discussions about the help of the medical staff and their moods to determine service for that day and which medical staff was having a good or bad day at the office. When I asked what the ARV tablets meant I was told by the person sitting next to me “its telling me I am going to die”. I then asked why are you picking it up and I was answered just to stay alive a little bit longer for my children.

The analysis was performed manually; coding schemes were developed to understand issues at broader socio-theoretical level. Quotations are selected to exemplify certain situations. Narratives are written extensively to describe the complex experiences and expectations of the PLWHIV, medical doctor and traditional healer. Thick descriptions of the experiences, expectations, stigma, hardships are used as a linked the theory.

2.13 Ethical considerations

I was concerned that it would be difficult to get permission from Ministry of Health and Social Services in Namibia since my research topic was sensitive. However my proposal was welcomed by the Ministry of Health and Social Services, Namibia, because they believed there was a need of a need to conduct such a study in the country. Formal permission was obtained from the Ministry of Social Services, Namibia in order to interview medical staff members under their jurisdiction. Although the study topic is so stigmatized and sensitive, it was not that difficult to find individuals who were willing to participate in this study. The privacy of the participants was respected at all times. Participants were interviewed individually in a location where they felt comfortable or “at home” as one of my participants said. I was interviewed each respondent individually and I was the sole researcher. This research was managed keeping in mind the best interest of the PLWHIV in my country, Namibia, and with the only intention to benefit them.

2.14 Communication Techniques

Individual face-to-face interviews were conducted to solicit the correct and relevant information.
The interviews were conducted in English and Afrikaans and one conversation had to be translated from Herero language into English. English is the formal national language, in Namibia and Afrikaans is my mother tongue therefore there was no problem to understand the conversations and translate them into English.

2.15 Constraints in the Field

From the start of my fieldwork it was clear that the terminology complementary therapy needed a lot of explanation and was not known to any person neither in the medical paternity nor to the PLWHIV and traditional healers. The only terminology known is “traditional medicine”, which is widely used by everyone.

People interviewed had transportation problems and had to be reimbursed for transport and food. PLWHIV experienced hunger and it was explained to me the ARVs makes them hungry. In most case the PLWHIV did not have any food for the day. Since it was not always possible to interview PLWHIV at their homes I had to first find food for some respondents before the interview could start because.

PLWHIV have to pick up their medication (ARV’s) which sometimes takes a full day or two and therefore they had to re-schedule meetings. In addition, public holidays and weekends made meetings impossible. The distances to drive to and from to be interviewed are vast. I often travel more than 100 km per day to get to PLWHIV and traditional healers in the outskirts of town. Some PLWHIV felt sick on the day of the interview and had no strength or energy and so the schedule had to change. For the traditional healer I had to get an interpreter. Doctors and nurses at the hospital were almost impossible to interview because of heavy workload.

2.16 Position of the researcher

When one performs research in their own country it’s difficult to distant yourself from the harsh realities PLWHIV face on a daily basis. To distance yourself from their “worlds” sometimes took a lot of guts and courage. I continuously had to remind myself that I was a researcher and had limitations to what I could and should do for them.

Carrying out research can prove to be a complex process, especially because it involves patience, understanding and dedication.
2.17 Fieldwork in general

In general my fieldwork was a good experience. The fact that I was in my own country made access to various institutions and people very easy in general. Most people were willing to help in any way they could assist. The systems in place for the distribution of ARVs to patients in the Katutura hospital were impressive despite the long waiting times for consultation with doctors and the dispensing of ARVs medication to patients. PLWHIV patients challenged me to go into the veld to collect their herbal medicine and the joy of tasting the “new bitter and sweet” sensations. The traditional healers showed dedication to their patients and their interpretation of HIV/AIDS intrigued me as a researcher. Unfortunately, six weeks was not adequate time for the fieldwork as it took time to win the trust of the PLWHIV as well as the traditional healers. I was forever reminded by PLWHIV and traditional healers of previous researchers who came and abused them by not coming back to talk about the findings etc.

Time management was of the utmost importance because the transcriptions had to be done the same day of the interviews. Nevertheless, research can also be exciting because there is always a possibility of contributing to the creation of knowledge and information. This research can surely be valuable in serving as a stepping-stone for further complementary therapies and HIV related studies.

In conclusion this chapter covered a description of the research design and method employed as well as problems encountered in the process. In addition, issues of validity and reliability are covered.
3.0 CHAPTER THREE: CASE STUDIES - REALITY

At the core of my research findings are my case studies; four PLWHIV using traditional medicine as complementary to ARVs. This chapter presents the analysis and discussion of the findings of the study. It includes an ethnographical account of the reality of the PLWHIV in Katutura, Windhoek Namibia a township with amazing stories. Common themes are extracted to indicate the meaning of complementary therapy for the participants in this study. Furthermore there is a focus on the daily experiences, hardships of PLWHIV, and challenges they face living with stigma. This chapter examines on why they choose traditional medicine as complementary therapy to ARVs, what “pulls and pushes them”, the cost implications, stigma coping strategies and support mechanisms that exist and are used by participants in Katutura. Finally the chapter focuses on the view of the medical doctor and the traditional healer. Each case begins with a short introduction accentuating the meetings with the informants, my first impressions with them, the quality of the conversation and some particular issues about each one.

3.1 Starting Point

“What you get is what you see” is the introduction words of one of my first participants in my study. On my way driving to the Red Cross Namibia the houses drastically change in shapes, colors and structures. As I enter Katutura I enter a “new world” totally different from where I was 45 minutes ago. The quiet is exchanged for buzz and hooting of taxis, people running and stopping taxis without adherence to the traffic rules. More people are on foot than in cars going about their daily routines. The smell of freshly slaughtered meat and small vendors everywhere trying to sell whatever is on display catches my eye; this is Katutura whose name has been changed by the people as “the place where I want to stay” Matutura.
3.2 The Cross
The Red Cross, Namibia sign is visible above all the action and I focus on where to park my car. On my arrival a secretary almost too busy to say welcome greets me. She is surrounded by people all asking at once about the arrival of the new consignment of E-Pap. E-Pap is a maize meal ready to eat cereal distributed by the Red Cross Namibia especially for those PLWHA who need a meal before taking the ARV'S.

3.3 Bomb Shell
Soon an official, coming from nowhere, introduces himself as Mr. Samaria and greets me. A "bomb shell" follows his introduction “I am leaving to Switzerland for a conference but have organized somebody else to help you to get people for your study”. I am told to come back the next day and all the hope and eagerness of getting a head start in my study “vanishes into thin air”. I rush back to my home and safe haven without noticing any of the surroundings.

3.4 Savior
I am hopeful and the next day I am introduced to Eben “the savior” of the day who takes me away from the entire buzz to his office. At first Eben is more interested in the “Red Light District” in Amsterdam, than the purpose of my visit which makes me worry. However, the conversation soon changes and Mr. Samaria gives final greetings on his departure and asks Eben if he could give me the list of possible participants. Eben carefully informs me that the participants’ names and contacts are on the list and all of them are aware of my study and are waiting for my phone call. Eben further explains that most of the participants are public speakers.
trained and used by the Red Cross Namibia to motivate others and to talk at various institutions on the matters of HIV/AIDS and being HIV positive. However he is quick to caution me that they are all very busy and travel on a frequent basis to different parts of the country. He further explains his responsibility at the Red Cross and suggests that we could draw up a schedule to regularly meet each other in order to touch base on the progress with the participants on the list. Looking and listening to him I am amazed by his office, which is very neat and well organized. When the phone rings he is quick to say that cannot attend to the call because he has a student from the Netherlands. He expressed during his whole conversation that I am not on my own and I may contact him at any time. His giving me more than three of his personal contact numbers supports this assurance. After almost three hours of conversation with knocks on the door by other people and the phone calls he hands me the list. With a quick look at the list I am really glad for the contact I previously made and the list of possible participants shows the work already done by my “gatekeepers”. A phone call halts the long conversation with Eben explaining that he needs to rush to Katutura State hospital to see one of the Red Cross officials having a problem. We agree to meet in the afternoon of the same day.

3.5 Sunshine
Walking out of his office makes the beautiful Namibian winter sun (I missed so much) more attractive. The afternoon greets me with eagerness to see my gatekeeper again. Eben explains that he would like all of the participants first to meet me at the Red Cross Namibia building to set up further appointments. The meeting is ended again by a phone call for him to rush to Red Cross officials in the area and I proceed to the Katutura hospital for my next appointment.

3.6 Bee Hive
Entering the gate of the Katutura State Hospital I am greeted by security officials and vendors sitting and trying to catch those entering the hospital building. I make my way to the parking space after almost 30 minutes because I have to wait for an available parking space. The Chief Hospital Superintendent’s office is in the HIV/AIDS and STD unit almost to the back of the hospital. Walking to the unit I am overwhelmed by the number of people almost like bees in a hive; everyone busy going in different directions. I am early for my appointment and upon entering the unit I am greeted by a thousand pair of eyes staring at me. A patient quickly tells me please ‘go there to the reception’. The receptionist greets me while she is busy scratching among
a pile of admission cards and about to announce another name to come forward. I explain to her that I am here to see the Chief Superintendent and she quickly shows me by hand to her office wanting to get rid of me to announce the next patient in line. In front of the Superintendent’s office are long rows of people sitting and waiting looking at a nearby television screen while waiting for the doctor. I am now worried if I will be able to see the Superintendent at all because of the long line of patients.

