

**THE ROLE OF TRADITIONAL HEALERS IN THE FIGHT AGAINST HIV/AIDS: THE
CASE STUDY OF TEMBISA TOWNSHIP, SOUTH AFRICA**

by

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Abstract

South Africa has a high HIV/AIDS prevalence. Due to the unavailability of antiretroviral drugs and South African's trust in traditional healers for health problems, traditional healers are involved in treating HIV/AIDS. This dissertation outlines traditional healers' role in HIV/AIDS in Tembisa, a township situated in the East Rand section of Johannesburg. People living with HIV/AIDS, traditional healers and health care workers were interviewed.

The dissertation also confirms the high prevalence of HIV/AIDS in Tembisa.. According to the dissertation, a reasonable highest number of People Living with HIV/AIDS (PLWAS) 8 out of 10 consulted Traditional healers to seek treatment of HIV/AIDS Opportunistic infections, although three out of eight indicated that consulting traditional healers was not necessarily their own choice. Two PLWAS do not believe in traditional healers and have never consulted them. Five PLWAS's view was that Traditional healers can treat opportunistic infections effectively and they indicated their own health bear evidence to such claims. The study had shown that, although traditional healers have shown good rapport with their clients, and have earned positive respect due to their involvement in HIV/AIDS prevention and treatment in their communities, there are also challenges with regards to their work that calls for urgent attention. For an example, a highest number of Traditional healers did misrepresent diseases related to sexual intercourse, and also they could not recognize the symptoms of HIV/AIDS. They also hardly gave all biomedical perspective of transmission of HIV/AIDS without being probed. Both the group that believed in traditional healers and those that do not, as well as Biomedicine indicated that using traditional healers alone without biomedicine is not a realistic option.due to their training that is not homogenous and their profession that is rarely regulated. All the participants interviewed were in support of the strong collaboration between traditional healers and Biomedicine

Declaration

I declare that this research report is my own unaided work except for the assistance of the people I have acknowledged. It is being submitted in partial fulfilment of the requirements for the degree of Masters in Social Policy at the University of Kwa Zulu Natal, Howard College Campus, Durban. It has not been submitted before for any degree or examination at any university.

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ABBREVIATIONS

THs – Traditional Healers

PWA – Person living with HIV or AIDS

PWAS – People living with HIV or AIDS

TMPs – Traditional Medical Practitioners

HIV - Human Immunodeficiency Virus

AIDS – Acquired Immune Deficiency Syndrome

STDs – Sexually Transmitted Diseases

OPERATIONAL DEFINITIONS

AIDS – Acquired Immune Deficiency Syndrome. A collection of specific illnesses and conditions which occur because the body's immune system has been weakened by HIV.

HIV – Human Immunodeficiency Virus, the virus that causes AIDS.

HIV positive – Refers to a person who has tested HIV positive and therefore has been exposed to the HIV virus and is infected with the virus.

HIV status – Whether someone is HIV positive or negative.

IMMUNE SYSTEMS – The part of the body's structure and function which fights against infections and other recognised foreign bodies.

OPPORTUNISTIC INFECTION (OI) – Infection of the body as a result of a weakening of the body's defense (immune system). These infections would not normally cause disease in a healthy body.

VIRUS – The smallest type of disease – causing organisms which can only reproduce within a living cell.

(Taken from the National Aids Manual Information Series for Positive People)

CHAPTER ONE

1.1 INTRODUCTION

This dissertation examines the role of traditional healers (THs) in their efforts to combat the HIV/AIDS epidemic in South Africa, for two principal reasons:

*Firstly, the vast majority of the population of sub-Saharan Africa is reported to obtain their health care and education from THs (Gdobossou, E.V.A. XIII International Conference, Durban, SA).

*Secondly, there are at present many efforts to promote co-operation between traditional healing and 'western' bio-medical health systems, on the grounds that each sector has much to contribute to containing the pandemic and both have much to learn from each other. This study uses research in a locality in South Africa as a case study to examine how THs are involved in treating HIV/AIDS, and to assess efforts to encourage co-operation between 'traditional' and 'western' medical systems

Throughout sub-Saharan Africa, THs are widely consulted for health care, spiritual guidance, and for advice on political, legal and social issues. Traditional healers are potentially the largest available community resource for providing people affected by HIV/AIDS with much of the information, care and support they urgently need. Most THs, however, still lack the technical knowledge which they need to carry out this role effectively. In the past, healers have demonstrated their readiness to adopt some aspects of western, or 'modern' medicine. Yet in the field of HIV/AIDS, there has been little genuine dialogue between THs and modern medical practitioners. In many countries relations between the two are generally marked by mutual distrust, rivalry and even hostility. However, there are examples of collaboration in HIV/AIDS care and prevention between these two groups.

For instance, in Uganda, when Dr Donna Kabatesi (an expert in the treatment of sexually transmitted diseases at Mulango Hospital in Kampala) went to meet a group of THs in early 1992 she was disappointed (Kaleeba, N *et al*, 2000:51-52). Dr Kabatesi and two medical colleagues wanted to test the efficacy of herbal treatments for medical conditions commonly associated with HIV infection. The initial reaction of the traditional health practitioners however, was entirely negative.

"They said we were only asking for help because we were failing to deal with AIDS ourselves. In the past we had always rejected their input, so why should they help us now. They also said that, since AIDS was a new, foreign disease, they did not know much about it anyway" (*op cit*: 51-52)

Undaunted, Kabatesi and her colleagues kept meeting with groups of THs, trying to establish mutual trust and to discover some common ground for collaboration. Finally, after many hours of patient negotiations, an agreement was reached to study the efficacy of herbal treatments for the three common, HIV-related conditions: chronic wasting, herpes zoster (shingles) and chronic diarrhea. Some 500 patients were selected for the study at the healer's clinic and at the TASO AIDS clinic at Mulago Hospital. Among the patients at Mulago Hospital, a group treated with modern medical drugs served as a comparison with those being treated with herbal preparations. The study which lasted for six months, found marked improvements in patients on herbal treatments who were suffering from herpes zoster and chronic diarrhea. These improvements were either comparable to, or better than, those in patients being treated with modern medicine. However, no substantial weight gains were found among patients suffering from chronic wasting, regardless of whether or not they were receiving herbal treatment or modern medicine. (Kaleeba, N *et al*, 2000:51-52).

Modern medicine is characterised by several deficiencies. In Africa there is only one physician for over 15.000 inhabitants in urban areas and one physician for over 150.000 in rural areas. Eighty percent of the HIV positive patients in the world live in Africa, while 80% of the monetary and treatment resources are in developed countries (Gdobossou E.V.A. XIII International Conference, Durban, SA). Traditional healers are often the only source of health care to a community, and serve as community advisors, in addition to village elders and policy leaders, as well as health care providers.

Studies continue to show the willingness of THs and modern medicine practitioners to collaborate. A study conducted among Zambian THs and formal health workers to determine their knowledge and practices in the field of HIV/AIDS and to examine their training needs and attitudes to collaboration, in preparation for planning a joint training workshop (Burnett, A *et al*, 1999) is one example of such collaboration. Several misconceptions concerning symptoms and transmission of HIV disease were found in both groups, particularly among THs. Twenty healers (51%) and four formal health workers (15%) claimed a cure existed for AIDS. The majority of traditional healers interviewed expressed difficulties discussing diagnosis of HIV directly with patients, mainly due to fear of the patient becoming depressed and suicidal. Most interviewees wanted more training – the majority of THs in recognising the symptoms of HIV/AIDS and their treatment, and the majority of formal health care workers in HIV counseling. Most were interested in supplying condoms. Almost all healers and half of the formal health workers were keen to collaborate in training and patient care. The study indicates that there is willingness amongst Zambian THs and formal health workers to collaborate in training and patient care in the field of

HIV/AIDS. Training should aim to increase ability to openly discuss HIV with patients, which many THs and some formal health workers find difficult (Burnett, A, *et al*, 1999).

Research shows that THs provide primary health care to approximately 80% of the population of South Africa and currently there are over 200,000 THs countrywide (Pretorius E, 1999). This resulted in a decision by the South African Department of Health to involve THs in the struggle against HIV/AIDS/STDs and TB by training, provision of basic information, and creation of awareness on HIV/AIDS in the community. Two THs consultants were contracted to train other traditional healers in all the provinces. Workshops were conducted in the provinces through collaboration between THs and provincial health care co-ordinators. Participatory discussions were used for exchange of ideas. Two hundred and twenty nine THs from urban and rural areas were trained in all nine provinces out of 180 targeted nationally (123%) an increase of 23%. Two provincial health care workers participated from each province. Good understanding has been shown on the part of both parties of the basic information on the spread of HIV/AIDS/STDs and TB and both have agreed to collaborate in the fight against these diseases (Manci, M. XIII International AIDS Conference, Durban, South Africa, p.9-14, July 2000).

The above discussion highlights the current context of interaction between different health systems in the effort to combat HIV/AIDS. In South Africa, however, there is as yet no clear idea of what THs are actually doing in relation to HIV/AIDS, what broader role they could play to combat the national epidemic, and how effective their interventions are. This study is an attempt to address this problem.

1.2 AIMS AND OBJECTIVES

The general aim of the present study is to examine whether THs are preventing the spread of HIV/AIDS. A number of objectives were formulated in order to fulfill the aim of the study. These objectives determined more specific areas of investigation that could be integrated to meet the overarching aim of the research. The objectives of the study are as follows:

- (a) to examine how THs claim to prevent the spread of HIV/AIDS.
- (b) to assess how these claims are validated by THs and by patients themselves .
- (c) to assess what THs are actually doing .
- (d) to identify specific areas in which they are making a contribution .
- (e) to examine how their contribution could be improved.

1.3 STUDY AREA: TEMBISA

The research was conducted in Tembisa, an urban township situated between Johannesburg and Pretoria in Gauteng province. Tembisa is the second biggest township in Gauteng following Soweto, with an estimated population of 2.3 million. It is one of the oldest township situated in Eastern part of Kempton Park.. Tembisa was established as a regional township in 1956, primarily to house 'black' workers employed in the surrounding industrial and commercial areas of Kempton Park, Germiston, Edenvale, Modderfontein, Lyttelton, Isando, Spartan, Sebenza and Elandsfontein. The majority of people staying in the area are Tswana, Xhosa, Zulu and Pedi speaking people. . It contains 30,000 formal housing units. There are nine Municipal Clinics. Furthermore there are two mobile clinics in the Winnie Mandela area and Kempton Park, as well as two Private Clinics, namely Birchmed and Medicross. HIV/AIDS is recognised officially as a major health concern in Tembisa. The statistics suggests that there are 127infections daily in Tembisa.([http://www.environment.gov.za//soer/reports/ekurhuleni/Report.](http://www.environment.gov.za//soer/reports/ekurhuleni/Report))

Like any other South African township, Tembisa is not without challenges. Some of the challenges experienced in this township are as follows:

- Lack of housing which was one of the inheritance of apartheid government . This has led into overcrowding.. Most people stay in shacks.
- High unemployment rate and obviously high poverty levels.
- High levels of crime especially domestic violence, substance abuse especially in high schools.. Due to overpopulation, the South African Police Service is unable to effectively deal with such crime.
- The accessibility of social services to community members remains a dream in the area. For instance senior citizens and people with disabilities have to travel long distances in order to access grants and pensions.
- The health system in this township is also a shame. Communities continue to wait in long cue before a service is offered to them. There are common instances where they wait in long cues and end up not being assisted due to unavailability of medications.
- All the spheres of governments are believed to have failed to make strides in some parts of the township, although it should be notable that local government has

played a crucial role with regards to infrastructure improvement in some areas such as roads, lighting, street signs etc.

However, given the above mentioned challenges, the high prevalence of HIV/AIDS in the area has compelled the community to adopt a holistic approach towards the response to the pandemic through the community project. Such project provides multiple responses in its effort to curb the pandemic such as home-based care, counseling and free medication.

1.4 LIMITATIONS OF THE STUDY

- The study was short and could not address all the issues involved in such a sensitive issue. It therefore focused on what occurs in one locality and thus only tackled a variety of broader issues. This helped the researcher to work with a designated population of traditional healers and people living with HIV/AIDS (PWAS) - i.e., the researcher needed to provide a 'focus' that is feasible for a study of this nature. A geographical focus was found to be one way of bringing the study down to a manageable size in the form of a case study.
- Documenting material is a new culture in traditional healing, so there are few studies conducted on it that have been reported in books and journal articles. The researcher therefore relied more heavily on newspaper articles for the literature review, although some books and journal articles have been examined. Much information has been derived from newspaper articles which are sometimes not 100% reliable but the researcher hoped to come with information from the media that would provoke discussion around the issue.
- Only *Sangomas* were interviewed. Other THs like Faith Healers and *Amaxhweles* were not represented.\
-
- Most of THs views were not visibly scientific or evidence-based.

1.5 STRUCTURE OF THE DISSERTATION

Chapter One introduces the study and gives the aims and objectives that have formed the basis of the research.

Chapter Two provides a literature review that outlines the negative and positive roles THs are seen to play, as well as discussion on definitions of THs. It also provides information on traditional medicine and its use and a number of aspects associated with HIV/AIDS.

Chapter Three identifies the research methodology and methods used in the study. It also provides the findings of the study through a discussion of the themes emerging from the analysis of the data. Qualitative methods of analysis have been used to analyse the data gathered in this study.

Chapter Four deals with THs local phrases to diagnose their perspectives of HIV/AIDS and their interaction with Biomedicine.

Chapter Five deals with PWA's disclosure and a NAPWA HIV/AIDS Support Group.

Chapter Six presents the data collected from THs about the treatment they provide as well the data on the PWAS' perception of THs' treatment.

Chapter Seven presents the data on PWAS' experience of THs and their healing practices.

Chapter Eight presents PWAS perception on THs and Biomedical treatment, focusing on the medication that can treat HIV/AIDS.

Chapter Nine presents the PWAS's experience of the support group.

Chapter Ten presents the data that was collected from the Biomedical health care providers.

Chapter Eleven provides key information that has been analysed from the data collected.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In 1982 the first South African was diagnosed HIV positive. For the next four years the prevalence of HIV in South Africa rose slowly – with a total of 44 people diagnosed with AIDS. In these early years HIV/AIDS followed the classic Western pattern in which gay men and intravenous drug users were the most commonly infected. By 1987 this pattern has begun to shift, and increasing numbers of cases were found among heterosexual people. HIV/AIDS was beginning to show the same pattern as in African countries to the north (Lawson 1997: 3-5).

Today South Africa has one of the fastest-growing HIV/AIDS epidemics in the world, with up to 2,000 new infections every day and a national doubling time of between 20 and 24 months in the number of HIV positive people in South Africa at 2.2 million (Lawson, L, 1997: 3-5).

The much debated Statistics South Africa Report released in early 2005 ‘discovered’ that HIV/AIDS is not the number one cause of deaths in South Africa. The largest circulation African newspaper in the country (*City Press* 27/2/2005:18), together with medical researchers and other statisticians, however pinpointed the flaws of this report conclusively.

It was accepted by Statistics SA itself that the data were collected through official death certificates issued by the Department of Home Affairs. However, it was commonly known that most people who die of AIDS-related diseases do not disclose their status as HIV/AIDS is still a taboo within African communities, a well-guarded secret which is protected in life and beyond to the grave. It is thus not disclosed as a real cause of death.

The data presented in the Statistics SA report were, however, very revealing. The profile of the dying has changed radically, as deaths happen mainly in the 25-35-39 age group. This was accepted by researcher in the medical field as the direct result of AIDS (*City Press* 27/2/2005:18).

Although people are beginning to die in large numbers in parts of KwaZulu-Natal and Gauteng, their deaths are explained away as TB, pneumonia and other illnesses. Unlike other illnesses, HIV/AIDS

mainly affects young adults between 15 and 45 years of age. These are the breadwinners, the workers, the leaders and the parents of society. Dr Neil Mc Kerrow, senior paediatrician at Edendale Hospital gives the following description:

“If you look at any population in a pre-AIDS era we basically have three groups of people: the children, the parents and the grandparents, and within this structure the greatest death and morbidity is found in the first and third generation. And your economically active proportion of the population is also the healthier with the lowest death rate. Now you introduce HIV/AIDS, and it targets your second generation and wipes out the support structure for the other two dependent generations. Therefore we are not only losing a number of economically active people, we are losing the entire support structure of the society” (Lawson 1997:3-5).

