

RAPPROCHEMENT OR RESISTANCE? UTILISING TRADITIONAL HEALING PRINCIPLES AND PRACTICE TO ENHANCE HIV/AIDS TREATMENT IN SOUTH AFRICA

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INTRODUCTION: UNDERSTANDING THE OBSTACLES TO HIV/AIDS TREATMENT

Statistics on HIV infection in South Africa record up to 5.2 million people living with the virus. Highest infection rates are reported from the townships and 'informal settlements' where the majority of black people live¹. These figures underline the grim reality that, despite improvements to the country's public health services, access to treatment continues to be highly problematic.

What are the obstacles to treatment in South Africa, and how are they explained? Barriers may be categorised as structurally imposed, and socially or self-imposed. In the former category the primary hurdle has consisted in the government's ambiguous stance on the disease, and on ARV therapy. President Mbeki's denialist pronouncements are well documented; the health minister has added to the confusion with her support for references to ARVs as 'poisonous' (a particularly loaded term in African healing understandings, where it is generally applied to describe witchcraft). This obfuscation accounts, at least in part, for the administration's delayed response to the epidemic - a persistently slow and inconsistent rollout programme which has been the subject of intense public debate and academic criticism (for example Ashforth 2005: 107-8; Benatar 2001: 364; Nattrass 2004a: chap 2). This is not the whole story however, for the rollout is further constrained by being implemented within an already overstretched and under-resourced Public Health Service that is now barely coping with the burden (Letsoalo 2006). Infrastructural weakness compounds the difficulty. In the rural areas public health facilities are often prohibitively remote from any form of public transport, but even in the sprawling townships patients must resign themselves to spending a whole day in travelling to, and then waiting for, treatment.

This picture is necessarily backgrounded by chronic unemployment, and although

joblessness obviously results in a state of general impoverishment, the persistence of gender inequality in South Africa ensures that the burden of dealing with the consequences falls disproportionately upon women. Indeed poverty and unemployment exacerbate the corrosive effects not only of enduring gender inequity (sometimes justified by dubious assertions of 'cultural' traditions (Mthathi 2006)), but also of gender-based violence. Younger women, girls, and boys are especially vulnerable to sexual exploitation (Mthathi 2006; Susser and Stein 2000), often accompanied by the sort of violent coercion that, as Dunkle et al demonstrate, represents an increased risk of HIV infection (2004). Unemployment and the despair associated with privation encourage the insidious commoditisation of sex. In the absence of basic welfare support, for example, women and girls can be more easily persuaded to exchange (frequently unsafe) sex for material favours (Dunkle et al 2004: 1417; Preston-Whyte 1994: 248-250), or to become pregnant to access the Child Support Grant. Meanwhile the link between an AIDS diagnosis, ARVs, and health-determined access to a Disability Grant has been shown to be potentially prejudicial to treatment regimes (Nattrass 2004b). For women poverty has other, more prosaic, consequences. To visit a 'local' clinic for instance, mothers are obliged to arrange childcare, albeit carrying their youngest with them, intensifying their anxiety. Since women rarely possess money of their own, sourcing the funds to finance the journey represents another barrier to their accessing treatment. When the trip is focused on treatment or testing, the issue becomes even more fraught, as even sympathetic partners will question the purpose of the visit.

This brings this examination of obstacles to treatment for HIV/AIDS to the socially or self-imposed, and thus to a consideration of the potent combination of stigma, fear, and denial which continues to envelop the disease in South Africa. Denial, whether of the disease itself, or of one's own status, whilst it is abetted by government pronouncements, is also stoked by a customary unwillingness to discuss sexuality. Add stigmatisation, and it is not difficult to understand why campaigns promoting HIV/AIDS testing and behavioural change are proving ineffective². Males are especially reluctant to test (Beck

1 The Western Cape Province in which this research is situated boasts the lowest HIV prevalence in the country, a tribute to its early commitment to antiretroviral treatment. See Naimak 2006.

2 To date, the government's primary policy intervention has focused on the familiar but ineffectual 'ABC - Abstain, Be faithful, Condomise' message.