A Red Cross official quickly greets me and explains that my gatekeeper Eben informed them that I would be coming to the hospital. She is neatly dressed in a uniform and is quick to ask “are you from Namibia?” I am quick to answer and then ask about her function in the unit. She explains to me that they are officials working for the Red Cross who help the Ministry of Health and Social Services with patients who come for HIV/AIDS testing. They basically do the pre-counseling before the test and post-counseling after the test. The vital role of these Red Cross workers is obvious when I observe the paucity of nurses on the unit. She is quick to tell me that she will inform the doctor that I am waiting because she needs to get back to her own office. I feel guilty to be invited into the doctor’s office with all the patients waiting. A young woman with a broad smile greets me and introduces herself as Dr. Beukes the Chief Superintendent of the HIV/AIDS STD unit. She is quick to ask if I have been granted full permission for my study by the Ministry of Health and Social Services. I reply yes. She is quick to say in a polite manner that she has a lot of patients to see too and I succinctly explain the background of my study and how I envision her help. She briefly explains her role and gives me permission to enter her office any time I need her. She explains that she does not know if she will have time to spend with me and that she does not feel well because she is pregnant. But she will refer me to the other doctor in her unit. I leave the hospital with mixed feelings. I am impressed by the staff of the HIV/AIDS and STD unit but also dazzled by the staff/patient ratio, which makes the waiting time for patients more than 8 hours.


3.7 **Holland Flu and Fresh Bath Soap**

I am back at the Red Cross Namibia, over anxious to meet my first participant. I find myself staring at a well-compiled list of names and contact details of PLWHA. My first participant who is asking Eben in Afrikaans “Is dit die vrou” “which means is this the woman I must see” soon interrupts me. He anxiously greets me with a broad smile and handshake and introduces himself as Jarold Nowaseb as he switches to English before sitting next to me. He smells like a person coming from a fire and the smoke left behind on his clothes gives me a quick sneeze. The participant asks, is it the “Holland Flu”? I grab a tissue and explain that I am fine and introduce myself in the presence of the gatekeeper. I explain the purpose of my study to Jarold. He is over eager to start the interview. However I explain the signing of the consent letter and make a follow-up appointment at a place convenient for him. As Jarold leaves the office I am greeted by Roswita Appolus, small fragile female body with a big smile. She is neatly dressed and smells of fresh bath soap. She takes a seat after a warm handshake. I explain the purpose of my study and the consent letter to her. She promptly says that her real name must be used in the interview. I am amazed and ask her why. She replies, “So that others can hear my story and learn from it”. She gave me her home address where I could make a follow-up visit.
3.8 Mr. Gentleman and Miss Modern
I return to the Red Cross, Namibia building to meet my third participant, Venius Rukoro. He is a very self-assured gentleman. He greets me saying that he has limited time because he runs a home for street kids and has public speaking meetings. However he assures me that he is more than willing to help me. I explain the purpose of my study and signing of the consent form. We agree upon follow-up date and meeting place. He quickly rushes off to his appointment.

Participant number four waits outside the office. A young school aged girl enters the office. I am struck by her modern style with earrings, bangles, brightly coloured rings on her fingers and toes. She does not meet my eyes and introduce herself looking out of the window saying, “I am Jutie Kaimu”. I explain the purpose of my study and the signing of the consent letter and we agree on a follow-up meeting at place of convenience.

3.9 Businessman and Mysterious girl
I am back at the Katutura hospital for a meeting with participants numbers five and six. I am told by the Red Cross official that both the participants will come to me individually and that she has an appointment for the afternoon and can use her office. I thank her and the participant number five enters. He smiles and introduces himself as Lazarus Shilongo. He explains that he is a volunteer counselor who makes himself available for a few hours a week to talk to patients who are HIV/AIDS positive. He hands me a business card and says, “I am an entrepreneur and please visit me”. I am amazed by the openness of the participant and am speechless. I explain the purpose of my study and the consent form, which he signs. We then agree to have all follow-up visits at the hospital unless he cannot make it. He tells me that he has a few patients waiting and
leaves the office. I thank him and wait a half hour for my next participant. I finally decide to leave and try to follow-up in the person the next day.

As I exit the hospital a strange girl touches me from behind. She tells me, “Please take this number and phone me tonight” before running away and I have no chance to respond. I am so anxious to make the phone call and to hear from this strange girl. Later that night I call her and the phone is answered by “Regina Titus” (not real name) who asks me, ‘Are you the HIV/AIDS woman”. She explains that she wants to participate in my study but would like to meet me at the hospital so we agree on a time and place. I then gathered that she was participant number six but was not willing to be seen coming to me in the office of the Red Cross official. This intrigues me as I think that now I can tackle the issue of stigma.

The next morning back at Katutura hospital I look eagerly for my “mystery woman” but do not see her. I prepare to meet participants seven and eight. I have the opportunity to meet the participants individually in the same Red Cross official’s office. Upon meeting the next two participants, I explain the purpose of my study, have them sign consent forms and agree on follow-up interviews.

3.10 Slow train to China

I proceed to the medical doctor’s office that was recommended to me by the Superintendent. It seems forever before I can find the doctor and so I made use of this opportunity to talk to the patients waiting in line. In general, the patients were not in a mood to talk because of long waiting periods. One by one they passed me until a few remained. I managed to have very interesting conversations with the patients in line and they asked me questions. (I have a short outline of these conversations in the interview section.) I waited for five hours before the doctor’s face eventually popped out of the office and he came to greet me. He is a young bright Namibian doctor and eager to talk despite having so many patients for the day. He invited me into his office (Conversation in the interview section).

In conclusion all eight participants could not participate in follow-up interviews due to reasons ranging from traveling to other parts of the country to seeing traditional healers, having ill health and business and sometimes other commitments. Only one of the two medical doctors and one nurse had time to be interviewed and one traditional healer was interviewed.
3.11 Interviews

Interviews with participants, medical doctor and traditional healer:

Interview with participants:

**Mysterious Women “Regina Titus”**

It’s a sunny day in the capital city of Windhoek, I travel for half an hour to meet the mysterious girl where she stays. She waits for me outside and takes me to the back of a house where she is renting a room.

This is her story

Researcher: Thank you for inviting me to your place. Previously you agreed to an interview on the following basis

1. Not to use your real name
2. Not to mention where you come from
3. No photos to be taken

Participant: Yes, you are right and I am “dead serious”.

R: Why are you so secretive: Well (laughing) I still want to live and not to be killed because of AIDS, but let me tell you my story. I was a youngster of 18 years old when the blood transfusion came to my town. I was so interested and then decided to go and give blood. It was okay I was very nauseous and wanted to vomit when I saw the blood running in a bag. Well I went home and went to sleep. A month or two I cannot remember I came home from school and my mother poured “lampolie” lantern oil on me. I first thought it was a joke but she told me to pack my bags and to leave the house because the nurse told her I have AIDS. I was shocked, crying, “deurmekaar” confused but had to leave by force. I had to leave town. Do you have an idea what it is to leave your home and town? (participant starts to cry)

R: Must we stop the interview for another day? (while giving a tissue to dry the tears)

P: By showing of hand indicating that I must just wait a few minutes

R: Gives some water from the nearby tap in room

P: I had no money, no place to stay nothing, nothing nothing

R: I walked for hours and went to sit at the nearby “vulstasie” (gas station) before taking a lift with a truck driver to Windhoek.

P: Within 30 or 40 kilometers of our journey the truck driver pulled over and said he wants sex. It was terrible the same day everything happening so quickly. The truck driver forced him on me and after having sex with me threw me out of the truck with N$20 dollars. I eventually got to Windhoek hungry, tired two days after the happenings with the local ambulance.

R: What happened in Windhoek

P: I still remember that during our church’s youth visit to Windhoek that we stayed at a place where I a “father of a church”(priests) who told us as a group that if we need anything we could come to him. For almost two days I walked around trying to find this place because I was so confused. I then got the church and the priest was on his way to a nearby town. He took time to listen to my story and decided to leave his appointment and first take me to a nearby clinic. The “father” priest first asked me to remain outside the clinic and after 30 minutes came to fetch me. I was taken to a “sister” nurse who asked me all kinds of questions until she asked me to undress. I felt bad standing naked in front of this woman and wanted to run away. After she examined me she took some blood and said I must come back to her and wrote the date on a small piece of paper. The father (priest) was waiting outside and told me that he had no place for me to stay but will take me to another place where I could stay until I find a work. I was taken to a place where women stayed who was beaten up by their husbands.

