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A PUBLIC HEALTH CONFLICT: TRADITIONAL MEDICINAL PRACTISE AND THE
BIO-MEDICAL HEALTH NORMS AND VALUES AT A TIME OF HIV AND AIDS IN
SWAZILAND

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DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: _____ G.G. Dlamini _____ Date: 24/02/2010

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LIST OF ABBREVIATIONS

ABC	Abstain, be faithful and use condoms
AIDS	Acquired Immunity Deficiency Syndrome
ATR	African Traditional Religions
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
AMICAALL	African Mayors Initiative to Combat Aids at Local Level
CANGO	Coordinating Assembly of Non-Governmental Organisations
CBO	Community Based Organisation
CSO	Central Statistics Office
FLAS	Family Life Association of Swaziland
HEU	Health Education Unit
HIV	Human Immunodeficiency Virus
MOHSW	Ministry of Health and Social Welfare
NERCHA	National Response Committee on HIV and AIDS
NGO	Non Governmental Organisation
OVCs	Orphans and Vulnerable Children
OTC	Over The Counter
PEPFAR	President's Emergency Plan for AIDS Relief
PHU	Public Health Unit
SNAP	Swaziland National AIDS Programme
STC	Save The Children Fund
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
UNAIDS	United Nations AIDS Programme
UNDP	United Nations Development Programme
WHO	World Health Organisation

ABSTRACT

Medical pluralism and the co-existence of a variety of different medical systems within a chosen context are common features in southern Africa as in the rest of the developing world. How do the different systems or practices interact? How does the dual systems of healing impact on the HIV and AIDS national mitigation programmes. The study assumes that the existence of different kinds of medical practices in the same community over a long period of time is an indication of the reality of medical pluralism in Swaziland. It questions its conflicting impact on the public health messages for managing the epidemic. The existence of different healers e.g. faith healers, medical doctors and traditional healers and herbalists is a significant aspect of health seeking behaviours among the larger population in Swaziland (only 22% of Swaziland is urbanized). The people's attitude towards and reception of the state's public health policies and public health messages are heavily interpreted along and in view of the highly respected traditional medical health care systems. This phenomena also covers the people's spiritual and emotional health care systems and points of references and health seeking behaviours. The study also reflects upon the bias by a number of post-colonial writing towards traditional healing driven by colonialists' impressions and local rulers left in charge thereafter. The study also refers to the bias of a number of African leaders and governments who readily give support to bio-medical doctors and are not equally supportive to the structures that support traditional healing and yet a bigger size of the population is mostly reliant upon traditional medical care. In southern Africa self-medication is documented as an integral part of the health care system. This research project reflects extensively on the attitude of traditional and developing communities towards ARVs, ART and biomedical interventions at a time of HIV and AIDS in southern Africa. The study concludes that there are no cultural barriers for the traditional healers to collaborate with the bio-medicine practioners; however there seems to be a lot of 'public health' constraints for the medical doctor to working collaboratively with the traditional healer. Is this a one sided conflict, tension, bias?

Key words: Medical pluralism, African traditional medicines, Hiv/Aids treatment Access, Public health in Africa, Alternative health systems, Faith/Religion and healing

Chapter 1

INTRODUCTION

The primary focus of this research project is an exploration of people's perception of public health messages in view of a highly traditional and cultural environment such as Swaziland; where public health messages compete daily with African traditional medicinal norms and practices. The secondary focus naturally is the impact of medical pluralism on HIV/AIDS prevention, treatment and mitigation programmes e.g. the use of condoms, ARVs etc. It is an attempt to identify specific points of conflict and or agreement between the teachings of culture versus the bio-medical public health messages. The study assumes that a vast majority of the public in Swaziland consults both traditional and bio-medical practitioners in times of illness, whether physical, emotional or spiritual. This is because of the number of traditional healers that can be seen in almost every community especially in the rural areas.

The global HIV/AIDS epidemic is most severe in southern Africa and other parts of sub Saharan Africa such as Uganda; where health assets and resources are highly limited (WHO: 2006). Despite the limited resources; and with a lot of support from overseas funding, extensive programmes have been carried out to stop or slow down the ever increasing infection rate, mitigate the impact of the virus at all levels; as well as to treat and support those already affected and infected and to reduce the number of deaths from HIV and AIDS related illnesses.