In South Africa, according to an early Medical Research Council report, 40.5% of deaths of those in the 15-49 age bracket in 2000 were related to AIDS (*News Update*, October 18, 2001). In Gauteng, the provincial health department’s director for its AIDS programme, Liz Floyd, is on record as stating that HIV/AIDS claims more lives than any other cause. She said that HIV/AIDS was the leading cause of death in the province, although it was difficult to quantify it. “We have seen an increase in the number of death in the paediatric tuberculosis and medical wards”. There had also been a rise in the death rate of pregnant women” (*News Update*, October , 2001).

The Chris Hani Baragwanath Hospital which is situated in the Southern part of Johannesburg says that more than 24 000 patients have died from AIDS since 1988. According to Doctor Alan Karstaed, head of the hospital’s HIV Clinic, 71% of people aged between 15 and 44 who die in the hospital are HIV positive, while 42% of all patients admitted have HIV/AIDS. In 2000 there were 6,848 AIDS deaths at the hospital. In 1999 the figure was 6,310 deaths and in 1998 it was 5,795. In 2001 there were 5,821 deaths from AIDS at Baragwanath (*News Update*, October 18, 2001).

HIV/AIDS prevalence ratios are not uniform in Sub-Saharan Africa. National HIV/prevalence ratios range from under 2% of the adult population in some West African countries to around 20% or more in the Southern part of the continent; with countries in Central and East Africa having rates midway between these. Conservative analysis show that in the eight African countries where at least 15% of today’s adults are infected, HIV/AIDS will claim the lives of around a 1/3 of today’s 15 year olds (UNESCO: 2002)

In 16 African countries south of the Sahara, more than one-third of the adult population aged 15-49 years is infected with HIV/AIDS. In seven countries, all in the Southern corner of the continent, at least one adult in five is living with the virus. These include:

- Botswana, where a shocking 38.8% of adults are infected with HIV/AIDS. In the same country at least one-third of women aged 15-24 are infected.
- South Africa, where 21.1% of adults are infected with HIV/AIDS. South Africa has the largest number of people living with HIV/AIDS in the world, with a total of five million infected people. This country is not far behind Botswana with 20-28% of woman aged 15-24 infected (UNESCO: 2002).

In the African section of its annual risk map 2002 survey Control Risk Group says South Africa and Nigeria, the continent's key countries, faces a further period of awkward choices and urgent structural form. Control Risk Group advises 86 of the U.S. Fortune top 100 companies' investment decision makers. In South Africa, the pressure on President Thabo Mbeki and his government to balance fiscal prudence with demonstrable socio-economic progress will grow. South Africa leads of group of countries in a low political risk relating, although the security risk rating is medium with some areas classed as high because of the crime rate control (Risk map 2002), (http://www.org.com/press_release_11.htm).

Predictions of the economic outcomes of a phenomenon such as HIV/AIDS should be treated with caution since reliable accurate data is scarce and may be skewed when it is extrapolated with predictive models. One fact is perfectly clear however. The epidemic primarily affects young working-age adults and far exceeds any other threats to the health and well-being of the South African workforce. Over the next decade the number of employees lost to AIDS could be 40-50% of the workforce (Love Life 2001). As many as 800,000 South Africans a year could be dying as a result of AIDS by 2010 and this cannot fail to have a massive socio-economic effect.

Direct cost to companies include the cost of health care and other employees benefits. Already HIV/AIDS has resulted in rising cost of employee benefits and the cost of an average set of

benefits is expected to double over the next five to ten years, unless the benefits are restricted (*Business Times*, 11 December, 2003)

The most significant cost to businesses is likely to be indirect. These include the cost of absenteeism due to illness or funeral attendance, lost skills training and recruitment costs, and reduced work performance and lower productivity. By 2010 it is estimated that approximately 15% of highly skilled employees will have contracted HIV. Labour-intensive companies may seem to be at a higher risk of lost production but the vulnerable companies are those that employ specialists such as highly trained machine operators and technical staff. In small and medium sized enterprises, the illness and death of owners or managers, or of a small pool of locally skilled people could prove disastrous (*Sunday Times*, May 23, 2003).

Factors that need to be taken into account by businesses include the risk profile of employees, HIV/AIDS education programmes and modification programmes which:

- Give the facts and dispel the myths concerning HIV
- Reduce stigma and irrational fears
- Give advice on, and treat sexually transmitted diseases
- Put condoms in the workplace
- Promote peer counseling and testing; counselors can perform the very important role of encouraging voluntary counseling and testing. It can be a preventative tool to help people who find out they are negative want to stay negative. But this depends on a moral obligation on the part of the employee. On the other hand, if businesses do not manage the epidemic they will lose irreplaceable workers. This is already happening (*Sunday Times*, May, 23, 2004).

The vulnerability of particular markets will be influenced by the nature of goods and services produced and demographic and risk profile of consumers. Certain markets will expand - notably health care services and funeral services. Non-essential and luxury goods and services are more likely to be affected negatively by household expenditure shifts. Many middle-income households will become poorer, and goods and services aimed at upwardly-mobile households may be affected. The risk of default on debt payments will increase. Long-term lenders and insurers have already begun adapting

products to reduce their exposure. Savings levels and credit supplies will suffer further reductions (www.worldbank.org).

The HIV/AIDS will impact on the population in a number of ways. Mobility and mortality will increase and will be reflected in decreasing numbers in the reproductive age group. This may reduce fertility and slow the population growth rate. It is, however, not expected to result in negative growth. The structure of the population will also change (University of Natal's Health Economic and HIV/AIDS Research Division [HEARD], 2001).

Life expectancy at birth is particularly sensitive to the AIDS epidemic. There are two sources of data. The United Nations Development Programme took AIDS into account in producing the 1997 *World Development Report*. Table one shows the difference in life experiences between 1993 and 1994. The U.S Bureau of Census has projected the impact of AIDS and future levels of life expectancy.

TABLE 1: CHANGES IN LIFE EXPETANCY DUE TO AIDS

COUNTRY	1993 LIFE EXPR	1994 LIFE EXPR	DIFFERENCE	1998 LIFE EXPR	2010 LIFE EXPR
BOTSWANA	65.2	52.3	-12.9	40.1	37.8
SOUTH AFRICA	63.4	63.7	+0.3	55.7	48.0
SWAZILAND	57.8	58.3	+0.5	38.5	37.1
ZIMBABWE	53.4	49	-4.4	39.2	38.8

In May 2004, South African President Thabo Mbeki identified the struggle against poverty and underdevelopment as the core challenge facing South Africa. He spelled out a comprehensive programme of action including deadlines to the government around proving that the economy benefits all South Africans. The *Sunday Times* (23 May 2004) quoted him as using the work 'will' 127 times in

his speech, leaving little room for compromise. Fewer than a dozen of his statements were diluted with words like 'should'. In an article in *A.N.C. Today* after the xxii Socialist International he spoke about the two types of economies: the first and the second economies that co-exist in South Africa and the need to build a social security net to help fight poverty. He defines 'first' economy as the first world economy with employed people with access to money and jobs. The 'second' is the poor people lacking access to money and employment to (www.anc.org.za).

As part of the Comprehensive Plan on HIV/AIDS President Mbeki said 113 Health facilities would be fully operational and 53, 000 people would be on treatment by 2005. On the other hand R14.2 billion has been earmarked for housing. The question arises. Why does the government put R2 billion aside for AIDS-related issues for the next five years if the intention is to create ghost cities instead of getting ahead in the fight against AIDS-related deaths? Or is a red herring?, Why?

HIV/AIDS-related deaths are extremely high among the teachers and school administrators especially in KwaZulu/Natal. In the Central African Republic 107 schools have closed because of teacher shortages, largely due to HIV/AIDS. In KwaZulu-Natal it is estimated that more than 11,000 teachers of the age of 35-45 years have died of HIV/AIDS (*KZN Budget, 2004*). On average, it costs the government R32,000 to train one teacher. How much money does government waste by not considering HIV/AIDS as a National Disaster?

About 94% of the children between the ages of seven and 15 are able to attend school in South Africa; however, "actual education attainment among school goers tends to be rather low. Children seem to be struggling to compete at both primary and secondary school. Relatively few people attend tertiary education (Statistics South Africa, 2001). About 16% of the population 16 years and older cannot read in at least one language. Attendance at non-school educational institutions tends to be low.

Given that this is a key area of government focus, it is surprising that the gains made over the period tend to be marginal in nature and that in some of the areas access is relatively low. It is true that service delivery and pricing regimes are being restructured to accommodate efficiency criteria guided by the Growth, Employment and Redistribution (GEAR) strategy, and that, increasingly, equity considerations are being compromised. With inflation and tariffs out in place for most services, one can expect further

constraints on access to services such as water, electricity, telephones, housing, healthcare and education. Finally, when an expanding population, increased migration and the consequences and care needs of the HIV/AIDS epidemic are taken into account, it is clear that the government has a huge task on its hands and that the constraints imposed by GEAR on service delivery become even more questionable from an equity perspective (Pillay, 2003). Access to land and the HIV/AIDS pandemic demand attention.

To date there are three significant socio-economic rights cases (Section 26 and 27). The first was *Soobramoney v Minister of Health, KwaZulu-Natal*, in which Mr. Soobramoney applied to the High Court for an order directing a state hospital to provide him with expensive dialysis treatment. His claim was based in part on s 27 (3), which provides that “[n]o one may be refused emergency medical treatment”. In rejecting his appeal to the Constitutional Court, the court held that the right did not extend to providing treatment for an ongoing, chronic condition, and that the state’s policy to limit the availability of dialysis treatment to specific patients was reasonable in the circumstances.

The second and most recent case is that of *Minister of Health v TAC* again dealing with the right to healthcare. In this case, the Court held that a government policy concerning the prevention of mother-to-child transmission of HIV/AIDS that provides for the distribution of anti-retroviral drugs only to selected state hospitals around the country is unreasonable and infringes the right to healthcare of HIV-positive women and their babies born in the public health sector, outside of these pilot sites. Limiting the programme for the prevention of mother-to-child transmission of HIV to pilot sites for a research period before deciding whether to expand the programme nationally was found, in the circumstances of the epidemic in South Africa, to be unreasonable and in breach of this right.

The third socio-economic rights judgment is that of *Grootboom* (Reddy 2005)

The economic and demographic impact of HIV/AIDS will have widespread consequences for society. The loss of productive members of the community, dependence ratios, orphans and economic pressures on households all have major implications. The quality of schooling and the health of orphaned children may deteriorate. Many orphans will end up in child-headed households or in the streets. Orphans have

to deal with trauma of losing parents; they are at greater risk of developing anti-social behavior and being less productive members of society (HEARD, 2002).

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impact at household and firm levels in macroeconomic projections. Some studies have found that the impact may be small, especially if there is a plentiful supply of excess labor and worker benefits are small. There are several mechanisms by which AIDS affects macroeconomic performance: AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur in workers' most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced:

- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.
- Lower government revenue and reduced private savings (because of greater health care expenditure and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.
- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.
- The overall impact of AIDS on the macroeconomy is small at first but increases significantly over time.

In South Africa, by the year 2010, child mortality will be 99.5 per 1,000 children including the impact of AIDS, while the number would have been 48.5 per 1,000 without the effect of HIV/AIDS. Life expectancy will decrease to 47.8 years from the previously expected 67.9 years, due to the impact of HIV/AIDS. Overall, the population growth rate with AIDS will be 0.4% by the year 2010, while the growth rate without AIDS would have been 1.4% (HEARD 2004)

AIDS will also have significant effects in other key sectors. Among these are:

Health. AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS *versus* preventing HIV infection; treating AIDS *versus* treating other illnesses; and spending for health *versus* spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce which is essential for economic development.

- Various hospitals report large numbers of HIV/AIDS illnesses; in Durban, 40% of adult medical in-patients at King-Edward VII Hospital were admitted with HIV-related conditions in 1997; the percentage of HIV-related admission in Gauteng in 1997 varied between 26% and 70%; and in 1996, the Chris Hani Baragwanath Hospital in Soweto reported that about 30% of children under age 6 were HIV-positive (HEARD 2001)

Transport. The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

- In KwaZulu-Natal, there are two major trucking routes, as well as two major harbour areas. Commercial sex workers are prevalent. There is also cross-border traffic between KwaZulu-Natal, Swaziland, and Mozambique; both of the latter countries have relatively high prevalence rates. KwaZulu-Natal has some of the highest prevalence rates in South Africa. A survey of 213 truck drivers in this area found that 35% had more than one sex partner in the week immediately preceding the survey. Although most of those surveyed had heard of AIDS and knew how to protect themselves, it was not clear whether they were, in fact, doing so (*KZN Budget 2004*)

Mining. The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centres forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining

engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

- It is estimated that approximately 284,000 men were employed in the mining sector in 1996, 122,000 of whom were foreigners (Mining Charter 2004) These men live in single quarters and are not allowed to bring their families with them, creating a high risk for HIV transmission. Apartheid also made any South African miners migrants once they went beyond the 'borders' of the 'homelands'. The National Union of Mineworkers in South Africa introduced an education campaign about HIV/AIDS in the late 1980s, and has advocated the provision of family accommodation. Even with these programmes, the union estimates that there could be between 12,000-14,000 AIDS-related deaths per year by 2010. The table shows the cost of AIDS to the mining industry, estimated for the years 1995 and 2010. The projections indicate that total costs will increase from R114 million in 1995 to R1,509 million in 2010. In KwaZulu-Natal, an area of high HIV prevalence, many miners migrate to employment in the Free State and Gauteng, and are separated from their families for long periods of time (Mining Charter, 2004)

During Mandela's presidency, the South African government's orientation towards addressing the problems of poverty and inequality underwent some marked shifts, in language and emphasis, if not in substance. The 1996 closure of the Office of the Reconstruction and Development Programme (RDP) signaled to some at least a symbolic reduction in the priority given to improving the access of the majority of South Africans to adequate shelter, sanitation and education. Patrick Bond refers to GEAR as "home-grown structural adjustment" (Desai 2005).

The irony is that, with few exceptions, GEAR has not done well even by its own objectives and targets. It has, for example, not come near its projected economic and export growth rates and sustained inflows of direct foreign investment, which many predicted or hoped would follow democratic change, have not materialised (Desai 2005). Moreover, prospects for increased flows of foreign investment have been further eroded by the rampant tide of violent crime and the exceptionally high HIV/AIDS infection rates, not to mention the government's horrific handling of HIV/AIDS.

Recent estimates have suggested that HIV/AIDS could reduce Gross Domestic Product (GDP) growth rate by between 0.3 and 0.4% per annum over the next 15 years. The impact on human and social development is expected to be much more profound than reflected by limited indicators such as GDP or *per capita* GDP. Affected persons, particularly orphans will also have greatly reduced chances of fulfilling their human potential. Reduced parent care may also increase anti-social behavior, crime levels and the numbers of homeless. Finally HIV/AIDS will increase socio-economic disparities (Love Life, 2003).

Development is about more than economic growth and GDP *per capita*: it includes longevity, standard of living, infant and child mortality and distribution of income. These broader goals are more vulnerable than economic growth to the impact of AIDS, particularly life expectancy, infant and child mortality and crude death rates. The epidemic will reverse some of the development gains made by infected countries, worsening the plight of their populations. AIDS will be a major obstacle in reducing poverty and inequality. Many poor households will be pushed further into poverty by the loss of a breadwinner.

Because HIV/AIDS targets the economically active, it has a far greater socio-economic impact than other health problems. Research in other African countries has shown that HIV/AIDS has retarded development goals and increased poverty. The impact of HIV/AIDS has been most severe on families and households of poor communities, which have then experienced reduced ability to pay for basics like food, housing and services. On the other hand, it is these already disadvantaged groups which are the most vulnerable to HIV/AIDS infection. Across the globe HIV/AIDS is most prevalent in poor, marginalized communities, with the majority of cases occurring in developing countries. Prof Alan Whiteside of the Economic Research Unit at the University of Natal (Durban) says:

“AIDS is the end result of an HIV infection and it is a health issue. But HIV/AIDS are born symptoms rather than causes. They are symptomatic of past injustices, dislocations and inequalities. I think when one looks at AIDS epidemic one has to look both upstream at the causes – like poverty, the violence, the position of women and downstream at the consequences” (Lawson 1997:3-5).