2004) and generally contest the use of condoms, notably within marriage relationships, aggravating infection risks for all women and for the children who result from unprotected liaisons. Women, on the other hand, are unjustly vulnerable to the gendering of blame (Leclerc-Madlala 2001), and wives and mothers advocating condom use are themselves accused of 'being dirty' (another euphemism for witchcraft), or 'having something to hide.' Regrettably, the gender inequities underpinning these attitudes are proving persistent across generations. Studies in KwaZulu-Natal for example, demonstrate a disturbing level of almost unconscious sexually coercive behaviour by young men (Leclerc-Madlala 2001; Tillotson & Maharaj 2001). Under these circumstances it is hardly surprising that infections continue to rise, especially amongst younger women (WHO 2006a).

COPING WITH HIV/AIDS - HEALTH POLICY AND TRADITIONAL HEALERS IN SOUTH AFRICA

How has the administration dealt with the issue of medical pluralism in the context of the availability of treatment? The existence of competing ideologies of healing in South Africa's public health environment has not improved access to treatment, a somewhat paradoxical situation which is, at least in part, again linked to government equivocality. Take for instance the Comprehensive HIV and AIDS Strategy (Department of Health 2006). In this document the administration expresses token respect for traditional healers, describing them as 'pillars' of the strategy. The text however completely fails to develop this apparently pivotal role, an omission

which doubtless helps to explain (and provides a convenient excuse for) the continued exclusion of traditional healers from HIV/AIDS interventions. Meanwhile, reinforced by the administration's ambiguity about ARVs, the health minister's advocacy of 'choice' in HIV/AIDS treatment has erroneously convinced some patients that 'natural' remedies will cure the disease. Her promotion of (often incorrectly labelled) 'traditional' therapies adds fuel to the fire by encouraging opportunistic claims for 'cures'³ (Beresford 2006; Geffen 2005; Herman 2006). Such evidence of charlatanry (whether or not it originates from traditional practitioners) validates medical professionals in their familiar characterisation of all traditional healers as incompetent or dangerous⁴ rogues or 'witchdoctors'⁵. Frustrated with the inadequate rollout of ARVs, doctors conclude that government is forcing patients into 'non-scientific' treatment choices (Lederer 2006; Natrass 2005). Overall then, the administration's assertion of a 'holistic' HIV/AIDS policy, whilst arguably intended to encourage treatment choice and rapprochement between medical paradigms, has perpetuated alienation. Thus a potential advantage of medical pluralism is lost; instead of being reciprocally engaged in interventions against the epidemic, the two ideologies continue to operate separately, often acrimoniously.

COLLABORATION OR INCORPORATION?

The theoretical notion of collaboration between the paradigms in HIV/AIDS interventions is hardly new (World Health Organisation 1978). Premised on the advantage to overburdened health services in harnessing an influential and culturally appropriate healing ally, many traditional practitioners support the idea, and notwithstanding historical differences, several efforts have been made to establish interaction in South Africa⁶. But 'cooperative' projects have tended to be uni-directional and educative, and participating healers frequently express disappointment at the persistent indifference of biomedical practitioners to the potential of learning from traditional African healing (Leclerc-Madlala 2002a: 9)⁷.

Before leaving this brief consideration of cooperation, it is important to draw attention to some doubts about the consequences of collaboration that act to deter some traditional practitioners from cooperation with biomedicine. First, there is the risk to individual healers that their collaboration with the local public health services face criticism, from clients and other healers, of betraying traditional aetiology and practice. Those who oppose cooperation across medical

3 The activities of the Rath Foundation are notorious in this respect, not least in the township of Khayelitsha in the Western Cape (Geffen 2005: 187-194). Some traditional healers, accepting the 'traditional' label attached to Rath's vitamin regimes, have supported their distribution.

4 Some anthropologists have also implicated traditional healers in the creation of 'dangerous' beliefs or practices. But the spread of the notorious 'virgin cleansing myth' for instance (Leclerc-Madlala 2002b: 92; Schoepf 2004: 23) whilst attributed to traditional healers is scantily evidenced (Matthews 2005: 149). Similarly alleged connections between re-use of razor blades and the spread of the disease are unproven. In this context, the iatrogenic spread of the disease through medical injections is not contested (Moore et al 2001; WHO 2006b).

