Unsettling knowledge boundaries: the Indigenous *pitiki* space for Basotho women's sexual empowerment and reproductive well-being

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ABSTRACT

Indigenous knowledge systems embody a holistic, inclusive view of the world and foreground interconnectedness for the promotion of life. Through reflective engagement with the author's positioning as an Indigenous researcher, this article explores Indigenous knowledges of sexual, reproductive health and motherhood shared by Basotho women. It draws on the life stories of twenty never-married women and uses decolonial African feminist approaches to challenge the assumed universality of conceptions of sexual and reproductive health that are both deeply embedded and produced within specific relations of power. It illuminates the Indigenous *pitiki* space as an Indigenous knowledge hub purposed to empower Basotho women's sexual and reproductive health. Within this space, Indigenous knowledges and skills are shared amongst women, with the elderly imparting knowledges to the young women. In the context of unsurmountable health disparities, the article shows how Indigenous knowledge-sharing outside the exclusive 'westernised' health systems enables communal support for the well-being of women and children in African contexts. It emphasises the need for inclusive and expansive knowledge production systems not only to better inform equitable health solutions for Indigenous communities but also for epistemic redress in the discipline of Sociology.

KEYWORDS: Indigenous knowledge; Lesotho; decoloniality; feminism; sexuality; reproductive health

Introduction

Indigenous knowledge systems embody a holistic, inclusive view of the world and foreground interconnectedness for the promotion of life. For many Indigenous communities, health and well-being are considered holistic and embedded within symbolic intersecting meanings tied to the environment, culture, physical body, land, community, kinship and the spiritual world. For example, De Leeuw (2018) points to the significance of the environment and land upon which the well-being of Indigenous people is pinned. Further, spirituality is also an important source of well-being which Yap and Yu (2016) highlight is guided by philosophical laws defining relationships, obligations and knowledges that are passed down intergenerationally through rituals and ceremonies. Significantly, there is 'continuity and connection between the mind, body, spirit, culture and land' (Yap & Yu, 2016, p. 28), which undergird the health and well-being of Indigenous people. Likewise, the sexual and reproductive well-being of Indigenous women is undergirded by these intersecting and holistic forces in ensuring that they embrace and embody healthy sexuality – holistically encompassing emotional, psychological, physical, intellectual and spiritual dimensions. Moreover, these forces ensure that Indigenous mothers and their offspring are cared for collectively and holistically. Amongst Indigenous communities, reproduction and the success thereof, is undergirded by spiritual and ancestral

forces, and oftentimes, this incorporates the use of traditional herbs and medicines not only to treat but to cleanse and purify this sacred process (Shewamene, Dune, & Smith, 2017).

According to Ozioma and Chinwe (2019), traditional medicine is 'a combination of knowledge and practice used in diagnosing, preventing, and eliminating disease' (p. 161). These ancient, cultural, spiritually based and holistic medicinal practices and knowledges are passed down intergenerationally and are relied upon by many people for their primary healthcare needs in practising societies (Oliver, 2013).

This stresses the significance and value of traditional medicines to Indigenous communities, borne out of their beliefs and experiences. The use of traditional medicines for sexual and reproductive conditions has been documented in many contexts, including the African continent. For example, across many African communities, pregnant women are given herbal mixtures which are believed to facilitate smooth, uncomplicated labour (Ngoma & Siachapa, 2017; Shewamene et al., 2017; Siveregi & Ngene, 2019). In particular, some of the medicines are believed to promote cervical ripening and induce uterine contractions during labour and, subsequently, prevent excessive bleeding once the woman has given birth. Additionally, medicines are used for preventing minor infant ailments and warding off evil spirits that are believed to be harmful during the sacred reproductive period.

Given the persisting health inequities in developing countries, it is estimated that more than a third of the global population lacks adequate access to essential western medicines. Possa and Khotso (2015) highlight that '[i]n most African societies, traditional medicine plays an important role in the lives of many people who can and cannot access Western medicine' (p. 34). In Lesotho – a small mountainous landlocked country in Southern Africa, completely enclosed by South Africa (enclosed by Indian and South Atlantic oceans) – health inequities have resulted in poor child, maternal and reproductive health outcomes. According to UNICEF (2020), maternal mortality reads as high as 544 per 100000 live births and under-five child mortality is currently 86 per 1000 live births. Despite its small population of two million, Lesotho has the second-highest HIV prevalence in the world. In 2020, the country reported an HIV prevalence of 21.1% in the general population (15–49 years) with women (26.1%) bearing the bulk of the burden (UNAIDS, 2020). Lesotho gained its independence from Britain in 1966 after many years of colonial rule. Consequently, the majority of Basotho (people of Lesotho, singular – Mosotho) speak Sesotho and English as official languages, and eighty percent (80%) identify as Christian (Chingono, 2016).

