

Full Length Research Paper

Preferences for complementary and alternative HIV and AIDS treatment among rural residents in Zimbabwe

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This was a cross sectional survey of the residents' perceptions on preferences for alternative and complementary treatments in wards 29 and 30 of Makoni District of Manicaland Province in Zimbabwe. Data was collected using a closed questionnaire in which the respondents were instructed to indicate yes or no on the statements provided. The objective of the study was to establish preferences for complementary and alternative treatment for HIV and AIDS among rural residents of Zimbabwe. The residents in Wards 29 and 30 have shown high levels of awareness of treatments for HIV/AIDS. They were both for the alternative and complementary treatments as shown by their acknowledgement of the need to have both ARVs and local traditional herbs. These belief systems have a strong bearing on preferences for treatments for HIV/AIDS and other diseases in general. Religious beliefs significantly shaped individuals' views and opinions on HIV/AIDS treatment within the study area since they provided a sense of peace and hope, and can also help people to prepare for and accept death.

Keywords: HIV and AIDS; Rural residents; Alternative treatment; Complimentary treatment; ARV

INTRODUCTION

The burden of HIV and AIDS disease remains high for Zimbabwe, with an estimated one in every four people infected (UNAIDS, 2004). Understanding the basic factors related to treatment and choice is fundamental to policy formulation and the development of strategies for care and treatment. It appears, very little has been published in Zimbabwe, on the use of complementary and alternative treatment as opposed to the now much publicized antiretroviral (ARVs). Contrary, traditional medicines are at the heart of most communities in Zimbabwe since for most people in rural settings it is the first port of call if sickness befalls a family. The delayed diagnostic process often associated with western medicine through collection of samples and the time taken to inform the patient particularly in remote points of the country may prompt people to resort to consulting

traditional and faith healers within their vicinity. Individuals are bound to be skeptical about the type of treatments they receive and some may find it more fitting to use a combination of treatments. In addition access to antiretroviral therapy (ART) is quite limited in Zimbabwe and has in 2005 been identified by the World Health Organization (WHO) as having the highest unmet need for ART and 3-5% of those in need were receiving ART. The use of complementary and alternative medicine is popular among people living with HIV and AIDS. While Antiretroviral (ARV) therapy halts disease progression the drugs do not cure the condition. The toxic effects of the drugs, the prohibitive costs, cultural beliefs as well as the perceived efficacy of the drugs are believed to be among some of the factors influencing the client's choice on treatment.

There is overwhelming acknowledgement that Acquired Immune Deficiency Syndrome (AIDS) is a serious public health issue in Sub-Saharan Africa and in Zimbabwe. To develop a justified argument surrounding complementary

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and alternative treatment for HIV and AIDS, it is imperative to explore the magnitude and nature of the preferences for treatment within the African context. The disease has been compounded by the effects of other social ills associated with the region like crippling poverty. It is documented that in excess of two thirds of those carrying the virus live in this region whilst 76% of all AIDS related deaths occurred in the Sub-Saharan Region (UNAIDS, 2006). Since the first confirmed AIDS case in Zimbabwe in 1985 there has been a sharp increase in the number of those infected (10% of the adult population by the end of the 1980s) and affected. The number of those infected increased to 26.5% in 1997 but has shown a steady decline to 23.7% in 2001, 16% in 2007 and 14.3% in 2010. Despite skepticism surrounding the decline in statistics of those infected it is pleasing that there seem to be some deceleration in rates of infection particularly among the economically active population and is in sharp contrast to what is happening elsewhere in Africa. A number of reasons have been advanced to explain the decline, including increased number of deaths from HIV and AIDS, high number of migratory population that could not be accounted through survey, increased awareness among the population and success in government intervention programmes. Though the declining trend is encouraging the figure is still high for a country with a population of approximately 12 million. These results have been based on surveys and clinical tests within the framework of western medicine thinking and none has been based on the impact of complementary and alternative treatments in rural areas despite the acknowledgement of the role of traditional medicines in the treatment of HIV and AIDS.

Problem Statement

Zimbabwe continues to experience high mortality rates due to AIDS and there has been an upsurge in scaling prevention, care and treatment programmes to combat the disease. Among the host of solutions that have been advanced to reduce HIV and AIDS are the preferences for alternative and complementary treatments encompassing the use of faith healing, traditional healing and other herbal treatments. The rural communities have always been caught between adopting the western approach of treatment and the traditional treatments. A number of factors influence such preferences including the cost involved, the issue of stigmatization, provision of counseling services, the religious and African traditional belief systems and levels of awareness. Conflicting reports have been made regarding the impact of alternative and complementary treatment of those infected from the scientific perspective.

The practice is strong among rural communities and its study may point towards improving the management of the disease in rural settings. Their preferences for treatment whilst is generally construed as to do with access to health facilities, cost and perhaps the non-availability of ART it is not very clear why exactly the treatments continue to dominate social life not only for HIV but also for other diseases. Valuation of the personal belongings lost through some of these treatments by the rural people will make one to doubt that the issue of cost is at stake but perhaps belief in one's traditional way of receiving treatment. The estimated costs of some of the traditional therapies are much higher than the modern treatment procedures. Despite the upsurge in advocacy, research and programming that has penetrated virtually all parts of the country the alternative treatment continue to be prominent among communities in wards 29 and 30 of Makoni Rural District.

Objectives

- Describe the social setting of the wards in relation to HIV/AIDS treatment
- Establish the use of complementary treatments among those affected by HIV and AIDS in wards 29 and 30 of Makoni District
- Evaluate the role of alternative and complementary treatments in improving the management of HIV and AIDS treatment in rural environments

Importance of Study

The study has practical and theoretical importance to the National Aids Council (NAC), the Ministry of Health, the local authorities; the general public and those affected by HIV and AIDS particularly the women. It broadens the search for solutions to the treatment and cure of the disease and to gather knowledge on why individuals continue to believe that traditional and spiritual practices can cure the disease that has decimated communities the globe over. The study could be a precursor towards the integration of modern and traditional treatment regimen. Community projects that have posted success usually recognize the status and knowledge systems of the local people. It is the first step towards removing stigmatization of the infected, affected and those that claim to have the skills to cure.

The study intends to explore the contextual and cultural meaning of alternative and complementary treatment of HIV and AIDS. From a policy perspective the study would contribute towards generating scientific information that

will feed into policy improvement and change. Most of the HIV and AIDS initiatives fail because the lowest groups of society are not consulted on topical issues like their preferences for alternative treatments. This will thus constitute a consultative forum for the national AIDS Council. Traditional practices are usually shrouded in myths and taboos that are at times difficult to understand due to the closed nature of rural communities. Studies of this nature are capable of unraveling the underlining drivers for the preferences for alternative treatments. Project planners in this field will have a guiding document for scoping alternative treatments HIV and AIDS.

Literature Review

HIV/AIDS has spurred controversies within communities ranging from infidelity, sexual abuse, lack of trust among family members and this has also spilled into the scientific community where there is divergence of views regarding the treatment and cure of HIV. There has been a general acknowledgement of the impact of ART on HIV treatment but some of the side effects have widened uncertainties about its efficacy. In addition some communities in Africa have the belief that local traditional healers have herbs that treat the disease and may trust to use both the western and local concoctions prescribed by traditional healers. There are likely to be lies and myths associated with herbal prescriptions that are not scientifically proven as the justification for their use is based on oral history from an African perspective. The improvement in the health of an individual infected may not point towards the efficacy of the traditional prescriptions in the absence of measured and quantified evidence. The western world has also promoted the use of ART, though widely tested have a series of side effects that tend to be ignored by those pushing for adoption of the western types of treatment regimes. Most communities are afflicted by problems of non-disclosure by members of their HIV status. The treatment of symptoms and related or opportunistic infections constitute one massive deception on HIV treatment by both the traditional, western and religious healing techniques. The interpretation points towards the cure of HIV and AIDS. However, we must acknowledge that there is evidence that the quality of life of patients has improved after adopting a range of treatments. Thus, there is hope in alternative and complimentary treatments for HIV and AIDS.

Combination antiretroviral treatment, typically three drugs taken daily, suppresses levels of HIV ("viral load") in the blood to undetectable levels and halts the progressive damage to the immune system and development of severe morbidity and mortality

(UNAIDS, 2009). In the USA, AIDS deaths declined by 83% between 1995 and 2001 after the widespread adoption of ART and their striking success has been demonstrated in developed countries. There has been widespread adoption of these types of treatment resulting in change in the quality of life for those affected. The growing international realization of the catastrophic impact of AIDS, particularly in Africa, lent support to the rapid expansion of HIV treatment programmes. However, this comes at the expense of locally available treatment regimen in which the local communities believe in and have practiced for a long time. One worrying dimension in the African context is the tendency to adopt western approaches without caution and only to revert to the old traditional techniques when the western approaches medicine becomes unsustainable.

