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INVOLVING TRADITIONAL HEALTH PRACTITIONERS IN HIV/AIDS INTERVENTIONS: LESSONS FROM THE WESTERN CAPE PROVINCE

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‘Involving traditional health practitioners in HIV/AIDS interventions: Lessons from the Western Cape Province.’

Abstract

Despite international recognition of the potential value of collaboration between traditional health practitioners and western medicine, examples of this approach in South Africa are rare. Contextualised within the aims and objectives of the HIV/AIDS and STIs National Strategic Plan 2007-2011(NSP), the paper looks at one initiative, based in the Western Cape Province. It presents evidence of the scheme’s success to date, its potential for assisting in the NSP’s goals, and the possibility of further developments, which might enhance HIV/AIDS prevention and care strategies. Finally, the paper explores some key problems, and makes recommendations for future initiatives based on the experience.

Introduction

This paper documents the results of the second year of operation of the HOPE Cape Town (HIV Outreach Program and Education) Pilot Traditional Healer Project,[1] an innovative HIV/AIDS collaboration between traditional health practitioners (THPs) and western medicine in the Western Cape Province. The paper identifies the project’s achievements, and explores key problems in operation and management, including recommendations for the design and implementation of future initiatives. Also considered in the light of the National Strategic Plan for HIV/AIDS and STIs 2007-2011 (NSP), the paper provides evidence to illustrate the potential of bi-sectoral medical cooperation in fulfilling some of the NSP’s aims and objectives

[1] For a study of the project’s initiation and first year of operation see Wreford *et al* 2006.

Background

The potential advantages of collaboration between South African traditional and biomedical practitioners have long been acknowledged (SAMJ 1994), although implementation of collaborative schemes remains unusual (SAMJ 2006). This dilatory situation both illustrates, and goes some way to explain the persistence of the uneasy relationship between the paradigms. In practice, medical doctors generally hold traditional health practitioners at an unhelpful distance, treating them with indifference, suspicion and occasional animosity (ibid). The importance to collaborative efforts of reciprocity - 'an open exchange of information and experiences... [with] fellow health- care professionals' - has been noted (UNAIDS 2006:6), but is yet to be understood in South Africa. Consequently, such initiatives as have taken place have generally been one-sided and uni-directional (SAMJ 2006; UNAIDS 2006: 6; Wreford 2005b). Not surprisingly, in the face of this insistence on the hegemony of scientific knowledge even those THPs involved in collaboration become disillusioned (Leclerc-Madlala 2002a:16).

A similar biomedical emphasis is evident in the text of the National Strategic Plan for HIV/AIDS and STIs 2007-2011 (NSP). This policy document - which otherwise provides an admirably comprehensive and vital framework for the prevention, care and treatment of HIV/AIDS - nonetheless tends to project biomedical preconceptions about traditional practitioners. Although it emphasises the paucity of research into 'informal health care settings' or between 'culture and HIV' (2007: 31 and 32), the policy nonetheless asserts scientific 'beliefs' about traditional practice and HIV (33), and describes traditional practices as 'unsafe' (79). This scientific bias, and in particular the resolute preference for biomedical solutions, clearly manifests the priorities of the parties involved in its design, priorities that in turn have been influenced by the divisive history of HIV/AIDS policy in South Africa. Until the appearance of the NSP in mid 2007, the government response to HIV/AIDS had been characterised by confusion and prevarication (Fourie 2006: 159-163; Nattrass 2007). Woefully dilatory, and often simply inadequate (Poku 2005), its deficiencies were fuelled (and arguably sourced) by denialist declarations made first by the President, and thereafter by the Minister of Health. Together these appeared to deny not only the reality of the disease itself but also the government's responsibility for dealing with it. The situation continues to attract ongoing local and international opprobrium in academe and the popular press (Beresford 2007; Geffen 2007; Nattrass 2007).

As infection rates soared, the administration's dereliction also promoted the formation of activist grass roots movements (notably the Treatment Action Campaign (TAC)), determined to ensure medical treatment for all those needing it. The health minister's divisive and often derisive rejoinders in the ensuing clashes - on the streets and in the courts (Fourie 2006: 186; Nattrass 2007) – can be seen to constitute, as Schneider suggests, more than a simple reaction to criticism of her department's policy. They betray also a political 'discomfort...[with] social movements that express certain styles of activism...outside of the immediate networks of political patronage and influence' (2000: 153). This evident disquiet helps to explain the lack of ministerial commitment to the South African National AIDS Council (SANAC). This cross-sectoral committee incorporated representatives of government, NGOs national and international, civil and grass roots organisations, and was intended to drive national policy. Before 2007 however, the body appeared stymied, and its civil members regularly chastised government for its refusal to convene meetings. In stark contrast, with the Minister temporarily absent due to ill-health, her deputy, the Deputy President, and SANAC worked diligently to produce the NSP 2007-2011 (Cullinan 2006). There can be little doubt that this new commitment to proactive policy-making helped to produce a treatment and care policy that, with targets and monitoring systems in place, seems for the first time to have a genuine chance of succeeding.