Traditional healing practices have existed amongst Indigenous communities in Lesotho for many years, and while many have been forcibly stopped through colonial Christian invasion, the few that survived continue to hold salience amongst Basotho. Their significance is felt particularly in rural highlands where there is a marked shortage of health care facilities. As such, Basotho are able to diagnose and make concoctions to treat minor ailments (Kose, Moteetee, & Van Vuuren, 2015; Possa & Khotso, 2015) as well as complex sexual and reproductive conditions (Moteetee & Kose, 2016). According to Moteetee and Kose (2016), traditional remedies are used for conditions such as infertility, period pains, fibroids, and others related to pregnancy, birth and afterbirth to aid recovery. Thus, with unemployment rates over 22 percent reported in 2019 (World-Bank, 2021) and soaring poverty and inequality, traditional medicines – that are easily accessible, affordable and are considered to represent cultural heritage for Basotho – are viable and culturally appropriate means for primary health care in the context of health inequities.

In addition to the curative properties, traditional medicines embody symbolic and spiritual significance for Basotho. This reflects that health and well-being, as well as illness, are considered to be holistic and undergirded by the physical, cultural, as well as spiritual forces. Thus, amongst Indigenous communities, one cannot speak about health without acknowledging the reality of ancestral and spiritual beliefs (Hlela, 2019; Morgan-Consoli, Yakushko, & Norsworthy, 2018) and the powerful linkage between the human and non-human worlds (TallBear, 2015). This is a critical aspect that marks not only the complex nature of Indigenous health care but also the appropriateness of Indigenous knowledges for BasothoFootnote[1] women's sexual and reproductive health and well-being. Sadly, however, the advent of colonisation and modern science has led to the denigration and marginalisation of Indigenous knowledges and medicines.

Colonisation across various contexts brought with it the ideas of civility and modernity, and subsequently eliminated the traditional, cultural, and spiritual teachings and sexual and reproductive health practices that were passed down to us by our ancestors. Kim, Oleribe, Njie, and Taylor-Robinson (2017) remind us that the introduction of modern imperialist medicine was a direct link to the racist and sexist colonial agenda. In particular, the racist colonial ideologies of 'diseased natives' needing to be treated with western medicine in a bid to pass as civilised (Kim et al., 2017, p. 402) led to the institutionalisation of western medicine and subsequent demonisation of Indigenous medicines and healing practices. Moreover, traditional medical practitioners – who were the custodians of Indigenous medicines – were associated with witchcraft and subsequently, outlawed by the colonial administrations (Dudgeon & Bray, 2019; Finestone & Stirbys, 2017; Teshome, 2017; Wambebe, 2018). However, despite the denigration of Indigenous healing practices, many Indigenous communities in Africa (and elsewhere) continued to practice them (Hlatshwayo, 2017; Teshome, 2017; Wambebe, 2018). Yet, notable is the persistent dismissals of Indigenous practices as 'backward' and 'heathen' in relation to western ways, particularly amongst some Christianised Indigenous people (Hlatshwayo, 2017; Mohlabane, 2020). This is not surprising as Morgan-Consoli et al. (2018) remind us of our 'colonised mindsets' whereby 'Western 'scientific' and patriarchal cultural assumptions are deeply rooted' (p. 9) and continue to shape our existential realities.

Further, due to racialised patriarchal oppression, women's Indigenous healing practices and contribution to Indigenous knowledge production have remained marginal (Moreton-Robinson, 2011). Yakushko (2018) reflects on the history of persecution, oppression, and racialised, gendered violence during colonisation and how these atrocities have shaped negative attitudes toward women's Indigenous practices, ways of healing and knowing. Thus, considering the suppression of women's Indigenous knowledges and a subsequent impediment to Indigenous women's access to culturally appropriate health care, scholars have argued these factors led to persistently poor health outcomes amongst Indigenous women (Paradies, 2016; Sweet, Dudgeon, McCallum, & Ricketson, 2014). However, we are reminded that this process need not be considered linear, but instead as convoluted yet with grave consequences on post-colonial Indigenous health outcomes (Paradies, 2016).