The terms "alternative," "complementary," or "unconventional" therapy cover a broad range of healing philosophies and approaches. Some approaches are consistent with physiological principles of modern medicine, while others constitute independent healing systems. The wards targeted by this study do not use conventionally known alternative and complementary treatments from modern medicine perspective but these have worked for the treatment of diseases by the locals. Some of the therapies could also be a fusion of three approaches encompassing use of herbs, religious ceremonies and treatment performances particularly among indigenous apostolic churches and ultimately the tried and tested ART treatments. Perhaps the effective treatment lies within the intersection of these treatments. To understand which of this amalgam of treatments contributed more to the recovery of the patient under such circumstances becomes a mammoth task when records of dosages are not known. Some therapies are so far outside the realm of accepted medical theory and practice that they are difficult to subject to standard evaluative techniques. Most of these therapies (Complementary and Alternative medication-CAM-WHO 2002) in the African context are outside the realm of what the western medicine specialists will refer to as unproved and shrouded in uncertainties due to lack of measurements.

These therapies may not target HIV and AIDS but the general physical and mental fitness of an individual. That is the biological requirements, the spirituality of the individual and the general social construct of disease treatments. African traditional religion believes that diseases are the work of evil spirits and these have to exorcise if effective healing is to take place.

It has long been established in literature that people are 'pushed' toward Complementary and Alternative Medicine (CAM) because they are dissatisfied with standard medical care and when such treatments are

congruent with their own world views (McGregor and Peay, 1996 and Astin 1998). The belief in the spiritual world is strong and vibrant in all social contexts particularly among the infected. People find CAM attractive because of its potential to improve both personal and public health while at the same time producing considerable savings to medical costs (Timothy and Daaleman, 2004). It is common among people who want to have control over their health and social issues. After all prescriptions are interpretations of signs and symptoms of a disease that one has experience with and have at times large margins of error when not based on measurements and samples. The idea of taking samples delays treatment and prolongs suffering.

Another dimension rarely advanced in literature since the 1990s presumes the centrality of the ill person's experience of illness. This ill-person-centred perspective is found in the literature on compliance with prescribed medical regimens (Conrad, 1985) and the illness experience (Charmaz, 1991, 1995 and Weitz, 1991). These experiences are not recorded in the context of African alternative and complementary treatment regimes. The experiences are stored in individuals that have taken care of the sick and from those who have undergone the pain of the disease both socially and morally. Individuals are active agents who reflect and act on the uncertainties and contingencies of daily life with chronic illness. The interest in religion and spirituality by health care researchers, educators, providers, and consumers has not only accelerated in the less developed countries of Africa but also in the United States of America (Matthews, McCullough, Larson, Koenig, Swyers, Milano, 1998). Two parallel, patient-centred movements—end-of-life care and complementary and alternative medicine—have contributed to the legitimacy of religion and spirituality in American health care. Both may be seen as an impetus to rehumanize a system of medical care that has become increasingly impersonal, spiritually barren, and grounded in technology. The current momentum to improve end-of-life care is understandably inclusive of spiritual and religious factors, despite the lack of consistency in how religion and spirituality are addressed in clinical settings (Daaleman and VandeCreek, 2000). In practice a medical doctor has to content with questions of metaphysics that one is not trained to answer.

There has been an attempt to go beyond recognising the role of the spiritual world in health but to adopt a health delivery approach that is more inclusive than our current understanding. That is a global perspective that places spiritual factors alongside physical, psychological, and social determinants. The ill are most likely to be in control of their medical condition and have perceptions

about what could be effective for their recovery and survival. From an African medicine traditional perspective family members trust in seeking advice from traditional healers and may prefer their prescriptions rather than the one suggested by a trained medical doctor. Other families prefer the three pronged approach in which they use the healing powers of self-proclaimed prophets, modern medicine, and the traditional healers. This may occur without the consent of the infected as families make decisions on behalf of a patient. The trust in home based care though reducing hospital costs on the part of relatives relegates to the infected to whims of complementary spiritual and traditional treatments. The communities are replete with examples of people whose quality of life has greatly improved after they were discharged from hospitals and clinics. The explanation for such recovery even if one is under ART treatment is within the social and spiritual realms.

To understand HIV positive people's illness behaviour it is important to account for the illness experience such as threats to future goals, stigma management, debilitating health complications, and increasing dependency on others (Weitz, 1991). People with any chronic illness continuously face uncertainties as they reassess who they are and what their future holds. In the ongoing reassessment process people try to reconstruct normal lives, to whatever extent possible, so that the situation becomes manageable (Charmaz 1991, 1995). The medical compliance literature, which examines reasons for not complying with physician-prescribed medical regimens, also stresses the importance of examining how ill people manage their daily existence, of which taking medications and interacting with the medical institution is only a small part (Conrad 1995). Thus, it is valid that we probe the circumstances surrounding the preferences for CAM among rural communities.

Given the importance of alternative treatments in our daily lives it is important that we embrace the strategies in the management and control of the HIV and AIDS pandemic. Most importantly, because the treatments are patient-centred and of how people manage their medications (Conrad 1995). The doctor's orders are understood as the 'prescribed medication practice'. For example, HIV doctors may prescribe three kinds of medication taken two times a day. People interpret the prescribed medication practice and then create a medication practice that may deviate from the prescribed practice. People intentionally reduce or raise their prescribed medication dose in efforts to test for progression of their disease, reduce dependency on others, to destigmatise their illness, and for practical reasons (Conrad, 1995). In creating different medication practices, ill people self-regulate their medical regimens to fit their daily lives. The experience of taking drugs on a

daily basis may traumatise and stigmatise the sick as they may wonder why their ancestors and god have actually made them social outcasts. These are people on a death role awaiting their judgment day and people may refuse to accept that the condition can be positively managed.

CAM practices also helped users manage stigma by reducing the 'shock value' of HIV and AIDS. It does this by resisting terminal understandings of HIV, avoiding potential stigmatisation from disclosure, and by reducing interactions that may be constrained by the constant awareness of HIV. Some feel more ruined and terminally ill when they visit their medical doctors whilst the popular local herbalist and healers give a sense of hope. Healing of a patient may also hinge on the psychological effect of the treatments and handling done. Interactions with alternative care providers are believed to reinforce images of HIV as a chronic illness. In contrast, medical encounters reinforced images of HIV as a terminal illness. To reduce the stigma of HIV some people often avoid medical doctors. Interactions with alternative care providers is in some communities perceived as a framework for spiritual strengthening and view the illness in a non-terminal way. However, not all practices in the traditional framework give a sense of hope for those who are ill, some treatment perpetuate stigma.

Traditional healing practices in Africa have a long history of success and are deep rooted among its people. It forms the reservoir of traditional technical knowledge and heritage for most nations. However, the cross cultural influences have diluted the essence of the African traditional healing systems and some locations are no longer treated effective systems of healing for various diseases that afflict the African people. African traditional medicine encompasses a diverse range of practices, including herbalism and spiritualism, and traditional healers represent a range of individuals who call themselves diviners, priests, faith healers or bone-setters, among others.

The term 'traditional healer' used here though an oversimplification of a complex range of practices, refers to either herbalists, spiritualists or to those (the great majority of healers) involved in both realms. African traditional healers reflect the great variety of cultures and belief systems on the continent, and possess equally varied experience, training and educational backgrounds. This diversity is further enhanced by their adaptation to the dramatic social changes that have affected much of the region since colonization, such as urbanization, globalization, population migration and displacement due to civil conflicts (Good, 1987). Whenever, African healers' knowledge, attitudes, beliefs and practices about STIs and AIDS have been explored, findings have reflected the stage of the epidemic, the amount of information these healers have been exposed to, and their

preexisting belief systems about health and disease in general, and STIs and AIDS in particular. Many reports have noted the genuine interest and enthusiasm of traditional healers to collaborate with their biomedical counterparts. Social research has shown that, in many countries, healers could name and describe numerous types of STIs (which do not always correspond to the biomedical definition).

The recent acknowledgement that the widely practiced culture of circumcision in Africa reduces by about 60% the chances to contract HIV is a confirmation of the authenticity of African cultural practices. The interesting dimension with this is that some of the people whose ancestors used to practice this tend to doubt the efficacy of such treatments in relation to HIV and AIDS.

However, some of the African traditional treatments deal with opportunistic infections and do not address the core of the disease and up to 80% of people in the less developed world rely primarily on traditional medicine for their primary health-care needs (WHO). Although the actual number of traditional healers is unknown in most countries, such healers constitute a significantly large group of practitioners who are recognized, trusted and respected by their respective communities. In Zimbabwe, attempts have been made to recognize the treatments prescribed by traditional healers through the recognition of the traditional healers association and their inclusion in complementary treatments. Traditional healers provide client-centred, personalized health care that is tailored to meet the needs and expectations of their patients. This makes them strong communication agents for health and social issues.

They have greater credibility than do village health workers, especially with respect to social and spiritual matters. They, thus, make valuable supporters and implementers of development initiatives. In resource-constrained settings, traditional medicine provides access to treatment where expensive imported pharmaceuticals cannot. Moreover, in some contexts, traditional medicine has been found to be as effective as biomedical treatment, if not more so, in treating HIV-associated opportunistic infections such as herpes zoster and chronic diarrhoea (Homsy, 1999). One worrying dimension is skepticism surrounding traditional medicine and traditional healing practices. The traditional healers are rarely included in health planning development issues despite their important role in treating diseases in the community.

