

**THE INCORPORATION OF INDIGENOUS HEALERS IN THE
FIGHT AGAINST HIV/AIDS**

An Exploratory Case Study of the Collaboration between Izangomas and the Formal
Health System operating through the Valley Trust

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Declaration

This dissertation represents original work by the author and has not been submitted in any other form to another university. Where use has been made of the work of others it has been duly acknowledged and referenced in the text.

The research for this dissertation was performed in the School of Development Studies at the University of Natal, Durban. Research was undertaken under the supervision of Professors Thokosani Xaba and Lisa Bornstein during the period of October 2000 to June 2002.

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Abstract

The purpose of this study was to get a better sense of what collaborative efforts between the allopathic and indigenous health systems to address HIV/AIDS look like 'on the ground' with the hope that revealed successes and failures could inform other initiatives. The pilot investigation took the form of a small case study of the Community Health and HIV/AIDS project at the Valley Trust in KwaZulu Natal's Valley of a Thousand Hills where HIV/AIDS collaboration with traditional healers has taken primarily three forms: 1) incorporation in the formal primary health care system as CHWs (TH/CHWs); 2) formal short-term HIV/AIDS training (Trained); and 3) informal second-hand HIV/AIDS training or information sharing (Untrained). The investigation focused primarily on how the indigenous healers' involvement in the Valley Trust's varying training programs affected their knowledge of the disease, their engagement in HIV/AIDS awareness and prevention efforts, their treatment of HIV/AIDS patients, and their perception and relationship with the formal medical system.

The findings show that collaboration between traditional and formal health services, in the form of the Valley Trust's training, results in 'better' HIV/AIDS work by participating traditional healers through enhanced performance on HIV/AIDS knowledge tests. As indicated by their superior performance on correlating knowledge indices, TH/CHWs engaged in the most effectual community prevention activities of the three groups. Additionally, the TH/CHW group appeared to have the most confidence and experience in treating patients with HIV/AIDS. Additionally as compared to the other two groups, their treatment methods were more varied, including psycho-spiritual ceremonies, diet, traditional medicinal herbs, and support of biomedical efforts. Given the comparative success of TH/CHWs, it was ironic that only the healers' themselves indicated wanting more *izangomas* to serve as Community Health Workers. As leaders among participating healers, TH/CHWs were critical to the success of the Valley Trust's collaborative project.

The findings of this case study suggest that the nature of the varying trainings offered by the Valley Trust accounted for the primary difference in the effectiveness of the healers' subsequent HIV/AIDS work. The study implies that both the skills-based nature and long-term supervision of the CHW training were instrumental in their superior performance. These findings point to the fact that indigenous healers can not function effectively as extension services without investment in infrastructure development and ongoing support.

In terms of the collaboration between biomedical and indigenous health systems operating at the Valley Trust, the primary point of contention between the participating parties was the collaboration's unidirectional referral system (healers would refer patients to the clinic and not vice versa). Discrepancies in the collaborative partners' perceptions of one another, which were revealed in the study, point to the need for greater dialogue and formal linkages between participating groups. A referral system of some content and magnitude appears to be the most critical and pressing issue the new structure needs to address.

Executive Summary

In the past decade, the inequitable and strained network of modern health facilities in South Africa has come under increased pressure given the emergence of HIV/AIDS. In order to meet the demand of this pandemic, the South African government is exploring collaborations with other means of health service, particularly the indigenous health system given its wide use and acceptance by the populace. The purpose of this study was to get a better sense of what collaborative efforts between the allopathic and indigenous health systems to address HIV/AIDS look like 'on the ground' with the hope that revealed successes and failures could inform other initiatives. The pilot investigation took the form of a small case study of the Community Health and HIV/AIDS project at the Valley Trust in KwaZulu Natal's Valley of a Thousand Hills where HIV/AIDS collaboration with traditional healers has taken primarily three forms: 1) incorporation in the formal primary health care system as CHWs (TH/CHWs); 2) formal short-term HIV/AIDS training (Trained); and 3) informal second-hand HIV/AIDS training or information sharing (Untrained). The investigation focused primarily on how the indigenous healers' involvement in the varying training programs affected their knowledge of the disease, their engagement in HIV/AIDS awareness and prevention efforts, their treatment of HIV/AIDS patients, and their perception/ relationship with the formal medical system.

The findings show that collaboration between traditional and formal health services in the form of the Valley Trust's training results in 'better' HIV/AIDS work by participating traditional healers. First, healers with Valley Trust training (TH/CHWs or Trained) performed better on the HIV/AIDS knowledge indices than healers without training. Second, as indicated by their superior performance on the correlating knowledge indices, healers trained as Community Health Workers (TH/CHWs) engaged in the most effectual prevention activities in the community of the three groups. Third, the TH/CHW group appeared to have the most confidence and experience in treating patients with HIV/AIDS. two groups, including supporting biomedical efforts, diet, and traditional medicinal herbs. Given the comparative success of TH/CHWs, it was ironic that only the healers' themselves indicated wanting more *izangomas* to serve as Community Health Workers. As leaders among participating healers, TH/CHWs were critical to the success of the Valley Trust's

collaborative project. Likewise, the findings indicate that healers recruited and trained second-hand, primarily through TH/CHWs, do not engage in as effective HIV/AIDS work as the original TH/CHWs. The findings suggest that the nature of the varying trainings offered by the Valley Trust was the primary difference in the effectiveness of the healers' subsequent HIV/AIDS work. The study implies that the skills-based nature and long-term supervision of the CHW training were instrumental in their superior performance. These findings point to the fact that indigenous healers can not function effectively as extension services without investment in infrastructure development and ongoing support.

Additionally, the study revealed the formal and indigenous health systems' HIV/AIDS collaboration operating through the Valley Trust lacked formal and consistent structural linkages. Despite this, the participating partners recognized the inconsistency as a problem and exhibited a general openness to understanding and working in conjunction with one another. However, the findings revealed a number of discrepancies in their perceptions of one another. The primary point of contention between the participating parties was the collaboration's unidirectional referral system (healers would refer patients to the clinic and not vice versa). The discrepancy in the collaborative partners' perceptions of one another points to the need for greater dialogue and formal linkages between the three groups. A referral system of some content and magnitude appears to be the most critical and pressing issue the new structure needs to address.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project of USAID
CHC	Community Health Committees
CHF	Community Health Facilitator
CHW	Community Health Worker
HIV	Human Immunodeficiency Virus
NGO	Non-Governmental Organization
PHC	Primary Health Care
PROMETRA	Association for the Promotion of Traditional Medicine
SATHC	South African Traditional Healers Council
TH	Traditional Healer
THETA	Traditional and Modern Health Practitioners Together against AIDS and other diseases
UNAIDS	United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Chapter 1: INTRODUCTION

1.1. PROBLEM STATEMENT

According to the latest World Health Report, HIV/AIDS is now the highest overall cause of death in Africa, and has moved up to fourth place among all causes of death worldwide. Although the scourge of AIDS has left no country or continent untouched, Africa is disproportionately bearing the brunt of the pandemic (Africa Region-World Bank, 2000; UNAIDS, 2000). In 1998, seventy percent of people worldwide who became infected with HIV and four-fifths of all deaths were in Sub-Saharan Africa (UNAIDS, 2000: 4). South Africa, with one of the fastest growing HIV prevalence rates (UNDP, 1998: 9), is no exception.

Centuries of colonization, marginalization, and impoverishment have not only degraded the health of the developing world's populace, but have also impaired their health care systems' abilities to alleviate the infirmity and disease of those who are their charge (Coovadia, 1991; UNDP, 1998). This is most acutely felt in the case of HIV/AIDS, as:

The problem of AIDS in Africa lies not only in the dimensions of its transmission. It is fraught with political and cultural sensitivity and compounded further by economic and social problems, which already impede progress in many spheres of development (Laver, 1988: 281).

In the past decades, developing countries in Sub-Saharan Africa and elsewhere have launched a series of national campaigns to raise awareness of the threat of HIV and halt its progression. Despite such prevention efforts, however, cases of decreased HIV prevalence are still the exception (UNAIDS, 2000: 4). Unfortunately, the South Africa's historical past has left a legacy of social dislocation, lack of access to basic services, inequity, and poverty that likewise complicates efforts to address the escalating pandemic (UNAIDS/UNDP, 1998).

Although the national health system of South Africa is based upon the allopathic biomedicine, somewhere between 60 to 80% of its citizens are said to utilize the indigenous health system (Baleta, 1998: 554; Burnett & Baggaley, 1999: 481; Chipfakacha, 1997: 417; Foster, 1983: 11; UNAIDS, 2000: 2). The pervasiveness of the indigenous health system is not limited to remote and underserved rural areas,

but extends into urban areas and among higher socio-economic groups that have access to official health services. Such trends reveal that the indigenous health system continues to perform a critical role in the black community. No where is this statement more true, than in the case of HIV/AIDS. In view of its widespread use, traditional medicine is in a sense already carrying the burden of the AIDS epidemic, treating the majority of South Africans living with HIV/AIDS. Therefore, if the government and the biomedical community's HIV/AIDS prevention and treatment campaigns do not include traditional healers, they will fail to wholly connect with their intended audience, undermining their intended objectives before their efforts have even begun. In the South African context, there needs to be a bridge between the two health systems that will not only bring the 'biomedically-understood' virus into the consciousness of black South Africans, but also impart an appropriate cultural context to HIV/AIDS prevention and treatment measures.

The modern medical community in Africa has been stunned by the HIV/AIDS epidemic as their interventions have proved relatively ineffectual against the disease. With their intimate knowledge of the lives and belief system of indigenous South Africans, traditional healers are considered a large available, accessible, acceptable and affordable resource which has considerable potential to address HIV/AIDS. Given their traditional role of counselor and advisor, traditional healers are seen as a vital element in effectual HIV/AIDS education and prevention initiatives (Staugaard, 1991; Schoepf, 1992; Boadu, 1993; Mancini et al., 1993; Kabetsi et al., 1994; King et al., 1994; Green, Zokwe, and Dupree, 1995; Nakyanzi et al., 1996; Galukindu et al., 1998; Boedeker et al., 2000). Additionally, traditional herbal remedies have shown considerable promise in boosting the immune system and treating HIV-AIDS related illness (Green, Tomas, and Jurg, 1991; Musinguzi & Twa-Twa, 1991; Ssenyonga & Brehony, 1993; Ssenyonga, 1994; Chileshe, 1996; Homsy et al., 1999).

Conversely, a variety of healer practices could be potentially harmful, particularly in the context of HIV/AIDS. If ignorant of the mode of transmission, traditional healers can put themselves and their patients at risk of contracting the disease either directly through practices like incisions, or indirectly through example and counsel that negates prevention messages (Goodwell, 1996; Nkangabwa et al., 1996;

LeClerc-Madlala, 1999; Touko & Kemmegne, 1998). In light of the seriousness of the pandemic, the government has a public health responsibility to ensure that the practices of traditional healers are safe.

Encouragingly, a number of dynamics reinforce the potential of traditional healers to assist in the prevention and treatment of HIV/AIDS. First, numerous studies reveal a great enthusiasm among traditional healers to collaborate with their Western-trained counterparts to learn about STDs and HIV/AIDS (Green, 1994; Kabetsi et al, 1994; O'Rourke, 1996). Second, research has shown that traditional healers regularly abstain from dangerous practices when educated about the risks (UNAIDS, 2000: 6). Third, educational and collaborative initiatives appear to improve the health delivery of indigenous practitioners through increased knowledge and skills, increased confidence in their practice, increased openness toward the community, and earlier referral to hospitals or health centers (UNAIDS, 2000: 6).

The current magnitude of the epidemic, the inadequacy of South Africa's modern health resources, the prevalence of the indigenous health system, and the inability of biomedicine to 'cure' HIV/AIDS have all contributed to the tacit recognition of the essential role of traditional healers in containing the epidemic (Good, 1988; Staugaard, 1991; Tindikahwa, 1992; Ssenyonga and Brehony, 1993; Mancini et al., 1993; Green, 1994; King et al., 1994; Ssemukasa and Melony, 1994; Chileshe, J., 1996; Kikonyoko et al., 1996; Nakyanzi et al., 1996; Okoth, 1996; Engle, 1998; Galukindu et al., 1998; Semucyo et al., 1998; Cisse, 1999; Homsy, 1999; Homsy et al., 1999; PROMETRA, 1999 UNAIDS, 2000). In order to stem the escalating tide of HIV/AIDS-related morbidity and mortality and reduce the strain on formal health services, the South African government and other sectors have begun to explore collaborations with the indigenous health system to provide HIV education, prevention measures and treatment of HIV related-diseases. The scale of the HIV/AIDS epidemic in South Africa and its repercussions for social and economic development requires nothing less than total community mobilization to minimize its impact and prevent its spread.

1.2. THE POINT OF DEPARTURE

The concern of this study is the practice and potential of collaboration between the allopathic and indigenous health systems for the prevention/treatment of HIV/AIDS in South Africa. Exploration of this topic will be based upon the collaborative partnership with indigenous healers currently in operation at the Valley Trust, a health and development NGO in the rural area of KwaZulu Natal's Valley of a Thousand Hills.

The Valley Trust is not the only organization to have established a working relationship with indigenous healers, but it does have one of the most long standing (Gumede, 1990: 229). A great deal of work has been done on the Valley Trust and the impact of its community health and development initiatives in the Valley of a Thousand Hills, but its relationship with traditional healers has never been explored, particularly not in the context of HIV/AIDS.

The on-going debate over the best means of delivering equitable, quality, and cost-effective health care is not a new one. In order to understand and assess any attempt at collaboration of the Western and traditional health systems to address HIV/AIDS, it is necessary to understand the unique context of health and health care in South Africa. To do so, the second chapter explores the nature of health care, tracing the growing disillusionment with the biomedical model's capacity to address the health needs of the developing world and the global reform movement for Primary Health Care (PHC) that emerged as a result. Outlining the tenets of PHC, I describe the means by which its community-based approach to health opened up a space for the involvement of traditional healers in health care services and outline the current debate regarding the efficacy of their involvement in formal health care services. I go on to relate how the unique characteristics of the HIV/AIDS crisis have brought the abilities of traditional healers to the foreground. Subsequently, I look at the involvement of traditional healers in health care services and addressing HIV/AIDS within the South African context. In the third chapter, I lay out the methodology employed and explain the selection of the Valley Trust as an appropriate pilot study. The fourth and fifth chapters present my findings from the Valley Trust study and discuss their implications.

Chapter 2: HIV, HEALTH & DEVELOPMENT

2.1. WHAT IS HEALTH CARE?

Of all the factors associated with 'quality of life', health is one of the most vital and most basic. However, only over the second half of the last century has a consensus emerged that health is one of the most important indicators of development (Coovadia, 1991; UNDP, 1998: 14). As the former Director General of The World Health Organization (WHO), Dr. Halfdan Mahler, expressed, "I fully realize that health is not the only thing, but without health, everything else is nothing" (WHO, 1983: 7). The paired perception of health and development grew out of the failure of traditional, often industrialization-based development schemes to alleviate the poverty of the South. Despite Western economic, social, and medical intervention, the health of the vast majority of the third world was not improving. With its reliance on discrete variables and emphasis on the germ basis for disease, Western biomedicine often "provided an ideological rationale for downplaying the roles that political, economic and social conditions played in the production of disease" (Baer, Singer and Susser, 1997: 209). The lack of attention customarily given by biomedicine to such factors provided grounds for many to question the appropriateness of the western biomedical-care model for serving the needs of developing world's populace (Illich, 1976; Foster, 1983; Morley, Rhode, and Williams, 1983; Marglin and Marglin, 1990; Walt, 1990; Werner and Sanders, 1997).

2.1.1. Western Biomedicine: Inappropriate and Inaccessible for the Third World

The introduction of Western biomedicine in the Third World was an extension of sixteenth-century Europe's capitalist global expansion. Urban-based, technologically-advanced, and costly, the colonial health care system was primarily concerned with the needs of Europeans, neglecting the indigenous population that was suffering from the impoverished living conditions of displacement and the devastation of introduced disease. Those biomedical initiatives that were aimed at 'natives' were typically focused on combating disease that might impair their capabilities as a labour force or spill over into the European population (Fourie, Pretorious, van Rensburg, 1992: Chapter 2).

As a product of its colonial context, Western biomedicine was seen as one of the tools colonizing nations used to manipulate the modernization process of developing nations from a position of strength (Jingfeng, 1988: 523 and Nandy and Visvanatha, 1990:167). However, the advent of national rule in many developing nations did not affect Western biomedicine's position of dominance, power, and prestige (Pearce, 1982: 1614). Advancements in biomedical pharmacology and surgical technology provided cures for a wide range of conditions that were previously fatal. As a result, the Western biomedical model of health care became coveted by the developing world's new leadership. However, frustration ensued as the limitations of biomedicine became apparent; "Although the era of the 'pill for every ill' began with great promise, the eradication of smallpox proved to be a peak of achievement which has not since been matched" (Hill, 1997: 9). In his notorious critique, Illich (1976) chronicled not only the shortcomings of the biomedical system, but also the means through which it aggravated, impaired, or undermined health through the persistence of resistant strains of infectious agents, such as malaria, and the failure to resolve urgent and common problems, such as diseases associated with malnutrition.

Often times, urban and hospital-based allopathic medicine perpetuated the socio-economic, racial, and geographic inequities of the colonial era. In the Third World "formal allopathic health services are accessible to only a small minority (less than 15%) of the rural populations, omitting those most vulnerable to illness because of a variety of different factors: a hostile environment, poverty, lack of education, undernourishment, and malnutrition" (Yangni-Angate, 1981: 240). Often times, allopathic medicine is not only inaccessible to a large portion of developing countries' citizenry, but also financially beyond the means of many of their national health budgets (Yangni-Angate, 1981). As J. Flahaut wrote, "In these conditions one is led to conclude that Western notions of therapy have nothing to offer when it comes to dealing with the problems of the underprivileged" (Yangni-Angate, 1981: 241). Hence despite the best endeavours of governments and international organizations, allopathic medical systems were notorious for failing to meet the basic health needs of Third World populations (Nandy and Visvanathana, 1990; Werner and Sanders, 1997).

2.1.2. Primary Health Care: A tool for conquering underdevelopment

The link between poor health and 'underdevelopment' and the inadequacies of 'imported' Western biomedicine gained international attention during the 1960s and 1970s and resulted in the growing demand for health reform. The reform movement culminated in the 1978 Alma-Ata conference hosted by the World Health Organization (WHO) and UNICEF in the Soviet Union. Declaring 'Health for All by the Year 2000', the conference, "consolidated the ideas, experiences and policies of a number of developing countries into a united [Primary Health Care] movement" (Lund, 1987: 38). The conference redefined health as, "a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity" (WHO-UNICEF, 1978). The aspiration of those convened at Alma-Ata was that "health" become "part of an integrated package that would help conquer underdevelopment" (Walt, 1990: 6). Health was perceived as the right of every individual and the realization of that right, would require a revision of the concept of 'development' as encompassing more than merely economic measures (Coovadia, 1991; Morley, Rhode, and William, 1983; WHO, 1978).

Support for Primary Health Care (PHC) and the conference's consensus was spurred by the tremendous success realized by community-based health programs in a variety of developing countries (Morley, Rhode, and Williams, 1983) like the Barefoot Doctor program in China, which virtually eliminated a number of diseases and reduced child mortality significantly (Rhode, 1983; WHO, 1983). Although initiated as humanitarian or public health initiatives, many of these comprehensive grassroots programs evolved to incorporate a strong socio-political agenda (Werner and Sanders, 1997: 16). As David Werner, one of the most well-known and outspoken proponents of preventative community-based health care, noted:

As people look more deeply into the reasons for their ill health, they recognize that sickness, disease and malnutrition are merely symptoms of a deeper malady stemming from social inequality, economic exploitation and political oppression (Werner, 1983: 322).

In the years following Alma Ata, it seemed that the supportive political climate necessary for the total human development that PHC envisioned was finally emerging.

The prevailing view of the time among health and development practitioners who were cognizant of developing country conditions was that considerable improvements in basic health could be achieved through teaching the community strategies of preventing disease through the improved use of locally-available resources (Bannerman, Burton, and Wen-Chieh, 1983; Werner, 1983; Werner and Sanders, 1997; WHO, 1983). Accordingly, PHC emphasized giving people and communities the necessary knowledge and skills to maintain their own health through self-care, participation in their local health structures, analysing their health needs, and asserting them with organized action (Kahssay, Taylor and Berman, 1998; Walt, 1990; Werner, 1981; Werner and Sanders, 1997). Swept up with growing evidence of the inadequacies of the biomedical model and a new socio-political movement, the World Health Organization spearheaded research and policy formation that characterized the deprofessionalization of health care as the most important step in improving national health levels and providing 'Health for All', a conclusion, Ivan Illich held, that would have shocked most of its founders (Illich, 1976: 227).

2.1.2.1. *COMMUNITY HEALTH WORKERS*

The principle agents of this alternative health care approach were Community Health Workers: "persons selected from and by their own communities and given brief courses showing them how to help their neighbours meet their most important health needs" (Werner and Sanders, 1997: 16). Community Health Workers (CHWs) were regarded as one of the primary vehicles of deprofessionalizing primary care and achieving community mobilization around issues of health. Over time, the introduction and employment of Community Health Workers became almost synonymous with the primary health care approach (Kahssay, Taylor, and Berman, 1998; Werner, 1983; Walt, 1990; Werner and Sanders, 1997). The strategic deployment of CHWs fostered the use of low-cost, local resources and community self-reliance. In their practice, Community Health Workers emphasized preventative measures, health education, and the involvement and leadership of community members. Lay CHWs were seen as a vital tool in providing communities with the most accessible, appropriate, affordable, efficient, and effective means of health care (WHO, 1978). If Primary Health Care was envisioned as a force to 'conquer

underdevelopment', then Community Health Workers were considered PHC's frontline troops.

2.1.2.2. *INDIGENOUS HEALTH PRACTITIONERS*

Primary Health Care emphasized the employment of appropriate technologies in all aspects of development. Traditional practices and traditional wisdom in the areas of agriculture, housing, irrigation, animal husbandry, and education were often found to be more appropriate and supportive of people's lives. A logical extension was therefore to look into traditional practices for appropriate provision of health care. Traditional medicine has "benefited from this return to the fountainhead, particularly because the inhabitants had never stopped making use of it despite the introduction of modern medicine by the colonial powers" (Ramanohisoa, 1983: 209). Accordingly, the shift in prevailing medical thought to the PHC approach opened an opportunity for the involvement of indigenous health practitioners in formal health services.

The PHC vision of a lay primary care force that stemmed from the community's local knowledge and resources brought attention to the long neglected and often maligned health care resource of indigenous or "traditional" health practitioners (Sindiga, 1995: 3). The incorporation of the culturally-relevant skills and knowledge of traditional healers and locally-available medicinal plants was soon considered significant in establishing the bottom-up, community-driven approach of PHC. The success of model community-based health initiatives that used aspects of the indigenous health system, such as China's barefoot doctors, substantiated the feasibility of combining the two systems (Dauskardt, 1990: 352; Pei, 1983; WHO, 1977b: 16).

2.2. **RETHINKING THE ROLE OF TRADITIONAL MEDICINE**

The World Health Organization (WHO), interested in providing 'Health for all' including the marginalized poor of the developing world, had spearheaded an ideological 'rethink' of the role traditional healing practices in health care coverage (Bannerman, Burton, Wen-Chieh, 1983). Steeped in the cosmological belief systems and natural environments of indigenous peoples, traditional health practices employ the medicinal properties of native plants and interaction with the 'spirit' world for

the purpose of healing. African traditional medicine is defined by Mamadou Koumare, Director General of the National Institute for Research in Traditional Medicine and Pharmacology, as:

The total body of knowledge, techniques for the preparation and use of substances, measures, and practices, whether explicable or not, that are based on the socio-cultural and religious bedrock of African communities, are founded on personal experience and observations handed down from generation to generation ... and are used for the diagnosis, prevention or elimination of imbalances in physical, mental or social well-being (Koumare, 1983: 25).

The curative arm of traditional medicine consists primarily of remedies prepared from various chemical substances in raw extracts from a single plant, several related plants, or from other animal and mineral substances, although the majority of the ingredients are plant-derived (Bibeau et al., 1981: 236). As counselors and community leaders, traditional healers are also involved in preventative aspects of health. Traditional customs and taboos often exist to protect the well-being of the tribe as a whole and the health of its members (Gumede, 1990). As custodians of these traditions, healers are considered to play a central role in the maintenance of social stability in the local community (Staugaard, 1985 in 1991: 22).

Some in the field have discerned a parallel between the collective and communal aspects of indigenous medicine and the community-based focus of Primary Health Care. As Green (1988) articulated:

From the [traditional health system] there comes health precepts such as balance, rhythm, coolness, purity and plenitude, and from the [primary health care system] comes the essential prerequisites of these states such as adequate and clean water, infant care, sewage facilities, adequate nutrition and good housing, all organized within local communities (1126).

Proponents of indigenous medicine postulate that the disparate health systems, given their common goal, could complement one another to produce a better overall clinical result. Organizing a number of conferences on the subject, principal ones being held in Dakar in 1968, Cairo in 1975 and Abidjan in 1979 (Yangni-Angate, 1981: 240), the governing bodies of WHO adopted a series of resolutions concerning the merits and suggested pursuit of collaboration with the indigenous

health system. Over the past decades, the nature of these resolutions has shifted to reflect current valuations of traditional medicine and have focused upon:

- Researching the methods and means of traditional medicine;
- Training doctors in indigenous health knowledge (WHO, 1977a in UNAIDS, 2000);
- Incorporating indigenous healers into government-sponsored programs as primary care providers (WHO, 1978);
- Including healers in national health legislation (Bannerman, Burton, Wen-Chieh, 1983);
- Allocating funds to the development of indigenous health systems (WHO, 1990a, in UNAIDS, 2000);
- Creating medicinal plant inventories (WHO, 1990b in UNAIDS, 2000);
- Surveying the way different countries train their practitioners and control their medicines (McNeil, 2002);
- Conducting evaluative studies of individual medicinal plants (McNeil, 2002).

In 1994, WHO suggested that upgrading the skills of indigenous healers made more sense than training lay individuals from villages and districts to become Community Health Workers. This recommendation was:

based on the premise, shared by many researchers, physicians and public health experts, that as a highly respected, widely distributed and highly consulted group of health practitioners, recognized traditional healers have the cultural knowledge and skills to make an impact on the prevention of disease as well as health promotion and care (UNAIDS, 2000).

Accordingly, it has long been thought that traditional healers could serve as a pivotal link between the government health service and the majority of the population, the coordinated efforts of which would undoubtedly have significant implications for primary health care education campaigns and patient relations (Green, 1992, 1994; Green, Jurg, and Dgedge, 1993; Green, Zokwe, and Dupree, 1995; Staugaard, 1991; Tanner, 1999; Hess, 1998; Offiong, 1999; Schuster-Campbell, 1998).

2.2.1. The Debate about Collaboration with Traditional Healers in PHC

The proponents for the incorporation of traditional medicine in formal primary health services are comprised of a diverse mixture of interest groups, which include:

Governments (whether parties, bureaucracies, or military men), who need both to cut costs and maintain popular support, and the WHO, (or a section within it) which is urging these governments on with

ideas and international pressure; psychiatrists, puzzled by solutions to patients' problems in other cultures, and pharmacologists, on the look-out for new compounds; idealists, seeking to develop a truly national medicine, and skeptics weary of the medical profession, its claims, and its drug companies; radicals of varying persuasion, backing 'the countryside against the town' or the 'folk against the bourgeoisie'; or realists, who simply remark that 'primary health care' is already de facto the province of traditional medicine and therefore want local knowledge and skills recognized for what they are (Last, 1986: 1).

This diverse coalition of proponents and their attempts to gain support from a variety of interest groups have resulted in a series of often contradictory justifications or validations for the importance and effectiveness of the indigenous health system. Confusion among proponents and criticism from opponents has created considerable debate about the possible role and effectiveness of traditional healers in formal health services. The following sections will outline the claims and contentions surrounding the advocacy of employing traditional medicine in formal health care services. This section assesses the viability of traditional medicine as a sound health care system in terms of the Primary Health Care requirements, offered by Coe (1978:413), of availability, accessibility, affordability, acceptability and accountability (Fourie, Pretorious, van Rensburg, 1992: 332). In the subsequent discussion, the categorical guideline of affordability is treated as an aspect of the accessibility.

2.2.1.1. *AVAILABILITY*

One means of assessing availability is the overall supply of a resource. Several studies (Ademuwagun et al, 1979; Anyiman, 1987; Green & Makhubu, 1984; Hoff & Maseko, 1986; Fourie, Pretorious, and van Rensburg, 1992) have attempted to measure the availability of traditional healers in various regions through their practitioner-to-population ratios. As a result of the lack of reliable medical information systems in many African countries, exact figures are difficult to determine. The variances of traditional healer-to-population ratios, which have been measured between approximately 1:44 to 1:2103, are typically preferable to historically low doctor-to-population ratios (Fourie, Pretorious, and van Rensburg, 1992: 332). The overall allopathic doctor-to-population ratio in South Africa was 1:1512 in 1998 (van Rensburg and van Rensburg, 1999: 211). Moreover, when one considers the well-documented skewed distribution (urban/rural and public/private)

of South African doctors (van Rensburg and van Rensburg, 1999; Ntuli, Kohsa, and McCoy, 1999), the doctor-to-population ratio in the rural areas, populated by the majority of black South Africans, worsens.