To unpack the above further Alan Whiteside and Clem Sunter (2000: 62-63) argued, that:

“Despite a relatively late start, HIV has taken off in South Africa. Apartheid may have delayed the onset of the epidemic, but its legacy is a fertile environment for HIV’s rapid spread. Under the apartheid system, the country was subject to extreme social engineering, designed for the benefit of the minority white population. The state sought to control who could live and work where. The Government policy stated: ‘Bantus’ are only temporarily residents in European areas for as long as they offer their labour there. As soon as they become, for some reason or other, no longer fit for work or superfluous in the labour market they are expected to return to their country of origin. The country of origin included both the homelands and the neighbouring independent countries. South Africa’s black population was forced into crowded, impoverished homelands which led to the breakdown of traditional cultural structures. Adults, mainly men, migrated to the urban areas to work in white-owned factories and mines and to live a single-sex hostels. They were prevented by law to bring their families. This created a culture of urban and rural wives and prostitution – not necessarily for cash but as part of survival strategy. Many children were cared for by adults other than parents, and in the wake of family break-ups, child abuse and child prostitution became a new phenomenon. Health services were limited, which meant many diseases including STDs were untreated (Whiteside & Sunter, 2000:91).

The links between poverty and health are increasingly recognized and understood. It is clear that AIDS is not simply a disease of poverty, although poverty undoubtedly helps drive the epidemic. In the early stages AIDS appears to infect the relatively well off: they have the disposable incomes that allow them to travel and, in the cases of men, purchase sex. Of course more poor people are infected – because there are more poor people – but it is likely that, as the epidemic evolves, they may be proportionately worse affected. What is clear is that AIDS increases poverty. Very strong evidence on this reality is provided by an in-depth study of a rural village in Tanzania (Whiteside & Sunter, 2000:91). This shows that AIDS-affected households are generally pushed into poverty and the situation faced by many can only be described as desperate. In effect, AIDS has the potential to push household even deeper into poverty.

The cost of the disease is also being shifted onto households in various ways:

- Where workers who are too ill to work are retrenched or medically boarded, they lose most of their benefits. Ultimately, they have to rely on state aid, help or grants or their families.
- State hospitals recognise that they are neither the appropriate location nor can they provide care for people with AIDS. These patients are discharged to be cared for at home which places an extra financial burden on the households.

- People living in urban areas may return to their rural homes when they fall ill, but can no longer access health services there (Whiteside. & Sunter, 2000:92).

As the impact of HIV/AIDS is felt, the implications for the low-income housing sector are only starting to be understood. Extended families have to provide for increasing number of orphaned children, and many households are already headed by children. With the loss of breadwinners in these households creating enormous financial difficulties, there is now a danger that impoverished families will no longer be able to afford to repay housing mortgages and loans. Nonpayment for municipal services such as water and electricity could soon have a major impact on the financial sustainability of local authorities (*Sunday Independent*, 2000).

2.2 PEOPLE LIVING WITH HIV/AIDS (PWAS) AND ACCESS TO ANTIRETROVIRALS

The nature of the virus also sets HIV apart from other health problems. Firstly, there is no cure for HIV/AIDS. Recent medical advances have shown that in developed countries, HIV may now be regarded as a chronic, manageable disease. However, the cost of the medication to achieve this will exclude the majority of people in developing countries such as South Africa. Secondly, research on the development of a vaccine, which would be more appropriate for developing countries, has lagged way behind. (Lawson, 1997:4-5). There are antiretrovirals that can manage the disease but poverty in South Africa makes it difficult if not impossible for HIV positive South Africans to access antiretrovirals because they are very expensive.

The well known negative position of both President Mbeki and the South African Minister of Health has exacerbated the problem of antiretroviral distribution in the country. This has become an international issue, especially after the various court victories of the Treatment Action Campaign (TAC) against the government and the Minister of Health regarding the free distribution of antiretrovirals to pregnant women throughout the country .

According to the Nelson Mandela Foundation's second national survey of HIV/AIDS, among the variables in question, knowledge and attitudes concerning HIV – related issues were explored. A lack of clarity / knowledge about whether HIV causes AIDS was discovered. For instance, just one quarter of respondents over the age of 50 (28.6%) disagreed or said they were unsure as did over 10 % of respondents aged 15-49 and nearly a fifth (18.1%) of 12-14 year old. This lack of

clarity on the latter two categories of age such as 12-14 and 15-24 is equally disturbing as the one in the older age of over 50 years for two primary reasons:

The first reason lies with the ages 15-24 and 12-14 since the same study reveals the youth aged 15-24 (28.8%) indicated that they felt vulnerable to HIV infection

The second reason lies with the ages above 50, since the same study reveal that males dating people younger than them can increase their risks of contracting HIV/AIDS, and they were also low condom users. However, such elements of confusions on whether HIV causes AIDS were expected to crop up in South Africa, where the then President of the Republic, Mr Thabo Mbeki was once accused of being an AIDS dissident himself.. The former President of the Republic, Thabo Mbeki once shared alarming views publicly, and said, HIV does not necessarily cause AIDS. He further referred to the Uganda Conference that was held in 2000, attended by 60 dissident scientists (a group of scientists who robustly stubbornly opposed to the scientific evidence that established a causal link between HIV and AIDS. The objectives of the conference were to find alternative view on the origins of the AIDS pandemic. And he pointed the following:

- Vaccines give rise to other diseases
- He questions what the HIV testing kits is actually testing
- Starvation and poverty are amongst other factors that can cause immunodeficiency
- The term HI virus has been fraudulently labeled by US government
- The main killer diseases in Africa are related to respiratory and malaria, not AIDS.
- He also opposed the HIV/AIDS statistics that suggested that quite a number of Africans die through HIV/AIDS, he said it is only 10% of Africans that died of HIV/AIDS.

In addition the former Minister of Health, who was serving under the leadership of President Thabo Mbeki, Dr Manto-Tshabalala – Msimang also rubbed salt on the wound when she reported that AZT (zidovudine, Retrovir) an anti HIV drug that reduces the amount of virus in the body) was not going to be made available for MTCTP (Mother- to- child Transmission Prevention) because of its cost and inadequate health infrastructure. She added that it weakens the immune system and could lead to mutations and birth defects. This led to an outbreak of protest and the birth of the Treatment Action Campaign (TAC) that was founded in Cape Town on the 10 December 1998, whose objective is to advocate for increased access to treatment, care and support services for people living with HIV and for

the reduction of new HIV infections.. TAC began an intensive campaign of mass action and took the South African Government to the high court demanding that the State must provide MTCPT as the fulfillment of the right to life as enshrined in the constitution. The government replied in court papers that MTCPT was unaffordable and would put too much strain on the health system. The TAC won since the court instructed the government to provide MTCTP.(Feinstein Andrew, 2007).

The current minister of Health in the Republic of South Africa, Barbara Hogan confirmed high prevalence of HIV/AIDS in the country, particularly to people between the ages of 20 – 34. She further confirms that South Africa has the highest roll-out of antiretroviral drugs in the world which many countries look up to. The high levels of unemployment and poverty in the country, have undermined such interventions. Studies continue to reveal that for a person living with HIV/AIDS to respond well to antiretroviral treatment, access to adequate food is essential. A recent pilot study from Zambia showed that food supplementation improved treatment adherence and there is growing evidence from various countries that health clinic attendance has decreased as food prices increase. This is for this reason that the World Food Programme (WFP) is involved in working through national governments and local partners to provide food and nutritional assistance to food insecure people living with HIV and their families. (UNAIDS, 26 Novemeber, 2008).

Inspite of the availability of free antiretroviral, that can manage the disease, poverty in South Africa makes it difficult if not impossible for HIV positive South Africans to access antiretrovirals. A study that was conducted in South Africa to explore patient and health worker perspective on issues surrounding adherence to TBPT (Tuberculosis Preventive Therapy and to derive lessons from improving access to care among HIV-infected individuals in rural South Africa reveal that there are factors that impede adherence to treatment, such as lack of transport fees to the clinics, .lack of food, lack of control over economic resources, fear of rejection and distigmatisation after the person has disclosed their status, as well as lack of social and financial support.(Rowe, K.A et al, 2005).

The studies cited above depicts challenges faced by people who are living with HIV/AIDS with regards to accessing biomedicine. Such challenges would compel people to explore other sources of healing such as traditional healing..

2.3 DEFINING TRADITIONAL HEALERS

A Traditional Healer (TH) or Traditional Medical Practitioner (TMP) is defined by the WHO (Oyebola 1986: 224 in Green, EC, 1994) as:

“Someone who is recognized by the Community in which he lives as competent to provide health care by using vegetable, animal and mineral substance and certain other methods based on social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well being and the causation of disease and disability in the community (Green, EC, ed, 1994).

Traditional medicine formulas are prepared from various natural substances (animal, mineral and vegetable). Traditional healers have extensive knowledge on the use of plants and herbs for medicinal and nutritional purposes. Some drugs are used as placebos, others for symptomatic [treatment] (Pretorius E, 1999).

2.4 THE ROLES OF TRADITIONAL HEALERS IN RELATION TO HIV/AIDS

For the purpose of this thesis, the roles of traditional healers will be divided into negative roles and positive roles.

2.4.1 NEGATIVE ROLES

Traditional healing has received negative publicity on occasion because of practices that can help spread rather than reduce the transmission of HIV/AIDS. Examples include:

- Instruments used to pierce or cut skin (syringes, knives, or razor blades) which are not sterilised may have tiny bits of blood containing HIV on them. If these instruments are used on another person, the HIV will infect the blood of that person.
- If a traditional healer has a cut or sore on his or her hands, their blood may, during treatment, may infect a patient.
- Another risky practice performed by traditional healers is scarification. Scarification is performed primarily as a means of getting medicine into the patient's body. Often the patients come to the healer with pain in a specific part of the body. The healer makes small incision in the patient's skin with a razor blade and rubs medicine into the cuts with his or her fingers or a soft tipped instrument. The part of the body to be scarified, in most cases, is the part which is painful. Often it is the joints where the incisions are made. Patients are at risk of contracting AIDS if the razor blade has been used previously and not sterilised. The healer is at risk if he or she comes into direct contact with the patient's blood at any point during the procedure.
- The use of *calabashes* and other containers for Medicine can also pose a risk. A *calabash* is a container which is used to store medicines which are not easily obtainable. If the finger or an instrument used to apply the medicine is dipped into the *calabash* or any other type of container after touching the patient's incisions or wounds, the contents of the calabash/container may become contaminated. Patients who have the contaminated contents applied to their cuts or wounds are at risk of contracting HIV.
- Maternity patients who come to traditional healers for delivery of babies are monitored from the start of the pregnancy up to the time when the baby is delivered. Contact with the woman's bodily fluids during prenatal care, labour, and delivery can put the healer at a risk of HIV infection if the mother is infected with the HIV virus.
- When a patient presents with a pain which he or she describes as moving all over the body, the cause of the pain is attributed to the presence of an object which has been induced into the body by witchcraft. In order to remove the object a traditional healer will scarify on the painful part of the body and, using his or her teeth, bit the incisions and suck out the object. The healer brings the patient's blood directly into his or her mouth. The healer is at risk, particularly if he or she has sores in the mouth or bleeding gums. The patient is also at risk during the procedure, if they have been cut with an unsterilised cutting instrument, or if the new incision comes into contact with the healer's saliva.
- With the rapid increase in the number of STD cases, female healers are being consulted by female patients complaining of discharge from the uterus. Treatment includes the cleaning of the uterus. To perform the procedure, the traditional healer must put her hands into the woman's vagina,

unavoidably coming into contact with the woman's vaginal fluids, including the discharge (Willms, Chingono & Wellington 1995).

2.4.2 POSITIVE ROLES

Although it is proven that some of THs' practices can jeopardise either their health or the health of their patients, studies reveal that traditional healers have a significant role to play in the continuing fight against HIV/AIDS through prevention and treatment. These positive roles can be subdivided into the following:

2.4.2 (a) TRADITIONAL HEALERS AS EDUCATORS:

Since the late 1980s, a number of HIV/AIDS prevention programmes in Africa have involved THs. Evaluation of these programmes have shown how they improve the way traditional health practitioners diagnose, treat and counsel clients with HIV/AIDS and other STIs. For instance, an evaluation of a South African AIDS prevention programme. (*The International newsletter on AIDS prevention and care ACTION Issue 46, Oct-Dec 1999*) discovered that a year after training, healers were able to:

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- Define and describe HIV accurately.
- Describe three or more AIDS symptoms correctly (and not give incorrect symptoms).
- Accurately describe three or more means of HIV transmission and prevention.

Almost all healers reported providing correct HIV/AIDS preventive advice and demonstrated the correct way to use condoms. Many of the healers also provided condoms (*The International newsletter on AIDS prevention and care ACTION Issue 46, Oct-Dec, 1999*).

Some traditional healers in Gauteng are involved in HIV/AIDS Education Campaigns in their areas. For instance a traditional healer Theresa Mbambo, a fieldworker of Tugela AIDS programme, says that the incidence of HIV/AIDS in her area is so high that she has given up her former role in the community to do AIDS Education. She said:

“We are not burying people like we used to. Before, a funeral was a big thing. Now sometimes only five people go to the graveyard. People are dying all the time and every weekend we must go to the

graveyard. Sometimes we are not even going to church because of this thing, its terrible (Lawson, 1999:12-13).

Traditional healers can also do much to help promote condom and spermicide use, safer sex practices, and restriction of the number of sexual partners (Green,1994:3).

It is not only in South Africa where THs have joined the war on HIV/AIDS by educating local communities .In Senegal, THs train people in family planning and AIDS prevention methods (Gbodossou, 2000). A Zimbabwean healer wanted to promote the use of a traditional spell that ensures fidelity, alongside the more conventional methods of condoms and abstinence to curb the spread of AIDS in Africa (Sapa, 2001). It has been stated that:

“In this context of traditional and powerful belief, traditional healers in South Africa represent an enormous resource in the struggle to educate people about the dangers of HIV/AIDS, said Nana Makhanya, a traditional healer employed as an advisor to the government’s AIDS programme. Makhanya spends a great deal of time in workshops with traditional healers around the country, encouraging them to inform people about condom use, to test for HIV and to refer HIV sufferers to hospitals if they feel they cannot help the patient”(Bronwen Roberts, 1999).

Because of their acceptance by the community, THs can play a vital role in disseminating AIDS prevention information in Africa, even when they are illiterate, according to a report from the International Eye Foundation. Researcher R.A. Berger and colleagues wrote that educational programmes detailing AIDS prevention efforts should be offered to these healers on a routine basis (Willms, *et al*, 1995). Traditional healers are common and culturally accepted healthcare providers in Africa, because they are trusted within in the community are free to discuss sensitive matters such as sex (Willms *et al*,1995).

Traditional healers themselves show enthusiasm for conducting HIV/AIDS educational programmes within their communities. In a South African study conducted in 1992, a total of 91% of healers said they would be willing to work with the Ministry of Health in AIDS control and 89% said they would be willing to hold village educational sessions (Willms *et al*,1995).

In the same token, as traditional healers are often sought out by community members for advice with respect to traditional customs and are likely to encourage their practice, it is important for the THs to

recognize the danger for HIV transmission with each practice and be able to advise community members accordingly (Willms *et al*,1995).

2.4.2 (b) TRADITIONAL HEALERS AS GIVERS OF CARE AND SUPPORT

Many people with HIV approach THs even when they have access to other health services. One reason is that THs usually treat the ‘whole person’, not just the disease. They take into account a person’s mental, emotional and spiritual as well as physical well being. This can include contacting the spirits for help. Traditional Health Practitioners often see patients together with other family members and can play an important role in family counseling and in reducing the stigma and discrimination against people with HIV/AIDS (*AIDS Action Issues* 46, Oct-Dec, 1999).

The traditional healers have also proved to be effective counselors of people living with AIDS, and they have helped remove some of the stigma that goes with the disease ravaging the continent (Njani ,1999).