METHOD AND MATERIALS

The Study Area

Wards 29 and 30 are two adjacent wards marking the southern limits of Makoni District of Manicaland Province of manicaland and are located 60 kilometres south of the

town of Rusape. The two wards cover Regions three and four of the ecological farming regions of Zimbabwe. They are typically marked by granitic features and outcrops particularly the northern end of ward 29 near Mutungagore Business Centre. The soils vary from sandy, loamy and some marked pockets of red clay soils. The rainfall is highly erratic in these wards with frequent droughts in recent years. The main mountains in ward 29 are Mutungagore and Weya whilst Nyakunu Mountain is a major boundary feature between the northern limits of the wards.

The vegetation is heavily decimated through human activities although banks of the major rivers and mountains still contain a representative stock of species typical of savanna climate. The two wards have typical remnants of typical dry and wet savanna vegetation with marked varieties of *branchystegia* speciformis to the northern ends whilst the southern ends are marked by typical acacia woodlands. The major river within ward 30 is Nyamidzi River from which the communities draw water for gardening and their livestock. The river drains west wards towards Mucheke River. Nyamatendera is the major river that dissects ward 29 and is a tributary of Nyamidzi River.

The population in Makoni District increased from 242 611 in 1992 to 272 578 in 2002(12.4%). This increase is attributable to the new settlers brought in by the land reform programme and to natural increase. According to the 2002 census ward 29 had a male population of 1788 (46.09%) and a female population of 2091 (53.91%) giving a total of 3879. The sex ratio was 85:51 from 948 households with an average size of 4.09. Ward 30 had a male population of 2995(46.94%) whilst females were 3385(53.06) giving a total of 6380 and a sex ratio of 88:48 with an average household size of 4.68. The two wards are dominated by communal farming growing mainly maize and rearing cattle for draught power. Currently, some farmers have shifted into tobacco farming with mixed fortunes since this is done through rain fed and the rain has been highly variable in recent years.

The population depends heavily on food handouts during time of droughts. There is an evident diaspora effect particularly in ward 30 with most people surviving on cross border trading into South Africa. The major business centre in ward 30 is Chitenderano Business Centre where services include a range of general dealer shops, bottle stores, a clinic, a police station and registrar's office.

The catchment area for this centre goes beyond the limits of the ward to cover a radius in excess of 25 kilometres. The population in the two wards gets most of their services from this centre. To the northern end of the ward is located Chikobvove Business Centre which services mostly the newly resettled population within the ward. Ward 29 has Mutungagore as its major business centre plus a small centre called Nhedziwa. The two major centres are connected to electricity. The wards have five secondary schools enrolling in excess of 1800 pupils and nine

primary schools enrolling more than 2500 pupils. The road network is not regularly maintained despite the high rate of mobility.

METHOD

This was a survey of the residents' perceptions on preferences for alternative and complementary treatments in wards 29 and 30 of Makoni District of Manicaland Province in Zimbabwe. The general approach combined qualitative and quantitative data to account for the discrepancies in both method and responses to the series of questions.

The qualitative technique adopted descriptive and interpretative variations of phenomenology so that a deeper understanding of the setting of the phenomenon could be better understood in its context. The qualitative approach has great impact in studies of this nature where the views of the residents and their lived experiences were critical in understanding issues of spirituality surrounding the HIV. Qualitative research describes life worlds from the point of view of the people who participate, so as to create a better understanding of their experiences in HIV and AIDS treatment. In depth interviews were useful in profiling the knowledge on alternative and complementary treatment of HIV and AIDS. Interviews alone were not adequate to capture the diverse opinions from a large proportion of the residents and thus a questionnaire was designed to cover for these shortfalls. Knowledge about indigenous practices is usually spatially constrained time dependent. Thus, the reservoir of knowledge around the communities in the wards was confined to a limited number of individuals and its extraction from these social repositories was constrained by secrecy and mythical approach to issues pertaining to traditional and cultural practices.

To afford individuals in the wards equal opportunity to respond to the questionnaire the population was stratified by ward and the population determined. Villages were then subjected to a simple random sampling to select the number of actual heads of households who were within their homesteads during the time of visit. Due to time, distance and cost constraints the survey was based on a small sample of 100 respondents equally split between the wards to 50 respondents per ward for responses to a pretested questionnaire. This was then followed by informal interviews and discussions with elders in the community, community health workers and officials within the wards who are privy to the issue of HIV and AIDS and its treatment. Interviews were critical in establishing the extent to which the residents in these wards used alternative treatments for various types of ailments related with HIV and AIDS.

The questionnaire comprised closed ended questions

Table 1: Respondents' Knowledge of HIV and AIDS

Variables		Religion	
		Christianity	Other
ARVs cure AIDS	Yes	3%	0%
	No	97%	0%
Total		100%	0%
HIV is transmitted through sexual intercourse			
Marital Status	Yes	No	Total
Married	64%	36%	100%
Single	73%	27%	100%
Widow	82%	18%	100%
Spiritual healing can treat the disease			
Sources of income	Yes	No	
Farming	11%	89%	
Self-Employed	3%	3%	
Other	1%	8%	
Total	15%	100%	

to which respondents had to tick yes or no to a variety of questions on knowledge, attitudes and perceptions on HIV origin, spread, cure, treatment and preferences for treatment. This model was selected basing on its strengths of enabling a quick feedback on a variety of questions and to limit wayward answers. To guarantee a high return 90% of the copies of the questionnaire were distributed through conducting personal interviews with targeted respondents. The background information on the knowledge of the respondents of the disease helped in evaluating the level of knowledge among residents and to establish any relationship with the preferred treatments.

Data analysis included reduction of data into manageable units, coding, data organisation and then data interpretation with the backup of existing theory (Alston and Bowles, 2003). The data were then organised according to subthemes covering the social background of respondents and their preferences on treatment for HIV and AIDS. The final presentation was guided by the major subthemes of the questionnaires and presented in the form of graphs and tables.

RESULTS AND DISCUSSIONS

Respondents' Knowledge Of Hiv And Their Socio-Demographic Characteristics

The respondents showed a general understanding of HIV and AIDS, its origins, spreading, management and treatment (Table 1). The small percentage that agreed that ARVs cure HIV and AIDS was most likely a conceptual confusion rather than fact. The same applied to the issue of transmission of the disease and the role of

spiritual healing. Most respondents attained basic primary education and have been exposed to information on HIV and AIDS through the radio, news papers, and television and community health workers in the area. This confirms the high level of global awareness on HIV and AIDS. Massive global resources have been committed towards disease management and treatment through the United Nations. The disease has become a central policy issue for non-governmental organisations and governments. Though rural settings could have taken long to accept the disease the information on the disease has broken cultural barriers to the extent of prompting the traditionalists to seek treatments. Knowledge of the disease is high among Zimbabweans. The disease has permeated all sectors of the social fabric and is a major killer in the communities. Awareness also came through experiencing high rates of deaths within a short space of time.

Local studies through the Central Statistical office (CSO, 2000) have since established that HIV/AIDS awareness in Zimbabwe was relatively high. For example, among young people of ages 15-24 years, almost three fourths (74%) of young women and 83% of young men knew that a healthy looking person could be infected with HIV (UNAIDS, 2004). The work of non-governmental organisations has helped to increase awareness in rural settings and to the extent of minimising stigmatisation associated with the disease. In the absence of people's voices, their needs and The socio-economic conditions of rural residents are expectations are assumed to be addressed at societal level.