5 The existence of charlatans is uncontested. Government legislation, in part aimed at curbing their activities, has recently been enacted but remains to be tested (THPB 2004).

6 See Wreford 2005b for a comprehensive review of collaborative schemes in Southern Africa.

7 It is not without irony that anthropologists engaged in ethnographies of traditional medical systems often discover their research marginalized or ignored by biomedical professionals and designers of public health programmes.

sectors for example, allege that collaboration actually represents (or inevitably results in) incorporation, and the consequent subjugation of traditional understandings of health and illness by the hegemony of biomedical discourse. Others are concerned about biomedicine's symbiotic relationship with the commercially driven interests of pharmaceutical companies. They fear the exploitative potential in collaborative medical relationships, not least in relation to the commercial benefits accruing to the development of 'indigenous knowledge'⁸. Nonetheless, the longevity of traditional healing in Africa, and the active support of many healers, suggests that the discipline is sufficiently flexible to flourish within a framework of mutually receptive cooperation.

Using a case study from the Western Cape Province, the remainder of this chapter examines the limitations of the educative approach to collaborative endeavours, and, whilst acknowledging the difficulties, makes some suggestions for the design of collaborative HIV/AIDS interventions organised within a methodological framework at once more extensive and mutually respectful.

THE CASE OF HOPE IN THE WESTERN CAPE

The HOPE⁹ Cape Town project which informs this study commenced in October 2005 with three specific aims¹⁰: To encourage collaborative referrals between biomedical personnel and amagqirha/izangoma; to avoid possible disruptions to ARV regimens through contraindications with traditional remedies, and to persuade more men to test¹¹. Nine Xhosa-speaking female amagqirha, and five HOPE Community Health Workers (CHWs), participated, all living and working in five townships around Cape Town. The project commenced with a six-week course, held at Tygerberg Academic Hospital in Cape Town, which covered familiar educative territory: Biomedical understandings of HIV/AIDS, STIs, opportunistic infections, and the action, prescription and administration of antiretrovirals, PMTCT, safer sex strategies, and so on. Treatment adherence, and the risks of contraindications to ARV efficacy were emphasised. The course was innovative in its incorporation of a four week-long VCT counselling module¹². The effect of this initial stage can be summed up in the words of one igqirha: 'everything was clearer in my eyes. This is what I've been looking for. You must know what you want to do for the people.'

The research evidence supporting the chapter is based on direct participation and observation

of the HOPE course, and follows the experience of its first year of implementation. Data sources include fieldnotes, supported by recorded in-depth interviews with participating amagqirha, and group interviews with the CHWs involved. Where appropriate, fieldwork evidence gathered over several years of involvement with traditional healers in the Southern Cape is also employed¹³.

TRADITIONAL HEALERS AND THE TREATMENT OF WOMEN AND CHILDREN

Some advantages to engaging traditional healers in HIV/AIDS interventions are obvious: They are accessible, usually affordable¹⁴, and available 'out-of-hours'; their appointments are open-ended, and they are culturally attuned to their clients¹⁵. As healers, the amagqirha/izangoma can rely on traditional respect and customary connections: They are popularly understood to be wise in local knowledge¹⁶. Sharing the township lives of their clients, the HOPE practitioners are all too aware of the risks (and temptations) for women and children living with impoverishment¹⁷. At least two have personal experience of living with HIV/AIDS, and most have shared stories of

8 The Medical Research Council in South Africa is one of several institutions carrying out in vitro research into the efficacy of some traditional remedies in treating the immune system. The MRC acknowledge however that their work is severely under-funded, and the question of the ownership of 'indigenous knowledge' in the context of intellectual property rights remains highly problematic (Dr. Matsabila, MRC: Personal communication Nov 2005).

9 HOPE (HIV Outreach Program and Education) operates training, education and outreach projects in clinics and day hospitals throughout the Western Province.

10 The project is the first of its kind in the Western Cape. For a complete description of the course design and objectives see Hippler et al 2005. Wreford 2006 presents an analysis of the effectiveness of the initial stages of the project's implementation.

11 A fourth objective to enable traditional healers to carry out sputum tests awaits a protocol from the Provincial Health Authority.

12 The counseling module was designed and co-ordinated by ATTIC (AIDS Training Information and Counselling Centre) Western Cape.