Lacking official figures for South African traditional healers, one must rely upon membership numbers supplied by traditional healer organizations to determine occurrence. Traditional healers are presently licensed by about 100 organizations (Pretorious, 1999). The South African Traditional Healers Council (SATHC), an umbrella body for traditional healers associations, claims that its membership is approximately 175,000. However, given that the SATHC does not predominate in all areas of South Africa and not all healers belong to an association, the traditional healer: population ratio is estimated at 1:200 (Pretorious, de Klerk, and van Rensburg, 1993: 15). These figures are consistent with those found in other African countries (UNAIDS, 2000: 6).

The low traditional healer to population ratios indicates that traditional medicine is available and geographically proximate to a large portion of the population. However, the PHC necessity that health care providers be close to the community they serve may not be in accordance with South African traditional culture. Osma Mbombo (1996), a black South African medical doctor, recounts, “In traditional culture, we actually say, *Sithathe intonga sawela imilambo* – We took up our sticks and crossed the rivers. Wellness can never be found next door” (112). For a variety of social and cultural reasons, indigenous South Africans often prefer to consult a traditional healer in another area (Fourie, Pretorious, and van Rensburg, 1992).

Apart from cultural considerations, neither sheer numbers nor geographic proximity indicates the quality of the healers available; “It is calculated that of the estimated 80,000 persons practicing traditional health care in Gauteng, only 8,000 are *bona fide* healers, *i.e.* healers who abide by the strict ethical code of the SATHC” (Pretorious, 1999). Given the current economic climate and rising unemployment rate, healers themselves admit that there has been an increase in charlatanism.

2.2.1.2. *ACCESSIBILITY*

Many authors have argued that even where both traditional and allopathic medical practitioners are available and geographically proximate, traditional healing is more *accessible* than biomedicine in a number of different respects. One of the much-touted means of traditional medicine's accessibility is affordability. As the majority of traditional healers' clients are from lower socio-economic groups, it is often assumed that this type of health care is cheap and affordable. However, a 1989 survey in Manguang (a township near Bloemfontein) indicated that the consultation fee of diviners was twice as high as that of Western medical practitioners – white and black (Pretorious, de Klerk, and van Rensburg, 1993). For the majority of black South Africans, the fees of a traditional healer are not cheap.

Though traditional healers may be more costly than biomedical service, especially in regards to government-run health clinics, they may be more convenient for their clientele. Working individuals can visit a healer in the evening or on the weekend, and therefore, do not have to lose part or all of a day's income waiting in long lines at the clinic or doctor's office (Maphumulo, 2000). According to Ngubane (1992), high fees ensure that healers are only consulted in cases of serious illness and not, say, for a mere cold or stomach upset; "The nature of the fees, rather than their amount accounts for the healers' accessibility" (370). According to Ngubane (1992) traditional healing rituals and services have a structured pay scale with which patients are familiar and for which they can save and prepare themselves. Biomedical costs cannot be as easily categorized. Payment for indigenous health services is typically more flexible than in the formal health care system. Patients can often trade goods for traditional health care service or give a promise to pay the fee at a future date.

The rising inflation experienced by many African countries, however, has undermined standardized fees and affordability of traditional medicine. Escalations in the costs of transport, apprenticeship, and training have caused the cost of traditional medicine to rise sharply (Fourie, Pretorious, and van Rensburg, 1992: 333). Green & Makhuba (1984) related that in Swaziland, where relatively low standard fees for preliminary diagnosis and specific rituals have been enforced, traditional healers compensated to cover their costs by 'discovering' that their patients were suffering from more complex diseases that were more expensive to

treat (1074). The current HIV/AIDS crisis would seem to only enhance that trend and healers' financial prospects.

Several studies have shown that traditional healers do relatively well financially (Green & Makhuba, 1984); "Healing for profit is much more lucrative than growing crops and raising livestock" (Thomas, 1975: 271 in Baer, Singer and Susser, 1997). Critics of traditional medicine often cite healers' relative affluence to refute PHC community-oriented characterizations. The adoption of entrepreneurial characteristics by many healers have often resulted from exposure to the capitalist market economy (Baer, Singer and Susser, 1997: 217) and the weakening of community ties that is inherent to such exposure. Regardless, observation of such a trend does not inform the comparative merits of traditional healers versus allopathic medical practitioners, for whom personal profit has always been an expectation and is not considered to conflict with medical ethic.

Arguments for the traditional healing systems' affordability are also often made on the macroeconomic scale, in terms of overall network expenditure. In developing countries, the technologically-intensive biomedical facilities available in urban areas are too expensive for the government to reproduce on a national scale. There is interest in traditional healing as an economically feasible alternative to providing total biomedical healthcare coverage and 'bridging the gap' left by the formal health services; "It is believed that the less expensive indigenous facilities could be merged with the hospital system of Western practitioners to produce a nationwide network of services" (Pearce, 1982: 1611). The risk is that overburdened and unscrupulous governments may endorse the concept of indigenous healing as a means of evading responsibility for supplying its citizenry with adequate health care, leaving communities to 'provide for their own needs' (Glasser, 1988). Velimirovic (1984) maintained that by blankly legitimizing indigenous healing practices, "The World Health Organization is pandering to nationalistic pride, but will fail to deal with the real health problems it might otherwise have done. In effect it may be settling for second rate medicine" (61). Without the proper resources, infrastructure, and government support, a collaborative system with the indigenous health system will not improve health care coverage, and may even reinforce socio-economic inequity.

Traditional healers are considered by many to be more linguistically and culturally accessible than their biomedical service counterparts, as they speak the language with which their clients are most fluent and comfortable. Allopathic doctors may have translators but in the nuanced and delicate matters of health, as Ngubane (1992) stated, “the risks of wrong translation or inappropriate phraseology are obvious” (367). Several studies have shown that miscommunication affects even willing compliance with medical instructions, due to information either not being understood when it is first communicated or not being recalled accurately (Mbombo, 1996; Steffensen & Colker, 1982). Steffensen & Colker, (1982) demonstrated that poor patient comprehension/recall is less a cause of language proficiency and more attributable to absence of the appropriate underlying conceptual schema connecting the patient and practitioner. To correct this, they maintain, “one needs a ‘cultural negotiator’ – a person with a transcultural view who can bridge the chasm separating the traditional and orthodox world views” (Steffensen & Colker, 1982: 1953). With their intimate knowledge of the lives and belief system of indigenous South Africans, traditional healers are considered a large available, accessible, and affordable human resource pool that holds the potential of being trained to function as such negotiators.

Many accounts relate the practice among biomedical staff of reprimanding patients for delaying a visit to Western health services due to patronage of a traditional healer for illness. Although reprimands may not deter an individual from attending a biomedical clinic or seeing a doctor, they could result in the patient’s unwillingness to open up to medical providers or his/her omission of crucial information from self-reported medical histories. Investigation (Gumede, 1990; Ngubane, 1992) has shown that patrons of allopathic medicine typically receive no such conduct in the hut of the traditional healer. The term ‘traditional’, which is used to describe the indigenous health system, should not be confused with the term ‘static’. In the traditional African health system:

There is a readiness to experiment, to try new medicines or discard some for better ones. There is also a general belief that the understanding of this type of natural illness is common to most people, including some people outside of Africa. For this reason, there is readiness to use curing techniques and medicine of Western type (Ngubane, 1977: 23).

The indigenous medical system, researchers purport, has always been very flexible, incorporating ideas from other medical systems to which it was exposed and changing to meet community needs. Traditional healers rarely refute the benefit of biomedicine, but acknowledge its efficacy. Many are often not only willing, but enthusiastic to collaborate with biomedical practitioners (Green, 1994; Kabetsi et al, 1994; O'Rourke, 1996).

2.2.1.3. *ACCEPTABILITY*

Primary Health Care enthusiasts and those who support biomedical collaboration with traditional healers feel that the traditional health system provides client-centered care that is culturally-appropriate and tailored to meet the needs and expectations of the patient (UNAIDS, 2000: 6). The highly professional, technological, doctor-centered, and drug-dominant approach of the allopathic medical system and its practitioners is seen by many as being discontinuous with the beliefs of the general population in developing countries and offering little solace, time, or respite for poor patients. Traditional healers, on the other hand, are considered not only respected health care providers, but also opinion leaders in their communities (UNAIDS, 2000: 6). They are frequently consulted as religious and spiritual guides, legal and political advisors, and marriage and family counselors (Staugaard, 1995).

Social and psychological factors are increasingly recognized as vital components in manifestation and maintenance of health and disease. "The fact that many diseases are psychosomatic, and that the psychological dimension of illness is important in effective therapy has increased the appreciation of the social analysis approach associated with indigenous healing" (Pearce, 1982: 1611). During a discussion with his biomedical counterparts a Zulu medical practitioner said:

Whites have failed to see that in Africa a human being is an entity, not in the first instance divided up into various sections such as the physical body, the soul and the spirit. When a Zulu is sick, it is the whole man that is sick, his physical as well as his spiritual being is affected (Bergland, 1976 in Buhrmann, 1996: 122).

The South African indigenous view of health is considered by proponents to be more holistic than the biomedical model (Campell, 1997; Gumede, 1990; Ngubane,

1977), which is often inadequate in the social interpretation of disease (Fassin & Fassin, 1988: 366). As a result,

In diseases that arise as a result of mind over matter, the traditional healer is adept. He knows his people, their culture, their religion, their joys and fears, their fiddles and foibles. Thus, he virtually holds his patient by the hand and leads him successfully on the road to health through the mists of the labyrinth of mental confusion states (Gumede, 1990: 220).

The traditional healer makes use of valid psychological techniques in the diagnosis, treatment, and counsel of their patients. Therapy through ritual – the psychosocial level – is based on a group of symbols and beliefs, some of which are general in scope and others which are specific to a particular society or ethnic group (Bibeau et al., 1981: 237). In depth anthropological fieldwork and studies have revealed that the skills and knowledge of the traditional healer are not the ‘mumbo-jumbo’ or ‘black magic’ that detractors purport. Jungian psychotherapist, Dr. Vehrah Buhrmann’s primary research with South African traditional healers relates that dreams are used to connect with the unconscious mind and that ‘ancestor’ spirits function like Jung’s archetypal complexes (Buhrmann, 1996: 120).

A number of social and cultural factors affect the effectiveness of Western medicine in the African context. In African countries, many people believe that there are certain types of illnesses that are due to forces that are beyond modern medicine’s comprehension. Therefore, only indigenous healers are seen as solely capable of treating and curing ‘African’ disease. Additionally, it is commonly believed that while biomedicine can effectively cure the physical symptoms of ‘modern’ illness, indigenous healers are seen as needed to treat the disease’s underlying cause and completely heal the body and spirit (Staugaard 1985, 1991; Green 1992, 1994; Green, Jurg, and Dgedge, 1993; Green, Zokwe, and Dupree, 1995). More directly in some intercultural situations, “variations in underlying values and assumptions of general medical information have been implicated as the basis for the *conscious* rejection of standard Western health care practices” (Steffensen & Colker, 1982: 1949). Thus Ademuwagun (1979) writes, “Since most professional health workers have limited knowledge of the cultural factors likely to promote or inhibit health, they would do well to consider working in partnership with native doctors” (In Pearce, 1982: 1611). The indigenous healer’s familiarity with the patient’s

cosmological view is seen as, if not essential to healing, capable of powerfully invigorating the healing process.

Long predicted to diminish and disappear, the presence of the traditional healing system continues to be felt, some say increasingly so, in urban areas and among higher socioeconomic classes, despite the growing availability of the official health care system (Fourie, Pretorius, and van Rensburg, 1992: 334). Gumede relates that biomedical practitioners often feel powerless to affect their patients' physical and mental afflictions, which are products of environmental and socio-politico-economic pressures (removals, resettlements, deprivations from unemployment) (Gumede, 1990: 219). Traditional healers, conversely, undergo long apprenticeships to learn not only about the therapeutic properties of plants, but also, "the various aspects of the balance of nature – which determines man's response to his ease or disease" (Gumede, 1990: 219). Some argue that,

traditional healers' psycho-socio treatment will be increasingly needed to minimize the trauma associated with the stresses of rural to urban migration, rapid industrialization and consumer capitalism, especially considering that the unique political situation in South Africa has aggravated the negative results of acculturation (Fourie, Pretorius, van Rensburg, 1992: 334-335).

Traditional medicine's endurance, continuing to thrive despite years of repressive colonial and apartheid regulations, would suggest that the *acceptability* of traditional medicine is only a point of contention for practitioners of biomedicine and policy makers, but not for the majority of the black community in South Africa.

2.2.1.4. ACCOUNTABILITY

Traditionally, indigenous healers were central figures in small close-knit clan or tribal communities, and as such were responsible for and answerable to community members and leaders and monitored by those under which they had apprenticed. The fragmentation of traditional societal structures that accompanied exposure to the West and urbanization has undermined the healing system's original means of accountability. Scattered throughout the country and often inhabiting densely-populated areas, the activities and claims of traditional healers are difficult to monitor. As critics point out, traditional healers are not trained in a standardized manner, so it is difficult to ascertain the extent of a healer's skills and abilities.

Additionally, the absence of institutional licensing makes it difficult to assure the quality of traditional healing services and prevent the practice of charlatanism (UNAIDS, 2000: 7). Such legitimization and professionalization processes are underway in many African countries (Last & Chavunduka, 1986), including South Africa. Unfortunately at the moment, many such endeavors are informal, voluntary, and sporadic; accordingly, fostering accountability is one of the greatest challenges facing the indigenous health system.

2.2.2. Critique

The wave of enthusiasm for traditional healing and its potential for extending health care services has not been without its detractors. Many have contended that the arguments in favor of traditional systems of health, considering them, at best, wishful and naïve, and, at worst, harmful (Glasser, 1988). Foster (1983) held,

Much harm can be done to the cause of people-oriented healing by stereotyping traditional medicinal systems, or putting them in straight jackets, like: all traditional medicine is good, harmless and/or sound; all traditional healers are poor people-oriented; all traditional healers are models of healer-healee relationships; or they are truly holistic in their approach and are as much spiritual healers as physical healers (22-24).

According to opponents of the traditional health system, the present shortcomings of and frustration with formal allopathic services have led some to hope and search for a health care panacea and, in their eagerness, have been uncritical in their analysis of traditional health systems. Glasser (1988) questions the objectivity of medical anthropologists that champion indigenous health systems, holding that their skepticism has been dulled by their antagonism with western medical practice; “We like to romanticize the powers of shamans and indigenous healers, but the facts often speak otherwise” (1462). Glasser cites the lack of outcome studies comparing indigenous and Western healers to refute exhortations of the effectiveness of indigenous healing. Many critics admit that Western biomedicine is imperfect, but feel that, “the ills [of Western medicine] cannot be redressed by a return to what it overtook – overlooking the own ills of the original system” (Glasser, 1988 1462). Traditional medicine is often accused of suffering from the same evils normally associated with allopathic medicine; for example, healers are also community elites – though a more diverse and disjointed group. According to Glasser’s argument (1988), the current health crisis of HIV/AIDS would only increase the potential

threat of such misguided undertakings, as “it is when we are desperate that we will rely on authoritative medicine, assume the dependent role and trust in magic” (1461). Indeed traditional healers’ treatments for HIV/AIDS, in particular, are often rendered at exorbitant prices (Touko & Kemmegne, 1998), and can be priced so because of peoples’ fear, desperation, and lack of other treatment and therapy options (biomedical or otherwise).

Biomedical health practitioners are often among the most vocal critics of traditional medical practices and practitioners (UNAIDS, 2000: 10). Although many acknowledge that indigenous healers would be useful in filling the void in formal services or providing services for specific diseases, such as HIV/AIDS, they refrain from advocating such proposals, because they feel “the danger of so doing would be to increase the credibility of a group who perpetuate superstition, who charge the very poor for their services, and whose remedies are often harmful and sometimes lethal” (Millard, 1998: 748). Western practitioners feel that not enough is known about indigenous practices or the effect of combining traditional and biomedical treatments. They fear healers may engage in harmful practices or cause delays in referrals to biomedical facilities, and they believe that official recognition of traditional medicine gives legitimacy to traditional healers when their treatments and methods are still largely untested (Yangni-Agnate 1981: 243; UNAIDS, 2000: 7). Such sentiments among biomedical professionals are problematic for proposed collaborative efforts with traditional healers, because “if the profession does not trust them, or if it resents or fears them, it will not refer patients to them nor will it graciously receive patients referred from them” (Pearce, 1982: 1612).

Many postulate that Western-trained health professionals’ fear and suspicion of indigenous healers is due to the fact that they lack scientific knowledge and skills (Ademuwagun, 1979 in Pearce, 1982: 1612). After all, biomedicine is based upon Cartesian scientific materialism and dualism, the rationale of which “introduced doubt where previously there had been belief; emphasized intellect and logic, and belittled emotion and intuition” (Foster, 1983: 11). Therefore, knowledge that is not derived from scientific method is looked down upon and not accepted as potential truth. The preconceptions of biomedicine are not solely limited to its Western founders, but have been passed down to its African apprentices; “Although

‘indigenous’ themselves, the developing world’s biomedical health practitioners are often ingrained with considerable prejudice about the justification, validity, and integrity of traditional medical practices and practitioners” (UNAIDS, 2000: 10). The lack of scientific anatomical and physiological knowledge among healers (UNAIDS, 2000: 7) leads Western practitioners to believe that they cannot reliably and safely affect medical conditions.

However even as more is learned about traditional medical techniques and the effectiveness of certain practices are proven in scientific trials, many doctors persist in their opposition to indigenous medicinal systems. This may be partially explained by the issue of control and competition regarding the production of knowledge (Fourie, Pretorius, and van Rensburg, 1992: 335; Flint, 2001), i.e. “the fundamental issue of where knowledge comes from, how it gets established as recognized knowledge, and how its development and utilization become organized, evaluated, and controlled” (Friedson, 1971 in Pearce, 1982: 1614). Engaged in the process of creating, communicating, and applying knowledge, modern health practitioners are identified and identify themselves with the organized and recognizable occupational group of the biomedical association” (Pearce, 1982: 1614). Accordingly, the inclination of the biomedical knowledge group is to “attempt to absorb or control relevant material from other groups, who are seen as threats to their dominance over medical practice” (Pearce, 1982: 1616). Knowledge control affects Western practitioners’ attitudes towards collaboration with the indigenous health system, as highlighted by Pearce. Pearce’s study (1982) revealed a desire among modern medical practitioners to collaborate and learn more about certain facets of traditional healing system, but reluctance to cooperate more closely with these practitioners. Interestingly, the majority of the doctors in the study revealed that they felt they could learn something from the non-quantifiable aspects of traditional practices, rather than the quantifiable/rationalizable aspects of indigenous practice that are the most similar to their own practices and knowledge systems (i.e. herbal pharmacopoeia). The desire of physicians to learn more about the aspects of traditional medicine that they as a group typically do not recognize as valid, while continuing to refuse to work together with the holders of this knowledge, would indicate a desire to add the knowledge and skills to their own set, without ceding authority to the separate health practice.

The issue of cooptation complicates debates about indigenous healer's role, purpose, and effectiveness in the overall public health system and concomitantly for specialties, such as HIV. Last (1986) points out a number of ambiguities concerning justifications for the use of 'traditional medicine'. First, if traditional medicine is seen as 'useful', because of pharmacologically-effective medicines, then the knowledge of these can be gained and applied through other avenues. If, however, traditional medicine's effectiveness is a product of the healers' valuable local insight and experience, then the traditional healer would be considered to have a place locally either in PHC or handling specific cases under supervision. Alternatively, if the biomedical model is inadequate or at best only partially equipped for treating the whole range of illnesses in Africa, and the effectiveness of the traditional healer is due to the importance of the mind's influence on the body and the effect of the social on the individual through the employment a heightened placebo effect (to use a biomedical explanation!), then the inclusion of the traditional healer within the system would dilute the 'traditional' aspect of the practitioner's 'traditional medicine' (3). The variety of justifications for the viability of traditional medicine has different implications for the appropriateness of collaboration with the formal health system.

2.3. HIV/AIDS BRINGS TRADITIONAL HEALERS TO THE FOREGROUND

Despite the adoption of PHC strategies by many African countries, the WHO's advocacy of indigenous medicine, and the persistence of many health problems among the majority of African people, very little action has been taken by the formal biomedical health system to formally collaborate with traditional healers (UNAIDS, 2000: 10). However, the recent HIV/AIDS pandemic has initiated a resurgence of interest in indigenous medicine.

The modern medical community in Africa has been stunned by the HIV/AIDS epidemic as their interventions have proved relatively ineffectual against the disease. Having little or nothing to offer AIDS patients in terms of treatment (Staugaard, 1991) and in desperate need of personnel (Chavunduka and Last, 1989: 259), the international and African health care communities have expressed renewed interest in collaboration with traditional healers (UNAIDS, 2000: 10). For that reason, the

WHO Traditional Medicine Programme and the WHO Global Programme on AIDS came together in Botswana in 1990 to consider ways to involve traditional health practitioners more actively in the hopes of finding new and more effective ways to fight and prevent the disease. Additionally, collaboration with indigenous health systems to address HIV/AIDS in Africa was a prominent point of concern on the agendas of both the International AIDS conferences in 1999 (Zambia) and 2000 (South Africa).

Within the framework of Primary Health Care and national AIDS programmes, the health care community identified specific areas concerning HIV/AIDS as appropriate for the involvement of traditional healers. Initially a number of projects attempted to assess the value of traditional herbal remedies for the treatment of illnesses associated with AIDS (Green, Tomas, and Jurg, 1991; Musinguzi & Twa-Twa, 1991; Ssenyonga & Brehony, 1993; Ssenyonga, 1994; Chileshe, 1996; Homsy et al., 1999). Then with the recognition of indigenous healers' traditional roles as community educators and counselors, a number of projects initiated trainings of traditional healers in HIV/AIDS awareness and prevention as early as the 1980's (Staugaard, 1991; Schoepf, 1992; Boadu, 1993; Mancini et al., 1993; Kabetsi et al., 1994; King et al., 1994; Green, Zokwe, and Dupree, 1995; Nakyanzi et al., 1996; Galukindu et al., 1998; Boedeker et al., 2000). Encouragingly, numerous studies reveal a great enthusiasm among traditional healers to collaborate with their western-trained counterparts to learn about STDs and HIV/AIDS (Green, 1994; Kabetsi et al., 1994; O'Rourke, 1996).

2.3.1. Prevention

In the past decades, massive HIV/AIDS public awareness and education media campaigns have been launched in Africa and elsewhere. Many of these initiatives resulted in increased awareness of HIV/AIDS, but "although levels of consciousness about the epidemic have been raised, misunderstanding still exists" (Laver, 1988: 282). Laver (1988) and others (Ssali et al., 1996) expressed early warnings about the indiscriminate use of mass media as a means of educating people about HIV/AIDS, advocating instead, "the use of interpersonal channels of communication to reach selective groups, generate in depth understanding, and influence sensitive behaviors within the community" (Laver, 1988: 282). In their role

as informal community leaders and guardians of social rules and norms, traditional healers are seen as a valuable, influential, and strategic means of channeling educational messages to the community (Staugaard, 1991: 23; Tindikahwa, 1992: 11; Mancini et al., 1993; King et al., 1994; Ssemukasa and Melony, 1994; Kikonyoko et al., 1996; Nakyanzi et al., 1996; Semucyo et al., 1998).

Many of the indigenous healer's traditional roles and functions are particularly salient and applicable to prevention and education efforts concerning HIV/AIDS. As Campell's study (1997) and others have shown, individuals receive biomedically-based information and interpret it through a filter of health knowledge and experience in which Western biomedicine plays only a partial role (275). This is particularly true of information concerning HIV/AIDS, which is fundamentally linked with the complicated subject of sexuality; "Sexuality is shaped by a complex process of identity formation, nested within the dynamic web of cultural, psychological, and social factors" (Campell, 1997: 280). The cultural connection that traditional healers share with their clients is perceived as facilitating communication around disease-related social issues (UNAIDS, 2000: 6), which is especially important in dealing with HIV/AIDS. In fact, traditionally and historically the diagnosis and treatment of sexually-transmitted diseases (STDs) has been the domain of the indigenous healer; "indigenous healers pay particular attention to prevention and treatment of STDs, because they are commonly attributed to a transgression of cultural taboos and thus represent a threat to social stability" (Staugaard, 1991: 22). For generations the African people have relied upon traditional healers to effectively treat the physical symptoms and correct the overall imbalance caused by STDs.

In South Africa HIV/AIDS is often considered an indigenous, rather than a modern disease that cannot be cured by biomedical health practitioners (Staugaard, 1991; Green, 1994; Green, Zokwe, and Dupree, 1995). The underlying cause of STDs and HIV/AIDS in the view of many healers is a transgression of existing sexual taboos with the immediate mode of transmission explained as a type of pollution, e.g. through contact with blood or semen – the two major agents of transmission of any disease in this category (Staugaard, 1991; Green, 1992, 1994; Green, Tomas, and Jurg, 1993; King, Homsy, and Allen, 1992); "Prevention of such diseases does

consequently – quite logically – include advice to the individual patient by the traditional healer on how to avoid such transgression of taboos” (Staugaard, 1991: 23; Therefore, indigenous concepts about the etiology and mode of transmission of HIV/AIDS thus appear to be fully compatible with modern, scientific concepts, although expressed in different terms, within a different conceptual framework.

Actions to prevent contraction of HIV that manifest from traditional beliefs about STDs and HIV/AIDS include: limiting the number of sexual partners; wearing protective charms or tattoos; having ‘strong blood’; using condoms to prevent the risk of ‘pollution’; or undergoing a traditional vaccination, which consists of applying herbs into the blood stream through incisions in the patient’s skin (Green 1992, Green, Jurg, and Dupree, 1993, and Schoepf, 1992). Therefore, conceptually the indigenous healer is already aware of the viability of preventive activities, and does not need to make the conceptual leap that many might expect to endorse such behavior to their clients. Healers that have been trained in HIV/AIDS prevention have devised ways of discussing safer sex practices with clients, distributed condoms, and demonstrated condom use with dildos (Manci et al., 1993). Healers have also been creative in using music, drama, and story telling in their education work (King et al., 1994). Additionally, traditional healers continue to serve the community as a primary means of treating STDs; “Most STD cases are never even presented at biomedical health facilities” (Green, 1992). The community relies upon traditional healers to provide this service, because of beliefs that the illness can only be cured by traditional treatment; the greater availability of traditional healers; and the perceived lack of cultural sensitivity and/or confidentiality in the clinic environment (Niang et al, 1996). Traditional healers express great faith in the efficacy of their traditional medicines to treat STDs (Green, Jurg, and Dupree, 1993). As the presence of STDs is a contributing risk factor to contracting HIV, the efficacy of traditional medicine in curing STDs needs to be studied, monitored, and supported to help curtail the spread of the epidemic (Green, 1992; Green, Jurg and Dgedge, 1993).

Though many traditional conceptions of sexually-transmitted disease are compatible with PHC’s behavioral prevention model, other indigenous cultural practices are not. Traditional values, beliefs, and customs are often cited as exacerbating risk

factors for the contraction of HIV (Dlamini-Kapenda, 1996; Ahmad, 2001; Barker, 2000). For instance, many African cultures consider semen an important element in nourishing the growing fetus and maintaining maternal health and beauty, which condom-use would impede. However, Ngubane (1977) purports that traditional healers, as guardians of the cosmology of their people, are in a position to innovate or modulate religious ideology in the context of the Zulu worldview to advocate disease prevention efforts (In Ngubane, 1992: 374). Out of concern for family and cultural survival, a vast number of indigenous healers have amended their traditional beliefs to accept and promote condom-use. In the case of the importance of semen, many traditional healers have reinterpreted the belief to suggest that as a vital element for the health of the unborn child and mother, semen merely served as a symbol for love (Green, Jurg, and Dgedge, 1993; Schoepf, 1992). Likewise, some healers have begun to encourage male circumcision to reduce the risk of STD infection, even when men in their culture are traditionally uncircumcised (Manci et al., 1993).

2.3.2. Treatment

By its own account, the South African National Health Service is not adequately providing care for individuals with HIV/AIDS and HIV-related symptoms. The government's refusal to import, manufacture, or provide cheaper versions of HIV/AIDS drugs, such as AZT, has rendered pharmacological treatment beyond the financial means of even wealthy South Africans. According to a leaked health department document, the growing stress on the health system caused by HIV/AIDS has to date:

been accommodated by three main mechanisms: crowding out of care for persons with non-HIV related needs, the provision of inadequate quality of care for many of those presenting with HIV-related needs, and not providing any meaningful care for a proportion of those sick with HIV/AIDS, especially in areas with generally poor access to health care (Beresford, 2001a).