Highly susceptible to the transmission of HIV because

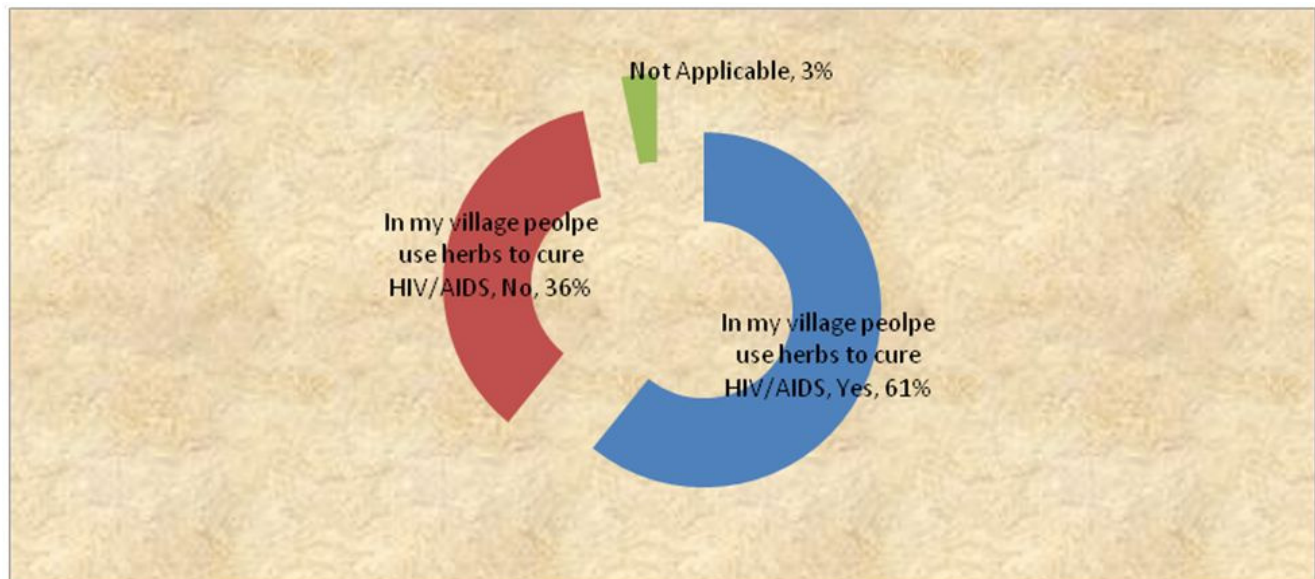


Figure 1: Knowledge on the use of herbs to treat HIV/AIDS

they constitute a risk population (Rugamela, 1999). They are exposed to the urban culture brought mainly by their spouses who work in factories in the cities. In the 1990s at the height of industrial production in the country the two wards used to have a high proportion of female headed households partly because their husbands had migrated to Harare in search of employment. Today the high rate of female headed households in the area could be due to deaths of spouses. The high proportion of people who are today on ARV treatment are evidence of the seriousness of the impact of the HIV and AIDS in the wards. In addition rural life is monotonous and the men indulge in alcohol, drugs and sex exposing their spouses to HIV and AIDS. The slow progress in rural development has also increased the burden of the disease.

The two wards are generally poor depending on rain fed farming. The rainfall is erratic and they harvest little to feed their families. Treatment usually should be supported by adequate food supply. Poor people globally are least able to access information and treatment let alone regulate their lives (Ainsworth, 2000). Gender inequality is another socio-economic condition found in most rural households and this increases the vulnerability of residents to HIV and AIDS infection. Gender inequality increases both women and men's vulnerability to AIDS because gender is the society's way of defining roles, responsibility and behavioral traits of men and women (Gupta, 2000). Such a set up fosters society's unequal treatment, which both inhibits many from protecting themselves against AIDS and from leading safe and sexually fulfilling lives (Heise and Elias, 1995). Women are also subject to gender inequality that includes less

access to HIV information and treatment.

Religious And Spiritual Thinking On HIV/AIDS Treatment

Sixty one percent (61%) of the respondents indicated that herbs were common in the two wards and were used to cure the disease (Figure 1). The use of herbs has been traditionally the domain of the traditional doctors as representatives of the spiritual world in communities. However, studies that have directly examined associations between religious involvement and hospitalization have produced mixed results. While terms such as religiousness and spirituality are often used interchangeably, they may have different associations with health and use of health services. Religion has been defined as an organized system of beliefs, practices, and symbols designed to facilitate closeness to a higher power, and it emphasizes relationship with and responsibility toward one another in a community. Spirituality, on the other hand, is characterized as the quest for understanding life's ultimate questions and the meaning and purpose of life; it emphasizes individual experience and may or may not lead to participation in a community. These beliefs systems have a strong bearing on preferences for treatments not only for HIV and AIDS but for diseases in general.

The respondents were in agreement that a number of the residents used herbs to treat HIV/AIDS. However, the number of those who did not use herbs was high enough to be a cause for concern regarding the importance of

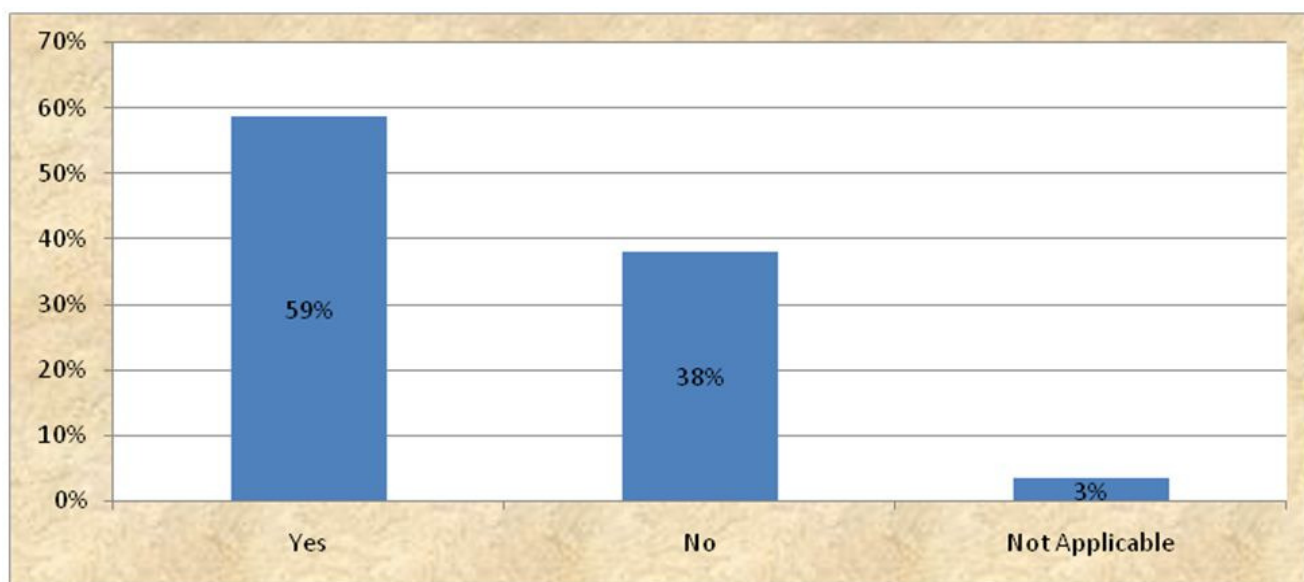


Figure 2: Opinions on the role of spiritual healers in the treatment of HIV and AIDS

herbs in the two wards. The use of herbs in the villages is an old tradition that has been practiced and adopted by rural communities. Communities tend to exploit resources within their localities for their benefit in the field of traditional medicines. Whilst the general public had some elementary knowledge of the traditional herbs this has always been the preserve of the elders and healers in the community. Thus, for the communities to fully benefit from this indigenous technical medicinal knowledge the myths surrounding the practice has first to be unmasked with a view to understand it and work towards integration with modern medicine. An encouraging dimension to this scenario was that the respondents recognised the role of these herbs in the physical and mental health of an individual.

Those vested with the powers to identify specific indigenous herbs for the treatment of HIV and AIDS do so under the influence of the spirits and the knowledge is not freely shared. The ancestral spirits are supposed to prescribe the drug to the patient. Members of the families taking care of the infected need only to know when the drug is to be taken and not the formulation of the drug. Whilst this is the general practice in modern medicine in traditional medicine there are no schools to teach people to prescribe drugs.

Residents indicated that there was a high number of people who sought treatment of HIV from the spiritual healers (Figure 2). The traditional healers in this area usually use both indigenous and exotic herbs. Residents have established herbal gardens for these purposes. Traditional medicine proved to be beneficial to HIV and AIDS treatment, prevention, care and support. Stigma,

myth, and mystery are perverting progress in the use and development of treatment programmes. There are those who believe that one can be healed through prayer and those that actually believe in the powers of prophets and other religious healers in treating the disease. However, 38% did not believe in this approach of treatment.

Figure 3 shows the distribution of respondents in relation to their opinions on the consultations of traditional healers with respect to the treatment of HIV and AIDS. The majority of the respondents (58%) were of the opinion that traditional healers had the treatments for HIV.

The traditional healers have been known to provide medical advice to those in authority as well as to guide the spiritual needs of society with regard to diseases and adherence to practices.

However, the number of respondents who disapproved this approach of treatment of the disease questions the very fabric of the cultural dimension to the treatment of the disease. The traditional healers have been known to provide medical advice to those in authority as well as to guide the spiritual needs of society with regard to diseases and adherence to practices. There is still a high element of confiding in the work of traditional healers and even in circumstances where it is established that a relative died of HIV and AIDS people conduct cultural postmortems through these traditional healers. The remainder could be doing the same but using the Christian platform as an alternative for consultation and treatment.