This dissertation seeks to explore the role and influence of culture and tradition on HIV and AIDS and other public health programmes treatment and disease management in Swaziland. *Motshane*, about 25 kilometres south of Mbabane (capital city of Swaziland) will be used as a case in order to focus on the real issues of community health issues. It is an attempt to identify specific points of conflict between the teachings of culture and tradition versus the messages of bio-medical public health messages. It is a critical discussion of the very elaborate public health calls for 'behavioural change' in order to deal with the epidemic more effectively.

HIV and AIDS cannot be explained simply in terms of medical science alone.

“The conditions in which it originates and in which it is transmitted are social; conversely its impact on social life is a reconstitutive and far reaching one [Panos Dossier: 1990].”

Nowhere is this truer than in the worst affected region of sub-Saharan Africa. Public health workers do their best in adapting their messages to suit the communities in which they work. However, I argue in this dissertation that that in itself can pose a problem. In ‘watering down’ certain aspects of a message, to suit a certain culture; there is a danger in presenting the message as if it were optional. For example culture emphasizes abstinence and in some communities (see discussion on findings) public health workers are not even allowed to teach, display or distribute condoms; so that when they visit or run mobile clinics in communities like these they have to either say nothing about condoms or present them as a less fundamental option to abstinence and HIV prevention. Something that one may choose to do; if culture or at times religion allows it e.g. in catholic communities. In the interpretation of the message the gist of what it is meant to convey may be lost or be offered as optional even in life or death situations e.g. use of condoms in sero discordant couples. Because of his own customary and cultural beliefs a man may refuse to wear a condom. Perhaps it is for this reason that many argue that HIV and AIDS is a development issue more than it is a health and medicine issue, in which the people’s levels of education, economic status and access to resources and information determines how they react to and manage the virus in their families and communities.

Sexuality itself continues to be a minefield to be carefully treaded on by HIV and AIDS prevention public health officers. This research is mindful of the fact that sexual health ideology is formulated and influenced by tradition and culture and that this manifests in public health for both traditional and bio-medical health practises. Party to this argument is the fact that it is essential to confront and seek understanding of the areas of conflict e.g. between the traditional sexual text generated by culture and religion against the public health messages. They may not necessarily be in direct conflict but the conflict may be observable

in their interpretations of health promoting behaviours and activities. Social science has long recognized the often great discrepancy, and sometimes even contradiction, between ideological constructs and actual behaviours [Benn C. 2002]. People sometimes will believe and proclaim one thing but in fact do the opposite of what they say and believe they do. The question is how do we address this problem in a context where people are already living with a plural system of belief.

1.1 Brief Political History of Swaziland

Swaziland is one of only two surviving monarchies in Africa, the other being Morocco in the North of Africa. Until recently, Lesotho was a member of this rarity but has since democratised and is now a constitutional monarchy. Contrary to this, His Majesty King Mswati III has recently [2005 constitution] managed to enshrine in the constitution that all legislative, judicial and executive authority remains vested in him. He is both head of state and head of government, an absolute monarch in a no-party state. According to the new constitution His Majesty can and does at his pleasure appoint and remove the Prime Minister, all cabinet ministers, 40 percent of members of both the House of Parliament and 60 percent of the House of Senate. In the past these very influential posts have mainly been occupied by members of his family as well as other popular traditionalist. This is the group from which he then picks members of cabinet and the Prime Minister. Constitutionally, members of the royal family are not allowed to campaign for parliamentary elections but they get appointed to Cabinet, Parliament or Senate by his Majesty as he pleases and there is no limit as to how many members of the royal family he can appoint to each House.

The king is appointed by a council of senior princes and princesses as well as a few carefully selected chiefs. There is no evidence to suggest that his father the late King Sobhuza II had anything to do with the selection of the current King. Theoretically and in terms of the constitution [2005] he rules with his mother as the Queen Mother and in council with the same group that appointed him king. In terms of traditional governance structures he is the supreme authority of all Swazi traditional religious practice and government. The king has practiced Swazi traditional religion and Christian worship concurrently since his ascension to

the throne. This appears to cement his mystic presence in all legislative, executive and political ruling of the country.

