

MA Research Report

What role do nurses play and what are the cultural challenges they face in culture brokering in HIV/AIDS prevention activities in Mophale's Hoek District, Lesotho?

Research Report prepared in partial fulfillment of the requirements for the Masters in Arts by Coursework and Research Report in the field of Health Sociology

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DECLARATION

I declare that this is my own unaided work. It is being submitted for the Degree of Masters in Arts at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any Degree or Examination in any other University.

Name

Signature

22nd Day of June 2011

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First and foremost I thank the almighty God for giving me the opportunity and strength to carry my Research Report through.

I thank my family for having faith in me and the work I have fulfilled. Mom, Dad, my two brothers and Nkhono, thank you for your undying support and prayers, for it is through your trust in me that I have been able to overcome all difficulties and completed my Research.

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ABSTRACT

This Research Report explores the cultural challenges faced by nurses in HIV/AIDS prevention activities in five Health Centers of Maseru, Lesotho. It investigates in turn what role nurses play as culture brokers. Lesotho faces major challenges from HIV/AIDS with high prevalence rates. Despite the governments' significant efforts in the fight against the disease, these efforts have been largely unsuccessful in combating new infections. At the fore front of the struggle against HIV/AIDS nurses play a crucial role by providing services related to HIV prevention, treatment and care. With the increased burden of HIV/AIDS on nurses, expectation is that as biomedical Health Care providers nurses should go beyond the parameters of biomedicine and provide a more holistic approach towards provision of care and support to the patients and educating their patients about HIV/AIDS. In conclusion this research was able to suggest positive aspects of Sesotho culture that can be included in HIV/AIDS prevention interventions.

This research focused on five Health Centers where fifteen face to face open-ended interviews with nurses at the Health Care Centers were carried out. The principle research method employed in this research was semi-structured interviews.

The research findings show that nurses working in the five Health Centers are responsible for facilitating HIV/AIDS prevention activities. Their responsibilities in providing various HIV/AIDS services not only take place in Health Center settings but often take place in nearby villages through interactions with community members and administering the HIV/AIDS services while making their community visits. Nurses described some of the personal challenges they faced but a lot of the problems that nurses have to deal with which constrains their efforts in the prevention of HIV are mainly structural and cultural in nature, ranging from economic dependency, overexposure to HIV/AIDS prevention messages, youth culture and HIV/AIDS to current prevailing perceptions about HIV/AIDS, gender and socio-cultural practices and risky sexual behaviours that expose men and women to HIV.

Overall the findings show first and foremost, though nurses are not aware of the concept of culture brokering, in fact they are not even aware that they are engaging in activities of brokering, the process of culture brokering is evidenced by the numerous activities that nurses engage with to successfully facilitate HIV/AIDS prevention strategies. Second, the awareness of

nurses that there are differences in values, beliefs, and behaviors of the people and communities they service, and understanding that these values, beliefs and behaviors are the basis for the way people interact with each other form part of the process of brokering. Third, another important role within this process is what nurses decide to do with the information they have about the people they work with. By guiding them on how to protect themselves against HIV through educational talks, interactions in the communities, collaborations with other significant figures and translations of messages in Sesotho qualifies as a tactic in problem solving. Lastly, drawn from the nurses' various opinions about what is suited as competent to be included in HIV/AIDS prevention strategies in Lesotho, the researcher was able to gather and conclude what aspects of Sesotho culture can be considered for inclusion in HIV/AIDS strategies.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral drug
BCC	Behaviour Change Communication
CHAL	Christian Health Association of Lesotho
CSW	Commercial Sex Worker
DETR	Department of Environment, Transport and Regions London
HCTNC	High Commission Territories Nursing Council
HIV	Human Immunodeficiency Virus
HSA	Health Service Areas
IRIN	Integrated Regional Information Networks
KYS	Know Your Status
LNC	Lesotho Nursing Council
NAC	National AIDS Commission
PEP	Post Exposure Prophylaxis
PHAL	Private Health Association of Lesotho
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
SANNAM	SADC Aids Network of Nurses and Midwives
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing

CHAPTER ONE

1.1 Introduction

Mohale's Hoek is one of the ten districts of Lesotho and includes in its constituencies five of the Health Centers chosen for this study. It takes about two hours to get to the district from the capital city Maseru. Mohalinyane Health Center is one the five Health Centers chosen for this study and the first to be visited by the researcher. This Center is positioned right at the hub of a village called Mohalinyane. Villagers from Mohalinyane and other surrounding villages are dependent on this one Center for health care services and assistance. It is enclosed by vegetable gardens and two huge water tanks, at the far end there are four staff houses for the nurses and two pit latrines. In the early hours of the morning villagers leave their homes to queue at the Center, by the time that nurses arrive for work they are greeted by a queue outside the Center, majority of which is pregnant women. From observation, nurses service large numbers of patients daily. They face daunting workload volumes especially with the impact of HIV/AIDS and services offered to minimize the impacts of the epidemic. This has negative implications for service quality as well as for retention of nursing staff. There is a high nurse turn over rate across the country and Mohale's Hoek has been experiencing shortage of nurses and doctors. Nursing assistants hence have to make up for the shortage of skilled nurses and these assistants often are left to do the job of nurses without proper training.

All the five Health Centers in Mohales' Hoek including Mohalinyane are located in the rural areas, outside of the urban town of Mohale's Hoek. At the primary level of health care, these Centers are part the 12 Health Centers in the district of Mohale's Hoek, that altogether including one Government hospital (Ntsekhe hospital), service a population of about 185,459 (Lesotho 2006 Population and Housing Census, 2009). Necessary arrangements to meet with 15 nurses had been made prior to arrival in the District. From observation, dressed neatly in their white uniforms the nurse assistants at Mohalinyane Center seemed eager to get started with their work and to shorten the queue of patients that they had to service for the day. Clearly evident is two differing interactions taking place at the Center, that of a biomedical world versus Sesotho culture. These nurses are bounded by biomedical practices and at the same time exposed to Sesotho traditions and way of life.

This Research Report explores the cultural challenges faced by nurses in HIV/AIDS prevention activities in five Health Centers of Mphahle's Hoek. It investigates in turn what role nurses play as culture brokers. In conclusion the report suggests positive aspects of Sesotho culture that can be included in HIV/AIDS prevention interventions.

1.2 Statement of the problem and Subsidiary Research questions

Lesotho has one of the highest HIV/AIDS prevalence rates in the world standing at an estimated 23.2% (UNAIDS, 2008). By way of responding to this alarming reality, Lesotho's HIV/AIDS Strategic Plan mission is to provide comprehensive high quality HIV and AIDS services and community led interventions which reduce new infections, provide treatment, care and support, and impact mitigation for all Basotho whilst recognizing and assuring participation of all stakeholders (Government of Lesotho, 2009). Despite the HIV/AIDS prevention initiatives that have been put in place, the epidemic still has profound effects in Lesotho and the challenge here is that these prevention efforts have not succeeded in combating new infections.

According to Gausset (2001) studies have shown how certain cultural factors have an influence positive and negative on HIV/AIDS. Moreover cultural factors in certain instances are viewed as barriers to the prevention of HIV/AIDS. Social and cultural norms and traditions in Lesotho are also recognized as hampering efforts to combat the rising HIV/AIDS epidemic (IRIN, 2003). Barriers can be understood as obstacles which prevent a given policy instrument being implemented, or limits the way in which it can be implemented which can result in strategies being much less effective. Thus cultural barriers refer to specific social and cultural practices, beliefs and traditions within a community or society and how these impact on self perceptions and the perceptions of others (DETR, 2000). These cultural factors are important because they have a huge influence on sexual behavior and some social and cultural norms or traditions can act as hindrances to HIV/AIDS prevention. Thus, cultural factors may act as barriers towards access and success of HIV/AIDS prevention efforts and the relation hypothesized is that the factors can further promote the spread of HIV/AIDS. However Gausset (2001) cautions against the sole focus on culture as an obstacle. For Gausset, cultural aspects are a wrong target of

HIV/AIDS prevention programs because they are not incompatible with safer behaviour and because their eradication would not ensure the protection of the people. Moreover to fight against them alienates the people whose cooperation is necessary if one wants to prevent the spread of AIDS. Hence, anti-AIDS projects should not fight against one culture in order to impose a biomedical cultural perspective but rather try to make behaviour and practices safer in a way that is culturally acceptable to the people (Gausset, 2001). This requires therefore for nurses to become culture sensitive brokers and for culturally competent HIV/AIDS prevention strategies to be developed.

Firstly, the primary research objective is interested in finding the cultural challenges faced by nurses in five Health Centers selected in Mohale's Hoek and in turn what role nurses play to confront the challenges. Further to this objective is; in what ways do they engage with their patients to convince engagement and use of relevant HIV/AIDS prevention services, and in what ways do nurses make an effort in understanding and connecting with their patients the importance of their different cultural views and that of biomedicine, which is referred to in this research as culture brokering. Second, having identified the challenges, the Research Report intends to gain a more informative understanding of the ways in which various aspects of the Sesotho culture may have an influence whether positive or negative, on the effectiveness of HIV/AIDS prevention activities. This means the ways in which Sesotho traditions, customs, beliefs, norms and practices may act as providing guidance to the way people view, accept and want to access prevention measures put in place in the country. Since nurses have the primary responsibility of carrying out HIV/AIDS prevention activities in health centers across the country, this research focuses on them to gain this knowledge, for they would know better about the challenges they encounter especially those that are more cultural rather than biological in nature. Having achieved these two objectives, the research envisions accomplishing contributions towards incorporating those positive aspects of culture in Prevention strategies.

Aligned to the above objectives the following are subsidiary research questions of interest to the research study. 1) What are the HIV/AIDS prevention challenges faced by nurses in Mohale's Hoek? 2) Have nurses recognized any prevailing social and cultural beliefs in Mohale's Hoek that link to HIV/AIDS. 3) From nurses' view point what is the influence of these beliefs and

norms on the sexual behavior that could possibly affect HIV/AIDS prevention initiatives? 4) From the beliefs and norms identified in what ways do nurses understand and interpret these beliefs and norms? 5) In what ways do nurses mediate or intervene to try to minimize the challenges faced? 6) What positive aspects of Sesotho culture can be included in HIV/AIDS strategic plans? Last, what does current academic literature say about culture and HIV/AIDS prevention?

1.3 background of the study

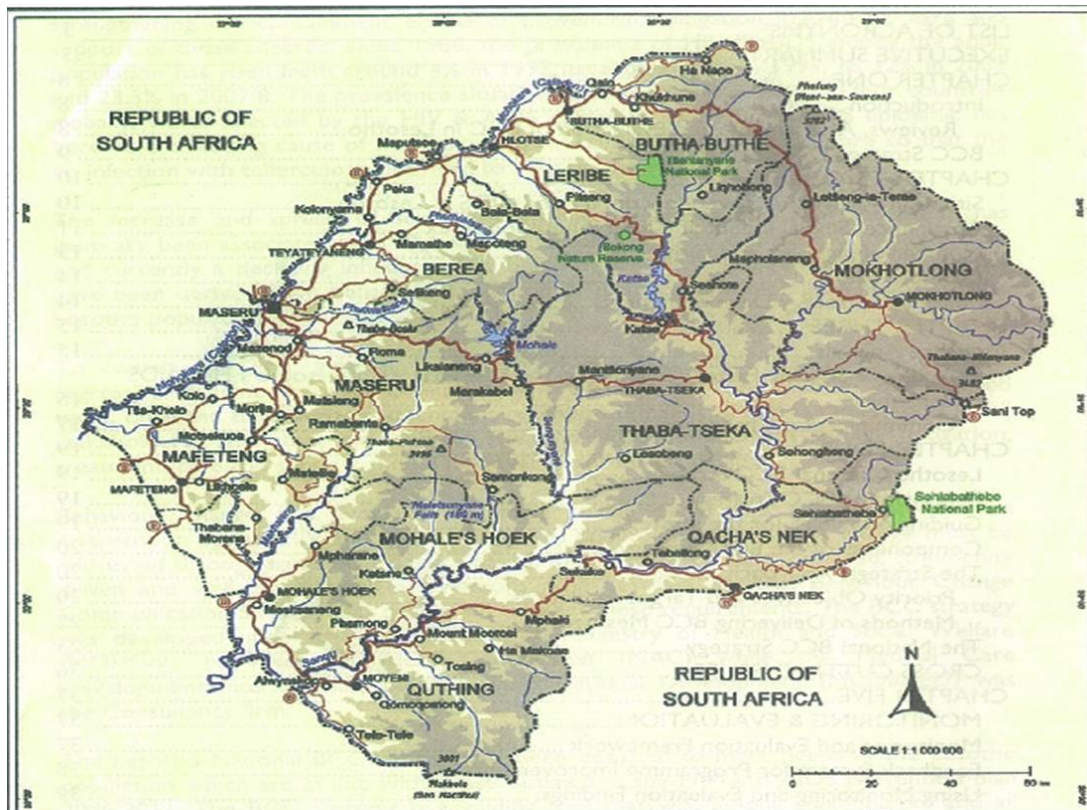
This Research Report explores the cultural challenges faced by nurses in Mohale's Hoek Health Centers within their HIV/AIDS activities and offered services, what role they play in culture brokering and lastly establishes which Sesotho aspects of culture should be included in the HIV/AIDS strategic Plan of Lesotho.

HIV/AIDS has become the leading cause of morbidity and mortality in Lesotho (*Behaviour Change and Communication Strategy, 2008*). According to the Lesotho HIV/AIDS Strategic Plan 2008, in 2007 there were an estimated 273,273 people living with HIV/AIDS in Lesotho where about 60 people die every day from AIDS related illnesses. The elevated rate is as a result of high risk sexual behaviours (*Behaviour Change and Communication Strategy, 2008*), including multiple concurrent partnerships, casual sex, intergenerational and transactional sex, the inability of couples to use condoms, lack of mutual monogamy within long term relationships and marriages, and the inability of men and women to share power and speak openly with each other and their children about sex and sexuality. Research has also shown that there is a rural/urban disparity, with cities containing factories and high traffic border posts having high mobility and higher prevalence rates than in rural areas (*Behaviour Change and Communication Strategy, 2008*). Further, the increase and spread of sexually transmitted infections and HIV/AIDS has generally been associated with multifaceted factors of which culture and tradition have had influence.

The Government of Lesotho together with relevant stake holders from Non Governmental Organizations have identified the need to change high risk behaviours as a critical prevention tool for reducing rates of HIV/AIDS and have implemented several HIV prevention strategies,

including educational campaigns and condom distribution, work-based HIV prevention initiatives, the targeting of high-risk groups and prevention of mother-to-child transmission. Hence all Health Care Workers including nurses are responsible for facilitating such services to the population of Lesotho.

Map 1 illustrates the ten Districts of Lesotho. Mohale's Hoek District is located in the South Western region of Lesotho (see map 1).



Map 1: Map of Lesotho showing Mohale's Hoek (Adapted from Lesotho National Behaviour Change and Communication Strategy 2008)

HIV/AIDS prevention is identified as the main strategy to effectively address the spread of HIV and AIDS and as the impact of HIV/AIDS in Lesotho remains profound, a culture-centered approach to HIV prevention is recognized by this Research Report as a critical means of minimizing the impact of HIV and particularly at reducing new infections. It is widely

understood that culture is the foundation on which health behaviour in general and HIV/AIDS in particular is expressed and through which health must be defined and understood (Airhihenbuwa and Webster, 2004). Hence, all communities understand health in terms of their culture because it shapes the ways in which people make sense of the causes and manifestations of health, disease and illness (Gilbert, 2010) and people's perceptions of healing and recovery are also informed by their culture.

Moreover, taking into consideration the multiple prevention approach advocated by the Lesotho HIV/AIDS Strategic Plan, this research highlights the importance of acquiring the use and practice of the two concepts cultural competence and culture brokering in future HIV/AIDS prevention strategies. Studies of culture are not new nor are its relationship to health behaviour recent, however culture as a central feature in understanding health behaviour by social and behavioural scientists is recent, both in the approach taken and the representations it provides (Airhihenbuwa and Webster, 2004). Cross et al, (1989), explain Cultural Competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. There is no one definition of cultural competence, however, because of the meaning of culture adopted in this research which implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group the word competence is used because it implies having the capacity to function effectively.