As a result of the scarcity of biomedical treatment and the high cost of essential HIV/AIDS drugs, South Africans are primarily relying on indigenous healers and herbal remedies for HIV-related conditions (Boedeker et al., 2000: 8).

At the present time, when the modern medical system in South Africa has very little or nothing to offer African AIDS patients in terms of effective treatment, traditional

treatment has many advantages (Cisse, 1999; Staugaard, 1991). The efficacy of indigenous medicine's treatment of illness is the result of the synthesis of two powers: the power of herbs and the power of the healer. Traditional pharmaceutical techniques consist of all the operations conducted by the healer to prepare their herbal remedies, which include selection, collection, preservation, preparation, and packaging. In selection, "The healers' knowledge is impressive, they show real ability – choosing the most effective part of a plant, according to organochemical elements" (Bibeau et al., 1981: 236). Proponents admit that indigenous healers' knowledge of anatomy and physiology is low, but find evidence of healers' biophysical competency in their development of a large and specialized pharmacopoeia to control the body's functioning, even if they cannot describe the mechanics involved (Bibeau et al., 1981: 234). Indeed, the biomedical community has long used traditional knowledge of plant and plant compounds to inform their own pharmacological investigations. "Of 110 plant-derived drugs in professional use throughout the world, two-thirds were investigated because of their reputed benefits in traditional practice" (Tindikahwa, 1992: 11).

Studies have shown that a variety of healer remedies are effective in strengthening the immune system and treating the opportunistic diseases that accompany HIV, and therefore can help improve the quality and prolong the life of seropositive individuals (Ssenyonga and Brehony, 1993; Chileshe, J., 1996, Okoth, 1996; Engle, 1998; Homsy, 1999; Homsy et al., 1999). Currently, a great deal of research is being conducted to analyze and test healers' herbal compounds in the hopes of finding a cure or better treatments for HIV/AIDS. Many healers see the interest in their herbal remedies for HIV/AIDS as an entry point into the medical community, and are eager for validation, recognition, and improvement of the efficacy of their treatments (Kabetsi et al., 1994), but have concerns about acknowledgement of their rights and ownership of this knowledge.

Although capable of curing a variety of common conditions, practitioners in the indigenous system often provide support and encouragement while the natural healing process occurs and (it is hoped) resolves the problem itself (Hill, 1997). Without the benefits of laboratory-based scientific research techniques, the traditional healer, historically, "simply applied a human approach to a complex

human problem, but this seemingly naive method paid large dividends in terms of a speedy recovery” (Gumede, 1990: 220). The healer’s potency in this arena springs from rituals and practices that provide patients with a familiar frame of reference and situate them in a mood, which is receptive to treatment and conducive to recovery.

Health, illness and death are woven into the fabric of everyday life, and most individuals have a role to play in their maintenance or prevention. Ritual and ceremony are important in regulating emotional burden that accompanies disease and death, placing those who perform these services in a prominent position (Hill, 1997: 9).

Indigenous healers’ practice of home-based care provides psychosocial support, emotional nurturing, and religious/ spiritual succor. Though overcrowded hospitals and clinics are turning away HIV/AIDS patients, literally, to die, traditional healing custom, according to Gumede (1990), prohibits turning away a sick person, even if the healer is not able to help (221). Dr. Mamphela Rampole, a seasoned community health worker, explains:

Health is not only measured in terms of physical well-being, but in a more profound way, which makes it possible for us to see health in a person who is disabled or terminally ill. The traditional western medical profession has great difficulty with this concept of health... Their difficulty is reflected in the inability of medical professions to relate meaningfully to someone who is terminally ill. They are ashamed of their failure ‘to heal’ this person and there is rejection of the object that personifies this failure (In Gumede, 1990: 221).

According to the indigenous belief system, one of the primary functions of the healer is to provide clients with hope and a positive outlook for the future; “The diviner’s role is to restore a natural balance and order, not by doing away with the problem, but by bringing the patient into a new order of being” (Ngubane, 1977: 27). This capacity is vital if South Africa is to transform HIV seropositivity into a chronic illness rather than a fatal infection. As scientific studies reveal more about the mind/body connection and the impact of emotions and stress on the capacity of the immune system, the indigenous approach becomes increasingly relevant in the fight against HIV/AIDS. Further, guided discussion and counseling by traditional healers often address related community issues, such as stigma towards infected individuals and how to ‘live’ with AIDS (Kikonyogo et al., 1996; Semucyo et al., 1998). If and when death results, the humanity of the indigenous practitioner may

also be important in helping the bereaved come to terms with their loss (Semucyo et al., 1998).

2.4. THE SOUTH AFRICAN CONTEXT

With the inevitability of majority rule becoming apparent in 1990, a flurry of consultation and policy formation activity around health issues was initiated by South Africa's progressive civic, political, academic, and medical groups, such as The African National Congress (ANC), CHISA, NAMDA, Centre for Health Policy (Wits), NPPHC Network, NEHAWU, and SAHWCO. Having witnessed the stark inequalities engendered by the rule of apartheid, these groups were cognizant of the socio-economic factors that contributed to ill health. The affirmation and resurgence of indigenous knowledge and culture was also an important platform of South Africa's resistance and democratic movement. Accordingly, they advocated the creation of an equitable, accessible, and unified National Health System that was based upon the precepts of Primary Health Care and included a place for the indigenous health system.

Although South Africa's new government has made a number of inroads in the provision of primary health care facilities in poor and rural areas, problems with capacity, implementation, and structural, cultural, and financial constraints continue to undermine health promotion efforts. As a result, many black South Africans lack access to formal health services and are dependent on the traditional medical system (Fassin & Fassin, 1988; UNAIDS, 2000).

2.4.1. Status of Health and HIV/AIDS

The health status of South Africa's various racial groups reflects the country's overall socio-economic disparity and inequity. Despite the end of Apartheid, class distinctions in South Africa remain strong. The health status of white South Africans is similar to that found in the First World, while Third World health conditions are the reality for the majority of black South Africans. Likewise, there is significant inequity between provinces in health provision:

Excluding central funding for hospitals, per capita expenditure on health services in Gauteng was nearly twice that of Mpumalanga and 1.6 times higher than that of the Northern Province. Hospital beds

ranged from 3.49 per 1,000 people in Gauteng to 1.82 per 1,000 in Mpumalanga, and there was unequal access to specialists with Mpumalanga having 0.9 specialists per 100,000 compared with Gauteng's 30.9 (Ensor, 2001).

Decades of inequality, segregation, marginalization, and impoverishment, as evidenced by the squatter camps and informal settlements that ring modern industrialized cities like Johannesburg and Durban, has resulted in the abysmal health of the majority of Black South Africans. Infant and maternal mortality rates (IMR and MMR) are high in South Africa. In 1998, the national average IMR was 45 per 1,000 births, with the provincial IMR reaching as high as 61 (Eastern Cape). The national MMR was 150 per 100,000 (In developed countries, the ratio of maternal deaths is estimated to be between 7 and 22 per 100,000) (Ntuli, Khosa, and McCoy, 1999: 10-12).

The extreme socio-economic power imbalance of South African society has also contributed to the proliferation of infectious disease. South Africa has one of the highest rates of tuberculosis (TB) infection in the world. The substantial prevalence of TB is expected to rise even further with the growth of HIV-incidence, as it is estimated that between 40-50% of people with TB are co-infected with HIV (Ntuli, Khosa, and McCoy, 1999: 12). South Africa has one of the highest HIV infection rates in the world and the prevalence of HIV/AIDS has reached epidemic proportions (Ntuli, Khosa, and McCoy, 1999; UNAIDS, 2000). HIV seroprevalence in South Africa has been rising rapidly in the past decades, conservative models of HIV prevalence rates suggest that already over 3-million South Africans are infected with HIV, with upper estimates exceeding four million (Beresford, 2001a). As a result, life expectancy, without major behavioral or medical changes, is likely to fall forty-one years by 2009, according to the Actuarial Society of South Africa's latest statistical model ASSA (Beresford, 2001b). As with most models, ASSA 2000 extrapolates from the annual surveys of pregnant women attending public antenatal clinics. Unlike many other countries, South Africa presently has no other coordinated nationwide studies into HIV prevalence (Beresford, 2001b).

The Medical Research Council's (MRC) report on the status of HIV/AIDS, which was initially denied publication by the South African government, stated that the

epidemic had taken on “shattering dimensions” and was now “the biggest killer of South Africans,” accounting for one-in-four of all deaths (Barrell & Kindra, 2001).

We estimate that about 40% of the adult deaths aged 15 to 49 that occurred in the year 2000 were due to HIV/AIDS and that about 20% of all adult deaths in that year were due to AIDS. When this is combined with excess deaths in childhood, it is estimated that AIDS accounted for about 25% of all death in the year 2000 and has become the single biggest cause of death (Barrell & Kindra, 2001).

A joint study this year by the departments of health, education, and public service found that, barring a preventative or curative breakthrough, cumulative AIDS deaths could be between 3.4 and 4.5 million by the end of this decade (Beresford, 2001a). Similarly understated 1995 figures were quoted by President Thabo Mbeki in questioning the funding priorities of the health department (Ensor, 2001). The MRC report, in contrast, predicts that AIDS will have killed between five million and seven million South Africans by 2010 (Barrell & Kindra, 2001).

2.4.2. Policy and Position on HIV/AIDS

The South African government launched a R80 million HIV/AIDS awareness campaign in October 1997 that emphasized focusing financial resources on prevention of the disease, rather than treatment. The government’s AIDS plan, formulated through the National AIDS Committee of South Africa (NACOSA), an umbrella body of NGOs and civil society, emphasizes an intersectoral approach and is funded at both the national and provincial levels. Measures of the preventative focus, however, have drawn sharp criticism from many quarters. Treatment Action Campaign, a non-profit advocacy organization, filed a suit, on constitutional grounds, against the Department of Health for its failure to provide anti-retroviral drugs at public health facilities to cut mother-to-child transmission of HIV (Beresford, 2001a). The government’s refusal to subsidize HIV/AIDS pharmaceuticals, according to Health Minister Tshabalala-Msimang, is due to concerns about drug toxicity, the availability of laboratory services, and ‘infrastructural and educational constraints’, particularly in rural areas (Anon, 5 June 2001). The government’s official position on the provision of antiretroviral drugs is confusing, given their recent landmark victory when thirty-nine of the world’s largest pharmaceutical firms dropped a suit to prevent South Africa from importing or producing cheaper versions of patented HIV/AIDS drugs (Quist-Arcton, 2001).

Despite the failed challenge, the government has not changed its stance on the long-term management of the disease, perplexing and frustrating many, who had been their allies and supporters in their fight against the pharmaceutical companies. Presently, the courts have become the arena for numerous challenges to the apparent resistance of government to support widespread anti-retroviral treatment.. An internal health department document, which was leaked to the Mail & Guardian, appears to confirm anecdotal reports that many state officials have also grown increasingly frustrated by the government's (particularly President, Thabo Mbeki's) confusing public stance on the use of anti-retroviral drugs, the extent of the epidemic, and the causal link between HIV and AIDS (Beresford¹, Sept. 21, 2001). The HIV/AIDS epidemic is placing increased pressure on the already inequitable and strained network of modern health facilities in South Africa (Sindiga, 1995: 4). At least an eighth of the national health budget, or R3-6-billion, is to be spent on the hospitalization of AIDS patients in 2001 (Beresford, 2001a). Perhaps even more immediately felt is the rise in AIDS-related diseases, such as tuberculosis. In 2000, last year a quarter of all public hospital admissions were AIDS-related (Beresford, 2001a). At the University of the Witwatersrand's Helen Joseph hospital, admissions have risen by 176% over the last five years, with Helen Joseph now admitting 37 patients a day. According to Professor Ken Huddle from Baragwanath, a growing sense of hopelessness and strains on resources are causing "dire" patient care. A decade ago 6% of admitted adult patients died, but HIV/AIDS has now driven that figure up to 15%. Among patients aged 25 to 44, 70% are dying of HIV-related illnesses (Beresford, 2001c).

The leaked internal report indicated that the Department of Health has asked for a cumulative total of R2.7-billion of additional funding over the next three years to finance an enhanced response to the HIV/AIDS epidemic. The aim, the document says, would be to "invest resources to shift the public health system from its present unsustainable and ultimately self-destructive coping responses to HIV/AIDS, and to move towards a more sustainable and cost-effective model of service provision" (Beresford, 2001a). The health department acknowledges that it is "politically dangerous" to fail to provide treatment for millions of people affected by HIV/AIDS. Without treatment, the report holds that the absolute number of people sick with AIDS, particularly among poor and vulnerable groups, will rapidly reach

unacceptable proportions, become unsustainable politically, and result in major inefficiencies in health provision (Beresford, 2001a). Overall the leaked document “paints a picture of a health system in a parlous state,” where even the most basic preventative practices, such as provision of drugs to treat tuberculosis and sexually-transmitted diseases at all health facilities, are not reliable (Beresford, 2001a). Indeed implementation difficulties have hindered South Africa’s AIDS initiatives and policies from the beginning; “It is very difficult to introduce an urgent, new programme through a government that is grappling with change on so many fronts and is faced with a multitude of more visible priorities” (Rosenbrook, 1998: 11). However, at present it is difficult to argue that the government is facing a more visible and pressing issue than HIV/AIDS.

2.4.3. Policy and Position on Indigenous Healers 55

South African policy and position towards the indigenous health practice has shifted over the course of its history from repression and exclusion to tolerance and the prospect of developing into a more inclusive system in the future. Prior to and sometimes well-after the arrival of the European powers, indigenous healers were the sole guardians of their people’s health and well-being, providing care and treatments that had evolved over centuries of living in and interacting with their environment (Fourie, Pretorious, and van Rensburg, 1992: 36). Little is known about the systems of healing prior to Western exposure, because indigenous healing knowledge was oral, “passed on by initiation within the same family or at most within the same clan” (Ramanohisoa, 1983: 210). Only the chronicles of early explorers and missionaries give any insight into the remarkable healing knowledge and capabilities that must have successfully maintained the health of indigenous communities prior to Western exposure. According to Liechtenstein, doctor, naturalist, and renowned observer, the Xhosas whom he visited in 1803/4 were “but little troubled by illness and treated fever (the only serious malady known for them) with empirical medicines, including local cupping” (Fourie, Pretorious, and van Rensburg, 1992: 50). Another renowned traveler described surgical techniques among the Khoi-Khoi that were unknown in Europe at that time. These and other accounts testify to the expansive and advanced knowledge and skills found among African traditional healers at that time (Fourie, Pretorious, and van Rensburg, 1992: 50).

Generally, the colonial powers did not respect or value traditional healing practices; “With the exception of some of the herbal medicines, the Europeans mostly ignored, disparaged, and even considered undesirable indigenous health care because of its strong dependence on the supernatural” (Fourie, Pretorious, and van Rensburg, 1992: 36). The European colonizers labeled the native people as ‘primitive’ and, concomitantly, perceived their thought processes as a lower and inferior form of cognition. Mysterious indigenous health traditions were perceived as primal, shadowy, and strange and, thus were regarded as sinister and threatening.

Traditional healers were, accordingly, governed by legislation that pertained to witchcraft. The Transvaal Crime Ordinance Act of 1904, Ordinance 26, made it illegal for:

Any person who for purposes of gain pretends to exercise or use any kind of supernatural power, witchcraft, sorcery, enchantment or conjuration or undertakes to tell fortunes or pretends from his skill or knowledge in any occult science.

In 1974, the South African Medical and Dental Council instituted a law that prohibited non-registered healers from performing any procedure pertaining to medical practice as well as forbid registered medical practitioners from collaborating with non-registered healers (Fourie, Pretorious, and van Rensburg, 1992: 336). However, in June of 1995, The Medical Association of South Africa formulated guidelines for cooperation between modern and African traditional medical practitioners, particularly in the case of referrals. However, the association’s change in official stance may not reflect circumstances on the ground; evidence (Pretorious, 1999) suggests that referrals still operate primarily in the direction from the traditional sector to the Western sector. Although traditional healers are covered under the Associated Health Services Professional Act (No 63 of 1982), the Witchcraft Suppression Act continues to exist and to this day KwaZulu-Natal is still the only South African province to have legally recognized any type of traditional healer.

2.4.3.1. *PROGRESS TOWARDS LEGITIMIZATION*

In November 1995, the new ANC-dominated government took the first step towards legitimizing traditional medicine. At the bequest of the National Health

Minister and the provincial MECs for health, a series of public hearings on the viability of indigenous systems of health were held in each province. The information gathered at those hearings, held between May and June 1997, were encapsulated in a report that was presented to the National Assembly's Portfolio Committee on Health at the end of that year. According to the report, all the provinces were in favour of: a statutory council for traditional healers, consisting of local representatives; the standardization of traditional medical practices; the recognition and registration of healers; and the inclusion of healers in medical schemes (Mathieson, 1997; Pretorious, 1999, 4-5). However, the 1997 White Paper for the Transformation of the Health System, which still has not been passed through Parliament, did not clarify an official role for indigenous health practitioners.

Subsequently, a number of national role-players, namely the National Health Committee of the ANC, several traditional healers' associations, the Inkatha Freedom Party (IFP), NEHAWU, the National Progressive Primary Health Care Network (NPPHCN) and Doctors for Life, submitted proposals regarding the character of a council for traditional healers, their training, and code of conduct. Except for the latter, all the parties were in favor of the incorporation of traditional healers into the formal health care system (Pretorious, 1999: 4-5). Subsequently, the Portfolio Committee presented a report on the future status of the indigenous health system to the Minister of Health in July 1998. The main recommendations contained in the report were that traditional healers be legally recognized and that they should be registered within three years. It was envisaged that legislation addressing the matter would be passed in 1999. In the meantime, an Interim Coordinating Committee (ICC), nominated by the provinces, was established to research and make policy recommendations for the creation of a Statutory Council for Traditional Healers.

According to Pretorious (1999) the ICC has proposed a Council consisting of thirty-four members, constituted as follows: two traditional healers from each province, one legal representative (not a healer), one representative from the Department of Health, one community member for each province (not a healer), one representative each from any of the other councils for medical and allied professions, and three

from the current ICC. Working in close collaboration with the Department of Health, they have created provincial structures for formalizing traditional healers and set in motion the electoral process for a national Interim Traditional Medical Practitioners' Council. In part due to historically lenient colonial authority and strong indigenous structures, KwaZulu-Natal is at the forefront of this national initiative to formalize the indigenous health system. KwaZulu Natal's traditional healer associations have come together to elect the supervisory body of the Traditional Healer's Council. The council's purpose is to regulate issues that affect healers in the province, coordinate information sharing among association members, and act as a representative body in negotiations with external agencies. It was envisaged that the Interim Statutory Council would pave the way for a fully-fledged Council within three years (5); however, their plan for the official recognition of traditional healers has not yet come to complete fruition.

The complexities involved in implementing a policy on traditional health care are elaborate and multifaceted. The first complication is the lack of a formal and consistent structure in the indigenous health system. South African traditional healers mirror the diversity of cultures found throughout the African continent and possess a broad range of practice, training and educational experience; "The diversity is further enhanced by their adaptation to the dramatic social changes that have affected much of the region since colonization, such as urbanization, population migration and displacement, and civil conflict" (Good, 1987 in UNAIDS, 2000: 5). In response to criticisms regarding inconsistency, traditional healer associations have engaged in measures to standardize their membership and practices, but with approximately 100 associations (whose membership is a closely guarded secret), license and registration processes may vary considerable. Although certified members subscribe to certain codes of ethics, associations do not have the mechanisms to enforce these codes, thus leaving the door wide open for quacks and charlatans (Pretorious, 1999).

Given the estimated 150,000 and 200,000 traditional healers in the country, the scope of the task alone is a serious obstacle and an additional complication in creating policy around the indigenous health system. The testing, registration, and licensing process is a mammoth task that will likely be costly, not to mention

difficult to implement given the need for consistent monitoring and evaluation of practice modifications. Complicating the task further is the need to also test and certify the myriad traditional remedies, herbal and otherwise, used by healers in their practices.

The third complication of formalization efforts is their inherently subjective and political nature, broaching such questions as by *whose* standards will legitimacy be based and judged. Fassin's book, *L'espace politique de la sante': Essai de genealogie* (1996) highlights the power relations inherent in illness and the legitimization of the behaviour of society's healers (Bradby, 1998). Some have argued that formalization efforts may misunderstand traditional legitimization dynamics and healers' motivations for registration. According to Fassin & Fassin (1988), the stronger a healer's traditional legitimacy, the less the need for rational-legal legitimization. Healers' motivation to invest the money and time for certification is dependent upon what they will gain from the process, therefore:

Healers who already have strong traditional legitimacy – great marabouts or respected witchdoctors – would not consider inviting such an evaluation of their therapeutic activities: for them and for their patients it is obvious that they are 'good healers'. In an officialization of their practice they would have much to lose and nothing to gain (355).

Rather than the presumption that a healer's possession or lack of certification will impact client demand, Fassin and Fassin (1988) argue that those who submit to certification tests are those who have the most to gain from them, "i.e. self-proclaimed healers – healers with little or no traditional legitimacy – such as beginners who did not inherit a clientele and whose social position has not yet been firmly established" (355). Conversely, Flint's (2001) historical review of the Inyanga's Association of KwaZulu Natal explores the formalization process to which respected healers did voluntarily submit themselves in response to increasing contact and competition with white doctors. According to Flint (2001), the healers used certification and testing as a political tool to not only defend their practices from attacks by white doctors and the government, but also to maintain control of the indigenous healing market and elevate themselves above *izangoma* and other healers who used less quantifiable means of healing (trance, prayer, divination). With over 100 healer associations representing the wide variety of healers' interests, it is difficult to know whose interests are being propagated and whose needs are being

met by each legitimization endeavor. However, the initial efforts toward standardization undertaken by healer associations and other bodies have begun to lay a foundation of accountability and create the base for a more systemic professionalization initiative.

2.4.3.2. *TRADITIONAL HEALERS ROLE IN PRIMARY HEALTH CARE*

Role in District Health System

The District Health System (DHS) is the backbone of the country's PHC-inspired health care system. As illustrated earlier, the context of PHC offers an opportunity to bring the traditional and allopathic health systems together. In the South African context the juncture of the two systems occur within the DHS with the most feasible point of entry for traditional healers, given the district structure of the National Health Service, being the Community Health Committee. However, this category of health care provider has, as yet, not been incorporated into the DHS in any real sense.

The fact that traditional healers have not really been incorporated into the DHS is not entirely attributable to a lack of openness by the public health service sector. For several years now, provincial Departments of Health have been actively involved in providing traditional healers and Traditional Birth Attendants (TBAs) with PHC training, particularly in respect of HIV/AIDS/STDs and TB. However, since the inception of the DHS, traditional healers' involvement with clinics has not become more formal or equalized. Despite efforts by provincial departments on the institutional level to involve the traditional health system, contact on the ground has been minimal. For instance, according to Pretorius (1999), in the Free State traditional healers have been invited to have representatives on the District Facilitating Committee, but they do not participate consistently, despite repeated invitations, due to the fact that some of the healers are not in favor of collaboration until the Statutory Council is established so that discussions will be conducted on an equal footing (Pretorius, 1999: 5).

Initiatives outside the Public Health Sector

Due to delays in official recognition, several private sector companies have undertaken separate collaborative efforts with members of the indigenous health

system. Instances of institutional change have begun to take place in some areas of the insurance and business sectors, as they realize the import and consequence of the indigenous health system in their employees' or consumers' lives. Since 1994, the South African electric utility, Eskom, has allowed employees to claim a limited number of visits to traditional healers on the company's medical plan. Likewise, the Chamber of Mines and the National Union of Mineworkers of South Africa now allow a panel of traditional healers at the mines and grant their employees three days leave to consult any healer on the panel (Schuster-Campbell, 1998: 3). Other examples are South Africa's largest medical aid administrator, Medscheme's introduction of limited traditional healer benefits and the Medical and Burial Savings Scheme's screening and recognition of more than 40 healers, whom clients may consult should they so wish (Pretorious, 1999).

As available health resources, recognized and utilized by the community, a number of non-governmental initiatives have attempted to involve traditional healers. One such initiative is the Traditional Medicines Programme (TRAMED) a collaboration of the Medical Research Council, the department of Pharmacology at the University of Cape Town, the school of Pharmacy at the University of the Western Cape and several traditional healers. TRAMED is engaged in scientific studies of healers' therapeutic techniques or, more often, their pharmacopoeia with a view to their possible application in allopathic forums. The growing number of cooperative relationships between modern medical and traditional health care practitioners typically center upon specific issues or shared concerns, none more so than those surrounding HIV and AIDS. One such initiative was sponsored collaboratively by the AIDS Foundation of South Africa (AFSA) and local traditional healer organizations (Matthew et al., 1998). Over the course of a two-year period, the project hosted 70 culturally-sensitive five-day training courses and trained more than 4,000 traditional healers.

2.4.3.3. *TRADITIONAL HEALERS' ROLE IN ADDRESSING HIV/AIDS*

According to Ngubane (1992), renowned for her anthropological and social research among the Zulu in KwaZulu Natal, traditional healers "maintain a meaningful worldview in a society beset with rapid changes and deep contradictions" (366). Never has this role been more critical than in Africa today, given the social,

economic, and community repercussions of the HIV/AIDS pandemic. With the absence of a cure for HIV/AIDS in the foreseeable future and the economic infeasibility of life-prolonging drugs, the healer's unique approach to HIV/AIDS may be useful in South Africa. Additionally with a primarily female clientele (King et al., 1992), traditional healers are seen as a potentially useful and much-needed means of targeting and addressing the needs of this group, whose social, cultural, and economic position in Africa renders them especially vulnerable to STDs and AIDS.

Operating on the manifold levels of the physical, psycho-social, cultural, and spiritual, the untapped reservoir of indigenous healing is thought by some to hold the key to addressing and coping with the new landscape of HIV/AIDS in South Africa. If properly educated and trained, traditional healers can be effectively used to achieve South Africa's national AIDS Control Programmes (NACP) objectives of: preventing the spread of the epidemic, primarily through promotion of safer sex; reducing the impact of HIV/AIDS through counselling and social support; and mobilizing local resources. It is thought that traditional healers can affect the treatment of the HIV/AIDS by offering support and counselling in ways that Western medical services cannot. As respected members of the community, traditional healers have the potential to be a powerful means of extending HIV/AIDS and also encouraging a new ethos and attitude towards the disease. They can support individuals living with HIV/AIDS along the lines advocated by the renowned traditional healer, Credo Mutwa:

The first thing you must do...is give something greater than hope: self-knowledge. You see with an HIV positive person, in over 30 cases that have come into my hands, ... the patient hates himself and is full of rage. ... Your first duty is to give him pride, to help him resist his illness because many people simply give up (In Desmond & Ewing, 2000: 15).

Results of USAID's AIDSCAP project have shown proof of the dramatic impact of HIV/AIDS and STD training for healers, through not only informing individual practices, but also through the multiplier effects of institutional change in the knowledge that is passed down to apprentices (Campell and Mahape, 1996). Accordingly, many feel that if given the appropriate tools and knowledge, collaborations with indigenous healers may be one of the best means to impact the spread of the disease and give the community hope that they can improve the health of their communities.

Other Country Models

Uganda, one of Africa's few AIDS 'success' stories where HIV rates have plateaued or decreasing, can also boast of one of the continent's most progressive collaborative programs between traditional healers and conventional health practitioners (CHP's) – Traditional and Modern Health Practitioners Together against AIDS and other diseases (THETA) an indigenous NGO initiated by a joint effort between TASO Uganda Ltd and MSF-Switzerland. Having started in 1992 as a clinical study evaluating the effectiveness of local herbal treatments for selected AIDS-related symptoms with traditional healers, the effort transformed to focus on its current mission of promoting traditional medicine to complement modern healthcare services, and utilizing Traditional Healers as health educators and counselors of sexually transmitted infections (including HIV) and other diseases. Its present activities include:

1. Training traditional healers as community counselors and educators on sexually transmitted infections (including HIV), as well as training for other organizations targeting THs country-wide.
2. Training THs in basic clinical diagnosis and supporting their efforts to provide quality health services.
3. Generating information through documentation and research about herbal medicine.
4. Establishing and managing a resource and training centre to facilitate collection and dissemination of information on traditional medicine.
5. Advocating for traditional medicine among health professionals and other scientists (Health Systems Trust, 1998).

Studies have shown the effectiveness of healers' herbal treatment for opportunistic diseases associated with HIV, the increased effectiveness of patient counseling and community education, and the establishment of an environment of mutual respect between traditional healers and conventional health practitioners in the fight against AIDS and other diseases (Engle, 1998; Homsy, 1999; Homsy et al. 1999). Initiatives such as Uganda's highlight the potential and possibility of collaboration with indigenous healers to improve national health services and disease control.