The respondents recognised the role of churches in the treatment of HIV and AIDS since they provide spiritual

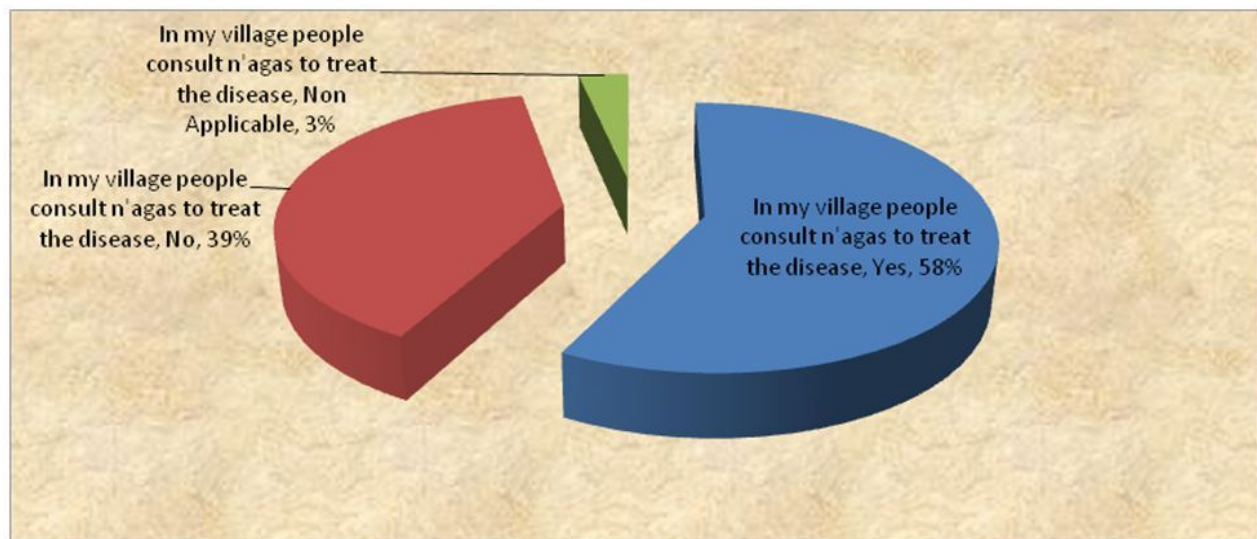


Figure3: The role of traditional healers (na'ngas) in treating HIV

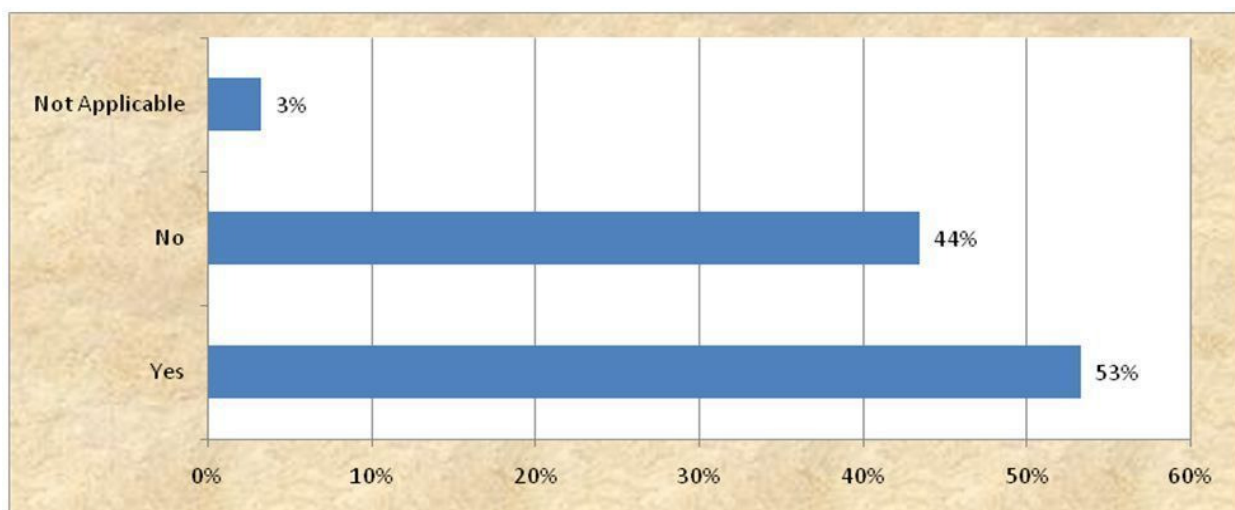


Figure 4: Treatment of HIV through the Church

and material support. However, they doubted its centrality in disease treatment in these wards since a combined 47% did not approve of it. Matters of spirituality and religion in the treatment of AIDS have widely been accepted. This trend is observed in literature as a process of dehumanising medical care particularly in the developed world.

From an African perspective the traditional practices are a way of life and there is more business that goes towards the traditional healers than through the modern medicine facilities. The impact of Christianity on the traditional values of rural residents in Zimbabwe has

become more entrenched with a daily discouragement of members from practicing 'acts of witch craft.' However, there has been a move towards the use of herbs including traditional ones within the church system (Figure 5). It was established during the study that the confusion surrounding individual identity on Christianity and traditionalism could have been the driver for some members of the community to opt for alternative treatments. Church congregations are strong drivers of complimentary HIV and AIDS treatment in the community (Figure 4)

The care goes beyond one's denomination including.

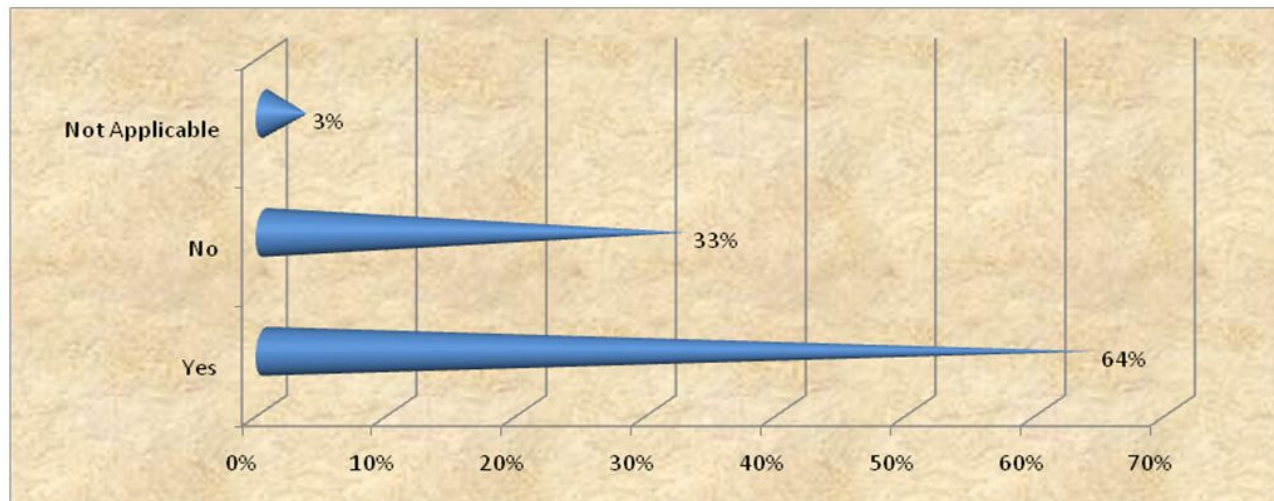


Figure 5: Use of traditional and modern methods in HIV treatment

non-church members. The response to the need for treatment varied from village to village depending on the level of advocacy and the availability of resources to support the infected. However, there seemed to be lack of organisation and coordination on psychological and spiritual support. Usually, a fraction of the church congregation in each village without necessarily having to be sanctioned by the authorities participated in the activities that provide moral support to those infected. These activities were sometimes part of the church routine, aimed at supporting members in distress, as well as similar regular or occasional activities outside the congregation (especially home prayer visits).

People often turn to religion to make sense of and come to terms with being HIV-infected. Prayer, meditation, faith in God, and other forms of religious participation have frequently been cited in literature to be part of treatments for those who are infected (Makaoe et al 2008). Studies conducted in the United States have found that the infected use religion to cope with their illness (Cotton et al. 2006 and Pargament, 2009), that being diagnosed with HIV often strengthens people's faith, that an increase in spirituality/religiousness after being diagnosed with HIV is correlated with slower disease progression and that spiritual beliefs about HIV influence end-of-life decisions.

There are a number of conceptual and empirical studies that documented the relationship between spirituality and health, particularly the role of spirituality in health and helping those with serious illnesses, especially where spirituality is viewed as a strong predictor of people's quality of life (Aldridge, 2000; Buck, 2006; Calderon, 1997; Goodier and Eisenberg, 2006; Mathews, Berrios, Darnell and Calhoun, 2006). This role of religion

continues to receive attention. Buck (2006) argues that spirituality influences adaptation to chronic illness. Spiritual meanings are linked to actions, such as prayer, meditation and worship, and healing. In some instances, ecology of treatment at, psychological, social, and spiritual levels all meet the needs of the sick, which includes prayer, laying-on of hands, and a celebration of their faith (Aldridge, 2000).