In light of persisting health inequities and the denigration of Indigenous knowledges, this paper illuminates the Indigenous *pitiki* space as an Indigenous knowledge hub purposed to empower Basotho women's sexual, reproductive health and well-being. *Pitiki* is a celebration of life through a series of activities and teachings performed by mothers in the community, particularly those who assisted with the birthing process and post-natal care to see to the recuperation of the new mother (Mohlabane, 2020; Mokala, 2020). Within this space,

Indigenous knowledges and skills are shared amongst women, with the elderly – as the custodians of wisdom – imparting knowledges to the young women (Mohlabane, 2020).

Unfortunately, the denigration of this Indigenous 'matriarchal umbrella' (Amadiume, 2002, p. 43) at the advent of colonial modernity in Lesotho led to the invisibilisation and marginalisation of Basotho women's knowledges and skills related to sexual, reproductive health and well-being. Accordingly, such practices continue to be considered 'pagan' and 'backward' contrary to the Christian modernist ways of life that were instituted in colonial states, including Lesotho. This implies that, for those rural communities that have limited access to western health care, options for health and well-being are further limited.

My positionality as a Mosotho who speaks Sesotho, a community member born and bred in Lesotho, underpins the intimate relationship that I share with my people, culture and land and, thus, my indebtedness to represent a true picture of submerged spaces, practices and knowledges of Basotho women in Lesotho. Thus, through decolonial African feminist approaches, in this paper, I aim to expose, challenge and address the persisting distortions to Indigenous practices and their invisibilisation through coloniality of knowledge in post-colonial Lesotho. The paper seeks to address the following questions: How can sexual and reproductive health care be decolonised in the face of persisting health inequities? How can Indigenous spaces like the *pitiki* amongst Basotho be re-covered, and re-signified as culturally appropriate means for Indigenous women's sexual, reproductive health and well-being in the face of persisting health inequities? Further, it aims to reveal the richness, and profoundness embodied by Indigenous spaces such as *pitiki*.

This paper actively questions the impact of Western, patriarchal, racist colonial ideologies on women's Indigenous knowledges and practices. It contributes to the body of literature on Indigenous knowledges that seeks to elevate voices about Indigeneity – knowledges and practices – by, with, and for women within Indigenous communities (Hlatshwayo, 2017; Moreton-Robinson, 2011; Morgan-Consoli et al., 2018; TallBear, 2013; Teshome, 2017; Yakushko, 2018). Further, following the work of scholars like Moreton-Robinson (2011), this paper reclaims Indigenous women's knowledges through scholarship grounded in an Indigenous epistemology. This paper expands international scholarship by positing a decolonial African feminist critique of coloniality of knowledge through which women's Indigenous knowledges, practices and spaces continue to be subjected to the racist, sexist, binarised colonial gaze. In doing so, the paper argues for the redemption and revisibilisation of Indigenous women's spaces as culturally appropriate knowledge hubs for women's sexual, reproductive health and well-being in the face of persisting health inequities.

The paper is divided into four sections. In section one I briefly reflect on decolonial and African feminist critiques of western hegemonies. This is followed by a reflection on my methodological approaches in section two. Section three provides a deeper examination of the Indigenous *pitiki* space. In closing, I reflect on the key arguments and implications for decolonising sexual, reproductive health care in post-colonial contexts.

Decolonial African feminisms

'Coloniality' is characterised by racist and sexist power relations that emerged during colonisation, but that have since continued to shape all spheres of modern-day life in post-independence states. Peruvian sociologist Quijano (2000) conceptualised *Coloniality of power* which refers to racialised and hierarchical forces of power that govern multiple dimensions of

social life including labour, sexuality, subjectivity and authority. C*oloniality of being* refers to dehumanising colonial ideologies that continue to shape how our identities and agency are constructed. *Coloniality of gender* refers to the realisation that colonial-modernity was characterised by intersecting gendered, sexist, racist and capitalist power relations. Lugones (2010) conceptualised decolonial feminism as the response to this.