The king has a lot more influence with the male Swazis in general than he does with female Swazis. More and more women are disappointed in his polygamist activities, a number of commentaries seem to make a tentative conclusion that him being polygamist gives licence to married men keeping several women in the periphery of the family unit. I suspect that this practice legitimises multiple sexual partners for many men young and old, married or single. He is seen as a symbol of true 'masculinity and virility', how a real man should be and how a man should handle his relationship with women. However, a recent study argues that his popularity is negligible among most of the educated males who sometimes see his lifestyle as non-progressive and backward. However he has considerable respect among the youth in the country both male and female [FLAS funded by PEPFAR survey, 2004]

The Swazi nation has a strong culture centred around the monarchy. The country is homogenous in terms of tribal groupings of the southern Africa region as well as in terms of the siSwati language. Ironically there are more Swazi people in South Africa than in Swaziland. With the majority of them found in the Mpumalanga Province of South Africa [FLAS survey 2004]. The homogeneity has had both positive and negative effects on the politics of the country. Because people see each other as relatives they find it hard to openly disagree with each other even when this might be necessary. However on the other hand because of this 'familial' emotional connection Swaziland has had no civil war or any other kind of community against community violence since her founding (Matsebula J.S.M. 1982). For HIV and AIDS programmes this mentality of one Swazi one system of behaviour has been problematic. For instance Swazi culture dictates that if a married man dies a younger brother has rights to his property including his surviving spouse and children. Historically [Matsebula 1982], this custom was meant to protect both the wife and the children and keep them in a safe family environment and provide the children with a father figure and mitigate the impact of losing their biological father, who would usually had been the main provider.

However, Matsebula explains that the wife had a right to refuse the brother and she could take the children with her back to her own people. If the children were in need of matter that their mother's family could not take care of; then messengers could be sent to their father's family to seek assistance from their late father's estate. More recently this custom has suffered abuse in cases where the surviving brother would fail to take care of his brother's children despite taking over all their father estate. Women who have refused to be inherited are treated badly at times evicted from their homes and blamed for having infected their late spouses with the HI virus with or without the evidence of an HIV test.

The second peril of the wife inheritance custom is that it endangers the lives of the surviving brother and that of his wife and unborn babies. With their eyes on their brother's estate men neglect to think about whether or not the late brother was HIV positive and the possibility that his widow might also be HIV positive. There have been reported cases [more in Discussion chapter] where it appears that the widow herself pursues the relationship with a 'well off' younger brother. There is of course always the possibility that both the inheritor and the inherited will practise safe sex. Slight though, because the whole idea of wife inheriting is generally practised by very conservative and rural families; and the very idea that this same community would welcome the use of condoms is highly improbable.

Governance

The system of government in Swaziland is referred to as '*tinkhundla*' which is basically a development philosophy with latent political ideology proposed by the late King Sobhuza II. Inkhundla is a region comprising of two or more chiefdoms. Its main axis is that systems of government should decentralize to community level in order to allow the people easy access to public officers and social services. The king came up with this philosophy of government just around the time when informal township settlements were really taking off in Manzini and Mbabane, the two main urban centres in Swaziland, [Mbabane's centennial celebration document: 2006]. It was intended to control the haphazard move of populations into towns without the relevant growth taking place in social services such as hospitals, schools, and water and sanitation services. If his vision had been well supported the levels of inner city poverty which have a huge impact on the HIV and AIDS epidemic today would have been

averted or better managed. The Centenary report explains that even though the city council clinic is approved to issue ARVs it is not the poorest of the poor who visit this facility and benefits from its welfare programmes because issue like clothes, what to wear when going to City Hall [it is right in the middle of the City] as well as how to get there, transport. Between 1968, when Swaziland got its independence and 2006 when Mbabane celebrated its 100th birthday 22% of the countries population has moved from the rural areas to urban areas because of the lure of employment in the industrial centres. The tinkhundla system was meant to decentralize industry to rural areas to encourage people to stay at their homes and be able to access employment within their communities.