R: A women’s shelter and how long did you stay there

Page 38 of 81
P: Almost for a month
R: How was your stay and did you go back to clinic for the blood test results?
P: It was okay and I had to tell my story to a (sielkundige) psychologist who sent me to another clinic for more test. What was funny (laughing) is that I knew nothing about HIV/AIDS and at this clinic the person said that she first want to tell me about HIV/AIDS. She further asked me if I want to take a blood test and I could come back to hear the results. Everything became clear to me why my mother wanted me out of the house and what HIV/AIDS was. I was too scared to tell her what happened at home and agreed to take the test. The (sielkundige) psychology at the place where I stayed (shelter) explained to me again about HIV/AIDS. The next week I received the test confirming that I was HIV/AIDS positive.
R: How did you feel?
P: Very very painful, hurting, hurting, hurting.
R: From there what then?
P: I was lucky to get a job at a local hospital and I then had to move to this place where I am still staying up to now.
R: Have you heard or seen your family?
P: It has been 15 years I only once saw my cousin who I tried to speak to but he ran away. I am glad God is looking after me and I have forgiven my mother for what she has done.
R: We have spoken so much may I still continue?
P: Yes, yes do you want some tea?
R: Sure it would be nice.
R: Do you use any medication for the HIV?
P: Yes, I got very very sick five years ago and was told by somebody at the hospital to take another blood test. After that I was told to go on the ARV medication.
R: Do you use any other medication than the ARVs?
P: No, but I sometimes get nausea and vomit of the tablets because they stuck in my throat and then take “boegoe” herb which is in a veld nearby.
R: Does it help for the nausea and vomiting?
P: Yes, and it helps to clean my system or my stomach I will show you one day where I get it and how I make it. Look! Look! she says anxiously this is the dry one and this is how it looks referring to the cup I am holding in my hand.
R: Where did you hear about his “boegoe”?
P: My mother used to give it to us when we felt nausea and vomited.
R: Did you tell your doctor?
P: No, no the doctor told me not to use any tablets or other stuff with the ARV.
R: But why are you using the herbs?
P: (Shaking her shoulders) It makes me feel good and better. I also think it helps me cope with my moods, frustration “of stress” or stress otherwise I cannot go to work and if people should find out I do not know what I will do.
R: Do you think that ARV is not good?
P: No, it is good but not good enough for everything and sometimes I get fed up with it because I have to drink it everyday and the “boegoe” helps for me.
R: Could I drink some to taste?
P: Sure be my guest.
R: (Pulling face) very bitter
P: Laughing!! but good for me
R: Will you take me to the veld nearby and show me (not today but on another day)
P: Yes, sure just tell me when
R: Are you afraid to take your ARV in front of other people?
P: Laughing!! Of course I always take them at home and that is why I stay alone
R: Why?
P: People will immediately know I am HIV positive
R: And the "boegoe"
P: No if my friends come here and it stands on the table they say do you have "kakmaag" (running stomach) then I will say I am using it because I am on a diet. Well everyone uses it these days to clean their stomach for diet. (Laughing laughing.............
R: Let me then try this for my diet............... Laughing Laughing
R: When you would get sick how would you be able to manage on your own?
P: I do not know. "I will cross that bridge when I come there"
R: Have you tried to join a support group?
P: What do you mean?
R: A group where only HIV positive people get together
P: No I have not thought about that
R: Why not?
P: I am always afraid that people will recognize me in the street and say I am positive. There was once a relative of mine in the disco I was very glad to see him. When he saw me he shouted "you have AIDS" luckily the music was too loud and nobody could hear him. He was also drunk. I then run out of the disco
R: You know it is not easy for me to tell you what to do but the best is to join a support group and ask how people who are also HIV positive handles maybe the same experience and learn from that. I could give you some names of organizations
P: No no there are a few which I know about
R: Is there anything you would like to ask me
P: How is it to study in the Netherlands. Please take me with you
R: Laughing no it's good and I have grown and learned a lot. However I need to come back and work here and live out my passion in the field of HIV/AIDS and try to help.

In conclusion: the next time I meet with Regina is on Saturday morning again at her house but walking to another part at the back of the house where there is an open space of land with grass and trees where she picks the "boegoe" carefully. She washes it when we get home and cooks it in a pot. She then strains the herbs and water separately and throws the herbs away. It is evident that she knows the herbs because there are so many but she picks a specific one. She ends off by drinking a glass of "boegoe" (saying can you see?) it's free and it works for me!!!
P: I am glad that I could be of help
R: Why did you agree to participate in my study?
P: I am always interested in HIV/AIDS matters and am not ashamed of being myself
R: What made you so bold and not afraid about what others will say?
P: I lost my husband, a baby, a brother and sister to HIV/AIDS. I lost everything but I have God. I think people cannot face God and that is why people cannot speak out and forgive themselves for HIV/AIDS. I once told my story to my psychologist who recommended me to become a public speaker. When I travel to the different places I meet people who are also HIV positive and I can encourage them and they encourage me. I also get extra money to help me pay water and electric bills. I speak everywhere in schools, churches, public meetings and it is through God that gives me the strength. People are amazed what God did for me and what God can do for them. Do you believe in God?
R: Yes indeed
P: Then we can talk together. I cannot talk to people that does not fear God
R: How long have you been on the ARVs?
P: Since the death of my husband two years ago, I got very sick and then the hospital recommended me to go on the ARVs
R: Is it helping?
P: …… Thinking …….. ahh yes but not really
R: What do you mean explain to me please?
P: We could talk until next year but let me say ARV is just to keep me going but my faith in God is really what helps. I had problems swallowing the ARV, nausea, headaches, fever and since I met God He helped me
R: Do you use any other medicine?
P: What do you mean?
R: Besides the ARV do you use complementary medicine?
P: ……. ahh what is that!!
R: For example herbs or traditional medicine
P: Now I understand, yes of course I use herbs although my doctor said it would not help
R: Did you tell your doctor?
P: Yes, I told him and he does not believe me although I took him the dried product
R: The doctor first thought I got it from a traditional healer and then I told him I go to my aunt's farm and bring it from there, everytime when I go to the doctor he asks me about the aloe vera plant but just shakes his head
R: So you combine ARV, prayers and aloe?
P: Yes because God gives me the strength to take aloe from nature. I cannot really rely on ARV as I said I have a problem to swallow the tablets, nausea and headaches. The ARV “is a gift” its is poison and to take it everyday I am praying that God release me from taking the tablets because it gives me stress and just using his natural product help to get away with the stress to look after my grandmother.
R: Have you tried leaving the ARV and just living on prayers and aloe?
P: It is impossible I tried only the aloe and prayer and as I said got sick so I must take all three. I feel with the ARV “eek gaa11 dood” I am dying because of taking tablets everyday of my life and the day I do not take I die. With the aloe and prayer I am not forced to drink it everyday and I feel good and happy if I take it and the doctor everyday tells me of death if I do not take the medication
R: How did you come to know about the aloe product?
P: Ah you people forget where you come from if you go to these nice schools. My grandfather and his father used to give it to us
when we felt sick and HIV is just another sickness just like the others you could also die from Aloe is natural, it comes from Gods earth and it is not mixed with all the rubbish of ARV which we only see in a tablet.

Conclusion Roswita spoke for hours more about her faith and even made me some aloe juice to drink. Its her faith that keeps her going together with the “natuuraike plant van God” Natural plant from God Aloe Vera and that keep her away from her fear of dying because she associates the ARV medication with a death penalty or as she said in Afrikaans the “doodstaf”.

Mr. Gentleman

I meet Venius Rukoro this time in a total different atmosphere where he is very relaxed and waiting for me at the gate of the shelter for homeless boys which he is in charge of.

R: I thank him for his time and enter his office, a “safe haven” as he calls it.

P: Thank you for coming here to meet me in my safe haven.

R: You are a very busy man how did it all start?

P: Let me tell you a little bit of myself I was on the street kid myself running from one place to another and staying in one to the other hole for safety. Life was not that easy I must tell you.... (laughing laughing and clapping hands together) “Girl I tell you it was weird, hard but I, Venius Rukoro survived. Look at where I am today. They say out there I have no life being HIV/AIDS positive but they are lying I am alive!!!(clapping of hands)... As I said not easy. I stayed with a religious family who took me in and gave me shelter. I went to school but fell sick. I was admitted to hospital and was eventually told that I was HIV positive. That was the start of my nightmare...girl I am telling you..... I was told in the hospital to tell the people with whom I am living about HIV status. In order for them to support me. After a long fight with myself I decided to tell the Pastor and his wife on a Sunday morning about my status. They were shocked and told me that they also have children and I have to leave their home.

R: What then?

P: No I am a tough cookie” while I was in the hospital I was counseled by a positive speaker who told me that they need more speakers to “spread the message of goodwill” meaning persons who are willing to share their stories with the public. Well on that stage I had nothing to lose because I already lost everything My God!!!!!! Tell me........girl .........I was without a house, bed everything just me!! I was laughed at by my fellow streetboys and they said they knew I would return and I could not deal with that no!! no!!no ways!!!! I then contacted the positive speaker person by going back to the hospital and then my life started again. I speak everywhere and I meet a lot of good people. I also get some money to help me with my daily life.

R: When did you start with the ARV treatment?

P: Four years ago I fell sick and after I was admitted they told me to go on this “Life to hell” Oh my there are many names for this tablets and I hate it!!!

R: Why so strong with hate?

P: Girl let me ask you would you like to do something for the rest of your life be and reminded and if you do not you die!!! If I drink the tablets it death sentence written all over!!! Look here I am glad that I am even alive but these tablets is not attractive looks ugly and nothing nice!!! Give me stress for just looking at it.

R: Do you use any complementary medicine to ARV and does it help to cope with stress?

P: Girl I do not understand you people to use such words because you went to school longer than me!!!! Laughing , Laughing....

R: Sorry sorry let me explain what I mean. Beside the ARV tablets do you still use any other herb or traditional medicine?

P: Now you talk girl I clearly follow you. Now let me explain. In order for me not to die I need to use the ARV right but I hate it
so I need to get to my “roots” girl

R: What do you mean get back to your roots?

P: I grew up with a “door dokter” in other words traditional healer and I went to one to ask what’s wrong with me, what happened to me. I got a better answer than the doctor that wanted to hear if I have slept around and how I got HIV. I told the doctor that he must go....... himself sorry for my language because he does not know me...

R: What did the traditional healer say?

P: I never told him my real sickness but just looking at me he said that there was something wrong he further told me I must tell him where it hurts the most in my body and he examined me he further looked at my hospital card and said that “is not my world” and gave me a mixture of power and ever since I drink it I feel better and it definitely help with my mood swings and stress

R: Do you know what is in the mixture?

P: Must all be good things like herbs and oh I forgot the traditional healer told me it mixture from the veld and I feel better. He also gave me some stones let me show you to protect myself against the enemy and I am keeping it with me.

R: Who is the enemy?

P: Anyone even you girl..... Laughing....

R: How much do you pay the traditional healer?