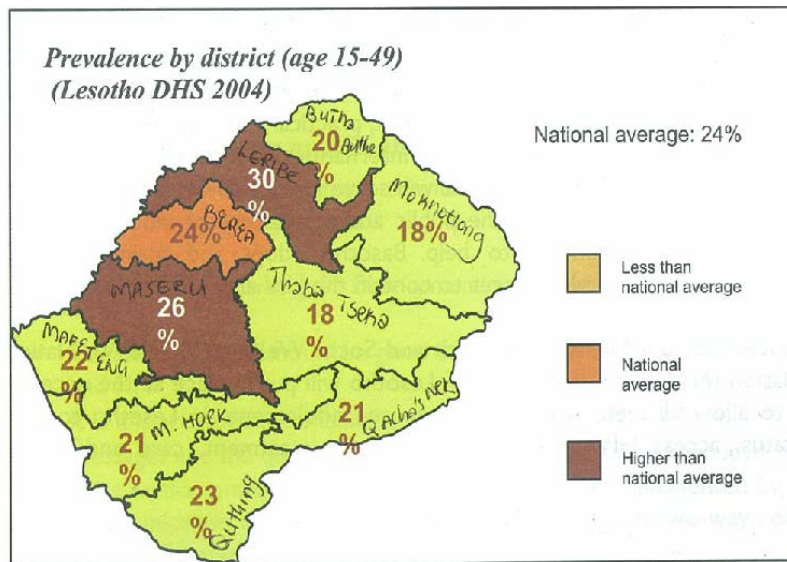
According to Cross et. al. (1989), five essential elements contribute to a system's institution's, or in this case the health system's ability to become more culturally competent which include valuing diversity, having the capacity for cultural self-assessment, being conscious of the dynamics inherent when cultures interact, having institutionalized culture knowledge, and having developed adaptations to service delivery reflecting an understanding of cultural diversity. Culture brokering as the act of bridging, linking or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change (Jezewski, 2001), also becomes significant to the multiple prevention approach as the role that

nurses can play in brokering can provide changes in the effectiveness of health care, specifically HIV/AIDS prevention activities.

Given their responsibilities as Health Care Workers, this study focused on the cultural challenges that nurses working in Mohale's Hoek Health Centers face within their daily HIV/AIDS activities. The five Health Centers selected for the study are predominantly occupied by nurses who basically run the Centers and see patients on a daily basis. Hence to answer the main research question nurses are better informed in knowing and being aware of the cultural challenges they face which may impede the success of implementation of HIV/AIDS services. Having identified the cultural challenges the study looked into the roles that nurses play as culture brokers, meaning how they mediate and intervene to try to minimize those challenges with their patients.

1.4 Rationale of the study

The HIV/AIDS prevalence rate in Mohale's Hoek is 21 percent (Government of Lesotho, 2009) just below the average prevalence level for the country. Map 2 below shows the comparative HIV prevalence rates for the ten districts of Lesotho. As already explained, Lesotho faces major challenges from HIV/AIDS with the high prevalence rates and despite the governments' significant efforts in the fight against the disease, these efforts have been rendered unsuccessful in combating new infections. Hence, the research seeks to investigate possible reasons for the failure of the prevention strategies by identifying existing cultural perceptions about HIV/AIDS in Mohale's Hoek, the influence culture has on sexual behaviour and what impact culture has on the prevention strategies that are being implemented as a way of determining what cultural aspects can be included to minimize the challenges that the prevention strategies face and to improve efficacy.



Map 2: HIV/AIDS prevalence rates by District in Lesotho
(Adapted from Lesotho national behaviour change and communication strategy 2008)

Further, because of the detrimental impact of HIV/AIDS, HIV/AIDS prevention is identified as the main strategy to effectively address the spread of HIV and AIDS. The recognition of the absence of culturally competent interventions and cultural features as opportunity for prevention in the Lesotho HIV/AIDS Strategic Plan has led this Research Report to explore the aspects of Sesotho culture that should be included within HIV/AIDS prevention interventions in Lesotho. Nurses constitute a significant and a primary group of health care providers because of the role they play in Community Health Centers in Lesotho as HIV/AIDS prevention interventionists. However, most of the prevention strategy documents, specifically the HIV/AIDS Strategic Plan do not single out the specific roles of nurses in relation to prevention but refer to them in the general umbrella term of health care workers of which are all expected to be capable of providing an environment supportive to behaviour change, provide knowledge to the population about other Sexually Transmitted Infections (STI)'s and HIV/AIDS. Further, very little is written about the challenges that nurses face in the HIV/AIDS prevention activities that they engage in. On this basis nurses become a very important group of informants to identify the cultural challenges to HIV/AIDS prevention and what culturally competent aspects can be included in the prevention strategies to improve effectiveness. Nurses particularly are at the critical interface of government interventions to the public because of the role they play as implementers of

HIV/AIDS policies including prevention strategies. They are better informed and knowledgeable in terms of the challenges they face with such implementation. The information obtained will contribute to knowledge about the ways in which culture as opportunity can be incorporated in future prevention policies and strategies.

1.5 Outline of chapters

This Research Report is broken down into six chapters. The first chapter provides an overall introduction to the study. Chapter two consists of the literature review. Chapter three outlines the methodology used in the study. Chapter four, five and six cover the findings, analysis and discussions and recommendations of the study respectively.

The following chapter provides a detailed literature review that highlights studies and discussions relevant to the research question.

CHAPTER TWO

Literature review and theoretical framework

2.1 Introduction

This literature review is broken down into four main themes. The first theme explains in depth the concept of culture brokering for its specificities are important in determining the role that nurses play in mediating or intervening to try to minimize the challenges they faced in their daily HIV/AIDS prevention activities. The second theme focuses on the various responsibilities and tasks that nurses are expected to service within the Health Centers, clinics and hospitals. Attitudes and perceptions of nurses about their work and patients are also looked into in, as part of the second theme, for the discussions provided coincide with one of the subsidiary questions that is interested in learning more about the roles that nurses play in the five Health Centers of Mophale's Hoek and how they interact with their patients. The third theme engages literature that looks into the relationship between various socio-cultural factors and HIV/AIDS prevention. The significance of this theme is that it provides a deeper perspective to another research question that is interested in finding out if cultural beliefs and norms have any influence on the sexual behavior that could possibly affect HIV/AIDS prevention initiatives. The last theme provides a brief discussion about the Government of Lesotho HIV/AIDS strategies, assessing whether the strategies have included in them aspects of cultural competence.

The literature discussed substantiates the argument provided by the Research Report that instead of simply viewing culture as an obstacle to HIV prevention, culture should also be recognized for the opportunities it can provide in HIV prevention initiatives in Lesotho. By definition, culture is “the organized set of normative values governing behaviour which is common to members of a designed society or group” (Merton, 2004: 246). Hahn (2004: 246), emphasizes the role of culture and society in relation to sickness and healing, and highlights the use of language in the understanding concepts of health and illness. Culture as a system of interrelated values acts to influence and condition perception, judgment, communication, and behavior in a given society.

Hence culture has a strong influence to all aspects of life and because it is closely linked to traditions, customs and beliefs it shapes people's behaviour (Gilbert, 2010). Indeed, culture is often shown to be a factor in the various ways that HIV/AIDS has impacted on the African population (Airhihenbuwa and Webster, 2004). These factors range from beliefs and values regarding sexuality, including when to become sexually active, the number of sexual partners and condom use, to the cultural definition of sexual orientation in the context of HIV/AIDS. Because of these factors among others, there is a need for culture to be at the centre of HIV/AIDS prevention and control efforts. This section will look into both culture as an obstacle to HIV/AIDS prevention efforts and the ways that culture as opportunity can be integrated to HIV/AIDS prevention strategies.

The extent to which HIV is transmitted from one person to the other is dependent on individuals' sexual behaviour. Incidence and prevalence rates are therefore determined by the sexual practices and behaviours that individuals in their respective communities engage in. This means in other words that the degree to which men and women are able to control the various aspects of their sexual lives (i.e. their ability to negotiate the timing of sex, conditions under which it takes place, and the use of condoms), plays a critical role in determining their vulnerability to HIV infection (Lindren, Rankin, and Rankin, 2005). The IRIN Report (2003) argued that it is not an easy task though to fully understand the meanings behind risky sexual practices in Lesotho as they are deeply embedded within social and cultural norms. Hence some social and cultural norms and traditions in Lesotho are hampering efforts to combat the rising HIV/AIDS epidemic and ignorance about HIV/AIDS has been a major stumbling block for efforts at halting the spread of the disease (IRIN, 2003). Corno and Walque (2007) further noted that in Lesotho education appears to have a protective effect: it is negatively associated with HIV infection although not always significantly and it strongly predicts preventive behaviours. In response to the crisis of the epidemic the government of Lesotho has developed interventions aimed at HIV/AIDS prevention. There are presently six strategic prevention interventions (HIV/AIDS Strategic Plan, 2008), namely 1) management of sexually transmitted infections (STI's), 2) behaviour change communication (BCC), 3) condom programming, 4) management of post exposure prophylaxis (PEP), 5) prevention of mother to child transmission of HIV and 6) safe male circumcision. These interventions are an integral part of the research because the ways in

which cultural norms have presented and influenced themselves in relation to sexual behaviour impacts on their efficacy. Further if culturally competent aspects should be recognized for HIV prevention implementation they would need to be integrated in ways that they form positive relations with the six strategic interventions. Additionally, the various roles that nurses play especially in culture brokering prove significant in creating spaces for positive cultural values to be included in HIV/AIDS strategic plans.

2.2. Culture Brokering and Cultural Competence

Gausset (2001) challenges the notion of the focus on culture as an obstacle in much of the literature. The fight against HIV/AIDS in Africa is often presented as the fight against cultural barriers that are seen as promoting the spread of the virus and this attitude according to Gausset is based on a long history of Western prejudices about the sexuality in Africa, which focus on its exotic aspects only, that is polygamy, adultery, wife exchange, circumcision, dry sex and various beliefs and taboos. However Gausset (2001) argues that those cultural aspects are a wrong target of HIV/AIDS prevention programs because they are not incompatible with safer behaviour and because their eradication would not ensure the protection of the people. To fight against them alienates the people whose cooperation is necessary if one wants to prevent the spread of AIDS. Hence, anti-AIDS projects should not fight against local African culture in order to impose a biomedical cultural perspective but rather try to make behaviour and practices safer in a way that is culturally acceptable to the people (Gausset, 2001). This requires nurses to become Culture Brokers and work with culturally competent HIV/AIDS prevention strategies.

Culture brokering is a systematic process that analyzes the role culture plays in an individual or family's experiences with services (Jezewski, 2001). Culture brokering gives professionals the tools to assess cultural factors, so that they can work more productively with clients from diverse backgrounds (Jezewski, 2001). It is the act of bridging, linking and mediating between groups or persons of differing cultural background for purposes of reducing conflict or producing change. However, the meaning of brokering has to be seen in relation to its specific theoretical framework. Beyond the generality that brokering refers to activities aimed at some sort of mediation between different interests and parties, its meaning shifts. Usually the broker is from

one or another culture but could be from a third group. Often they are capable of acting both directions. Cultural factors play a significant role in the response to health behaviour as well as illness behaviour. In every society there are some conventions about what people should do to remain healthy and how people should behave when they are ill (Lewis, 1981), and the extent to which such conventions and expectations can determine how people behave when ill varies with the disease they suffer from. Crawford (1994) argues that health is an important symbolic domain for creating the self and if health in its various meanings is important for construction of the social self, it also has implications for the cultural construction of HIV/AIDS. In all cultures, illness represents a danger both to the individual and to the social order and because of the stigma surrounding HIV/AIDS, the cultural implications of HIV/AIDS is negative for carriers and those viewed as risk groups which in turn affects the identity and construction of the self. Religious beliefs may also have an influence on the ways in which people perceive disease and illness and ways of healing hence communication between nurses and their patients can be understood and identified as existing within cultural as well as religious factors.

As a result the task of culture brokering becomes paradoxical and the process of culture brokering is not as straight forward as the Jezewski's definition explains. Because it usually involves people of differing cultures, communication can be problematic as ideas about illness and what to do when ill vary with culture. Lay people perceive illness differently from doctors or nurses (Lewis, 1981). Nurses spent time learning patterns of disease and how to treat illness well and patients usually do not share this knowledge hence the name of a particular sort of illness or symptom does not necessarily have the same associations for the lay person. The ways in which nurses communicate with their patients in brokering would therefore have to be in ordinary language as opposed to biomedical specialist terms. The dominance of biomedical Western medicine is such that the understanding of the links between symptoms, physical signs, correct diagnoses and treatment makes it necessary for medical professionals including nurses to be granted certain privileges of access to the patient and to tell the patient what to do (Lewis, 1981) which automatically creates a division between the understanding of the perspectives of biomedicine and lay persons' perceptions. Taylor (2007) explains that culture as a set of processes appears to be productive to the extent that it is a prerequisite to preventing HIV prevention yet simultaneously constraining. For biomedicine, culture has always appeared to

compromise intervention, the concept has been employed as the means to exercise power whereby for example culturally defined risk groups are identified, surveyed and regulated which can also enforce inequalities.

The paradox in culture brokering presents itself within power dynamics where disease is understood foremost as biological which in turn has resulted in HIV/AIDS prevention policies privileging biomedical models over other models. This is true of Lesotho as HIV/AIDS strategies predominantly advocate for biomedical interventions. Because of their professional trainings, nurses working in the Health Centers follow the regulations of biomedicine, hence can be viewed as holding a biomedical authority over their patients which can create situations of dominance by exerting a one way direction of communication, the culture of biomedicine over community and lay person's cultural values. It can create further complications if the nurses are from a different cultural background and want to impose their own values over those of the people they work with. According to Taylor (2007) one of the critiques of biomedical research is the reification of culture, whereby it is viewed as a thing to be possessed and powerful people can act over the less powerful however noble their intentions. Moreover, prevention has been constructed as the outcome of changed behaviour, but biomedical approaches leave little space for understanding how human behaviours are related to social conditions, nor do they always acknowledge the extent of cultural constraints that prevent people from protecting themselves from the virus. Culture in this context has been used by public health officials to create difference, subordinate the other and maintain a hegemonic social order and in this sense culture becomes tied to the exercise of power. Also, professional medical people, in this case, nurses, are not so likely to have the time or opportunity to see their patients at home and without this opportunity, a nurse may have a small chance of imagining very accurately the conditions in which they live or the conditions in which they live where illness is played out.

Arguably, patients or people in communities do exercise their agency that acts against biomedical principles. People make their own choices and interpretations about health, illness and disease and their behaviours are informed by specific cultural values. Whilst people are aware of the differences between HIV/AIDS and other more familiar diseases, the links they make empower them to interpret, understand and react to threatening phenomenon (Taylor, 2007). Nurses also have the power to act within and outside of biomedical settings. The necessity

of brokering lies with negotiating with patients and to effectively do so means the nurses would need to persuade people to take preventive measures or treatment which would also require nurses not to confine illness, prevention and treatment within biomedical terms only but to consider societal cultural factors. It requires nurses working with and wanting to act with others by recognizing individually determined differences in the process of culture creation, use and change (Taylor, 2007).

Equally important is the practice of culture competence. According to Cross et al (1989) Cultural Competence involves a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. Five essential elements contribute to a system's institution's (Cross et al, 1989) or in this case the health system's ability to become more culturally competent which include valuing diversity, having the capacity for cultural self-assessment, being conscious of the dynamics inherent when cultures interact, having institutionalized culture knowledge, and having developed adaptations to service delivery reflecting an understanding of cultural diversity.

This Research Report therefore seeks to understand the manner in which nurses act as culture brokers and look into the ways that culture influences perceptions about HIV/AIDS in Mohale's Hoek, whether in a negative or positive way and how nurses mediate these perceptions with the patients they interact with in the health centers. Communication in this context can be both ways or multifaceted.