Lastly, *Coloniality of knowledge* is characterised by eurocentrism in which the European knowledges and epistemes are privileged whilst all others are invisibilised and marginalised (Mignolo, 2007). Essentially, European knowledges are positioned as the 'golden standard' against which all other knowledges are 'compared, measured, evaluated and judged' (Mignolo, 2007, p. 155) as invalid and backward in relation to European knowledges. A 'decolonial-turn' goes beyond challenging western-centric universalisms but also requires challenging and correcting delegitimising discourses that consider Indigenous knowledges as 'backward' and uncivilised (Maldonado-Torres, 2007). Further, it requires pluralising knowledge production systems wherein all knowledges play an equal role in informing the future of the world (Ndlovu-Gatsheni, 2013). This critically informs how I ground the key concerns raised in this paper around the invisibilisation and suppression of Indigenous knowledges related to Indigenous Basotho women's sexual and reproductive well-being.

African feminists have called out the persisting white supremacist and patriarchal modernist ideologies that continue to silence Indigenous African knowledges (Oyěwùmí, 2016). Oyěwùmí (2002) argues against the universalisation of 'gender' and the imposition of a gendered lens to African realities. This, she argues, ultimately led to the distortion of Indigenous social relations that have since become gendered, yet prior to colonisation they were based upon the principle of seniority, not gender. In striving to recover African knowledges, she insists that: '[t]his global context for knowledge production must be taken into account in our quest to comprehend African realities and indeed the human condition' (Oyěwùmí, 2002, p. 1). This refers not only to western universality but also the subsequent denigration, invisibilisation and submersion of African Indigenous knowledges including those that relate to sexual and reproductive health.

For a paper that seeks to elevate Indigenous Basotho women's knowledges related to sexual, reproductive health and well-being, maternal and child health within and around the Indigenous space of *pitiki*, I consider the decolonial African feminist approach as appropriate for re-reading the space beyond defamatory, racist colonial discourses. African feminist, Babalwa Magoqwana (2021) points out that 'we need new alternatives and sometimes this means revisiting the old wisdoms and tapping into the maternal legacies of knowledge in Africa' (p. 88). These are legacies that privilege and recentre Indigenous values such as communality, solidarity and personhood, which undergird social relations in Indigenous communities. Thus, I posit that in 'going back to our ways of knowing' (Magoqwana, 2021, p. 90) that are drawn from our maternal ancestors not only will we deconstruct and decentre eurocentric universalisms but also redeem, revisibilise and resignify Indigenous women's knowledges linked to *pitiki* as valid and appropriate in the face of persisting health inequities. In so doing, we enact 'ethnographic refusal' conceptualised by Audre Simpson (2014) not only as acknowledgment of 'asymmetrical power relations that inform the research and writing about native lives and politics' (pp. 104–105) but also as a refusal to write in a way that compromises and misrepresents Indigenous realities.

Methodology

This paper draws from a completed doctoral thesis (Mohlabane, 2020) wherein the methodological approaches are detailed. Briefly, the study used decolonial African feminisms to interrogate fixed hetero-patriarchal conceptions of womanhood in Lesotho. It used life history methods to collect the narratives of twenty 'never-married' Basotho women. Both convenience and snowballing sampling methods were used to select participants of diverse backgrounds from diverse contexts in Lesotho. Narrative analysis was applied through a process of storying stories (McCormack, 2004). Boonzaier and Van Niekerk (2019) assert that decolonial feminist methodologies are useful for revealing 'the continuities in the decimation, destruction and dispossession wrought by colonisation and for challenging the ways it manifests in the present through knowledge production, representation, and everyday life' (p. 2) of marginalised communities. In this respect, I opted for decolonial feminist approaches (Smith, 1999) to reveal and challenge colonially derived, racist, patriarchal misconceptions about womanhood in Lesotho. For this study, decolonial feminist research approaches allowed me to do research that is respectable, ethical and inclusive of 'Othered' groups – including Basotho women.

The study illuminates the usefulness of Indigenous languages when speaking with Indigenous women about their constructions of identity. By conducting the in-depth life history interviews in the Sesotho language, I afforded the women space 'to affirm and reinforce [their] cultural identities' (Ndimande, 2012, p. 216). Not only did Basotho women articulate and construct womanhood from their cultural world senses, but this was closely tied to and enabled through their use of Sesotho expressions, idioms and proverbs. Taking this into consideration, I paid close attention to how I transcribed, translated and presented the women's narratives. I presented the rich narrated stories as direct translations of the verbatim in an attempt to retain their expressiveness and depth. For complex terms, I retained the Sesotho verbatim as well as the direct translations in the text and footnoted the explanation.