When the late king introduced this concept of government he said:

“The system of government for Swaziland is a democratic, participatory, Tinkhundla based system which emphasizes devolution of State power from central government to tinkhundla areas and individual merit as basis for election or appointment into public office. The primary objective of the Tinkhundla based system of government is to bring government closer to the people; so that the people at sub-national or local community level progressively take control of their own affairs and govern themselves” [Decentralization Policy, Government of Swaziland : 2005 pg 6]

This philosophy seems to be in line with traditional leadership structures whereby any group of chiefdoms have always had a traditional way of understanding hierarchy between the chiefdoms. This arrangement had nothing to do with the size of each chiefdom either geographically or in terms of population size. When the British Protectorate government took over they introduced political regions which were in fact administrative districts and completely disregarded the indigenous ways in which people understood their boundaries and political areas of control [Matsebula 178]. There is a growing suspicion within the NGOs and other public health workers in Swaziland that this issue has a negative impact on a number of development efforts. This is evident when people are invited to meetings where for instance an NGO needs to meet with a certain region and they will choose a meeting venue in a political district centre. Some neighbouring communities and chiefdoms will not

attend these meetings because they possibly feel that they really do not belong to that district historically; in terms of their understanding of where and to which chief they must pay allegiance. In other words the place for the meeting might be a government facility e.g. an agricultural centre but it will still be in an area that belongs to a different chiefdom. Also during the meeting people who are from the vicinity of the centre tend to dominate in both number and actual participation during the discussion, putting off those who have walked from further chiefdoms.

Later on (1989) as the HIV and AIDS epidemic took off; problems associated with chieftaincy disputes have caused divisions among the population and have delayed and hampered public health programmes and development projects unnecessarily. The breakdown or the failure to merge the traditional life and traditional public health systems with the new health paradigm presented by the scourge of not only the HIV virus but other diseases as well; such as malaria and Tuberculosis rendered many of the mitigative programmes less successful. Writing in a foreword for a review of the HIV/AIDS Emergencies for Swaziland both Allan Whiteside and Derek Von Wissell and Naysmith agree that:

“..While, in many ways, Swaziland’s response has been admirable and unique, it is clear that the HIV prevention programmes have not worked so far, and more importantly, that the social and economic implications of the epidemic have not been adequately thought through”
[Naysmith S. et al: 2007 pg iii].

Perhaps there is indeed more urgency, than previously thought, to consider more carefully the unique social context for every community in which this epidemic exists. Most of the time the public health messages [e.g. Stick to one wife or Abstain from sex if you are not married] are presented as if they in themselves are judgemental of the traditional health seeking ways of local populations; e.g. the interpretation of polygamy versus the concept of multiple sexual partners. Whereas a polygamous man will have two or more known sexual partners; multiple sexual partners can refer to anything from having a one night stand per month to having one girlfriend in every town. Either way if this epidemic is to be managed

better it might be in order that each circumstance is viewed empathically and without judgement.

Public Health Issues in Swaziland

According to Kaseje, Juma and Oindo [2005] public health can be defined as:

“... The process of mobilizing local, state, national and international resources to solve major health problems affecting communities. It can also be understood as the health status of a population, the extent to which they are free from disease and premature death. Alternatively it can be seen as a philosophy of interventions aimed at promoting the health of the population [Kaseje et al: 2005, pg 49].

It is highly possible that the public health of the people of the southern Africa region is probably undergoing one of its worse attacks in recent history. Judging by the sheer volume and demographic details of the people who are dying this epidemic is unprecedented in recent history [Panos Dossier 1990]. Governments in southern Africa continue to struggle to find enough resources to cover all the necessary public health costs that the HIV epidemic demands. This increases the levels of poverty especially in rural communities because a huge amount of any fiscal gains the family unit makes or even the countries make; are taken up by public health programmes including HIV/AIDS mitigating programmes such as the distribution of ARVS and other illnesses such as TB treatment. The Panos Institute explains in short that the situation is one of clear despair; that post independence Africa has lost a number of development achievements it had made prior to the emergence of this pandemic. The development plans of many of the developing world have had to be shelved in pursuit of balancing national budgets in order to take care of a heavier cost of health [Panos Dossier, 1990].