The biomedical tradition has for years been the most dominant system as opposed to other healing systems but this domination has been shifting where people are increasingly opting for complementary or alternative medicines. Stevenson et al (2004) explain that the traditional model of adherence (also known as compliance) does not value patients' beliefs, concerns and preferences about medicines. The concordance model, a new approach to the process of prescribing and medicine-taking, was originally conceived and has most commonly been used to define a process of prescribing and medicine-taking based on partnership. In a concordant consultation the patient and the health care professional participate as partners to reach an agreement on when, how and why to use medicines, drawing on the expertise of the health care

professional as well as the experiences, beliefs and wishes of the patient (Stevenson et al, 2004). However their conclusion is that there is little research that examines fundamental issues for concordance such as whether an exchange of views actually takes place. The concordance model has similar characteristics as those of the process of culture brokering in the sense that they both put in the forefront sharing of social beliefs and perceptions from nurses as well as patients.

Despite its tendency to dominate, like any other medical systems the biomedical tradition is not fixed and has been changing its approaches. For purposes of clarity, this research does not seek to focus on the dominance of biomedicine and how it has influenced people's health behaviour but is more interested in finding out how the Sesotho aspects of culture have influenced the peoples' health behaviour in relation to HIV/AIDS, if these influences restrict the effectiveness of HIV/AIDS prevention efforts and how nurses have mediated between the two different knowledge.

The concept of healthworlds taken from Germond and Cochrane (2010) will also be discussed in the research to further conceptualize culture brokering and culture competence. From their definition, healthworlds relates to people's conceptions of health, to their health seeking behaviour, and to their conditions of health. The importance of healthworlds is that it shows how individual's healthworlds are shaped by and simultaneously affect the socially shared healthworld constituted by the collective search for health and well being. The concept of healthworld can further accommodate and explain multiple ways of understanding health and plural health seeking strategies while opening up perspectives on how to improve health practice and outcomes. (Germond and Cochrane, 2010). To be effective culture brokers nurses need to mediate between biomedical healthworlds and the variety of Sesotho healthworlds of the communities they work with.

2.3 The role of nurses as Health Care Workers

Nurses are at the forefront of the struggle against HIV/AIDS. Gardner has explained this point very well.

With an increased perception of HIV/AIDS as a nursing disease and with the holistic approach that they provide, nurses can make an important contribution toward the prevention and treatment of HIV/AIDS. Nurses are urged to become more active in professional societies, be patient, advocate, counsel patients and educate other about HIV transmission (Gardner, 1991:8).

Health Care Workers are key players in the prevention and management of HIV-infection. The Health Centers in Lesotho are staffed with nurse clinicians, a cadre of registered nurses with skills in preventive and curative care as well as dispensing. Some of the activities undertaken in health centers include immunizations, ante-natal and post-natal care, family planning and other curative and preventive public health services. From the implementation of Behaviour Change Communication, all health care workers including nurses in Lesotho are capable and expected to provide an environment supportive to behaviour change (Government of Lesotho, 2008). Further, nursing practice invites nurses to embody caring practices that meet, comfort and empower vulnerable others. Such a practice requires a commitment to meeting and helping others in ways that liberate, strengthen and avoid imposing the will of the caregiver on the patient. Being good and acting well occur in particular situations (Benner, 2000).

Four studies on nurses are of particular relevance to this study, the first three Graham, Cohen and Holzemer speak directly to the situation of nurses in Lesotho while Khan and Kelly study nurses as culture brokers in the adjacent Eastern Cape. Graham's (2008) study analyzes the dominant discourses of health at the Scott Hospital in Morija, Lesotho and how they affect Health Care providers' health perceptions. She proposes that understandings of health are constructed by drawing on particular discourses of health that are perpetuated through culture, literature, policy and teaching. She concludes by stating that there are diverse understandings of health provided by Health Care providers ranging from relational aspects of health to socio economic aspects of health and she shows how the dominant discourses namely biomedical and public health discourses have come to the perceptions of health that Health Care providers hold and how they have come to affect Health Care in Lesotho. Cohen et al (2009) case study identified

antiretroviral outcomes from a nurse driven, community supported HIV treatment programme in the rural clinics of Scott catchment area in Morija Lesotho. The decentralized model of Health care developed in Scott catchment areas relies on a nurses driven approach. Hence their study validated several critical areas for task shifting that are being piloted in other Southern African countries. From their findings Cohen et al (2009) concluded that HIV/AIDS care and treatment can be provided effectively at the primary care level by nurses. They also recommended ongoing training and mentorship for nurses, increasing nursing staff and boosting programme management capacity. Holzemer et al (2009) measured the levels of stigma reported by people living with HIV/AIDS and the experiences of nurses as people who care for HIV/AIDS patients in five African countries of which Lesotho was one. Findings confirmed that stigma is highly discrediting and traumatic experience. Further nurses were shown to contribute to perceived stigma towards their patients hence Holzemer et al (2009) recommend that there needs to be research strategies to understand the phenomenon of stigma better and intervention strategies are necessary to eliminate it from practice. Kahn and Kelly (2001) explored how nurses manage apparent incompatibilities between their practice of Western psychiatry and the use of traditional healing services amongst Xhosa in South Africa. Nurses hold beliefs about health and illness from two domains, that of their culture and that of Western biomedicine. This dual belief system, coupled with the nurses' presence at the critical juncture in the biomedical referral network, places nurses in the role of primary 'broker' between traditional culture and biomedicine (Barbee cited in Kahn and Kelly, 2001). Thus the position of broker is an exposed one because brokers must serve some of the interests of groups operating on both the community and national levels. Nurses in such situations might reject socio-cultural beliefs from Western concepts but most adopt a position of coexistence (Kahn and Kelly, 2001). Hence Kahn and Kelly (2001) suggest that there is a need to explore the possibility of cultural inclusion and multiculturalism in the Health field but they also caution the inclusion as it may jeopardize the protection afforded to cultural practices.

Further afield, Ehlers (2009) studied the challenges that nurses face in coping with HIV pandemic in Africa. Ehlers (2009) affirmed that HIV/AIDS pandemic necessitates greater preventive health education inputs from Health Care Workers especially because nurses are knowledgeable about HIV and are also familiar with cultural traditions and taboos of specific

communities. This means that they could play a pivotal role in implementing and maintaining such effective health education in schools, at youth centers, at colleges and universities, and at clinics and hospitals. Gardner (1991) argued that the role of nurses as advocate, nurturer and educator becomes important as AIDS is increasingly viewed as a burden for nurses. Gardner (1991) explained that nursing is the only health care discipline that provides for the needs of the whole person and suggested that provide quality care nurses must be in touch with the emotions elicited by HIV/AIDS and must deal objectively with their own prejudices and feelings.

2.4 Nurses' perceptions of and attitudes towards HIV/AIDS

The relevance of this section is to highlight how nurses' perceptions of HIV/AIDS and their attitudes towards HIV/AIDS can influence how they act as brokers.

Studies of HIV/AIDS knowledge, attitudes and practices among healthcare workers in developing countries have shown gaps in knowledge and fear of contagion of HIV. Coupled with ambivalent attitudes in caring for patients with HIV/AIDS there is also an inconsistent universal precautions for adherence. A study undertaken by Reis et al (2005) titled "Discriminatory Attitudes and Practices by Health Workers toward Patients with HIV/AIDS in Nigeria" shows that a significant number of health care workers reported engaging in discriminatory and/or unethical behavior. Unethical practices towards patients are corrosive to the health professions as they taint all health professionals and erode trust in them. Inadequate education about HIV/AIDS and a lack of protective and treatment materials appear to contribute to these practices and attitudes. Saunamaki, et al (2009) showed over 90% of nurses in Sweden understood how patients' diseases and treatment might affect their sexuality but older nurses felt more confident in their ability to address patients' sexual concerns, and the older the nurses, the more positive were their attitudes towards discussing sexuality. Nurses with further education also had a more positive attitude towards discussing sexuality.

Ehlers (2006) reported the personal and professional challenges nurses face in Africa in their daily HIV/AIDS activities. The findings show that nurses fear becoming HIV positive through contact with HIV positive patients' body fluids. Myths and beliefs were found to affect nurses personally and professionally. From Ehlers (2006) data, the selection of virgins as sex partners

because of the belief that virgins cure HIV/AIDS creates fear for nurses as at times they fear for the safety of their own daughters and student nurses. The nurses from Ehlers findings also mentioned how the HIV pandemic and being understaffed is a burden to nurses and importantly, Ehlers notes how in order to avoid nurses from suffering from fatigue and feeling burnt out they need physical, social and emotional support not only from family and community members but also from governments and employers. Delobelle et al (2009) make note of several studies in South Africa whereby health care workers describe how HIV has had an impact on their work which affects the quality of their care. Health care workers were reported to be reluctant to provide HIV/AIDS care as a result of concerns about occupational infections and said that they experienced stress, fear and frustration but also sympathy and empathy towards patients with HIV/AIDS (Delobelle et al, 2009).

2.5 Contextual cultural dynamics

Local cultural dynamics are as seen central to HIV/AIDS prevention efforts. A discussion of three central cultural dynamics, namely gender, migrant labour system and cultural perceptions that impact HIV/AIDS prevention are discussed below.

2.5.1 Gender roles

Women of child bearing age (15-49) years account for almost half of the total female population in Lesotho (Gender Report, 2004). In most of the circumstances women's health is compromised by socio-economic status that result in inability to decide freely to seek, reach and receive appropriate quality obstetric and medical care (Gender Report, 2004). The influence and impact that societal gender roles play are crucial in shaping sexual behaviour which in turn also determines vulnerability to HIV infection. According to Lindren, Rankin, and Rankin (2005), the gender roles prescribed for women can demand a submissive role, passivity in sexual relations, and ignorance about sex. They can also restrain women from seeking and receiving information related to HIV prevention. Masculinity requires men to be more dominating, knowledgeable and experienced about sex. This assumption puts many young men at risk of HIV infection as such norms that prevent them from seeking information or admitting their lack of knowledge about sex or methods of protection. These norms also promote promiscuity and

reinforce risk-taking behavior. As such, personal risk of contracting HIV is determined by numerous social and cultural factors that shape gender and sexuality perceptions, attitudes and behaviors (Lindren, Rankin, and Rankin, 2005). Gender norms are deeply rooted in the socio-cultural context of each society and enforced by that society's institutions and practices. These culturally-defined gender values and norms evolve through the process of socialization starting from an early stage of infancy and they determine and reinforce themselves through traditional practices.

Gender inequality and patriarchy generally encourage multiple sexual partners for men inside and outside of marriage, while women are required to be faithful and monogamous. Such socio-cultural practices and norms make men and their partners especially vulnerable to HIV. In this context, the dangers of multiple sexual partners relates to the fact that if one person in a 'circle' of partners gets infected with HIV, there is a very high likelihood that all persons involved will become infected. Corno and Walque (2007), highlight the vulnerability of married women who engage in extra-marital sex without using a condom in Lesotho. Married women who have extra marital relationships are less likely to use a condom than non-married women. In addition, they show that more than 40 percent of HIV infected couples are discordant couples, i.e. couples where only one of the two partners is infected.

This result suggests that there is still room for prevention amongst couples. Another study undertaken in Lesotho to explore the social, cultural, and behavioral factors that contribute to concurrent sexual partnerships show that while monogamy was most frequent among those who self-identified as being in stable relationships, concurrent partnerships were also commonly reported by both men and women (Hildebrand et al 2008). Concurrency during the period of acute infection increases the potential for HIV transmission to more people. Sexual behaviour remains the primary target of AIDS prevention efforts worldwide, but it is widely diverse and deeply embedded in individual desires, social and cultural relationships, and environmental and economic processes. This makes prevention of HIV, which could be an essentially simple task, enormously complex involving a multiplicity of dimensions. According to King (1999) nearly all prevention interventions are based on theory and most rely on the assumption that giving correct information about transmission and prevention will lead to behavioural change. Yet research has

proven numerous times that education alone is not sufficient to induce behavioural change among most individuals. Since complex health behaviours such as sex take place in specific contexts, socio-cultural factors surrounding the individual must be considered in designing prevention interventions.

2.5.2 Migrant labour

Amongst the various modes of HIV transmission migrant labour is one of the reasons for high HIV/AIDS prevalence rates in Lesotho (IRIN, 2003). Many men from all parts of Lesotho travel to South Africa to work in mines where they live in single sex housing and are away from their wives and families for months at a time, often having interactions with sex workers. According to Corno and Walque (2007), mines host a large sex industry. Evidence suggests that once from their families men might be more likely of have multiple sexual partners. Once they have contracted HIV they might infect their partners when they return back home in Lesotho (Corno and Walque, 2007). Further, women waiting for their men to come back home have been known to engage in sexual relationships with other partners. Daza and Yolanda (1994) argued that the continuous migration of men in and out of Lesotho has had and carries on having effects on the health of Basotho. The separation of families for periods of up to several years weakens family cohesion and very often leads to the establishment of extramarital relationships on the part of both spouses which in turn increases the risk of contracting HIV and other STI's.

2.5.3 Cultural perceptions about HIV/AIDS

Like many other misfortunes, HIV/AIDS provokes a crisis of meaning (Niehaus and Jonsson, 2005). People tend to understand HIV/AIDS within the context of societies they live in. Where there is lack of proper knowledge and understanding of HIV/AIDS people may create their own perceptions and beliefs about the disease. This crisis may be illustrated in a number of examples. First is the debate about condoms. Hildebrand et al, (2008) noted that women and men expressed dislike for male condoms in a number of focus groups, which has obvious implications for HIV prevention programming. Some men and women reported beliefs that condom use could cause a decrease in the physical attractiveness of women by, for example, causing acne and “shiny” legs or “jelly-like” thighs. Varga’s (1997) study explored the dynamics behind condom use among Durban commercial sex workers (CSW). The findings are similar to other studies highlighted in her study and they show the risk denial for HIV infection and the self-perceived benefits of unprotected sex among impoverished urban African-American and Durban women. Women’s avoidance of condoms was interpreted as a psycho-social and economic strategy to maintain self-esteem and domestic economic stability. By denying risk for HIV infection and shunning protected sex, women created both a public and personal image of monogamous, secure, trustworthy sexual relationships. Admission of the necessity for condoms would require acknowledgment of steady partners’ infidelity, leading to women’s personal humiliation and loss of dignity (Varga’s, 1997).

Secondly, other instances where culture acts as a hindrance to prevention efforts include the belief that having sex with a virgin will cure the infected person of HIV/AIDS and there are beliefs also among some people that condom's are actually responsible for the spread of the disease (IRIN, 2003). Thirdly, Niehaus and Jonsson (2005) show how the attribution of blame for HIV/AIDS articulates gendered concerns in the South African Lowveld of Northern Sotho and Tsonga-speakers. They suggest that women blamed men and envious nurses for spreading the virus and that these discourses expressed women’s ideological association with the domestic domain. By contrast, men invoked conspiracy theories, blaming translocal agents—such as Dr. Wouter Basson who was a Doctor working there, Americans, soldiers, and governments— for the pandemic. They suggest that these theories are informed by men’s humiliating experiences of job losses and deindustrialization in the global labour market.

Lastly, though not a myth, a study carried out by Kalichman and Simbayi (2003) shows that AIDS related stigmas create barriers to seeking voluntary counseling and testing (VCT) but not to learning one's test results. Participants in this study who were not tested for HIV held significantly more AIDS related stigmatizing beliefs than people who had been tested, including negative perceptions of people living with AIDS, a sense that people with AIDS should feel ashamed and guilty, and the endorsement of social sanctions for people living with AIDS. The study noted that AIDS stigmas were also prevalent among people who had been tested for HIV, although to a lesser degree than among those who had not been tested. Further cultural beliefs and stigma associated with HIV and AIDS prevent pregnant women from accessing prevention of mother to child treatment. Due to stigma still associated with the disease, they fear people in the community might get to know about their status and look down on them.

The cultural factors discussed above are amongst the many factors which may be identified as having a negative impact on the success of HIV/AIDS prevention initiatives and are useful in order to understand which components of positive culture can be incorporated for efficacy. The following section provides a brief discussion of HIV/AIDS prevention strategies in Lesotho and relates the strategies to other strategies in some African countries.

2.6 Government of Lesotho HIV/AIDS prevention strategies

An interest of one of the subsidiary research questions is to look into what Sesotho cultural aspects could be included in HIV/AIDS strategic plan of Lesotho in order to develop cultural competency. This section provides a brief discussion about the Government of Lesotho HIV/AIDS strategies, assessing whether these strategies are culturally competent.