P: N$100 namibian dollars but all worth while

R: Where do you get the money if you do not have a stable income

P: Sometimes on credit or I lend or I pay with money I get here and there

R: The ARVs is almost free and you pay so much for the traditional healer?

P: Free but it is rubbish its killing me. Nasty to swallow and “death sentence” written all over my face, but with the medicine of the traditional healer much better and it help kill my constant “kopsee, maagwerk en naaghcid”- headaches, running stomach and nausea. The traditional healer does not tell me about death he talks about life and me as a person and how I could live

R: Is there something you would like to ask me

P: How old are you?

R: Forty years old why?

P: No you look good like a young girl

R: Thanks for the compliment anything else

P: How long will you still stay in Holland and when will you come back?

R: Until the middle of August and then I will come back to my home and family

Constantius Meyer

I am amazed to find the Police car outside the address of my participant. Being worried I question myself if it is indeed the proper address given. No place to park the car because of no demarcation or pavement I decide to park my car a little bit away from the address and walk back to the house. A bystander informs me that the guy inside tried to commit suicide and the police are here to investigate. On confirmation I am told that it is my participant. Not sure if I should enter or not a police officer approach me. The police officer is under the impression that I am a social worker who they had phoned for assistance. Even before I could answer him he asks me to follow him into the house. The person I see is totally different from the person I saw the day at the hospital for our first meeting. I see a broken hearted, confused person surrounded by so many strangers. I confirm to the police that I am not the social worker but it seems he does not listen and after a phone call leaves to another urgent matter. I am left with Constantius
and two elderly people. I am confused talking to the elderly person. I am informed that Constantius tried to hang himself and the police took the rope. The reason for him wanting to do such a thing is not known. I asked if he should not be taken to hospital and is told that he is not dead and the hospital is full of sick people and he is not sick. Everyone seems to disappear one by one leaving me behind.

Finally I have the chance to talk to him. He looks tired but smiles when I sit next to him. I offer him some water that I had in my bag, which he eagerly drinks. I then offer to take him to the hospital and he refuses. I then feel that I cannot leave him alone and ask him if he would like to eat something. He replies that he has not eaten and needs to take his ARVs. I carry a lunchbox in my bag and give him my lunchbox, from which he immediately starts to eat from. After a long silence Constantius gives my lunchbox back saying, “you saved my life”.

R: I could come back another day for the interview
P: No no do not go I want to talk to you
R: Are you sure?
P: Yes, yes I am sure I need someone to talk to. They think I am crazy but what have I to live for? The person who I am renting the house from has just put me out of this place, where will I go? I have no work to get income and even no food it’s crazy. I am HIV positive and this ‘shut” (referring to the ARV) I have to drink everyday
R: Do you belong to a support group?
P: Yes, but I have not been there
R: Why not?
P: Sometimes it is good and other times it is a little “verstord”- frustrated with all the complains of all of us and our sorrows of not having work, food. But it is also good sometimes because people share information of jobs and also warns you about public place where HIV people are discriminated against and must stay away from.
R: How long have you been using the ARVs?
P: I started the ARV two years ago after I got sick, but ever since I started to drink this “shut” ARVs whatever I need more food and everything!!
R: Are you okay do you need more water?
P: No, I am fine still have water in this bottle. I just mean the government gives you this stuff but wants to kill you more
R: Why do you not go to Red Cross and get some E-Pap?
P: The food is there but look where I am staying more than 30 km away from Red Cross by the time I get there the E-Pap is finished and I am dead
R: Is there any other way you could get some food?
P: The only way I feel better is when I drink the aloe
R: What do you mean the Aloe?
P: Just look outside the door. Do you see all the plants on that mountain that is Aloe, I go there cut off and drink the juice and the rest I make dry and eat
R: How long does it take to get dry?
P: It takes two to three weeks
R: How better does it make you feel, does it make you full or what?
P: No it does not make me full but it cleans my system and I do not know but I get a lot of headaches and I feel if I drink it gives me energy to walk and to do things. The other issue is I get depressed easily and Aloe helps with that so that I can think clear again..............
R: Do you use the aloe with the ARVs?
P: Yes, at the beginning the tablets was hard to swallow and a friend of mine who are also HIV told me to drink Aloe
R: Did you tell the doctor?
P: No, I cannot tell they said that we must not drink any “nonsense” with ARVs but they do not live here and they do not have HIV. I also know aloe because I grew up with it and my grandmother made it for us when our stomach was not well. Why I did not think of it I do not know?
R: Have you tried only to drink the Aloe without ARVs?
P: No I did not try the one without the other because the ARVs I drink and the aloe is also part of my life so its here and it is free so why also not use it everyday
R: Could we go into the veld on another day and you show me how to cut it?
P: Yes
We are interrupted by the social worker and I make a follow-up appointment with Constantius and leave
When I returned to Constantius for the follow-up visit he looked much better. He took me into the veld and we had a lovely time and took beautiful pictures. The good news was that he got a job at a nearby hair salon, which would provide him an income.

In conclusion the effects that HIV, as an illness, has on the person’s body is significant. Further the effect on the mind, body and soul is even more. People’s circumstances of poverty and not having a stable income make matters worse and the struggle to survive is a challenge. Performing research in your own country makes you realize the poverty, anger and frustration that people endure. I was just the researcher and wish I could do more. (Appendix 3: PHOTOS VAN ALOE 1 - 3)

Interview with medical doctor:

I meet with Dr Cooper a very young modern Namibian doctor currently working in the HIV/AIDS STD unit, Katutura State Hospital. We have agreed that we meet on a Friday afternoon when the heavy load of patients are gone.

Interview
R: Thank you once again for taking time from your busy schedule to do the interview
D: Not to mention (however I do not know if I could be of any help) but its okay
R: How long have you been a medical practitioner?
D: For the past three years
R: How many patients do you see per day?
D: It depends on the day. On a Monday we are normally very busy and between myself and the other doctor more than 300 patients
R: Do you enjoy what you are doing?
D: Yes, indeed I am very interested in HIV/AIDS STD matters and also learn a lot from my patients everyday I would like to go and do more research on these matters
R: What do you know about complementary medicine?
D: Well well ahah... let me think only from a medical term you tell me
R: (Laughing) well doctor you are the expert in medicine however I look at complementary as additional or as a supplement to the ARV
D: Okay... okay and now
R: Does your ARV patients tell you about any complementary medicine as I explained to you now that they are using
D: Well we discourage our patients to use any other medicine besides the ARV and we also tell them that the ARV has a combination of vitamins that helps for their immune system. However patients sometimes comes and show us these ‘Aloe Vera products etc and we look at it and advise them accordingly.
R: Is it the Aloe Vera fresh or in a package form?

D: No! In a package form. On the other hand patients do not come and tell us what they use until they are about to die and the family will show us herbs etc mixed by the traditional healer that are supposed to be a cure. You know these traditional healers just wants money and are cheating people out of money they do not have.

R: Did you ever try to consult with a traditional healer about what they do mix?

D: Laughing...........

R: What’s so funny?

D: No. to be serious but I think we need to think about it for the future

R: Why for the future and not now?

D: Well, you have a point but who will see to patients if I consult a traditional doctor, maybe the Ministry of Health and Social Service etc. On the other hand I am from this country and I grew up with all the herbs that you can imagine growing on a farm. I firmly believe that there are ones that could help but it must be tested.

I ended the discussion with a very dedicated young doctor but also being tired after a day's work. I can conclude that he firmly speaks from a bio-medical perspective.

Interview with traditional healer:

**Onyana-Yongwe – Herero name for – Nail of a tiger**

It was definitely not in my initial proposal to see a traditional healer but it came up numerous times in the interviews with my participants that the traditional healer plays a vital role in their lives. I have never been to a traditional healer and get a contact through a well known Canadian Medical Anthropologist who previously did her research in Namibia. I am not that familiar with the area and got lost. I phone the traditional healer who informs me to wait for him at a certain point and he will get me soon.

While I am waiting so many things goes through my mind. The interviews of my participants and what I will ask the healer. As I look in my rear mirror I see a old man approaching my car dressed neatly and he knocks at my window.

T: I am the traditional healer you cannot find what do you want from me?

R: I smile and get out of my car to greet and introduce myself

T: You young people only needs us when you are in trouble

R: I am sorry for not finding your place (opens the door for him to get in at the passenger side)

T: Just turn left and right again you see here is my house

R: Thank you

T: This is my place let go to my “spreekkamer” consultation room and you tell me what you want

R: Thanks for allowing me into your house and thanks for your time I am grateful

T: Okay, tell me what you want

R: I am a student looking at what other medicine besides ARVs the PLWHA is using and what it means

T: So you want to see my medicine

R: Yes but I am specific looking at the medicine that you give to people that come to you that are HIV positive

T: My child let me tell you people do not come here and tell me they have HIV.

R: What do they tell?

P: They say something is wrong and when I ask what is wrong they do not say

R: Then how do you realize of what sickness they suffer?
T: My child you have to listen to what people are saying and not just examine and you have to listen carefully. They will start off by saying that they got up one morning and they were sick. I will then ask did you have an argument with somebody and then they will reply or not. From there we look at different things that could cause the sickness.

R: Different things like what?

T: Starting with the family, work matters, Christian of God matters and see what could cause it

R: Let me then ask you do you have different medication for different sicknesses?

T: Laughing yes of course does your doctor give the same medicine for your toes that are sore and for your lips that are swollen.

R: Laughing now I understand. Could you tell me how you determine what medicine to give.

T: Let me tell you some people come straight from the hospital and they have their admission card and they then give it to me to look. I then read and look. Another thing I do not want my patients to die of the medicine I give. If in some cases I see I cannot help I tell them to go back to their doctor again. Yes people can bring you into trouble and sometimes blame the traditional healer and I do not want that. I am now a traditional healer for more than 30years and I do not want anything to happen. To tell you this thing of HIV is not just HIV. I know that people say we cannot cure but many people said they feel better with my medicine.

