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Bioprospecting for ‘green diamonds’: Medicinal plants used in the management of HIV/AIDS-related conditions

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I believe that while scientific research is necessary to improve the way in which our natural resources are exploited ... our people must not be completely disowned ... of resources that they have possessed for generations. It will be a sad day when the medicinal formulas of devil's claw are patented by big pharmaceutical companies and thereby become depleted and unavailable to the natural owners of the resource.
(His Excellency Dr Sam Nujoma, Founding President of Namibia at a symposium on devil's claw, as reported by Wickham, 2001.)

INTRODUCTION

Namibia first described four cases of acquired immunodeficiency syndrome (AIDS) from infection by human immunodeficiency virus (HIV) in 1986 (GRN, 2002). Since then, many Namibians have continued to witness the multi-faceted impacts of HIV/AIDS in their households and neighbourhoods. By 2002, AIDS was the ‘number one’ killer, accounting for almost 51% of all deaths (GRN, 2002). In 2014, the overall prevalence of HIV in Namibia was 16.9% (GRN, 2014). In order to win the battle against the devastating effects of HIV/AIDS, some Namibians are turning to indigenous knowledge on two fronts: to use it to foster local understanding of HIV infection and AIDS-related symptoms, and in the use of medicinal plants to manage opportunistic infections related to AIDS. In many parts of Namibia, indigenous knowledge is now the cornerstone of resilient households and communities that continue to defy the impacts and shocks of HIV/AIDS.

This chapter is a modest attempt to showcase local knowledge of plant remedies used for managing HIV-related diseases and symptoms in Namibia. To help put it in perspective, the chapter first describes the HIV/AIDS scenario in Namibia, which includes the indigenous names and terms related to HIV infection and AIDS, and describes the challenges facing antiretroviral therapy (ART). It then goes on to examine the prospects for using ethnomedicines in Namibia and the processes for initiating collaboration with traditional healers. Finally, the chapter focuses on ethnobotanical surveys of plants used to treat the symptoms and opportunistic infections related to HIV/AIDS in Zambezi (formerly Caprivi) and Ohangwena regions of Namibia. This chapter is an extension of the rich vein of publications based on previous fieldwork in north-eastern Namibia.

HIV/AIDS SCENARIO IN NAMIBIA

Namibia has a generalized HIV/AIDS epidemic. By 2001, there were about 230,000 people between the ages of 15 and 49 living with HIV/AIDS – out of Namibia’s small population of 2.1 million people at that time (GRN, 2002). By the year 2008, the number of people infected with HIV was 204,000; 14,000 new HIV infections were diagnosed during that year alone, giving a rate of 38 new diagnoses per day (GRN, 2008a). The national HIV prevalence rate increased from 17.8% in 2009 to 18.8% in 2010 (GRN, 2010). HIV/AIDS accounted for almost half of all adult deaths in 2006, and caused life expectancy (at birth) to decrease from 62 years in 1996 to 44 years in 2006 (Family Health International, 2007). Geographically, the prevalence of HIV/AIDS is higher in north-eastern (more than 25%) than southern (4%) Namibia.

By 2014, the average national HIV prevalence rate among pregnant women attending antenatal clinics was 16.9% (GRN, 2014); this was a slight reduction from the national average of 18.2% in 2012 (GRN, 2012). A diagram showing the average national HIV infection rates among pregnant women attending antenatal clinics from 1992 to 2012 is shown in Figure 1.1.

A confluence of geopolitical, biological, socio-economic, behavioural and cultural factors drives the HIV epidemic in the Zambezi Region. Katima Mulilo is a major hub that links five countries: Angola, Botswana, Namibia, Zambia and Zimbabwe. The Trans-Caprivi Highway passes through Katima Mulilo, bringing heavy traffic to and from these countries in southern Africa. Truckers, merchants and migrant workers are serviced by a booming commercial sex industry at this border town (GRN, 2008b).

Other factors that have silently conspired to fuel the HIV/AIDS epidemic in Katima Mulilo are: low frequency of circumcision, high levels of poverty, low levels