The Government of Lesotho HIV/AIDS Strategic Plan 2006-2011 highlights that the level of awareness and internalisation of the threat of HIV and AIDS is needed to change the behaviour of the population to the risk of HIV in Lesotho is still not sufficient. The level of knowledge and understanding of the way the HIV virus is acquired and spread among the general population is low especially among vulnerable groups due to inadequate access to information and services. Access to information and the ability to act on the received information was found to be hampered by a number of factors including illiteracy, poverty, stigma and state of denial of the

existence of HIV and AIDS (Government of Lesotho, 2006). The greater majority of HIV infections result from high risk unprotected sexual acts and this could persist if appropriate knowledge on how to prevent infection remains low in the general population. Knowledge of mother to child transmission will have profound implications on child health and welfare, especially as infected children often become orphans (Government of Lesotho, 2006).

The challenge is to scale up prevention as the main strategy for effective reduction of the spread of HIV and AIDS in Lesotho. It is imperative therefore that that broad based programmes to educate the general population about HIV/AIDS be developed in order to promote safer and responsible sexual behaviour and practices. Such practices should include delaying the onset of sexual activity, practicing abstinence, being faithful to one uninfected partner, reducing the number of sexual partners and using condoms properly and consistently (midterm HIV/AIDS Strategic plan 2008-2011). Hence the national goal of prevention in Lesotho is to increase awareness of HIV and its prevention, create capacity for people to protect themselves and sexual partners, to reduce transmission of HIV from mother to child, promptly manage occupational exposure to HIV and ensure negligible transmission through blood transfusion. The prevention strategic intervention includes managements of STI's, behaviour change communication, condom programming, management of post exposure prophylaxis, prevention of mother to child transmission and safe male circumcision (mid-term HIV/AIDS Strategic plan 2008-2011).

The quest for effective intervention approaches is to reduce the spread of HIV/AIDS is on going. The relative importance of different approaches such as the channels of communication or which risk reduction messages should be promoted have been long debated similarly to the need for multi-faceted approach interventions and the broader thinking about prevention options. Tawil et al (1995) reviewed the one area of HIV prevention that has received insufficient attention: influencing the social and determinants of risk. Most HIV/AIDS prevention efforts continue to focus on changing behaviour of individuals and such efforts usually involve increasing personal awareness and risk perceptions with the premise that individuals will take appropriate decisions about personal behaviour and will subsequently act on those decisions. Thus Tawil et al (1995), make a distinction between prevention approaches that aim to persuade individuals to undertake

behaviour change and those that enable to change to occur. The latter focuses on non-individual or the social and environmental determinants that facilitate or impede behavioural choice.

Comparing to different literature outside of Lesotho, according to Tawil et al (1995), evidence shows that altering the environment in which risk taking might take place through comprehensive STI treatment can result in decrease in HIV incidence rates even in the absence of any significant behaviour change. While still continuing to recognize the role of the individual in decision making, all structural interventions acknowledge that meaningful reduction of HIV transmission can still occur even though the range of an individual's actions may be limited to a certain extent to allow for sufficient behaviour change. Arguably, restrictive legislation may act as a barrier to the adoption of preventive measures and because of this, policy reforms have advocated particularly in the countries where urgency for to prevent HIV has been recognized (Tawil et al, 1995). The threat of the epidemic for example has led to the decriminalization of prostitution.

Hence, the need for culturally competent HIV Prevention Strategies cannot be ignored in Lesotho. As elsewhere outside of Lesotho, culture is central to HIV/AIDS prevention, care and support in Africa thus behavioural analysis and intervention points of entry into a community should focus on culture rather than on individual behaviours, as commonly done in HIV/AIDS interventions (Airhihenbuwa and Webster, 2004). PEN-three is a model that addresses culture in the development, implementation and evaluation of health promotion programmes. PEN-3 is a cultural model that was developed by Airhihenbuwa in 1989, to guide a cultural approach to HIV/AIDS in Africa. It has been applied to child survival intervention in Nigeria and HIV/AIDS in Zimbabwe More recently it has been used for planning and analysis of health intervention research related to cancer and intervention research related to cardiovascular risks reduction. Finally, it has been used to guide an evaluation of cultural interpretations and meanings of the use of female condoms to reduce HIV/AIDS in South Africa (Airhihenbuwa and Webster, 2004). The model is composed of three primary domains, each with three components. The three primary domains are: cultural identity, relationships and expectations, and cultural empowerment. Once a health issue has been identified, such as HIV/AIDS, a three by three table is created to assess and appraise the interaction between the domain of relationships and expectations, and the domain of cultural empowerment. The model provides an opportunity for

interventionists to address positive and existential behaviour so that negative practices, values and behaviours are located within the broader context of culture.

This section has provided various studies and discussions highlighting issues of relevance to the research study. The following chapter provides a detailed account of the methodology used for the study.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents a description of the research design used for this research. The procedure used to gather data is discussed and a description of the method used to analyze the results has been explained. Ethical considerations of the study have also been provided.

The approach used for the study is that of qualitative research in order to enable the researcher to understand, describe and explain questions that underpin the current study. The principle research method employed in this research is semi-structured interviews. According to Greenstein (2003), qualitative research is an approach in the social research that is based upon the need to understand human and social interaction from the perspective of insiders and participants in the interaction. Qualitative research is empirical research (Punch, 2000), where by the data collected are not in the form of numbers as in quantitative research. As Strauss and Corbin (1990) explain, the requisite skills for doing qualitative research is to be able to step back and critically analyze situations, to recognize and avoid bias, to obtain valid and reliable data and to think abstractly (Strauss and Corbin, 1990). Further, the questions asked and data collected has helped answer the research question and ensured that the findings reflect the evidence of the research design. Shuman (2002) states that interviewing can inform researchers about the nature of social life hence the interviews will give the researcher access also to observations. For this study the researcher managed to learn about the work and occupation of nurses and how they have fashioned their work, about their cultures and values, about their perceptions and those around them, how they interpret perceptions and about the challenges they confront as they lead their lives.

All the interviews took place at the Health Centers. Prior to arrival at the Centers, the nurses had been telephonically contacted by the researcher and appointments were set according to the nurses' preferred timings. Overall majority of the interviews lasted for one hour and it took the researcher three weeks to complete the interviews.

3.2 Study design

The researcher developed an interview guide (see Appendix A) and by using semi structured interviews, the interviews allowed a free flow of conversation with the participants. Semi structured interviews usually involve a clear list of issues to be addressed and questions to be answered (Greenstein, 2003), but there is more flexibility around the sequence in which they are asked and the interviewer allows the respondent to speak more broadly about the topics discussed. Purposive sampling was used for this study to select both the Centers and the nurses. As Greenstein (2003) states, purposive sampling is used when researchers want to target particular individuals and categories of individuals for investigation. The researcher also used a tape recorder for the interviews conducted as part of data collection which later were transcribed. Further an analysis of data recorded entailed looking at specific themes that came out from the interviews and were grouped according to their commonality. These themes were compared to similar discussions from the literature review to infer if the findings are similar or dissimilar and lastly, analyze arising issues that were not covered in the literature review.

3.3 Study population

Mohale's Hoek is one of the ten districts of Lesotho with a population of about 185,459 (Lesotho 2006 Population and Housing Census, 2009) and the HIV/AIDS prevalence rate standing at 21 percent. The district has one Government Hospital, Ntšekhe Hospital, 15 Health Centers with one serviced by Lesotho Flying Doctors Service and one private practitioner in 2009 (Government of Lesotho, 2009). The interest in Mohale's Hoek is because it is understudied as compared to Maseru, the capital city. The interviews conducted in the rural Health Centers gave the researcher an opportunity to learn firsthand about the HIV/AIDS

prevention challenges faced by nurses in the rural settings. These Health Centers are places where patients interact with the nurses and a space where different cultural translation may take place. Hence studying Mohale's Hoek contributed to knowledge about the area.

3.4 Sample size

This research focused on five Health Centres where three nurses were interviewed at three Health Centers, four nurses at one Health Center and two nurses at one Health Center. Overall, 15 face-to-face open-ended interviews with nurses at the Health Care Centres were carried out. The sample size of the site Centers was purposively selected because of their specific setting in the rural areas of Mohale's Hoek. Since nurses occupying the Health Centers are few, all the nurses in each Health Center were interviewed to add up the number 15. The Health Centres chosen were Mohalinyane Health Centre, Holy cross Health Centre, Lithipeng Health Centre, Ha Tsepo Health Centre and Liphiring Health Centre.

3.5 Ethics appraisal

An application to conduct this study together with the Research proposal was submitted to the University of Witwatersrand Ethics Committee for ethical clearance and within a period of a month the application was approved (Ethics Number H100632).

Permission was also requested from the Lesotho Ministry of Health and Social Welfare to access the Health Centers and interview the nurses. Once the ethics committee at the Ministry had read and understood the purpose of this study a letter of approval was issued out and the Public Health Nurse at the District Health management team in the District of Mohale's Hoek was formally informed of this research which was also made known to the nurses concerned.

The participants were given an information sheet (see Appendix B) with details about the research aims and objectives and they were asked to participate and to provide consent, all of which they were told is voluntary. A written consent form (see Appendix C) was developed to be signed by both the respondents and the researcher. Confidentiality and anonymity was assured to the respondents of the research report, of which pseudonyms would be used and the

information they provided would only be used in this Research. A written consent form for the interviews to be recorded was also made available (see Appendix D).

3.6 Limitations of the study

The main limitation is the time constraint experienced by the researcher. By time that the proposal was approved by the Lesotho Ministry of Health and Social Welfare the researcher had a limited time to conduct the research in Mphahlele's Hoek. Further because of the enormous work load of the nurses they could not give the researcher their full attention thus jeopardized some of the information that was crucial to the researcher. During the actual interviews, as mentioned, because nurses are usually overworked at the Health Centers the interviews were regularly interrupted by patients.

The researcher also experienced a language barrier as three of the nurses are Kenyan and could not speak Sesotho therefore some of the questions that the researcher asked, the nurses could not understand or answer because of their unfamiliarity with Sesotho practices and customs. However the three Kenyan nurses did mention that because of the similarity in symptoms that patients usually complain about it is usually very easy for them with time to catch up with the Sesotho language and the way in which Basotho describe symptoms. For activities that involve community outreach the Kenyan nurses are usually accompanied by Basotho nurses assistants to help with translation where necessary. Both at the Health Centers and during community outreach Basotho nurses are present to work together with the Kenyan nurses. Data analysis was slightly affected because some of the questions that involved Sesotho cultural aspects the Kenyan nurses could not respond to because of unfamiliarity.

Some nurses were also suspicious of the researcher, assuming that the researcher could be a government official sent to spy on them, thus at times the nurses were skeptical in answering some of the questions asked which affected the way they responded to the researcher.

Chapter Four

Background Findings: Health Care, Health Centers and Nurses in Lesotho

This chapter introduces the Health Care System in Lesotho. The significance of this chapter is to provide an overview of the Health Care System in Lesotho, its function and the duties it attaches to its health care services, in this case Health Centers before providing a detailed account of the actual findings from the interviews. A comprehensive background to the Health Centers in Molepolole, history of nursing and nurses in Lesotho and the responsibilities attached to the nurses working in the Health Centers is provided. Hence the chapter looks into some of the responsibilities attached to the Health Centers and nurses in order to determine if any of the tasks have elements of culture brokering and culture competence.

4.1 The Health Care sector in Lesotho

Lesotho's health care services are delivered primarily by the Government of Lesotho and the Christian Health Association of Lesotho (CHAL). The key institutions for the delivery of health care services in Lesotho are Health Service Areas (HSA). The country is divided into Health Service Areas (HSA), each based on a government or mission hospital. A central hospital in each HSA service covers a number of Village Health Centers with nurse practitioners, as well as clinics, which receive regular visits from doctors or nurses. It also trains community health workers from individual villages, thus extending health care throughout the whole service area (Lesotho Review, 2000). The World Health Organization plays a key role in directing, coordinating and supporting a wide spectrum of health related activities in Lesotho. These include the strengthening of health planning and management, development of human resources, programmes such as AIDS control, mental health, school sanitation, disaster preparedness, community participation and family health, including safe motherhood.

Embracing curative, preventive and rehabilitative services, Lesotho's health system consists basically of the following levels, a village network of over 5,000 volunteer community health workers, 94 Health Centers, where teams serve from 6,000 to 10, 000 people and Health Service Areas, with teams operating from referral hospitals (Lesotho Review, 2000). Health Centers are staffed by clinicians that are able to diagnose and prescribe or by nurse assistants and District hospitals which are expected to staff all facilities with appropriately qualified staff and the equipment needed to deliver health services. Apart from the village health workers, various other categories of community based health workers include traditional birth attendants, distribution agents and water minders (Lesotho Review, 2000). The government accords high priority to the control of the spread of HIV/AIDS, the national AIDS programme is an integrated approach towards the prevention and control of the disease, with countrywide activities involving all government ministries and non- governmental organizations.

There are ten government hospitals and 94 Health Centers in the country. Since 2005, CHAL has helped run and manage the country's health care through a network of about eight hospitals and about 73 Health Centers (PSI Report, 2006). The hospitals of CHAL were contracted to provide additional antiretroviral therapy services and receives subsidies from amongst others Lesotho Government, Irish Aid, UNICEF World Vision and the Global Fund programme to provide health services (PSI Report, 2006). Christian Mission Hospitals and Clinics have been operating in Lesotho since 1863 (PSI Report, 2006). The establishment of a formal structure for the coordination of health services provision by church-owned institutions took place in 1974 with the formation of the Private Health Association of Lesotho (PHAL). In 1997, PHAL was officially registered as CHAL. Currently, CHAL has six church-members (the Anglican Church of Lesotho, Assemblies of God, Bible Covenant, Lesotho Evangelical Church, Roman Catholic Church and Seventh Day Adventist Church).

4.2 The history of nursing and nurses in Lesotho

In 1930's the enrolled-nursing programme was introduced in Lesotho under the Basutoland Executive committee. Before this time registered nurses were white and the Basotho girls who worked in the hospital were ward attendants (SANNAM Report, 2003). In the mid 1950's, Scott Hospital in Morija joined efforts with the Government of Lesotho in an effort to raise the

standard of nursing education in Lesotho. Training for the registered nurses started under the High Commission Territories Nursing Council (HCTNC), which kept register of nurses, trained in Botswana, Lesotho and Swaziland for the categories of registered nurses, midwives and enrolled nurse-midwives. After independence October 1966, the Lesotho Nursing Council (LNC) was established and it took over the functions of the colonial HCTNC. By this time only Scott hospital was producing enrolled nurses. Registered nursing and midwifery were practiced at Queen Elizabeth II Hospital in Maseru and Muluti Hospital in Mapoteng and later St Joseph's Hospital in Roma (SANNAM Report, 2003). Currently, there are about five training institutions for nurses, the National Health Training College, Scott School of Nursing, Maluti School of Nursing, Paray School of Nursing Assistants and the National University of Lesotho.

In 2006, there were about 1,101 nurses employed throughout the Health sector which accounts for approximately 33% of the total formal health sector labour. 95% percent of all nurses are women and 99.6% are Basotho. During the same year, 2006, the nurse supply at Health Centers was just 28% of what is required. Nursing coverage rates across the country varies and the nursing supply coverage has declined (PSI Report, 2006). There are on average five doctors and 62 nurses per 100 000 population (Cohen, et al, 2009). According to the PSI Report, 2006, nursing supply coverage has declined and nursing workload has increased. Based on available health service production statistics, it is estimated, for example, that hospital nurses currently face daunting workload volumes that have negative implications for service quality and as well as for retention of staff. This contributes to the high turn over rate at 37.5% over 5 years from 2000 to 2005 (PSI Report, 2006). Lesotho depends heavily on nursing assistants to make up for the shortage of skilled nurses, these assistance often are left to do the job of nurses without proper training.

Doctors (Specialists and Medical Officers) represent the second largest health service occupation after nurses, but they account for only 2.9% of all health sector employees and 8% of all employees directly engaged in health services provision. Coverage rates for doctors across Health Service Areas also vary considerably from a dismal high of 0.16 Medical Doctors per 1000 population in Maseru to 0.02 in Molele's Hoek (PSI Report, 2006). As one of the health service areas in the country, the Lesotho Flying Doctor Service provides more than an emergency medical service to the remote mountainous areas of the country. It has also initiated

rural health care programmes and brings in essential supplies, including fuel and vaccines, to areas in distress (Lesotho Review, 2000). Further, Patients needing a specialized medical treatment not available in Lesotho are referred to hospitals in neighboring South Africa. The table below shows the tasks of Doctors, nurses Counselors and Community Health Workers in accordance to HIV/AIDS services at Primary Health Care Level.