Considering the geopolitics of knowledge – who speaks from where and for whom (Grosfoguel, 2007) as an Indigenous Mosotho, my thinking about, speaking about and writing about Indigenous Basotho women's knowledges and practices not only entails my socio-historical experiential position. In addition, it meant thinking, speaking and writing from the position of Indigeneity 'with' rather than 'about' or 'for' Basotho women about our practices hence, my insertion of my own experiential knowledges – as reflected in the findings section of this paper.

Given the sensitive nature of the research, as part of the ethical procedures, I allocated pseudonyms to each participant using the first four to six letters of their real name. This allowed me to retain, as far as possible, the symbolic and ancestral meanings that inform naming processes amongst Basotho. Further, the study processes were explained in full to potential participants including, the objectives and key questions to be addressed. This was to ensure that they were informed and in a better position to decide whether to participate or not. For those agreeing to take part, a consent form detailing the study procedures was read out to them and thereafter they were asked to attach their signatures as an indication that they were participating voluntarily. Prior written consent to record the conversations digitally was also requested and participants were assured that the interviews would be kept safe and confidential.

Findings: the Indigenous *Pitiki* space is an Indigenous knowledge hub

Pitiki ceremony is performed in seclusion by mothers in the community. In the following paragraphs, I will shed light on the various activities that women perform within this space. 'Me Libu explained some of the processes that take place,

> I attend *pitiki* … *pitiki* is place where women entertain themselves but *pitiki* is for a baby … let me give you an example … if you have a baby now … when they are about one year or a few months old, you will have *pitiki* … it is only mothers that attend. The women form a circle and place the baby in the centre, and we jump over it while we are singing and dancing. We wear short fibre skirts, or you can choose to keep your top on or become completely naked. The women will also pass the baby from one person to the next while we are singing. ('Me Libu, 50 years)

Significantly, the *pitiki* ceremony reflects women's acknowledgement that mothering is a shared, communal responsibility. This is reflected by passing the baby from one mother to the next whilst a celebratory performance continues. This sense of communality, solidarity and interdependence exemplified by Basotho mothers reflects the African values that inform not only social relations in African communities – acknowledged by decolonial African feminisms (Magoqwana, 2018) – but also the realm of motherhood in these communities. This contrasts with western conceptions that regard motherhood as an individual, private task borne by the biological mother (Collins, 2005). Typically, mutual support and peer learning about motherhood, childcare, reproductive well-being and sexuality are fostered within the *pitiki* space.

The women share information on post-birth care and reproductive well-being within the *pitiki*. In the following extract, the role of elderly women – the custodians of Indigenous knowledges and wisdom – in imparting knowledges to younger women is amplified. 'Me Lifutso pointed out that,

> I was taught by an elderly woman that in *pitiki*, women learn many things from one another … she said when a woman has given, she has to rest completely for three to six months … this helps to retain the heat around the reproductive area … so that the pelvic bones that the baby has separated when she gave birth can heal. The woman also has to tie her abdomen tightly. Most of the time we think that we tie the abdomen so that it does not become big … when you tie it, it also helps the healing process in the uterus. It gets reconstructed … she stated that Basotho women have their own science … once you have given birth there is a difference in here [pointing to the vagina], it is no longer tightly closed like it was before … so Basotho women are taught to use a cloth sanitary pad (*litaepa*) … to retain the heat in here so that when you entertain your man it is still the same as before … ('Me Lifutso, 30 years)

Notably, Basotho women and girls make their own sanitary pads with a tightly folded, multi-layered cotton cloth. This pad is worn throughout, particularly following childbirth to retain the warmth inside the vagina. Women believe that occluding the vaginal opening generates warmth which aids recovery and reconstruction of the birth canal as well as to prepare the vagina for sexual intercourse. Significantly, for young girls, the return to Indigenous forms of menstrual management with reusable sanitary pads like the '*litaepa*' is critical in the face of poverty and poor access to modern technology. Furthermore, vaginal steaming, with or without the use of herbs, is done to cleanse and enable healing and tightening of the vagina. These traditional knowledges and practices are imparted by elderly women within the *pitiki* space to guide the younger women.