R: Do you mean that you have a cure?

T: My child people say they feel much better and do not get sick and they even get more children that are healthy

R: That is good but do those who are HIV tell you that they are on the ARVs?

T: What is ARV I know that tablets. My patients are saying it kills them and they come to me for my mixture to feel better. Let me show you this is what I have mixed for HIV. (Traditional healer gets up and goes to a cupboard to fetch the mixture)

R: What is in this mixture?

T: Its my secret but its all herbs that we all know, but people make stories to say there are other things in like bones of babies etc no I do not go that way. I believe in God and that is why you see the Holy Bible open. I use the Holy Bible and herbs to help my patients and not other funny things people believe traditional healers use.

R: Why is it then a secret?

T: Laughing you know if you know something that works will you tell it to the whole world if the whole world is not prepared to give you something back. You know here in Namibia people thinks they know everything of the medicine and say we just fraud people. They make a lot of money. Look at the cars they drive and the houses they have. We do not want terrible things to their patients but we do not tell terrible things to our patients about them we just help our people. I once went with somebody to a doctor in town we were not even in his office for ten minutes then he called in another patient without listening what the patient really wanted to say. Medical doctors know how to get money from people and we do not care. I tell you sometimes my patients do not have money and I simply tell them to pay when they have money. But a medical doctor if a patient do not have money then you die. I tell you die. Do you see my house if I had a lot of money from my patients would I live like this. You can also see patients waiting for me outside but I do not tell them to go away if they do not have money. Another thing is I will show them my herbs and where I get it but they will go to a place to put it in a packet and forget about me. It happened already with many other traditional healers. Namibia must first give us recognition for what we are doing and then HIV will go away.

R: How do you mean go away?

T: As I said my child I may or may not have a secret and if it works then what. It is not just the ARVs or what ever you call it I have medicine that can make people healthy but they say we cannot prove it. If we get help then we can work together with that ARV people. I treat the patients mind and everything. This is a whole body and you cannot cut up the body and say that one goes there for treatment and that one goes there. No it is impossible you must treat everything together as one body.
3.12 Findings and discussions

3.12.1 The use of complementary therapies

Traditional medicine as complementary therapy used simultaneously with ARVs can be understood as treatment practice used by people to manage living with HIV and construct a sense of normalcy in their daily lives. By normalcy, normalization, or normal, I mean the internalization of self-images of someone who can fulfill their social roles without experiencing impairment or discrimination because of their health status. This is clearly seen in the case study of Regina Titus when she hides her ARV medication from her friends but if asked by friends about the herbs she explains that they are for diet purposes; something that is known by her friends as a normal explanation. Regina also states that she uses the herbs so she can be seen as healthy in her work situation and not be known to be HIV positive.

All of the participants reported using traditional medicine as complementary therapies to manage health complications, especially side effects of ARVs and also as a way to maintain good health. The participants reported that the traditional medicine helped to clean their systems and to address, nausea, fever and headaches. For these respondents psychological reasons for using traditional medicine were equally important. Many reported using traditional medicine as complementary therapies because it helped them effectively cope with emotional problems and stress. Most respondents indicated that it helped with mood swings and the use made them feel happy. These therapies also offer strategies for self regulated treatment practices to allow PLWHIV to evaluate their disease progression, gain freedom from medical constraints, and manage stigma. These meanings reveal the push and pull factors, people with HIV, use when incorporating traditional medicine in an effort to normalize their lives.

The respondents use of terms such as “death sentence” and, “rubbish” for their ARVs helped the participants to cope with the ARV treatment. Although users reported using more than one kind of strategy like Roswita with prayer, for clarity purposes, I will discuss each strategy separately.
Managing symptoms, medications and emotions

The participants in this study often spoke of how they used traditional medicine as complementary therapy for physical relief and to manage the emotional effects of living with HIV. Receiving an HIV positive diagnosis means having to cope with uncertainties of living with a life threatening disease and a variety of family, financial, relationship, legal and work related concerns (Pawluch et al. 2000, Weitz 1991; Siegel and Kraus 1991). This is clearly indicated in the case of Constantius Meyer. He does not have a job, life is tough to handle, and he has financial constrains etc. Regina was thrown out by her mother and alienated for 15 years because of the disease. Venecius was put out of the house of the pastor and his wife and had to go and look for other accommodation. The stress of living with HIV can profoundly affect emotional states and increase feelings of anxiety and depression and Constantius’ desire to commit suicide is a profound indication of this phenomenon. Can PLWHA use traditional medicine as complementary therapies as a strategy to reduce the physical and emotional uncertainties of their illness?

The people in these case studies reported experiencing side effects from their ARV medication ranging from nausea, diarrhea, difficulty swallowing the tablets, vomiting and headaches. Instead of abandoning standard care altogether, they found practical ways to continue the use of ARV medication through the additional use of herbs either by going to the veld or getting it from the traditional healer. Roswita also mentioned that she finds the complementary medicine she uses to be “coming from the earth” or being “natural” and that they give her a “chemical balance”.

Respondents such as Roswita also tell the doctor of their experience in an effort to educate health providers that traditional medicine as complementary therapy is another option. However, because physicians in Namibia do not regard traditional medicine as scientifically tested or proven her efforts proved to be fruitless. Would the sharing of knowledge in both directions be beneficial? Then we would not have just a “one way traffic” where the physicians regard ARVs as the only relief for HIV and do not allow any conversation about complementary therapies.

Would this change the thinking of the lifelong burden of ARVs?

All participants saw that adherence to ARVs medication was important. However it is quite surprising that the experiences of the participants in most cases of ARVs are not so positive perhaps due to the side effects and the burden of having to drink the ARVs everyday. All of the
participants indicated that they managed to use the standard medication and the traditional as complementary therapy. They stated that they already tried to use the one without the other and it did not work. Regina remarks that the ARV is good but not good for everything and it was echoed by Roswita who said that she tried using prayer and aloe alone but it did not work out.

Using traditional medicine as complementary therapies to manage symptoms and side effects enabled PLWHIV users to maintain normal social roles. For example Regina stated that the complementary medicine helped with her diarrhea and she could maintain a normal life at work. People would not suspect her of having HIV and she could escape stigma. Complementary therapy offered PLWHIV a practical way to manage their illnesses so they can, as in Regina’s case, not be absent from work or be constantly sick in the working place raising some suspicion. In this way PLWHIV can manage their employment roles better.

PLWHIV with serious disease such as HIV/AIDS can evaluate the severity of their disease for themselves by reducing or stopping their medications (Conrad 1985). Large variations exist in the progression from HIV diagnosis to AIDS. If left untreated, some people progress relatively quickly within two to three years from the initial exposure to HIV. In most of the case studies presented it was reported that after the PLWHIV were diagnosed with the HIV they felt sick. In most cases the participants were hospitalized and advised to go on ARV treatment. With the start of the ARV treatment most of the participants had side effects and then resorted to traditional medicine as complementary therapy either referred to by a friend as in the case of Constatius or on their own as Regina did who takes “boegoe” previously known to her from her tradition.

3.12.3 Freedom from medical constraints

Illness is often upsetting because it is experienced as disrupting the order and meaning by which people make sense of their lives. This was evident in the case study of Regina with her mother’s discovery of her HIV positive status and consequently almost burning her out. Disease inflicts uncertainty, unpredictability and loss of control. There can be shortness of breath or memory, intermittent pain, fatigue, organ deterioration, and all other failures of a sick body (Frank 1991). For PLWHIV this loss of control often means increasing interactions with medical providers, and taking highly regimented medications, which can lead to profound loss of freedom and dependence on others (Siegel and Krauss 1991). Can complementary therapies reduce feelings of
medical dependency and constraint? Issues of control over one’s illness and treatment decisions were also cited as important reasons for using complementary therapies in the case studies. Participants with feelings of medical dependency said they felt that ARV is “rubbish”, “death sentence”, “poison”, all terms expressing their anger and resentment with the ARV medication. However, it was remarkable that none of the participants stopped the ARV medication and everyone continued. Maintaining personal control over treatments is important to people with HIV. This means what to use and when to stop, start, or change therapies. The expression of taking the ARVs as heard by the respondents is that they have to take it everyday. However, when asked about the traditional medicine as complementary therapy it was discovered that they had more flexibility in the intake of traditional medicine as complementary therapy, and did not mention feeling any risk as they were under no pressure. The one doctor who I spoke with believed there was no basis for complementary therapies because it is not scientific based. The autonomy of doctors in Namibia who are telling patients not to use any other medicine then the ARVs was evident. However, one doctor, Dr. Cooper grew up with traditional medicine and told me he would like to learn about this kind of medicine but has not time. These cases all demonstrated that the participants made choices outside of the autonomy of the doctors taking personal responsibility for their lives and decreasing their dependency on the medical system and maybe leading to therapy failure.

3.12.4 Stigma management strategies

Goffman (1963:13) defines stigma as "an attribute that is deeply discrediting" with the power to reduce individuals from being "normal" to "deviant" due to the negative connotations attached to it. Goffman describes stigma as "special kind of relationship between attributes and stereotypes" (1963:14) and points out that the social identity of individuals can be distorted for others as well as for the individuals themselves. As Goffman points out, when stigmatizing attributes are not visible or known to others, the issue for the individual then becomes how to control or manage information about their situation. HIV stigma stems from fear as well as associations of AIDS with sex, disease and death and with behaviors that may be illegal forbidden nor taboo, such as pre- and extramarital sex, sex work, sex with men and injecting drug use.