It has been reported that THs living within the boundaries of the Roman Catholic diocese of Marianhill in Durban are among the hundreds of voluntary, home-based care workers being trained to look after patients with HIV/AIDS in their own homes. The project was established to help the estimated 35,000 people with HIV/AIDS living within the borders of the diocese of Marianhill. The Catholic Relief Service Organisation has given a grant to St Mary’s Hospital to provide the training and equipment necessary to manage the project’s Community team. According to a media statement from the hospital, it was envisaged that this team would grow to 350 voluntary, home based care workers (*Star Verve/ Sport*, 25 July 2001).

A study that was conducted in South Africa in 1992, focused on 70 trained healers selected from 10 geographically representative sites. Of 18 healers who said they had treated cases of AIDS, three mentioned giving advice and counseling to their clients without being prompted (Green, 1994). When prompted, the other 15 described promoting positive attitudes about people with AIDS, or showing care and understanding as to the type of advice or counseling given, while eight mentioned advising on condom use (Green, 1994).

African methods of healing fall within the academic field of cross-cultural psychology, but are not yet a distinct area.

“We need the two world views to start speaking to each other”, Makgathi, a psychology lecturer from Rand Afrikaans University, says. “Their different traditions of treatment have much to offer each other and a combination of the workable aspects would be very powerful. What draws them together is that they both support the needs of the person in trauma” (*Sowetan*, October 12,2000:13).

2.4.2 (c)TRADITIONAL HEALERS AS TREATERS OF HIV/AIDS RELATED OPPORTUNISTIC INFECTIONS (OIs)

HIV/AIDS treatment should not be narrowed down to a single issue of antiretroviral drugs because this undermined efforts made by developing countries in dealing with challenges of the epidemic, Health Minister Manto Tshabalala Msimang has said on a few occasions, despite the (correct) criticism she has received from the medical fraternity and NGOs, CBOS and communities.

Addressing the United Nations general Assembly special session of HIV-AIDS, she said, “Antiretroviral drugs are not the only form of treatment for HIV-AIDS. Those who propagate this thinking serve only to create unnecessary animosity between the people in the developing world and their governments”. Many developing countries, including South Africa, did not have the capacity and sufficient resources to procure and administer these drugs. “These countries have opted for other effective treatment options. It is a known factor that vigorous treatment of opportunistic infections, coupled with good and healthy nutrition can make people with HIV-AIDS live long and healthy lives (Sapa, 2001). Research conducted by F. Egal and A. Valstar shows that the chance of infection with the HIV virus might be reduced in individuals who have good nutritional status, with micronutrients and, especially, vitamin A playing significant roles. At the same time, the onset of the disease and even death might be delayed in well-nourished HIV-positive individuals (<http://www.fao.org/docrep/X4390t/X4390t04.htm>).

Some Ths claim to cure HIV/AIDS but most confess that they are unable to cure HIV/AIDS yet can treat HIV/AIDS-related OIs like sexually transmitted Infections (STIs), Tuberculosis (TB), diarrhea etc. Opportunistic Infections: “are sicknesses that take hold in the body because the body is weak and unable to fight the sickness off. The sickness ‘takes’ the opportunity to infect the weakened body. When HIV infects a person’s body, it slowly, over years, starts to make the fighting cells that fight sicknesses weak (Sapa, 2001).

African traditional medicine has proved in some instances to be superior to western drugs in the treatment of HIV/AIDS infections, according to some findings presented at the AIDS conference in Lusaka. (Njanji, 1999).

Takalani Mathiva, the President of the Traditional Healers Association reported that in HIV positive patients treated by traditional healers, the signs and symptoms of the disease disappear and they gained weight. He also revealed that there are plants that Africans use as prevention against the epidemic as well as plants that are used to prevent STDs in young people. He said that there are trees that treat stomach illnesses and cure gonorrhoea (*Venda Mirror*, 2001).

Doctor Donna Kabatesi of the Traditional and Modern Health Practitioners Together Against AIDS in Uganda said that in the East African country, 500 patients with AIDS using traditional therapies had been clinically monitored. She said the trial found that traditional herbs were more effective in treatment of herpes, chronic diarrhea and other ailments associated with HIV/AIDS than available pharmaceuticals (Njanji, 1999).

Traditional medicines and health practices can help reduce symptoms (such as pain), strengthen the immune system, and treat opportunistic infections. These examples suggest that various traditional medicines can be effective against OIs or can be used to help strengthen the body's immune system. In Thailand for example, studies are being carried out in regard to the use of a paste of greater galangal (a member of the ginger family) to treat oral thrush, acupuncture to help people with nerve damage (Neuropathy) and the herb slippery elm to relieve diarrhea (*AIDS ACTION ISSUE* 46 , Oct- Dec, 1999). The African potato and the cancer bush are boiled and drunk across the continent, to boost the immune system. The plump leaves of the sour fig are a potent remedy against oral and genital thrush and far cheaper than R100 pill Diflucan. And the ground shell of the snail rubbed onto sores heals them, traditional healers say. Yet it is not just the remedies that are effective (*AIDS ACTION ISSUE* 46, Oct – Dec, 1999).

A study by the Medical Research Council at Hlabisa in KwaZulu-Natal, used traditional healers to manage directly observed therapy, which ensures patient recovery and avoidance of multidrug-resistant TB. This study revealed that two-and-a half times more patients under the care of traditional healers complete their medication, compared with those who were monitored by clinics or health workers. Four times more patients not monitored by traditional healers died. These results are important because, as the

researchers state, “The TB epidemic is being driven by the HIV epidemic with 28% of TB patients in 1993 being co-infected with HIV, 59% in 1995 and 65% in 1997” (Smith 2001).

“Why we claim we can cure HIV/AIDS is because the signs and symptoms (of the illness) disappear after the treatment. This doesn’t necessarily mean they are cured”, one healer claimed. “If we have cured the signs and symptoms, we claim we have cured the virus – but we really can’t say. We don’t actually know what happened to the virus”, another healer said (Smith C, 2001).

Another study that was conducted in the Bushbuckridge Region of South Africa’s Northern Gauteng Province that seeks to assess health seeking behavior among tuberculosis patients reveal that most patients, 72% presented first to health clinics or hospitals for assessment, but a considerable proportion (15.4%) first sought treatment at a traditional or spiritual healer such as the Zionist Christian church or a local sangoma (traditional healer). The same study also looked at the levels of delays to hospitalization of such patients. Patients delay was less among patients presenting to hospitals with their symptoms than among those presenting to clinics or GPs. Comparisons of median suggested that those presenting initially to hospital had the shortest delays. Among those who initially sought treatment at a spiritual or traditional healer there was an additional median delay of three weeks before presenting to a recognized health provider. However, clinics (72%) and spiritual healers (98%) were more much likely to give advice on medication not appropriate for tuberculosis as a first response to patients presenting TB symptoms. The use of traditional healers as the preferred source of care for tuberculosis patients was only 15% - far low than anticipated. Previous works in South Africa, conducted prior to the introduction of the free primary health services, had suggested a higher preference for traditional healers. These findings also contrast with recent work in Tanzania, where approximately 40% of patients use traditional healers as the point of first contact for their symptoms.. It is however notable that approximately one –quarter of TB patients overall consulted traditional healers at some time during their illness. As such, calls for strengthening the collaboration and interaction between traditional and health system should continue to be supported.(Ponky, P.M.et al, 2008).

2.5 TRADITIONAL MEDICINES AND THEIR USE

It is very difficult to get serious literature on traditional medicine and its use because traditional healers' knowledge has been passed orally by parents to their children or by grand parents to their grand children. Some THs claim that their ancestors come to them mostly at night and tell them their patient's problems and the medication they have to use. Researchers come to traditional healers, looking for help regarding traditional medicine and then take the knowledge gained free and go and develop their treatment, which they are paid for. This type of treatment or attitudes towards traditional healers makes it difficult for traditional healers to share their knowledge and treatment (Kaleeba, 2000)

Their treatment is comprehensive and has curative, protective and preventive elements, and can be either natural or ritual, or both, depending on the cause of the disease. It includes among others, ritual sacrifice to appease the ancestors, ritual and magical strengthening of people and possessions, steaming, purification, (e.g. ritual washing or the use of emetics and purgatives), sniffing of substances, cuts (African mode of injection), wearing charms, and piercing (African acupuncture). They deal with many health problems such as conditions of the respiratory system, e.g. cold, flu, conditions of gastro, intestinal system e.g. diarrhea, conditions of urogenital systems e.g. STDs etc and other conditions such as cancer, HIV/AIDS (*South African Health Review*, 1999:252). They use medicinal plants. For instance, the *Hypoxis* species is used to make weak infusions and concoctions such as strengthening tonics in adults and children with wasting diseases (Ashley Mashigo, personal communication). The plant is known to have anti-inflammatory and immuno- modulatory properties (Van Wyk & Gericke, 2000: 146).

Dagga, called 'umya' in Xhosa, *Dagga* (Afrikaans), Marijuana (English), *nsangu* (Zulu), and *matokwane* (Sotho) has a well established use in indigenous medicine as a remedy for asthma, bronchitis, headache, migraine, epilepsy, pain, colds and flu, coughs, insomnia, labour pains, hypertension and diabetes. In modern medicine the crude drug and some pure chemical derivatives are used for treating migraine, glaucoma, nausea from chemotherapy, for improving appetite with cancer, AIDS and anorexia nervosa and for suppressing muscular spasm in multiplesclerosis (Van Wyk & Gericke, 2000:158).

Another frequently used plant is *Harpagophytum procumbens* (*Pedaliaceae*) – Devil's claw, *sengaparile* (Tswana) *duiwelsklou*, *kloudoring* (Afrikaans). This plant has a reputation for efficacy in osteoarthritis, fibrositis and rheumatism and is particularly effective in small joint diseases. Devil's claw is taken as a bitter tonic to stimulate the appetite, and for indigestion. It is also taken for fever and as an important tonic in infectious diseases including tuberculosis (Matambo, personal communication). The dry

powdered tuber is used directly as a wound dressing, or is mixed with animal fat or vaseline to make a wound-healing and burn-healing ointment (Van Wyk B. *et al*, 2000:146).

The people who suffer from tropical diseases tend to be poor. For example, Oku Ampofo in his practical guide for health workers, *First Aid in Plant Medicine* (1983:VIII) lists remedies for the following conditions cough, asthma, burns, skin rashes, snake bite, jaundice, cuts, wounds, diarrhoea, and convulsions (Even with these, Ampofo – a medical doctor – suggests that the health worker might want to use an allopathic medicine along with traditional plant remedy). Virtually none of these conditions except diarrhea are high-priority concerns among African health ministries (Van Wyk *et al*, 2000).

In a workshop to train 30 THs as trainers of trainers skilled in HIV/AIDS prevention held in Port Elizabeth, five traditional healers associations participated that claimed national membership:

*The Traditional Doctors Aids Project (TRADAP) with headquarters near Johannesburg,

*The traditional Healers Organisation of South Africa (THOSA) with headquarters in KwaXuma,

*The Professional Herbal Preparations Association of Inyangas (PHPAI), with offices in Johannesburg, Qwaqwa and Bergvill,

*The Traditional Healers Organisation of Africa (THOA), headquartered in Siteki, Swaziland, but said to have two branch offices in South Africa; and

*The African Natural Healer's Organisation (ANHO) with offices in Johannesburg (Van Wyk *et al*, 2000)

Virtually every major region of South Africa was represented in the final roster of participants. Bearing in mind problems inherent in classification and the overlap of healer roles in Africa, 19 healers described themselves as primarily diviner – mediums (*sangoma, ixhwele or ngaka*) the other nine described themselves as herbalists (*inyanga*). All but one healer regarded herself as specialist. The specialities identified (allowing for more than one) were sexually transmitted diseases, mental illness, barrenness or fertility, diarrhea, and evil spirit. Other specialities mentioned included tuberculosis, stroke, diabetic sores, arthritis, bone problems, hiccups, heart disease, ulcer, unemployment, blood purification, counselling, oedema, whooping cough, luck, medicine, pneumonia, breached birth, headaches, swollen feet, traditional birth control, female bladder complaints, warts, and training other healers. Treatment of

STDs was the most common speciality. Healers were asked if the diseases they treat are related to sexual intercourse, their causes and treatments. They mentioned the following:

- Drop (oozing genital pimples, sores discharge. It is caused by:
 - (a) Many sexual partners, his / her body gets dirty,
 - (b) Failure to practice safe sex,
 - (c) Sex with someone who has had an abortion.

- The treatment is:
 - (a) prepare special medicine, then give as enema,
 - (b) herbal tea only, no referral for injection,
 - (c) special herbs cooked –drink at 6am and again at 6pm,
 - (d) enema, douching,
 - (e) “I prefer to treat two partners if one approaches me. I tell my patients to stop sexual action”.

- *Gcushuwa* (greenish, thick discharge, sores, boils), is caused by
 - (a) many sexual partners,
 - (b) use of herbs, i.e. *intando*. The treatment is to clean infection and *muti* treatment.
 -
- VD – unspecified, is caused by having sex with person with STD, and sexual contact with person with bad blood and its treatment is (a) hot vapours, (b) enemas, (c) give drinking medicine and powdered medicine.
- Syphilis is transmitted by sexual intercourse and THs give the patient traditional medicine for drinking, washing and application on genital sores. They give patients herbal tea, enema, or refer them to a medical doctor.

- Gonorrhoea is transmitted by sexual intercourse and THs prepare medicine for drinking, washing septic areas and apply powder.
- Prolonged menstruation is an STD and the treatment is hot vapour.
- *Lombu* (back stomach, testes, bladder, kidneys, headache) caused by having sex with STD infected person is treated by traditional herbs that are a 1-3 day treatment.
- Grey horse (*Thosula*) it is caused by many sexual partners and their blood is very dirty, and THs prepare a special *muti* (Van Wyk, B *et al*, 2000).

2.6 CONCLUSION

In South Africa, HIV seroprevalence has been rising rapidly in the past few years. The inaccessibility of antiretroviral drugs has also contributed to traditional medicine remaining an important component of health services, despite a high rate of modernisation. The positive roles that are played by THs in addressing a variety of psychosocial and physical problems call for respect and acknowledgement. On the other hand the message that their healing practice can be potentially dangerous is disempowering and defeating their purpose. However, the studies conducted in South Africa and some African countries reveal that if THs are capacitated, despite their level of literacy, they become competent in their healing practices. The studies show traditional healer's enthusiasm for collaborating with biomedical health care providers. All the diseases are HIV/AIDS related opportunistic infections and THs seem to have the potential to treat them. If THs can treat HIV/AIDS opportunistic infections effectively, just like Biomedicine can, exploring collaboration between these two groups can be the only option that can also address the limitations of traditional medicine. This collaboration could be extended to other stake holders like local leaders, health authorities, government and key non-governmental players.

CHAPTER THREE

RESEARCH METHODOLOGY AND METHODS

3.1 INTRODUCTION

The aim of this chapter is to provide a detailed description of how the researcher recruited respondents for the study. The data gathered was used as the basis for a qualitative analysis of the role of traditional healers (THs).

The research involved interviews and interactions with the following participants:

10 THs

1 THs who are the organisers of the Traditional Healer's Organisation (THO)

10 People living with HIV/AIDS (PWAS)

The organiser of the NAPWA support group

1 matron from the Tembisa Hospital

1 sister from Tembisa clinic

The Assistant Director who is co-ordinating an HIV/AIDS/ STD Programme in the East Rand region (which Tembisa is part of), from the Department of Health.

3.2 DATA SAMPLING

The study sample was recruited from THs and PWAS from the NAPWA support group in Tembisa.

Eight of the THs selected were members of the THO and two were members of the Nyangazizwe Traditional Association in Tembisa. They were selected through purposive sampling , due to their status in the profession and the community.

The PWAS were from the NAPWA support group in Tembisa. They were selected through the systematic random sampling method, a probability sample that guarantees that their responses represent similar populations in terms of inference.

The formal health workers comprised of two nurses, one of whom is a matron from Tembisa Hospital who is in charge of an AIDS clinic within the hospital, while the other one is a sister from the Tembisa clinic who works closely with THs. Both these sample selections were based on purposive sampling.