The TAC and the AIDS Law Project are to be congratulated for the mobilisation of a provocative and extremely successful national grass roots movement demanding the right for South Africans living with AIDS to receive adequate and timeous treatment. That the TAC envisages that treatment in terms of western medicines – and in particular ARVs – is hardly surprising. However their insistence on the value of 'proven' western medicines against 'untested substances' (Hassan and Heywood 2007) can appear to traditional African healers and their supporters unreasonably doctrinaire. To argue that genuine traditional medicinal preparations should be denounced because they are untested, misses an important point. As the NSP itself makes clear, almost no research is available (especially *in situ*) on traditional remedies that are regularly employed by THPs to boost immunocompromised clients. It is to be hoped that the policy's call for 'research on the efficacy of traditional and complementary medicines for HIV treatment and OI prophylaxis' (2007: 108) will produce some tangible evidence to refute or confirm what at present are scientific 'beliefs' about these therapies.

It is clear that relationships between the TAC, medical doctors working in the field, and traditional practitioners, have been soured not only by the administration's

denialist response to the epidemic, but by the minister of health's (often inappropriate) advocacy of 'traditional' solutions to the problem. For example, Tshabalala-Msimang's support of the merits of testing a 'traditional' concoction known as *ubhejane* confused popular opinion, infuriated doctors and academics working in the field and undermined the TAC's position on ARVs (Beresford 2006). Whilst entrepreneurs have cynically exploited this situation,[2] some traditional healers express their support for these false claims of 'cures', increasing the alienation of the TAC and the medical fraternity from traditional practice.[3] Taken together with the minister's inappropriate conflation of African 'tradition' with her recommended diet of olive oil, lemons, beetroot and garlic - nutritional supplements in any event unattainable for the majority of those living with the disease (Westhead *et al* 2006) - an already sceptical scientific community has felt justified in declaring all things 'traditional' as lacking in validity.

Nonetheless, the reality is that, in a medically pluralist system, South Africans continue to utilise both western and traditional practitioners, albeit to different extents and often for different purposes (Nattrass 2006). Given this situation, the suggestion by the AIDS Law Project that the minister of health should be criticised for 'brazenly promoting the right to choose untested substances over proven medicines' seems curiously unrepresentative (Hassan and Heywood 2007). To THPs and their supporters this censorious attitude represents another version of denialism, this time of the knowledge and experience of traditional practice in the face of HIV/AIDS. It is important that both medical paradigms are absolutely transparent about HIV/AIDS treatments: neither system can cure the disease. ARVs, taken in time, taken correctly and for life (and often with a remarkable degree of experimentation (Levin 2006)), are usually able to return a person to a better state of health (Amoroso *et al* 2002). Likewise, many traditional practitioners, who eschew false promises of 'cures' and the profits to be accrued thereby, and wish to cooperate with western medicine, argue that several of their remedies have an equivalent efficacy to that of ARVs. Administered at an earlier stage of infection, the medicines may dramatically boost the immune system and possibly halt the rapid progress of the disease, as even some medical doctors are prepared to attest (Homsy et al 2004; Scheinman 2002; Stangaard, 1991; UNAIDS 2006: 17,38). On the other hand, scientific research suggesting that ARVs and some remedies used by THPs may result in negative interactions with ARVs

[2] The case of the Rath Foundation in Khayelitsha, Cape Town, is especially notorious.

[3] It should be emphasised that less than scrupulous academics too, have been tempted to claims of 'anti-HIV' remedies (Thamm 2006).

(Cohen and Maartens 2002; Mills *et al* 2005), in fact reflects the position of some traditional healers.[4]

Gaps in the NSP

It is difficult to see whether there can be any meeting of minds on this issue, but given the contentious background, it is unsurprising, if nonetheless disappointing, to find that the NSP tends to reinforce scientific preconceptions about traditional health practitioners rather than produce innovative proposals. For instance, the document suggests the creation of new strata of 'mid-level' health workers - 'community caregivers, lay health workers' and so on (2007:97). This proposal, clearly intended to address the serious shortfall in health service personnel (ibid), is nevertheless remarkable in its apparent disregard of the THPs - a cohort of healers that already exists, that is trained and qualified in its own disciplines, and is often popularly understood to offer an equivalently professional, but different, service to that of doctors. Such wilful disregard of the THPs is unlikely to promote reciprocal relationships; indeed it may well serve only to alienate the many healers who would like to, and should, be important allies in the care and treatment of HIV/AIDS in South Africa given an appropriate accreditation method – such as the one illustrated by the HOPE Cape Town project.

To take another example, the document assumes that the THPs will volunteer information about traditionally used remedies that may be efficacious in HIV/AIDS treatment (2007: 108). In doing so, the policy designers seem not to recognise (or to have given adequate consideration to) existing tensions concerning the status of indigenous knowledge: the complex of issues surrounding intellectual property rights for example, and particularly the potential for financial exploitation by powerful pharmaceutical companies (Crossman and Devisch 2002; Cullet 2003; O'Manique 2004: 83-85). Finally, there is an unhelpful tendency in the document to present scientific 'beliefs' about traditional health practitioners in terms that emphasise their potential for harm, 'risk' or negative influence (for example NSP 2007: 31, 33). By personifying them in this way as just another problem, the NSP is likely to prolong the healers' alienation, and postpone or even extinguish any aspirations they have to becoming part of the solution.

[4] In an ironic echo of biomedical accusations about traditional medications, I have heard THPs argue that ARVs are 'too strong' for those who are severely immunocompromised.

Set against this disputatious history, it is clearly important that the beneficial effects of collaborative HIV/AIDS interventions in South Africa be documented: this paper is intended to make a significant contribution to that literature.