There is a substantially intolerant attitude towards AIDS and HIV positive patients in Namibia. Research conducted on individual attitudes, perceptions and behaviors related to HIV and AIDS
in the country showed a strong prevalence of cultural perceptions. As a result of these beliefs, people infected with HIV and AIDS were and are still physically and socially ostracized and discriminated against, and some have even been killed (Haihambo, 2005). This can be seen in the case of Regina Titus where her mother tried to set her on fire after the discovery of her being HIV positive. She had to flee and after 15 years has not made contact with any of her relatives.

People with stigmatized illnesses often attempt to control information about their illnesses to minimize the effects of stigma (Conrad, 1985, Weitz, 1991). Taking medication can compromise information control, create physical symptoms in the presence of others, and compound already being a member of a stigmatized group. This was clearly evident in one of the presented cases. Regina would hide her ARV medication from her friends and hide the reason for drinking the herbs and substituting an explanation that was known and acceptable to everybody.

People may try to avoid others when they are ill, take their medications in private, or tell others they have a less stigmatized illness. Can people use complementary therapies to manage disease information as a way to minimize the effects of AIDS stigma? Managing AIDS stigma is another reason for using traditional medicine as complementary therapies. Traditional medicine as complementary therapies could be used as part of a strategy to hide one’s HIV status from other people. Taking ARVs is a constant reminder that respondents had HIV. Medication use acknowledges the difference between well bodies and sick bodies and symbolizes a deviance from normal body control. This health strategy helps to avoid occupying the status of HIV positive (and some stigmatized statuses) in the presence of others. By maintaining wellbeing, whether perceived or actual, complementary therapies help to minimize the stigma of AIDS.

Traditional medicine as complementary therapies also helps participants to manage stigma by reducing the “shock value” of HIV/AIDS. It does this by resisting terminal understandings of HIV, avoiding potential stigmatization from disclosure, and by reducing interactions that may be constrained by the constant awareness of HIV. One of the participants felt better in the presence of his traditional healer than in the presence of his doctor who wanted to know how he contracted the virus rather than being interested in him as a patient. Interactions with medical doctors reinforced images of HIV as a terminal illness. Medical doctors can contribute to the stigma of traditional medicine as complementary therapy use. One participant stated his doctor described traditional medicine as complementary therapy as “nonsense”. This attitude makes
patients hide of the types of traditional medicine as complementary therapy they use and why. Openness could lead to more discussion and dialogue and help the PLWHIV with stigma. This could resolve the issue around "secrecy" and information about traditional medicine as complementary therapy being kept secret from medical doctors. However given the doctor patient ratio this might take many more years.

Respondents also managed AIDS stigma by restricting their social circle to avoid contact with others. One participant reported that she prefers to stay on her own and thereby has no need to explain her HIV status. The same participant had experienced previous discrimination against her status that made her completely isolated from the society. She believes that her life is in danger if she reveals her status. On the other hand two of the participants were public speakers and felt that being open helped them to cope better and they had nothing to hide. They believed that through their public speaking they were more accepted and people treated them with respect. Both indicated that their public speaking process generated much needed money. Another participant regarded the support group as a good place to share information about jobs and the safety of certain places where there is discrimination against people who are HIV positive. The sharing of information in the company of others who are also stigmatized helps avoid the full impact of stigma by decreasing interactions that may be strained by a constant awareness of HIV. In this case of some PLWHIV the self-stigma is very high especially their perceptions on what might happen if they disclose their status.

3.12.5 Secrecy

In my study I explored the important aspect of secrecy and lying for PLWHIV. When they are lying to the doctor about the medicine they use and therefore concealing their status it poses the question of why the need, what’s the gain, what’s the loss? Is secrecy used towards everyone? In "Secrets: On the ethics of concealment and revelation" Bok (1984), explores the key moral questions about secrecy and the justification of it. She also describes several settings in which secrets can be found. Van der Geest (1994) elaborates on the concept of secrecy and refers to secrecy as a strategic tool used by people in some situations to further their own interest. Secrecy is linked to the concept of stigma.
3.12.6 Culture and Illness

An interpretive anthropological study examined the relationship between culture and illness, in order to understand the patient’s view or condition that serves as a pragmatic idea for clinicians to look at the “native point of view” during their clinical work (Kleinman, Eisenberg, and Good 1978). Kleinman (1988) for example seeks to persuade his colleagues in medicine to listen closely to what patients have to say, how they say it, and what they are trying to communicate. In other words, research in medical anthropology often describes the experience of the sufferer, especially for those who suffer in silence because more powerful social groups or strata discount their voice. In the context of my study PLWHIV in Namibia are left at the mercy of clinicians who do not want to listen to how they feel or what traditional medicine as complementary therapies they are using with the ARV medication and a power relation is apparent.

Namibian patients are continuously reminded that no other medications than the ARV must be taken and no other discussions are allowed. This practice was reflected in my interviews with the medical personnel. Traditional aspects of Namibian life include both therapies and their emotional, cultural, psychological, economical, and political interactions for PLWHIV as they strategize to manage their everyday lives.

Kleinman (1980) and Helman (2000) argue that medicine practices vary from professional to popular to folk. The “professional sector” refers to Western (modern, scientific) medicine that is practiced in clinics and hospitals by a range of professional including physicians, nurses, midwives and other auxiliaries. Authorities recognize their training. The “popular sector” refers to the care that takes place in families and constitutes the real site of primary care in the society. Laypersons, relatives and friends perform the care in this sector. In the Namibian context this includes care to HIV/AIDS affected persons and communities and necessitates the mobilization of all potential resources. Given the complexities involved in HIV prevention and care diverse intervening factors at the individual, micro- and macro- levels require multi-sectoral approaches for HIV/AIDS control strategies (Mayaud and Mc Cormick 2001; WHO 2003a; Pawinski and Laloo 2006).

The “folk sector” is made up of practitioners specialized in specific forms of healing. In general, the training for traditional healers occurs by inheritance, revelation, apprenticeship to another
healer, and sometimes by acquiring personal interest and skills. These practitioners are either pure technicians such as herbalists, birth-attendants or spiritually orientated healers such as spiritualists and diviners (Helman 2000). The training of the folk sector is not institutionalized and their legitimacy rests on the recognition given by their clients, rather than on authorization by state or professional bureaucracy (Mac Cormack 1986). Patients and healers consider the medical world not only from a biomedical perspective but also from a cultural perspective and how it affects people. Kleinman (1980) considers it important to include psychological and cultural aspects when looking at the family, medical self-treatment, and folk medicine and not as just treating the physical aspects of illness.

Medical anthropologists believe that to understand health and illness concepts one must also understand how culture and corresponding ideas influence what individuals think about and do as it relates to health and illness (Helman 1984). One cannot understand how people react to illness, death or misfortune without an understanding of the type of culture that they have grown up in... that is, of the ‘lens through which they perceive and interpret their world’ (Helman 1984:164).

3.12.7 Disease Theory
A corresponding approach to this study is disease theory system which also guided my study in regard to health care system (Foster and Anderson 1978). A disease theory system (similar to Kleinman’s 1978 explanatory model of illness) includes beliefs about the nature of health, causes of illness and curing methods for dealing with illness (Foster and Anderson 1978). Disease theories attempt to explain why or there is for a lack of wellbeing. This is a concept important in my current study because in Namibia PI.WHIV go to the traditional healer for answers or interpretation of their illness and experience a feeling of being happy or content. A group’s disease theory is related to other cultural beliefs (Barfield 1997). Disease theory is an attempt to classify, determine and explain the cause and effects of illness (Barfield 1997). All disease theories make sense if analyzed within cultural context from which they arise (Good 1996; Foster and Anderson 1978). Disease theory is only thought of as irrational or irrational or illogical when viewed out of its socio-cultural context or when scrutinized by people from outside the culture (Good 1996; Foster and Anderson 1978). In terms of this study the framework of conceptual explanation for the occurrence of illness within a specific culture refers to the
consultation of PLWHIV with a traditional healer of their own culture and whom they understand and can relate with. Efforts to correct these approaches have been varied. A more narrow focus on disease classification and etiology, for example, has led researchers to an indigenous approach that seeks to draw classifications of disease as a way of understanding the underlying logic of disease entities and their classification into distinct categories (Warren 1974, 1975, 1989; Broksana, Warren, and Werner 1980). For others such as Foster (1976) and Lieben (1977) what has caused the illness and the interpretation of it must be seen central to an integrative understanding of medical phenomena and cultural settings and as key to developing a cross-cultural comparison of non-Western systems. Other scholars follow a similar line by focusing specifically on medical knowledge and practices and give meaning to the disease as part of diagnosis and the search for treatment. This leads to further arguments about the natural and supernatural causes of illnesses. It is stated by Karim et al. (1994:16):

“Nature causation applies to illnesses which have a specific, recognizable and predictable course. ‘Supernatural’ causation applies to those culture-bound illnesses that are perceived to be inexplicable by natural laws, that is their aetiology, diagnosis and treatment are all inextricably bound up with the African traditional world view of health and sickness”.

According to Chavunduka (1994), illnesses in this category have a cultural or social cause. Afflictions such as cough, cold, slight fever, stomach ache and headache are generally regarded as “natural” since they occur from time to time as part of normal life, are usually of a fleeting nature, and resolve completely. They respond to traditional medicines, although there is a readiness to use biomedical curing techniques. Only if the symptoms are severe and persist, i.e. when the illness fails to respond to ordinary treatment, is it regarded as deviant, and why a deviant case has occurred needs to be explained. Thus, while biomedicine asks what caused the condition and how did the patient fall ill, the traditional belief system requires answers to the question of “who” and “why” (Karim et al. 1994).
3.12.8 Push and pull factors

In this research, my aim has been to provide an ill-person centered perspective on traditional medicine as complementary therapies in Katutura, Namibia. Push and pull factors are clearly at work in the strategies discussed by respondents. For example, users push away from ARVs medication because of negative attitudes towards medications and their dependency on ARVs. At the same time they are pulled towards traditional medicine as complementary therapies because of positive attitudes towards these therapies. PLWHIV perceive these as additional therapeutic options as that have minimal harmful effects.