Interestingly, in contemporary communities, cotton cloth is preferred compared to conventional sanitary towels because the latter is believed to contain toxins that may cause adverse reproductive conditions. ‘Me Lifutso added that,

> she also spoke about using toilet paper … she said we must stop wiping ourselves with toilet paper after urinating … I asked her why not … she said it has chemicals … they are made with many different chemicals that may get stuck in your vagina and end up in your uterus … hehe [chuckling] Basotho women have science! Mosotho woman always has a cotton pad in place … panty liners are new. They always have that cloth … Basotho women have great science! … and these are things that Basotho women speak about when they meet in *pitiki*. They believe that it retains the warmth … and it does not have many different chemicals that may cause reproductive problems one day. Yes … Basotho women speak about all those things when they meet … (‘Me Lifutso, 30 years)

‘Me Lifutso highlights Basotho women’s empowerment within the *pitiki* space and critically, she emphasises Basotho women’s science which is linked to Indigenous knowledges about reproductive wellbeing. Contrary to the racist colonial discourses that consider African women to be ignorant and incapable of rational thought – the women’s narratives demonstrate their capacities to make informed decisions about their reproductive wellbeing and the prevention of adverse conditions linked to foreign modern technology. Therefore, contrary to Mokala’s (2020) observation that *pitiki* is a form of entertainment for mothers in the community, these narratives show that it is an Indigenous process of engagement that utilises Indigenous methods and reflects the significance of peer-to-peer and intergenerational knowledge sharing that takes place in a fun culturally-appropriate manner amongst Indigenous women. Similar discussions are being had about the importance of ‘women’s business’ relating to childbirth and the reclamation of traditional practices of birthing on Country within some Aboriginal communities in Australia (Marriott et al., 2019). Within *pitiki* insightful messages are reinforced through song and dance to ensure comprehensibility and cultural appropriateness. For example, Mokobocho-Mohlakoana (2008) refers to a song that is sung within the *pitiki* space that goes ‘*u motsoetse u nyants’a ngoana empa mahlo ona a shebile betheng* (you are a mother and breastfeeding your baby but your eyes are directed towards the bed). The author interprets this song as a reflection of Basotho women’s sexual repression. However, within the *pitiki* space mothers are taught how to perform the *litolobonya* dance which emulates an erotic sexual movement. Therefore, I read this as implying that whilst the resumption of sexual activity is important for the new mother, equally important is the need to breastfeed the baby for its benefits – for the mother and the baby.

Literature has shown that exclusive breastfeeding has health benefits not only for the infant but also for child spacing (Shats, 2019). For the infant, breastfeeding provides optimum nutrition, and protection against common childhood infections which may cause death (WHO, 2018). Likewise, breastfeeding and child survival are critical within Indigenous communities. I remember when I was a new mother and soon after I had given birth, I had to remain in seclusion for approximately three to six months to aid my recuperation. During this time, the women in the community supported me by preparing nutritious meals, washing my clothes and cleaning the home. This was to ensure that I recuperated undisturbed and that I focused on feeding my baby. Further, I was told to sleep separately from my husband for fear that we would contaminate the breast milk by engaging in sexual intercourse too soon and subsequently, cause ill-health to the baby. However, my interpretation is that I was prevented from being intimate with my husband for fear that I would fall pregnant soon after I had given birth, and this would interfere with caregiving for my newborn.

Traditionally, a mother is expected to breastfeed her child for two years and this, not only ensures that the infant receives nutrients for survival but also it is believed that it assists with child spacing. This highlights the significance of child survival and child spacing amongst the Basotho and hence, their emphasis within *pitiki*. Therefore, prior to the introduction of modern contraceptives, these constituted Indigenous pregnancy prevention methods that were well-established in Indigenous communities ('Me 'Matlali, personal communication, 6 May 2021). Equally important is Basotho women's celebration of their sexuality within *pitiki*.