13 The author is a practicing isangoma and a social anthropologist.

14 The question of charges for amagqirha/izangoma services is complex. For some considerations of the issue discovered in relation to the HOPE project see Wreford 2006: 26-28.

15 This is by no means universal of course. One HOPE igqirha, acknowledging the importance of belief, humbly remarked: 'It depends on the individual person's belief and faith, whether they believe in traditional healing or in western medicine.'

16 The healers' relationship with women in particular often starts during pregnancy: For example, expectant mothers approach the amagqirha for medicine to ease delivery (isicakathi), and after childbirth protective beads (amatatyiisi) may be tied at the child's waist and neck to help to promote growth.

17 In this cash-strapped economy several of the HOPE practitioners maintain second jobs to support their practice.

unfaithful partners. Building on these relationships, and equipped with counselling skills, the HOPE healers are ideally positioned to open up dialogue about HIV/AIDS.

In the context of the HOPE scheme additional general benefits can be identified. First, the healers' acceptance of the biomedical interpretations of HIV as (for the present) without cure, and their advocacy of ARV treatment, should ensure that these amagqirha will not offer bogus or harmful treatments¹⁸. Secondly, because HOPE amagqirha are able to recognise the biomedical difference between symptoms of STIs and HIV/AIDS, they are unlikely to offer remedies which might treat the former but leave the virus untouched¹⁹; nor will they employ remedies which might undermine an immune-compromised system. Thirdly, they act as conduits of all these new understandings to the community, and can encourage other healers in their neighbourhoods to take up collaborative opportunities. Fourthly, their understanding of means of transmission makes them useful promoters of behavioural change, including the use and distribution of condoms²⁰. Finally, since men tend to consult amagqirha/izangoma before biomedical doctors (particularly regarding STI symptoms), the benefits already described should support women in their struggle for access to testing and treatment. This potential returns the discussion to the question of secrecy, stigmatisation and denial of HIV/AIDS introduced earlier in the chapter.

The combined fears of discovery, and of stigmatisation after disclosure, continue to enforce the necessity for trust, secrecy and confidentiality in treatment programmes (Almeleh 2006). In the public health sector this is a particularly contested arena. Many patients refuse to visit their neighbourhood clinics 'because people will be curious' - simply being seen there is perceived as enough to generate unkind gossip. Moreover,

18 Bogus 'cures' for the disease are distributed by charlatans posing as traditional healers. They demand considerable sums of money. Two HOPE CHWs reported cases of 'traditional healers' in their areas asking up to R3000 for 'the medication for HIV.' Tangwa remarks that the very act of requesting such exorbitant sums is the mark of the fraud (2005). Genuine healers, as the author's teacher stressed, must never over charge, and risk losing their healing gift if they do so.

19 The question of 'cure' in traditional African healing equates with absence of symptoms, with obvious and serious implications for the asymptomatic stages of HIV. See Wreford 2005a: 64-66.

20 HOPE amagqirha report that young people, in particular, visit them to obtain condoms.

clinic staff are notorious for their indiscretion, being seen, as one HOPE CHW bluntly put it, 'too easy about disclosing status.' But popular censure and attitudes also operate as powerful deterrents to clinic attendance. In particular, adolescents seeking condoms are vulnerable to very public admonitions, especially from older clinic workers, for their 'dirty' behaviour.

In contrast to the clinics' porous reputation amagqirha/izangoma are obliged to keep their diagnosis, and all client information, confidential. One igqirha underlined the importance of secrecy: 'If you diagnose someone then whatever they should discover from that person you have to keep it to yourself because it's a secret. That person can then say OK, I am able to come back to this person because this person can really keep confidential information.' The igqirha/izangoma surgery then, is trusted as a safe environment for the sharing of personal secrets. The HOPE amagqirha are extending this acknowledged responsibility, providing active support and relief until clients living with the virus are prepared to disclose. One healer has adopted a positive woman into her household, encouraging her to talk until 'She becomes stronger and can live with the problem.' Other healers voluntarily accept visits from clients seeking 'talking' (as counseling is popularly described) and food.