Respondents acknowledged the use of combined treatments for HIV (64%). The reason for this could be that people have a fusion of cultures and practices that when they are faced with illness they resort to using different methods until the patient recovers. Some of the residents are driven into these combinations through the shortage of ARVs or their erratic supply to those in need. Furthermore some have taken the medications and they have not improved in fact their health deteriorated. Perhaps the combination will save the situation. Figure 6 shows the distribution of respondents concerning knowledge on the side effects of ARVs. There was a greater proportion (76%) that was aware of the side effects of taking modern medication. Whilst the respondents indicated that they would prefer the use of traditional medicines in the treatment of HIV and AIDS, treatment adherence is a major challenge facing those on ART and traditional herbs. The experience is just nasty given that the treatment could be for one's life time. When this is compounded with other religious ceremonies and rituals it becomes too much for an individual. These treatments need also to be augmented with balanced diet in both rich and poor countries.

The visit to traditional healers could be as a result of denial of the disease. Denial is found at an individual level where most people, think that they are safe from

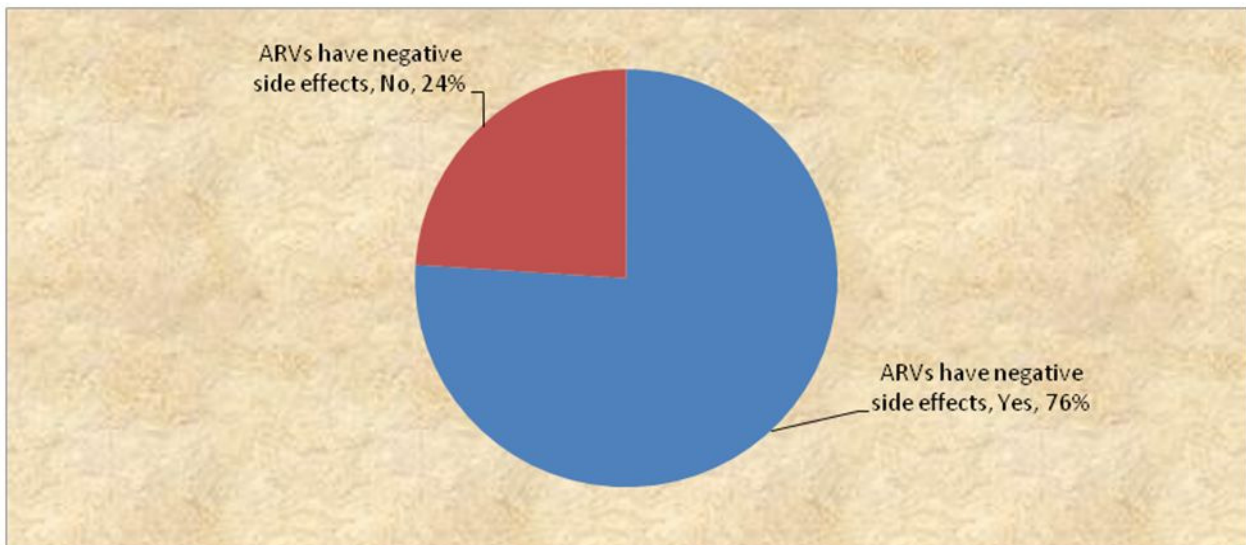


Figure 6: Distribution of respondents by knowledge of the side effects of ARVs

infection even as they engage in risky sexual behaviours (UNAIDS, 2004). The proportion of respondents that indicated that ARVs have side effects could be driven by denial of their status. It has been established that some people in Africa believe that AIDS is nothing more than a new name for old diseases therefore no preventive measures can be taken to reduce its infection (Wakantse, 2000). Denial is characterized by two things that is denial that AIDS as a disease exists and the denial by some people that everyone can get it. For example in the Tswana culture any long illness is interpreted as the result of a spell or a curse rather than anything having to do with sexual behaviour (Wakantse, 2000). Locally rural people continue to allege the play of witchcraft whenever a relative succumbs to the disease. Even the post mortem is conducted for some families using the traditional ways of consulting a traditional doctor. They still believe in the powers of the evil spirits in fanning death in a family. Such behaviour is denial of what the western medicine has established as fact globally. For them a long illness may be attributed to the breaking of a taboo such as sleeping with a woman during her menstrual period, having intercourse with a widow or with a woman who has had a miscarriage. These beliefs particularly in the rural areas continue to hamper progress in the management of the disease.

Until very recently, the family was given little attention on the consequences of AIDS to the family. One reason for this inattention to the family and household consequences of AIDS might be the presumption that AIDS is first and foremost an individual disease: that is, the chain of HIV exposure, infection, disease, and death is obviously an individual phenomenon. In the first place,

the primary avenues of HIV exposure do occur in a family context: sexual relationship, pregnancy and childbirth, and breast feeding to some extent. Secondly, the responsibility for care and support, especially in Africa as already mentioned, rests to a greater extent on the family and kin. Finally, in all societies the family or household is the important interface between the individual and the society. For example, if individuals are shunned or ostracized, either socially or economically, the family bears the brunt of the stigma and its consequences. Depending on the belief systems of the family they may resort to traditional treatments of HIV and AIDS as a way to cover up for the stigma associated with having to be tested and informed of one's status at a local clinic.

Traditionally, illness and health have been held to be a moral and social, rather than an individual and private, affair. This is because it is believed that a person falls ill because of sins of commission or omission against the gods and the ancestral spirits who are believed to (Anarfi, 1995) have a direct link with the living that is the whole society. The healing of the sick, therefore, makes use of ritual support involving a healer and some relatives of the sick person designated by the patient's family head. Having realized these entrenched societal belief systems and values it is imperative to the communities the right to choose alternative and complementary treatments in the face of the HIV and AIDS epidemic. The treatment of the disease is the responsibility of the family and ultimately a societal construction.

In order to undersatnd the respondents's knowledge of HIV treatments they were asked to express their views on the quality of those that were on ARVs (Figure 7). The general feeling was that taking ARVs could not result in