Conclusions Regarding Traditional Healers in South Africa

Considerable efforts to formalize and recognize indigenous healers have been set in motion by the ANC government, and in many ways more has been done in the past five years than in the past century. Despite complications and constraints, the

legitimization process of the indigenous health system undertaken by the government constitutes a significant achievement; “In the past, disunity in the ranks of traditional healers was entrenched to such an extent that all previous attempts to unite the various traditional healers’ associations into a single governing body for purposes of registration - and thus control of the profession - failed dismally” (Pretorius, 1999: 5). However, there is still much that needs to be done, as very little has changed on the ground and the government still does not financially support traditional healers.

Despite the enormity of the formalization task, the complex interaction between traditional and legal legitimization dynamics, and difficulty with policy implementation, the fact remains that further delay of legalizing indigenous healers by the government will undermine aims of ensuring the quality of the indigenous health system and will continue to deprive the nation of a considerable resource for health care. The demands of the HIV epidemic have served to highlight the deficiencies of the health system and the flaws of past, less-than-successful, collaborations with indigenous healers. Given the government’s need to prevent the potential spread of HIV by traditional practices and inability to single-handedly address HIV/AIDS, institutional inertia towards collaboration shows signs of shifting. Despite protracted battles over official recognition and the intransigent stance of many allopathic practitioners and associations, evidence exists to warrant optimism about the incorporation of indigenous healers in formal health services. Though in the past ‘uneven’ partnerships (in which the strength and position of the biomedical participants predominated) were the norm, the present context of HIV/AIDS may have created the conditions for a more positive integration of the two health systems.

2.5. CONCLUSION

Even with the rapid socio-cultural change that has occurred in South Africa over the past few decades, indigenous health practitioners continue to occupy a critical role in the black community. If the past is a reliable indicator of the future, the presence of the indigenous healers is not likely to diminish soon. However, "African governments have the responsibility to ensure that traditional practices are not harmful and to foster what is effective and beneficial, in keeping with the beliefs of the people" (Chipfakacha, 1997: 418). If the estimates are correct, then traditional healers are *already* treating a substantial number of people living with HIV/AIDS, and are therefore at risk of acting as a potential mode of transmission for their client base or themselves. Therefore, whether one advocates use of the indigenous health system or not, there is a public health responsibility to regulate these practices.

A number of factors exist that reinforce the potential of traditional healers to assist in the prevention and treatment of HIV/AIDS. As a case in point, research has shown that traditional healers regularly abstain from dangerous practices when educated about the risks (UNAIDS, 2000: 6). Educational and collaborative initiatives appear to improve the health delivery of indigenous practitioners in a number of ways: increased knowledge and skills, increased confidence in their practice, increased openness (transparency) toward the community, and earlier referral to hospitals or health centers (UNAIDS, 2000: 6).

In view of its widespread use, traditional medicine is in a real sense already carrying the burden of clinical care for the AIDS epidemic in Africa, a trend largely overlooked by health ministries, international agencies and donors (Boedeker et al., 2000: 8). Unfortunately, there is a dearth of research identifying the actual techniques used by traditional healers or comparing the outcome results of their prevention or treatment of HIV/AIDS (UNAIDS, 2000: 2). Education efforts around HIV/AIDS need to build upon the strengths and the areas of convergence between the two systems in order to better involve traditional healers. As Friedman (1998) says,

If we have been trained in the paradigm of the conventional western-orientated health sciences, then, whether we are white or black, before we are ready to fully appreciate the role of traditional practitioners and other healers and enter into partnership, we must be prepared to suspend our scientific judgments long enough to be

able to truly listen and learn. This is the first step and most vital step of a methodology aimed at achieving partnership.

Education initiatives need to take the form of an open communication or dialogue in order to establish the accord and create the understanding and respect for *both* healing systems that is necessary to build a collaboration between biomedical personnel and indigenous healers that will best benefit communities both infected and affected by HIV.

Chapter 3: METHODOLOGY

3.1. RESEARCH METHOD

The overwhelming consensus of the literature was clear: in order to best meet the health needs of the majority of the population and confront the significant challenge posed by HIV/AIDS in South Africa, collaboration between formal health services and the indigenous health system should occur. The questions in my mind were: what forms of collaboration with traditional healers ‘should’ be taking place; what effects do such collaborations have on their participants; and can individuals and practices from these two disparate health systems be integrated together for the prevention and treatment of HIV/AIDS?

I felt that a Case Study approach would provide the most nuanced, informative, and valuable findings. I wanted to detail the experiences of a small group of individuals, because I was not concerned with how many traditional healers were collaborating with the formal health system or even how much they knew about HIV/AIDS (questions characteristic of much of the literature in this area), but interested in a picture of what the “collaborations” that are so often touted in the literature actually look like on the ground.

To that end, I approached the Valley Trust, a well-established health and development organization whose original stance of non-interference in the affairs of indigenous healers evolved into a closer collaborative association in 1980 with the inception of its Community-Based Health Education (CBHE) program. The Valley Trust granted me permission to conduct the research project and offered me access to the resources of their facilities, library, staff, and translators and referred me to pertinent information sources and community contacts.

Although the research would have benefited from a comparative study of different organizational approaches to collaboration with traditional healers or perceptions of such collaborations from the HIV/AIDS patient’s perspective, this project was limited due to the time and resource constraints of the master’s dissertation, especially given my recent arrival to South Africa and relative inexperience with its indigenous health system.

3.1.1. Sources of Information

I began the research with a review of the literature on international and South African experiences of collaborative initiatives with traditional healers for the prevention and treatment of HIV/AIDS. Materials reviewed from libraries in South Africa and the United States and from Internet resources encompass subject areas such as: the impact of the AIDS pandemic; health and development; Primary Health Care; the philosophy and practices of the indigenous health system; the South African Ministry of Health's past and present policies concerning the indigenous health system; formal training and involvement of traditional healers in community-based health initiatives; and the response of traditional healers to HIV/AIDS.

As an unfolding subject area, the role of the traditional health system in HIV/AIDS initiatives is in flux and, as of yet, ill-defined. The substance of much of the debate is emerging not in medical periodicals or journal articles, but in backroom conversations and negotiations. Therefore, I conducted a number of informational interviews with members of the key stakeholder groups (government, medical community, traditional healers, academics, and civil society) to get a comprehensive view of the dynamics of the current debate (See Appendix A). These interviews were conducted in English and in person, with the exception of a phone interview with Johannesburg-based Rebecca Rogerson.

The Community Health Department at the Valley Trust introduced me to Alvina Bhengu, a *sangoma* of considerable standing and one of Valley Trust's original Community Health Workers. Alvina 'Ma' Bhengu currently serves as the Valley Trust's Traditional Healer Facilitator. In her capacity as Head of the Amakhosi Traditional Healer's Association, Bhengu was able to introduce me to traditional healers in the KwaNgcolosi area of the Valley of a Thousand Hills that fit the study's criterion of having received training as Community Health Workers or in HIV/AIDS.

3.1.2. Design of Method & Analysis

I visited Valley Trust and the area of KwaNgcolosi seven times between November and December 2000, with visits ranging from a few hours to a week-long stay. A range of research techniques was used to gather information. Initial visits centered on gathering general information regarding Valley Trust and the practices of the area's traditional healers through informal conversations and observations and semi-structured interviews and focus groups with Valley Trust personnel, clinic staff, and the healers themselves.

Establishing trust with the traditional healers was very important; to that end, I spent time with them outside of the formal researcher role as a guest at a *thwasa's* initiation ceremony, a participant in KwaNgcolosi World AIDS Awareness Day educational seminar/celebration, and an observer at a local electoral commission voter workshop to which the healers were invited. Whether at an event or an interview, I never arrived empty-handed, but always brought some food and drink to show respect for Zulu customs, demonstrate my appreciation, and establish trust.

Subsequent visits with the healers involved a more formal schedule of semi-structured interviews and an HIV/AIDS knowledge questionnaire. Interviews lasted between forty-five minutes and two hours and were conducted in Zulu, but translated into English at the time of the interview so that I could pose questions of clarification and/or further investigation. The interviews were tape-recorded with the interviewees' permission and transcribed in English, but examined by the Zulu translator to ensure correct transcription. All healers received remuneration (R50) for participating in the formal interviews to compensate them for their time and loss of possible income.

Areas explored in the interviews with traditional healers included: personal information (age, years of schooling, association affiliations, years of practice, number of patients served a week, etc); ideology concerning health and illness; means of integrating or differentiating their roles as a CHW and a traditional healer; information sharing activities; perceptions of the Valley Trust; perceptions of

Western medicine; perception of traditional healers relationship with government; and difficulties experienced (See Appendix C). The HIV/AIDS questionnaire covered knowledge concerning symptoms, means of transmission, risk perception, means of risk reduction, traditional practices, treatment, education and prevention, HIV counseling, and testing (See Appendix B). The questionnaire included both open and closed questions, but interviewees were encouraged to expand upon answers regardless of question-type. For the subject of transmission, an individual may answer 'Yes' to the closed question "Can you become infected with HIV by touching an infected person?" and then go on to explain only if you have a cut and you touch that person on an open sore or wound. For open-ended questions, multiple responses were encouraged; all were recorded and interviewees were not prompted to mention specific answers. Qualitative data was categorized under broad themes. A coding frame was developed to categorize each answer. Answers to closed questions were coded under 'Yes', 'No', 'Don't Know' or 'Not Applicable'. For open questions, the coding frame was broader (e.g. for means of protection against infection, the codes were condoms, abstinence, limiting partners, testing, wearing gloves, etc...)(See Appendix B).

3.2. PROFILE OF THE REGION

The Valley of a Thousand Hills is an area of KwaZulu-Natal that borders the corridor between Durban and Pietermaritzburg. As a result, the Valley's residents are affected by the health concerns that characterize those urban centres as well as its rural surroundings. The Valley's population of approximately 80,000 people is distributed over roughly 250 square kilometres as loosely clustered settlements of traditional homesteads, which are demarcated into five tribal areas. The people are primarily Zulu-speaking. The climate is subtropical, with warm winters, (avg. max: 22°C) and humid summers (28°C). Densely folded hills, numerous plateaus, granite outcroppings, and ravines characterize the landscape of the Valley. KwaNgcolosi is particularly hilly; its difficult terrain imposes severe constraints on access to all basic services, such as transport, water supplies, and health care.

Prominent in the Valley is the Nyuswa plateau. Though said to have once been rich and fertile, the plateau is now sparse and barren. Characterized by high unemployment and endemic poverty, some have observed that, "The life of the

people [in the Valley] has in many ways mirrored the changes in the veld” (Friedman, 1983: 2). Typical of rural areas in South Africa as a whole, the Valley has very few doctors and trained nurses to provide primary care. According to the area clinics’ October 2000, month-end morbidity statistics, the most prevalent health problems presented by clinic attendees consist of gastro-enteritis, hypertension, respiratory disease (including tuberculosis), and STDs (Ellse, 2000). Infectious diseases, injuries, and accidents are also common causes of illness and death. Malnutrition, although less overtly present than was previously the case, is an associated factor in the severity of much illness. A number of studies conducted by the Medical Research Council on the nutritional status of communities in the Valley (Faber, Smuts, Benade’, 1999; Oelofse et al., 1999) indicate that there is a high prevalence of micronutrient deficiencies, particularly anemia, iodine, and marginal Vitamin A deficits, among school children in Valley communities. Illness in the region is further compounded by the related problems of illiteracy; poverty; inadequate technology; poor knowledge of agriculture; lack of water and soil conservation; potentially harmful traditional practices; and the inequity of society as a whole.

3.2.1. HIV/AIDS

The prevalence and impact of HIV/AIDS in the Valley mirrors the circumstances of KwaZulu Natal Province as a whole. Although I could not access clinic data particular to the Valley of a Thousand Hills, one can assume that the incidence of HIV/AIDS in the Valley would be consistent with the 33% prevalence rate found in KwaZulu Natal’s public sector antenatal attendees (an indicator used to estimate the infection rate among the overall population) (Ntuli, Khosa, and McCoy, 1999: 15). KwaZulu Natal has the highest incidence of HIV-positive pregnant women of all of the provinces in the country (Ntuli, Khosa, and McCoy, 1999: 15). In 1998/99, almost the entire provincial health budget was used to fight AIDS-related disease, particularly pneumonia or tuberculosis. In November 1998, the MEC for Health, Zweli Mkhize, conceded that, “the province is losing the fight against HIV/AIDS. And because so much money is dedicated to fighting AIDS, the province is neglecting its other health responsibilities” (Mail & Guardian, 27 Nov. 1998). However, reports released by organizations such as the Institute for Democracy in South Africa’s Budget exposed that in 2000/01, the first year of the National

Integrated Plan (NIP) for HIV/AIDS, the provinces managed to spend only 36.5 percent of the total HIV/AIDS grants available to them (Anon, 2001). KwaZulu-Natal with the highest estimated prevalence spent only a mere eleven percent of its conditional grant funds in 2000/01. The trend of underspending may be the result of the late transfer of the funds, lack of provincial capacity, particularly for financial and project management and business plan development, lack of political support, or the amount of funds dedicated to HIV/AIDS from provinces own budgets (Anon, 2001). Likewise in 2002, it was reported that the KwaZulu-Natal education department only spent R1-million of the R19-million allocated for its AIDS awareness in schools campaign since 1999, allegedly due to structural capacity problems (Mohale, 2002). Given the above circumstances and causal factors reflect, HIV/AIDS is a mammoth challenged facing the provincial health systems that the distribution of more funds will not necessarily solve.

3.3. PROFILE OF THE VALLEY TRUST

The Valley Trust is a non-governmental organization (NGO) located in Bothas Hills on the cusp of the Valley of a Thousand Hills. According to its Annual Report (1999), the mission of the Valley Trust is to offer quality education and training and associated resources in fields relating to comprehensive primary health care and sustainable development, in order to strengthen the capacity of individuals and communities to improve their own quality of life (3).

3.3.1. Organizational History

In 1950, Dr. Halley Stott established a health clinic in Bothas Hills, because he felt that the medical field's curative approach was inadequate in treating malnutrition-related disease and wanted to provide a more holistic and preventative approach that targeted the root causes of such disease. The clinic served as the means for Dr. Stott to establish credibility with the local community and to gain a better understanding of its problems. In 1953, he created the Valley Trust to provide complementary health promotion services to the health centre, focusing on proper nutrition, organic agriculture, sustainable resource use, and mother and child health issues, such as breast feeding and good hygiene.

In the 1970's, a new deputy director prompted a shift in the organization's focus from individual households to larger communities. The Valley Trust began collaborating with local community structures, namely the local tribal authorities and elected development committees. A wide range of projects were initiated by Valley Trust in response to the expressed needs of the community, ranging from health care, agriculture, appropriate technologies, education, and infrastructure development.

In anticipation of the societal transformation that would accompany the advent of democracy in 1994, Valley Trust and the community participated in a joint strategic planning exercise in late in 1992. The outcomes of this initiative were two decisions: 1) the Trust's projects and resources were to be handed over to the community for management through the establishment of a District Health System in the catchment area of the Halley Stott Health Center in Bothas Hills; and 2) Valley Trust was to restructure itself as an educational and training centre. After directly serving only the communities of the five adjacent tribal areas in the Valley, the focus of the Trust has shifted to more indirect development support for the entire region of KwaZulu Natal and provision of training services for individuals and organizations from all over South Africa.

3.3.2. Community-Based Health Programs

Valley Trust launched its Community Health Worker (CHW) Training Program in 1979 to help address the inequities in the South African health care system and provide communities with the means of improving their own health and well-being. Valley Trust's Community Health Workers, who elected to call themselves *Onompilo* (a name derived from the Zulu work *phila* - "to be in good health"), primarily focus their efforts on diseases or problems that have been identified as priorities by their communities. Priorities are based upon community perceptions of magnitude, seriousness, and amenability of the problem to local intervention. As with any enduring initiative, the objectives of the CHW program have evolved over time. A 1994 evaluation, sponsored by the Centre for Health and Social Studies (CHESS), outlined the following program objectives as being mutually agreed upon by all of the CHW program's relevant stakeholders:

To promote the health of families through home visits and health education;

To facilitate the communication links between the community and the providers of health, social, and environmental services (water, housing, agriculture, sewage, refuse removal, etc.);

To assist communities in organizing themselves, particularly in health and development committees, to enable them to take greater control over their own health and to advocate for essential services;

To assist households and communities in meeting their nutritional needs;

To provide follow-up for the chronically-ill and to ensure that the sick are correctly referred (Sigwaza, 1994: 88-89).

The main areas of *Onompilo* health care activity include: the prevention and treatment of water-related diseases, e.g. the teaching of personal and environmental hygiene, sanitation, and oral rehydration; the prevention and elementary treatment of respiratory disease, e.g. diagnosis and referral of TB cases, detection of bronchopneumonia, advocacy of immunization, etc; the prevention and treatment of malnutrition, e.g. the measurement of growth, teaching basic nutrition, and advocacy of breast-feeding; education and prevention of HIV/AIDS, e.g. advocacy of safe sex, testing referrals, etc; First Aid; and home-based care to the elderly, disabled, and seriously-ill, including AIDS patients.

The 1994 CHES evaluation found that the majority of community members surveyed (75%) thought the CHW program useful. However, when respondents were asked to identify the specific activity that they perceived as most useful and desired in the future, the most common response was “food distribution,” an activity not normally considered part of CHW activity (Sigwaza, 1994: 89). When the responses for the individual activities associated with the traditional CHW role (i.e., health education, encouraging cleanliness, and giving advice) were tallied together, however, they had a higher significance than supplementary feeding (Sigwaza, 1994: 90). The study did not find any significant differences in health or sanitation factors between those households in the Valley that were visited by CHWs and those that were not. The breadth and scope of the CHW program’s community-oriented activities could explain the difficulty in comparing households, but it is interesting to note that the one difference identified related once again to food; households that were visited by CHWs were more involved in community gardens. According to the evaluation’s authors, “The CHWs themselves are very motivated and interested in vegetable gardens and this is evidence that, in activities that are their strength and

concern, they are good motivators” (Sigwaza, 1994: 100). These findings support the evidence of micronutrient deficiencies among children found by the Medical Research Project and compel one to conclude that, “households in the Valley regard the procurement of sufficient food as a battle that they have never won” (Sigwaza, 1994: 89).

3.3.2.1. *THE TRANSITION TO A DISTRICT SYSTEM MODEL*

The District Health System model used by The Valley Trust has centered around the establishment of Health Posts, which provide a focus for health related activities in the community. There are eleven Health Posts in the area with each one designed to serve up to 500 people and comprises: 2 consulting rooms, 1 child screening area, staff room, large waiting area and a community centre. The facility is run by a Community Health Committee (CHC) which coordinates a Community Health Worker (CHW) group and it provides a venue for a mobile service, health promotion activities, CHC meetings, a demonstration of appropriate technologies and vegetable gardening, other health related services (mental health, optometry, rehabilitation activities, health science student activities), and an emergency pick-up point in the community. The community centre room is used for meetings, for work groups such as sewing clubs or even a creche as determined by the community.

One of the purposes of the Health Post is to serve as a base to train the community health committees (CHCs) and CHWs in basic skills to enable them to run community health services, and including orientation to the District Health Systems and Primary Health Care. Each CHC sends representatives to a community-based Advisory Health Committee which in turn is meant to feed into the main coordinating body. This whole process should be facilitated at the health post level by a CHW facilitator chosen from each of the Tribal areas by the area Development Committee. A further important role of the health post is to provide an interface between health services and the community through a Community-Based Health Education (CBHE) programme. A senior professional nurse at the health centre has been appointed to facilitate this interface (Pitt, 1997).

3.3.2.1. COLLABORATION WITH TRADITIONAL HEALERS

At the onset of his socio-medical project in the Valley of a Thousand Hills, Dr. Halley Stott avowed a stance of non-interference in the affairs of traditional healers (Pitt, 1998: 3). Over the years, the Valley Trust attempted to build a constructive dialogue between the two health care systems, meeting with *Inyangas*, *Izangoma*, *Abuathadaz* (spiritual healers) and prophets on a regular basis. Valley Trust's approach shifted in 1979 with the inception of its Community-Based Health program in which a number of traditional healers volunteered to participate. These volunteers were trained and employed as Community Health Workers (CHWs) to assist in educating the community in preventative and primary health care, and thus became active agents in the Trust's health delivery system. From the time the first *izangoma* volunteered as CHWs, the collaboration between the two health systems has expanded.

Historically, Valley Trust's outreach to traditional healers was undertaken with a non-judgmental approach that emphasized areas of common interest. According to Dr. Irwin Friedman, (1998) former Valley Trust director,

The workshops were principally run as Adult Education sessions where we, as Western practitioners hosting the meeting, shared with the Traditional healers some of our 'secrets'. Traditional healers were likewise encouraged to share their experiences with the prevention and management of disease. These included our own view of how diarrhoeal, respiratory and nutritional disorders in particular, were caused (no page).

In accordance with the characterization of the indigenous health system openness, flexibility and willingness to adapt to meet emerging needs in the community, healers in these workshops would test approaches suggested by Valley Trust practitioners and learn for themselves its effectiveness. Friedman (1998) reports:

The willingness of the traditional healers to resort to empirical testing was an eye-opener... Just as with other individuals they are part of dynamic social change. My experience has suggested that in many respects they are leaders of social change and are early rather than late adopters of new ideas. The traditional garb they don and their bones should not mislead us into misunderstanding them. It would be as foolhardy to judge them by their dress as it would be to judge a doctor by his white coat and stethoscope (no page).

The impetus behind the Valley Trust's approach was to transfer beneficial knowledge from Western medicine with healers to improve their abilities and practices, so that the health service they delivered to the community would be improved. The assumption was not that Western medicine was better than traditional medicine, just that they had material to share. In 1998, the Valley Trust was given an award at a meeting of the Iyanga's Association in KwaZulu Natal, for servin'g as an example to the rest of the traditional healers and Western doctors in South Africa (Clarke, 1998: 8).

Bhengu was one of the healers who volunteered to become a CHW and participate in Valley Trust's initial training program that spanned over three years and roughly corresponded with the curriculum developed in the Primary Health Worker Training Manual, published by WHO (Sigwaza, 1994: 2). To share her newly acquired knowledge with fellow *izangoma*, Bhengu initiated training sessions for them on primary health care matters, in particular the harmful nature of certain traditional medical practices. Eventually, the group of *izangoma* she gathered for training officially became the Amakhosi Association¹. By comparison, the women of Amakhosi Association are in a better position than the rest of their community. Since the 1970's, the women share a history of working together, training together and sharing skills with one another.

According to Pitt (1997), former Halley Stott Clinic physician, traditional healers have been involved wherever possible in health post activities; "With some CHWs being practicing traditional healers, health post activities have input from these highly respected practitioners who are used by 80% of clinic attenders" (no page). Additionally, gardens have been planted at health posts which contain plants for use by traditional healers. The traditional beehive hut that serves as the Amakhosi Association's gathering place was built next to the Valley Trust's 'Bhekisizwe' health post, so that the local Community Health Workers and healers could meet and interact regularly. The Valley Trust's mobile clinic visits health posts weekly, bi-weekly, or once a month depending on the number of people served and the

¹ The literal definition of the Zulu term Amakhosi (plural) is "kings". It is often used when speaking of traditional leaders, e.g. Mongosuthu Buthelezi is an inkosi (singular) of the Buthelezi clan. Depending on the context, however, Amakhosi can also refer to traditional healers, because of their supernatural powers and connection to the ancestor spirits of past Zulu kings.

presence of other clinics in the area. The traditional hut's location next to the Bhekisizwe health post enables healers to also access the mobile clinic nurses and resources. With the technical support of the Valley Trust, Bhengu and the Amakhosi Association have established at Bhesiziwe:

- A Community Garden – which provides vegetables to over 50 families;
- A Medicinal Plant Garden – a secure source for the healers' remedies;
- Two VIP latrine sanitation facilities;
- A Craft Stall;
- A crèche for disabled children – run by community members trained in early childhood education;
- A traditional pharmacy outlet.

Bhengu and the Amakhosi Association are also concerned with improving income generation within the community. The women of the Amakhosi Association, like the majority of the poor in the South and increasingly the North engage in a wide range of activities and diverse strategies in order to secure their livelihoods, such as making soil bricks and crafts (Chambers, 1995: 23-24). Referred by Valley Trust, the Amakhosi Association has become a beneficiary of the Heifer Project and, as such, has received six dairy cows. Discussions and plans are currently under way to obtain chickens to begin an egg-selling venture. Various members of the Amakhosi Association meet once a week to maintain the gardens, engage in income generation projects, share information, and discuss issues relating to health of their clients and the community.

3.3.2.2. *HIV/AIDS INITIATIVES*

The Valley Trust, given the emerging health crisis of HIV/AIDS, launched an education and prevention campaign. HIV/AIDS education and prevention became one of the foremost priorities of Valley Trust's Community Health Workers, including the traditional healers among them. Recognizing the prevalence of traditional healers and the extent to which the local community relied on their health services, Valley Trust extended their HIV/AIDS training to target those traditional healers who were not formally involved in the Community Health Program as CHWs. These traditional healers, members of the Amakhosi Association, were invited to attend a week-long training session on HIV/AIDS education and

prevention. According to Community Health Coordinator at Valley Trust the training consisted of: explanations of the immune system and how it is affected; modes of transmission; signs and symptoms of HIV; universal precautions; attitudes and beliefs around HIV, such as myths around transmission and acceptance of HIV-positive people; gender issues, such as rape and negotiating condom-use, and home-based care. They are not trained in traditional healing knowledge or practices, but discuss traditional ideas about health and HIV/AIDS as they are brought up by the participants and the positive and negative aspects of traditional practices.

Similarly to those serving as CHWs, the traditional healers who received the week training were expected to share the information they had learned with other traditional healers and with the community. Healers chosen for the training were selected on a referral and volunteer basis.

3.3.3. HIV/AIDS Collaboration with Traditional Healers

At Valley Trust collaboration with traditional healers to address HIV/AIDS has taken primarily three forms: incorporation in the formal primary health care system as CHWs, formal short-term HIV/AIDS training and informal second-hand HIV/AIDS training or information sharing. This study addresses the effectiveness of the HIV/AIDS collaboration between Western and traditional medicine at Valley Trust through a comparison of these three forms of collaboration in terms of:

- HIV/AIDS knowledge possessed by traditional healers in each group;
- HIV/AIDS communication/education efforts undertaken by traditional healers in each group;
- HIV/AIDS patient treatment employed by traditional healers in each group;
- Attitudes toward the allopathic health system and Valley Trust held by traditional healers in each group.

In the assessment, particular notice is taken of the difficulties experienced by the participants in each form of collaboration with the hope of finding means that they may be addressed.

3.4. CHARACTERISTICS OF THE SAMPLE

All of the healers interviewed were Zulu *Izangoma*, defined by Ngubane (1977, 1992) as “indigenous diviners/mediums that have clairvoyant powers as well as a comprehensive knowledge of African medicines.” The nature of the *sangoma*’s traditional role suggests that they are the more appropriate candidates among traditional healers for collaborative initiatives. Hammond-Tooke (1989) and Ngubane (1977, 1992) suggest that they are less likely to engage in anti-social activities because the Zulu believe that “the spirits which possess the diviners expect of them a high moral code. [Therefore, the diviners] would lose their clairvoyant powers if they used the medicine revealed to them to harm other people” (Ngubane, 1977: 34). All of the *izangoma* interviewed were female, which is appropriate as *sangoma* membership tends to be overwhelmingly female in Southern Africa, perhaps as much as 90% (Green & Makhubu, 1984: 1073). The two male members of the Amakhosi Association, whom I encountered, either did not fit the study’s criteria or were unavailable during site visits, and therefore were not included in the study. Given the lack of literature examining what impact (if any) gender plays in the effectiveness of traditional healing, I felt that the inclusion of a male subject would have further complicated, rather than clarified, the study.

The ages of the vast majority of the healers fell in the range between the early forties and mid-fifties. The only two exceptions to this were Ma Bhengu, who is 69-years-old, and perhaps another healer, who did not know her age. Leaving these two individuals out of the calculation, the average age of the women interviewed was 47.5 years. There was no significant difference in the average ages between groups.

The education levels of the individuals in the Amakhosi Association are low. None of the women interviewed had matriculated, four of them (36%) had never attended school, and the average amount of schooling among the remaining seven was just above standard four (with a range of standard one to standard eight). Among the three groups, the Community Health Workers had the highest average standard of schooling, followed by the healers with formal HIV/AIDS training and then, lastly, the healers with no formal training. However, each group included individuals with no schooling at all.

3.4.1. Traditional Healers/ Community Health Worker (TH/CHWs)

This group, which I will refer shorthand to as TH/CHWs, consists of three traditional healers that currently serve as *nompilos* and Ma Bhengu, who, although no longer making household visits, is intricately involved in their work. These healers are held accountable to the same standards as all of the Valley Trust's Community Health Workers. Three of the healers had become CHWs after volunteering for the Valley Trust for several years. The fourth healer was enrolled as a CHW before she initiated her training as a *sangoma*. These healers were presented with information regarding HIV/AIDS during their CHW training. Their HIV/AIDS training was subsequently reinforced in meetings with their supervisors, the Community Health Facilitators, and additional training opportunities. All of the TH/CHWs are members of the Amakhosi Association lead by Bhengu.