Methodology

The paper is the result of an ongoing qualitative study based on direct participation and observation of the HOPE Cape Town pilot and its implementation in the field. Data is taken from fieldnotes, supported by in-depth recorded interviews with participants. The content of this paper is concentrated in three peri-urban areas, Mfuleni, Delft South, and Wallacedene, and includes anecdotal evidence and contributions from the healers themselves, from health service personnel involved in the project, and from HOPE staff and Community Health Workers (CHWs). Limited quantitative data is also used to record the numbers of clients successfully referred by the THPs to clinics.

HOPE: Interacting in the Western Cape

Although the Western Cape is a noted pioneer in HIV/AIDS care and treatment (Naimak 2006), the HOPE Cape Town project is the first intervention in the province to include traditional health practitioners (THPs). To briefly recap, this small pilot scheme was established in October 2005 with three main aims: to encourage medical collaboration between doctors and traditional healers and cross referrals between them in HIV/AIDS interventions; to avoid potential disruptions and interactions with ARV regimens through prescriptions by THPs, and to persuade more male clients to test. Nine THPs were recruited to work with five HOPE Community Health Workers (CHWs) in five townships on the outskirts of Cape Town.

The scheme commenced at Tygerberg Academic Hospital with a six-week course of education for THPs in biomedical understandings of HIV/AIDS and its treatment. The THPs were specifically advised of the possible interactions between some traditional remedies and ARVs (Cohen and Maartens 2002; Mills *et al* 2005) and recommended to avoid invasive treatments where they suspected a depleted immune system. To monitor the success of referrals, the THPs were shown how to complete the referral forms which clients were to present to the clinics; the THPs

were further instructed in how to maintain a client register whilst ensuring client confidentiality. The first week of intensive medical instruction was followed by four weeks of Voluntary Counselling and Testing training (VCT); designed and run by ATIC,[5] at the end of the module all the participants received accreditation as VCT counsellors. After the course, the participating THPs and CHWs returned to work in their communities.

Assessing the results

Three THPs are now successfully liaising with their local clinics in Mfuleni, Wallacedene and Delft South. Together they have referred a total of 80 clients since the project's inauguration in March 2006,[6] a most encouraging result. The number of male referrals further suggests that the THPs are indeed able to operate as a useful conduit between men and the testing centres, even when, as in this case, the THPs are women. What is more, the healers have established cooperative relationships with the clinics: although there are some exceptions, staff generally express approval of the THPs' involvement, and support the enrolment of more healers in similar initiatives.

Extra-curricular activities, bigger benefits

This numerical outcome offers rewarding evidence of the efficacy of the collaboration. In addition however, the HOPE THPs have undertaken significant extra duties, assuming responsibility for tasks that coincidentally (and in the light of the earlier discussion, somewhat ironically), often reflect several of the aims and objectives of the national strategy for HIV/AIDS 2007-2011. Collectively these extra-curricular activities suggest enormous potential for the involvement of traditional healers in the NSP's agenda - as treatment and testing advocates, relationship counsellors, promoters of responsible parenting, advisers in matters of sexual debut, to name a few.

[5] AIDS Training Information and Counselling Centre (Western Cape).
[6] These numbers may be understated. Clients often opt to visit clinics remote from their homes where HOPE CHWs may not be employed, and the Referral Forms are not recognised.

By way of illustration, the healers report that some clients (notably women who are newly-arrived from the Eastern Cape)[7] are reluctant to visit the clinic on their own. This may be due to unfamiliarity with the systems, with the language, or simply out of fright, but whatever the reasons, to ensure attendance, the healers take it upon themselves to accompany such clients. Moreover they continue to act as powerful advocates after the initial visit, encouraging their clients to adhere to treatment regimens and to return for aftercare.

Disclosure of a positive HIV diagnosis, always difficult, can often be hazardous for women in South Africa (Dunkle *et al* 2004; Kalichman *et al* 2007; Moffett 2004). Many face abuse and blame for the infection, or abandonment by partners who meanwhile continue to resist testing themselves (Ndinda *et al* 2007: 97). One HOPE traditional healer graphically describes a typical case:

> After the woman tested positive she will go to her man and explain that 'they tell me I'm HIV positive.' The man don't want to hear the name HIV positive. What does he do? He packs a suitcase and takes himself off to another lady, another wife!

The HOPE practitioners have shown remarkable determination to intervene in these situations. The same healer recalls one experience:

> There in the shacks there were two that came to me, both of them. Another one was positive another one was negative. The people were tested at the clinic. Now it's a new thing that I heard that they are fighting with each other. You know they are not sick at this time, but really it's about their marriage and HIV/AIDS. Now the wife came to me to tell me that they are fighting about this and that. She wasn't even coming for medication, no, she was coming just to talk and for advice. Yes, I said to her, 'you must call your husband [to come here]' – the husband was the one who wouldn't admit to this thing, accept this thing.

Here the healer emphasises her ability and willingness 'to talk' – to offer counselling – in an effort to resolve a very difficult personal problem for her client, a woman who had tested positive and was experiencing new relationship

[7] Large numbers of poverty-stricken people from the rural areas (especially of the Eastern Cape Province), continue to migrate to the townships of Cape Town. As Ndegwa *et al* have shown, there is a causal link between these patterns of migration, poverty, and [ill] health (2004).

difficulties because of her husband's negative status. Having invited the couple to her surgery she was able to encourage a frank discussion and eventually persuaded the man that he should support his partner. As the healer reported with measurable satisfaction: 'I talked to them and counselled them and now they are happy, they are staying together now.'