District level Doctor	Tasks: <ul style="list-style-type: none"> • Carries out monthly visits to Health Centers. • Provides refresher trainings. • Provides clinical mentorships at Health Centers. • Prescribes Antiretroviral Treatment (ART) to patients. • Formally admits patients to hospital and provides inpatient care.
Health Center level Nurse Clinician	Tasks: <ul style="list-style-type: none"> • Initiates and manages first –line ART for adults and children. • Initiates second-line ART in the case of treatment failure after doctor’s approval. • Stages HIV positive adults and children and determines clinical need for ART. • Manages opportunistic infections. • Initiates short course AZT prophylaxis for PMTCT. • Prepares children’s caregivers to provide ART. • Provides education and counseling on HIV prevention and treatment.
Trained Nurse Assistant	<ul style="list-style-type: none"> • Initiates and manages first –line ART for adults and children. • Initiates second-line ART in the case of treatment failure after doctor’s approval. • Stages HIV positive adults and children and determines clinical need for ART. • Manages opportunistic infections. • Initiates short course AZT prophylaxis for PMTCT. • Prepares children’s caregivers to provide ART. Provides education and counseling on HIV prevention and treatment.
HIV/TB lay counselors/ Know Your Status (KYS) Counselors	<ul style="list-style-type: none"> • Provides HIV testing and counseling via rapid tests. • Provides HIV prevention education and commodities. • Facilitates support groups and provide health talks on pertinent topics about HIV/AIDS. • Counsels pregnant women on PMTCT and testing schedule for infants. • Provides preparatory counseling before patients are initiated on ARV’s. • Schedules appointments for HIV patients. • Manages folders and file cards of HIV patients. • Identifies ART and TB treatment defaulters and mobilizes Community Health Workers to trace them.
Community Based Health Worker	<ul style="list-style-type: none"> • Traces HIV and TB treatment defaulters. • Provides education and encourages uptake of HIV negative and TB related services. • Refers symptomatic patients to Health Centers. • Carries out awareness- raising activities.

Table 1: tasks of Health Care Workers in accordance to HIV/AIDS services in Lesotho (Adapted from Cohen, et al 2009)

4.3 The role of the Health Sector in response to HIV/AIDS

Because of the impact and challenges from HIV and AIDS the health Sector in Lesotho has suffered many constraints and has had to respond in differing ways to come up solutions of minimizing the challenges. According to the HIV/AIDS Strategic Plan, 2008, the Health Sector has a central role to play in providing technical input needed to guide the overall national responses to HIV/AIDS in Lesotho. The Lesotho Ministry of Health and Social Welfare together with the Health Sector in general focus on prevention, treatment, care and support and impact mitigation programmes. The Lesotho National Behaviour Change Communication (BCC) strategy 2008-2013 has been designed to meet the needs of the Lesotho population which are in line with those outlined in the HIV/AIDS prevention plan 2006-2011 and to goal of this strategy is to help change behaviours related to HIV/AIDS over the period of five years (2008-2013).

The National AIDS Commission (NAC) is a corporate body that was established by an act of Parliament NO.8 of September 2005. It is charged with an overall mandate of coordinating the national response towards HIV and AIDS in Lesotho. The specific areas of its mandate are as follows: to develop and coordinate strategies for combating HIV and AIDS; to provide policy guidance to implementing agencies in the country; to provide technical and financial support to the implementing partners; and to facilitate implementation, monitoring and evaluation of programmes.

Corno and Walque argue access to ART in Lesotho is progressing at rapid pace. In July 2007, out of an estimated 56 000 people in need of ART, 24 000 had received ART treatment as compared to 8 000 in 2005. As such a number of institutions have begun implementing HIV prevention programs in the country. There is the life skill curriculum proposed by the Ministry of Education in which HIV/AIDS education has been integrated in primary schools. Population Services International (PSI) through its program called Condom Social Marketing has managed to market three male condom brands and distribute both in the urban and rural areas of Lesotho.

Having provided an overall National health care system of Lesotho, the following section turns to the immediate background of the study.

4.4 Background to the Health Centers and their function in Mohale's Hoek

This section takes a look into the health care services in Mohale's Hoek, particularly the chosen Health Centers of the study and their responsibilities.

The Mohale's Hoek District Health Management Team under the Ministry of Health and Social Welfare is responsible for providing health care in the District. At district level, the Ministry of Health and Social Welfare and the health sector on general focuses general primary health care including HIV/AIDS prevention, treatment, care and support and HIV impact mitigation programmes (HIV/AIDS Strategic Plan, 2008).

Mohalinyane, Ha Tsepo, Liphiring, Lithipeng and Holy Cross are the five Health Centers where I conducted my interviews. Mohalinyane, Liphiring and Lithipeng are run by Government of Lesotho whilst Ha Tsepo and Holy Cross are managed by CHAL. At the primary level of health care, these centers are part the 12 Health Centers in the district of Mohale's Hoek, that altogether including one Government hospital (Ntsekhe hospital), service a population of about 185,459 (Lesotho 2006 Population and Housing Census, 2009).

The Health Centers' main responsibilities like other healthcare facilities include prevention and treatment of HIV/AIDS, immunizations, ante-natal and post-natal care, family planning and other curative and preventive public health services. Health centers provide outpatient services only and in the case where there are pregnant and waiting mothers, assistance is provided. Further, supervision of community based public health and training of community health workers are some of the key management responsibilities of the health centres. There is also Health Inspector from hospitals to Health Centers to ensure that communities are effectively sensitised about good health practices, particularly those related to personal and environmental hygiene (HIV/AIDS Strategic Plan, 2008).

These Five Health Centers are located in the rural areas, outside of the urban town of Mohale's Hoek. At most the furthest distant travelled is about an hour's away to get to Lithipheng Health Center, the rest range between 30 to 45 minutes of travel distance. To get to the clinics was a bit tricky because of their location, there are no road signs indicating directions to the Centers and to get to them required leaving the main road to join gravel roads. Further, once at the Health

Center there is no board indicating the names of Center. However because the names of Health Centers are derived from the villages they are situated in, once in the village it is not difficult to spot a Health Center as all have the same building design and painted in similar colours. The Health Centers usually service a village where they are located as well as nearby surrounding villages, for example whereby Mohalinyane Health Center is located in the village of Mohalinyane, it services Mohalinyane villagers and other surrounding villages that do not have a Health Center close to them. Below is a picture of a Health Center.



Figure 3: Typical structure of a Health Center in Mohale's Hoek
Adapted from: Ministry of Health and Social Welfare facilities list 2009

4.5 Background to Nurses and their responsibilities in Mohale's Hoek Health Centers

In this section a short biography of the nurses is provided to further understand the manner in which nurses act as culture brokers.

Fifteen nurses were interviewed from the Health Centers, Three nurses at Mohalinyane, three at Ha Tsepo, three at Liphiring, four at Lithipeng and two at Holy Cross. Six of the 15 Nurses qualify as Nurse Clinicians and nine as Nurse Assistants. To become a nurse clinician requires a Degree in General nursing plus a Diploma in either Primary Health Care or Midwifery, whereas to become a nurse assistant entails Diploma in General Nursing. Despite their differing qualifications and occupation status, all the nurses working in the five Health Centers are responsible for providing Primary Health Care and for facilitating HIV/AIDS programmes. HIV Prevention services they are involved in include HIV Testing and counseling, Sexually Transmitted Infections (STI) management, Prevention of Mother to Child Transmission, Post Exposure Prophylaxis (PEP) services and blood and tissue safety. HIV treatment services offered include Antiretroviral Therapy (ART) services, management of opportunistic infections such as TB and home based care programmes. Because of the shortage of nursing staff, nurses at all the five Health Centers often collaborate with Community Healthcare Workers, Know Your Status (KYS) counselors and Social Workers to help out in their daily HIV prevention and treatment activities.

From the 15 interviews, two of the respondents are males while 13 are females. Their ages range from 25 to 66 years and work experience ranges from one year to 20 years. Twelve of the respondents are Basotho and three Kenyan. At most at the Health Centers there are three nurses with at least one of them as a Nursing Officer who manages the Health Center.

As a result of the nursing qualifications that all the nurses possess there was very little difference in the way that they perceive their roles and challenges they have at the work place. A striking difference identifiable was amongst the Kenyan nurses whom because of their nationality, background and upbringing found some of the Basotho traditions and practices foreign and strange but with time have learned to understand and accept them. Apart from that there was no significant difference between the Kenyan nurses and Basotho nurses and to a large extent there was coherence in the manner in which they responded to the questions asked. When asked about their experience with the nursing practice, all the nurses expressed how they loved working as

nurses, the only complaint emphasized was the burden of workload especially in the HIV/AIDS activities and how challenges encountered within HIV/AIDS prevention activities has had drastic impacts on the efficacy of their work. The ways in which they perceive their patients' beliefs about HIV/AIDS in also parallel, the major concern highlighted is that some of their patients take the seriousness of HIV very lightly which results in patients not adhering to medication prescribed or having less interest in learning more about HIV/AIDS.

When asked about their own understanding of HIV/AIDS before acquiring their biomedicine qualifications and training majority of the nurses admitted that they had limited knowledge about HIV which made them question its existence just like the rest of the villagers they lived with but they stated that they never believed in any myths. Only two of the respondents explained how because of lack of proper HIV education once believed that HIV could as result of witchcraft but once they had proper training from nursing institutions they went to, they stooped believing in false information. Lastly when asked if they play any role in the planning and running of HIV strategies answers differed in accordance to occupation status. The Nurse Clinicians said they engage a lot with management where they discuss issues at hand and provide recommendations or suggestions. Most of the Nurse assistants affirmed that they provide very little contributions as at times they do not attend management meetings and are not given any space to get involved in planning of HIV strategies.

The following chapter discusses the findings from the interviews with the nurses in the five Health Centers of Mohale's Hoek.

Chapter Five

Discussions and findings: The challenges that nurses face in HIV/AIDS prevention activities and the roles they play in culture brokering

This chapter covers a discussion of the research findings presented by the nurses in the five Health Centers of Mohale's Hoek. The findings reflect mostly the voices of the nurses in relation to the main research question; the cultural challenges they face within HIV/AIDS prevention services and their responsibilities as nurses in addressing HIV. Pseudonyms are used for all quotes and to refer to the nurses in all the five Centers.

5.1 The role of nurses in HIV/AIDS prevention activities

Nurses working in the five Health Centers are responsible for facilitating HIV/AIDS prevention activities. Their responsibilities in providing various HIV/AIDS services not only take place in Health Center setting but often take place in nearby villages through interactions with community members and administering the HIV/AIDS services while making their community visits. As described in the previous chapter there is a similarity in the manner in which the nurses across the five Centers responded to the questions asked around the roles they play in HIV/AIDS activities, in culture brokering, and challenges faced. Hence findings are similar and representation of the responses is consistent through out the chapter.

5.1.1 Professional requirements as nurses

As demonstrated in the literature review, a lot has been written about the role that nurses play and their importance in the Health Care Sector. Nurses play a vital role and are on the front line in patients care, they have the responsibility and opportunity to provide care for patients including HIV/AIDS sufferers. In some instances, like in the Health Centers of Mohale's Hoek,

nurses maybe the sole medical providers of Health Care. According to Shaw, (2007) nurses have the responsibility to provide compassionate ongoing accessible care, to educate, advocate, continually update knowledge, carry out community outreach and act as role models within the context of HIV/AIDS, Shaw (2007) further argues that nurses' tasks include reinforcing HIV/AIDS prevention strategies, emphasize the importance of safety for both HIV negative and positive patients and encourage patients to become teachers in prevention efforts. Additionally, Benner (2000) provides a detailed description of the nursing practices and what is required as duties of a nurse. The nursing practice invites nurses to embody caring practices that meet, comfort, empower and advocate for vulnerable others. Such a practice requires a commitment to meeting and helping others in ways that liberate and strengthen and not impose the will of a nurse or caregiver on patients (Benner, 2000).

At the five Health Centers nurses spent a bulk of their time involved in HIV/AIDS prevention and treatment services. From my observation, HIV/AIDS education forms a crucial component of HIV prevention as nurses are able to interact with patients at the clinics and provide them with the necessary HIV/AIDS knowledge. Equally important services offered for HIV prevention are Voluntary Counseling and Testing (VCT), promotion and free distribution of condoms, prevention and treatment of Sexually Transmitted Infections (STI's), and Prevention of Mother to Child Transmission (PMTCT). Nurse Thato from Mohalinyane Health Center explained:

Health education is normally held within the Health Center facilities and at times at the communities and schools. Education in general is based on avoiding behaviors that can expose people to the virus which include to mention but a few prevention and treatment of other STI's, the importance of sticking to one partner, abstaining from sexual intercourse until marriage. Voluntary counseling and testing encourages not just patients but members of the community at large to know about their HIV status with the hope of taking more charge of their lives.

From the nurses' view point they have been successful in facilitating and encouraging community members to make use of all HIV/AIDS services, though participation varies by gender. According to the nurses, women show more effort and enthusiasm than their male counterparts by making regular visits to the Health Centers and accessing and using services offered. Nurse Matthews from Lithipeng Health Center stated "Women, including school girls

have been responding better than men to educational talks and using up the services offered for HIV/AIDS prevention”.

5.1.2 Nurse driven approaches to HIV prevention outside of the Health Centers

The impact of HIV/AIDS in Mohale’s Hoek has created a situation whereby nurses not only have to work in the Health Centres to try and curb the disease but at every chance they get, they mobilize village members and conduct HIV prevention activities at the community level. This is an additional effort to the tremendous workload that they are faced with but which they gladly do for the emotional reward and satisfaction experienced. When asked about the activities they do at community level, the nurses identified them as nurse driven approaches as a fight against HIV/AIDS. These approaches include what they referred to as conductive outreaches. Conductive outreaches as explained by Nurse Bob from Mohalinyane are “where people are traced at their homes to assess how for those who are HIV positive, have been responding to treatment and for those who are HIV negative been protecting themselves”. He further stated:

Mohalinyane Health Centre in the month of June 2010 organized PMTCT awareness campaigns as an initiative by the nurses. They took PMTCT messages to near by villages where they engaged with the members and communicated with them through songs, plays and poems and competitions.

Similar findings on nurse driven approaches identified in this research have been recorded by Cohen et al, (2009). their study which describes a two year outcome of a decentralized HIV/AIDS care programme run by Doctors without Borders/ Medecins Sans Frontieres (MSF) in Lesotho validates nurse driven ART for children and adults and lay counselor supported testing and counseling, adherence and case management which highlight critical areas for task shifting that are being piloted in many Southern African countries. Cohen et al (2009) stated that:

In relation to rapidly increasing coverage of ART and related services in the Lesotho, the MSF supported programme through a nurse driven approach in Scott catchment area has managed to incorporate some of the latest national and international guidelines for PMCTC and ART that support important improvement of care by nurses.

Evidence based approaches were also mentioned and described by Nurse Malineo from Liphiring as involving an activities whereby nurses go to the surrounding villages, mobilize members and use statistics to explain the realities of HIV/AIDS. Nurse Malineo elaborated:

The statistics used are taken from clinic charts and records then shown to village members as a way of making members aware of prevalence of HIV, how it is transmitted, how it is treated, numbers of people who use up HIV/AIDS facilities, how members can actively prevent transmission from a pregnant mother to the child. The purpose of this approach is to make people aware of what they do to prevent and treat HIV, and importantly to show people using numbers exactly how many end up taking prevention methods.

With the realization of lack of participation from men in the surrounding village of the Health Centres, evidence based approaches aim to show all people especially men the changes they can bring just by knowing their status and by supporting HIV prevention initiatives. Mohalinyane and Liphiring Health Centres recently used this approach using statistics that show the future of an unborn baby whose expectant mother is HIV Positive. The column showing the status of the pregnant mothers is usually filled whilst most of the fathers' remains blank. Nurse Mathabo from Mohalinyane clarified:

The purpose of this initiative is to provide evidence to both men and women on how they can prevent transmission to the child but also particularly to men about the importance of knowing their status. The men themselves during these activities can then see first hand and hopefully learn to take more leadership in protecting their families against the virus.