In some communities, prior to the onset of menarche, girls are taught to elongate their inner labia in preparation for their sexual roles in marriage. This rite of passage marks the girl's entry into the realm of womanhood. The self-pulling and mutual-pulling of inner labia allow young girls to discover sexual pleasure-inducing sites and ultimately, they become sexually empowered (Mohlabane, 2020). Elongated labia minora are highly prized within the *pitiki* space and are believed to enhance sexual pleasure for a man as well as a woman (Batisai, 2013; Mohlabane, 2020). Within this space, Basotho women celebrate sexuality and acknowledge themselves as sexual beings, and as such, women without elongated labia are taught the labial elongation process. Further, acknowledging the new mother as a sexual being, as alluded earlier, women sing and perform erotic dances (*litolobonya*) either naked or wearing short, flared fibre skirts. This traditional dance involves a synchronised waving and swirling movement of the waist, buttocks and hips – emulating the sexual act – to the rhythm of a song and drum. This is done to remind the new mother of the erotic movements she is expected to perform when she resumes sexual activity with her husband. While all the women are expected to showcase their talents in terms of singing and dancing, attention is given to the new mother who is also equipped with skills for ensuring pleasurable sex following a long pregnancy, birthing and post-birth processes. Demonstrations with self-made penises (dildos) also take place within this space as reflected below.

> It is only women who have children that can participate because a woman without a child cannot go in there. They participate completely naked because it is only women who go in there. They teach each other about sexual intercourse, how to handle a man during sex. If a man dares to enter that space, the women will embarrass him by removing his clothes and jumping on him with their naked bodies. The women also make their own penises which they cover with condoms and demonstrate to others how to engage in pleasurable sexual intercourse with a man. ('Me Moteka, 60 years)

As reflected earlier, the sense of communality is demonstrated through peer learning as Basotho women 'eat out of one pot' to become sexually empowered (Amadiume, 2002, p. 43). Notably, despite being an Indigenous women's space, the use of modern technologies such as condoms – to make dildos – signifies the possibilities for the blending of traditional and western knowledges and technologies. This is in respect not only to socio-economic and cultural changes but also to health inequities that typify post-colonial societies. Further, in the face of the devastating scourge of HIV particularly amongst women in Lesotho, and the persisting challenges with access to preventive care and support services in rural areas – *pitiki* is a viable space and ideal platform wherein much needed health education on HIV prevention and condom use in particular – can be shared amongst women. In other words, I see an opportunity for expanding the scope of the teachings on sexuality to encompass safer-sex practices over and above sexual pleasure. Within this space, information sharing and learning take place in a fun, culturally appropriate manner, in contrast to top-down health services – which are inaccessible to many women in rural areas, as alluded earlier. The value embodied by this space and the developments therein is tied to its potential for affording Basotho women bargaining

power within their sexual relationships around safer-sex and sexual pleasure – oftentimes defined as men's prerogative.

African gender scholars have reflected on spaces in which women learn about sexuality particularly as it relates to women's provision of pleasurable sex for their husbands (Motalingoane-Khau, 2010; Venganai, 2017). Relatedly, in many patriarchal contexts, a 'normative precedent' of established rules and practices confer sexual authority on men (Vyas, 2020) and sexual pleasure is considered men's prerogative. According to this school of thought, it suffices to read *pitiki* as a hetero-patriarchal space merely purposed to teach and reinforce the sexual double standard that considers women as sexual objects for the sexual appeasement of men. It is without a doubt that women who attend *pitiki* are expected to be heterosexual, married and pro-natal in accord with the hetero-patriarchal climate that governs Lesotho. However, in accord with the decolonial Africa feminist lens undergirding this analysis, we need to theorise Indigenous realities beyond hetero-patriarchal binarism which forecloses and, ultimately, invisibilises the multiplicity and creativity borne by Indigenous spaces such as *pitiki*.

Thus, my re-reading of the *pitiki* space through decolonial African feminist lenses reveals significant benefits for Basotho women in Lesotho. It is a rich traditional space wherein the erotic *litolobonya* dance, the uninhibited sexual talks and demonstrations of sexual positions as well as knowledge sharing about Indigenous reproductive well-being – mark the space as ideal for Basotho women's empowerment. A central concern that the paper addresses is that Indigenous spaces like the *pitiki* are critical not only for women's sexual empowerment and reproductive well-being but as culturally appropriate knowledge-sharing platforms for Indigenous communities in the face of persisting health inequities.

Conclusion

This paper is informed by my interest in challenging eurocentric universality – borne by coloniality of knowledge – according to which Indigenous Sesotho knowledges and practices continue to be marginalised in post-colonial Lesotho. This follows the realisation that the profound Sesotho knowledges passed down from our elders, traditionally shared within Indigenous women's spaces such as *pitiki* and *thakaneng* for Basotho girls, have been stopped and substituted for colonial-modernist knowledges that contrast the holism and communality embodied by the former.