Even when their partners have tested positive, men are very often reluctant to undergo a test, and persuading them to accept counselling is problematic. One healer tries, as she puts it, to persuade the person '[to] bring her partner so that they can both be aware of the situation and talk about it and try to resolve it in a way that will not lead to confrontation'. But, in one instance where this approach failed, she took the lead and, at some personal risk, actually visited her client's shack. Her intention was to try to convince the male partner of the importance of ascertaining his status. Here she describes what happened:

> It's sometimes difficult to meet the [male] partners. In one case I visited this guy, then this guy – others are welcoming and understanding and they will listen to me – but this one didn't want to listen. In fact he said 'you will never come to my house again!' But I said 'no, I will come here. I haven't done anything wrong, so if I come here I'm here to see you and your partner.'

Although in this case her arguments fell on deaf ears, it is to be hoped that the awareness that this respected traditional practitioner is 'on his case' may yet change the man's mind.

Another example of extra-curricular activities is the THPs' interest in the wellbeing of children, whose particular vulnerability to HIV/AIDS may encompass dealing with the emotional trauma of being orphaned, of being abandoned or of carrying the burden of care for intensely ill and dying parents (Germann 2004; Jooste *et al* 2005; Kistner *et al* 2004; Richter *et al* 2004). Children and young people throughout Africa are also exposed to the negative repercussions of a particularly pernicious myth that is (anecdotally) often attached to traditional healers. The story, which attracts the ignorant or gullible desperate for a cure, is typified by the notion that sexual intercourse with a virgin, or any uninfected beings including young children, will cleanse the disease. Regularly cited in academic and popular texts as a driver of the epidemic, the myth is freely attributed (without corroborating evidence) to unidentified 'traditional practitioners' (Leclerc-Madlala 2002b: 88; Schoepf 2004: 23). So prevalent is this assumption that it has even found a place in

the NSP where THPs are cited as 'recommend[ing] sex with a virgin as part of their treatment' (2007: 33). Yet it is important to recognise the reality that men in particular, faced with HIV/AIDS, may behave in similarly irrational ways without any resort to a traditional healer (Ndinda 2007: 97; van Dyk & van Dyk 2003: 5). Whilst the HOPE THPs do not deny that charlatans[8] (or even some misguided THPs) may indeed be involved in spreading the tales, they vigorously and publicly condemn the stories, and their perpetrators.

There are more immediate tasks. As mothers themselves, the THPs enthusiastically promote the Mother to Child Transmission (PMTCT) programme. But they are painfully aware of the manifold hazards that threaten their own children, dangers that are compounded by HIV/AIDS. The traditional healers are quite prepared to do what they can to protect local children, and to alleviate their suffering. One for example, requested specific training to help her counsel orphaned children:

> I think I need more information about HIV and AIDS more specially about how to counsel the children whose parents passed away. I mean the orphans of HIV and AIDS – how to counsel them and show them the affirmative things in life.

This healer (despite a still unsuccessful struggle to obtain social grants to assist her) is already taking care of several orphans along with her own grandchildren. Another of the healers opens her home to HIV positive women and their children, until as she puts it, 'they are strong. They must see that from me. I must set the example, to make sure she is strong.'

A pressing issue of concern to the THPs and the NSP (2007: 65-67) is the continuing exposure of young people to HIV/AIDS (Ndaki 2004; Rehle *et al* 2007: 194; Simbayi *et al* 2004), and the importance of instilling behaviour change particularly in the younger generation. In this regard, the HOPE trained healers have become an important source of condoms within the community,[9] and report a special interest from young people. Although condoms are distributed free at clinics, adolescents often report that this service is accompanied by a disparaging

[8] THPs accept that 'charlatans' or rogue practitioners are working within their ranks, but the issue has become particularly sensitive in relation HIV/AIDS as these fraudsters promote expensive bogus 'cures' for the disease. Legislation, in part aimed at limiting the activities of these frauds, has yet to be enacted, apparently due to a legal challenge by the anti-abortion lobby group 'Doctors for Life'.

[9] The local clinics have undertaken to deliver boxes of condoms to the THPs' dwellings.

lecture, especially from older staff members scandalised at youthful sexuality (Campbell 2003: 126-127; Ribiero da Cruz 2004: 141-144). Youth (and other clients) are also concerned that their confidentiality is at risk in these very public environs (van Dyk and van Dyk 2003). In contrast, the young people appreciate the healers' non-judgmental advice, and are confident that their sexual relationships will remain secret. This trusting bond with the THPs could conceivably open up a much-needed conversation about adolescent sexuality (Scorgie 2002: 70), and develop into a fruitful supportive role, encompassing discussions with youth on a number of related issues: the age of sexual debut, responsible parenting, safer sex, intergenerational sex, drugs, violence, and so on. The THPs themselves are enthusiastic about additional counselling training along these lines, one saying: 'There are [sic] lots of training I would like to receive.' Another put it even more simply: '*iyakunceda kakhulu* (That would help a lot)!'

In a final instance of interventions pertinent to the NSP, all three of the practitioners report examples of a very real contribution, vital to the successful absorption of ARVs - the distribution of food. In the impoverished environment of the townships, people struggle, literally, to make ends meet. In this respect HIV/AIDS has simply added to an existing burden of everyday problems produced by a vicious poverty cycle. Even when, as is the case in the Western Cape (Nattrass 2006), patients are actually able to access ARVs, this apparent advantage confronts them with another obstacle - they must find food to take with their medications. What has been the healers' experience of this situation? Here are two scenarios as told by a practitioner:

> And then other people they come here with children who are very hungry, and the person didn't even pay [for treatment] but I still have to get something out of my pocket and buy something for the child...
>
> Most of the people who come to see me are my clients, and they often come back to me to say they've got treatment [from the clinic] 'we're eating treatment' they say, 'but today we don't have food to eat...'