A member of the Department of Health, the Assistant Director who is co-ordinating HIV/AIDS /STD programmes in the East Rand region (which Tembisa is part of) was selected through the purposive sampling method.

The researcher initially interviewed one of the THs, Mercy Mancini who was employed by the Department of Health in order to co-ordinate TH's programmes.

The Traditional Healer's Practitioner Grace Mhaule who is the co-ordinator and organiser of Traditional Healers from THO introduced the researcher to eight members who were selected to be interviewed. Random sampling was not feasible because there was no way of establishing the actual population of THs in Tembisa. The Director of NAPWA introduced the researcher to the NAPWA support group in Tembisa.

In order to gain entry to Tembisa Hospital, the researcher wrote to the CEO of the hospital explaining the aims and objectives of the research and was given permission to interview a matron who was in charge of the HIV/AIDS clinic within the hospital. To gain entry to the clinic the Researcher asked permission from the sister in charge who referred the researcher to another sister who is working with THs.

Participation was voluntarily, and no one refused. Of the THs, eight were women and two were men whilst the PWAs comprised of seven women and three men. The ages of the healers ranged from 30 to 80 years. The ages of PWAs ranged from 19 to 45 years.

3.3 DATA COLLECTION TECHNIQUE

Participants were interviewed through an interview schedule based mostly on a qualitative research design. Both open-ended and closed questions were used and respondents were invited to expand their answers through careful probing. It was felt that the qualitative research design was the most appropriate means of conducting this research on the grounds that this was an exploratory study involving observation and interaction with people in real life settings, and the purpose was to gain insight and understanding of a range of sensitive issues rather than to provide statistical verification of particular behaviours (Martin, 2002; Robinson, 1988).

THs were asked questions regarding whether they have or are currently treating PWAs:

- Whether they give patients a combination of symptomatic treatment or they focus on physical symptoms, or whether they do physical counseling.
- As PWAS tell their problems what do they think they expect them to do?
- At which HIV stages do patients come to them.
- Whether they give help to them.

The response of their patients to treatment was also examined by asking the following:

- Whether they know of any cases where have got rid of AIDS in patients.
- The patient's response to their treatment, whether they rate it as effective, ineffective or other.
- How do they validate their response?
- What THs see as their general role in the HIV/AIDS epidemic and how other people view this role.

Regarding the PWAS, the researcher arranged to interview members from a NAPWA support group in Tembisa but most of them fell sick so they were not able to be interviewed. Thus the researcher chose several other members from NAPWA which were from the same support group. These are the PWAS who are open about their HIV/AIDS status within their community and who were prepared to disclose the fact that they have been using traditional medicine. Before they were interviewed, they attended a series of extensive meetings of the PWAS support group to enable them to get to know the researcher. This was extremely educational for a number of reasons, especially the fact that the researcher mixed with PWAS and other people involved in the fight against the virus and the disease.

PWAS were interviewed one by one from a support group because the researcher felt that a focus group would not be suitable due to personal sensitivities, and there was a possibility that participants might give the same responses, thereby causing bias in the data. Interviews lasted between 40 minutes to two hours and were conducted by the researcher in the local languages (Sotho and Zulu). English was also used by some participants. The respondents' answers were written down as notes with their permission, and translated into English. The researcher wanted to record the responses on tape but the participants found this intimidating and so this method was not used. Areas explored included STIs, other opportunistic infections, transmission of HIV/AIDS, treating and treatment of PWAs, experiences of the support group, self disclosure, whether THs have a role to play in dealing with general health problems or in HIV/AIDS, traditional practices, and collaboration between Ths and Biomedicine.

The research period was September to November 2004. One PWA who was a participant died of HIV/AIDS related illnesses in January 2005. Copies of the interview schedule are attached as an appendix.

3.4 CONCLUSION

It was a challenge for the researcher to recruit the different respondents but the interviews went well and the recruitment exercise benefited the study.

This chapter explored the methods employed in the empirical part of the study and the data instruments utilised. Due to the sensitivity of the topic and the responses utmost care was exercised in the research process.

PWAS, THs and hospital staff were the main sources of information for this study.

CHAPTER FOUR

4.1 INTRODUCTION

This chapter aims to give traditional healers' (THs) perspective of illnesses and the causes of illness including THs' local diagnostic terms. It also highlights their perspective in terms of how people get HIV/AIDS, their interaction with Biomedicine and their patients, the role of their organisations as well as the origins of HIV/AIDS.

4.2 GENERAL APPROACHES TO DIAGNOSING HIV

One TH pointed out that, when they diagnose sicknesses, it's either a patient is bewitched or it is because of a natural cause. If they treat a patient and the patient does not respond to treatment, they say it is because of a natural cause and they say a patient has to undergo *Thwasa*. Even if a patient is suffering from an STD they diagnose a patient as being bewitched. Before THs were educated on HIV/AIDS they used to give PWAS other diagnoses because they did not know HIV/AIDS. Even today some THs give other diagnoses to PWAS. Some THs diagnose the following illnesses in PWAS:

'*ULUFULWENDLU*' (in Xhosa), *Intsila* (in Zulu), *Marhume* (in Sotho). *Ulufulwendlu* is a disease that people suffer from when someone has been involved in sexual intercourse with a widow(er) before the end of the stipulated mourning period. According to THs if someone has got *ulufulwendlu*, when he/she sleeps with someone else either than the widow(er) the person will not infect the other person he sleeps with. Before THs were educated on HIV/AIDS they used to diagnose their patients as suffering from *Ulufulwendlu*. According to Green (1994), even today there are THs who diagnose other illnesses to PWAS because only 30% of THs have information on HIV/AIDS. Having sex after the loss of a relative is bad luck. The person needs to consult a TH. Failing that the person dies or someone in the family dies.

In a workshop to train THs as trainers of trainers skilled in HIV/AIDS prevention held in Port Elizabeth THs were about the diseases they treat that are related to sexual intercourse, their causes and their treatments (Green, 1994 p. 177-183). Included in the list the THs drew up were sores or genital sores/or burning urine which are caused by having many sexual partners or by having sex with a widow(er) or by having sex with a woman who has aborted. Another disease that they mentioned is genital warts or *Bhajiwe/ikhubalo*. It is like drop but symptoms are immediate. A jealous husband 'protects' his wife from infidelity – it is a type of sorcery (Green, 1994).

'IDLISO' (in Xhosa) which means poisoning is when someone has been given something poisonous to eat in order to make that person get sick or ultimately die. *Dliso* is a word which comes from the Zulu word *'idla'* which means to eat.

THWASA – is a process that THs undergo in order to qualify as a TH. The person starts by getting sick with a disease that Biomedicine cannot treat. When a person approaches a TH, the TH will tell the person that the cause for his or her sickness is that he/she needs to undergo *Thwasa*. In most cases the TH will claim that there was a person who was a TH in the family so that person is saying *"Itasi zakhe maziqhubeke"* which means her or his bags must continue. THs have bags to carry their medication so the person will be told by a TH to undergo *Thwasa* where s/he has to leave her or his home for a while and live with a TH who will train her or him on THs' issues and medication. Most THs reported that they were very sick before they underwent *Thwasa*. Some were walking with crutches, some were in wheelchairs, some stayed in water for some years, others were told by the doctors at hospitals to go home and wait for their death but after they underwent *Thwasa* they were healed. Makgati, a psychology lecturer from Rand Afrikaans University says that another very important aspect of traditional healing is pain, particularly in the calling to become a TH. In this way it is more of a vocation than psychology, she says "Very often when the TH is called there may be some resistance and this plunges the person into some pain. Only when the calling is recognised does the pain starts falling away" (*Sowetan*, October 12, 2000, p.13). People who are undergoing *Thwasa* are called *Amathwasa* (initiates in training)

After the person (*ithwasa*) had completed the training period, a day of graduation takes place and an initiation takes place where the person *ithwasa* is blessed and reborn as a true *Sangoma*.

Four THs used to diagnose HIV/AIDS as '*Ulufulwendlu*' in Xhosa, *Intsila* in Zulu, *Marhume* in Sotho. At first they did not know that their patients had HIV/ AIDS. *Ulufulwendlu* has symptoms that are similar to those of HIV/AIDS but these traditional healers reported that *Ulufulwendlu* was treatable with traditional medicine. This is the reason why before THs were educated on HIV/AIDS, they used to diagnose people who are living with HIV/AIDS as suffering from *ulufulwendlu*. However, only old people used to have *ulufulwendlu*. THs became shocked and confused when also young people were showing symptoms of *Ulufulwendlu*. Six traditional healers did not talk about *Ulufulwendlu*. They only reported that they did not know what their patients were suffering from.

4.3 HOW PEOPLE GET HIV/ AIDS

Three THs reported that people get HIV/AIDS

- through blood transfusion, through sharing blades
- through sexual intercourse with someone who is infected
- through mother to child transmission

It is interesting to note that the three THs who clearly acknowledged a Biomedical perspective of the transmission of HIV/AIDS without being prompted were the ones who work for the Department of Health. The one who is also a nurse and another is an organizer of the traditional healer organisation. The above three traditional healers also gave the examples of intravenous drug users who can transmit HIV/AIDS through sharing needles. Seven traditional healers reported that HIV/AIDS is contracted through sexual intercourse and sharing of blood. When probed further, they reported that having sex with somebody who is HIV positive can infect a person. When they were asked about what they meant about sharing of blood, they seemed not to be clear.

4.4 HOW DO THs INTERACT WITH CLINICS?

THs maintained that they work hand-in-hand with clinics and hospitals, because after throwing bones and having found that the patient's illness is incurable they refer patients to clinics and hospitals for an HIV test. Three traditional healers who seemed to have knowledge of HIV/AIDS issues reported that they do not treat any patients without the results from a doctor or a nurse.

4.5 WHAT THs THINK OF BIOMEDICINE

THs feel that Biomedicine undermines them. They do not want to refer patients even if they cannot help the patients. Traditional Healers claim that Biomedical treatment makes PWAs better and Biomedicine uses drugs that have side effects, whilst they use natural medication that treats patients effectively. They argue that Biomedicine is unable to cure some of the opportunistic infections in PWAs. As a result even after treatment PWAs get attacked again by the same opportunistic infections that they were treated for, but traditional medication treats the infections effectively.

THs do not apologise for the fact that they publicise that cure AIDS. They maintain that they cure AIDS by treating a patient with AIDS effectively, so that the patient moves from the stage of AIDS and goes back to the stage of HIV. They are able to heal the collection of diseases in a patient that are caused by a compromised immune system because of HIV which is by definition AIDS. One TH said:

“ For a long time people have misunderstood us, they think when we say we are able to heal AIDS, we mean we are able to destroy HIV, but we meant we are able to heal the infections that are caused by HIV, our mission is to take our clients from AIDS back to HIV. The opportunistic infections that attack PWAS have been around for a long, we are used to them and we have been treating them effectively”

4.6 WHAT TH ORGANISATIONS DO

TH's organisations empower THs by giving them information through workshops where they are trained in counseling, Primary Health Care, HIV/AIDS, Basics Home-based care and other health issues. Three THs reported that there are no policy guidelines that they work under and there is no legal policy or law protecting them. They acknowledged the government for including them in the partnership against HIV/AIDS.

4.7 RELATIONSHIP BETWEEN PWAS AND TH

THs reported that they build good relationships with PWAs because they treat them in their homes. Sometimes PWAs stay in their homes for a long time so that they can monitor their health. They argue that it is easy to communicate with PWAs because they speak the same language in most cases and THs also found that PWAs disclose their HIV status to them very easily.

4.8 ORIGINS OF HIV/AIDS

Eight THs believe HIV/AIDS originated from 'whites'. They said that it is possible that the white people have injected the virus into food to eliminate the 'black' nation. The THs who believe AIDS originated from 'white' people are the ordinary THs, meaning those that are not trainers of the traditional healers including the one who was the leader of a traditional healers organisation. Two traditional healers were not clear about the origins of HIV/AIDS – one of these is the nurse and the other a Department of Health official. Although the level of education of the THs was not part of the questions, it should be noted that those two traditional healers seemed to have formal education as compared with the other eight. This was displayed by their high level of understanding of HIV/AIDS and their fluency in English as compared to the other eight.

4.9 CONCLUSION

This chapter has examined how THs perceive themselves, their patients and Biomedicine. It is interesting that THs who may be assumed to have been exposed to HIV/AIDS education, for instance the ones from the Department of Health and the one who is their organiser seemed to be more knowledgeable about

HIV/AIDS than ordinary THs. This supports the literature that suggests that after training THs became able to define and describe HIV accurately and to give the correct symptoms of HIV/AIDS.

CHAPTER FIVE

5.1 INTRODUCTION

This chapter provides data on the PWAs' perspective of THs with special reference to the THs' practices, their treatment and Biomedicine's treatment.

5.2 PEOPLE LIVING WITH HIV/AIDS (PWAS)

Two of the PWAS do not believe in traditional healers and have never consulted them for their health problems. Out of the 10 PWAS, eight although three said that this was not their own choice, but that they were forced by other people to do so. The literature that claims that about 80% of Southern Africa's population consult traditional healers is supported by this data.

No PWA went for Voluntary Counselling and Testing (VCT) without a reason, i.e., because they just wanted to know their status. They did so because they were ill, had been raped and/or were pregnant.. VCT allows a person to find out whether they are infected with HIV. Voluntary means that a person decides whether or not to have the test. Counselling means that the person has the opportunity to discuss whether to take the test with a trained counsellor. Testing involves the use of an accurate scientific test of a person's blood to show if they have been infected with HIV. In all cases, the process of testing did not follow the proper way of pre-test and post-test counselling. VCT is in the process of being rolled out at national level, with some 1 000 clinics expected to be in a position to offer counselling and rapid HIV testing in 2000 (Parker, 2002). Because most of these PWAS were diagnosed in the late 1990s when there was a lot of stigma and discrimination around HIV/AIDS, it makes sense that they undertook an HIV test without the pre-and- post test Counselling.

One PWA was raped at the age of 10 by a person who is assumed to be HIV positive because:

- His wife died of HIV/AIDS related illnesses.
- The participant he raped was found to be HIV positive after the rape.

It is interesting that all the PWAS who used THs went back to Biomedicine afterwards. What is more interesting is that even the PWAS who reported that they were healed of their opportunistic infections by traditional medication and also those who claimed that Biomedication is toxic also went back to Biomedicine after using THs. This is a clear evidence that people believe in using both THs and

Biomedicine but they rely more on Biomedication. Although PWAS reported that Biomedicine did not support them like traditional healers did, they still preferred Biomedicine rather than THs.

PWAS see the THs' role in the fight against the epidemic as treaters, educators and counselors. The PWAS seemed not to like the THs way of treating such as vomiting (*gabha* in Xhosa), It is a treatment whereby traditional healers give their clients water that contains medicine and a client has to drink it, but the water should come out immediately, usually through the mouth, and being given enema (*cima* in Xhosa). The medication is kept a secret. The respondents also complained about the measurement of their medication and claimed that it was not accurate and was too strong. Five PWAS reported that the THs they consulted managed to treat their opportunistic infections effectively. Four reported that they used African Potato which is a traditional herb and it also treated the opportunistic infections effectively.

The studies that revealed that THs do treat opportunistic infections effectively have thus been confirmed. It is also interesting to note that the CD4 count (which is a molecule on the surface of some cells onto which HIV can bind) count of a PWA who consulted a Faith Healer was strengthened,, even though she was disappointed with the Faith Healer's practices and behaviour and decided not to continue with the treatment.. The CD 4 cell count roughly reflects the state of the immune system. The lower the person's CD cell count, the sicker the person usually becomes. In this case the CD4 cell count increased and her viral load (which is the measurement of the amount of virus in a sample) decreased. The HIV viral load (which indicates how much or how quickly HIV is reproducing in the body) dropped.

5.3 HOW PWAS FIRST APPROACHED TRADITIONAL HEALERS

Foru PWAs reported no problems in approaching THs and disclosing their HIV status. Most of these THs were people they knew very well, so much so that one PWA mentioned the fact that the TH she approached helped them in building their support group and is also playing a significant role in HIV /AIDS work in their area. Three PWAs indicated that they were forced by either a spouse, parent, relative or a friend to see a TH, but that they did not believe in THs and in traditional healing. Two PWAS never consulted a TH and they do not believe in them.