Despite the acknowledgement of the significance of Indigenous knowledges, practices and medicines for Indigenous people, in reality and in practice these continue to be posited within racist binarised categories that define them as 'backward', 'traditional' and thus, uncivilised in relation to 'advanced', 'modern' western – thus, civilised knowledges. This is not surprising, considering that the manifestations of coloniality continue implicitly not only within systems of knowledge production and practice but also in the minds of Indigenous people. Consequently, this has meant that poor Indigenous women who lack access to westernised health care are left without options for sexual, and reproductive health care – and this, reinforces racial, gendered, classed health inequities borne by colonial-modernity. In response, this paper engaged in a decolonial African feminist critique against coloniality of knowledge that plagues knowledge production around sexual, reproductive health and well-being.

However, what does a decolonial African feminist critique entail? What does 'decolonise' sexual, reproductive health care entail and is it possible? In light of the preceding discussion,

an affirmative or contradictory response will not suffice and notably, the process of 'undoing' the damage is not straightforward and may require greater efforts to dismantle the rigid racist ideologies, including those held by Indigenous people. A point of departure is my re-reading of the *pitiki* space beyond defamatory, racist colonial discourses – as purported by decolonial African feminisms. I gave prominence to Basotho women's 'knowledges from below' on the various developments that take place within *pitiki*. Noteworthy, are the values of communality and solidarity that undergird social relations not only within Basotho communities but also *pitiki* wherein they facilitate intergenerational Indigenous knowledge sharing and learning about sexuality, reproductive well-being, childcare and motherhood. This deconstructive analysis revealed the richness and profoundness embodied by Basotho women's Indigenous spaces and more importantly, Basotho women's capacities for rational thought in contrast to racist, sexist colonial ideologies that deny them the ability to think.

I also read *pitiki* as a space that can potentially be utilised to mitigate the effects of Basotho women's poor access to health services, particularly in relation to prevention of sexually transmitted infections such as HIV. *Pitiki* holds deconstructive power against racist, sexist, colonial discourses according to which Basotho women were defined as 'promiscuous, grotesquely sexual, and sinful' and thus, needing to be restrained (Lugones, 2010, p. 743). The women's embrace and celebration of their sexuality is contrary to colonial discourses that demonised not only African women's sexuality but also the notion of sexual pleasure. Instead, within this space women are taught to experience and embrace healthy sexuality as part of their sexual rights. My reading of this space is that it serves as a platform for decolonising knowledges on the sexual and reproductive well-being from an Indigenous women's standpoint. Thus, the resurgence and revelation of women-led Indigenous spaces dedicated to strengthening women's sexual, reproductive health and well-being represents an urgently needed cultural rebirth of Indigenous women's knowledge systems (Dudgeon & Bray, 2019)

However, my suggestion for reclamation of the Indigenous *pitiki* space and the Indigenous knowledges about sexual, reproductive health and well-being is not an insinuation for rejecting western knowledges – positioned as universal and superior – because this would be impractical. Instead, it is a quest for a pluriversal world where all knowledges – including Indigenous knowledges – hold salience in determining the future of health care provision for Indigenous communities in the face of persisting health inequities. Currently, the denigration of Indigenous knowledges and practices has meant that poor Indigenous communities have been left without options for affordable health care and subsequently, this has contributed to the exacerbation of poor reproductive health outcomes in the 'post-colonies' such as Lesotho. Unsettling knowledge boundaries requires centralising Indigenous knowledges on sexual, reproductive health and well-being alongside western modes of care. In so doing, not only do we deconstruct western hegemonies, but we also achieve multi-versality, inclusivity, diversity in knowledge production and practice. Ultimately, in broadening the circle of knowledges not only will rigid knowledge boundaries be dismantled, but redress for silenced Indigenous knowledges will be achieved. Critically, through 'new alternatives' borne out of our maternal ancestral knowledges, inclusive and expansive knowledge production systems will contribute towards the development of equitable health solutions for Indigenous communities.

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1 I acknowledge my misuse of the Sesotho noun, Basotho, as an English adjective in ‘Basotho women’. However, specific reference to this group is necessary because not only does the paper addresses their specific needs, but it also celebrates and elevates the voices and knowledges of this particular group. I also acknowledge the differences within the group, and my reference to ‘Basotho women’ does not suggest essence or fixity.

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