In these excerpts the healer demonstrates at once a broader, social, responsibility for her clients' welfare, and the struggle to make a living – a reality that many THPs share with their clients. In both cases the healer had previously given a consultation, made her recommendations, and received payment. Now the same clients re-visit the healer, this time not for an official consultation, but rather as friends seeking material assistance. In the former case, despite her own limited

resources, the healer feels obliged to offer help to 'buy something for the child'. In the second example she offers food from her own supplies to ensure that her client who is 'eating the treatment' does so on a less than empty stomach.

Other Potential benefits

There exist at least two other potential benefits of this sort of collaboration, neither of which entered the remit of HOPE Cape Town scheme. I have described my vision of the first - the testing of the efficacy of traditional remedies *in situ* – elsewhere (Wreford 2007).[10]

Contextualised in the theme of medical reciprocity elaborated throughout this paper I will here concentrate on the second – the incorporation of the transformative potential of ritual (especially in the context of stigma) in HIV/AIDS interventions. I want to suggest that medical collaborations such as the HOPE initiative create an ideal platform from which to explore the possibility of incorporating new versions of the ritual practices that provide meaning and structure to traditional healing. Used imaginatively and with sensitivity, such rituals could have especial efficacy in countering the stigma of HIV/AIDS, and thence on the success of biomedical treatment interventions.

In their introduction to a volume on witchcraft in Africa, John and Jean Comaroff suggest that modernity, with its 'magical, impenetrable, inscrutable, uncontrollable [and] darkly dangerous...signs, commodities and practices' (1993: xxx) can itself be easily linked to witchery. It could also be argued that HIV/AIDS as one of the most dangerous of those signs, is symbolic of the consequences of a global modernity. As such, to follow the Comaroffs' line of reasoning, the disease, like witchcraft, should also be especially susceptible to the alterative power of ritual. THPs (and their clients) customarily draw on the authority of ancestral spirits for answers to the 'why me? Why now?' questions that usually accompany the appearance of illness in Africa (Wreford 2008: Chap 2). The THPs are equivocal about the power of the ancestors to identify HIV/AIDS (Wreford 2005a: 76-77), and this aetiological ambivalence is particularly significant in respect of STIs, including HIV/AIDS, for the ambiguity creates the sort of interpretative lacunae

[10] A larger collaboration with up to 375 THPs is currently underway at the Nelson R. Mandela School of Medicine at the University of KwaZulu Natal (Phillips 2006).

popularly filled by notions of pollution, contamination, and witchcraft discourse.[11] Sexual infidelity, for example, may provoke guilty feelings. If symptoms[12] then follow, fears of pollution and the threat of witchcraft are also evoked. Having made the connection between sexual (mis)behaviour, pollution, and possible witchery, clients, male and female, consult with the *healer of contamination and witchcraft* - the traditional healer. In the absence of a cure for HIV/AIDS, the impotence of receiving a positive HIV diagnosis can lead to hopelessness and despair (Ellis 2004: 82-83). On the other hand, the imputation of witchcraft to the diagnosis restores agency:[13] Impotence can be transformed into empowerment by means of ritual - an intervention aimed at emotional healing.[14]

I suggest that versions of the cleansing rituals familiar in the treatment of witchcraft (Wreford 2005a: 68-77) could be powerfully employed in the context of THP practice. The HOPE healers have all expressed interest in the idea. Appropriately designed cleansing ceremonies could provoke, not bogus physical recovery attached to false claims for 'cure', but a real and powerful healing of the emotional distress of the disease, for the client, their family and community. Such rituals, carefully executed, would help to undermine the personal and collective negativity of the stigma that attaches to HIV/AIDS, an outcome that should lead to a more proactive social engagement with the disease, and its prevention and treatment in South Africa. Needless to say, given the disputatious and controversial history of HIV/AIDS policy described earlier, such an intervention will require careful and sensitive planning and preparation, with potential clients, their kin and community, and also at a political level.

[11] While ideas such as the agency of ancestors, or the power of witchcraft may seem anachronistic to western medical practitioners they continue to have enormous authority in the lives of many South Africans. For discussion of the umbilical relationship between THPs and witchcraft see Wreford 2008: Chaps 3 and 8. For the implications for HIV/AIDS see Wreford 2005b: 68-77.

[12] The symptoms of witchcraft, and its aetiology, are remarkably congruent with those of HIV/AIDS. For additional coverage of the connections see Wreford 2005a: 68-74.

[13] See Reynolds-Whyte for discussion of this in connection with research in Uganda (1997: 215-216).

[14] I am not describing a physical cure here, but evidence suggests that reducing emotional stress has a positive effect on the immune system, and it is reasonable to propose that this sort of intervention will thus have an associated beneficial physical component.

Discussion of problems experienced in the HOPE approach and how to overcome them

Despite its successes the HOPE project also experienced its share of difficulties[15] and disappointments, and it is to a consideration of these that this paper now shifts. A selection of the major challenges will be presented. Based in this experience, the final part of the paper makes recommendations intended to guide and support future interventions.

Confounding numbers

The first, and perhaps most obvious setback is revealed in the numbers: of the nine THPs originally recruited for the scheme, only three are now practising. At first sight this suggests a high dropout rate, and certainly the HOPE Team was initially deeply disappointed with this result. But a more nuanced investigation revealed a more complex situation.