3.4.2. Traditional Healers with Formal HIV/AIDS Training (Trained Healers)

The Trained Healer group consists of four healers who volunteered to receive HIV/AIDS training. An HIV/AIDS facilitator at the Valley Trust conducted the training that consisted of a week's worth of lessons. The daily lessons ran from 8/9:00AM until 4:00PM. All of the trained healers are members of the Amakhosi Association lead by Bhengu.

3.4.3. Traditional Healers with No Formal HIV/AIDS Training (Untrained)

The Untrained Healer group consists of three healers that had not attended the formal week-long training in HIV/AIDS conducted by the Valley Trust. Two of the untrained healers were members of the Amakhosi Association. The third was not an association member, but had in the past visited Bhengu's home for events/meetings. Therefore, all of these healers had the opportunity to receive second-hand HIV/AIDS information from the *izangoma* who are CHWs or trained in HIV/AIDS.

3.5. CONCLUSION

Due to time and resource constraints and the complexities of the indigenous health system, I employed a pilot methodology that looked closely at the experiences of a few individuals with the hope that insights derived might inform future research. I

began the research with a review of the literature on international and South African experiences of collaborative initiatives with traditional healers for the prevention and treatment of HIV/AIDS. Additionally given the unfolding nature of this subject area and my relative unfamiliarity with the South African context, I conducted a number of informational interviews with representatives of government, medical community, traditional healers, academics, civil society to get a comprehensive view of the dynamics of the current debate. Likewise, I spent a considerable amount of time in the company of the study's subjects observing their behavior and engaging in informal conversations. I employed the use of individual semi-structured interviews, group interviews, and an HIV/AIDS knowledge questionnaire to engage healers in a variety of dialogue techniques in order to accommodate varying comfort zones and preferred methods of communication. The study would have benefited from the inclusion of the perspective of the healers' clients, particularly HIV/AIDS patients, but issues of confidentiality, location, and time made this beyond the scope of this study. Likewise, a wider pool of healers from which to choose at random rather than a referred sample would have garnered the results with more generalizability.

Chapter 4: COMPARISON OF HIV KNOWLEDGE AND TREATMENT/ PREVENTION ACTIVITIES FINDINGS

Introduction

This chapter presents findings that respond to the research query of whether varying levels of training and collaboration with the biomedical system affect traditional healers' HIV/AIDS knowledge and prevention/ treatment activities. It describes the results of interviews with *izangoma* who practice in the area of the Valley of a Thousand Hills regarding their knowledge and experience with HIV/AIDS. Information about the traditional healers' HIV/AIDS knowledge and practices was collected on the basis that healers with more training and a stronger collaborative relationship with the biomedical system would know more about HIV/AIDS and engage in more productive HIV/AIDS prevention and treatment activities. The premise of the study is that TH/CHWs, given their unique positions as members of both the biomedical and the indigenous systems of health, should be the most informed and proactive regarding HIV/AIDS, thereby functioning in the vein of the *cultural negotiator* suggested by Steffensen & Colker (1982). The following sections compare the results of the three different traditional healer groups in terms of their HIV/AIDS knowledge and treatment/prevention activities.

The findings regarding level of training were divided into three categories: TH/CHWs (Traditional healers who were trained by the Valley Trust as Community Health Workers); Trained (Traditional Healers who had received a weeks worth of HIV/AIDS training by the Valley Trust); and Untrained (Traditional healers who had never engaged in a formal training program conducted by the Valley Trust). It is important to understand, however, that while level of training by the Valley Trust is an important characteristic in analyzing the data collected from the participants, it is not the only factor. Characteristics such as age, level of education, and years of experience as a traditional healer could also play significant roles in affecting the outcome of the data collected. Further study with a larger sample would help to illustrate other important factors affecting data analysis.

4.1. HIV/ AIDS KNOWLEDGE

There was no evidence of HIV/AIDS denial among the traditional healers interviewed. The *izangoma* in the Ngcolosi area of the Valley of a Thousand Hills saw

HIV/AIDS as a problem in their community and a disease that could affect or infect anyone, not just select groups. When I asked specifically who the healers perceived as being most at risk, young people (73%) and women (36%) were the most common answers. None of the healers suggested that they knew what caused HIV/AIDS. Only three offered theoretical causes, such as the greater traffic of people in and out of the region and rising promiscuity that had accompanied modernization. (Although, regarding promiscuity, one of the three equivocated that even if a woman was faithful, her husband could still commit adultery and infect her.)

4.1.1 Definitions of HIV

I considered a fully correct definition to be one that included knowledge of the nature of HIV and its mode of transmission or consequences, such as a) a virus/germ that causes AIDS; b) a virus that affects the body's immune system (any description thereof, such as vulnerability to disease); or c) a virus that is passed through sexual relations and/or intravenous blood contact, such as sharing needles or razors. An incomplete response was defined as a response that was not incorrect, but did not meet all of the requirements listed above for a fully correct definition. The results of the healers' responses to a request to define HIV are listed in the table and chart below.

Chart 4.1. Comparison of HIV Definition Results

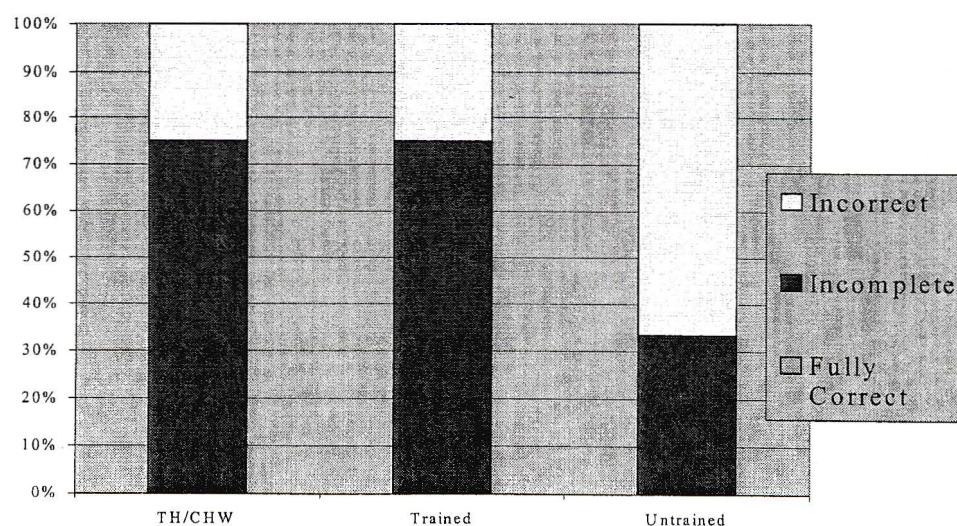


Table 4.1. HIV Definition Responses

	TH/CHWs	Trained	Untrained
Incomplete	“A germ that is transmitted through blood”	“That’s where AIDS begins.”	“It’s in the blood cells, those white cells.”
	“A horrible germ that kills people.”	“HIV comes before AIDS.”	
	“A disease/ a germ.”	“It’s a disease that gets to people a lot.”	
Incorrect	“A bacteria that causes HIV.”	“It’s AIDS.”	“I hear that it is AIDS.”
			“It is an indication that someone is going to get HIV.”

Although it became clear throughout the interview process that all of the traditional healers had a sense of what HIV was, none was able to correctly define it. There was no distinct difference between the groups’ abilities to fully define HIV. As may be expected from their formal health training, the TH/CHWs were the only healers to make specific mention of pathogens, such as, ‘a germ’ or ‘bacteria’ in their definitions; although surprisingly, a traditional healer with no training was the only one to make specific mention of white blood cells, a biological component of the immune system.

4.1.2. Definitions of AIDS

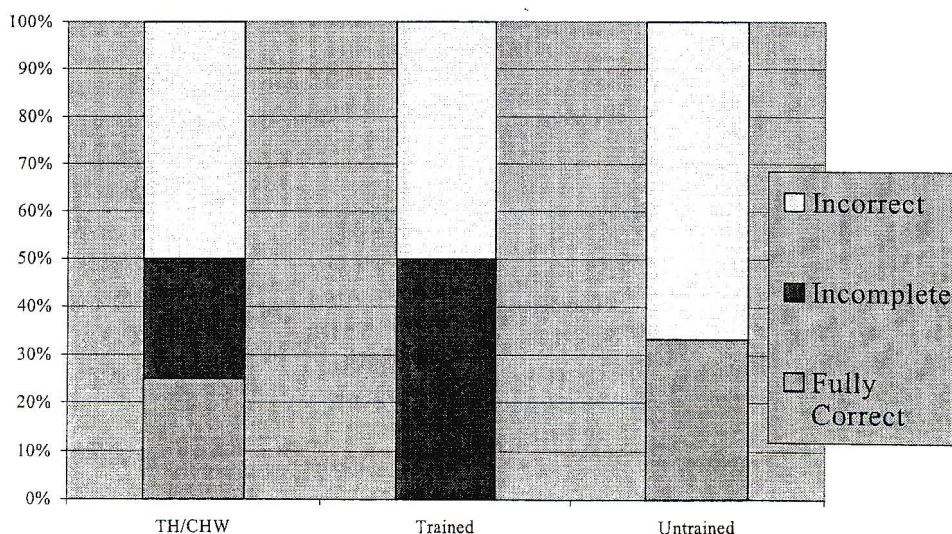
I considered a fully correct definition of AIDS to be one that mentioned the deterioration of the body’s immune system or symptoms thereof (sickness, disease, death, etc...) as a result of the viral infection. An incomplete definition was defined as a response that was not incorrect, but did not meet all of the requirements listed above for a correct answer. The results of the healers’ responses to a request to define AIDS are listed in the table and chart below.

Table 4.2. AIDS Definition Responses

	TH/CHWs	Trained	Untrained
Fully Correct	“That’s when the germ enters the body and diminishes everything in the body.”		“AIDS is when someone has HIV and it’s full-blown. Some people don’t say that they have AIDS and you just see it later, all the signs are there.”
Incomplete	“When the person gets sick.”	“It’s the final stages, I’m not sure.”	
		“HIV causes it.”	
		“The stages vary as the disease progress – starts with HIV, then AIDS and then you get <i>Umkolazi</i> .”	
Incorrect	There’s no difference [between HIV and AIDS].	AIDS is when the germ is in you.	Infection in the blood you get through sexual relations
	It’s when the germ is definitely in the body.		“In the blood.”

I further questioned the trained healer whose definition included the Zulu term *Umkolazi*, the direct translation of which is AIDS. She reported, “With AIDS, you’ve

Chart 4.2. Comparison of AIDS Definition Result



got it, but it's not evident, no one sees it – when it's *Umkolazi*, it's full-blown, the person is completely deteriorated.” Though not entirely accurate (AIDS also describes when a person has evident symptoms), the response highlights the need to explore Zulu characterizations of the disease.

Only a few of the *izangoma* were able to correctly define AIDS. As with the definitions of HIV, there was no specific difference in the groups' abilities to define AIDS. However overall the healers fared worse in defining AIDS than they had in defining HIV, as their AIDS definitions consisted of a higher number of 'incorrect' as opposed to 'incomplete' responses. Despite a paucity of correct definitions, it was apparent that both the TH/CHW and trained groups grasped the concept of causation and progression between HIV/AIDS. The same could only be said of one of the members of the untrained group.

4.1.3. Identification of Modes of Transmission

The healers were given a list of eleven situations and asked to identify those that could result in HIV transmission. The eleven situations listed were: touching an infected person, sex, sharing needles, blood transfusion, mosquito bite, contact with blood of infected person, infected mother-to-child, sharing utensils/cup with an infected person, sharing a toilet with an infected person, and kissing. The number of correct answers per group for each situation and overall group averages for overall performance on the exercise are listed in the table below.

Table 4.3. Comparison of 'Mode of Transmission' Identification Results

<i>Scenarios</i>	TH/CHW (4)	Trained (4)	Untrained (3)	Total (11)
Touching an Infected Person	3	3	2	67%
Sex/ intercourse	4	4	3	100%
Sharing Needles	4	4	3	100%
Blood Transfusion	4	3	3	90%
Mosquito bite	2	3	0	45%
Blood contact	4	4	3	100%
Mother-to-Child	4	4	3	100%
Breastfeeding	3	1	3	45%
Sharing Utensils	2	4	1	64%
Sharing a Toilet	2	4	3	82%
Kissing	2	3	1	55%
TOTAL	34 (77%)	37 (85%)	25 (76%)	

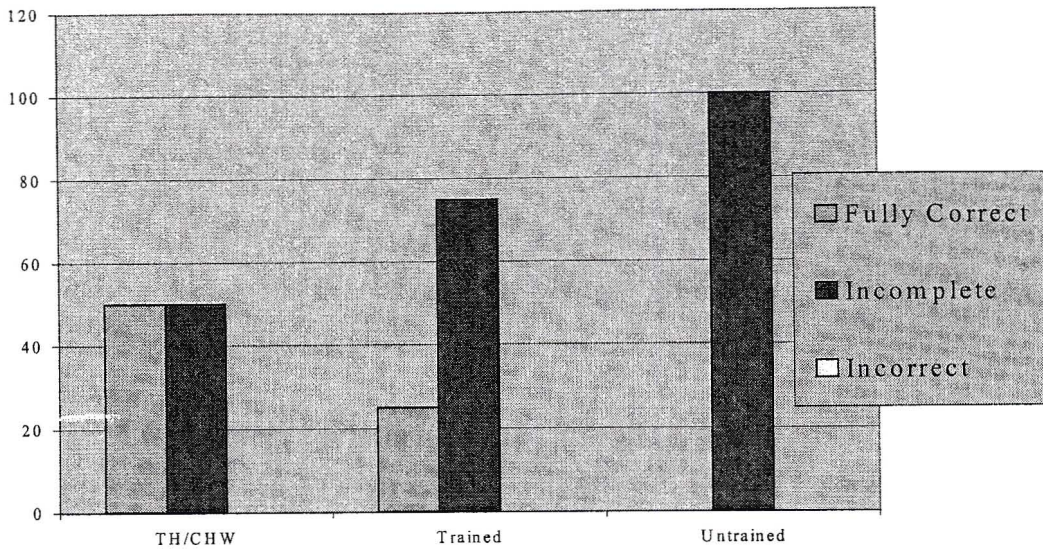
The group of Trained traditional healers had the highest average of correctly identified modes of transmission. There was little difference between the correct answer averages of the TH/CHW and the Untrained groups. This may be due to the fact that the trained healers received the most recent and specific instruction in HIV/AIDS. All of the groups correctly identified the major modes of transmission of sex, needles, blood, and infected mother-to-child, which is not surprising given that these are the major foci of HIV/AIDS trainings and public awareness/education campaigns. Interestingly, the Untrained group had the most consensus in their answers (common correct/incorrect answers). Additionally, all of the Untrained healers identified breastfeeding and sharing a toilet correctly, whereas all of the healers in the two other groups did not.

It is clear from these findings that all of healers are confused about the nature of blood as a mode of transmission and do not fully understand intravenous infection. The incorrect answers given by many of the members of the TH/CHW and Trained groups were often accompanied by explanations/equivocations, such as: kissing was a mode of transmission, “if it was heavy/ French kissing”; touching was a means of infection because “one needs to wear gloves”; breastfeeding was only a means of transmission, “if the baby had sores in its mouth when sucking milk from the mother”; or a blood transfusion was not a mode of transmission, because “the blood in hospitals is tested.” These incorrect answers may reflect these healers’ education and training as they are constantly reminded to wear gloves in their practice or to be wary of sores. Apparently, in some cases their education had confused rather than clarified certain modes of transmission. Likewise, the emphasis on proper sanitation and construction of VIP toilets may possibly explain why out of all of the healers only two TH/CHWs listed toilets as a possible mode of infection.

4.1.4. Identification of Means of Prevention

All of the traditional healers were posed the open question, “What can a person do to protect himself or herself from getting HIV/AIDS?” I considered the reference of three or more correct means of protection as a ‘fully correct’ answer. ‘Incomplete’ answers were those that made mention of one or two means of prevention. An answer was considered ‘incorrect’ if it referred to a flawed prevention strategy regardless of the number of correct means of prevention also listed. The findings for each group are reflected in the chart and tables below.

Chart 4.3. Comparison of 'Means of Prevention' Knowledge Results



Two of the TH/CHWs gave 'fully correct' responses and two gave 'incomplete' responses for means of HIV/AIDS prevention. One TH/CHW answered that to protect themselves from HIV/AIDS,

People should abstain, and then once they get married and have sex for the first time, get their blood checked to make sure everything is OK, have kids, and then once they are done having kids, use a condom.

Table 4.4. 'Means of Prevention' Responses

Means of Prevention	TH/CHWs (4)	Trained (4)	Untrained (3)
Condoms	2	3	3
Abstinence	2	2	2
One or limited number of partner	2	1	-
Get blood test for HIV	1	2	-
Wearing gloves during Treatments	2	-	-
Not using the same razor during treatments	1	-	-
Speak to Traditional Healers that know about HIV	1	-	-
AVERAGE PER HEALER	2.75	2	1.7

Only one Trained healer gave a fully correct answer, which seemed right out of a public awareness advertisement, "Condoms, abstaining, have blood checked, and be faithful to one another." Two of the Trained healers only listed one means of

prevention (condoms). Additionally, two of the Trained healers made statements, such as, “There isn’t anything anyone can do; unless they have sexual relations, they condomize,” that alluded to a sense of powerlessness concerning the epidemic. The untrained healers all gave incomplete responses, which consisted of few means of prevention (primarily condoms). Likewise, two of the untrained healers highlighted the problems with preventative measures as they listed them, through such statements as, “There are ways: condoms, abstain – but the disease could get in anyway.”

The TH/CHWs gave the most ‘fully correct’ answers and listed the most means of prevention (2.75/healer), followed by the Trained healers (2/healer) and then the Untrained (1.7/healer). Of all the groups, the TH/CHWs were the only ones to make mention of means of preventing transmission in their traditional healing practices, such as wearing gloves and using one razor per person. The correct answers mentioned by the other two groups primarily dealt with sexual intercourse (abstinence and condoms). Although all of the TH/CHW and Trained traditional healers affirmed that HIV can be prevented, the responses of the Untrained group, in particular, expressed a sense of powerlessness, as two of the untrained healers highlighted the problems with preventive measures and one refused to state that HIV/AIDS could absolutely be prevented.

4.1.5. Identification of HIV/AIDS Symptoms

Healers were asked the open question, ‘What are some of the signs and symptoms of a person having HIV/ AIDS?’ For an answer to be considered ‘fully correct’, the healer had to mention three or more symptoms that were correct and none that were incorrect. For example, a fully correct answer given by one of the healers was:

They lose weight. They stop eating. They get chest pains. They get stomach cramps. They get diarrhea. They get headaches and they get very very thin. Then the next thing you hear, they’ve got TB. Meanwhile, there is something else going on.

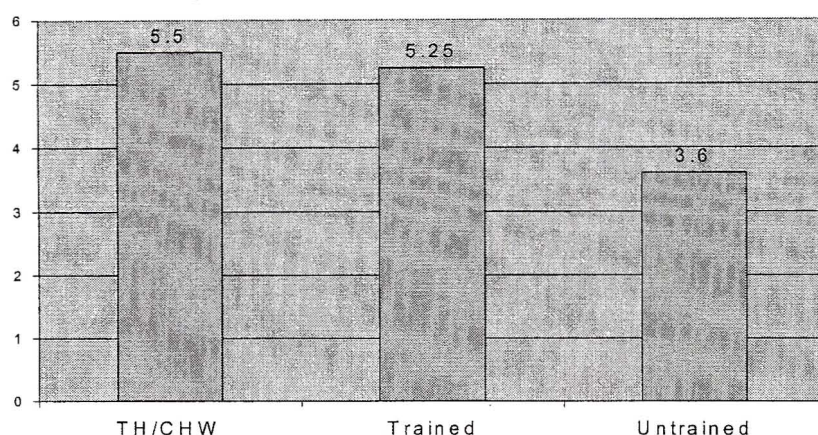
An answer was considered ‘incomplete’ if it contained less than three symptoms. An ‘incorrect’ answer had one or more incorrect symptoms, such as ‘gains weight’. The

group results and the average number of symptoms reported are presented in the table and chart below.

Table 4.5. Comparison of 'HIV/AIDS Symptom' Results

	Fully Correct	Incorrect
TH/CHW (4)	100%	-
Trained (4)	100%	-
Untrained (3)	100%	-

Chart 4.4. Average Number of HIV/AIDS Symptoms Given per Group



All the healers in each group were able to give correct accounts of HIV/AIDS symptoms. The untrained healers reported the fewest number of symptoms averaging 3.6 symptoms per healer as compared to 5.5 (TH/CHW) and 5.25 (Trained). Only the members of the TH/CHW group made mention of the length of time it takes for many of these symptoms to become apparent and the need for a blood test to ascertain HIV status. As one of them stated, "It's a guessing game."

When asked specifically, "Does someone know they have HIV immediately after they are infected?" All of the traditional healers answered "No" correctly. In response to the follow-up question, "How can a person be sure that they DO NOT have HIV/AIDS?" the TH/CHWs gave the most accurate answer of a blood test. The healers who had received HIV/AIDS training typically responded that people needed to be "checked"; only one of the trained healers mentioned blood. Of the three untrained healers, one gave the incorrect answer, "condomize;" one gave the

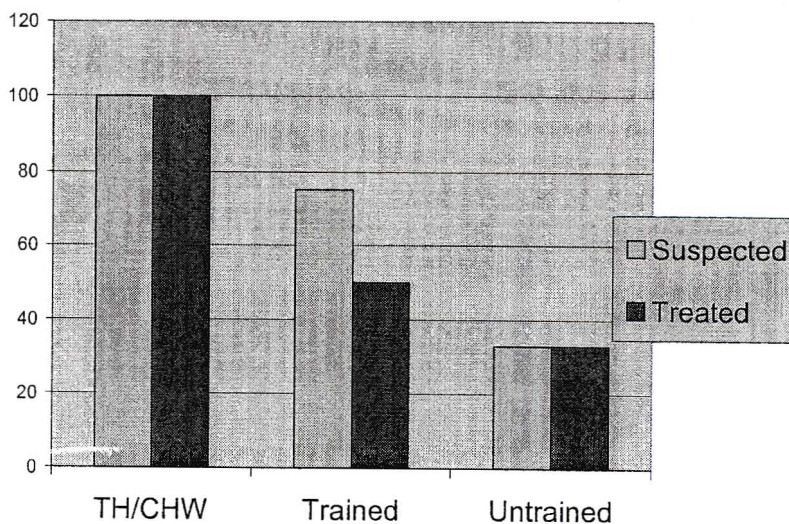
incomplete answer, “go to the doctor;” and one gave the fully correct answer, “a blood test.” When asked, “If a person is infected with HIV, is it possible that they could still look, feel, and act like a normal person?” one of the TH/CHWs and one of the trained healers answered “No” and related that “It’s not possible, because certain illnesses come up that weren’t there before” and “The disease suddenly takes them and they end up dead.”

4.2. DIFFERENCES IN EXPERIENCE TREATING HIV/AIDS

Unlike the common perception, all of traditional healers stated that at present there is no cure for HIV/AIDS. However, one trained healer had originally responded that HIV/AIDS could be cured if, “you went to the doctor early enough,” but upon clarification said that the disease would not go away completely. I then asked the healers whether they had ever suspected that one of their clients had HIV or AIDS and if they had ever treated a patient with HIV/AIDS. The group results to these questions are listed in the table below.

I subsequently asked the healers in each group, who had positively answered the previous questions, to describe their general treatment or subsequent actions taken

Chart 4.5. Comparison of Percentage of healers Suspecting & Treating HIV/AIDS Patients



with suspected or actual HIV/AIDS clients. All of the TH/CHWs responded that upon suspecting an individual of being HIV positive, they would encourage them to go to the clinic to get a blood test; one mentioned sending a letter with the patient

and another reported encouraging an HIV/AIDS patient whose health was not improving to go to the hospital and visited him during his month-long hospital stay. Three of the TH/CHWs specified that they would administer traditional medicine to HIV/AIDS patients, particularly treating external sores with herbs. Two of the TH/CHWs specified that they tried to nurse patients back to health by feeding them traditional and boiled foods. Of all of the TH/CHWs, Ma Bhengu had the most experience treating HIV/AIDS patients. She described at length an AIDS patient, who was a young woman:

As I am talking, I am talking about the lady that came to me and she told me that at the clinic they advised that she needs to distribute her possessions, because she will no longer be alive. And this thing hurt her and I told her that it is totally wrong, because now that she is ill, she is not eating because of those words. It is totally wrong. I did advise her don't concentrate on that and I asked her to eat, but not fatty foods with coconut oil. I just used to boil food for her and she became fat. And the mobile [clinic], they gave her the mealie meal PVA. I used to cook it and give it to her and her tablets for TB. I gave her traditional medicines, but I used to stop the medicines, not to mix traditional medicine and Western medicine. Her sisters were very happy and they asked us to take off her clothes so they could see her body [that she was gaining weight]. And then she went back to her home and lived three years. When she went back to her home, she got friends and proceeded straight with the alcohol and passed away.

All of the TH/CHWs mentioned that one or more of the people that they had either suspected of having or treated for HIV/AIDS had passed away.

Of the Trained healers, only one responded that she had never suspected anyone of being or treated anyone who was HIV positive. The remaining three reported referring suspected HIV clients to the clinic for a blood test; one mentioned writing and sending a letter with the patient. Of the healers that reported suspecting clients of being HIV positive, only one reported never treating a person with HIV/AIDS, because, she explained:

For me, it has been a long time since I have been connected with the practice, with the ancestral connection, so my experience with people who are definitely HIV positive, when I haven't taken a moment of doubting, have been very few, if not at all.

The remaining two acknowledged that they had treated HIV/AIDS patients, specifically mentioning the administration of *imbeza* (medicine). However, one of those two treatments had been performed as part of a group effort by several of the

Amakhosi Association's healers. I asked how they had tried to heal the patient together; she replied:

Imbeza and the power of all of us preparing at once. Everyone brings their own certain ingredient to put into it and it's more powerful than having one individual prepare something. That's what we gave him.

Both of the trained healers who had treated HIV/AIDS patients also mentioned knowing individuals who had died as a result of the disease.

Of the three untrained healers interviewed, only one had ever suspected a client of being HIV positive. This healer reported that she told the individual that they must go and have their blood checked. When I asked this healer if she had ever known and treated anyone that was HIV positive, she replied, "She wasn't next to me. She just had that disease and she went home... How can I treat them? They are not like other patients. I can't do anything." I tried to clarify her answer by asking if, therefore, she thought it was best for HIV positive clients to return to their homes. Her reply was, "No. I can treat it with my hands. I won't say she must go home. She can stay with me. I am not scared of AIDS." One of the untrained healers had assisted in the care of an HIV/AIDS patient as Ma Bhengu's *ithwasa*. The untrained healer reported that she had helped care for this bedridden individual by feeding them with a bottle and giving them 'herbs and stuff.' Therefore, none of the untrained healers has ever solely treated an HIV/AIDS patient.

Summary

The TH/CHWs had the greatest amount of experience with patients with HIV/AIDS. Primarily, the TH/CHW and trained groups reported identifying suspected HIV patients and referring them to the clinic for a blood test. Facilitating this process are the referral forms that were provided to both groups by the Valley Trust. The untrained group reported the lowest incidence of suspecting patients of being HIV positive, despite being able to provide 'fully correct' albeit comparatively shorter answers to the HIV/AIDS symptoms question (See Table 4.5). The TH/CHW group appeared to have the most confidence and experience in treating patients with HIV/AIDS. These healers mentioned treating the symptoms of their patients through a variety of means, such as supporting biomedical efforts, diet, and traditional medicinal herbs. The experiences of the healers in the other two groups

were primarily restricted to group efforts or apprentice duties with the aforementioned TH/CHWs.

4.3. PREVENTATIVE MEASURES

4.3.1. Practice of Educating Clients and Community

I asked the healers if they provided condoms and/or discussed preventative measures with their clients. I then asked if they discussed these same practices with people in the community and, if so, with what groups and through what means. The results for each group are listed in the table below.

Table 4.6. Percentage of Healers Reporting Engagement in Preventive Education/Activities

	Talking to CLIENTS	Distributing CONDOMS	Talking to the COMMUNITY
TH/CHW (4)	100%	100%	100%
Trained (4)	100%	100%	100%
Untrained (3)	67%*	67%*	100%

**does not have a lot of clients, as of yet*

Regardless of group, all of the healers reported that they discussed HIV prevention with members of the community. On World AIDS Awareness Day, a majority of the healers interviewed took part in a day-long community meeting and HIV/AIDS teach-in in Ncngolosi. The healers participated in the day's activities by performing a traditional dance and participating in a role-play conducted by Yvonne Sliep, a psychologist with expertise in HIV/AIDS that lives in the area. Likewise, all but one of the healers reported that they discussed prevention with and distributed condoms to clients. The exception of the one untrained healer was due to a lack of clients, rather than a lack of desire. The circumstances of community education and prevention activities did differ somewhat for each group in terms of their formality and preparation.