In this journey of discovery I found that PLWHIV use complementary therapies for self-regulation and strategies to manage the contingencies of everyday life when HIV positive. Contingencies include the uncertainties of managing symptoms medications and emotions that make it difficult to maintain normal social roles, increasing dependency on others, effects of stigmatization and possibilities of a shortened lifespan. Traditional medicine as complementary therapies for PLWHIV in Katutura, Namibia were used as coping strategies to help increase personal control and attain a sense of normality in their daily lives. Furthermore traditional medicine as complementary therapy was perceived as more flexible and rarely posing a risk to health and wellbeing.

The ARV treatment as mentioned is essentially free in Namibia and measures are in place to even waive the cost if the patient cannot pay. However, it was surprising that in one case study the patient still consulted a traditional healer despite the fact that he had to borrow money or accept the treatment on credit. He stated that the reason he visited the traditional healer was because he grew up with a traditional healer and he also sought meaning for what happened to him including the cause of his illness. Traditional healers are an integral part of Namibian people and society. They know the way of the Namibian people. When I observed in the consultancy room of a traditional healer I noted that he spent up to two hours with a patient. I further observed that the shortest visit was 25 minutes. I wondered if traditional healers were more knowledgeable about local treatment options, as well as the physical, emotional and spiritual lives of the Namibian PLWHIV. If traditional healers have an influence on behaviors how could this be used in the plight against HIV/AIDS? The enormous effort made by a PLWHIV without
money or stable income to seek traditional medicine further illustrates the importance of a traditional healer in the lives of PLWHIV in Namibia.

It appeared to me that there was substantial mistrust between the Namibian medical doctors and the traditional healers. This was evident from the doctor’s interview as he told me that traditional healers just “cheat” people. Furthermore, there is resentment from the traditional healer who told me that medical doctors only want to make money and he knew this by looking at the luxurious lifestyles they have.

Traditional healers also resent medical doctors for not spending adequate time with a patient, charge too much money or demand medical insurance whereas the traditional healer treats the whole body, mind and soul using a holistic approach.

Biomedicine treats the body while in the African perspective traditional medicine treats the soul. Both play a vital role in healing in the majority of PLWHIV. ARVs are the only medical intervention available to alleviate the physical effects of AIDS. The traditional healer is a part of the African healing process that Western medicine does not address.

This raises urgent concerns that the biomedicine and traditional healing system in Namibia need to join hands in the fight against HIV/AIDS. The health benefits of both must be taken in consideration and amicable solutions must be found to bridge the current gap.

Finally it must be noted that although this research has generated useful findings on the use of complementary therapies there are limitations. In particular the sample size was not representative of all people living with HIV in Namibia. Most of my participants were identified at the Red Cross Namibia. All of the participants are State-care patients and those on private medical care may not share the same sentiment or may have other opinions. All of my participants made use of the traditional medicine obtained from the veld and this may be different for people with a dissimilar values or belief systems. There was also no investigation of people buying complementary therapies over the counter in a package and how they felt.

These findings also suggest the need for more comparative work to focus on complementary medicine use among people with different illnesses. Do people living with cancer or asthma use complementary medicine to regulate their illnesses. If so, do they attach the same meaning as
those living with HIV? Other research lacking in this study concerns those who are not using any complementary medicine but are living only on the ARV therapy and how they cope and survive.
4.0 CHAPTER 4: CONCLUSION AND RECOMMENDATIONS

4.1 Introduction

This study found that all participants said they regularly use traditional medicine as complementary therapy to the ARVs. Although push and pull factors are important for explaining why people in Namibia use traditional medicine as complimentary therapy and the meanings people attribute to these therapies in their everyday lives also prove determinative. Many of the cases found traditional medicine as complimentary therapies attractive because of its healing power to address diverse aspects of not just a person’s health but also a person’s everyday life.

Furthermore in the Namibian context complimentary therapies are seen as being more compatible with the patients’ values, spiritual/religious philosophy or beliefs regarding nature and meaning of health and illness. Participants who held strong beliefs about traditional theories of health, illness and remedies were more likely to use complementary therapies. We have seen that the grandparents of the participants used most of the herbs for other health related illnesses and still used by PLWHIV for illness they experience. These findings suggest that culturally transmitted values and beliefs have strong influence on complementary therapy use.

This study in Namibia demonstrated that the use of traditional medicine as complementary therapies led to a lower medical dependency and constraints by giving the PLWHIV a sense of control over HIV/AIDS to manage their lives everyday. The respondents felt that they had reached the “end of the road” and seeing the biomedical doctor constantly reminded them of that fact. Traditional medicine as complementary therapy use gave back control to these PLWHIV and hope to live.

Taking the ARV medications was a constant reminder that the respondents had HIV. Knowledge about the use of medications differs between well bodies and sick bodies and symbolizes the deviation from normal bodily control. To maintain well-being, whether perceived or actual, traditional medicine as complementary therapies help to minimize the potential stigmatization of AIDS. Traditional medicine as complementary therapies helped users manage stigma by reducing the “shock value” of HIV/AIDS. It does this by resisting the terminal understandings of HIV, avoiding potential stigmatization from disclosure, and by reducing interactions that may be constrained by the constant awareness of HIV. In mentioned earlier, the action of going to a medical doctor is perceived as being told of death but in the message of the traditional healer is there is hope. By developing complementary practices PLWHIV can reduce the stigma of AIDS.
by resisting fatalistic constructions of the future. In the context of this study participants were involved in public speaking and some joined support groups. The support group was a way to express the desire to be treated like any normal person who is able to share their emotions and feelings with people of the same group and to help with coping mechanisms. Therefore in the company of other who are also stigmatized this helps avoid the full impact of stigma by decreasing interactions that may be strained by constant awareness of HIV.

This brings us to the why the participants in the case studies uses traditional medicine as complementary therapies, and, how they uses complimentary therapies. It was clearly indicated that they use it because it makes them feel better, some even indicated it was for happiness and many mentioned the fact that they grew up with the medicine.

The participants clearly go to length to obtain the complementary medicine. They go into the veld, pay for the medication although the ARV is almost free in Namibia and some even traveling vast distances to find an traditional healer of their choice.

All of the above is a clear indication that there is an organized system in place; a system that could lead to further education of all stakeholders who are important in the fight against the HIV epidemic in Namibia and thus address the simplistic recommendation not to use traditional medicine while on ARVs.

4.2 Where to from here

The use of complementary therapies by PLWHIV and the known contraindications of certain ARV drugs and some herbal remedies highlight the need to discuss complementary therapy use routinely as part of any discussion or treatment for HIV/AIDS patients. This might require physicians and other health care professionals to increase their knowledge about complementary therapies in Namibia. However, there are still many gaps in our understanding of complimentary therapies and possible interactions between ARVs and complimentary therapies.

Indeed traditional healers make a unique contribution that is complementary to other approaches. They also tend to be the entry point for care in many African communities, and even more so for the complex HIV-related diseases that frequently jolt family dynamics and shake community
stability. Traditional healers often have high credibility and deep respect among the population they serve. They are knowledgeable about local treatment options, as well as the physical, emotional and spiritual lives of the people, and are able to influence behaviors. Thus, it is imperative and practical to consider traditional healers as partners in the expanded response to HIV/AIDS, and to maximize the potential contribution that can be made towards meeting the magnitude of needs for care, support and prevention.

UNAIDS (2007) makes a number of key points in favor of collaboration with traditional healers. Importantly, UNAIDS (2007) note that traditional healers” provide client- centre, personalized health care that is culturally appropriate, 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 issues.

Friction is evident from the case studies between the “Western” medicines or biomedicines that looks at ‘material causation’ to understand and treat and illness: and traditional healers who generally looks towards the ‘spiritual’ origin such as witchcraft and displeasure of ancestors in order to cure an ailment. The fact that Namibia is one of a few African countries where the Traditional Health Practitioners Bill has not been approved by parliament makes matters worse for the two ‘worlds of biomedicine and ethnomedicine to join hands in particular for the HIV epidemic in Namibia. It is in my view, as in many other bordering neighbors like Zimbabwe that as soon as the approval is there issues could be ironed out around a joint table of discussion.

Governments should establish the necessary institutional and financial support to promote the potential role of herbal medicine in primary health care delivery. Priority should be given to research the development of herbal medicine by the means of the following measures:
(1) Inventory and documenting the various medicinal plants and herbs that are used to treat common diseases in the country
(2) Setting up of testing laboratories with adequate facilities for the assessment of the efficacy of medicinal herbs, and establishing dosage norms for the most efficacious us of herbal extracts, whether in tablet, capsule, powder, syrup, liquid or other form.
This partnership could play a significant and deeply influential role in Africa’s response to HIV/AIDS and Namibia in particular.

### 4.3 Recommendations for future research issues

Many studies of ARVs have been conducted since the disease was first diagnosed in Africa specifically addressing adherence and availability of medication. However, to date there have not been studies on the “non medical meanings and effects of medicine” as described by van der Geest and Hardon (2006).

It is prudent to be cautious about the emphasis on availability and distribution of ARVs and rather give attention to what the African PLWHIV are saying about their ARV use and their needs and understandings of medicine in general. Medicines mean different things to different people and authorities must take this into consideration when planning any pharmaceutical intervention.