The three successful practitioners are all graduate healers (isiXhosa: *amagqirha*; isiZulu: *izangoma*). They have established practices and a trusted reputation within their communities ensures a regular supply of clients. Considered statistically then, the fact that the three graduate THPs have all become active participators demonstrates a success rate of 100 percent amongst healers *qualified to practice*. The remaining six healers were discovered (unfortunately only after the training), to be *thwasa*, or trainee/initiates.[16] As such, like apprentice doctors, they work only under supervision, and crucially lack the social status required to attract their own clientele. HOPE might have avoided this situation had they consulted beforehand with their own staff. Interviews with HOPE Community Health Workers, for instance, revealed valuable insights about the status and reputations of local healers; local knowledge that was not utilised.

One CHW also emphasised an acute awareness of the potential problems of setting up this sort of initiative. She stressed that it was important to avoid the competition

[15] For early indications of some of these see Wreford *et al* 2006.

[16] For a description of the protracted process involved in becoming a graduate *isangoma* see Wreford 2008: Chaps 4 -6.

that exists between individual healers: organisers should rather go directly to the community:

> Call a meeting involving the people that are not traditional healers, involving the community health workers; it would also be in a way, to avoid the conflict between the traditional healers themselves. Because if you have to choose one healer, that's where the problem starts! Then if the community health workers are involved in that way there's no jealousy, there's less conflict. And in that way you'll also get now the proper traditional healers, by proper I mean now the graduated ones...If you involve the people that are quite informed, it will work.

The speaker went on to express surprise that *thwasa* had been recruited because 'If they are being properly trained, believe me, they've got enough and they've got to focus on that so that they can be proper traditional healers...simply avoid the non-graduates.' Whilst she may have inflated the powers of the CHWs to affect the choice of candidates, the point about public consultation is well taken. In HOPE's case for example, clinic staff, and members of other counselling organisations have also volunteered names of THPs who might have been recruited, or who might want to enrol in future schemes. HOPE has learned two lessons the hard way: First, to ensure the most appropriate and effective participation, choose only graduated THPs. Second, canvass as wide a range of local knowledge as possible to produce suitable candidates.

Another dilemma, also concerned with the question of participants, is more difficult to resolve. The health service clinics in which this study is set are small and local.[17] Only one (very recently) has been accredited to distribute ARVs. Clients seeking antiretrovirals (as is the case in all more serious medical interventions) must go to the nearest hospital. Staff at the clinics are predominantly made up of nurses. In each clinic in this study, one doctor, half a day per week, is available; their sole responsibility is to supervise the adherence of patients on TB medication. As remarked earlier, the nursing staff are enthusiastic in their support of the HOPE initiative, but they lack the authority to take the project further – by making policy recommendations to the Provincial Health Authority for example. For this to happen, and for projects like this one to make a greater impact on the relationships between western medicine and traditional healing, it is clear that doctors need to be

[17] Nonetheless, they each serve, on average, 4,500 clients every month.

directly involved. If, as seems likely, the present chronic staff shortages in the South African health service persist, then perhaps the venue for collaborative projects must also shift to the hospital environment.

Practising difficulties

Traditional healers are not exempt or immune to the straitened circumstances that characterise life in the townships of South Africa. Given the poverty and unemployment that surrounds them, private practice is precarious. As described elsewhere clients often try to avoid payment, presenting a series of inventive excuses for delaying the THPs' remuneration (Wreford *et al* 2006: 26-28). THPs like everyone else, have family responsibilities, and are often forced to take temporary employment to make ends meet, or to fund financial obligations. Research into the status of 'voluntary' workers in the health sector has suggested that the payment of a stipend, however modest, tends to increase motivation and encourage participation (Panjabi 2005). The NSP appears to acknowledge this point (NSP: 97). In the HOPE Cape Town Project the question of payment was exacerbated by controversy about how much the THPs should charge for VCT sessions (Wreford *et al* 2006: 26-27). Initially. HOPE sought to enforce a very low fee for the VCT work, a proposal that was actually prejudicial to the project in its early stages (ibid). Although it was later agreed that the THPs should combine payment for VCT with the fee they would normally charge for a consultation, this does not take account of the fact that a VCT session alone can take up to an hour. Testimony from meetings and interviews with the healers suggests that they still feel that they are 'subsidising' their clients. Commenting on this predicament a HOPE community health worker, sympathetic to their plight, reported:

> According to them it's wasting time. You find a situation whereby there's so many people while she's still busy in the session, the counselling session. There's people waiting outside for the same traditional healer for the *vumisa* (divination session and diagnosis) so she's losing money while she's still busy!...[so] you do the counselling when you have time to do it...

None of the HOPE healers have suggested that they take this attitude, nor is there any evidence to suggest that their commitment to the project is in debate. They evidently feel that they have a responsibility to ensure the best treatment for their clients, and that this involves VCT and referrals to the clinics. Nonetheless the fact

that the question of fees is raised so often does tend to imply that the sort of stipend (as envisaged in the NSP for home based carers, for example) would provide welcome relief from financial pressure.[18] Careful thought needs to be given to the question of charges for this sort of additional service and this should be discussed with healer participants. While the HOPE experience suggests that the THPs can be encouraged to include the knowledge and skills gained from the training as part of their customary service, with charges levied according to that convention, the award of a stipend should be given serious consideration.