Kaseje et al [2005] argue that globally there are more notable advances in medicine, science and technology atleast in the last 50 years. In the developed world public health strategies and interventions and socioeconomic development have improved life expectancies and

greatly reduced mortality. Health education and medical infrastructures have expanded for both men and women. Unfortunately these gains have been by no means universal. The health status of populations within and among countries are still entrapped in the glaring reality of the haves and the have nots. The health gaps between countries have widened. This leaves public health realities even more precarious. In countries like Swaziland the people who make social welfare policies [Cabinet ministers and department directors] have enough money to not need to use the public health and social welfare service systems themselves. Whenever they and their families need serious medical attention they go to neighbouring South Africa, where there is a totally different medical infrastructure especially if you have the right kind of money. They therefore feel no urgent need to fight for better health care since they themselves may not feel the pinch.

These inequalities and injustices continue to perpetuate the preferential option for the poor by disease [Farmer, 2003]. Farmer contends that poor people lack even the voice to demand the prioritization of public health in national government. For an example in most governments in southern Africa, becoming a Member of Parliament automatically qualifies one and their families to the most comprehensive health insurances. Possibly for these policy makers public health issues are probably not a big issue for them individually and collectively. Poverty increases a population's vulnerability to disease and at the same time reduces the chances of inclusion and access to the public health care systems for the poor of the poor. This situation perpetuates the entrapment of 70% of the households of developing nations in the vicious cycle of poverty and ill health [WHO: 2002]. Kaseje et al puts it more succinctly:

“Africa continues to suffer under the yoke of the unjust world order: unbalanced global trade, imposed reforms and the relentless debt burden driven by insensitive, corrupt, and undemocratic leaders, insulated by looted wealth, and supported by their external friends against their own citizens. The health of Africans is probably one of the greatest challenges to the economic development of the continent and its peoples....The situation is aggravated by weak systems of governance, the decline of systems of social contract, accountability and transparency on the one hand, and ecological stress, rapid demographic change and competition for resources on the other... All these reflect the challenges of economic

feasibility of effective public health actions, the political realities, and choices that governments face” [Kaseje et al: 2005 pg 201]

It is however important to note that in Swaziland and indeed many sub-Saharan countries; it appears that after the 2001 Abuja Declaration [National Multisectoral HIV and AIDS Strategic Plan: 2005], some major effort was undertaken to make substantial increases in the budget allocation for Public Health. A bigger increase is observable in training funds for public health officials including doctors and other specialists such as epidemiologists. The issue is that the HIV virus has ridden on the backs of years of social injustices and public health messages whether traditional or bio-medically inclined; have to take the social welfare realities of these communities into consideration to come up with competent and effective public health messages.

The public health system in Swaziland used to be among the best in the region. As a teenager my grandparents sent me to a boarding missionary high school in Manzini. Typically, within this missionary compound was a huge church, a co-educational boarding high school, a teacher training college, a nurses training college and of course the second biggest referral hospital in Swaziland. Incidentally, I was born in this hospital, and up to the time when I went to University (1988), the most expensive procedure at this hospital would have cost the patient no more than ten Emalangeni (E10 Emalangeni Swazi currency = R10), the equivalent of about \$1.50. Health care was virtually free in Swaziland and highly competent. Today it is a shadow of its former self. Not only are the bed spaces permanently full, there is an endlessly long line of outpatients with scanty staff to attend to them. It is more than likely that patients return home without receiving any treatment. Half the equipment is outdated and malfunctioning. Worryingly, even private clinics are reportedly [Times of Swaziland: November 2007] struggling with the sheer volume of patients coming to their rooms daily and the lack of good laboratory services. HIV alone represents a huge increase in the need for specialised care and treatment including laboratory based support. A large portion of health needs have shifted from curative care to palliative care which in general terms implies more visits to the health centre and sometimes longer confinement periods in hospitals for instance TB patients [WHO: 2005].

The study also makes reference to adequate financing as one factor that influences the capacity to respond adequately to the HIV and AIDS epidemic. Equally important is having enough qualified health professionals to undertake the various essential activities. Alan Whiteside [2003] makes the argument that HIV and AIDS influences human capital in two ways. Firstly, that it reduces the number of personnel available e.g. through absenteeism and mortality to prepare and respond to the pandemic. Secondly, that it affects human capital accumulation in the long term. Due to the early deaths of parents young children are left orphans with a lower chance of attending school and reproducing new professionals in the future. These children lose the benefit of inter-generational knowledge transfer. They can not build on whatever professional advances their parents may have gained; as a result of this chain of loss public health promotion suffers.