As an incentive for collaboration, the healers' new treatment advocacy role presents other important potential advantages for the development of their own practice. For instance, it offers an opportunity to re-open a dialogue with disenchanted young people, whose outwardly disrespectful attitude often masks a very real apprehension about African healing traditions (not least in its ambiguous relationship to the discourse of witchcraft). Making use of their access to condoms, for example, the amagqirha/izangoma may engage the youth in conversations that will not only reinforce safer sexual practice in the time of HIV/AIDS, but may conceivably dilute fears about traditional practice, and lead to renewed interest and respect for the paradigm.

Pursuing this alternative theme, there exists another potentially dynamic transformative role for the healers, this time in the field of gender relations. Thus the amagqirha - already recognised as community counsellors and confidantes - may conceivably develop this advisory responsibility to include a subtle mode of gender activism to challenge the customarily dominant (and often violent) behaviour of men, especially in intimate

relationships (Dunkle et al 2004; Moffett 2006). In their interactions, these older, wiser, and mostly independent women could be influential in drawing their male, and female, young and older clients, to a consideration of new values for intimate sexual relationships and the distribution of power within them.

BUILDING RECIPROCITY, ENLARGING THE FOCUS OF COLLABORATION

The HOPE project has to date followed a familiar educative pattern. Although the treatment benefits in this approach are evidenced in increased numbers of clients referred by the healers for testing, as a genuinely collaborative tool the method is limited by its bias towards the biomedical model. The remainder of this chapter develops two versions of the HOPE pilot project, envisaged now as a more expansive and reciprocal act of collaboration. The first suggests incorporating elements of the traditional pharmacopoeia into the scheme, while the second visualises the project incorporating a direct engagement with the aetiology and ritual practice of amagqirha/izangoma.

Increasing therapeutic efficacy 1: The traditional pharmacopoeia and the treatment gap

The HOPE course focused on ensuring that the amagqirha work in concert with biomedical understandings of HIV/AIDS and its treatment. To this end, the risks of possible contraindications between ARVs and traditional treatments were highlighted. However, in the context of the competition between therapeutic ideologies traced earlier in the chapter, and this chapter's emphasis on reciprocal medical collaborations, the absence of any discussion of the healers' remedies (for the immune system and STIs for instance) was significant, not least because the clients who visit an igqirha are seeking a remedy in terms of the amagqirha/izangoma paradigm. Even after testing positive, some will refuse the biomedical route. Recognising this reality, the scenario outlined below attempts to demonstrate how collaborations like the HOPE project could be developed to provide environments for the active investigation of the efficacy of amagqirha/izangoma remedies in the treatment of HIV/AIDS.

In South Africa public health patients who manage to access ARVs do so only with CD4 counts of 200 or below. The time between a positive HIV diagnosis and this point may be several years long: a period I will call the 'treatment gap'. During this stage biomedicine offers palliative care, antibiotic

treatment for STIs and opportunistic infections (with potential further damage to the immune system), and nutritional and lifestyle guidance. Amagqirha/izangoma meanwhile, insist that there exist traditional remedies that can be safely and effectively used to strengthen the immune system and treat STIs, notably during this period. Since there is no evidence of contraindication between traditional remedies and antibiotic therapy, could amagqirha such as the HOPE participants not be encouraged to employ immune-boosting herbs and STI therapies during the treatment gap? This approach (if only for patients preferring the traditional route) would have the additional advantage of offering a manageable locus for scientific research into the efficacy of the healers' remedies.

In the HOPE situation, unfortunately, the persistence of biomedical prejudice already threatens to sabotage this possibility. One igqirha reports that clinic staff are actively deterring clients from re-visiting the healers, telling them 'to stick with the clinic'. For patients prescribed ARVs this position might seem explicable, but for those who do not qualify for ARVs, it is unjustified, and undermines the confidence of the amagqirha in the reality of collaboration²¹.