The nurses expressed that it is not only HIV/AIDS prevention that is nurse driven, HIV/AIDS treatment is as well. "Treatment of HIV/AIDS in Lesotho is actually nurse driven" stated Nurse Bob, "with the support of District Health Management Team (DHMT) and Non Governmental Organizations (NGO's) nurses have adopted the same HIV treatment approach for HIV prevention with the aim of reducing prevalence rates". Most of the times nurses combine with community health workers for these initiatives, hold public gatherings and use traditional Sesotho songs, plays, poems and plays are sometimes used as modes of communication about HIV awareness. The interaction with community members is to further engage them where everybody can watch and ask questions.

5.1.3 Good relations with patients and community members

Besides the formalities of interactions between patients and nurses at clinical settings, nurses spoke of patients and community members as their friends which suggest sociable, open relationships between them. This form of interaction is identified by Nurse Limpho from Ha Tsepo as making their job less difficult because people have slowly become accommodative to HIV and do not see nurses as only having that power to treat HIV related diseases but also friendly to them for which they feel comfortable around and there is a sense of corporation and willingness to test and take on family planning advice. The nurses identified good working relations between them and community members which are evidenced through calling them by their first names instead of formal titles.

This role stands from the other roles out as it holds a particular importance to the concept of culture brokering. The special relationship that nurses have with their patients denoting friendship, mutual respect, and openness is essential to culture brokering and culture competence as these characters determine how nurses mediate any kind of conflict that may exist between the them and their patients so that they can work more productively with their patients. The argument provided by Cross et al (1989) about the various elements which contribute to a health system's ability to become more culturally competent falls short. While they suggest having amongst others the capacity for cultural assessment and being conscious of the dynamics inherent when different cultures interact, they make no mention of the importance forming friendly relationships with their patients which I feel is essential in being a cultural broker and developing skills for cultural competence.

Regardless, the overall findings on the various roles that nurses play in HIV/AIDS activities confirm what Shaw (2007) and Benner (2000) describe as responsibilities for nurses in the Health Care system. From the findings, nurses do advocate, educate and provide knowledge about HIV/AIDS to patients and community members and they do carry out a compassionate role of care which is evidenced also in their initiative to build friendly relations with their patients. Evidence based approaches and community outreaches moreover parallel to the empowerment theory as explained by Jemmott et al (1998). The empowerment theory is based on the idea that bringing people together to discuss problems and jointly propose solutions can

engender a sense of empowerment that promotes better health (Jemmott et al, 1998). Nurse driven and evidence based approaches contain in them similar attributes as the ones mentioned about the empowerment theory.

The different approaches that the nurses have been using in addressing HIV/AIDS prevention shows a commitment to the roles and responsibilities that they hold in the Health Centers and to the public that they serve. The following section outlines challenges that the nurses face in the Health Centers.

5.2 Personal challenges faced by nurses in the Health Centers

The nurses in the five Health Centers identified a number of challenges encountered in relation to the HIV/AIDS prevention activities they are involved in, some personal but the majority structural and cultural. First to be discussed are the personal challenges faced by nurses in their daily activities at the Health Centers.

Firstly, most of the nurses complained about being overworked and understaffed. They spoke of HIV/AIDS as a burden having created twice as much workload to them so much that they have limited time to other clinical duties. What frustrates them most is that they feel like they are not getting any support from their superiors whether in the form of incentives or hiring more nurses. “Our work is not appreciated by our superiors which for us is not so encouraging” states Nurse Lilloane from Ha Tsepo, “Stress has become the outcome of our frustrations and I wish we could get more on job training on how to handle large numbers of patients, being overworked and stressed”.

The second concern for nurses is patients who disappear or do not adhere to medication which in turn makes them look incompetent when doing their job. Myths and beliefs about HIV/AIDS are recognized as affecting their work because not being able to get through to the patients who unfortunately because of what beliefs or myths that they may have distorts their understanding of the virus and results in patients disappearing or not adhering to medication. Nurse Puleng from Holy Cross explained:

We are not able to make proper follow ups when patients disappear and often we get stuck in trying to convince and make people understand the reality of HIV. However when we do get stuck, we always try to report such situations to higher authorities at the Ministry of Health and Social Welfare and at times consult with the older nurses and Doctors at the Mohale's Hoek Hospital who have more experience on how to deal with difficult circumstances.

Despite these challenges, the nurses did not express any negative attitudes towards their patients. The literature from Lesotho that I engage with does not cover any studies on personal challenges that nurse's encounter in their work. However Ehlers (2006), reported the personal and professional challenges nurses in Africa in their daily HIV/AIDS activities. Though Ehlers findings have few similarities to my data as they mainly mention nurses' fears of becoming HIV positive through contact with HIV positive patients' body fluids which nurses from my findings made no mention of, one similarity is how myths and beliefs affect them personally and professionally. From Ehlers data, the selection of virgins as sex partners because of the belief that virgins cure HIV/AIDS creates fear for nurses as at times they fear for the safety of their own daughters and student nurses. The nurses from Ehlers findings also mentioned how the HIV pandemic and being understaffed is a burden to them which is another similarity to my findings. Importantly, Elhers notes how in order to avoid nurses from suffering from fatigue and feeling burnt out they need physical, social and emotional support not only from family and community members but also from governments and employers which is one plea that nurses from my findings stated especially from the side of employers. Delobelle et al (2009) make note of several studies in South Africa whereby health care workers describe how HIV has had an impact on their work which affects the quality of the their care. Health care workers were reported to be reluctant to provide HIV/AIDS care as a result of concerns about occupational infections and said that they experienced stress, fear and frustration but also sympathy and empathy towards patients with HIV/AIDS (Delobelle et al, 2009).

Interestingly, none of the respondents indicated that they had negative attitudes towards HIV/AIDS which literature shows that attitudes can have an impact on the efficacy of their work. Delobelle et al (2009) report in their study how some findings in developing countries indicate negative and discriminatory behaviour against HIV positive patients. From the interviews I carried out, nurses did not talk about fears of HIV contamination and did not show any negative or discriminatory attitudes towards patients who are HIV Positive instead they expressed

compassionate and caring emotions towards patients despite feelings of distress that they spoke about. Perhaps the knowledge about HIV/AIDS prevention treatment that the nurses in the Health Centers of my study area possess enables them to have a more positive attitude towards HIV which also helps them to cope even under conditions of stress.

Personal challenges can create situations of despair as explained by the nurses but they have also managed to find ways of dealing with whatever personal challenge encountered.

5.3 Structural and cultural challenges faced by nurses in the Health Centers

Apart from the personal challenges, a lot of problems that nurses have to deal with which constrains their efforts in the prevention of HIV are mainly structural and cultural in nature. In answering the research question, a presentation of the structural and cultural challenges faced by nurses in their HIV/AIDS activities is discussed in the following section.

5.3.1 Structural challenges: a culture of economic dependency

Socio-economic constraints are often associated with the transmission of HIV/AIDS. Migrant labour for one has been pointed out by the nurses as having a negative impact on HIV prevention efforts that they facilitate in the Health Centers because good number of men who are working in the South African mines end up having different sexual partners other than their wives. Many men from all parts of Lesotho travel to South Africa to work in mines where they live in single sex housing and are away from their wives and families for months at a time, often having interactions with professional sex workers. In the past decade, about 60% of the total workforce of Lesotho was employed in the South African mines and literature describes mines as hosting a large sex industry whereby once away from their families, men might be more likely to have multiple partners. (Corno and De Walque, 2007). In turn, if contracted HIV, they might infect their partners when they return to their families in Lesotho. But the involvement in extra marital sexual intercourse is both ways, nurses in the Health Centers stated how wives too back at their homes have that freedom to move around. A nursing officer, Bob at Mohalinayne Health centre also spoke about his concerns around the casual approach to sex. Women and men according to him take sex very casual which, he said:

A woman will tell me that my husband is not encouraging PMTCT because this is not his child. I have more than one case. And it seems there are women who go outside of their marriages and men at the mines who go out of their marriages. I don't know to what extent it is culture or socio-economic situations but it happens.

A general notion from most of the nurses interviewed is that the socio economic dependency of wives on their husbands may drive them to have extra marital affairs to support themselves if the husband who works away from home fails to provide financial support. Corno and De Walque (2007) highlight the vulnerability of married women in Lesotho who engage in extra marital sex without using a condom. They argue, many women engage unsafe means of survival including prostitution, early marriage or sexual favours with older men hence the poor socio-cultural status of women might be another reason for the spread of HIV (Corno and De Walque, 2007).

For those people especially women who know about their HIV status, disclosure becomes difficult because of fear of being abandoned or divorced by husbands and other family members, whom are their main financial supporters. They would rather keep their status to themselves which from the nurses' perspectives does not help in decreasing the rates of infection. This dependency is mostly prominent amongst the youth and those who are not working who are dependent on other people, thus there is a belief among them that if they disclose they will be abandoned by their families or husbands. Nurse Mampho, a nursing assistant at Lithipeng Health Center explained:

I understand women are taught by the elders how to satisfy their men, so women grow with these in mind, they do anything to keep their men happy to an extent were they can put their health at risk. For those who are literate I don't think it has to do with culture especially the youth. But I think unemployment, and being dependent puts women at risk.

I also began to understand from the interviews that women in the rural areas of Mohale's Hoek are viewed by nurses as different from women in urban areas; they do not know how to stand for themselves mainly because they are unemployed and are dependent on either family members or husbands and are most of the time afraid of being disowned or divorced if known that they are HIV positive.

5.3.2 Structural challenges: Educational culture

The better educated and literate community members were shown by the nurses as having a broader understanding of HIV/AIDS and more willing to use prevention services offered than the less educated. Nurses identified a gender variation, whereby most women in the villages are better educated than men hence make use of services much more frequently than men. Lack of education therefore is identified as a barrier to HIV prevention:

Women show a willingness to ask and learn more about HIV, they even consult more than men do, which teaches us that the more educated and literate a person is, the easier they are to work with (Nurse Puleng from Holy Cross).

In their study Corno and De Walque (2007) show that education in Lesotho appears to be an important aspect of preventing HIV infection and adopting less risky behaviour. The probability of being HIV positive decreases with education, which suggests an important role for education in HIV prevention.

5.3.3 Structural challenges: a culture of overexposure to HIVAIDS prevention messages

On the other hand, whereas the health talks provided by the nurses would be expected to raise the knowledge attention to HIV/AIDS, some nurses explained that a recent constraint to their education is that the HIV topic has been exhausted to a point where when they have community outreaches people no longer attend or even pay much attention. Solomon and Venkatesh (2009) argue that at times cultural or religious inhibitions may hamper wider communication and implementation of sex education interventions. Nurse Joyce, Nurse Malillo and Nurse Nthabiseng, from Lithipeng, Ha Tsepo and Liphiring respectively drew attention to people who go to the Health Centers and test HIV negative that will come back a year later to test positive despite of the counseling and education taught and how to stay HIV negative. Such a situation is interpreted by the three nurses as showing the failure of Voluntary Counseling and Testing. Nurse Joyce explained:

People will test and diagnosed either positive or negative but continue with behaviours that expose them to HIV infection. Pregnant women on ARV's for PMTCT also show lack of commitment to treatment which at times results in transmitting the virus to the unborn baby.

The elderly members even go to the lengths of opposing the educational campaigns, for they are blamed for teaching the youth immoral behaviour.

As nurses, we are limited in trying to bring the elderly aboard to learn more about HIV because we believe that they are the ones who could actually help encourage the youth to protect themselves, explained Nurse Malillo.

5.3.4 Structural challenges: Youth Culture and HIV/AIDS

There seems to be an evident difference between youth/students in the villages and the older community members. A schooling culture exists whereby according to the nurses students detach themselves from their own Sesotho norms and values taught. "Students exist in an abnormal freedom that has no respect for the elders", explained nurse Matthews from Lithipeng. Nurse Thuto from Lithipeng argued:

What we see are students that behave in unacceptable ways; the number of pregnant students or a young married student at school who come to the Health Centers in increasing, public intimacy between male and female students and school girls renting houses that have no adult supervision. These are just a few examples of how student in these villages behave like.

Nurse Malineo from Liphiring Health Centre described a conversation she once had with a student:

I was once talking to a student who said they don't care about HIV/AIDS, not afraid because there are drugs that you can take and move on. That cavalier approach might tell you that they don't mind getting infected because there are drugs to take available.

Failure to use condoms and youth safety to HIV is also a great concern for the nurses. Nurse Cecelia elaborated that adolescents like to experiment and do not use condoms and the nurses have observed that adolescents believe HIV is a disease of the elderly and the elderly believe it is

a diseases of the adolescents. Most of the time girls are pressurized to have sex. Teenagers are focused more on prevention of pregnancies than prevention of HIV mainly because they think it is a disease of the elder people. Further, Nurse Cecelia explained “the use of traditional beer by teenagers increases their exposure to risky behaviours”. There is a trend realized by nurses amongst the youth who go to the health centers to be treated for STI’s and when asked how they got the infections they blame it on their drunkenness which inhibits their capacity to use protection during intercourse. These situations are problematic because as nurses interpret, a lot of women are willing to use condoms and protect themselves but do not receive the same support from their male partners. This discussion links to risky behaviour as the youth expose themselves to HIV transmission through unsafe sexual conducts.

There is another challenge that nurses face, the rising numbers of teenage pregnancies. What the nurses have observed is that most teenage girls are involved with older men, some who are already married who work in the mines of South Africa. Nurse Malineo clarified “It is a concern because these young girls become exposed to risks of infection”. What is not clear though for the nurses is whether these school girls get involved with older men for socio-economic reasons or as a youth life style which was pointed out as existing in many schools.

5.3.5 Cultural challenges: Prevailing perceptions and beliefs about HIV/AIDS

From what nurses described as existing perceptions and beliefs about HIV/AIDS, there seems to be a relation between the state of denial, lack of acceptance, ignorance, lack of education and education and what people have conceptualized as their beliefs and myths about HIV/AIDS. There is a trend of people who know about HIV/AIDS and are aware of the virus and very few who don’t which creates two scenarios:

For those who know about HIV and are aware of it, acceptance is quick and denial which is a state of refusing to acknowledge the existence of HIV/AIDS is dismissed easily, whereas the opposite happens for those who are not aware of HIV explains Nurse Matthews.

There is also a gender divide where most women easily accept the existence of HIV and majority of men choose to remain ignorant. Nurses emphasized on how a lot of patients they saw claim condoms give them kidney infections which in Sesotho they refer it to as ‘*lipheo*’.

Some men blame condoms for making them ill, they claim condoms are also responsible for spreading the virus and giving them kidney infections” stated Nurses Mampho from Lithipeng.

Nurse Matthews, in support to the statement provided by Nurse Mampho explained how most of the patients he saw blame condoms for giving them *‘lipheo’*.

Witchcraft is understood as a way of passing the virus from one person to another. Whilst some people believe that the virus is a type of bewitchment, others think that there is no such thing as HIV but just a normal witchcraft curse. “Those who are in denial are the most likely to blame witchcraft”, explained Nurse Cecelia.

Further there is a general belief that HIV is just another STI called *‘mokaola o motona’* or syphilis in English which can easily be cured by a traditional healer. Additionally, there is a belief that there are certain traditional herbs that cure HIV which can be obtained from a traditional healer or spiritual healer. Potassium permanganate, in Sesotho known as *‘makhona tsohle’* is believed to cure any disease including HIV. Nurses Limpho and Malillo from Ha Tsepo explained that people drink it before they go to the Health Centre to test for HIV because there is a belief that permanganate can alter results, where a person is positive the results would show negative after drinking it, or if diagnosed positive, drink it to cure them which would change their HIV status back to negative.

Nurse Malillo drew attention to churches and traditional healers whom not only her but other nurses from Holy Cross and Liphiring contest because they claim to cure HIV and give people false hope and information. Further, amongst the youth, as described by Nurse Matthews from Lithipeng, common knowledge is that if a man does not ejaculate inside a woman, there is no transmission passed regardless of the number of sexual partners they might have.