One of the untrained healers reported that she spoke with the community about HIV/AIDS at church; the other untrained healers primarily reported speaking to young people, particularly their own children's friends. They stated that they did not

gather people in groups to discuss HIV/AIDS with them, but just spoke to them around the area, i.e. “I tell my sons and their friends by the grounds, the playing fields, the shops. I am quite familiar with young people and tell them to use a condom, especially those with many women.”

In terms of prevention activities, all of the trained healers reported giving condoms to their clients, but two of them specifically mentioned using the demonstration models, with which they were supplied to show proper condom use. One healer related in her practice that she gave out condoms:

to young boys, girls, and mothers, especially because the mothers want to teach their husbands. The first time I would probably come, just to show how it is used and by the second time, you know it has been agreed upon that they are going to use it.

A few of the Trained healers mentioned difficulties with clients not taking their warnings and counsel seriously. One healer confided, “a lot of [my clients] tell me secretly that they don’t see what the point of a condom is, because they like *yama enyameni* (flesh on flesh).” In terms of community education, one trained healer’s response illustrated the mandate of their training, “Yes, of course, [I talk to the rest of the community about HIV/AIDS] because we were trained to tell anybody who wants to hear, especially the older people, because they think that they’ve gone past that stage [of possibly being infected].” Even so, similarly to the untrained healers, the trained healers most frequently cited speaking to youth when describing their community education endeavors. One trained healer narrated her approach:

I say to the youth, “My children.” They say, “Yes, Ma.” I say, “Do you see the times we are living in? What do you say when people talk of HIV/AIDS?” They say, “Yes, we hear about it, but we’re not convinced.” I say, “How do you feel, when you see one of your friends or another young person die of AIDS?” And then I ask them, “What do you feel? Don’t you think you should take more caution? Because the way that the world is right now, people are talking about it on the radio, here, overseas, everywhere. Surely, it’s an issue to take notice of. If you’re not taking precautions, you’re selling your lives away.” And they say, “Yeah, we hear about it”, but they don’t necessarily do something about it. And she says to them, “Well that means that you don’t take yourself seriously enough.”

Not surprisingly, the community education/prevention activities of the TH/CHWs were the most formal of the three groups as they have a venue that the other groups

lack – household visits. One TH/CHW reported, “When I go into a house, for whatever reason, whether as a *nompilo* or healer, I will say to people, ‘Well, do you know about AIDS?’” They also reported speaking to people at meetings and gatherings. One reported that every Friday, she visits the sports grounds with condoms and all of her equipment and speaks to the youth about HIV/AIDS. Similarly to the trained healers, several of the TH/CHWs mentioned the need to demonstrate or explain how to use a condom. One commented, “Condoms are only useful, if you know how to use them properly.”

4.3.2. Comfort Levels with Varying Age and Gender Groups

I wanted to get a sense of the healers’ ease and ability with speaking to different gender and age groups in the community, so I posed the question, ‘How comfortable do you feel giving out condoms and discussing sexual behavior with each of the following groups?’ [boys; girls; young men; young women; married men; married women; elderly men; and elderly women.] I asked the healers to rate their comfort level on a scale from one to five (with one being ‘very comfortable’ and five being ‘very uncomfortable’). The scaled response question proved very difficult to translate and for the healers to understand and appropriately answer. Some took the question to refer to the ease of talking to different groups, because of how comfortable the healer felt speaking to those types of individuals. Others took it to mean, the effectiveness of their discussion with each group in terms of individual compliance with prescribed behaviors. The few numerical responses that I did receive from the healers were not reflective of clear intent. Therefore, I abandoned the scale and simply recorded the healers’ comments regarding their perceptions of each age/gender group. The responses I received were very diverse and variable, so much so that I did not feel I could adequately compare them between groups. I have summarized the overall commentary on the healers’ discussions about HIV/AIDS prevention with distinct age and gender groups in the sections below.

4.3.2.1. *BOYS AND GIRLS*

The general consensus among the healers is that children (boys and girls) readily listen and therefore, are easy to talk to about HIV/AIDS prevention. All of the healers felt comfortable speaking to boys and girls, but several noted that girls are

the more difficult of the two groups. In these instances, girls were described as not wanting to follow or listen to healer's advice. Girls were portrayed as wanting sex – in part to secure a man – or as shy, scared, and reticent to take condoms.

Table 4.7. Healers Comfort Level Responses for Boys/Girls

	TH/CHW	Trained	Untrained
Boys	Very easy	It's easy, because they are often unaware that they have been learning about all these preventive measures.	The boys are very cheeky
	I'm comfortable talking to boys.	I have boys so it's easy. It tell my boys to gather them together and then I talk to them all at once.	It's easier with the boys if you can actually sit them down and show them [condom use].
Girls	Very easy.	It's easy because now especially with girls, we can't hide from them how to get pregnant, we have to talk to them and reveal things so that they know about it.	It's easier with the girls [than the boys], but they complain it's the boys that don't want to.

	With the girls, I can explain to them, but they are reluctant to use the condoms, because you 'can't eat a sweet with the wrapper on it.' They want to get the men, so they are in a hurry for sex.	For the young girls, they still have the Zulu mentality [i.e. being chased]. It's just a matter of passing on the information and making sure they are not doing it, especially for those who are active or a little more stubborn.	Some insist on flesh on flesh – these are difficult. They are generally O.K.
		It's more difficult than with boys, because young girls are afraid.	

4.3.2.2. YOUNG MEN AND WOMEN

Regarding young men, the overall feeling I got from the healers was that though they felt comfortable speaking to young men, they felt that doing so was ineffective, because the young men do not listen to their advice. Young women seem to be one of the easiest groups for the healers to talk to, both in terms of the healer's comfortableness in approaching them and in their willingness to hear and accept the

teaching. Several of the healers noted that the young women were very interested in HIV prevention and a few specifically mentioned their interest in female condoms – so as not to rely on anyone else for protection. One healer did advocate that young women be protected through traditional virginity tests as she did with her own daughters, but was not opposed to informing them about safer sex.

Table 4.8. Healers Comfort Level Responses for Young Men/Women

	TH/CHW	Trained	Untrained
Young Men	It's in between, but there's difficulty. You can talk to them, but they tell you that it's not really the way you say things are.	It's easy because they know this is the work that I'm doing so they listen	They are even worse. They tell you, you can't get into a shower with a raincoat on.
	It's easy to talk to them, but it's ineffective because they don't follow through	It's easy to talk to them.	I can talk to them, but they don't listen. They are afraid their girlfriends will ask why they are suddenly using them.
Young Women	It's easy	It's easy to talk to them.	They realize that there is a need to use a condom. They want to protect themselves – and want a female condom
	It's not the same as with the younger people who readily listen. The older ones are just a little more difficult that why I try different tactics. I don't mind because I am old and can pursue what ever I want to tell them.	They are still very afraid – that's why I tell the boys.	I don't talk to them, but I imagine it's easy. They need to be taken care of in the old way [virginity tests]. But if they're not I imagine it would be fine to speak with them.

4.3.2.3. *MARRIED MEN AND WOMEN*

Across the board, the majority of the healers found it difficult to speak to married men about HIV/AIDS prevention. Firstly, the healers felt uncomfortable approaching married men due to their status. Secondly, they characterized married

men as being closed to receiving such messages. Some never spoke to married men about this subject. Some reported speaking to married men, but that doing so was ineffective, because the married men wouldn't listen. One healer confided that even her own husband did not want to use condoms. Some noted other problems in conducting outreach to married men. One healer said that when approaching them to speak about sexual practices and HIV/AIDS, "[the men] think you want them." However, a few of healers mentioned that married men were beginning to improve and become more aware and receptive to HIV prevention messages.

Table 4.9. Healers Comfort Level Responses for Married Men/Women

	TH/CHW	Trained	Untrained
Married Men	It's a matter of talking to them and making them aware as opposed to trying to teach them.	It is easy, but you find that there are some who are hard headed and stubborn, who tell me, "Listen, I have been on this planet for ages. The way I sleep with women is fine."	At first they were hard headed and stubborn, but now they are beginning to see there is a need.
	Very difficult - they'll say no because they don't wear plastic.	With the men, it's easy if you are just going to talk to them, but to gather them to talk about it - that's not easy at all.	Some are easy. Some are difficult. When you talk to them [about sex] they think you want them.
		I never tell men, because they don't discuss it and they don't want to discuss it.	
		They are in respectable positions [by virtue of marital status]. It's a thing you discuss behind closed doors not in public. I could never tell them.	
Married Women	They are aware and they want to protect themselves, but their men don't want to because they've gotten used to doing it without a condom. So the attitude of married	Very easy with women, because they already gather together. And once they talk, they realize that they are the ones at greater risk so they can all decide, 'well since we're at greater risk, it is our duty to inform our	They want to use condoms desperately.

	women is 'we've been doing this for so long, we might as well die.	husbands.	
	The mothers generally take the condoms, but their whole attitude is that this disease came with white people.	The women hear and they do want to use condoms, but then they'll come back and say to me, 'I have a big problem because I tried to talk to my husband, but he doesn't want to use it.'	Don't want to. Their partners/husbands will say 'who taught you how to use condoms.'
		I talk to them a lot but they say their husbands won't hear it - so they don't even take them [condoms]	

As was the case with the young women, the healers feel comfortable speaking to and addressing married women. Women were seen as easy to approach about HIV/AIDS because frequent gatherings of women give healers an easy avenue for communication. The healers considered outreach to women difficult only in terms of the effectiveness of the message, because married women often expressed powerlessness in dictating condom-use with their husbands. The women themselves, the healers confided, are interested in using condoms, but their husbands are not. One explanation for this phenomenon may have been shared with me by a healer who had mistaken my question about condom-use in her practice as inquiring about her *personal* condom-use. Her answer was, "Yes, I use it. I have a husband, but I don't believe in him. It's a man." In a personal conversation with Bhengu, I asked what advice she would give a woman, who wanted to use condoms, but her husband refused. Ma answered that she would tell the woman, "just to beg her husband." Unsurprisingly, Ma Bhengu reported in her HIV knowledge questionnaire/interview that many married women have taken the attitude that, 'We've been doing this [i.e. having sex without condoms] for a long time; we might as well die.'

4.3.2.4. ELDERLY MEN AND WOMEN

Elderly men were also seen by the majority of the healers as being difficult to approach and speak with about HIV/AIDS. As a result some healers did not speak to elderly men at all; one healer reported being afraid of them. Others noted that it was ineffective to speak to elderly men because they did not believe in HIV/AIDS

or did not think it pertained to them. However, a few noted that the older men who liked to have affairs with younger women (“their ‘roll-ons’ – little things on the side”) wanted to learn about HIV/AIDS prevention. The healers saw speaking to the elderly women as being easy, but not extremely relevant as the older women reported that they were no longer sexually active.

Table 4.10: Healers Comfort Level Responses for Elderly Men/Women

	TH/CHW	Trained	Untrained
Elderly Men	It’s difficult, but not too much as they’re familiar with us and our role as <i>nompilos</i> – but it’s not the same as with the elderly women	It’s not easy with the elderly men, that’s why you talk to the women, because the men say ‘Hey, what is happening to our manhood.’	They say it’s a thing of the past [a traditional illness] and ask why it is so difficult that people aren’t being healed.
	For the men, that’s something that doesn’t even exist	It depends because there are those who do like to have affairs with younger women, but often they are a little reluctant	Those that want to have sex with young women use them
		I am afraid of them	
Elderly Women	We can talk easy, but generally with the older people, they laugh because they say that are not sexually active anymore – but we explain there are other ways of getting it.	I know they are not active	It’s difficult to talk to them, because they are too old for the disease [not sexually active].
		It’s easy to talk to them.	They say they don’t even have sex anymore.

Summary of Age and Gender Group Data

Regardless of their level of training, the healers’ traditional/ cultural roles and hierarchy contributed to their ability to engage in HIV education/prevention activities with various age and gender groups. Internally, as explained by one Valley Trust staff person, “Gender goes with cultural belief. When it comes to gender equality, the way the *sangoma* was brought up was that when she marries, she must

honor her husband, never argue with him.” Therefore as women, all of the healers reported having difficulty speaking with men about safer sex practices and HIV/AIDS as a result of their internalized gender roles. Externally, gender roles impact the way in which the healers’ prevention and education messages are received. The compliment which a hospital administrator was quoted in a New York Times Article as giving to a South African *sangoma*, “Mama Mtshali is so influential that even men listen to her” (McNeil, 2000), highlights the influence gender roles have on the *sangoma*’s ability to engage in effective community education with men. On the other hand, education efforts with young and married women, with whom the healers are comfortable, appear to be undermined by the cultural/ traditional roles of the target group rather than their own. Social and cultural circumstances impact any HIV prevention effort, but pose a unique challenge for the indigenous healer whose authority is derived from his/her traditional role. In the case of these women, the traditional authority of their roles as *izangoma* appears to be negatively impacted by the traditionally inferior position of women in indigenous Zulu culture.

4.4. CONCLUSION

The findings show that collaboration between traditional and formal health services in the form of the Valley Trust’s training results in ‘better’ HIV/AIDS work by participating traditional healers. ‘Better’ HIV/AIDS practices were indicated by healers’ correct identification of modes of transmission, means of prevention, and HIV/AIDS symptoms; engagement in prevention activities in the community; and treatment of HIV/AIDS patients.

My research indicates two key findings. First, healers with training in HIV/AIDS (TH/CHWs or Trained) performed better on the HIV/AIDS knowledge indices than healers with no training. However, the training did not significantly impact participating healers’ ability to define HIV and AIDS or completely dispel misunderstanding around modes of transmission.

Second, healers trained as Community Health Workers (TH/CHWs) were best able to transform their knowledge into effective practice, outperforming the other two

groups in their prevention and treatment activities regardless of their ability to answer corresponding knowledge indices. TH/CHWs reported recognizing and treating more cases of suspected HIV/AIDS among their clients. Their methods of HIV/AIDS treatment were more diverse and extensive than either of the other groups. Furthermore, TH/CHWs engaged in the most extensive and effectual prevention education in the community, and likewise were best able to identify means of HIV/AIDS prevention.

It is possible that the group results may be due to healers' varying experience or status as opposed to their level of training. During my research, I discovered that the number of years since a *sangoma's* calling, apprenticeship, and commencement of seeing clients did not necessarily demonstrate her experience in the practice— as some healers were less active than others. Both the Trained and Untrained healers indicated that their HIV/AIDS treatment activities often occurred in partnership with other healers, which may have been a result of their lack of experience. This discrepancy complicated the findings and would suggest the need for research with a greater understanding of each healer's reputation, strength activeness, and experience with the ancestral practice.

Chapter 5. EFFECTIVENESS OF PROGRAM COLLABORATION

Introduction

Indigenous healers are integral aspect of health care in their communities and, based upon the previous chapter's findings, have the potential to play a significant role in HIV/AIDS treatment and prevention. Evidence suggests a direct correlation between healers' effectual HIV/AIDS knowledge, prevention, and treatment practices and the nature of their HIV/AIDS training, i.e. healers that received training in community health work engaged in more extensive and effectual prevention and treatment practices than their counterparts who received either no formal training, or strictly HIV/AIDS training. In lieu of these findings, my evaluation of the ongoing collaboration between the three partners of clinic personnel, Valley Trust staff and participating healers stems from its ability to strengthen this trend.

This chapter present findings that assess how the collaboration as structured by the Valley Trust's Community Health project affects the relationship between indigenous and formal biomedical system and whether the collaboration 'works' in terms of supporting those aspects of TH/CHWs training and organization that made their HIV/AIDS activities the most effectual.

The following sections examine this effect through measurement of collaborative participants' (Indigenous healers, TH/CHWs, clinic doctors, clinic nurses, and Valley Trust staff) perceptions of the overall project, perceptions of one another, and practice of patient referrals. The experiences of TH/CHWs, given their unique role as participants of both health systems, were given special attention.

5.1. COLLABORATION STRUCTURE

According to the Community Health Coordinator of the Valley Trust, Community Health Workers (CHWs) visit the clinics on a regular basis and attend monthly meetings with clinic staff where they report on the health issues encountered in the community. Subsequently, this information is then recorded and reported to the Department of Health. Nurses participate in the CHW program, by acting as

supervisors and providing CHWs with training. The mobile clinic nurses, however, reported that CHWs do not come into clinics, but meet nurses in the field at the mobile stations. Additionally, the clinic doctor said that the referral system to CHWs was somewhat unclear as they were not present in the clinic. These and other contradictory accounts led me to conclude that inconsistencies exist within the current CHW program due to a number of challenges faced by all three partners that I will address later in Section 5.5.

If the structure of the relationship between the clinics and CHWs was somewhat irregular, then the arrangement between traditional healers and the clinic was even more so. According to an article written by Pitt (1997), a former doctor at the Halley Stott Clinic, “CHWs and traditional healers are a common sight at all health facilities where reciprocal referral of patients occur. Bridges have been built at the health posts between the community and health services, and between western and traditional medicine” (no page). However, the Acting Matron expressed:

I don't think that [the relationship between the healers and the clinic] is that good, but we are trying, because there aren't any set programs – like with the CHWs – where we are working together with traditional healers. Although we meet sometimes, but there isn't anything that you can point a finger at and say, 'this is where we are working together.' Really, I think that we are lacking in that.

The doctor confirmed that there had been some efforts to open up lines of communication with indigenous healers in the area. She recounted, “We were invited to attend a joint meeting on the use of medicinal plants, but, once again [like with CHWs], there aren't a lot of formal links.” Though the doctor had attended a few such meetings, she was not personally familiar with any of the healers who are CHWs. Pitt had occasionally visited and meet with Bhengu and the *izangoma* at Bhekisizwe Health Post. At the time of this investigation, the current doctor had not initiated a similar practice.

The mobile clinic nurses classified the clinic's relationship with indigenous healers as functioning primarily through those healers that are Community Health Workers. They testified:

Yes we do work with [traditional healers] though not as much as the CHWs, but if they have problems they refer patients to us. They

teach them because other traditional healers are community health workers; they help us very much.

The instruction program for traditional healers exists through the support of the Valley Trust and outreach by those healers who have been trained as CHWs. Of the TH/CHWs, Bhengu had the most significant contact with the formal health services. As Ma Bhengu explained, “If there is anything that needs to be known by the *izangoma* they just inform me to let the *izangoma* know.” One of the Valley Trust’s Community Health Facilitators confirmed, “I work hand in hand with Ma Bhengu to organize traditional healers to form groups so that they can work together with one another, and so that we can access them as health care providers.” According to this individual, every health post in the Valley has a group of traditional healers working it around like the model of Bhekisizwe. These groups were reported to be beginning to build beehive huts and gardens like those created by Ma Bhengu and her association at Bhekisizwe health post. However, the mobile clinic nurses testified, once again in contrast, that they did not encounter traditional healers at health posts when they were out in the field.

5.2. EXPERIENCES OF TRADITIONAL HEALERS WHO ARE CHWs

5.2.1. Motivation

Though the individual circumstances by which each was introduced to the Valley Trust’s Community Health Worker Training Program varied, the *Izangoma* reported similar experiences in their roles as CHWs. Already engaged in the work of healing, it appears that the women’s incorporation into the primary health care initiative transpired with relative ease. This ease of transition was in large part due to the openness and attitude of the Valley Trust. One healer recounted:

Dr. Friedman came here in the community, and he asked the community members to have a meeting... He asked us if we were interested to work as community health workers and I just raised my hand and asked, ‘Am I accepted?’ And they said, ‘Why are you asking such a question?’ I said, ‘because, I am a *sangoma*.’ In my mind there was a big difference between *izangoma* and other people. And they said, ‘You as you are working with many people. We need you so much.’

Another healer related that she was specifically encouraged by a clinic nurse to become a CHW. And so, for these women, the Community Health Worker program

was the first opportunity they had to augment their skills, knowledge, and abilities as healers with information outside of the indigenous health system.

All of the healers expressed that their motivation to become CHWs was to gain knowledge regarding health, nutrition, and hygiene, as they all expressed being extremely concerned with the health of their community; “General health is something that we have learned a lot, which has changed things dramatically for us and for a lot of people in the community – that is what we love.” They reported that their training has augmented their knowledge and skills and improved their practices. As one explained, “For black people, when someone has TB we think that they’ve been bewitched. People don’t realize that it could be a result of an unhygienic lifestyle and breathing the germs in the air...Now we are noticing things that before we would have mistaken [for traditional illness].” As CHW positions were initially unpaid, added value to their client-based practices insufficiently explains the healers’ motivation for participation. One healer clarified their motivation: “We worked as Community Health Workers for six years without earning even a cent. But because I was gaining help that was useful for me and encouraging people that were next to me, I didn’t mind that I was not earning money.” These findings contrast with the sentiment of the KwaZulu Natal’s Health Ministry’s Primary Health Care Head, Kay Naidoo:

In my point of view, we don’t have anything to offer them as traditional healers – except to look at how to incorporate them and the health system. This is a very hands-on practical training. They are mentored for a long time and [the tradition] goes back.

The healers themselves considered the CHW training to be extremely useful for them personally and for their community.

As a result of their training in community health, the *izangoma* reported engaging in public awareness and education activities. After learning about essential nutrients like protein, one healer recounted: “When I got back, I came as a mad person spreading this message to the people telling them that they have to feed children eggs.” Therefore, the information they had gained not only benefited the healers’ clients, but the community as a whole. In addition to the community, the women also recounted passing along to other *izangoma* the lessons they had learned. One related: “I did [the training] so I could spread the knowledge among other *izangoma*

and break down the barriers between health workers and *izangoma*.” The information-sharing endeavors undertaken by the healers with other *izangoma* varied in their formality. Ma Bhengu, who reportedly “collected *amathwusa* (apprentices) and taught them all,” provided the strongest example of systemic change within the traditional practice that may have been inspired by the community health training.

5.2.2. Reasons for Illness

To gauge whether training in Western medicine had changed their traditional conception of health and illness, I asked all of the TH/CHWs, “When people become sick, what is the underlying reason?” The first causal element of illness mentioned by the group was lack of proper food or hunger/starvation. As their initial response, I felt this answer reflected the influence of their training and the prevalence of hunger in their community.

Subsequently, the healers recognized that even people who are not hungry become ill. In those cases of illness, as one healer stated, “There are causes that require medical attention and there are causes that don’t. The lack of traditional practices can also cause illness.” It was at this point, that the healers began to elucidate aspects of the indigenous healing knowledge system, emphasizing the psychosocial explanation of disease, rather than Western medicine’s bio-mechanical. One healer explained, “It’s not just a superficial wound. It’s not just physical. It’s more than that.” The healers explained that illness was often a sign of imbalance within a person’s life, particularly in social relations. And thus in their practice, one healer reported, “Instead of just healing the physical wound, when we heal, we heal the home as well.” Indeed, the TH/CHWs described how and when illness could be a blessing, as for example when a sick child provides a *sangoma* with the opportunity to investigate the child’s home environment and try to improve familial tensions.

The healers also conceived of illness as resulting from a lack of connection with the greater powers through traditional practices. One healer expressed, “Disease; social inequality; all these things are happening because we are not holding to our traditional values... We have to return to what we know, because it has been neglected.” Although, the TH/CHWs’ conceptions of illness diverged from the ideology of their Western-based community health training, they did not preclude

the healers' acceptance and admiration for western medicine. "There are illnesses that western medicine can heal," a healer explained, "They can stitch people for example, but at the same time we also have our own medicine and have our own ways of healing that go beyond just stitching or whatever. It's a complementary relationship."

5.2.3. Merging Roles

In terms of how they maintain their separate roles of *sangoma* and Community Health Worker, the TH/CHWs' responses were as contradictory as, some may consider, the two healing systems they represent. On the one hand, all of the *izangoma* maintained that they kept their work as traditional healers and Community Health Workers separate. Logistically, they perform the duties of each role on separate days, signified by donning a blue and white uniform when acting as a Community Health Worker and making home visits. One healer explained, "People know that on this day, we function as health workers and that day we are available as *izangoma* to help people." All of the healers reported that when they visited homes as CHWs, they treated patients as 'health workers'. As one healer explained, "When I was visiting homes, I just told them about what I learned at the Valley Trust because if a person wants to be helped by my traditional medicine, she just comes straight to me."

On the other hand, the training CHWs received at the Valley Trust had a tremendous impact on their traditional practices. The TH/CHWs reported giving clients biomedical information during traditional healing sessions. "When they come to me, I tell them about traditional medicine, and then at the end I can add what I learned at the Valley Trust." Not only has the healers' public health knowledge been added to their repertoire of traditional counsel, it has also altered the nature of some of those practices. Concerned with hygiene, the healers reported having shifted the way they store, prepare, and administer their herbal remedies, being sure to reduce germ contamination and avoid exposure to blood or other bodily fluids.

The healers' experiences as CHWs have also changed the way that traditional healers identify illnesses. They have been trained to recognize symptoms of TB and other common diseases. As a result of that training, when clients presented with

symptoms of diseases like TB, TH/CHWs testified to refraining from conducting complete healing rituals; instead, they reported performing something smaller for the patient's benefit and sending him/her to the clinic. Of course, one of the major shifts in the healers' traditional practices that resulted from CHW training is the increasing prevalence of clinic referrals; "What we do is we refer them to the clinic first to get healing and then go out there and give them traditional medicine." TH/CHWs reported making referrals to the clinic on a regular basis for a variety of reasons.

The changes reported by TH/CHWS were not, however, an indication of a unilateral shift away from traditional practices and ideology towards Western biomedical ideas. The healers reported that their knowledge as healers and community health workers complemented one another. "They work hand in hand. If I get [to someone's home] and I find I need to use my training as a health worker, I use it. But if the situation calls for traditional training then I use it. There is no separation." The healers reported using the strengths of both health systems to support one another. As one healer explained, "My knowledge as a Community Health Worker helps me identify the problem, but I'll heal it as a traditional healer because I know that in order to completely heal [a physical problem], it needs traditional healing methods." Their common practice is to identify physical illness that they or the clinic might treat, but then employ their psycho-social and ritualistic healing methods to address the 'underlying cause' of the illness – as to why *this particular* person became sick at *this particular* point in time.

The TH/CHWs' contradictory accounts of the discrete nature of their dual roles may be due to pressure from the biomedical community. According to the healers, "In training we were told that we couldn't go around telling people that we could sense certain things about what was wrong with them." Aware that the majority of the biomedical community frowns upon the use of traditional healing methods in their roles as CHWs, the healers may have been cautious in revealing to me the true nature and extent to which they engaged in such activity.

The 'inevitability' of such practices, was one of the primary reasons Dr. Bulayi, Director of KwaZulu Natal's Health Ministry, gave for not supporting the

incorporation of indigenous healers into the formal health system as CHWs. According to Bulayi,

CHWs and Traditional Healers are two separate things. They need two separate backgrounds. ... Where it has worked is the exception rather than the rule...It is dangerous because when it serves them they will revert to the other model. Traditional healers themselves do not agree on whether the two should be combined.

The proposed inability of an individual to isolate their knowledge and experience from one context when operated in another is not an inherently positive or negative trait. One's perspective and perception make it so. The TH/CHWs view their duality as positive; they perceive their practices, which have been informed by both western and traditional health systems, to represent the 'best of both worlds'. The alternate view, as expressed by Bulayi, is that such duality undermines the 'reliability' of the practitioner, in that one cannot be sure on what information or basis the practitioner is suggesting or taking particular actions. One could argue that those individuals that are the most successful in any society, but particularly given South Africa's cultural and historical background, are those who are adept and skilled at shifting between different contexts when appropriate and necessary, who can speak the 'Queen's English' in the boardroom and *tsotsi-taal* in the township, who understand the norms and rules of each context and, therefore, are able to adeptly use and maneuver both to achieve their intended aims. Indeed, such individuals are the most successful, but this type of fluidity and adaptability is not the norm.

5.3. PATIENT REFERRALS

5.3.1. Practice of Referring Patients to the Clinic

To empirically evaluate their working relationship with the formal health services, I questioned healers about their practice of referring clients to clinics for the purposes of a) HIV testing; b) HIV counseling; c) HIV treatment; and d) other reasons. It appears that some of the healers possibly failed to make a distinction between the above categories. Nevertheless, the number of healers in each group that reported they *did* or *would* make referrals to the clinic in the above cases are listed in the table below.