Background to public health Issues in Swaziland

The political history of the people of Swaziland is unique in that there seems to have been no internal wars or fighting from the time they settled in present day Swaziland. However, due to public health challenges presented by disease including those related to HIV and AIDS; there is now an undeniable threat to survival itself. With a proud history behind them, the future is uncertain. Like many of the clans who belonged to the Nguni tribe or Nguni people; the Swazis also had their own tried and tested traditional medicines. Even after colonialism some of these practices have successfully carried on. Gerard Jansen writes:

“When the pioneer medical missionaries of the 19th century introduced their Western style medicine into sub-Saharan Africa, they all faced an age-old ethnomedical system dominating the medical care of the local population. Throughout the continent there was a diversity of medical traditions between the various ethnic groups but within each community traditional medicine had a monopolistic position [Jansen Get al., 2001: pg 69]”.

It is important to mention that just like in many African countries; Religion came hand in glove with a number of the social changes that were to occur in Swaziland in the 20th

century. This is important because of the moral values attached to illness. The stigma attached to HIV and AIDS is largely influenced by ignorance but also by the various notions of faith mainly driven by the Christian traditions in Africa. Perhaps the sociological question to ask is do cultural interpretations of God, faith, spirituality, religion, death and health play any part in the designing of public health messages both in traditional health and Western public health practice. Possibly throughout an individual's life, from birth, marriage and death their physical and spiritual health is interlinked with what public health message his or her parents receive, she or he receives; and how they all respond to these messages collectively and individually.

Before the arrival of missionary hospitals, which were built way before any government health centre, the Chief and the traditional herbalists (tingedla), spirit diviners (tangoma), and traditional healers (tinyanga) were at the centre of 'public health' initiatives. The important issue with this group is that they were and are still leaders and part of the community and live with the people. When the missionary driven 'public health' initiatives were introduced, they were essentially seen as outside the realm of the traditional community livelihoods. The settlers in turn saw traditional healing methods as a 'primitive' and 'defective' version of public health. These tensions between the two 'public health' leadership transferees to the people with some families within the same community being more receptive to the Western medicine and public health procedures than others. And yet still others choosing to reject the 'new' health seeking ways and the third group choosing to use a combination of both. In between the toing and froing the essence of public health may have been compromised. At times within the same family members will not agree on which regime to adopt should one of them be ill. Sometimes this conflict will occur when a child is sick and mother and father will fight over whether to take the child to hospital or to a traditional healer. It may also cause conflict when an elderly parent, dependent on their offspring falls sick and they start squabbling over what type of health care s/he should be receiving. On the other hand it is in the belief systems of the people that most health decisions are influenced; resulting in a multiple public health system for many communities in Africa. Jansen again puts it more succinctly:

“There are three medical streams found in Africa: African ethno-medicine, Western scientific medicine and the healing ministries of African Independent Churches (AICs). Before Western medicine penetrated Africa through medical missionaries, traditional medicine was an integral part of African societies. African ethno medicine is embedded in African medicine and is used as a means of restoring balance between good and evil. The introduction of Western medicine forced people to choose between different forms of healing. Medical pluralism developed as Western medicine found a place alongside the traditional practices in Africa, and as AICs established themselves with a distinct approach to healing. The AICs include the ministry of healing into their church life and liturgy; AIC healers link healing with God and the Holy Spirit, as opposed to a dependence on ancestor spirits. This medical pluralism challenges churches in Africa to become healing churches in the new millennium” [Jansen G., 2001: Introduction].

Several misconceptions are made when medical plurality is introduced to situations where a society can make choices between several competing models, values and religions. The problem is further compounded by the fear of death whereby people are willing to just try anything in the face of a threat to their survival. The irony is that in the panic to try any medical regime to survive, they may be risking putting their health in more peril. Gelfand [1964] as cited by Jansen [2001] expands and explains that it is accepted by both medicine man and patient that it is quite normal for Africans to seek two or three or even more opinions; before they are satisfied and ready to undergo treatment e.g. where invasive surgery is concerned. He continues to say that this type of desperate patients run from the traditional healer, to prophet, to hospital or vice versa, in search of a cure of a possibly incurable disease; that the ‘choice’ of treatment can cause such a long and detrimental delay before the necessary treatment is undertaken. Perhaps the critical issue is in the standardization of ‘public health messages’ that are sent out by each medical regime or lack there of.