These findings confirm what Solomon and Venkatesh (2009) describe about lack of appropriate information, that a lack of proper education about sex and sexual health can lead people especially men to believe various myths associated with HIV transmission and prevention behaviours. Niehaus and Jonsson (2005) provides a series of studies that also confirm how in

local South African villages and townships there is intense speculation about the origins modes of HIV/AIDS through media rumour and gossip. These studies acknowledge that meanings and representations of HIV are often multilayered and contradictory but detect a general tendency to allocate blame onto disreputable and dangerous others such as witchcraft (Niehaus and Jonsson, 2005).

5.3.6 Gender and Socio-Cultural practices

As already observed, the significance of gender variations in response to HIV/AIDS and behaviour change could not be ignored. A clear observation from the interviews is the differing ways in which women and men understood and made sense of HIV. Nurses described how women when educated about HIV/AIDS without difficulty shifted from a state of denial to acceptance, whilst men would consistently try to find false answers to make sense of the virus and it is easy for them to blame other occurrences such as witchcraft or condoms for why there would be such a disease. Hence one of the major challenges for nurses is bringing men on board as they have been repeatedly identified as having less interest in learning about HIV. For men, admitting ignorance about sexual matters can be affront to their masculinity explains Solomon and Venkatesh (2009), conceptions of masculinity that promote promiscuity and can cause men to experiment with unsafe sex and sexual violence. Nurse Bob explained how it is unfortunate that men are not participating as much to protect their loved ones. One example he quoted is the lack of support for PMTCT for their wives and unborn babies. Men were presented as being less encouraging to their partners to make use of PMTCT.

Bringing more men on board, nurse Bob stated, would help in the success of PMTCT as an HIV prevention strategy in the country. Even during community outreaches, the participation of men is low and the few that are around usually do not interact with the crowd. Generally women make an effort to attend outreaches and participate but the challenge that the village women encounter is passing messages that they have learned about HIV to their husbands or partners. This challenge presents a disassociation from interactions between nurses and males whether at the Health Centers or in the villages. Nurse Matthews further explained that:

There is no link with our male counterparts; they are generally not interested in getting involved because at the end of the day they are the heads of households and make final decisions which make our efforts unsuccessful such as partner testing. For those men who work in the mines in South Africa, they are hardly involved in family planning.

Nurse Puleng from Holy Cross Health Centre stated:

I work mostly with pregnant women, for those that we test positive and the husbands know, they disagree and discontinue their wives on PMTCT. Even when we tell them to breastfeed for 6 months the husbands tell them to give them other foods which put the baby at risk.

Gender norms related to masculinity can encourage men to have more sexual partners and older men to have sexual relations with much younger women. The social construct of gender where men are viewed as playing a more dominant role and women a submissive one and patriarchal power relation can make women highly vulnerable to HIV infection. Forced elopement/abduction and polygamy were referred to by nurses as having a negative impact on their HIV prevention efforts. Abduction is where a woman is forced into marriage by the interested man, in this manner a woman as viewed by the nurses in this situation has limited chance of protecting herself even against sexual conduct. Polygamy as they interpret it has an indirect relation to having multiple partners for the custom of Basotho encourages a man to have more than one wife. Polygamy is not as frequently practiced but men loosely use this custom as a grip for having many sexual partners though they are not bounded by a polygamous marriage. Because of patriarchal powers, though not encouraged, Solomon and Venkatesh (2009) argue that in many societies it is socially acceptable for men to have pre-marital and extra marital sexual encounters. Men believe in the Sesotho saying that “*ke mekopu ba nama*” meaning men are like pumpkins and because of the design of a pumpkin that spreads its seeds they can scatter themselves as well, that is how they justify having more than one partner, as part of a Sesotho practice. Nurse Thuto at Lithipeng Health Centre, expressing anger in her tone said:

This practice is very casual and when such practices are cultural it's very hard to change. There is a causal approach to sex which is a big worry us nurses. Having more than one partner is not a big deal to Basotho people. Patients who usually go to the Health Centers to be treated with for STI's when asked how many partners they have, they openly say two or three and for men nurses explain, the number is always more.

The lack of support from male counterparts denotes a safety concern for women in general but with emphasis on young school girls. Solomon and Venkatesh (2009) suggest that changing or addressing cultural vulnerability to HIV infection requires that prevention efforts confront entrenched gender norms which is neither simple nor quick but rather requires a long term multi faceted community based approach.

Forced elopement or abduction raises further concerns about the safety of women. Nurse Marethabile elaborated “older men abduct school girls for marriage, which totally denies girls the right of choice and protection”. Though it is an old Sesotho custom and not viewed as criminal, the nurses felt that it can put women at risk as forced as it is it means sexual intercourse could also be forced against the women’s’ will.

There is a tendency for men to want to be in control of all situations which links back to the ways in which gender roles have been constructed by assigning more powers to men, so much that nurse Marethabile explains, safe sex is jeopardized. This tendency is interpreted by her and other nurses from all Health Centers as having a relation to the Sesotho norm of men as heads of households which puts them in charge of what happens in their families. In fact Sesotho custom allows for husbands to control sexual activities and even talk about them. If a wife shares information learned about protected sex like the use of condoms to the husband, if the husband prohibits the use of condoms, the wife is said by Nurse Lilloane to shut up and most of the time feel like they have no right to protect themselves.

It is unfortunate that in the context of HIV/AIDS, this norm exposes women and men to infection, for the same norm is used to justify why men do not use condoms, why men can decide to have more than one partner and why men can decide the fate of an unborn baby who could be protected from the virus, Nurse Lilloane explained.

Nurse Cecilia from Holy Cross Health Centre affirmed “Men always want to be in control so much that safe sex is compromised”. In the Sesotho custom women are taught by the elders how to satisfy their men, and men are taught that as the husbands they have control and the last saying about sexual activities. Both men and women adopt this teachings especially in marriage, women

are told to do anything to keep their husbands happy to an extent where they can put their sexual health at risk. Nurse Cecilia elaborated that women have been taught not to speak about sex which makes it hard to initiate use of condoms to their husbands or partners.

The structural and cultural challenges denote a series of factors contributing to the inhibition of proper facilitation of HIV prevention activities and promote exposure to HIV for the population living of Mphahle's Hoek. The findings provide clarity to the relation between structural and cultural factors and the influence they have on the sexual behavior that could possibly affect HIV/AIDS prevention initiatives.

5.3.7 Risky sexual behaviours that expose men and women to HIV

Alongside structural and cultural challenges, risky sexual behaviour also increases exposure to HIV. Discussed below is the many ways in which Sesotho practices can present themselves as problematic within the context of HIV transmission.

Behaviour change and avoidance of risky sexual behaviours remain key in the HIV/AIDS prevention. According to the *National Behaviour Change Communication Strategy 2008-2013*, risky behaviours that drive the HIV and AIDS epidemic in Lesotho include multiple and concurrent partnerships by men and women, early sexual debut, intergenerational and transactional sexual relations, casual sex, inconsistent use of condoms, gender imbalances and the inability of men and women to share power and speak with each other and their children/youth about sex and sexuality.

Sesotho cultural practices that expose both men and women to risks of HIV infection were described by nurses in the Health Centers as having a negative impact on HIV prevention activities and efforts. Alongside these practices, behaviour change was emphasized as another factor contributing to an increase in prevalence rates. Nurse Bob from Mphahle's Hoek defined risky behaviour as when people engage in irresponsible sexual practices which means behaviour change requires people to leave irresponsible behaviour sexual practices and adopt responsible ones. Partner testing is another challenge to most nurses. "There is lack of commitment from

males to test with their partners which forfeits the whole purpose of protection in relationships because if one partner tests and the other doesn't, there is a possibility of transmitting infection to other sexual partners as well", affirmed Nurse Bob. Lack of behaviour change was linked by most nurses to a dilemma of a lenient society by the nurses. Parents were revealed as having no interest in the HIV/AIDS and safe sex education of their children; about how they can protect themselves from the virus. "Parents are not bothered by the fact that their children at very early ages are engaging in sexual relationships", stated Nurses Malineo. According to the nurse's interpretation lack of concern from the parents is evidenced by their unwillingness to talk to their children about sex and by some parents encouraging their young daughters to be on the contraceptive pill which in a way shows that they are not bothered by their children engaging in sexual activities.

Further Nurse Cecelia from Holy Cross explained:

It is also a norm not to use any protection in marriage; many married women tell us that their husbands do not believe in the use of condoms because it is not supposed to be like that in marriage. It is problem for those who are already positive because they fall pregnant and put their unborn babies in danger.

Unequal gender relations matter in terms of HIV risk. When the nurses tell these pregnant women about PMTCT, some of them do not make use of the service because they are afraid to tell their husbands. At times as Nurse Cecelia clarified, it is the choice of some pregnant to decide not get enrolled on PMTCT or in other instances the husbands will tell them not to. Hence as already discussed in the gender section, social- cultural norms regarding sexual expression within the confines of accepted masculine and feminine behaviour limit choices of protection from pregnancy and disease (Solomon and Venkatesh, 2009) and increases vulnerability to HIV and other STI's.

Adherence to medication, also linked to behaviour change seems to be huge problem for nurses. People on ARV's for example do not take their medication as prescribed and some continue with their risky behaviours of engaging in unprotected sexual intercourse and having more than one partner.

In trying to understand why people lack adherence or compliance to medical treatment, the theory of psychological reactance as discussed by Forgy (1997) seeks to explain why people often do the opposite of what they are asked to do and why efforts are often ineffectual. Integral to this theory is the idea that each person believes him/herself to possess a set of free behaviours in which they could realistically engage. A threat to any free behaviours could generate a motivational state aimed at recapturing the freedoms. In a medical context, patients' perceptions of threat to their freedom or control may induce non-compliance (the failure of a patient to precisely follow recommendations of a physician or nurse or other health care workers (Forgy, 1997)). Patients may exceed, fall short of or refuse to take prescribed dosages of medication.

Risky behaviour is fostered by various elements ranging from false perceptions and beliefs about HIV/AIDS, to actual cultural practices which can result in increased rates of HIV transmission. There is also a prevailing youth culture which has not been linked to Sesotho practices but rather experimentation, peer pressure and a casual approach to sex exposes the youth to HIV.

5.4 Culture brokering and Cultural competence

Culturally competent health provision requires that nurses in Mphahlele's Hoek be aware of what is going on in the villages where they work. Learning about people's perceptions and beliefs about HIV and essentially how people respond to the HIV services offered from the Health Centers is therefore crucial in the process of brokering. According to Jezewski's (2001) culture brokering gives professionals the tools to assess cultural factors so that they can work more productively with patients from diverse backgrounds. Within the process itself nurses need to be aware of differing cultures that exist which may be different from theirs. From that, nurses will try to solve whatever challenges or problems encountered which negatively impact on the success of HIV/AIDS prevention efforts.

Scott, Gilliam and Braxton (2005) suggest that for programmes to be culturally competent, race, ethnicity, gender, along with population specific, culturally based attitudes, beliefs, and behaviours must be considered in strategies. Further within the health care sector the duties of

health workers are important because the interaction between the health care worker and the patients influences the patients' health care seeking behaviour as well as participation in health care and services. Thus an understanding of different cultures is a skill necessary for health care workers to identify components of a patients' whole social and physical wellbeing (Scott, et al 2005). Within the process of culture brokering the attributes of culture competence are equally important. Cross et al (1989) discuss five essential elements crucial in developing abilities to becoming more culturally competent which include valuing diversity, having the capacity for cultural self-assessment, being conscious of the dynamics inherent when cultures interact, having institutionalized culture knowledge, and having developed adaptations to service delivery reflecting an understanding of cultural diversity. The concept of healthworld and lifeworld are also of significance in the process. According to Germond and Cochrane (2010) the healthworld relates to people's conception of health, to their health seeking behaviour and to their conditions of health. Understanding peoples' Healthworlds can help explain the complexity of multiple ways of understanding health and plural health seeking strategies, while also opening up perspectives on how to improve health practice and outcomes (Germond and Cochrane, 2010). In their study, Barry et al (2001) used voices of lifeworld which refers to the patients' contextually-grounded experiences of events and problems and the voice of medicine which reflects a technical interest and expresses a 'scientific attitude' to suggest that increased use of the lifeworld makes better outcome and more humane treatment of patients as unique human beings. Because of exposure to differing healthworlds the relationship between biomedical nurses and Sesotho healthworlds may appear as though nurses have dominance over their patients as health practices require biomedical interventions. However they have expressed within their work how they try to mediate between their biomedical understandings and Sesotho culture which has resulted in appreciation of Sesotho customs and traditions.

From observation, it seems though that nurses in all the five Health centers go beyond their professional duties in fighting against the spread of HIV/AIDS. Linking the Jezewski's (2001) explanation of culture brokering to the roles that the nurses play in the Health Centers discussed in section 5.1, particularly strong relations they have built with their patients, nurses not only show case the importance of this role as a tool to work more productively with their patients but also a skill necessary for cultural competency. Trust is also important in these relations, for

strong relations means patients trust the nurses thus becoming easier for the patients to confide in the nurses and are more willing to consult. Clearly evident is the amount of time spent interacting with patients inside and outside of consultation rooms. The activities aimed at prevention of HIV/AIDS also make it possible for nurses to have relations with patients. Voluntary Counseling and Testing though carried out by Social Workers requires the nurses to firstly encourage patients before recommending a Social Worker. A lot of time is spent during educational Health talks at the clinics which according to nurse Marethabile from Lithipeng and Nurse Thato from Mohalinyane are held almost on a daily basis to provide the necessary knowledge about HIV/AIDS to patients. The dedication held in hosting these health talks seems to characterize a form of mediation between nurses and patients whereby both parties have the opportunity to discuss and consult matters related to HIV. These talks are not only limited to patients at Health Centers but to students at schools and other community members in their respective villages. This dedication further characterizes Scott, Gilliam and Braxton (2005), suggestion, that for programmes to be culturally competent, the duties of health workers are important because the interaction between the health care worker and the patients influences the patients' health care seeking behaviour as well as participation in health care and services.

The shortage of nursing staff and being overworked creates a challenge as well as a barrier to the process of brokering as nurses are not able to go out to communities as often as they would have wanted. Because brokering requires spending certain amount of time learning and acquainting oneself with patients' differing view points, perceptions and cultures nurses may be inhibited in fulfilling this requirement as they are overworked and have to see a large number of patients and may not have the adequate time to fully commit to the process of brokering. Community outreaches are equally important in the process of mediation for nurses can further interact with those other community members and students who do not often go to Health Centers. Lack of funding and deficiency in logistics as described by the nurses has also rendered outreaches less successful. Where nurses fall short in achieving tasks and objectives planned, the use of Community Healthcare Workers has been taken which in a way contributes to the process of brokering where nurses fall short. Nurse Lilloane from Ha Tsepo explained Community Health Workers as volunteer workers usually residing in the same villages where Health Centers are located. These volunteers described as people who can read and write, whom do not have any

tertiary qualifications and are trained by nurses for about two weeks with regard to the duties that they are expected to carry at the villages. The trainings are based on HIV/AIDS education, prevention and treatment, are conducted at the Health Centers and their work is carried out in the villages.

As discussed in the section on structural and cultural challenges experienced by nurses in their daily HIV/AIDS prevention activities, I interrogated the nurses about the ways in which they deal with such challenges and came up a number of ways in which nurses solve and try to come up with solutions. Of significance is the process of mediation undertaken by nurses to try and mitigate the challenges. At least once a month nurses shift their education awareness campaigns from the Centers to near by surrounding villages, mobilize community members to attend through public gatherings or “*lipitso*” in Sesotho. During these gatherings nurses initiate evidence based approaches for interactions with the people. At times Sesotho plays, poems and songs are used to portray and translate HIV education. Men and women as well as students are asked to participate as actors for any topic related to HIV/AIDS that they want to teach the villagers. These evidence based approaches intend to make people interact with one another, interrogate questions about HIV and collectively try to come up with answers and solutions. Mediation automatically happens through these public gatherings because nurses use a bottom up approach, come to the level of patients. The nurses elaborated and how they go about mediating. Villagers are given a chance to tell their stories and concerns about HIV, carefully listen to their worries. Nurse Thato from Holy Cross explained:

When we mediate yes we do give them a chance to clarify to us their own HIV/AIDS understandings, so that we can also assess how far they know, what facts or myths they are aware of, from that we can explain to them about HIV and how it can be prevented.

The importance of such interactions is that they allow for differing ideas and perceptions to be heard, both from biomedical perspectives and laymen perspectives. Majority of the nurses clarified that they do not immediately dismiss cultural beliefs but part of their duty is to enlighten people about facts and realities of HIV/AIDS so that they possess understandings about the disease.