Liaison and follow up

The third point for consideration concerns support and follow-up training for participating healers. The HOPE project generally adheres to the pattern of other 'educative' collaborations (Wreford 2005b: 90-117). It is distinguished by the combined training of THPs with CHWs, and the VCT component, which, taken together, initially at least encouraged 'group solidarity' and a commitment from both THPs and CHWs to work together. In the frenetic environment of the clinics however, working relationships have sometimes proved fragile, and the THPs often (albeit obliquely) express the need for more encouragement and support. They have, after all, stepped outside the conventions of their customary practice, and although their communities seem to respect this stance, they are vulnerable to criticism, not least from healers who may be less inclined to cooperate with western medicine (Wreford 2005a: 60-68).

Apart from regular contact with clinic CHWs and occasional visits from other staff, HOPE has by and large left the THPs to their own devices. This is understandable: the costs of further liaison and the administrative responsibilities can be complex. But there are risks in this *laissez faire* approach. From interviews with the THPs, it is clear that although they can, and do, refer to their course notes when they are unsure or unclear about how to advise a client, in the absence of follow-up there may also be a tendency for them to revert to earlier, non biomedical interpretations related to HIV/AIDS. As has been recommended for nursing staff (Oyeyemi *et al* 2006: 201), regular training sessions for the healers will not only ensure that HOPE can be secure about their contribution but also boost the THPs' confidence.

[18] A small monthly payment for each client counselled and referred would also have confirmed to the healers that their contribution to this HIV/AIDS initiative was recognised and appreciated by HOPE.

Publicity, stigma and collecting data

The problem of the stigma that continues to be attached to HIV/AIDS in South Africa is considered next. Somewhat incongruously, this difficult subject is discussed here alongside the question of how to advertise and inform associated organisation about the HOPE project. As will become clear, although apparently disconnected, these issues have actually combined to prejudice the successful collection of data in support of the project.

As initially envisaged, the THPs had expected to refer counselled clients to the HOPE CHW at their local clinics. From the start however, it became clear that in order to avoid stigmatisation, clients were resisting this option, preferring to visit other clinics - often very remote from their homes. In the light of this situation, HOPE's decision to limit publicity about the project (most especially unwittingly overlooking advice to other counselling organisations and clinics), created further obstacles for the scheme. The fact that clients could (quite correctly) choose which clinic to visit meant that HOPE's referral forms appeared in public health facilities where they were not recognised. Alternatively, the counselling already done by the THP was repeated, wasting time and already limited resources.

HOPE Cape Town took four steps to overcome these obstacles: the THPs were given a list of *all* the facilities in which HOPE operates so that, with the client's consent, referrals could be made to a clinic staffed by HOPE; all HOPE CHWs received guidance on the scheme and a protocol document regarding their tasks in support of it; meetings were held with other counselling organisations to publicise the project and outline how they should respond to the referral forms; finally, meetings have been held with clinic staff (supported by another protocol document) to ensure that they are more familiar with the project and understand how they can support it. It is hoped that together these will enable the number of referrals to be monitored more accurately, and, by harnessing the associated health providers, lead to a more effective intervention.

Recommendations for future projects

The HOPE Cape Town pilot scheme produced some useful guidelines that should inform future projects. Whilst several of these recommendations are incorporated in a recent UNAIDS policy statement on collaborative projects (2006), the remainder of this paper amplifies that document with experience specific to the HOPE experience. If certain of the matters considered here appear repetitious, or somewhat prosaic and mundane, they are included precisely because the impact of such practicalities on the successful outcome of the project can be considerable, yet tend to be glossed over in academic reports.

Selection of Traditional Health Practitioners

The choice, and means of selection of THPs is crucial to the success of collaborative projects. To rely on individual recommendations, as was the situation in the HOPE scheme, or even to consult with local healers' organisations, may simply play on private or collective influence, and reinforce existing unhelpful professional jealousies. THPs should rather be selected from as broad a social spectrum as possible, and with the active assistance and support of the local community. Local CHWs, Home Based Carers, clinic staff and other organisations working in the field should be invited to participate in this process.[19] All participating THPs must have evidence of their registration as graduated practising healers under the terms of the Traditional Health Practitioners Act 2004, but at the same time, a serious attempt should be made to assess the reputations of THPs within the community, with those who are well-known and trusted being preferred.

All the participants in the HOPE project are female, and there were concerns that male clients in particular might feel constrained by consulting a woman. Although this has not proven to be the case in the peri-urban environment of the HOPE scheme, in more rural areas this gender specificity might have produced a different response. The selection of THPs should then be representative of gender and generational difference, to ensure that social restraints on the discussion of intimate matters between generations, or across genders, are taken into account. Finally, there is the question of the other participants in collaborative projects. As discussed earlier in the paper, in the HOPE scenario it has not yet been possible to bring

[19] One CHW suggested that a panel of local community representatives might be convened for the purpose of final selection.

doctors on board, a reality that has limited coverage of the project within the broader public health environment, and thus reduced the possibilities of extending the project elsewhere. As UNAIDS has recognised, the involvement of biomedical professionals is an important factor in the success of collaborative efforts (UNAIDS 2006). Future initiatives should seek to encourage the recruitment of western-trained doctors from the outset.[20]

Terms and conditions of participation

In the HOPE scenario, participation involved the healers in a six week absence from their practice and families. Prospective THPs were made aware that their participation required them to attend the training course for its duration, and all participants signed a document agreeing to this requirement. Several options exist to avoid the personal and practical complications involved in this arrangement. The simplest option would see healers being chosen from immediately adjacent communities, and the initial training course organised in a location easily accessible to all participants (a local Community Hall, Library, or Church Hall for instance). Alternatively, where participants are from different, far-flung communities, organisers should include costs of accommodating the THPs, on weekdays, at a location convenient to the training venue. Payment for transporting the THPs to and from the venue, and costs of meals should also be included. Healers appreciate having tangible evidence of their participation in non-traditional trainings, with which they can promote their practice and encourage new clients. Obviously this would benefit the aims of any collaborative HIV/AIDS project, and arrangements should therefore be made to ensure that THPs who have successfully fulfilled the terms and conditions of a collaborative course receive a Certificate(s) to this effect. Finally, as an example of an often overlooked item of vital importance, all course materials should be available in the participants' first language.