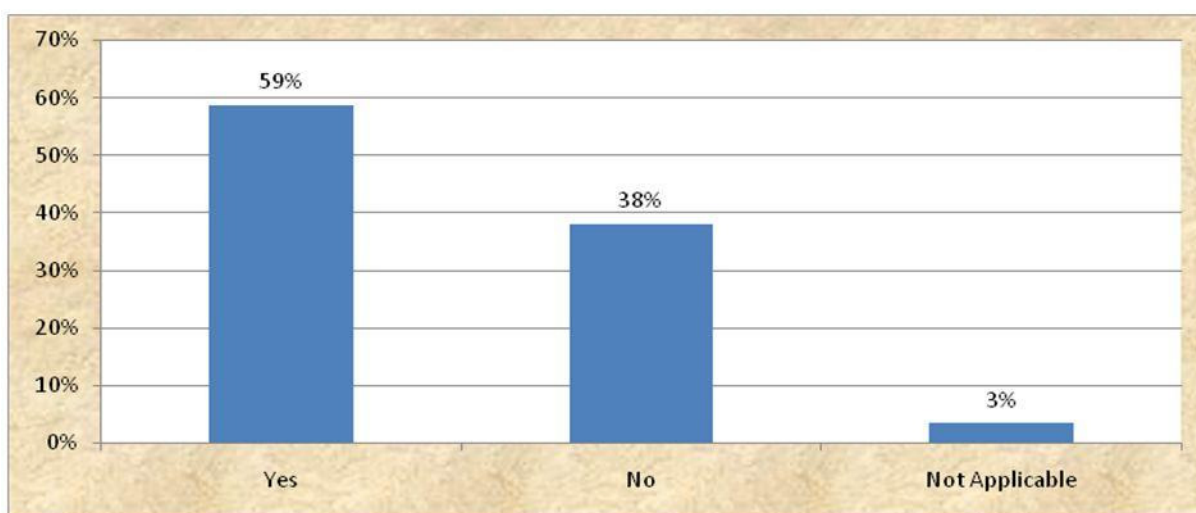


Figure 7: Distribution of respondents by knowledge of the effectiveness of ARVs

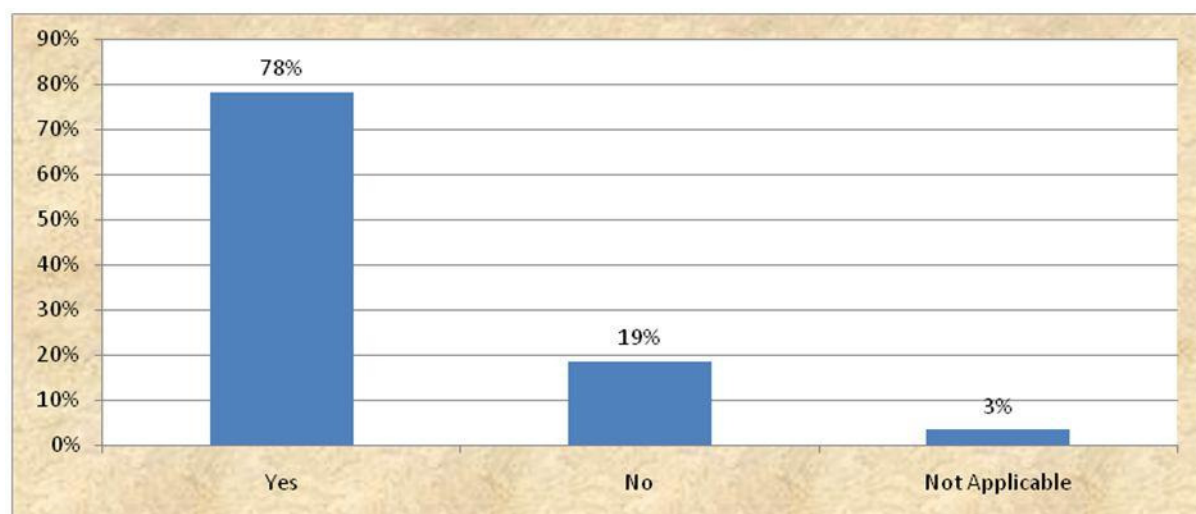


Figure 8: Preferences to use ARVs for treatment

the improvement of a patient. There are a number of reasons that could be advanced for these opinions. Firstly, some of the patients usually join these treatments too late when actually the taking of these drugs can no longer save the situation. Some it could be due to the use of complimentary treatments and they usually succumb to the side effects of such treatments. Thirdly, patients usually find it difficult to adhere to a treatment regime whilst others could be that the psychological effect that they are infected depresses them as they get into a denial mode. The family and ultimately the community has to take responsibility of those infected. However, the expected family care is usually absent due to other social pressures including absence from as people struggle for

their survival. The disease requires that one be on monitored diet but with the frequent droughts and related social maladies the family is unable to fend for the sick. The society has to take over but in most cases the people are incapacitated to help and let alone the clinical system where one has to pay for treatment.

Preferences For HIV/AIDS Treatment

When the respondents were asked on their preferences on different types of treatments (78%) for HIV and AIDS the ARVs came out as the most preferred treatment (Figure 8). This was almost identical to those

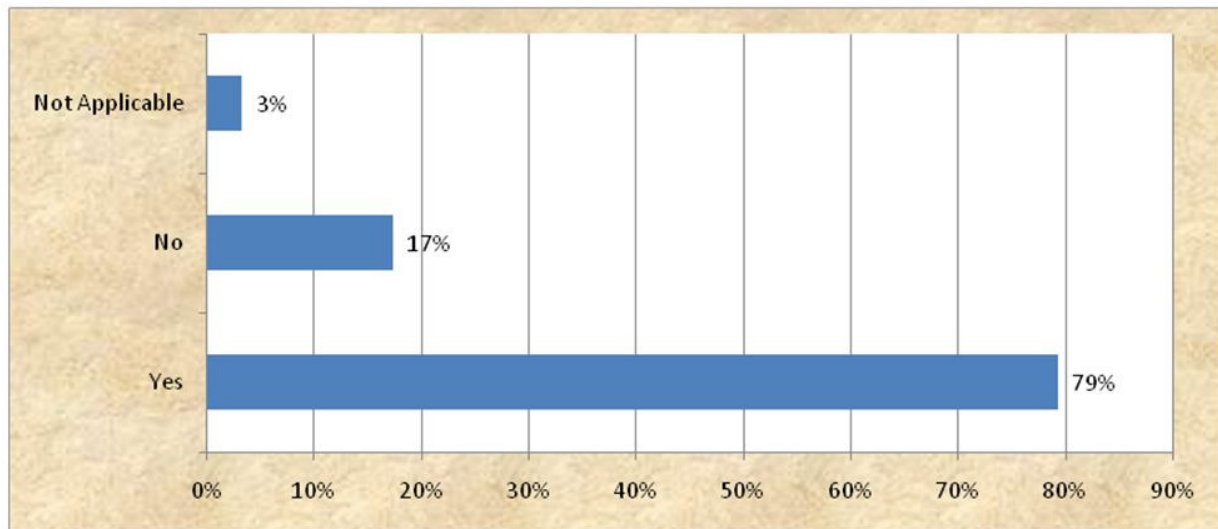


Figure 9: Distribution of respondents by preference of ART for HIV/AIDS treatment

who suggested that they would prefer to have their relatives on ARVs (79%). However, a combined 22% was against the idea of preferring ARVs (Figure 8) whilst (21%) were also against the opinion to recommend their relatives to be on ART (Figure 9). The emerging pattern is that ART is popular in the community since these are locally driven through the clinic and sometimes doctors make visits to observe and educate those on ARVs on how to live positively. The community in general appreciates the role played by the ART for most families and those infected.

Despite the observable improvements in the quality of life of those on ART there was still a large proportion of residents who could not trust the use of ARVs. Acceptance of a treatment plan can be driven by lived experiences with regard to the positive impact of the drug on the general physical and health condition of the beneficiary. ARVs have been proved to reduce the viral load but without eradicating the virus in body. These views are therefore valid that the eventual risk of the individual to death is not removed. This gives a sense of hopelessness particularly among the infected. The burden remains for the family members and the infected can succumb to the disease anytime. This large proportion of people which does not approve of the ART could not be adequately informed about the efficacy of the drugs in reducing the risk of death. Another dimension arises from the fact that, the wards have a proportion of the population that believe in the African types of churches (apostolic churches) where they do not take modern medication but rather survive on the powers of God the Almighty. These churches have in the past refused to give into the demands of the Ministry of Health

and Child Welfare and non-governmental organisations to have their children immunised against the killer diseases.

Figure 10 confirms that the majority of the respondents preferred the use of a combination of treatment (79%). The common packages of alternatives and complementary treatments identified in the two were concoctions of both indigenous and exotic herbs, faith healing and the traditional practices of exorcising the evil spirits associated with disease in the African community. The ceremonies practiced included the brewing of beer to appease the ancestors through communicating with them during the ceremonies. The belief is that the ancestors will help to fight the disease and cure the infected. Such practices are most likely to perpetuate ignorance on HIV and AIDS.

The respondents could have suggested that alternative treatments are better because of the erratic supply of ARVs. In instances where these are available in the country they usually are not delivered on time. It has been established in literature that in relation to HIV, alternative therapies are most commonly used in areas where it is difficult to access Western medicine. In the absence of antiretroviral treatment, people may seek other ways to delay the onset of AIDS, or to treat opportunistic infections. In sub-Saharan Africa, for example, traditional healers outnumber medically qualified doctors eighty-to-one (Mills, et al (2006). Traditional healers also usually provide immediate treatment, whereas clinics may have lengthy waiting lists and tests for eligibility. Most people living with HIV in developed countries have ready access to antiretroviral therapy and conventional treatments for opportunistic infections. In Zimbabwe the ARVs are