It is evident from this study that traditional as complementary medicine is compatible with Namibian PLWHIV’s values, spiritual/religious philosophy, and beliefs about the nature and meaning of health and illness. So, there is a challenge to medical anthropologists to put knowledge of meaning and distribution of medicine in general into more practical use for the people who suffer.

**Two key follow-up issues to do further research and where almost nothing is known in Namibia:**

1. **Exploring the contribution of traditional healers in the HIV/AIDS and ART** (and this could be comparative with different kinds of healers, across countries etc.

2. **Exploring the issue of Adherence further in relation to perceptions and practices and how adherence to complementary medicine can be used to create positive messages about ART and also improve the patient provider relationship** (this too can be comparative and both these issues have great policy relevance.)
APPENDIX 1: REFERENCES

Abdel-Malek, S.

Adewunimi, Clement O. and John A.O.Ojewole
2004 Are the Institutions Ready to Empower Local Herbsits? African Journal of Traditional Complementary and Alternative Medicine, 2(1) 1-3


Arimore, S.

Astin, J.

Balick, M.J.

Barfield, T.
1997 The dictionary of Anthropology, Blackwell: Oxford

Bensoussan, Alan and George T. Lewith
Bernstein, J.H. and J.T Shuval.
1997 Nonconventional medicine in Israel: consultation patterns of the Israeli population and attitudes of primary care physicians, Social science and medicine

Brown, L., K. Macintyre, and L. Trujillo

Bok, S.

Bolognesi, N

Boseley, S
http://www.guardian.co.uk/world/2005/may/14/southafrica.internationalaidanddevelopment (retrieved 23 July 2008)

Brown, W.A.

Buseh, A.G, C.G Park, P.E. Stevens, B.J. McElmurry, & S.T Kelber,
Centre Statistics Office (CSO)

Charmaz, K.

Charmaz, K.

Chavanduka, G.
1974 Traditional Medicine in Modern Zimbabwe, Harare: University of Zimbabwe Press

Chi, C.

Christakis, N.
1944 Illness Behaviour and the Health Transition in the developing World. In Health and Social Change in International Perspective: Harvard School of Public Health

Civic, C, & Wilson D.

Colebunders, R., Dreezen, C, Pelgrom. Y. and Schrooten W.

Collins R.

Cox P.

Delius, P. & C. Glaser,

De Vos, A., Strydom, H., Fouche, C. & Delport, C.

Ellis, C.
1996 Ukufa kwaBantu: benchmarks for busy GP’s. South Africa Family Practice

Eisenburg D.M, Davis R.B, Ettner SL et.al

2008 Antiretroviral therapy (ART).

Foote-Ardah, C. E.

Foster, G
1969  
Applied Anthropology, Little, Brown and Co: USA/Canada

Foster, G.

Foster, G and Anderson, B
1978 Medical Anthropology, John Wiley and Sons: New York

Frayne, B.
1992  Urbanisation in Post-Independence Windhoek. NISER/UNAM: Windhoek

Furler, M, D, Thomas R, Einarson, S, Walmsly, M, Millson, Bendayan, R.

Gilmore, N & Somerville, M.A

Good, B

Goffman, E.

Goffman, E.

Gumede, M
1990 Traditional healers: A medical practitioner’s perspective. Cape Town: Blackshaws

Haihambo, C.K.

Hardon A, Vander Geest S
2006 Social and cultural efficacie of medicines: Complications for antiretroviral therapy
*Journal of Ethnobiology and Ethnomedicine* 2006, 2:48

Helman, C

2003 Complementary and alternative medicine use substitution for conventional therapy by HIV-infected patients, Acquire Immune Deficiency Syndrome. International Development Research Centre.

http://archive.irdc.ca/media/complants e2.html#Backgrounder (retrieved 22 July 2008)

Integrated Regional Informants Networks

2007 SOUTH AFRICA: Quackery hinders AIDS treatment efforts. UN Office for the Coordination of Humanitarian Affairs.


Jackson H,
2002 Aids in Africa continent in crises. Harare: SAFAIDS


Karim, A

2002 Complementary Therapy Use in Persons with HIV/AIDS, J Holist Nurs, 20, 264-278

Kleinman, A
1978 “Concepts and a Model for the Comparison of Medical Systems as Cultural Systems” Soc Science Med
Kleinman, A.  

Knippels, H. and J. Weiss  

Langlois-Kalssen, D., Kipp W., Gian S., Jhangri S., Rubaale. T.  
2007 Use of Traditional Herbal Medicine by AIDS Patients in Kabarole District, Western Uganda. *American Journal of Tropical Medicine and Hygiene*, 77(4), 757-763

Langewitz, W., Ruttiman, S., Laifer, G., Maurer, P. and Kiss, A.  

Letter to the Editor  
2008 Namibian, April 18: 5,55

Le Beau, D.  
1999 Seeking Health: The hierarchy of resort in utilization patterns of traditional and western medicine in multi-cultural Katututra, Namibia. PhD. Dissertation Rhodes University : South Africa


Lumpkin, T.,  
Li, B.


Lieban, R
1977 "The field of Medical Anthropology" In D. Landy, ed., Culture and Disease, and healing, New York: Macmillan.

Mac Cormack, C
1986 The articulation of Western and traditional systems of health care, in The professionalization of Africa medicine: Manchester: Manchester University Press

Mc. Knight I & Scott M.

MacLennan A.H, Wilson D.H, Taylor A.W.
Prevalence and cost of alternative medicine in Australia. Lancet 1996

Mayaud, P. and Mc Cormick, D.
2001 Interventions against sexually transmitted infections (STI) to prevent HIV infection, BR Med Bull.

MacLachlan, M
1997 Culture and Health, John Wiley & Sons: England

Maclean, Ula and Robert H
1982 "Utilization of Indigenous Healers in National Health Delivery Systems. Social Science and Medicine, vol 16

Mac Cormack, C.
1986 The articulation of Western and Traditional Systems of Health Care Manchester: Manchester University Press

Melangu, N.


Ministry of Health and Social Services, Namibia


- 2007 United Nations General Assembly Special Session (UNGASS) country report 1-42.

Middleton. J et.al
197 Magic, Witchcraft and Curing : Natural History : New York
Mufune, P.
2005 Myths about Condoms and HIV/AIDS in Rural Northern Namibia. Windhoek: UNESCO

Nakano M

National Planning Commission

Ostrow, M.

Otaal, B
2000 Impact of HIV/AIDS on the University of Namibia. Windhoek Printech

Parker, R., Aggleton, P., Attawell, K., Pulerwitz, J. and Brown, L.

Pawluch, D, Cain, and J,Gillett
2000 Lay constructions of HIV and complementary therapy use, Social Science and Medicine, 51: 251-64

Pawinski, R. A. and Laloo, U. G.
2006 Multisectoral responses to HIV/AIDS: applying research to policy and practice, Am J. Public Health
Phillips, L.

Piras, G
1997 Sho-saiko-to, a traditional medicine, enhances the anti-HIV-1 Activity of Lamivudine (3TC) in vitro. Microbiology Immunology 41(10):835-839.

Pirota M.V, Cohen M.M, ET.AL

Piscitelli, SC.

Rao, D., Kekwaletswe, T.C., Hosek, S., Martinez, J. and Rodriquez, F.
2007 Stigma and social barriers to medication adherence with urban youth living with HIV, AIDS care, 19 (1), 28 – 33.

Recker, G AND Wong , P.

Reid, G. and Walker, L.

Runganga, A & Kasule J.

Scoub, B.

Singer, M & Baer, H.

Silvester, J., Wallace M. and Hayes, P.

Simmons, D

Swanson B, Keithley J, Zeller J, Cronin-Stubbs D.

Tvedten, I. and Moono M.
2005 Urbanisation and Urban Policies in Namibia. SSD discussion paper# 10 SSD/UNAM: Windhoek

United Nations Development Programme (UNDP)
2006 Base studies on financial, economic aspects in Namibia. Health Sector review. UNDP: Windhoek

Visser G, & Peter L.  
1990 Alternative medicine and general practitioners in The Netherlands: toward acceptance and integration. Fam Prac

Van der Geest, S  

Van Dyk, A. C.  

Van Dyk, A.  
1997 The history of nursing in Namibia: Gansberg Macmilan: Windhoek

Van Wyk, Elliot  
2007 Die harde stryd teen ARV, Die Republiekein, August 18:

Van Zyl, D.  
2003 An Overview of HIV-related Research in Namibia Since Independence. Windhoek: IPPR.

Vasilyuk, F.  
1991 The psychology of experiencing: The resolution of life’s critical situations. New York: Harvester Wheatsheaf

Warren, D.M.
1986 The expanding role of indigenous healers in Ghana’s national health delivery system, in African medicine in the modern world. Fyfe Edinburgh: Centre of African Studies

Yoder, P.
1982 “Zimbabwe AIDS Prevention and Control Project” Prepared by Diana Patel, IRT/Species consulting Services for USAID

Weeks, J.

World Health Organisation


Winnick, Terri A.
2007 Trends in attention to complementary and alternative medicine in the American medical literature. Health 11(3) 371-399
## APPENDIX 2: ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral treatment</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly active antiretroviral therapy</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>CAM</td>
<td>Complementary and Alternative Medicine</td>
</tr>
<tr>
<td>MOHSS</td>
<td>Ministry of Health and Social Services Namibia</td>
</tr>
<tr>
<td>PLWHIV</td>
<td>People living with HIV</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Aid for International Development</td>
</tr>
</tbody>
</table>
APPENDIX 3: HERBAL MEDICINE

Cutting of aloe to be used as complementary medicine

Cutting in smaller pieces. Drying of Aloe takes up to 3 weeks.