Increasing therapeutic efficacy 2: Using traditional aetiology to enhance treatment

HIV/AIDS epitomises the 'magical, impenetrable, inscrutable, uncontrollable [and] darkly dangerous' symbolic qualities which define the global consequences of modernity as envisaged by the Comaroffs (1993: xxx). Accepting their hypothesis, HIV/AIDS is also, I suggest, especially susceptible to the alterative power of ritual. Developing the theme of medical reciprocity elaborated above, the subsequent section focuses on the aetiology and ritual practice of amagqirha/izangoma and proposes that the appropriate incorporation of both could have significantly impact on popular perceptions of HIV/AIDS and

21 As pointed out in Fn18 the definition of 'cure' in HIV/AIDS is contested, and the attitudes of the clinic staff may be further influenced by allegations of charlatanism. Nonetheless, much in the same way as ARVs (albeit at the most advanced stage of the disease), act to slow down or inhibit progression of the virus, traditional therapies can boost the immune system. Both paradigms successfully strengthen immunity - at different stages of the disease. Both can restore a patient to better health, but neither can cure. I have suggested elsewhere that the substitution of 'cure' with the phrase 'restore to health' would avoid confrontation in this arena and thus assist medical cooperation (Wreford 2005a: 66).

thence on the success of biomedical treatment interventions.

Despite the fact that illness interpretations have enormous agency in healing strategies the HOPE project has notably omitted consideration of amagqirha/izangoma aetiology. For example, amagqirha/izangoma 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. This position is no less operative in the context of HIV/AIDS²². Amagqirha /izangoma are however, equivocal about the ancestors' role in identifying HIV/AIDS. One HOPE practitioner confirmed 'yes, the ancestors do recognise AIDS', but immediately qualified this by noting that the 'old people didn't have this AIDS.' Another exclaimed: '[the ancestors] they died earlier before! It's a new illness! They knew only about other illnesses.'

This aetiological ambivalence is particularly significant when discovering the appearance of STIs and HIV/AIDS, for the ambiguity creates the sort of interpretative lacunae popularly filled by notions of pollution, contamination, and witchcraft discourse²³. Sexual infidelity, for example, may provoke guilty feelings, but should symptoms²⁴ then appear, 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 igqirha/isangoma. Whist it is undeniable that some clients employ witchcraft simply as a mask behind which to hide their HIV status (Ashforth 2005), in the context of accessing treatment that informs this volume, my researches suggest another, more potent, rationale for assertions of witchcraft causation in HIV/AIDS (Wreford 2005a: 72-77). What is at stake is the issue of personal agency in the face of a death-bringing illness. ARVs may be available in South Africa, but an HIV diagnosis is nonetheless often received as a death-sentence: In the absence of a cure, the patient feels impotent. The imputation of witchcraft, on the other hand, has agency, for it offers the possibility of an intervention aimed at healing, the chance of an empowering action.

For instance, regardless of the source of the pollution, the first, essential, step to recovery involves the ritualised application of a remedy to cleanse and purify the body (and spirit) of the corrupting influence²⁵. In the case of alleged witchcraft, harsh purges are customary, which of course, presents a challenge for HOPE amagqirha. They recognise that enemas and emetics are to be avoided in an immune-compromised patient²⁶. The client, on the other hand, offered a less aperiens medicine (amayeza), may feel cheated of the expected treatment for the problem, and thus be left in doubt as to its efficacy. I now suggest a means of transforming this apparent stalemate. Building on the authority of the amagqirha/izangoma as healers of pollution and witchcraft, I propose that the aetiological construct of witchcraft as an agent of HIV/AIDS causation, and cleansing rituals as an agent of its transformation, could be powerfully employed in the context of amagqirha/izangoma practice. I am persuaded of three potential outcomes of the voluntary participation of those living with the HI virus in appropriately designed cleansing ceremonies: First, individuals and families living with the HI virus could thus be provoked, not to bogus physical recovery, but towards a powerful healing of the emotional distress of the disease. Secondly, such rituals, carefully executed, would do much to undermine the personal and collective negativity of the stigma that attaches to HIV/AIDS. Finally, taken together, these outcomes would enhance the possibilities of a more proactive engagement with the disease, and its treatment in South Africa.

CONCLUSIONS AND RECOMMENDATIONS

In this chapter I started by suggesting, somewhat controversially, that it is a little unreasonable for biomedical doctors to continue to blame amagqirha/izangoma for their medical ignorance,

22 Wreford 2005c: Chap 2 offers a comprehensive exploration of 'the question of ancestors' in amagqirha/izangoma practice.