Table 5.1. Healers Comfort Level Responses for Young Men/Women

	HIV Testing	HIV/AIDS Counseling	HIV/AIDS Treatment	Other
TH/CHW (4)	100%	50%	100%*	100%*
Trained (4)	100%	75%	100%*	100%*
Untrained (3)	66%	66%	66%	100%*

**only if it is very serious and she can't handle it*

5.3.1.1. HIV TESTING

All of the TH/CHWs and Trained Healers confirmed that they sent clients suspected of being HIV positive to the clinic for testing. Two-thirds of Untrained Healers said that they would refer a patient to the clinic for HIV testing. The remaining Untrained Healer said that she would never directly tell someone to go and get tested for HIV, “because they don’t like that.” So she merely tells them to go to the clinic; when they ask for a reason for the referral, she explains that everyone has to go for ‘general health’. This practice assumes that the patient will make the often arduous trip to the clinic for the mere reason of ‘general health’ and relies entirely on the clinic staff’s ability to test, counsel, and treat this individual for HIV without indication of the need to do so from either the healer or, most likely, the patient. The Untrained healer admitted that her practice was problematic as she was uncertain if clients heeded her recommendation and visited the clinic for ‘general health purposes’ or not. Half of the Trained Healers corroborated that people do not like to know that they are being sent to the clinic due to suspected HIV/AIDS. One disclosed that she refers clients by saying to them, “Why don’t you make sure that you don’t have it?” She admitted that clients often do not return after she tells them to go the clinic.

In the black South African community, there is considerable resistance and denial around the subject of HIV/AIDS. As their practices rely upon intimate connections and trust relationships with patients, indigenous healers are particularly vulnerable to the backlash of HIV/AIDS denial and fear. Often times traditional healers fear that

they will lose their clients if they focus on AIDS counseling. The findings indicate that healers with the most training and the closest collaborative relationship with the biomedical system (TH/CHWs followed by Trained Healers) were best able to overcome disincentives to refer clients specifically for HIV testing. As corroborated by other studies (Nakyanzi et al., 1996), I would conjecture that their education received concerning the importance of testing, the individual and communal benefits of knowing HIV status, and the prospective hope of an individual 'living' with HIV were integral in making the distinction between the healer groups.

5.3.1.2. *HIV/AIDS COUNSELING*

Only half of the TH/CHWs reported that they would send clients to the clinic to be counseled for HIV. One of those reported that she would refer in such instances because the clinic in her community specifically has an HIV/AIDS support group for young men. Three-fourths of the Trained Healers reported that they would send patients to the clinic to be counseled for HIV. In contrast, the remaining Trained Healer reported that she does not refer patients to the clinic for counseling, because:

Generally when we refer someone to the clinic, it's just to get certainty whether they are positive or not. But before we even send someone, we try to sit the person down and talk to them, because sometimes when they go to the clinic they actually never come back. So if we can, because we have had the training ourselves, we try to talk to the person and see how they are doing, to give them love and to ensure that they are feeling OK. And just to let them know that there is someone here who is looking after them, because their body doesn't function the way it should, so we will nurse them and try to maintain them, because often they are bedridden.

The majority of the Untrained Healers reported that they would refer patients to the clinic for HIV counseling.

In contrast with the other areas of referrals, those healers with the most training and closest collaboration with the biomedical system were the least likely to refer patients to the clinic for the purpose of counseling. Indigenous healers receive years of training in understanding the patient's psyche and counseling them through life's difficulties. The importance of emotional, social, and spiritual support is emphasized considerably more in the indigenous than in the biomedical health system – both

because of the curative disposition of biomedicine and the time constraints placed on biomedical services as a result of the severe resource deficiencies in primary care. One might hypothesize that those healers with the closest collaboration with the biomedical system would be the most familiar with these circumstances and, therefore, recognize their advantage in providing counseling. The negative experiences with clinic staff reported by some HIV positive patients (See quote on page 71) might also explain some of the TH/CHW healers refrain from referring patients for counseling.

5.3.1.3. *HIV/AIDS & OTHER TREATMENT*

All of the TH/CHWs reported that they would send clients to the clinic to be treated for HIV; however, two of their responses may have confused treatment and testing. The remaining TH/CHWs indicated making referrals only in serious cases of illness like TB. As one healer explained:

I would send them to the clinic if it was something very serious. Otherwise, I am also a health worker myself. So between being a health worker and being a traditional healer, I don't really need to, but if there is something I know I can't treat, I send them.

Additionally, all of the TH/CHWs positively responded that they refer clients to the clinic for a multitude of other reasons. One reported that she liked to tell people that the clinic is not only for serious illness, but also for general check-ups. Another reported that she likes to send people to the clinic first and, once the general symptoms are gone, have them return to her for traditional treatment.

All of the Trained Healers said that they would send someone to the clinic to be treated for HIV/AIDS if the symptoms were serious enough. One Trained Healer made mention of the referral forms given to them by the Valley Trust. Like the TH/CHWs, the Trained Healers primarily said that they readily refer patients to the clinic for a multitude of other reasons. As one Trained Healer related, "it's almost a given now that if I have a patient and I can't help them, they'll get sent to the clinic and then they can come back and they can continue their healing." Another healer reported that she sometimes gives money out of her own pocket to the young people who can't afford to go to clinic.

Two of the untrained healers said that they would refer a patient to the clinic for HIV treatment. All of the untrained healers said that they would send someone to the clinic if they found that he/she were beyond their capacity to heal.

5.3.1.4. *CLINIC PERSPECTIVE*

To corroborate the healers' accounts, I asked members of the clinic staff if they had ever encountered patients referred by healers. The doctor reported that she had come across indigenous healers accompanying patients to the clinic in instances when disability would be considered as if to lend their applications credibility. All of the nurses interviewed reported that healers regularly referred patients to them. The Chief Professional Nurse and Acting Matron at the time of my visit, affirmed that healers referred patients to the clinic, but was uncertain of the source of impetus for the referrals.

I am not sure because you find that most of the people that are referred are because there are CHWs that are also traditional healers. Now I don't know if they are referring to us, because they are CHWS or because they are traditional healers.

The Sister's observation raises again the issue of the TH/CHW's dual roles and potentially conflicting ideologies, questioning whether the TH/CHW's behavior is a mere reflection of their CHW duties and/or training. However, the healers' commitment to undergo the training and fulfill the obligations of CHW and their own testimony bears witness to their belief in the utility of and their desire to collaborate with Western medicine. An investigation of non-collaborating traditional healers' practices of clinic referrals and the ideas/beliefs that inform those decisions would help elucidate this line of inquiry. Additionally, as only TH/CHWs and Trained Healers have forms for referrals, it is more difficult to visualize and measure referrals from other traditional healers.

5.3.2. Practice of Referring Patients to Indigenous Healers

I subsequently asked all of the healers if they had received any referred patients from the clinics. Their responses broken down by group are listed below.

Table 5.2. Percentage of Healers Reporting Receipt of Referrals

TH/CHW (4)	25% *
Trained (4)	0%
Untrained (3)	0%

*Not personally, but others

Only one healer reported that the clinic made referrals to traditional healers. She stated:

Yes, now they do try to refer to us, especially to those *izangoma* that are well known. Those who aren't they don't send them there. They refer when they see that this [disease] is for the elderly powers [i.e. the ancestors] to heal. For example to Ma Bhengu, we see this.

However, the rest of the healers, including Ma Bhengu, reported that they did not receive referrals from the clinic. As one of the healers put it,

I don't get patients from the clinic – often the clinic doesn't do a follow up by notifying us what they discovered. I don't understand because we refer [patients to the clinic], but then I only see the patients weeks later to find out what happened. Meanwhile, I have been wondering what happened all that time.

According to my research, referrals to healers involved in the Valley Trust's project exists only inadvertently in the case of TB; the clinic refers TB patients to Community Health Workers (CHWs) in the field so that they can ensure patients adhere to its lengthy pharmaceutical regimen. Therefore as CHWs, the healers receive TB referrals to whom they administer their medication. In these instances, TH/CHWs, testified to supplementing pharmaceutical treatment with traditional medicine, such as, "*Muthi* for the chest that softens everything up to make it easy to bear the pain." The lack of reciprocal referrals was an issue of significant concern for all of the healers.

To corroborate the healers' accounts, I asked various members of the clinic and Valley Trust staff if they had ever personally or had known of other staff referring patients to indigenous healers. A Valley Trust Community Health Facilitator confirmed the healers' accounts, stating "The only problem that traditional healers are having, they do referrals to clinics and hospitals, but they don't get the referrals back from the hospitals and clinics." The responses among clinic staff varied dramatically. Though having done so in the past, the doctor related that she did not

currently refer patients to indigenous healers. She described having moved away from the practice, because:

I'm not quite sure what [indigenous healers] do or who they are and there is such a variety of traditional healers that I'm not quite sure who is out there and what they're doing. Before I [referred to indigenous healers] for culture specific syndrome. I now tend to believe in spiritual causes of illness, and from my paradigm and world view being Christian, I don't know what spiritual connections traditional healers have. So I have grave reservations. I would more likely refer someone to be prayed for if there was someone appropriate in the community.

The Acting Matron reported that she was unaware of clinic staff referring to indigenous healers, but described:

We don't discourage people if they want to go to a traditional healer, but we don't point at a particular healer, like if I was going to refer to a certain hospital... You can't say go to this particular one. There are some that are known in certain things and some that are good in a particular area. I don't know their hierarchy.

Contrastingly, the mobile clinic team of nurses reported that they did refer patients to indigenous healers, but only in certain instances, for instance:

There is a gentle man who is from Umlazi – he was on TV. He is working with some of the professors from University of Westville.... He's using some certain *muthi* for the HIV people. So someone who has been recognized, we will refer people to those. To him we do refer.

Though different, all three responses of participating clinic staff centered upon the same issue – that of 'recognition' or legitimacy. One of the most overwhelming problems cited with the creation of policies and collaborations with indigenous healers is the lack of uniformity among healers' expertise and the absence of independent certification of their abilities. In that vacuum, interestingly, it appears that individuals manufacture their own requirements for 'legitimacy'. For the doctor, the legitimate or, at least, benevolent abilities of healers might depend upon their adherence to a Judeo-Christian ethic. The Acting Matron appeared to feel that the hierarchy and associations established by the healers themselves, which she confessed knowing little about, could inform the recognized status of healers. Lastly, for the mobile clinic nurses a university affiliation and prominence through a national television broadcast were grounds for legitimacy.

In addition, it is worth mentioning that the garnered responses suggested that clinic staff's own personal experience or knowledge of a healer might not qualify as sufficient to lend legitimate recognition. Therefore, though Ma Bhengu, as a Christian and a recognized member of several traditional healer associations, who has worked with University professors, been featured in various publications, and been sponsored to present at a conference of alternative medicine in the United States, possesses similar criteria desired by clinic staff, in her case proved insufficient to denote 'legitimacy'. Perhaps this discrepancy was due to her close proximity to and familiarity among the clinic staff.

5.4. PERCEPTIONS OF COLLABORATION

5.4.1. The Healers' Perspective

All of the healers made positive remarks about Western medicine. Most of them emphasized the need for the two medicines to work together, as one trained healer explained, "We use it everyday. We need it. It's not about choosing sides, you do what is necessary to heal." Many of the healers emphasized the useful and helpfulness of Western medicine. A pill of crushed Zulu medicinal herbs, demonstrated by Sliep, particularly impressed a few of the healers. In terms of the HIV/AIDS epidemic, one healer made the statement, "Western and traditional medicine need to put their heads together, so that something does come out." The healers hope that the joined knowledge and capabilities of the two health systems will hold an answer to stemming the tide of morbidity and mortality due to HIV/AIDS.

I asked the healers to describe how they felt about the relationship between the *izangoma* and the formal health system. As my research progressed, however, it became clear that the healers were often confused as to whether their relationship with the formal health systems consisted of their interaction with the Valley Trust or with the local primary health clinics. For example, one healer recounted:

When I was at the Valley Trust in the meeting and there were white doctors who were coming closer to me and touching me, it made me feel like a person who was very welcome. When I was talking in the

meeting, they were paying much attention and that showed that I am important even to them.

With time, I came to learn that doctors present at a Valley Trust meeting did not necessarily practice in the area, and have contact with the healers on a regular basis. Therefore, I grew to understand that a warm reception by doctors at a Valley Trust meeting was not necessarily reflective of systemic change within the formal medical and clinic structure in the Valley. Although generally intoning a positive relationship with the formal medical system, the healers, when pressed for clarification, would more often than not describe contributions made by the Valley Trust rather than the clinics. It was necessary to clearly differentiate their feelings regarding the two.

Overwhelmingly, the healers have high regard for the Valley Trust and perceive its program and services as having positively affected their own lives and their community. They saw the Valley Trust as an organization that accepts them. One healer related, “To me, the Valley Trust just takes out the apartheid of white and black. Nurses, community health workers and *izangoma* just working together as one until this day.” They appreciated having learned about health, nutrition, and the potentially harmful traditional healing practices in which they were unknowingly engaging. They also noted valuing the knowledge, because it was a mechanism to put them on more equal footing with the biomedical health workers. The healers also cited community gardens and income generation projects as positive contributions made by the Valley Trust. The cows given to the *izangoma* by the Heifer Project were thought of as an extremely valuable contribution that not only provided them with milk, but also illustrated to the community that the work of the Amakhosi Association was worthwhile. They said that the Heifer Project and other such developments were slowly ‘changing the minds’ of *izangoma* in the area that did not participate in the association.

Many of the healers said that they would like to see the opportunity for more of them to become *nompilos* (CHWs). With selection currently falling under the jurisdiction of the local Tribal Council’s Health Subcommittee, healers can no longer simply volunteer to become Community Health Workers. They expressed this desire

despite expressed difficulties juggling the demands of both positions, because they felt that they already received the training and engaged in the community health work of *nompilos*, but were not recognized officially or compensated for it.

Given the fact that many of the healers often spoke highly of Sliep, who does not work for Valley Trust, and had attended several of her HIV/AIDS training seminars, I asked how useful they considered the HIV/AIDS training that they had received from the Valley Trust. They all reported that the HIV/AIDS training that they received from the Valley Trust had been very useful, despite the fact many of them reported that their knowledge of HIV/AIDS became clearer after working with Sliep. Upon further questioning, one TH/CHW maintained that her confusion about HIV/AIDS was not the fault of the Valley Trust, but rather her own for being “late in understanding”. In describing her teaching style, the healers reported that Sliep was very specific and would take her time while teaching. They liked the way she posed questions and would verify that they understood the material. From their description, Sliep’s style of teaching appeared to be very interactive and visual. Her introduction of HIV/AIDS treatment pills made of crushed Zulu medicine, female condoms, and HIV-positive guest speakers were all extremely salient to the healers. Ma Bhengu shared that it was good to have someone like Sliep around, because, “she encouraged them and kept them going.” The healers saw Sliep as critical to reinforcing their training as HIV/AIDS information is constantly changing and they ‘often forget’ if are not kept reminded.

After prompting them to differentiate their relationship with the Valley Trust from the one they had with the clinics, the healers expressed appreciating their ability to refer people to the clinic and nurse-led trainings on such topics as TB. However such initially positive responses typically grew more critical as our discussions continued. Expanding upon her initial answer, for instance, one trained healer remarked:

It’s good learning from each other, but I thought that the purpose of talking to [doctors/nurses] was so that if I send someone to the hospital, because I can only treat some of their ailments and not all of them, that I could then go to the hospital and still treat those things that I can treat. It’s not happening.

Another said more bluntly,

Well there isn't really a relationship. The only way that we relate is that we refer people to them [the clinic]. You can tell that there is no real love or working relationship between us because we are the only ones to refer people, they never refer back.

The character of their relationship with the local clinics was particularly worrying to those healers participating in the Community Health project due to pressure from other traditional healers. One explained:

[The other healers] try to undermine us. In other areas, they say that Mrs. Bhengu is wasting the time of other *izangoma*. 'What are they doing? She is just wasting time to take *izangoma* to white people'... They are thinking about their traditional healing but me, I'm still concerned about health, I am willing to work with whites too, whereas *iyangas* they just look at it as useless.

Having to sustain such criticism, the healers were particularly concerned about the image that their collaboration conveyed to peers and the community. Worried about the community's perception, one healer said of their collaboration with the clinics, "It's a laughing matter. People need to see that the relationship exists – that it's a two-way street." The healers worried that an inequitable collaborative relationship with clinics would damage their reputation in the community. Their reasoning can be summarized as follows: if community members consistently hear of the *izangoma* sending patients to the clinic and never witness the same being done in return, then they will begin to believe that the *izangoma* have no power of their own to heal and are dependent upon the clinic to treat people. One of the TH/CHWs commented that this circumstance has made her doubt whether the collaboration with Western medicine, which she had undertaken, was "right" as the lack of an exchange "makes her look like a fool."

5.4.2. The Valley Trust's Perspective

The Valley Trust has taken an open and pragmatic approach to traditional medicine that does not view its underlying etiology as inherently opposed to that of Western medicine. As Executive Director, Keith Wimble, testified, "I don't think the underlying philosophies are different when you get down to the fundamentals. Western has just become too curative-oriented." Accordingly, he argued,

There is absolutely no reason why we can't give a traditional health practitioner all the knowledge of a CHW in which place she could be

a better health worker, forget being called traditional, but as a health worker she could be far better skilled and more competent with that technology.

While noting the ways in which indigenous healers could benefit from biomedical knowledge and techniques, Valley Trust acknowledges the strengths of the practice. As the Executive Director, Keith Wimble reported:

Traditional healers are important for a number of reasons. They understand the community's needs and they understand the patient. They understand someone through their psyche in different capacities and these people were very good at it, using the ancestral linkages. They are an important asset in the community.

Honoring the cultural significance of the practice and the healers' place in the community, Valley Trust has worked to support and strengthen the 'positive' aspects of the practice. In doing so, their objective was to address through collaboration, as opposed to confrontation, those traditional healing practices that are dangerous particularly in the context of HIV/AIDS. Keith explained their approach, saying:

Traditional healers have a powerful influence in the community. If one is able to influence their influence and it's directed in the right direction than one has a very useful ally. Equally so, if one antagonizes traditional healers than you will also find that a lot of what your interventions were set out to do, won't get achieved because they are cutting across one another. They are not only a useful ally, but we also see them as a mechanism through which we can do quite a lot of good work.

By adding value to healers who they see as important service providers, the Valley Trust has attempted to assist and strengthen not only the healers themselves, but also the entire community.

The role of the Valley Trust, as envisioned by its Executive Director, is to serve as a mediator and conduit for understanding between the two health systems. Wimble explained,

Not everything comes out of one school of thought. As long as we play the role as facilitator of learning than I think we are doing our job, both to the department of health staff and to the traditional health practitioners – plus helping them cross pollinate.

Valley Trust reported bringing clinic staff and healers together for several informational seminars on health and healing. Through my consultations with Valley Trust staff, I learned that the Community Health Worker curriculum consisted of a strictly Primary Health Care approach to health. When I questioned whether indigenous health perspectives and practices were incorporated into the curriculum, I was informed:

We do not train CHWs in traditional healing knowledge or practice, but the women themselves bring up these things. They discuss traditional ideas about health such as what people do at home for a certain disease – whether this is positive or negative depends. When they go to people’s homes and people tell them what they use for a certain disease, the CHW can’t just say that is bad; they have to explain why theirs is better.

I found this response intriguing as a health care user in the biomedical schema would not be considered expert enough to speak with authority about the practice. The Valley Trust, according to my knowledge, does not offer indepth training on understanding indigenous health practices and concepts to clinic staff or other biomedical personnel.

5.4.3. Clinic Personnel’s Perspective

The perspective of the biomedical personnel involved in the Community Health project varied considerably among its participants. In general, the nurses had an accepting view of traditional medicine and healers. They acknowledged problems of overtoxication with herbs and harmful practices, but felt that these could and were being addressed through education and, therefore, were not cause to indict the entire indigenous health system. They reported that traditional healers were an integral part of the community, testifying that healers were more trusted by and accessible to patients than themselves.

Most of the time people trust traditional healers more than us. Our examination is painful or intrusive. We need to ask for a diagnosis – we don’t just tell them the problem. If they don’t have the money, they can just pay the healer with a goat or something. In the clinic we write things down; information about the patient needs to be recorded, so that we can inform our colleagues. With the healer, it is just between them.

In their discussions with indigenous healers, the nurses reported that they were able to perceive parallels in the approaches of the two health systems; “Sometimes you can see that the traditional healers are using the same things you are using, but they are using in a primitive way.” All of the nurses reported that they had visited indigenous healers themselves.

The nurses’ perceptions of the healers’ ability to treat disease were often conflicting and contradictory. On the one hand, they acknowledged healers’ aptitude with psychological aspects of the patient and ability to treat disease. As a chief nurse expressed, “I think there are some diseases that they can treat, perhaps that we cannot help as good as they would. I think they are important.” Some clinic nurses corroborated this account, attesting:

They are helping us because they treat the psychological part – Yes they really do. They are very good... Most people believe they have been bewitched – so if they can treat them psychologically and they can help them, ‘you go to the hospital and get some treatment and then I will counsel you’ that would be much better.

While acknowledging that traditional healers have unique abilities outside of the expertise of the biomedical system, the nurses appeared to have a difficult time conceiving of these unique abilities as ‘real treatment’. Exemplifying this incredulity, one nurse said of the healers’ treatment; “Traditional healers do treat patients, you can’t say that they are not treating them, because [the patients] do believe that they are being treated by them.” The statement is similar to biomedicine’s persistent disregard for what has been termed ‘the placebo effect’. In biomedicine, mental or emotional causes for healing are seen as flukes or scientific inconsistencies, rather than indicators of the mind as a powerful medium for healing and a useful tool for practitioners to utilize. The nurses appeared suspicious of healers (joking that a typical diagnosis statement offered by a healer would be, “It’s your neighbor who is doing this”) while at the same time acknowledging their value and patronizing them.

Overall, the nurses felt that collaboration with indigenous healers should take the form of ‘recognition’ rather than actually working together. Attempting to clarify the distinction, one nurse explained:

It's different – not really to work together, but to recognize the traditional healers, because some of the doctors don't even recognize them. You will tell the doctor that I've been at the traditional healer and they will start talking bad things about them. I don't think people feel happy about that – they will just deny. So, I think it is to understand each other as they are doing the same job that [medical staff] are doing, but in a different way.

The nurses additionally argued that indigenous healers would not want to work with nurses and doctors. One nurse expressed, "I don't think they would want to work with us. They think we would overpower them, which they don't want. They just want us to recognize them. And it is easy to recognize them, if they are well-equipped and educated." A second added, "It's about money – if they worked with us they wouldn't make as much money." Both of these perceptions differed from the example and expressions of the healers I interviewed. As exclusively black South African women, the nurses I interviewed at the clinic were culturally closer to the healers than either clinic doctors or many of the Valley Trust staff. One would hypothesize, therefore, that the nurses would have the best understanding of the indigenous healers. The contradiction of their cultural background and then their scientific training in Western medicine may account for the discrepancy in nurses' attitudes towards indigenous healers.

The doctor at the clinic had the most cautious stance towards traditional healing. As a primary care doctor with extensive experience in rural areas, the doctor was familiar with and acknowledged the healer's role in the community. However, she was skeptical of the healers' knowledge and abilities for a few reasons. First, she was wary of broadly categorizing healers, because of the diversity of practices, knowledge, and expertise among healers. She explained,

The problem with traditional healers is that they resist the idea of standardization. So with any given traditional healer – you don't know how long the training is, you don't know what their training basis is, you don't know how much they use different things, and traditional healers have resisted anyone looking too close into their makeup and training.

Despite this problem, which healers themselves acknowledge, the doctor expressed that she was open to meeting with and trying to understand healers' practices. She explained:

I know they are part of the community and I would far rather work with them, talk to them, see what they understand, help them with what they don't understand, but not necessarily trying to force my views on them. I'm not anti-them in the sense that they are wrong or bad, I just have a problem with this direct referral thing.

However when describing indigenous healers' medicine or *muthi*, she related, "There are a lot of frankly, peculiar things, but they do use traditional plants in a fairly natural way." Such statements and the use of terms like 'bizarre' or 'peculiar' when describing healers' practices by the doctor gave an indication of a subjectively negative perception, rather than an objective denotation of difference between biomedical and indigenous healing practices.

The doctor's caution and distrust of indigenous healing methods is particularly interesting given that she acknowledged a belief in spiritual causes of illness – a considerable deviation from the scientific principles underlying biomedicine. It is this belief that is the substance of the doctor's second cause for concern regarding traditional healing (page 98). The doctor felt that there was a distinct difference in the philosophies underlying the two systems of health that, she felt, could not be easily reconciled. When I asked for her perception of the two systems' ability to collaborate, as in the instance of traditional healers serving as Community Health Workers, she responded:

The community health worker training program trains around a Western paradigm of illness. I'm not sure how much you can put these two together and how much confusion that causes. [Traditional healers] are eclectic and they have a lot of different ideas and backgrounds. It's too general to answer. I don't think that it would be easy.

Overall, the doctor did seem willing to learn more about healers and work collaboratively with them in some capacity, particularly in the context of HIV/AIDS, stating:

As far as HIV/AIDS education and prevention, I think that they are very valuable and we should work with them and I would be very happy and very open to having meetings with them to see where they are coming from and to see what they are doing.

She described herself as being more tolerant than most doctors: “I am a bit concerned and wary, but I am not out and out negative.” The nurses affirmed this categorization of her.

Summary of Collaborative Participants’ Perspectives

The findings reveal discrepancies in the collaborative partners’ perceptions of one another. While the indigenous healers were quite open and accepting of the value of Western biomedicine, members of the biomedical fraternity, for a variety of reasons, were less so with the indigenous health system. The findings may be explained by a categorization put forth by Naidoo of KwaZulu Natal’s Health department; “Western medicine sees itself as superior. They feel that if things are not scientific, they are not as good. [Biomedical practitioners] are trained that way and don’t appreciate other methods.” The superiority in the doctors/nurses perception is not surprising given that they did not initiate the collaboration. Having initiated the collaboration, the Valley Trust staff’s perceptions of indigenous healers were characteristically positive. However, their positive regard has less bearing on the efficacy of the overall collaboration than the perceptions of clinic personnel.

Despite findings of this discrepancy, the attitudes and perceptions of the biomedical staff towards the indigenous healers were more open and liberal than those of many of their contemporaries. Though not ideal, their attitudes and perceptions were not prohibitive of collaboration with indigenous healers, but rather indicative of a starting point from which to work.

5.5. CHALLENGES

5.5.1. Insufficient Resources

A more substantial barrier to effectual collaboration between the formal and indigenous health systems was that of insufficient resources. The limited staff and resources that clinics have to perform their primary duties leaves little time for extended outreach efforts with indigenous healers. As the doctor explained:

I am the only primary care doctor in the public health service between Pinetown and Pietermaritzburg. I have to see 60 patients a day. I am supposed to teach nurses, but I have very little time for

that. Nurses see 30/40/50 patients a day, and therefore have very little time to talk to patients. I think being under resourced, we can't do that much.

Constantly shifting staff also makes it difficult to build the foundation of knowledge and trust that members of the biomedical and indigenous health systems need to truly be able to come together. In the recent past, it was noted the clinic had experienced some significant turn over in resident doctors.

Lack of consistent staff, sufficient time, and appropriate resources are issues that stem from circumstances well beyond the scope of Valley Trust's Community Health project. Examining some of these broader dilemmas, one biomedical staff person critiqued:

There is a big question as to whether or not people really want to change the health system. There is a lot of rhetoric out there. But the medical schools are quite conservative... [There is] basically zilch support, interest, vision at this point. [UND] is not a progressive medical school. Everyone talks primary health care, but there aren't the resources, there aren't the training programs, there aren't the posts and there isn't the support. Just all hot air.

Substantiating the noted barriers of both lack of resources and lack of top-down support, Naidoo of the KZN Health Department expressed, "I don't know if traditional health practices are what we have time for. They want to be registered and recognized as healers, the system is not ready for that, but we haven't closed the door yet." Utilizing indigenous health practitioners as a service extension network is often touted as a solution to deficient health budgets and resources. However, training and involvement of indigenous healers is not a quick fix. As Sliep noted,

A lot of workshops [for indigenous healers] are done once off and are very superficial. Statistics can say that *izangoma* have been trained, but it's really how they have been trained and what support they have that makes the difference. [You] need to get their input. It can't just be one day, their questions change as their experience change. [They] need ongoing process.

The study's findings support the argument that indigenous healers will not function effectively as extension services without investment in infrastructure development and ongoing support.

5.5.2. Unidirectional Bias of Program

The largest challenge reported by the TH/CHWs was the lack of equality they perceived in their relationship with the clinics. The potential for such inequality is the reason that some do not support the idea of incorporating traditional healers into the formal health system as Community Health Workers. Sliep, a trained psychotherapist working informally with the healers, felt:

[The two systems] should be separate, but with a good bridge. CHWs are quite indoctrinated with Western medicine. In the Western structure, CHWs have very low status; [Indigenous healers] have more status in the informal system. CHWs start with no knowledge; it's very different for healers. Traditional Healers have something unique that CHWs don't have. If you absorb them as CHWs, then you will kill their uniqueness and bring them down to the level of CHWs. For me, it would be like saying that they have to work for the formal health system. I promote them working alongside in an equal partnership, not one being subservient to the other.