[20] The project now in progress in KwaZulu Natal appears to be organised on this basis. See footnote 10.

Monitoring, assessment and evaluation

During the course of the project HOPE Cape Town discovered several shortfalls in its monitoring and evaluation of the outcomes. One of the most important concerned the lack of statistical evidence, which has prevented HOPE from garnering the widest possible publicity for the scheme, especially in academic coverage. It is for example, important that the efficacy of the initial training course be evaluated. To facilitate this, all participating THPs should be asked at the outset of the project, to complete a questionnaire to assess their existing knowledge of HIV/AIDS. These questionnaires should be retained, and repeated at the end of the course, and the results compared and assessed to ascertain the extent of changes in knowledge/understanding of HIV/AIDS gained from the course.

The success of collaborative projects such as that described in this paper relies on the availability of dependable statistics of referrals from the healers to local clinics or health facilities. A second omission in the HOPE Cape Town project concerned the use, follow up, and evaluation of referral forms to clinics. As discussed in an earlier paper describing the initial stages of the HOPE scheme (Wreford *et al* 2006), the complications involved in keeping track of referrals are complex and difficult. They involve first, ensuring that the healers themselves are familiar with the forms: that they know how to complete the forms, how to keep careful records of consultations, and finally that they understand the importance of all these.

But successful monitoring does not simply devolve on the healers; staff at clinics, other health facilities, and NGOs dealing with VCT counselling have also to be incorporated. Considerable efforts must be therefore be made to publicise the project and ensure that as many organisations as possible are aware of it, and involved. To this end, either during, or as soon as possible after the end of the initial training, organisers should personally visit as many health facilities and other counselling providers as possible, in the communities appropriate to the participating THPs. These sessions should carefully describe the purpose of the particular project, its content, duration and expected outcomes. Referral systems should be explained, with specific reference to the systems required for ensuring that all associated paperwork is completed and retained for data collection.

Since collaboration across medical sectors is still somewhat controversial, meetings should encourage medical staff in particular to discuss any doubts or concerns that may arise, and take steps to deal with them constructively. Where CHWs, or other community based health care workers are not included in the initial training course,

the meetings should further identify a person or persons who will be the first point of entry for THPs their clients, and the referral forms, at the clinic or day hospital.[21]It is recommended, but not essential, that at this stage, private doctors in the community are also apprised of the project and its systems of operation. Printed materials in the form of protocols, posters, leaflets etc should be prepared as a corollary to this exercise, and in response to it.

As soon as possible after the course, each participating THP should be introduced by the organisers to the medical staff operating at all the local health facilities in their community. Staff should then be reminded of the principals of the project, in particular, the associated referral system. At this stage, posters advertising the new THP service should, with the permission of the supervising medical personnel, be prominently displayed in each health facility. These should include the desired protocols for the scheme, details of the staff identified as first point of entry for patients referred through the scheme, and personal details of the participating THPs operating in that area: their names, addresses, contact numbers, and if thought desirable, photographs.

If all of this sounds very time-consuming successful implementation and evaluation may depend upon it. It is important that health care workers across the spectrum are apprised of the project and its advantages to their work at an early stage, so that by the end of the initial training course, and afterwards in their communities, the THPs may be confident that their counterparts understand the scheme (especially the referral system) and will cooperate with it.

Following up

HOPE Cape Town chose not to initiate follow up trainings for the THP participants in the first two years of the project. This omission became a matter for concern since, apart from the numbers of clients referred, there existed no other means of assessing the effects of the training on the healers' existing practice. To eliminate the possibility of confusion -that healers might over time revert back to earlier explanations of HIV/AIDS for example - this paper suggests that regular additional training sessions are held for all participating THPs at intervals of not more than three months, or as agreed with the practitioners. These sessions could reinforce

[21] Where CHWs are not available, counsellers from associated NGOs could be asked to fulfil this role.

and enhance the THPs' knowledge, but also expand on their experience; themes such as PMTCT, STIs, gender violence, relationship counselling, youth counselling, and stigma could be considered for these follow up sessions. Participating THPs should also be invited to suggest their own topics. By involving health practitioners from local clinics and hospitals sessions such as these would have the additional advantage of reminding the THPs that they are recognised and valued as participants in their local health service network.

Conclusion

This paper has presented some of the immediate advantages that may accrue to provincial and national HIV/AIDS strategies through the involvement of traditional health practitioners in western medical interventions. It has drawn attention to some additional benefits that may be gained from a collaborative approach, and has provided a sketch of the way in which the ritual processes that characterise traditional practice may be implemented to assist in the reduction of the emotional distress attached to the social stigma of the disease. The paper also looks at a few of the problems that often arise in cooperative efforts, and makes recommendations for future interventions. It is hoped that the content of the paper will stimulate debate about the merits of better cooperation between medical paradigms in South Africa, and encourage the establishment of other, more ambitious projects.

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