23 While ideas such as the agency of ancestors, or the power of witchcraft may seem anachronistic to western medical practitioners steeped in scientific certitude (and indeed in other African countries such as Uganda: Noerine Kaleeba, Personal Communication Nov 2006), the aetiology of the beneficence and malevolence of living or other-worldly beings continues to have enormous authority in the lives of many South Africans. For discussion of the umbilical relationship between amagqirha/izangoma and witchcraft see Wreford 2005c: Chaps 3 and 8. For the implications for HIV/AIDS see Wreford 2005a: 68-77.

24 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.

25 The harsh action of some purging substances is a source of contention between amagqirha/izangoma and western trained doctors, especially when applied to clients with HIV/AIDS. Severe applications are generally administered by enema or emetic, but gentler methods such as steaming, smoking, ointments, and bathing in herbal mixtures are also available.

26 Looking at this issue from the traditional perspective, some healers use the same logic to question the efficacy of ARVs for immuno-compromised clients.

or accuse them of sabotaging western care, unless the doctors themselves are willing to engage the healers in reciprocal collaborative arrangements. Biomedical professionals will doubtless have appreciated the 'educative' content of the HOPE course described here, while the explanations of the healing agency attributed to ancestors, or notions of pollution and witchcraft discourse may have been more problematic. Nonetheless it is my hope that overall, the chapter has underlined the urgency of establishing reciprocal contact between traditional healers and biomedicine in HIV/AIDS interventions.

I have promoted a more respectful engagement with the principles of amagqirha/izangoma in the belief that this might contribute to a better outcome for the future rollout of ARVs in South Africa. Obviously, biomedical doctors could benefit from the human resource represented in traditional healers. But I argue that simply seconding them into existing programmes prolongs the one-way communication familiar to 'educative' cooperative experiments, and potentially alienates a powerful healing ally. I propose that drawing amagqirha/izangoma into the design and implementation of treatment interventions would be more productive and mutually beneficial. To achieve this however, doctors need to develop professional relationships with traditional healers, and better understand the complexity of therapeutic choices faced by patients. Through these reciprocal discoveries doctors might begin to appreciate that, for many of their patients, traditional methods and practice actually work, and may be effectively incorporated into western medical interventions.

To facilitate such dialogue I recommend that policy designers and project planners give consideration to the following:

1. That guidelines for interventions like the HOPE project be established to facilitate their establishment in conjunction with public health facilities in urban, and rural areas of South Africa.
2. That staff in the public health sector be encouraged to develop professional relationships with amagqirha/izangoma focused on reciprocal familiarisation with understandings of health and illness²⁷.
3. That medical education promote these initiatives by incorporating modules that actively engage with amagqirha/izangoma and their

aetiologies²⁸: (To facilitate this, where necessary, students should become familiar with at least one black South African language).

4. That, in cooperation with traditional healers, additional resources be invested in scientific research into the efficacy of remedies used by amagqirha/izangoma, with particular emphasis on the 'treatment gap'.
5. That, drawing on the healing dynamics of notions of contamination and the power of ritual cleansing in amagqirha/izangoma practice, traditional healers, working in partnership with public health facilities, be encouraged to evolve rituals to counter the emotional distress, and stigma attached, to HIV/AIDS.

I am aware that considerable resources would be required to successfully implement these proposals. However, in the light of government's commitment to traditional healing as expressed in the Comprehensive HIV and AIDS Strategy, and its advocacy of 'choice' in South African HIV/AIDS treatment regimes, I suggest that political and financial assistance for the recommendations offers the administration an opportunity to demonstrate genuine support for, and encouragement of, these aims.

27 Anderson and Kaleeba 2002 describe successful examples of such partnerships from Uganda and Kenya.

28 The author is currently engaged in such an initiative with the Primary Health Care Unit, Groote Schuur Hospital Medical School, University of Cape Town.

**DISCUSSION AND COMMENTS,
J. WREFORD**

- Traditional African medicine is capable of integrating aspects of biomedicine without being absorbed or appropriated by it.
- Discussion focused on whether medical institutions should be the main proponents of “integration” or “collaborative relations” between different medical systems, or whether this should be left to persons who already, in their normal practice, integrate different medical systems.
- If traditional medicine can be analyzed as a “medical system”, it is also the case that they contain an important mystical and religious component that is inseparable from their “medical” aspect.

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