Though TH/CHWs saw their roles as CHWs as important and felt that they received a great deal of benefit from the training program, I detected underlying resentment at their treatment by the biomedical system. Their treatment was standard of any other CHW, but, as such, did not take into account their expertise, knowledge and position as healers in their own right. This inappropriate treatment was represented for the healers most concretely by unidirectional referral system.

Regardless of their previous characterization of the formal medical services, all of the healers agreed that the unidirectional bias of the program was its major shortcoming. In conversations with clinic nurses and doctors, it was clear that even those that supported working "hand in hand" with indigenous healers, conceptualizing that collaboration primarily in terms of healers referring patients and extending clinic services more. Acknowledging the obstacle, Naidoo recognized that: "[The healers] have always felt that we want to use them when it suits us. That we come to them when we want something, but we never look at what they do and refer to them." Accordingly, the inequitable relationship with the clinics was a large source of frustration and basis for mistrust on the part of the healers. They particularly felt that they were not being given equal weight and respect in their relationship with the biomedical health system due to the lack of patient referrals

from clinics. They purported that this inequity undermines their credibility with the community.

As evidenced by the findings, considerable misunderstanding about indigenous healers and their practices persists among biomedical personnel. Such misconceptions preclude viable collaborative relationship between the two health systems, as Bulayi acknowledged:

Traditional ways of healing are in conflict with Western knowledge, [but I'm] not sure if that's where problem lies. [It is] more where western practice gets given training in how traditional healers approach disease. We need as much orientation and training.

Though some forums to promote such understanding have been held to address this need in the Community Health project, a more integral and expansive reorientation is needed in daily operational structure and ongoing trainings, but particularly in the institutions where biomedical personnel are educated. Likewise, though open and progressive in its attitude towards the indigenous health system, the Valley's Trust's Community Health Program's major focus was to bring the knowledge and skills of biomedicine – through the more community-based primary care model – to bear on traditional practices, and not the reverse.

The care, support, and housing of HIV/AIDS patients for extended periods of time was the basis of the healers' second grievance. The participating healers were frustrated by the formal health system's lack of support for these services, the onus for which fell upon them in the clinics' absence. The AIDS patients that the healers have been treating often require extensive care. In many cases, they are bedridden and need constant attention, nourishment, and herbal remedies. Care of AIDS patients requires a hygienic environment with access to rubber gloves and sterilized equipment. However due to lack of resources and proper facilities, the healers' HIV/AIDS patients are housed on the floor of their homes.

Members of the Amakhosi Association purport to accept the onus of caring for HIV/AIDS patients. As one healer said, "Western medicine can't treat this disease. They don't have a cure. They should try to do what they can do and also send

[HIV/AIDS patients] here to let us try.” Arrangements of this nature are often contentious due to the burden of long-term care for HIV/AIDS, as Bulayi recognized: “It is unfair, without being able to put a cost feature, to leave it to traditional healers to engage in home-based health care.” Mirroring this sentiment, the healers feel that they should receive assistance in serving this function. According to the healers, an understanding was established (though it was unclear to me exactly with whom) that they would receive assistance to construct and furnish a small hospital for AIDS patients. Unfortunately any such promises of a hospital/clinic have not materialized. The healers are upset because, they believe, the construction of such a building would not only alleviate the burden of patient care, but also afford people the opportunity to witness the relationship between the healers and the health system, thereby strengthening their place and image in the community.

5.5. CONCLUSION

The purpose of this chapter was to convey a sense of the relationship between indigenous healers and formal medical staff that has resulted from the Valley Trust’s HIV/AIDS collaborative project. The purpose of this investigation was not the determination of one health system’s superiority over the other, but rather how HIV/AIDS could best be addressed in the Valley of a Thousand Hills through a collaborative effort between the two. For a variety of reasons including lack of resources, little access to pharmaceuticals, and absence of executive vision and commitment, the formal biomedical health system at present has little to offer HIV/AIDS patients in rural areas. However, even with state-of-the-art technology and cutting-edge HIV/AIDS programming clinics could do little to address the disease if the community refused to use them. In the South African context, there needs to be a bridge between the two health systems that will not only bring the ‘biomedically-understood’ virus into the consciousness of black South Africans, but also impart an appropriate cultural context to HIV/AIDS prevention and treatment measures. According to the findings of this study, TH/CHWs are best positioned to operate as such a bridge.

Although the findings reveal discrepancies in their perceptions of one another, all of the collaborative partners exhibited a general openness to understanding and working in conjunction with one another. Likewise, they all recognized the lack of formal and consistent structural linkages as an inadequacy of the current collaborative. Their conceptions of a potential working partnership, however, differed dramatically.

The biomedical personnel's conception revolved primarily around the need for healers to be educated about health and disease so that they and their clients would better understand and utilize clinics as a resource. Accordingly, they wanted indigenous healers to refer their clients to the clinic for biomedical treatment, but were uncomfortable reciprocating such referrals.

Likewise, the Valley Trust's conception of the working partnership centered on the education of indigenous healers and their incorporation into health care extension services through outreach and referrals. The view of the Valley Trust is that improvements to healers' practices will benefit the larger community. Therefore, the aim of their training and capacity-building activities (community gardens, etc) is to support local indigenous healers. They envision better communication and understanding between formal medical personnel and indigenous healers, and recognize that the unidirectional referral system supported by the current program is frustrating for healers, but are not currently working to redress this issue.

The indigenous healers conceived of a partnership in which they continued to learn and teach others about health and disease prevention and refer appropriate clients to clinics, but also in which they were informed and consulted about referred clients and received patients referred by the clinic. They wanted the clinics to recognize their expertise and abilities and for this recognition to be concretely visible by the community. They further wanted to be better financially supported for their HIV/AIDS and community health work, as these services, for which they did not charge, took time away from their private practices.

Given the vacuum of viable biomedical HIV/AIDS biomedical treatment, indigenous healers, as their opponents often point out, have the opportunity to profit tremendously from HIV-infected people. Offering hope and fake cures at exorbitant costs, some healers are making a tremendous profit off of others' desperation. The healers engaged in the Valley Trust's HIV/AIDS collaborative stand in direct opposition to profiteering *iyangas* and *izangoma* of this type, but doing so does not always make them very popular in a community where a culture of denial persists. If HIV/AIDS health programs and services wish to encourage and continue having cooperative as opposed to antagonistic relationships with the indigenous health system, they need to support right-minded healers. The Valley Trust's model approach to working with indigenous healers – of starting from and supporting the good, rather than diminishing the bad – has worked very well, and is a primary reason indigenous healers in the Valley regard the Trust with such high esteem. The clinics and formal medical system need to learn from this model and, if not in the form of direct referrals, consider where they can try and do the same.

Given the comparative success of TH/CHWs, it was ironic that only the healers' conception entailed incorporated more *izangoma* into the Community Health Worker Training Program. The findings indicate that among the healers interviewed, TH/CHWs engaged in the most effectual HIV/AIDS practices. Therefore, they, particularly Ma Bhengu, were heavily relied on as leaders by the collaborative to train and coordinate healers.

Despite their importance to the overall collaboration, neither the Valley Trust nor the formal medical system was actively engaged in seeking more indigenous healers to become Community Health Workers. The preferred recruitment model evident in this investigation was for TH/CHWs to hold meetings with indigenous healers to inform them about HIV/AIDS and other health issues. Subsequently, those healers are enlisted to become involved in community-based prevention activities, but not to become Community Health Workers. This approach to garnering more healer participants in the Valley Trust's HIV/AIDS collaboration addresses a variety of issues brought up earlier concerning incorporating indigenous healers into the formal health system as CHWs (i.e. schedule and time conflicts, limited payroll,

selection by Tribal Council, and subservient role). However, in the case of this pilot study, healers recruited and trained in this way do not engage in as effective HIV/AIDS work as the original TH/CHWs. Though the scope of this investigation precludes substantiating the causes for this finding, it was a trend of which Ma Bhengu herself was aware and was, for her, a cause for concern.

Chapter 6: CONCLUSION

Despite an expansive national health care system, modeled on Western allopathic medicine, the majority of South Africans continue to patronize indigenous health practitioners. This is particularly true of individuals suffering from HIV/AIDS whose needs are not being met by the formal health system. Already consulting the majority of HIV/AIDS clients, indigenous healers need to be embraced by formal HIV/AIDS education, prevention and treatment efforts so that: 1) healers do not propagate misinformation about the disease or inadvertently act as a mode of transmission; and 2) these messages not only reach, but are made more salient to their intended audience. In order to best meet the health needs of the majority of the population and confront the significant challenge posed by HIV/AIDS, it is evident that collaboration between formal health services and the indigenous health system should occur. Thus, the question guiding this research was: what form should the involvement of indigenous healers take in order to be the most appropriate and effective?

The purpose of this effort was to offer some possible answers to that question through a closer examination of the current collaborative Community Health and HIV/AIDS project at the Valley Trust in KwaZulu Natal's Valley of a Thousand Hills. This pilot investigation was conducted to get a better sense of what collaborative efforts between the allopathic and indigenous health systems look like 'on the ground'. This was investigated primarily in terms of how the indigenous healers' involvement in varying Valley Trust training programs affected their knowledge of HIV/AIDS, their engagement in HIV/AIDS awareness and prevention efforts, their treatment of HIV/AIDS patients, and their perception/relationship with the formal medical system. The hope is for the successes and challenges of this program to inform the practice and potential of collaborations between the two health systems to prevent/treat HIV/AIDS in South Africa.

To that end, I began the research with a review of the literature on international and South African experiences of collaborative initiatives with traditional healers for the prevention and treatment of HIV/AIDS. As the subject area is still unfolding, I conducted a number of informational interviews with representatives of

government, medical community, traditional healers, academics, civil society to get a comprehensive view of the dynamics of the current debate. I used a number of techniques throughout my field work, which ranged from informal conversations and observations, semi-structured interviews and focus groups, to an HIV/AIDS knowledge questionnaire.

Major Findings

The findings show that collaboration between traditional and formal health services in the form of the Valley Trust's training results in 'better' HIV/AIDS work by participating traditional healers. First, healers with Valley Trust training (TH/CHWs or Trained) performed better on the HIV/AIDS knowledge indices than healers without training. It should be noted, however, that the training did not significantly impact participating healers' ability to define HIV and AIDS (though TH/CHW and Trained healers grasped the concept of progression) or completely dispel misunderstanding around modes of transmission. It is clear from these findings that all of the healers are confused about the nature of blood as a mode of transmission and do not fully understand intravenous infection, but in this they are similar to a large percentage of the population. Results reveal little significant difference between the two groups' knowledge as exemplified by their abilities to define HIV/AIDS, identify modes of transmission, and recognize symptoms. Interestingly, rather than enabling them to categorically outperform Trained Healers, the TH/CHW's more extensive community health knowledge appeared to confuse rather than clarify their understanding of HIV/AIDS modes of transmission. However, TH/CHWs did surpass Trained Healers in their ability to distinguish a greater number of HIV/AIDS prevention methods, including those in their healing practices, foreshadowing another of the study's major findings.

Second, as indicated by their superior performance on the correlating knowledge indices, healers trained as Community Health Workers (TH/CHWs) engaged in the most effectual prevention activities in the community of the three groups. Although all of the healers correctly identified *at least* a few means of HIV/AIDS prevention and indicated that they discussed these practices with clients and members of the community, the activities reported by TH/CHWs were the most organized. They

gathered groups for discussions on the topic, spoke with a range of people, and indicated not only distributing, but explaining and demonstrating how to use condoms. The Trained Healers also reported similar activities, but they were conducted less systematically and with a smaller target audience, primarily discussing prevention with youth and clients. Additionally, remarks concerning the ineffectiveness of prevention measures or resistance to prevention counsel made by both Trained and Untrained Healers conveyed a sense of powerlessness in the face of HIV/AIDS that I did not find among TH/CHWs.

Third, the TH/CHW group appeared to have the most confidence and experience in treating patients with HIV/AIDS. Although all the healers' were able to correctly identify symptoms, TH/CHWs reported recognizing and treating more cases of suspected HIV/AIDS among their clients. Their methods of HIV/AIDS treatment were more diverse and extensive than either of the other two groups, including supporting biomedical efforts, diet, and traditional medicinal herbs. The experiences of the healers in the other two groups were primarily restricted to group efforts or apprentice duties with the aforementioned TH/CHWs.

Regardless of their level of training, the healers' traditional/ cultural roles and hierarchy contributed to their ability to engage in HIV education/prevention activities with various age and gender groups. The traditional authority of their roles as *izangoma* appears to be negatively impacted by the traditionally inferior position of women in indigenous Zulu culture, both internally in their confidence to engage in conversations about sex and HIV/AIDS with men and externally in the authority that their prevention and education messages have on their audience. Social and cultural circumstances impact any HIV prevention effort, but pose a unique challenge for the indigenous healer whose authority is derived from his/her traditional role.

In South Africa, as elsewhere, there is considerable resistance and denial around the subject of HIV/AIDS. The findings indicate that healers with the most training and the closest collaborative relationship with the biomedical system (TH/CHWs followed by Trained Healers) were best able to overcome disincentives to refer

clients specifically for HIV testing. As I would conjecture that their education received concerning the importance of testing, the individual and communal benefits of knowing HIV status, and the prospective hope of an individual 'living' with HIV were integral in making the distinction between the healer groups.

The study's findings support the argument that indigenous healers will not function effectively as extension services without investment in infrastructure development and ongoing support.

In the case of the Valley Trust Community-based Health Program, although the findings reveal discrepancies the collaborative partners perceptions of one another, they all exhibited a general openness to understanding and working in conjunction with one another. Likewise, they all recognized the lack of formal and consistent structural linkages as an inadequacy of the current collaborative. Their conceptions of a potential working partnership, however, differed dramatically.

Overwhelmingly, the healers have high regard for the Valley Trust and perceive its program and services as having positively affected their own lives and their community. They appreciated having learned about health, nutrition, and the potentially harmful traditional healing practices in which they were unknowingly engaging, and gaining the resources to engage in community gardens and income generation projects.

The community health training TH/CHWs received at the Valley Trust had a tremendous impact on their traditional practices. The TH/CHWs reported giving clients biomedical information during traditional healing sessions, and altering the nature of some of those practices in light of concerns about germ contamination and exposure to blood or other bodily fluids. Additionally, the healers report readily referring patients to clinics, when they found their conditions were beyond their healing capacity. Interestingly, HIV/AIDS counseling was the one instance in which healers did not unanimously report referring clients to the clinic. To the extent that this information was passed along to other healers and apprentices, it affected systemic change within the indigenous health system.

The changes reported by TH/CHWS were not, however, an indication of a unilateral shift away from traditional practices and ideology towards Western biomedical ideas. Using their knowledge as healers and community health workers to complement one another, TH/CHWs reported identifying physical maladies that they or the clinic might treat, but then employing their psycho-social and ritualistic healing methods to address the ‘underlying cause’ of the illness – as to why *this particular* person became sick at *this particular* point in time. The TH/CHWs view their duality of their role as positive; they perceive their practices, which have been informed by both western and traditional health systems, to represent the ‘best of both worlds’. In fact in many ways, the findings regarding HIV/AIDS knowledge, prevention, and treatment practices support this perception.

Though TH/CHWs saw their roles as CHWs as important and felt that they received a great deal of benefit from the training program, they had some resentment toward the biomedical system, particularly with regard to the unidirectional referral system. All of the healers felt that they were not being given equal weight and respect in their relationship with the biomedical health system due to the lack of receipt of patient referrals from clinics. The participating healers were also frustrated by the formal health system’s lack of support for their care and housing for HIV/AIDS patients, the onus for which fell upon them in the clinics’ absence. They purported that this inequity undermines their credibility with the community.

In conversations with clinic nurses and doctors, it was clear that even those that supported working “hand in hand” with indigenous healers, conceptualized that collaboration primarily in terms of healers acting as extensions for the clinic services. The lack of an official working collaboration, particularly in the form of reciprocal referrals, exemplifies the biomedical community’s distrust or wariness towards traditional healing. The biomedical community was wary of referring to healers because they were uncertain of the safety or efficacy of their practices, the abilities of certain members, their hierarchy, or their views concerning HIV/AIDS and Western medicine in general. An additional barrier to effectual collaboration between the formal and indigenous health systems was that of insufficient resources,

as limited staff and resources left clinic personnel with little time to engage in extended outreach efforts with indigenous healers.

Given the comparative success of TH/CHWs, it was ironic that only the healers' themselves indicated wanting more *izangoma* to serve as Community Health Workers. As leaders among participating healers, TH/CHWs were critical to the success of the Valley Trust's collaborative project. Likewise, the findings indicate that healers recruited and trained second-hand, primarily through TH/CHWs, do not engage in as effective HIV/AIDS work as the original TH/CHWs.

Implications

HIV/AIDS education initiators, both at Valley Trust and throughout the nation, agree that the major challenge they face is no longer awareness of HIV/AIDS, but behavior change in the context of HIV/AIDS. Education about the disease is important, but not sufficient. The same conclusion could be drawn in the instance of the Community Health Worker and HIV/AIDS training of indigenous healers through the Valley Trust. As Bulayi remarked of the Community Health Worker curriculum:

What they are being taught can be taught to any school child. [It is] nothing substantial that anyone cannot get from health promoting messages.

To some degree, the findings validated this observation. With varying degrees of in-depth comprehension, all of the healers interviewed shared a basic understanding of the disease. However, the findings also indicated that those healers with Community Health Worker training (TH/CHWs) were best able to translate that knowledge into effectual HIV/AIDS initiatives in both their indigenous practices and community activities. If the informational content of the curriculum, as Bulayi suggests, was not responsible for the difference, then what was?

I would suggest that the nature of the varying trainings offered by the Valley Trust was the primary difference in the effectiveness of the healers' subsequent HIV/AIDS work. The findings point to the skills-based nature of the CHW training as being instrumental in the varying performance among healers. TH/CHWs received hands-on experiential training, practice, and skills-development in outreach,

negotiation, persuasion, and communication. As CHWs, healers need to have the ability to go to homes and be adaptable and flexible enough to address a wide array of social, cultural, and economic issues affecting health. As they become more practiced, TH/CHWs gain confidence in themselves and their ability to impact change. These endowments were revealed in a number of the study's indicators of effective HIV/AIDS work, such as their ability to overcome disincentives to not confront suspected clients about HIV/AIDS and their lack of the powerless sentiment expressed by other healers. Such findings suggest that experiential training and empowerment workshops may be more helpful and useful for traditional healers' HIV/AIDS work, as opposed to informational HIV/AIDS workshops. Along those lines, healers' would also be in need of and encouraged to facilitate similar learning environments for their *amathwasa* and other healers. Likewise, healers may be more useful in promoting the cultural and societal changes needed to impact the spread of HIV/AIDS if they addressed issues of women's empowerment in relationships, encouraging fewer sexual partners, and lessening stigma around the disease.

The discrepancy in the collaborative partners' perceptions of one another and the suggested structure of the collaboration, as shown in the results, points to the need for greater dialogue and formal linkages between the three groups. Though some forums to promote such understanding have been held to address this need in the Community Health project, a more integral and expansive reorientation is needed, not only in its daily operational structure and ongoing trainings, but also in the institutions where biomedical personnel are educated. Proof of this need is the comparative success of the *izangoma* who work as CHWs, who, therefore, benefited from such a structural system. Such a system could provide clear expectations and goals for each partner and provide a basis for the greater understanding of one another that is needed to overcome present uncertainty and concerns. A referral system of some content and magnitude appears to be the most critical and pressing issue the new structure needs to address. In the absence of the complete licensing and registration process by the government, the Valley Trust could act in its capacity as mediator between the two systems and help create a foundation of mutual support and benefit, which members of both groups could agree upon.

Further Research Inspired

Due to its exploratory nature, this study is instructive primarily in the research directions it implies. Firstly, the field would benefit from a reproduction of the study with a larger sample of healers, chosen at random from throughout the area of the Valley of a Thousand Hills, and a larger sample of doctors and nurses from other clinics throughout the Valley. Further studies into the effectiveness of indigenous healers' collaborative efforts with formal health systems to prevent and treat HIV/AIDS would benefit from the inclusion of the HIV/AIDS patient's opinions and perspectives.

In terms of improving the collaboration at the Valley Trust, outcome studies of the effectiveness of healers prevention efforts (salience of message received with varying age/gender group) and treatment (improvements in health) would be very valuable in strengthening the collaboration and addressing concerns of clinic staff. An investigation of non-collaborating traditional healers' practices of clinic referrals and the ideas/beliefs that inform those decisions would help elucidate this line of inquiry. Another area of interest would be outcome studies of healers' treatment of STDs, as the healers felt confident in their abilities to heal such conditions and did not necessarily refer such cases to clinics. Individuals who the healers know and trust, such as Janine, Ma Bhengu's white South African *ithwasa* and recent initiate, might be best able to perform such research to ensure that the healers benefited from usage of the results. More broadly, the research would benefit from a comparative study of different organizational approaches to collaboration with traditional healers, particularly if model collaborations, such as those in Uganda, were also considered.

According to the findings of this study, TH/CHWs are best positioned to operate as a bridge between the two health systems to address HIV/AIDS that will not only bring the 'biomedically-understood' virus into the consciousness of black South Africans, but also impart an appropriate cultural context to HIV/AIDS prevention and treatment measures. Therefore, the most relevant area of exploration identified by this study would be to evaluate: 1) what properties made TH/CHWs HIV/AIDS

work more 'effectual' than other formally trained or untrained healers; and 2) could these factors be reproduced without incorporating traditional healers into the formal health system in the subordinate roles of CHWs.

Admittedly, recognition of the indigenous health system is long overdue. But, the fact remains that the institutionalization of more standardized training of traditional healers and the creation of an authority and mechanisms to regulate the safety and efficacy of the indigenous health system are still a long way off. However, the biomedical community will not begin to work more equitably with indigenous healers until they feel able to entrust patients to their care and expertise. And until they do so, the multifaceted health care needed to address the diverse communities of South Africa and effectual disease prevention will continue to elude them. Therefore in the absence of national legitimization efforts, progressive NGOs with established records of trust with the indigenous health system, like Valley Trust, need to start facilitating this work on the ground and spearhead collaborative partnerships between biomedical personnel and indigenous healers that are equitable and acceptable to all parties.

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APPENDIX A

INTERVIEW SCHEDULE

Informational Interviews (Semi-Structured)

- | | | |
|------------------|---|--|
| Dr. Bulayi | - | Director, KwaZulu Natal Provincial Ministry of Health |
| Kay Naidoo | - | Head of Primary Health Care Division, KwaZulu Natal Provincial Ministry of Health |
| Myra Taylor | - | Professor, Department of Community Health, UND Medical School |
| Obed Kuhle | - | Program Officer, AIDS Foundation, Traditional Healer Training Program |
| Queen Ntuli | - | Secretary, KwaZulu Natal, Traditional Healers' Council |
| Rebecca Rogerson | - | Sangoma, Canadian-born |
| Janine Andrews | - | Sangoma, white South African and recent initiate of Ma Bhengu |
| Alvina Bhengu | - | Amakosi Association Head, Traditional Healer Facilitator, Valley Trust, and former CHW |
| Keith Wemble | - | Director, Valley Trust |
| Tstitsti Ngubo | - | Head of Community Health, Valley Trust |
| Sipho | - | AIDS Trainer/Facilitator, Valley Trust |
| Sazi | - | Community Health Facilitator, Valley Trust |
| Penelope | - | Community Health Coordinator, Valley Trust |
| Dr. Janet Giddy | - | Head Physician, Halley Stott Clinic |
| Sister Sibanda | - | Chief Professional Nurse, Halley Stott Clinic |
| Yvonne Sliep | - | A psychotherapist with training in HIV/AIDS education in that provides training for healers in the Valley of a Thousand Hills. |

Group Interviews (Focus Group)

Halley Stott Clinic Nurses (5)

Traditional Healers/ Community Health Workers (3)

Individual Interviews (Semi-Structured)

Traditional Healer/Community Health Workers (4)

Traditional Healers with Formal HIV/AIDS Training (4)

Traditional Healers without Formal HIV/AIDS Training (3)

HIV/AIDS Questionnaire

Traditional Healer/Community Health Workers (4)

Traditional Healers with Formal HIV/AIDS Training (4)

Traditional Healers without Formal HIV/AIDS Training (3)

13. Where can a person go to get an HIV test?
14. If a person is infected with HIV, is it possible that they could still look, feel and act like a normal healthy person?
 Yes No Don't Know
15. Can HIV/AIDS be cured?
 Yes No Don't Know
- a.) If yes, how and by whom?
16. Can anyone get AIDS?
 Yes No Don't Know
17. Who is the most at risk of getting AIDS?
18. Do you think that people in your community are at risk of getting HIV/AIDS?
19. Can a person do anything to protect him/herself from getting HIV?
20. What can people do to protect themselves from getting HIV/AIDS?
21. Do you talk to your clients about starting these practices?
22. Do you talk to the rest of the community about HIV/AIDS?
 a.) If yes, how?
 b.) And what do you tell them?
23. Are condoms an effective way of preventing getting HIV/AIDS?
24. Do you have or use condoms in your practice? Who do you give them to and how?

On a scale of 1 to 5 with 1 being very uncomfortable and 5 being very comfortable:

25. How comfortable do you feel giving out condoms and discussing sexual behavior with your clients who are:

a.) boys?

Very comfortable	comfortable		Very uncomfortable
1 2	3 4		5

b.) girls?

Very comfortable	comfortable		Very uncomfortable
1 2	3 4		5

c.) Young men?

Very comfortable	comfortable	Very uncomfortable
------------------	-------------	--------------------

- | | | | | | |
|--------------------|---|---|-------------|---|--------------------|
| | 1 | 2 | 3 | 4 | 5 |
| d.) Young women? | | | | | |
| Very comfortable | | | comfortable | | Very uncomfortable |
| | 1 | 2 | 3 | 4 | 5 |
| e.) Married men? | | | | | |
| Very comfortable | | | comfortable | | Very uncomfortable |
| | 1 | 2 | 3 | 4 | 5 |
| f.) Married women? | | | | | |
| Very comfortable | | | comfortable | | Very uncomfortable |
| | 1 | 2 | 3 | 4 | 5 |
| g.) Elderly men? | | | | | |
| Very comfortable | | | comfortable | | Very uncomfortable |
| | 1 | 2 | 3 | 4 | 5 |
| h.) Elderly women? | | | | | |
| Very comfortable | | | comfortable | | Very uncomfortable |
| | 1 | 2 | 3 | 4 | 5 |

26. What are the signs and symptoms of a person having HIV/AIDS?

27. Have you ever had a patient who you suspected was HIV positive?

a.) What did you do?

28. Have you ever had a patient who you knew was HIV positive?

a.) How did you know?

b.) What did you do?

29. Do you refer people to the clinic to be tested for HIV?

30. Do you refer people to the clinic to be counseled for HIV?

31. Do you refer people to the clinic to be treated for HIV?

32. Do you refer people to the clinic for any other reason? Or under any other circumstances?

33. Does the clinic ever refer HIV/AIDS patients to you? Under what circumstances?

34. Is this always the way you have thought about HIV/AIDS?

a.) If not, what made you change your mind?

APPENDIX C

Semi-Structured Interview Questions

TH/CHWs:

1. Why did you want to become a Community Health Worker (CHW)?
2. How do you understand illness? And how do you heal people?
3. How do you bring your two roles as a CHW and a traditional healer together?
4. When you visit homes as a CHW do you use your knowledge and skills as a traditional healer?
5. When patients visit you as a *sangoma*, do you tell them what you've learned as a CHW?
6. As a CHW who is a traditional healer, are your responsibilities different than other CHWs?
7. Do you train other traditional healers about HIV/AIDS?
8. How do you train them?
9. What information do you give them in the training?
10. What are the difficulties you have had being a CHW who is also a *sangoma*?
11. What is the relationship like between *izangomas* and the doctor and nurses that work at the health clinic?
12. What do you think of Western medicine?
13. Does the community treat *sangomas*, who are CHWs differently than other traditional healers?
14. Are you a member of a traditional healer association? If so, which one?
15. Do other traditional healers treat *izangomas* who are also *nompilos* differently than other traditional healers?
16. What is the relationship like between the traditional healers and the government?
17. Do you think that traditional healers should work together with the government? How?

Traditional healers with HIV/AIDS training:

1. How do you understand illness? And how do you heal people?
2. Since you've been trained in HIV/AIDS do you train other traditional healers about HIV/AIDS?
3. How do you train them?
4. What information do you give them in the training?
5. What is the relationship like between *izangoma* and the doctor and nurses that work at the health clinic?
6. What do you think of Western medicine?
7. Are you a member of a traditional healers association, which one?
8. What is the relationship like between the traditional healers and the government?
9. Do you think that traditional healers should work together with the government?
How?

Traditional healers without HIV/AIDS training:

1. How do you understand illness? How do you heal people?
2. What is the relationship like between *izangoma* and the doctor and nurses that work at the health clinic?
3. What do you think of Western medicine?
4. Are you a member of a traditional healers association, which one?
5. What is the relationship like between the traditional healers and the government?
6. Do you think that traditional healers should work together with the government?
How?