Public health messages can and do sometimes appear to cancel each other out at the risk of the rest of the public. In 1978 the World Health Organisation called for recognition of traditional healers but failed to address the issue of faith and religion in healing. WHO

proposed that indigenous health practitioners be considered as recognised health workers. This was well received by the health administrators and politicians of many African countries but the health workers themselves appear to be sceptical and less welcoming. Wreford J. (2005) adds that in the 1978 WHO conference, the call was made for official recognition of traditional health practitioners to be recognised by all governments. The conference argued that as part of local culture, traditions and community, traditional health practitioners constituted a valuable resource for inexpensive primary health care provision. Indeed these health workers have been taking care of the health of the local population for centuries. To then dismiss them offhand seems premature; perhaps there is a greater opportunity for cooperation between traditional medicine and bio-medicine. The study explores the reason for this dismissive attitude.

Citing Maclean (1987) and Pillsbury (1982), Jansen makes the point that the so-called integration of traditional medicine within a modern health care system was the new WHO policy of the 1980s for improving the world health status. The late 1970s were a major turning point in the long history of uncomfortable if not downright antagonistic relationship between 'modern' and 'traditional' healing systems. However, Maclean concluded the outcome of this WHO programme by summarizing that the integration of traditional medicine has apparently fallen on deaf ears. The question is what really qualifies as 'scientific' medicine. Whose science sets the standard?

Conclusion

The researcher is aware that sometimes people will say that they do not consult traditional healers yet at the same time they will take traditional medicine if a relative or friend who has been to a traditional healer offers to share it with them when they fall sick. Not unlike people who will share painkillers sometimes even antibiotics with friends and relatives if they have been to the chemist or the clinic. These relatives who may profess 'I do not like hospital medicines, they are not safe, I prefer our own indigenous medicines passed on to us by our fore fathers'. For this reason therefore the interview questions will be asking the respondent unstructured questions like: What do you do when you are feeling unwell as well as who you go to see if you are feeling unwell. So that the discussion covers both what they think they

would do as well as what they actually do on regular every day basis e.g. they may go to their grandmother, neighbours, pastors, the chemist etc. The researcher will prepare to ask probing but none judgemental questions so that the participants are able to tell their 'health seeking experiences' as they really happen.

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Chapter 2

Literature Review

Introduction

It appears that there is not a lot of material written on the question of the existence or lack thereof, of the conflict, bias and tension between traditional medical practice and or treatment, and the western bio-medical practice. However, there is available a number of publications within the southern Africa region as well as globally by researchers looking at the impact of tradition, culture and religion on a peoples's health seeking ways; as well as research looking into the viability of traditional healing methods and the extent to which people living with HIV or any other chronic illnesses. Some researchers believe there is a huge conflict between traditional medical practise and western medical practise; and yet still others argue there is no tension between traditional medicinal practices and those medicinal practices deemed to be of a more western persuasion. There are quite a few researchers who argue that there is a difference between traditional medical practise also referred to in many publications as indigenous health systems and alternative health practice which may include for an example the practice of homeotherapy, yoga acupuncture, warm baths, mud baths e.t.c. Islam Nazrul [2005] explains that the coexistence of modern and various traditional and or alternative healing methods in societies is a well recorded phenomenon. He writes that the term 'healing' evokes a variety of complex and overlapping treatment systems.

Whereas the western model of medical practise is assumed to be a scientifically proven construct, traditional or indigenous healing methods are often regarded by many researchers as very closely tied to the world of spirits and ancestral ordinances [Wreford J, 2008, Esser M. and Hippler S. 2008, Islam N. 2005, and Mall S. 2008]. This difference is cited by many researchers as the key to understanding the conflictive and tense and; yet at the same time a mutually supportive relationship between the two medical traditions. Wreford [2008] explains that the term 'traditional' is advantageous when read as an implicit acknowledgement of the very longevity and genealogy written or otherwise of the indigenous healing knowledge of Africa. She [Wreford] cites Hours 1986, for the explanation that

concludes: '*...these are after all medical systems practised by Africans long before the arrival of Europeans and the brutal transformations associated with colonial rule [2008:3]*'.