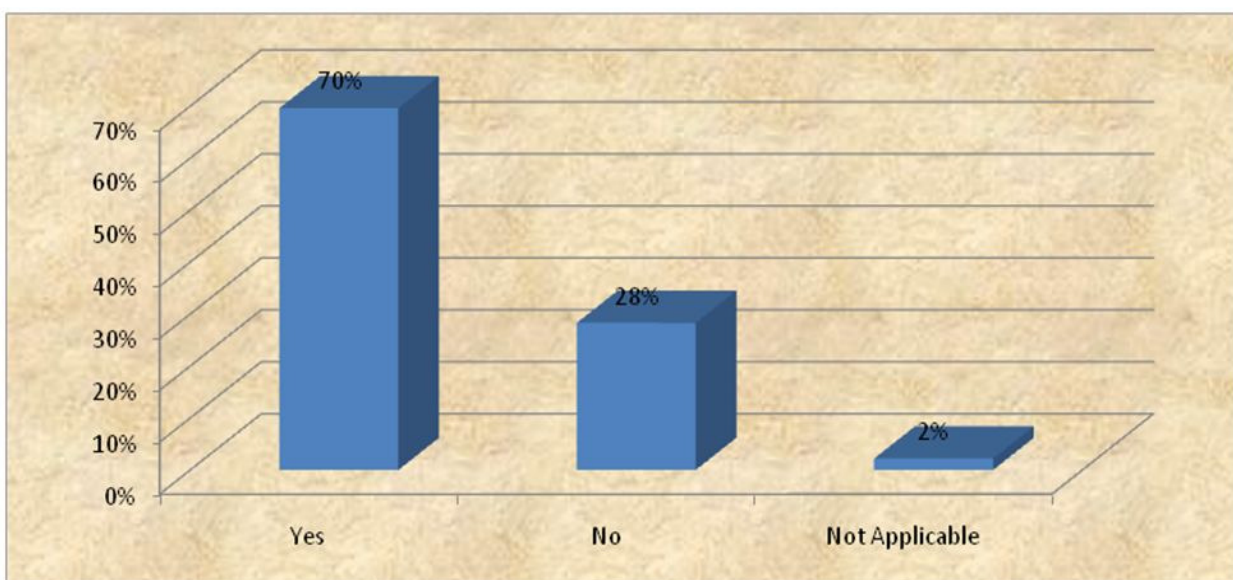


Figure 10: Preferences for a combination of treatment for HIV/AIDS

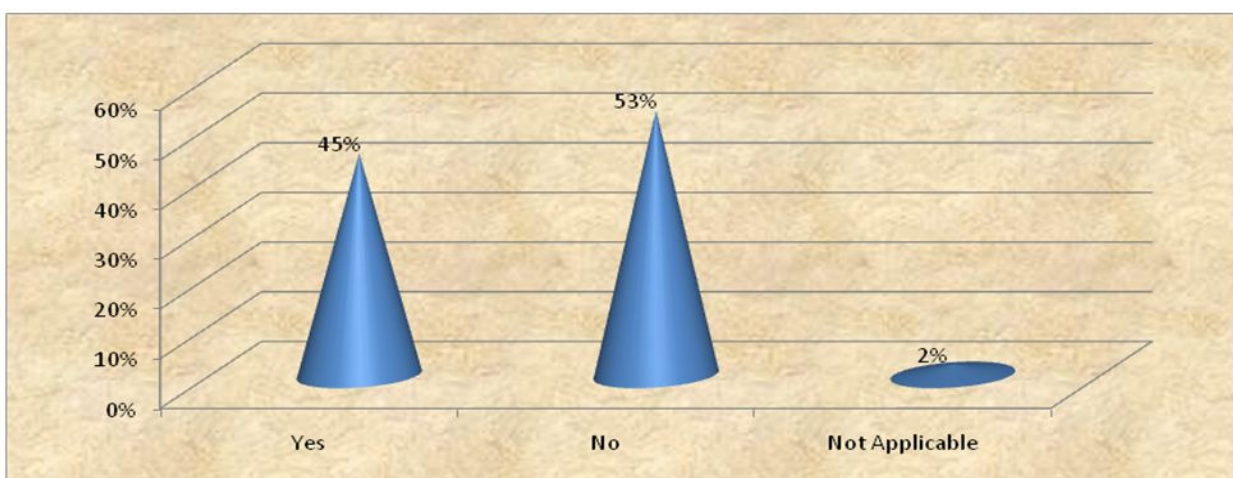


Figure 11: Preference for traditional means of treating HIV/AIDS

available in urban centres particularly whilst in the communal areas the population is deprived of medication. This may not only as a result of shortage in the country but logistical problems including lack of transport to the areas where they are needed. Some have recorded positive results using alternative and complementary treatments. Usually, opportunistic diseases are through these approaches treated at times at a very low economic and social cost. Economic costs refer both to the expenses incurred for treatment and the social costs refer here to the stigma and time wasted to travel to the nearest health centre. Many instead look

to complementary medicine as a way to prevent or relieve aids treatment side effects, some of which are not easily treatable with conventional medicine. There is also demand for complementary therapies that might boost immunity, relieve stress, or improve general health and wellbeing. At the political level there has also been a lot of discord with regard to the use of ARVs and alternative and complementary treatments for HIV and AIDS. This national discord in approach naturally cascades down to rural communities creating chaos and confusion.

Figure 11 shows 53% of the respondents preferring the use of traditional means of treatment. These

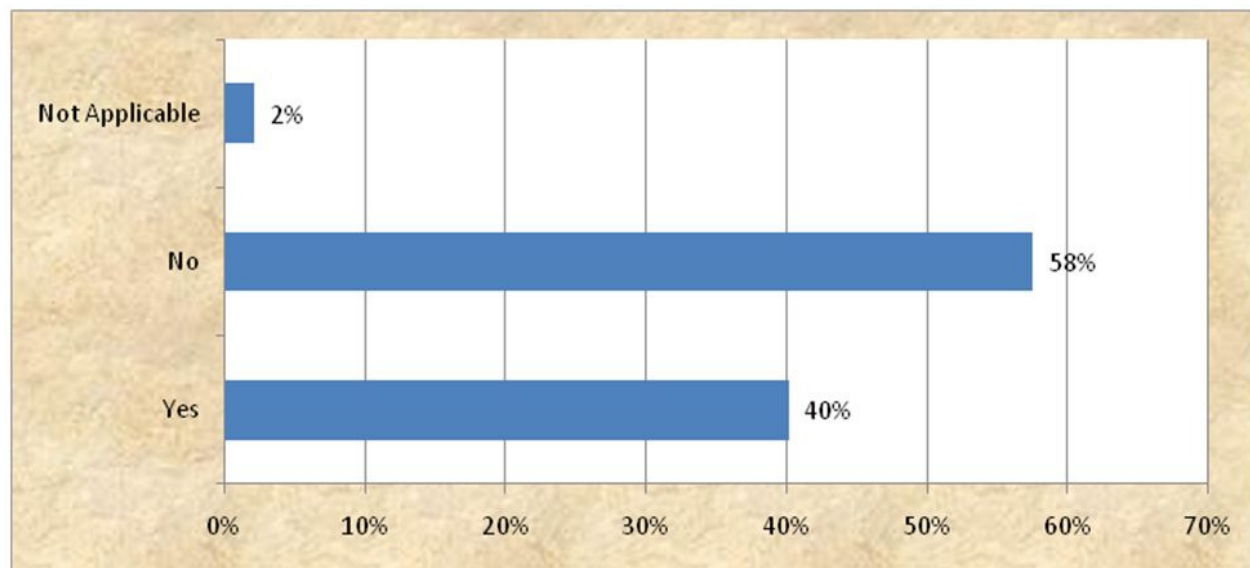


Figure 12: Distribution of respondents by effectiveness of spiritual healers in the treatment HIV/AIDS

encompassed ceremonies and traditional herbal concoctions as prescribed by the traditional healers in the communities. Some even sought assistance from outside their wards. Despite increased awareness about the disease people continue to give faith to the traditional beliefs systems. This dimension needs to be explored more profoundly with a view to understand the underpinnings of these practices and their impact on HIV and AIDS treatment.

Figure 12 below, shows the responses on the question that 'the spiritual healers perform miracles in the treatment of HIV and AIDS in which 58% were against the view of miracles in HIV and AIDS. However, the 40% that indicated that spiritual healing was taking place in the wards gave essence to the issue of Christianity and African traditional religion in matters of HIV and AIDS. Such feelings are not confined to the limits of these wards as elsewhere in literature there is increased awareness on the role of traditional and spiritual treatments in HIV and AIDS treatment and management.

Despite the lack of laboratory tests for most of the traditional treatments there is little doubt that some of the doses given by traditional healers are effective in treating HIV-related opportunistic infections. However, in common with all forms of medicine, these therapies may also do harm through side effects, drug interactions, or delaying use of conventional treatment. It should be noted that the reuse of implements for rituals such as, tattooing and circumcision can transmit infections, including HIV. Some African healers blame illness on witchcraft, which can lead to ostracism of those accused. Collaboration between traditional healers and Western doctors has the

potential to improve safety, for example by encouraging better hygiene.

Religious beliefs significantly shape individuals' views and opinions on HIV and AIDS treatment. Genrich and Brathwaite (2005) acknowledge that faith practices and beliefs can provide a sense of peace and hope, and can also help people to prepare for and accept death. Religious beliefs about HIV can also contribute to fatalistic attitudes and passive resignation, which hinders participation in treatment. In one study from rural Mali, people who believed that AIDS was a punishment from God had more fatalistic attitudes (e.g. agreeing to the statement "I believe that if a person has HIV and AIDS most treatments will not change anything") than those who did not (Hess and McKinney, 2007). The belief that prayer can cure HIV may also challenge adherence to antiretroviral (ARV) treatment programmes. A study on ARV adherence in Uganda found that 6 out of 558 (1.2%) patients discontinued their treatment because they believed that their pastors' prayers had cured them of HIV (Wanyama, 2007). These treatments were also common in the area of study despite the lack of a coordinated approach for its implementation.

Conclusions and Policy Implications

This study focused on preferences for alternative and complementary treatments for HIV and AIDS in wards 29 and 30 of Makoni District of Zimbabwe using a pretested questionnaire. The major forms of complementary and alternative treatments in the study area include the

spiritual and the traditionalist approaches of treatment that uses herbs collected from the wild forests. These CAM were popular in the study area as evidenced by the high number of respondents who preferred to use combinations for treatments. The traditional belief systems are still alive and have a strong bearing on the treatment of HIV and AIDS. The treatment regimes should take into cognizant the expectations of those who are ill, the society and most importantly the family unit. The disease treatment regimens are first and foremost the responsibility of the family and ultimately a societal construction. These societal construction of those affected and infected must be translated into inclusiveness in terms programme design and development.

The belief that prayer can cure HIV may also challenge adherence to antiretroviral (ARV) treatment programmes. The use of ARVs for treatment was generally perceived to have improved the quality of life of individuals in the community although some continue to succumb to the disease. There is room for scoping for the disease in a manner that will improve adherence to treatment regimen and explore the possibility of using CAM treatments in a more progressive manner. From a policy perspective those responsible for the development and monitoring HIV and AIDS control and management like the Ministry of Health and Child Welfare and the National Aids Council should take note of the popularity of the complementary and alternative treatments in the wards and initiate programmes to record the stock of traditional methods. These would then be implemented in other areas and may assist in combating HIV and AIDS at a national level.

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