5.4 VISITS TO DOCTORS

Most PWAS consulted Biomedical Doctors because they were sick with various diseases. Others had severe headache, diarrhoea and swollen glands. They took an HIV test and got to know their HIV status.

Like many South African women, two PWAS got to know their HIV status during their pregnancy, after being diagnosed by a Biomedical doctor. Three female PWAS knew their HIV status after being raped. One PWA stated:

“Being raped stresses me more than being HIV positive, I believe I still need to attend a rape support group too”.

“I was raped by my father’s youngest brother at the age of 10 and then his wife went sick and was diagnosed HIV positive and ultimately she died of HIV/AIDS related illness, then my family felt I also need to take an HIV test too, that is when I was diagnosed HIV positive, another PWA reported.

Thus the visit to the doctor was seen as a natural progression on their part after they were basically diagnosed with HIV.

5.5 PWAS AND BIOMEDICINE

All the PWAS went back to Biomedicine even after using THs because they believed in using them both. Others went back to Biomedicine after using THs because they were disappointed with the TH, their attitude and the treatment meted to them. Thus their preference changed in the process. They believed that THs are ‘liars’, for instance. In some cases the THs diagnosed PWAS as people having *Idliso*, or people who have to undergo *Thwasa* or just diagnose a different sickness instead of HIV, like suggesting that people have been bewitched at school. Two PWAS reported that they became more ill after using traditional medicine. This was for them an additional incentive in seeking the help of biomedicine.

5.6 CONCLUSION

The most interesting issue is that eight out of 10 PWAS have approached THs for treatment. Such findings support the study that was cited earlier that pinpoints that 80% of South African people do consult THs for their health problems. Some PWAS see THs as having a role to play regarding HIV/AIDS as treaters, educators and counselors.

However it became evident that as the treatment is not considered successful, patients change to bio-medicine

CHAPTER SIX

6.1 TREATMENT

6.1.1 INTRODUCTION

This chapter deals with the data provided by traditional healers (THs) on their healing practices and on how they provide their medication to patients. It also highlights their perspective on the reasons they are being consulted by People living with HIV/AIDS (PWAS).

6.2 HOW TRADITIONAL HEALERS TREAT HIV/AIDS

THs reported that they counsel PWAS on a very regular basis as they are considered part and parcel of the community. They believe it is easy to counsel patients because most of them are Africans, as well as members of their communities. They speak the same language and they know each other. They also provide them with traditional medication but they cannot tell which treatment they give, because this is a secret. Keeping their medication a secret is one of ancestral requirement according to THs. Hence it is sacred as it is based on the customs and traditions of the ancestors and history herself.

THs diagnose HIV/AIDS by throwing bones; this is their way of asking the ancestors about the patient's problem. This process of diagnosing is called "*Bhula*" in Zulu. Most of the THs argue that the bones do not know HIV/AIDS but they show a dark situation when a patient's sickness is incurable. Then the traditional healer will advise the person to go for an HIV test. Sometimes they see the symptoms of HIV/AIDS in a patient and they advise the patient to have an HIV test. They did not talk about the instances where they diagnose, but reported that they treat patients after they are diagnosed by Biomedicine.

When people come to TH Phumuzuyise Mbatha in anguish, he studies his bones, to see what is wrong and talks to them before deciding on the best treatment (*Sowetan*, October 12, 2000:13). Such an attitude indicates a more or less holistic examination of the patient's condition on the part of the TH.

There was only one PWA who used the services of a Faith Healer. The Faith Healer does not throw bones. The PWA approached the faith healer with a group of other patients who disclosed their HIV positive status to him.

The common treatment that most PWAS received was being cut with a razor blade on their back, breast, feet etc. One PWA had swollen feet so he was cut with a razor blade. THs also reported that they cut their patients with a razor blade. They said that bring their own new blades. If they do not bring them, they are asked to buy one. THs keep a packet of new razor blade for those patients who cannot buy their own.

Razors were reported by traditional healers to be used for the following:

- Evil spirits
- Stroke
- Headaches
- Knee problems - arthritis
- Acupuncture
- Razors relieve tension in the muscles and prevent germs from spreading.
- Mentally disturbed patients
- Patients with pains in their body
- Patients with problems with their veins – the veins are cut with a razor blade and the TH uses his/her hands to pump blood from the patient's body. This condition is highly prevalent in Tembisa and mostly affects women.
- Patients with high blood pressure – are cut with a razor and given *muthi* (medication).

Women were likely to suffer the above-mentioned sicknesses while men came to them with erection problems. Women over the age of 30 are likely to report chronic headaches due to depression.

THs also reported that that make pills from raw plants for:

- Women with abnormal discharges
- Women whom men cannot feel during sex
- Women who cannot feel men during sex
- Women who have wet dreams (women who dream of having sex and secrete vaginal fluids during the night)

A PWA reported that the TH cuts a tennis ball into two halves. One half was put where there was a cut and it was pressed hard to suck blood from her feet. In some districts, THs have asked their spirits to

allow for a halved tennis ball to be used for extracting objects from the patient's body (Willms, Chingoro & Wellington, 1995). The TH also pricked her with a straight pin from head to toe and rubbed her with a black ointment. Most PWAS were given "*muthi*" (medication) that they were advised to mix with two to five litres of water, and drink it. The water is supposed to come out immediately through vomiting. THs believe that the water cleanses the person of internal diseases and when the person takes it out (usually through the mouth), it comes out with the dirty stuff that was inside the person.

THs reported that the process of cutting their patients with a razor blade involves blood. Asked if other healing practices involve blood and bodily fluids they mentioned:

- Blood sucking – which is done with a horn, or a tennis ball. This is useful for *idliso* (poisoning). THs suck the dirty stuff from their patient's body using a tennis ball. They reported instances where the tennis balls are covered with visible substances that can be seen by people, for example, hair. Another process used in the biting out is a cow's or goat's horn. If a patient complains of pain that moves inside the body, the TH uses an animal's horn to take out the object. The horn is placed where the pain is and the TH sucks the horn in order to take the pain out. Not all THs perform this healing practice. They use razor blades to open a hole for *umuthi* to come out. They insert a stick to prevent blood from getting to the mouth.
- Giving birth- they help women deliver. THs feel that they are at a higher risk of being infected with HIV than their clients. They have been trained to hold a razor so that they do not come in contact with people's blood and they wash their hands after each and every client consultation.
- Physical beating – they sometimes beat clients that are attacked by evil spirits, at times causing them to bleed. These clients have mental disturbances and see things that are not seen by normal people.
- Circumcision – THs cut the foreskin and apply *umuthi*. Sometimes untrained THs perform such rites. They were regarded by THs as 'fly by nights'.
- Washing of corpses – THs wash dead bodies on a frequent basis. It was also mentioned that some THs have sex with corpses. Again this meant that THs are exposed to a high risk of HIV.
- Having sex with the clients with an intention of putting some *muthi* into the body of a client. This also exposes THs to HIV. There is no traditional healing practice that require that a TH should have sex with a client. One of the THs confessed that before she underwent initiation, she had womb problems and a male TH asked her to undress and lie on her back so that he could put *muthi* in to make her sexually aroused. She refused and went to a biomedical doctor for treatment.

Some THs reported wearing gloves when cutting patients while others confessed that they do not wear gloves. Two PWAS reported that some THs either force or ask their patients to vomit. THs also give medication to their patients. Eight PWAS reported that they were given medication by the TH they consulted.

One PWA consulted a Faith Healer whose treatment was different from those of a TH. These PWAS decided to go as a group of five people who were open about their status and who had already accepted their status as HIV carriers. They were taken to Port St Johns in the Eastern Cape and they were told to worship their ancestors according to their clan names. There would be a star that would come out of the sea and follow them when they went back where they were residing. The star would follow them till they reached their destination. They stayed there for a month. Every morning they would go to a place called Sinuka where there were two rocks. One person would inhale the gas that was coming out, the person would inhale slowly. There was a basin called *Bhafu* in Xhosa, where they used to bathe. There was also water which looked like it was boiling but it was cold, and their feet were washed there. There was other water for drinking and it was very sour. They were given mud to put on their faces. They went to the mountain to vomit and to be given enemas. The Faith Healer took them to his church to sing and pray. The faith healer used to preach without referring to the Bible. He used to preach about *Qamata* whom he explained as God who has been there for Africans before missionaries came.

6.3 EXPECTATIONS OF THE TREATMENT

Nine PWAS' expectations of Biomedicine was to be treated in relation to their infections. Only one PWA reported that he relied on traditional medicine because traditional medicine does not have side effects whereas Biomedicine does. Even those PWAS who claimed to rely on traditional healing also used Biomedicine because they said they want to use both methods, so that the chances of them healing improve considerably. Four PWAS also consulted THs with the hope of being healed. Three PWAS did not believe in traditional healing, but they were forced to consult a TH by a spouse, parent or relative. The PWA who consulted a Faith Healer reported that they decided to consult him because there were rumours that this particular Faith healer could cure HIV/AIDS. This group of PWAS were not certain that the Faith healer would heal them but they felt that they should consult him since they had accepted their HIV/AIDS status. They thought that if the Faith Healer failed to heal them, they would be able to cope better than PWAs who had not accepted their HIV positive status. Their aim was to go and give feedback to their communities about their experiences of the Faith Healer since rumours about a healer who could cure AIDS were spreading faster. Such rumours have become a very prevalent feature in

African areas ravaged by HIV/AIDS and shows the desperation of large sections of the affected population.

6.4 CONCLUSION

Although THs claim that their healing practices do not put either themselves or patients at risk of contracting HIV/AIDS, it is clear that some of their healing practices, such as having sex with clients, physical; biting and having sex with corpses, can put them at risk.

It became evident that the relationships between traditional and faith healers and their patients go through various phases and ups and downs, especially since patients face major health and social problems related to their status, relations with their families and communities as well as society herself.

CHAPTER SEVEN

7.1 PWAS' EXPERIENCE OF THs

7.1.1 INTRODUCTION

This chapter highlights the PWAS' experience of traditional healers (THs) and their interaction with them.

7.2 WHAT THEY FEEL

Most PWAS (7) believed that THs are liars and they have different views to substantiate their argument. One PWA reported that her mother forced her to consult a TH because she was sick after she had been diagnosed through Biomedicine that she was living with HIV. However, she had not disclosed her HIV status to her mother during the time when her mother took her to the TH. The TH diagnosed her as suffering from '*Idliso*'. *Idliso* is when a person has been given poisoned food by evil people. The TH suggested that it was possible that one of the students at school had bewitched her so the TH went with them to school and took soil next to the school gate and told them not to look back on their way from the school.

Another PWA reported that the TH she consulted told her that the cause of her sickness is that she had to undergo '*thwasa*'. She was also told that she had too much dirty blood in her body and the TH sucked her blood with a tennis ball, claiming that she was taking out the dirty blood in her body and paving the way for the new blood to enter her body.

Another PWA reported that the first TH she consulted told her sickness was caused by her refusal to answer questions at school even if she knows the answer. This PWA was not in school, but was working.

The PWAS also believe that THs have no knowledge in relation to HIV/AIDS issues. Some said that if THs are involved in HIV/AIDS issues they should be monitored by Biomedicine because most of them are illiterate, they give medication that is too strong to PWAS, their medication is given in large volumes, and they do not know how to measure their medication. They also shared personal experiences which showed that THs do not have knowledge on HIV/AIDS issues. For instance, two PWAS reported that, THs cut them without wearing gloves.

The PWA who consulted a Faith Healer reported that the Faith Healer always suggested that they must be involved in activities that would make them reinfect each other or infect other people. For instance during the morning the Faith healer would ask them the dreams they had the previous night. One morning, she told him that she dreamt that she was being attacked “by a TH, which is called Biting out” (*‘Qutyulwa’* or *‘Qubula’* in Xhosa or *‘ukulumeka’* in Zulu). Biting out is a process where a TH attacks his/ her patient when he/she is unaware, bites the patient where he/she has a problem and sucks the patient's blood. The Faith Healer suggested that the PWA should consult a TH who does the biting out. The PWA refused because she knew that the process might infect the TH.

Three PWAS believed that THs have a role to play in HIV/AIDS because it is easy to communicate with them because they share common language. These PWAS reported that when they consulted THs they were the easiest people to communicate with and understand. It was said that the *muthi* that they gave them healed HIV/AIDS-related opportunistic diseases but they all believed that THs need to work hand-in-hand with Biomedicine. Three PWAS reported that they have never consulted THs and did not believe in THs because of their Christian upbringing and traditions .

7.3 RELATIONSHIP BETWEEN PWAS AND THs

Four PWAS reported that they had a very good relationship with the THs that they consulted; it was easy to disclose their status. THs gave them love, support and acceptance, and it was easy to communicate with them. Thus one PWA reported that the TH that she consulted counseled her and is also counseling some PWAS in her area and is involved in their support group.

On the other hand, three PWAS who were forced to consult THs reported that they did not have good relationship with them. They said that the THs were forcing them to participate in healing practices they disliked, such as vomiting, cutting with a razor blade etc. One PWA reported that the Faith Healer he consulted had problems relating to women and that she found it very difficult to communicate with him. . The PWA visited the Faith Healer with her boyfriend, and the Healer only communicated with the boyfriend and not with her directly. The PWA referred to the Faith Healer as someone who was undermining women.

The three PWAS who consulted THs after being diagnosed HIV positive reported that they hated the fact that the THs gave them a false diagnosis like *idliso* (food poisoning), *thwasa* and witchcraft. Five PWAS reported that they did not like to be forced to do vomiting and be given enemas.

Two PWAS said that they did not like to be cut by razor blades. One reported that she hated to be pricked with a needle by a TH, while a PWA who consulted a Faith Healer shared many things she did not like, including:

- The Faith Healer was always suggesting that they should be involved in situations that they knew will cause re-infection or infecting other people, like having sex with her boyfriend without using a condom and allowing sucking blood by a TH who does biting out.
- The Faith Healer was forcing them to advertise him in the media as someone who heals HIV/AIDS.
- The Faith Healer sent journalists to them who wanted to interview them about their consultation with him without their consent.
- The Faith Healer tried to force them to resign from their jobs in order to work for him. He was always saying that he is going to be wealthy, so they realised that his aim was not helping PWAS but to become wealthy at their expense.
- The Faith Healer had three wives, and he used to have sex with one of the wives in their presence. All the female PWAS were sleeping in the same room with the Faith Healer and the male PWAS were sleeping in their own room.
- The Faith Healer would not talk women directly.

Nine PWAS said that THs must be monitored by Biomedical doctors in their work. Their reasons included:

- Most THs are illiterate and they do not have knowledge of HIV/AIDS.
- Their ways of treating HIV /AIDS, like using the same blade to cut more than one patient, are not safe.
- Their medication (*muthi*) is strong and they have no scientific methods of measurements. This can kill PWAS who already have compromised immune systems .
- Their false diagnosis can encourage PWAS to deny their HIV positive status.
- Their ways of treating can promote re-infection among PWAS and can put themselves at a risk of HIV infection.

- Keeping their medication a secret puts their clients at risk because they will never know the medications they are allergic to.

7.4 CONCLUSION

It is very interesting that although eight out of 10 PWAS had consulted THs for treatment, seven out of 10 believe that traditional healers need to be monitored by Biomedical practitioners when playing their role in health issues.. This will only be possible through dialogue and co-operation between the two sectors.

CHAPTER EIGHT

8.1 COMMON VIEWS ON WHAT MEDICATION HELPS

8.1.1 INTRODUCTION

This section provides information on PWAS' perceptions of traditional healers (THs)' medication as well biomedical medication used to treat HIV/AIDS.

8.2 TRADITIONAL MEDICINE

According to THs it is very difficult to disclose what medication helps because the ingredients and the names of their medication are not to be revealed to other people. Most PWAS do not know the name of the medication they received from THs. However, PWAS seem to be aware of a traditional herb called 'African Potato' ('*Labatheka*' in Xhosa and '*Inkomfe*' in Zulu), which was reported to boost one's immune system. Another traditional herb that is believed to cure AIDS is dagga. One TH reported that dagga is effective for PWAS because it has got antibiotics.