Because nurses cannot go out to the villages on daily basis, the health talks held at the clinics compensate. Further the use of Community Healthcare Workers is a common course of action to continue the interactions between village members and healthcare workers in spreading educational messages about HIV/AIDS. Their various duties include going at large within nearby villages to also give health education, making follow ups and patients who disappear or who do not adhere to ARV medication and because of the trainings they have received monitor people on treatment. There are also Know Your Status (KYS) workers who are responsible for offering Voluntary Counselling and Testing (VCT) at the villages. These counselors test people in the villages and take blood samples to the nurses and they continue motivating villagers to test or go to the centers for treatment. From observations, it seems that nurses in this case have a minimized role in brokering, most of the mediation can take place in the villages with Community Healthcare Workers but whatever is translated is reported back to the nurses, in that way nurses remain informed about what is going on in issues related to HIV/AIDS.

If nurses identify a certain crisis or challenge that has been taking place in villages, where need be they collaborate with traditional leaders/chiefs, traditional healers, spiritual healers and community Healthcare Workers to collectively solve any problems. A common problem according to Nurse Mathabo from Mohalinyane and Nurse Malineo from Liphiring is mixing of medications, that is, medication from Health Centers and medication of healers. According to the nurses, a lot of times when such collaborations occur are when they realize that people have been getting false information from traditional healers or spiritual healers or that people have been taking medication elsewhere that deteriorates their health and there is need to educate. The purpose of the chiefs is also to mediate because Basotho people have respect and loyalty to their chiefs and most of the time attend gatherings and listen when addressed by traditional authorities.

From what I gathered, nurses are not aware of the concept of culture brokering, in fact they are not even aware that they are engaging in activities of brokering. Regardless, the process of culture brokering is evidenced by the numerous activities that nurses engage with to successfully facilitate HIV/AIDS prevention strategies. The awareness of nurses that there are differences in values, beliefs, and behaviors of the people they service and understanding that these values, beliefs and behaviors are the basis for the way people interact with each other form part of the

process of brokering. Another important role within this process is what nurses decide to do with the information they have about the people they work with. By guiding them on how to protect themselves against HIV through educational talks, interactions in the communities, collaborations with other significant figures and translations of messages in Sesotho qualifies as a tactic in problem solving.

However the nurses are limited as culture brokers because they have not received any training on culture brokering and culture competency which in turn affects how they treat their patients. From the findings nurses described the structural and cultural factors which act as obstacle to their HIV/AIDS prevention work and what they do to try to mitigate these challenges. Gausset (2001) challenges the focus on culture as an obstacle. According to him, the fight against HIV/AIDS in Africa is often presented as the fight against cultural barriers that are seen as promoting the spread of the virus and he argues that those cultural aspects are a wrong target of HIV/AIDS prevention programs because they are not incompatible with safer behaviour and because their eradication would not ensure the protection of the people. To fight against them alienates the people whose cooperation is necessary if one wants to prevent the spread of AIDS. Hence, anti-HIV/AIDS projects should not fight against one local culture in order to impose a biomedical cultural perspective but rather try to make behaviour and practices safer in a way that is culturally acceptable to the people (Gausset, 2001).

Chapter six

Concluding Chapter and Recommendations: Towards Cultural Competence

This last concluding chapter looks into what positive aspects of Sesotho culture can be included in the HIV/AIDS strategic plans of Lesotho which in a way would guide the health system's ability to become more culturally competent.

Drawn from the nurses' various opinions about what is suited as competent to be included in HIV/AIDS prevention strategies in Lesotho, the researcher was able to gather what aspects of Sesotho culture can be considered for inclusion in HIV/AIDS strategies. The most common mode of transmission of HIV in Lesotho is through heterosexual intercourse. I found it crucial to ask nurses if they think there is a relation between sexual practices and behaviour and Sesotho culture as a way of investigating which aspects of Sesotho customs, norms, values, and traditions can be included in HIV/AIDS prevention strategies to qualify as competent. Two general perspectives emerge, the nurses showed a negative and a positive relation between Sesotho culture and sexual behaviour.

Polygamy as an old Basotho custom is criticized by the nurses for the connotations attached to sexual behaviour. Polygamy as a practice involves a husband married to more than one wife. How is it being interpreted these days? From the findings not a lot of people are in polygamous marriages but instead have multiple partners. To justify why they have multiple partners, nurses argue that men equate it to polygamy, that their forefathers long ago had many wives and for them currently because they cannot afford polygamy, having more than one partner still signifies their duties as men. This practice is problematic for nurses because it has resulted in the spread of HIV amongst groups of partners. Further it has transcended to the youth particularly students whom nurses stated that also have multiple partners. The Sesotho saying that "*monna ke mokopu*

oa nama” (a man is like a pumpkin that spreads its seeds) further elaborates how men justify having multiple partners.

It used to be a Sesotho custom for a girl to be married to an older man, though some people according to the nurses still practice this tradition, a lot of its meaning has been taken out of context whereby there is an increase in intergenerational sex which possibly also increases infection rates. Nurses named a couple of instances where older married men have affairs with school girls. Some of these men are positive because nurse recognize them from their visits to the Health Center and this situation is a huge concern because there are possibilities that they are infecting young female students.

According to Sesotho custom sex is sacred, meaning it is taboo to openly talk about sex especially amongst intergenerational ages sets like parents and children. It is only within certain contexts that sex can be discussed like amongst married couples, and even within that context it has to be initiated by the husband as the head of the household. Interpreted by the nurses, these norms are also problematic in the fight against HIV especially for prevention and treatment. For the sacredness of sex, it means that it is one of those topics that are not normally discussed by families; nurses explained how difficult it is for parents to speak to their children about sex, children cannot confront parents about sex and women cannot speak about sex to their husbands or partners, men have control over sexual activities which at times because of the choices they make, put women at risk. That is why amongst the challenges that nurse face are, women not being able to confront their husbands or partners about sexual activities, use of protection, PMTCT and family planning, children and parents not being able to communicate to each other about sex issues and at times the elderly actually blaming nurses for promoting immoral behaviour through their health talks. All of these negative Sesotho customs are viewed by nurses as resulting in spread of HIV and promoting risky sexual behaviour.

On the other hand nurses revealed some positive aspects of Sesotho culture which if continue to be emphasized can decrease risky sexual behaviour. No sex before marriage has always been a cultural value to Basotho and the nurses stipulated it should be value that continues to prevail amongst Basotho. Circumcision is also a Sesotho custom which should continue to be practiced. Alongside circumcision, safe, regulated initiation schools should be promoted because

traditionally, it was through these schools that boys and girls were taught about moral behaviour. Extended families are an important component of the structure of Basotho households, ties to extended families are important to nurses, especially grandmothers and fathers for the role they can play in education the youth about good behaviour. For these positive aspects of Sesotho culture, they form the basis for what should be included in HIV/AIDS strategies.

Basotho are praised by nurses for special ties they have to their extended families. From their observations; they have noticed the important role grandparents play in taking care of their grandchildren. If the elderly could be involved in educating the youth, it could be useful because it seems the baggage of HIV is shifting to the grandparents especially grandmothers in making sure that children are not orphaned.

There is also a general realization of the respect that Basotho have for their chiefs. These are traditional leaders and they need to be brought on board and included when strategizing HIV/AIDS policies. They can be trained and empowered so that they can bring other men on board with the hope of tackling HIV. Community health work seems to be a burden of women but it is an important part of care within communities, thus there needs to be more of such helpers to be included in HIV strategies. Further, Basotho have a lot of dynamic cultural practices, songs and dances, which can be used to pass on HIV messages, these can be tapped exhaustively to address HIV, as at the moment it is not happening.

Most of the nurses explained that they do not dispute or condone the work done by traditional healers, that is why they think they can be included in improving HIV prevention strategies, they can align together but nurses clearly specified that they too would need to test their medication first which can be used alongside ARVs. Because a lot of Basotho people still believe in healers even if they consult with the nurses, they will still go and ask for an opinion from the healer. Suggestions are that traditional healers should be trained in dealing with HIV, how to use blades when circumcising or using herbs (*ho pats'a*). Thus, traditional healers should be brought onboard so that nurses can work with them and monitor the medication they give to patients if it is harmful or not. Church leaders as important figures in communities should be involved; they should be trained on how to deal with issues of HIV/AIDS and how to help community members at large. Nurse Thuto emphasized:

Sesotho culture advocates for certain kind of behaviour when it comes to sex like no sex before marriage, the Sesotho norm of no sex before marriage should really be stressed because it reduces chances of getting infected. Traditional healers should be brought onboard so that we can work with them and monitor the medication they give to patients if it is harmful or not.

Most nurses argue that Basotho can benefit from drawing back to old customs which have abandoned. As an old custom young girls used to be prohibited from eating food too rich in proteins like eggs. There was a reason for that with cultural significance. It is because according to nurses, food rich in high protein helps girls mature too early which results in them getting involved in sexual activities at early ages. Their diet was regulated by the elderly to prevent them from developing at a young age, such as puberty and getting their periods as an early age.

There is also a Sesotho custom known as *thakaneng* and *Khotla* which was practiced. The elder women would sleep with the younger girls in same rooms to teach girls about sexual behaviour, how they should conduct themselves as girls and they should stay away from sex before marriage. If HIV strategies could draw back to this custom, similarly this practice can teach girls how to conduct themselves, how to stay away from sex before marriage. Like wise men used to advise boys on how to behave and conduct themselves, even during circumcisions the healer would advise men how to respect sexual activities and conduct themselves. The adoption of these practices *thakaneng* and *Khotla* with the current knowledge about HIV, the older women and men can be trained on how to know focus on sexual behaviour and HIV and continue giving guidance to the youth. Alongside *thakaneng* and *Khotla*, nurses supported the old customs of virginity testing which would help to monitor the behaviour of unmarried women. Lastly there is an emphasis from the nurses about safe male circumcision that it should become a priority and encouraged because of the positive results it has.

6.2 Recommendations

Cultural competence requires the adoption of interpersonal skills that will allow individuals to increase their understanding and appreciations of cultural differences and similarities between groups (Scott et al, 2005). The previous two chapters have in numerous ways tried to demonstrate the ways in which nurses act as culture brokers and suggestions of how culturally competent HIV/AIDS prevention strategies can be developed. There is no single widely accepted set of criteria for maintaining cultural competence as the concept of culture itself is dynamic and changes overtime. However, this research has established that competency cannot be achieved first of all if nurses do not have an understanding and knowledge of patients' values and view points. O' Connor (1996) argues that gaining cultural competence is a developmental process that takes time, efforts active awareness and practice. These attributes are crucial when adapting patient-nurse interactions and patient education. From the research findings it can be concluded that though not aware of their act as culture brokers, nurses in the five Health Centers do have within them skills of culture brokering and competency, however because they have received no formal training lack in some aspects of being effective culture brokers and developing culturally competent HIV/AIDS initiatives. The Lesotho HIV/AIDS strategic plan moreover lacks in itself sufficient culturally competent HIV prevention strategies.

As Gardner has suggested "HIV/AIDS is a nursing disease" (Gardner, 1991), this is true in Lesotho particularly in the five Health Centers where this study took place. This Research Report has addressed some of the principal challenges that nurses face in their encounter with HIV/AIDS. Most critically it has highlighted the need for culturally competent HIV prevention strategies and effective culture brokering by nurses.

What is clear is that to respond more effectively to HIV in Lesotho nurses need to be empowered in some specific ways. First, nurses should be trained as culture brokers. This means that their knowledge of Sesotho culture, practices and customs needs to be affirmed and they need to receive formal training in Basotho healthworlds. They also need to be taught communication skills at the point of cultural competency for more effective HIV/AIDS interventions. Nurses need to be empowered to be culture brokers which means within the biomedical settings culture brokering needs to be placed at a more equal privilege.

Second, to support the above recommendations Government of Lesotho needs to develop culturally competent HIV/AIDS prevention and treatment strategies. Nursing institutions thus need to include as part of their curriculum trainings and empowerment on how to become effective culture brokers as well as be culture sensitive.

Finally, as the Research Report has demonstrated effective culture brokering is heavily dependent on the relationships of trust between nurses and the communities and patients they interact with. The importance of trust needs further attention and more studies on the relationship between nurses and their patients need to be conducted.

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APPENDIX A

Interview schedule for nurses

The questions below follow a life history approach where by the participants will be asked to describe about their lived experiences, where they were born, how they were raised in terms of traditional customs and beliefs, schooling and their experiences within the nursing practice. The first few questions will allow for free flow of conversations where by the nurse can talk about their own cultural backgrounds and then engage in the influences that the biomedical field has had on them and how they have managed to separate or integrate their own beliefs to those of biomedicine.

1. Demographic details. Please tell me about yourself and your background.
2. How do you find the field of nursing practice?
3. What are the main HIV/AIDS prevention activities that you engage with on a daily basis?
4. Do nurses have a contribution in the planning and running of HIV/AIDS prevention activities?
5. What are the prevailing beliefs about HIV/AIDS in the community that you work in?
6. What are the challenges that you are faced with in HIV/AIDS prevention activities that you engage in?
7. And how do those beliefs impact on the efficacy of your work on HIV/AIDS prevention?
8. How do you deal with the HIV/AIDS prevention challenges that you encounter?
9. And how do you mediate with your patients in regard to the perceptions they have about HIV/AIDS and prevention?
10. In your view point is there a relation between sexual behaviours/practices and Sesotho norms and beliefs? If so what kind of relationship?
11. What do you think about your patients' beliefs about HIV/AIDS?
12. Did you used to believe in similar things?
13. If so when did your understanding change? Has it changed completely or do you still hold onto some of those beliefs?
14. What does your family think of these ideas?
15. Do you think positive aspects of Sesotho traditions/customs/norms should be included in HIV/AIDS prevention strategies?

APPENDIX B

INFORMATION SHEET

Study title: WHAT ROLE DO NURSES PLAY AND WHAT ARE THE CULTURAL CHALLENGES THEY FACE IN CULTURE BROKERING IN HIV/AIDS PREVENTION ACTIVITIES IN MOHALE'S HOEK DISTRICT, LESOTHO

Greeting: HELLO

Introduction: MY NAME IS POLO LEROTHOLI

I am doing research on nurses and the cultural challenges they face in their daily HIV/AIDS prevention activities. In this study I want to learn about the existing cultural perceptions about HIV/AIDS in the villages of Mohale's Hoek, the influence culture can have on prevention of HIV/AIDS and the ways in which nurses tackle the challenges they face. The study is important because it seeks to identify the difficulties nurses are faced with in terms of HIV/AIDS prevention in order to identify in what ways positive aspects of culture can be included in prevention strategies.

Invitation to participate: I kindly ask you to participate in my research study. Your participation involves you taking part in an interview whereby I will ask you questions that are related to my study and you can provide me with the answers you know. There are about 15 nurses that will be interviewed, the interview can take place at the health centre where you work or we can arrange a different place if you feel otherwise and the time that will be spent during the interview is roughly 1 hour 30 minutes. There are no risks involved in the study and your participation will be highly useful for my findings. A Pseudo name will be used during analysis to ensure anonymity

Confidentiality: Efforts will be made to keep personal information confidential. Absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law. Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the Research Ethics Committee

Contact details of researcher: if there is a need for you to contact me afterwards my number is 0781764341 and my email address is pglero@yahoo.com

APPENDIX C

INTERVIEW CONSENT FORM

I _____ have agreed to take part in the research study. I understand that participation is voluntary, that the information I will provide is out free will and the refusal to participate or discontinue to participation at any time is allowed and will involve no penalty.

Participant' signature _____ Date _____
Researcher's signature _____ Date _____

Contact details of researcher: if there is a need for you to contact me afterwards my number is 0781764341 and my email address is pglero@yahoo.com

APPENDIX D

RECORDING INTERVIEW CONSENT FORM

I _____ have agreed to take part in the research study and have agreed that the interview can be recorded. I understand that participation is voluntary, that the information I will provide is out free will and the refusal to participate or discontinue to participation at any time is allowed and will involve no penalty.

Participant' signature _____ Date _____
Researcher's signature _____ Date _____

Contact details of researcher: if there is a need for you to contact me afterwards my number is 0781764341 and my email address is pglero@yahoo.com