8.3 BIOMEDICINE

Two PWAS believe that Moducare helps boost one's immune system. The PWAS who consulted Biomedical doctors believe that opportunistic infections were treated effectively but do not know the medication that they were given.

8.4 COMMON PERCEPTIONS

Seven PWAS believe that THs are liars; they do not want to admit when they cannot help their clients and they also believe that THs do not have knowledge in respect of the complexities of HIV/AIDS; they need to work hand in hand with Biomedicine practitioners. Three PWAS believed that THs do not have a role to play in HIV/ AIDS because they are not scientifically trained for such new diseases.

It is clear that there are seriously negative feelings regarding the role of TH *vis a vis* HIV/AIDS and their treatment.

8.5 PWAS' EXPERIENCE OF BIO-MEDICAL DOCTORS, CLINICS AND HOSPITALS

One PWA expressed confidence in Biomedicine. According to him Biomedicine has a significant role to play in the fight against HIV/AIDS. Six of the respondents reported good relations with Biomedicine. Even those who reported that when they were sick Biomedicine failed to treat them also maintained that Biomedicine has a significant role to play in treating HIV/AIDS and they preferred using them to THs. Three PWAS reported that Biomedicine diagnosed them without their permission and without the pre-and post-counseling and that they were told they were going to die soon. Despite that these PWAs believe that Biomedicine has a significant role to play in HIV/AIDS and in health problems generally when compared with THs.

Nine PWAS reported that Biomedical doctors have a negative attitude to THs and to patients using traditional medicine because they believe THs do not have knowledge of HIV/AIDS and because of their medicine that is kept a secret. It is difficult for Biomedical doctors to know when the patient has got complications through using traditional medicine. These PWAS believe that THs must work with Biomedical Doctors because THs can heal some HIV/AIDS-related opportunistic infections.

Although most PWAS seem to prefer Biomedicine to THs, only three PWAS reported having a good relationship with Biomedicine, and reported that Biomedicine supported them. However, seven PWAS said that Biomedicine did not support them. The fact that Biomedicine helped them through an HIV test without pre-and-post-test counselling was disliked by PWAS. Biomedicine was regarded as discriminating and judgmental. They reported that after they were diagnosed they were told by the nurses to go home and wait for their death and they were also accused of having contracted HIV due to their promiscuity.

8.6 CONCLUSION

It is interesting that what THs reported in terms of their healing practices is not always confirmed by PWAS. Some traditional healers claim to use gloves to protect themselves and their clients from HIV transmission. While some THs confessed that they do not use gloves, even those who say they do could not vouch for others, since they do not visit them in their homes. On the other hand, the PWAS reported that traditional healers do not use gloves even if they are involved in healing practices that involve blood and other body fluids. They see that as one of the limitations in their healing practices. Traditional healer's practices like iting out, diagnosing through throwing bones, and cutting with a razor is also confirmed by PWAS. The fact that out of 10 THs, only three acknowledged the Biomedical perspective of

transmission of HIV/AIDS shows that THs need to be trained in order to effectively curb the spread of HIV/AIDS. Traditional healers seem to be enthusiastic about collaboration and they report referring to Biomedicine. Given the belief that traditional healers can cure HIV/AIDS, it is very interesting that they do not mean that they destroy HIV, but that they treat the opportunistic infections. All these THs seem to understand that there is no cure for HIV/AIDS.

CHAPTER NINE

9.1 PWA SUPPORT GROUPS

9.1.1 INTRODUCTION

This chapter explores the formation of the support group and PWAS' feelings about the support group. Efforts are made in this chapter to establish PWAS's perceptions of the support group and the management of their emotions in terms of processes of disclosure and their lives after the disclosure.

9.2 PWAS' EXPERIENCE OF THE SUPPORT GROUP

All 10 PWAS reported that the support group played a very significant role in their psychological and physiological lives. They felt a sense of belonging and identification after they joined the support group when they saw other people having the same problem as they have. Some of the PWAS were discriminated against by their families and communities. The support group made them accept their status because they are also given information on HIV/AIDS i.e. how one contracts HIV/AIDS, how does one protect him/herself from contracting it, how to live a long and positive life if one has already contracted it, which healthy diet one can follow, why, where, how and when to disclose their status, the advantages and disadvantages of disclosing and systems of treating HIV/AIDS. PWAS also received counseling from their support group.

It was a general feeling that the support group was of great importance and value for the HIV patients, and made a positive contribution to their lives.

9.3 THE NATURE OF THE SUPPORT GROUP

The support group is very organised. The Co-ordinator of the group is a social worker who is also a community development worker and a TH who is active in HIV/AIDS work in the area. It is composed of community stakeholders (pastors, doctors, community leaders and people living with HIV/AIDS).

It was formed because there were many PWAS who were members of a certain HIV/AIDS Non-Governmental Organisation (NGO) that was funded by the Department of Health, which was composed of young people irrespective of their HIV status. Some of the people who were not HIV positive discriminated against those infected. They disclosed the patients' HIV status without their permission, and they also forced them to disclose it. Three PWAS reported that they used to work in that NGO, but because of discrimination on the part of people who were not infected with HIV, they had to leave the organization.. These PWA's were making presentations, and disclosing their status to companies representing this NGO and were never remunerated as promised. Those who were remunerated were given less than promised.

These PWAS are members of a NAPWA (National Association of People Living with HIV/AIDS) branch in Thembisa. NAPWA has existed in South Africa since 1994, and is oriented towards protecting the rights and interests of PWHAS, but is also increasingly becoming involved in the development of a

practical support of PWHAs and affected persons. NAPWA has a membership of some 20,000 persons infected and affected by HIV/AIDS located in 134 branches countrywide. Branches are currently volunteer-based structures receiving little direct support. NAPWA addresses the interests of PWAS through the development of a strong partnership with government, as well as leading non-governmental and other organizations. Mostly these are the PWAS who get referred either by the clinics or hospital for counseling to the support group.

In the support group, the group counseling is done by the organiser, the TH and other PWAS who have been trained in counseling. PWAS also share their experiences. They also do HIV/AIDS Awareness Campaigns on occasions like World AIDS Day and Valentine's Day and on Television HIV/AIDS programmes. Their meeting is conducted in a TH's house because they do not have an office but they have a computer and funding already and they are looking for an office. The support group has 25 members, 10 of whom are HIV positive. The aim of the group is to give PWAS emotional support, empower them on how to live positively with HIV/AIDS and help them deal with the problems they might experience from their communities because of their status.

9.4 PWAS' FEELINGS ABOUT HIV/AIDS STATUS

Six PWAS reported that after they joined the support group, they accepted their HIV positive status and started to disclose it openly. Their understanding of the advantages and disadvantages of disclosure encouraged them to open up to their communities and the public at large. These PWAS disclosed their status because they wanted to help other people to understand the realities of HIV/AIDS.

One PWA argued, "*once a person hides something people begin to gossip about it*". To her, disclosure was a way of discouraging people from gossiping about her status. Three PWAS disclosed their status because they were forced to do so by an NGO support group that they were members of. They reported that during that time, they were not informed on PWAS' rights such as their right to confidentiality.

Among the six PWAS interviewed two were not publicly open about their HIV status. One had disclosed her status to her parents, siblings, boyfriend, support group and people at work. She is working for an HIV/AIDS NGO. Another PWA had disclosed her status to the people at the support group and at work only. Her husband and children did not know her HIV status and she did not want them to know since her husband had never taken an HIV test. The other concern she had was that should the children be aware of her status, they would be devastated. Another PWA reported that she was not publicly open about her status because her close relative visited her with her friends at hospital while she was sick and passed

nasty statements against HIV/AIDS. One PWA reported that he did not plan to disclose his HIV status but his sister discovered his HIV test results in his shirt pocket and the sister disclosed his status to other people in their area.

It can be seen clearly, then that the stigmatisation of the HIV/AIDS status of large numbers of people is still a very serious problem amongst African people and communities, and it is extremely difficult for HIV positive people to be open about it in most cases.

9.5 EFFECTS OF THE DISCLOSURE

The six PWAS who disclosed their HIV status, whether publicly or to only their families or support group, reported that disclosure has helped them to accept their HIV status, to accept themselves and to live positively with HIV/AIDS. Disclosure has also helped them to educate other people about HIV/AIDS. The three PWAS who were forced to disclose their status reported that disclosure did not help them in a useful way. They became physically and psychologically sicker than before and they regretted the fact that they disclosed their status.

9.6 CONCLUSION

Several forms of HIV/AIDS stigmatization were reported to have taken place in Tembisa by families, communities and an HIV/AIDS NGO was also reported to have discriminated against people living with HIV/AIDS. However, the support group was seen to be providing a sense of emotional support by both male and female PWAS. It was seen as having created a sense of belonging and has encouraged them to accept their HIV status. The support group was also acknowledged as educational not only to PWAS but to the Tembisa community at large through HIV/AIDS awareness campaigns. Members of the support group displayed a sense of trust among one another by noting that some of the HIV/AIDS patients had only disclosed their status to people in the support group. PWAS who disclosed their HIV/AIDS status willingly were reported to cope much better than those who disclosed their status unwillingly.

CHAPTER TEN

10.1 BIOMEDICAL HEALTH WORKERS' INTERACTIONS WITH THs

10.1.1 INTRODUCTION

This chapter presents the data collected from Biomedical health care providers, i.e., two nurses, one from the Tembisa clinic and the other from the Tembisa Hospital and a Department of Health official who is co-ordinating HIV/AIDS/STD programmes. These Biomedical health care providers commented on the prevalence of HIV/AIDS infection in Tembisa and the role of traditional healers (THs) in health issues, focusing on the healers' successes and failures.

10.2 TEMBISA CLINIC

The nurse that was interviewed in Tembisa Clinic reported that they work co-operatively with THs by providing capacity building to them in the form of training workshops. In these workshops, they first examine the perceptions of traditional healers on HIV/AIDS and then capacitate them on HIV/AIDS issues, including:

- Basic HIV/AIDS information
- Counseling especially counseling people living with HIV/AIDS
- Some HIV/AIDS opportunistic infections like TB, diarrhoea etc, how to recognize them in patients
- Home based care because they also admit patients and treat them in their homes

According to the nurse THs do have a significant role in HIV/AIDS and those that they work with are currently playing their role in many ways. THs also refer clients to them. She said:

“It is a reality that African people believe in traditional healing and they approach traditional healers for their health problems, so this group must have an input in the medical point of view and they must be well trained in HIV/AIDS because it is a disease that affects most of the people”.

According to her if THs are given workshops on the basics of HIV/AIDS i.e., how to protect themselves and clients from contracting HIV/AIDS through their healing practices like cutting them with razors, they can be effective in their role against HIV/AIDS. According to her, THs can also do counseling. She stated:

“All those that work with us are good; some are involved in HIV/AIDS education by teaching the communities and their patients about HIV/AIDS. They have a significant role in HIV/AIDS.”

But she also noted that although THs have a role to play in HIV/AIDS, they are being undermined by Biomedicine. According to her the successes of THs lie in their holistic approach to healing, meaning they treat the person as a whole. They go an extra mile by treating the family and all the surrounding people of the client, which Biomedicine fails to do. She indicated that this was a very good approach because a person's sickness cannot be separated from his / her environment, so the person's environment must be looked after simultaneously. Another area she described as the THs' success is that they do not work alone; they refer their patients to other THs when the problem becomes beyond their control. However, the health care worker also highlighted practices that THs perform that she found unacceptable:

- The way traditional healers give their medication - they were not accurate in giving medication, and always overdosed the clients.
- Some of their healing practices such as enema and vomiting were not always relevant to some patients, for instance they were very dangerous to patients who have diarrhoea.
- They also made poor people spend unnecessarily, for instance a patient who is coughing can be told by a TH that the cause of her or his sickness is the failure to observe a certain ancestral ritual. In most cases those ancestral rituals involve a lot of expense, which increases poverty for African people.
- Some THs and also their medication are not very tidy, which is very unhygienic and can cause patients to be more exposed to other germs that can make them sick.

She concluded by saying that in the Clinic they also have a role in HIV/AIDS because they treat opportunistic infections. According to the records, HIV/AIDS is a very serious issue in Tembisa, with 52% newly diagnosed HIV/AIDS patients every year.

10.3 TEMBISA HOSPITAL

In the Tembisa Hospital, the matron who was responsible for HIV/AIDS issues and who worked with THs was interviewed. According to her, the hospital has continuous interaction with THs; they refer patients to each other. The hospital also educates THs on health systems generally. She sees the role of THs as only to counsel the patients that believe in them. Other than that she believed they do not have a role to play regarding HIV/AIDS.

The matron did not see any successes on the part of the THs as far as HIV/AIDS is concerned except claiming to possess an AIDS cure. However, when those patients they claim to have healed have another HIV test, they test positive again. On the other hand Biomedicine does have successes in HIV/AIDS. Even though they do not cure HIV, they can assist in boosting the patient's immune system so that the person becomes strong again. The matron did not hide the fact that personally she does not believe in THs.

According to her, THs are liars. They claim to possess some AIDS cure, yet they do not. They mislead patients and also raise people's hopes. Another limitation is caused by the fact that they have to keep their medication a secret; it can be difficult to treat patients who reacted negatively to their treatment.

The matron concluded by saying that although she does not have accurate figures for HIV/AIDS statistics in Tembisa, HIV/AIDS is a serious problem in the township, as new people are being diagnosed every day.

10.4 DEPARTMENT OF HEALTH

The person who was interviewed in the Department of Health is the Co-ordinator of HIV/STD programme in the East Rand of which Tembisa is a part. She stated that HIV/AIDS is a serious threat in the East Rand. It is because of this that the Department of Health entered in a partnership with THs so that they can devise ways of working together to curb the spread of this killer disease. This partnership focuses on capacitating THs on health issues especially on HIV/AIDS opportunistic infections.

“Since our services are directed to the community, our aim is to guide traditional healers so that they are able to help”, she stated.

She sees THs as having a role to play in HIV/AIDS as treaters of opportunistic infections, as educators of their communities and as counselors, but she also maintained that they need to work with Biomedicine because:

- Traditional healers have limitations when it comes to treating; when the client is terminally ill for instance, this is the stage where Biomedicine is needed because THs do not have the necessary equipment like putting a patient on a drip etc.
- Some THs get infected with diseases like TB, and diarrhoea because of the lack of information.

Because of the above reasons, she believed that THs can be involved in the support and care of PWAS because they are respected by communities and they live within the communities.

10.5 CONCLUSION

Although THs reported Biomedicine’s reluctance to refer clients to them, the representatives of Biomedicine seem to believe that the process of collaboration between THs and themselves is already taking place. THs were reported to refer their clients to Biomedicine. THs were acknowledged to have a significant role to play in HIV/AIDS and other health problems and were seen to be currently playing their role. Their successes were reported to be associated with their holistic healing and referral approach. However, their failures were also acknowledged, like false diagnosis that can lead people to unnecessary spending, false claims of possessing an AIDS cure that raise people’s hopes and their untidy environment that can expose patients to other germs. The health care providers seemed to have conflicting views regarding the role of THs in HIV/AIDS. A high prevalence of HIV/AIDS is reported in Tembisa, with new infections every day.

CHAPTER ELEVEN

11.1 INTRODUCTION

This study has used Tembisa township as a case study in order to assess the role of traditional healers (THs) in curbing the spread of HIV/AIDS. This chapter summarizes the main findings of this research and an analysis of the findings. It also provides a list of recommendations developed by taking into consideration the participants' responses and the literature reviewed.

11.2 ANALYSIS OF THE FINDINGS

This research shows that HIV/AIDS education has helped THs to recognise the symptoms of HIV/AIDS which they did not recognise before the education provided for them. Although some THs used to give other diagnosis, like '*Ulufulwendlu*' to their patients, it seems as if the majority of them did not know anything about *Ulufulwendlu*. Out of 10 traditional healers, only four agreed that they had been diagnosing their clients as having *Ulufulwendlu*.

From the THs themselves, it became strongly evident that the HIV/AIDS education that was organised by their organisation through the Department of Health was an eye opener to them. Even the six THs who were not diagnosing *Ulufulwendlu* for their clients pointed out that before the workshops they did not know what their clients were suffering from.

Because THs give only two causes to sickness, i.e., either a patient is bewitched or it is because of a natural cause, where they believe '*Thwasa*' has to intervene when a person does not respond to treatment, it makes sense when they say that even when a person has an STI, they believe the person is bewitched. This belief can defeat the whole purpose of the prevention strategies of Abstain, Be Faithful, Condomise (ABC) in South Africa. Given the fact that there are few people who want to come out about their positive HIV status because of the stigma surrounding it, and that THs are the most respected people in their communities several conclusions can be arrived at.

Some THs' beliefs can increase denial of the existence of HIV/AIDS amongst people and this could have a negative impact on the already existing preventative strategies that South Africa has put in place, because people will be influenced by THs to think they have to undergo '*thwasa*' while they are HIV positive.

Some THs' way of diagnosis had a sense of disciplining their patients. For example, in the case of 'Ulufulwendlu', they believe that a person contracts *Ulufulwendlu* through sleeping with a widow(er) before the stipulated mourning period. Whether this is true or not is immaterial, but it was enforcing the African culture that believes in mourning when one has lost a partner, especially women. The mourning period lasts for a year. Women wear black clothes for one year after she lost her partner, and men put on a black button. Not having a sexual relationship is an integral part of the mourning. This diagnosis controls people's sexual behaviour, thereby protecting them from acquiring sexually transmitted infections and it also enforces people's culture. This also has limitations because it is said that when a person who has contracted *Ulufulwendlu* through sleeping with a widow(er) sleeps with someone else, s/he will not infect that person. This means that the person who is already infected could easily pass the disease to other people. Another limitation regarding this belief is that it only makes people change their sexual behaviour for one year.

All the THs claimed that the patients were very ill before they underwent 'thwasa'. Biomedicine could not heal them, and after *thwasa*, they were healed.

Nine out of 10 of the THs said that they gave counseling and medication to their clients, while only one mentioned the fact that, besides counseling and medication, she was also involved in education programmes against HIV/AIDS in her area. This means that most of the THs concentrate on counseling and medication.

The data shows that all the THs interviewed fall under the category of 'Sangomas' because they said that:

- They diagnose illnesses by throwing bones.
- They have all undergone 'thwas'. This means that other types of traditional healers like Faith Healers, *Inyangas* and *Amakhwele* were not represented. This can be easily understood because all these THs from the same organisations - eight of them were from the Traditional Healers' Organisation and two from the Nyangazezizwe Traditional Healers' Association.

According to THs, Biomedicine undermines them, although they refer patients to them, while Biomedicine does not refer patients to them. It is surprising that Biomedicine is not confirming that on the contrary they refer patients to THs.

It is very interesting to understand the meaning of "curing HIV/AIDS" as reported by THs. It means that they heal AIDS not HIV. Because of the alarming claims that were circulating in the townships, stating

that THs are able to cure HIV/AIDS, their meaning of “curing” makes sense. It shows that THs, even though they can treat HIV/AIDS opportunistic infections, are unable to cure HIV.

What can be deduced strongly from this data is that if THs are playing any role in HIV/AIDS, they must be monitored by Biomedicine. PWAS, and Biomedical health care providers believe that THs must be monitored by Biomedicine. The reason for this monitoring is because PWAS experienced situations whereby THs gave them false diagnoses and would suggest healing practices that would expose them to re-infection.

The THs’ practices such as:

- (a) Enema
- (b) Vomiting
- (c) Healing practices that expose one to infection/re-infection like cutting with a razor blade and biting out etc.
- (d) False diagnosis
- (e) Giving medication in large volumes
- (f) Unhygienic environments

(g) Their medication is kept as a secret which can be difficult to trace if the patient has complications

It is also interesting that in spite of the effective treatment by THs of several opportunistic infections, as well as their love, care, support, and acceptance that created a conducive environment for being approached by PWAS the HIV test without Pre-test and Post test Counselling is highly problematic and creates problems for patients.

What emerged from the data is that THs can play a significant role in HIV/AIDS if they can work in collaboration with Biomedicine. Another issue that was raised consistently was that THs need to be trained thoroughly and scientifically on HIV/AIDS issues. The THs themselves attested to that because they believed that after the workshops that were organised by their associations, they became informed about HIV/AIDS issues. This also shows that it is important for THs to join associations and to work hand in hand with Biomedicine and with the Department of Health. The Department of Health, the clinic and the hospital in Tembisa do capacitate traditional healers in HIV/AIDS as part of the spirit of partnership.

The data collected indicated that the myth that “raping a virgin cures HIV/AIDS” still existed in Tembisa, where one of the participants was raped at the age of ten and became infected with HIV.

This data also shows the importance of a support group as a place of care, support, and empowerment of PWAS as it provided them with the platform to disclose their HIV status which they see as a relief and an opportunity to teach people about HIV/AIDS.

The most important aspect emanating from this data is the THs explanation of their meaning of “curing HIV/AIDS”. THs have claimed that they are able to treat AIDS. It is also interesting that the study reveals individuals who have claimed to possess an AIDS cure. It was a relief to hear from THs that when they say they cure AIDS, they mean they are able to heal opportunistic infections in an HIV infected individual. Some THs reported that they compared the conditions of their patients when they were brought to them and after the treatment. If the symptoms of AIDS disappear, it means that the patient has responded to the treatment. It is also revealing to note that THs are aware that there is no cure for HIV/AIDS.

Although THs have been educated about HIV/AIDS, only three subscribed to Biomedicine’s explanation for how HIV is contracted. Almost all THs seem to be aware that HIV/AIDS can be contracted through penetrative sexual intercourse and blood. They seemed not to have clear details of how blood gets to be risky. It is also important to note that THs are aware that there is no cure for HIV/AIDS. The last important aspect that is interesting in the data is able to confirm the studies reviewed which state that 80% of Southern African population consult THs. This study clearly indicates that 80% of the Tembisa population consult THs.

11.2 CONCLUSION

Eighty percent of the Tembisa population consult THs either by choice or through familial or other pressure, irrespective of whether they believe in THs or not, whether they like THs’ healing practices and their medication, and whether they go back to THs after using their treatment or not. The important fact is that they do consult THs. In spite of the limitations that THs healers have, they can play a significant role in HIV/AIDS if they can work in collaboration with Biomedicine. Their role is seen as treating opportunistic infections, as counsellors and as educators because of the respect that they have earned from their communities. It is believed that they can be influential in curbing the spread of HIV/AIDS in South Africa.

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APPENDIX

INTERVIEW SCHEDULE

The research tool that was used to gather data was a structured questionnaire given below. The researcher used it as a guide to the interviews. It was not asked line by line. The researcher was also flexible to explore the issues that were coming up from the respondents.

Type of information wanted from Traditional healers

(a) How patients discuss AIDS with them

Do people ask directly for treatment for AIDS or phrase their problems in other ways?

Is it easy for patients to disclose about their HIV/AIDS status at first consultation?

(b) How TH go about treating AIDS

Do you give patients a combination of symptomatic treatment or you focus on physical symptoms, or do you do psychological counselling, which of the above way you do?

As HIV/AIDS patients tell their problems, what do you think they expect you to do?

At which stages do patients come to you i.e., (Please tick the correct one)

A) As soon as they have just been told about their HIV status

(B) After sometime they have known about their HIV status

Do you give same help to patients? If yes, why, If no why not?

(c) How TH go about deciding whether core health problem is AIDS or not?

Are you able to diagnose HIV/AIDS from your patients before they tell you or it is patients who tell you that they are living with HIV/AIDS? If yes how, and how do you validate that the patient is living with HIV/AIDS?

(d) What TH thinks to be cause(s) of aids; how that shapes the way they treat patients?

Do you see yourselves as contributing in fighting HIV/AIDS in a way that stops its spread not only treating symptoms. If yes How, If no, why not?

(e) Do TH see AIDS as a critical health problem- If so why, if not why?

Do you believe in the saying that "AIDS is not only a health issue, it is also an economic issue or a poverty issue", if yes what have you done to PWA's in responding to that?

(f) Do TH work together on cases- Do you refer patients to others- if yes when, and what circumstances. If not why?

Do you have any idea of what medication do other traditional healers give to AIDS related illnesses.- Do you give the same medication to patients?

What kind of cooperation do you wish traditional healers in Tembisa should have (Please tick)

- (A) Working together in the same clinics
- (B) Sharing medication
- (C) Sharing information
- (D) Referring patients among one another
- (E) Working alone without sharing anything
- (F) None of the above
- (G) Other - Specify

(g) Has individual TH views on AIDS changed - If yes since when, why did they change, if no why not?

Was there any efforts that were used to educate TH on AIDS, if yes by whom, and has that education been effective, if yes how effective, if no why TH were not educated on AIDS?

(h)What do TH see as major difficulties in treating aids

Do you have enough equipment of treating AIDS? If no, what is that you do not have and why you do not have it?

What do you think contributes in the fastest spread of HIV/AIDS in South Africa?

What challenges do you encounter in your involvement with HIV/AIDS. If there are any, how do you think can be solved?

(j) Do TH get assistance from their associations -how; if not why not

What type of assistance do you get from your association?

Do your associations give you enough assistance, if no how do they fail you?

Are you all members of the same association or some of you affiliate to other associations?

(j) Do Th consult with Dept of health - when, why; if not why not

Do you see Department of Health as a sector that you can work with in combating HIV/AIDS if yes why and how, if no why not?

Is there any contribution that the Department of Health has helped you with, if yes, what is it?

(k)Do Th consult with bio-medical doctors/hospitals/clinics -in what circumstances, if not why not

Is there a major difference between bio-medical treatment and traditional medicine in treating AIDS - If yes, what is that difference?

Do you see a need of TH working together with biomedicine, if yes how can they work together, if no why not?

(l)What do Th see as main failure of bio-medical health system in treating AIDS

What can you advise biomedical health to do inorder to fight HIV/AIDS effectively?

(m) What do Th see as useful in way bio-medicals stem treats AIDS

What methods can you say biomedical health need to get rid of and what are those that they need to maintain in order to fight HIV/AIDS?

Do PWA's rush to you after they've been told of their HIV/AIDS status or they come to you after biomedical health has failed them?

Do Ths employ any methods of bio-medical system in their treatment?

(o)How could government improve its policies on AIDS?

Are you aware of government policies on AIDS? What are they?

Do these government policies meet the needs of people infected and affected with HIV/AIDS- If not how do you think the government can improve its policies on AIDS?

Do you have any policy guideline that you work under?

Do you have any legal policies or law that protects your rights?

(p) Apart from AIDS, what is main health problem that TH deal with and do they see any patterns in the causes

As TH have been there even before AIDS cases were discovered in South Africa - Do you see AIDS as a disease that started in the 1980's or long before? If it started long before, how did you call it before medical health termed it "AIDS"?

Does treating PWA's challenge you more or it is like treating other diseases?

(q)Do THs see health problems generally as physically caused or having other causes?

What are those causes if there are any apart from physical causes?

Where do you think HIV/AIDS originated and how and why it originated?

(r)Do they know of cases where have got rid of AIDS in a patient

What criterion do you use to make sure that the patient's problem is AIDS?

What is the patient's response to your treatment? (Please tick)

(A) Effective

(B) Noneffective

(C) Other

How do you validate the response that you have ticked?

(s)Why do patients come to them?

Is there anything that they give patients that is different to what is offered by bio-medical system?

Do you treat other races either than Africans, if yes who are those?

(t) Do patients tend to use them and other healers (bio-medical/homeopathic; other)

If the patient mixes their medicine with other healers, what do they think is the reason?

If the patient uses their medication alone, what do they think is the reason?

TH Associations

Names, membership, office location

1. What is the name of your association?

How many members does it have?

What is the criterion of becoming a member?

Do you have membership cards?

Do you pay membership fee if yes how much

Where is your office located?

2. Aims

What are the aims of your association?

Do you see yourself as meeting your aims?

3.How do they assist Ths

What challenges do you encounter in assisting TH?

How do you think those challenges can be solved?

4.How do they interact with bio-medical system of health/ with Government (Dept of Health/clinics etc)

From you own point of view, how do biomedical doctors/hospitals and clinics perceive traditional healers?

How does government and Department of Health perceive traditional healers?

5.Successes of associations

Do you see yourself as having any successes?

If yes What are those successes if no how and why not?

What do you and whom do you think contributes in those successes?

5.Association policy re- AIDS

Do you have any policies on your involvement with HIV/AIDS?

Do you have policy guidelines that you work under. If yes what are they?

Are those policy guidelines being followed?

What role can associations play in improving government policy on Aids?

6.What do they see as main health problems encountered by TH

Do traditional healers have a role to play in fighting health problems?

7.what role can associations play in treating Aids

Are they currently playing their role?

If yes- how do they play that role- If no why are they not playing their role?

what role can associations play in improving govt policy on aids, plus health policies generally?

8.number of traditional healers in Tembisa

How many TH in Tembisa

How many TH association in Tembisa and what are those associations

Which Association has most traditional Healers and why?

9.are there different types of Th in tembisa -what types/specialisations

Are there any different types of traditional healers in Tembisa?

What types and what is their specialisation?

PWA's (People living with HIV/AIDS)

1.Why they came to the support group

How did you happen to know about this support group?

Is it the only one in Tembisa- if no why did you come specifically to this one?

2.Have they been to TH- why, why not

Who is the traditional healer that you consulted and where is s (he)?

How did you happen to know about that traditional healer?

How can you explain your interaction during the time of consultation. Was the interaction the same with biomedical system, if yes how similar, if no what was the difference?

3. They still consult TH -why; why not

When did you last approach a TH for help?

How long did it take a TH to help you?

What did you like most in your interaction?

What did you not like most in your interaction?

4. Have they found TH helpful -why; if not why

In which condition were you in when you consulted a TH?

What sort of help did you expect from a TH?

Did a TH meet your expectations?

How was your response to a TH's help?

What effort did you do to check whether his/her help has been effective or not effective to your problem?

5 What was the treatment given by TH (did treatment focus on AIDS or another health problem)

Did the TH diagnose that you are living with HIV/AIDS or biomedicine did?

Did you go to a TH at the first time or you went after you were disappointed somewhere?

6. How does the support group help you?

Do you feel any difference in your health after you joined a support group?

are THs important for people generally in dealing with ai

Do you see TH as having a role in fighting health problems?

Do you see TH as having a role in combating HIV/AIDS. If yes what do you think is their role?

Do you see TH as currently playing their role?

Are the TH succeeding in fighting HIV/AIDS. If yes -How are they succeeding- if no why do you think they are failing?

what do they think of government policy on AIDS?

Are you aware of government policies on AIDS

Are these policies fair to PWA's?

How could these policies been improved?

Do they find that bio-medical personnel (doctors/nurses) support people going to TH - reasons

What is biomedical personnel's (doctors/nurses) attitudes to TH?

Do they support patients using TH - If yes how, and why they support them, if no what are the reasons for not supporting them?

After using traditional medicine did you go back to biomedical system If yes why, if no why not?

Does support group discuss different systems of treating aids -do THs figure in these discussions?

What constitutes your discussions in the support group?

Do you discuss different systems of treating AIDS?

Do Traditional Healers feature in those discussions?

Dept of Health

statistics on AIDS in Tembisa

What is the current statistics of AIDS in Tembisa

Is there consultation with TH Associations

Do you have any relations with TH Associations, If yes what of kind of relations?

Do you see any need of working together with TH associations - If yes how and why, if no why not.

(for clinics) in Tembisa- is their interaction with TH

Do you have any interactions with TH - if yes what is that interaction and how do you interact, if no, why not?

Do you see TH as having a role to play in combating HIV/AIDS - If yes what is their role?

What are the challenges that are experienced by TH?

What are the successes of TH?

What do you like most about TH?

What you don't like most about TH? Do you treat many AIDS patients?

What is the estimated percentage of HIV population in Tembisa?

Tembisa Hospital

Do you treat many AIDS patients?

What is the estimated percentage of HIV/AIDS population in Tembisa?

Do you have any interactions with TH - if yes what is that interaction and how do you interact, if no why not?

Do you see TH as having a role in combating HIV/AIDS - If yes what is their role?

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What are the successes of TH?

What do you like most about TH?

What you don't like most about TH?