A number of literature explains that due to the 'belief systems' in the training regimes of how one becomes a healer in each of the healing systems a value judgement gets assigned. Where as in the bio-medical field training is book and laboratory based towards clinical diagnosis [Islam 2005]; in the traditional healing system training just like practise is often times organised around a framework of rituals which typically involve the slaughter of an animal, the brewing of sorghum (*umqombothi*) based traditional beer, singing, dancing and drumming [Wreford: 2005]. This is collaborated by Helman, 2001 who opines that in this system of healing traditions are strongly observed in order to maintain health. They suggest that in many developing societies, a majority of the people may believe that certain diseases, bad luck, and misfortune are caused by supernatural powers and evil beings. Therefore, ceremonies and rituals are continually performed in an effort to cure prevent misfortune, sicknesses, enhance body wellness, promote health, secure good marriages, and ensure success and to communicate with ancestors and other supernatural beings in the yonder [Islam: 2005].

How is disease perceived?

Allan Brandt [1987] makes an interesting observation that seems to agree with this explanation of the interaction between traditional healing methods and sociological perceptions of illness and disease. He argues that fundamental to the notion that illness and disease is socially constructed is the premise that disease is profoundly shaped by both biological and cultural variables. He argues that when we understand the way disease is impacted by social and cultural forces, issues of class, race and ethnicity, only then can we address its physical dimension. Personally, I would like to also add issues of development. Brandt concludes that 'in this light' medicine is not just affected by social, economic and political variables but it is imbedded in them'. Benn C. [2002] takes this argument further and says that whenever society encounters health problems or any other social ill for that matter their 'health seeking' ways are influenced by three different paradigms, the scientific, the religious or the traditional. He says that the overarching influence of religion and

traditional medical practise and what is seen as normal health seeking behaviours can not be overemphasized. A persons' wellness is not just in the physical body but also their spiritual, economic, emotional as well as mental wellness. Cochrane (2007) puts it more succinctly:

"... What this means is that health behaviour and health choices are not governed simply by an accounting that takes cognisance only of one's own body or mind. Indeed, one's body is also understood to be a construct of internal, external and social bodies in this context" [2007 lecture notes].

Disease in context

Writing about collective responses to HIV and AIDS in Zambia and Tanzania, Baylies and Bujra [2000] make the connection between disease and culture and conclude that the nature and tactics of the management of this epidemic varies from place to place, depending on historical circumstance, cultural context, and the contemporary political economy. They argue that within any given locality HIV and AIDS may appear as a series of superimposed epidemics, making out fractures along lines of gender, generation or any other social and political divisions. That disease is a social event, which expresses the central realities of the society in which it occurs. Concluding that, 'given its social embeddedness' it highlights internal flaws observable in the social fabrics even as people scramble to put together a health system traditional or otherwise to cope with this illness. Schoepf, Schoepf and Millen [2000] take this thought further and explain:

"Response to AIDS is political in Africa as elsewhere. Public health action takes place on a terrain of contested meanings and unequal power, where different forms of knowledge struggle for control. Epidemiologists and health planners in the development agencies greatly underestimated the potential magnitude of HIV and AIDS in Africa. The disease was initially 'constructed' as an urban plight from which 'traditional' rural areas, home to a majority of the population, would be spared. Dismissing those who foresaw a catastrophic pandemic; health officials proposed to control AIDS by targeting most prevention efforts to 'core transmitters'. These included sex workers and long-haul transporters, recognized as having multiple sex partners" [Schoepf, Schoepf and Millen: 2000, pg 107]

This quote illustrates the intuitive response of western public health traditions of ‘looking’ for perpetrators of the ‘risk’ e.g. in southern Africa truck drivers have been one of the most ‘work shopped’ group because they were considered as in more likelihood of having more than one ‘wife’ or sexual partner in other words a ‘risk group’. An unfortunate conclusion by most of the literature is rushing to ‘*identify*’, who has this disease and therefore ‘isolate’ them and ‘deal’ with them. Other analysts refer to this reality as ‘othering’ [Wreford: 2008]. This might have been a correct assumption in other cases of communicable epidemics e.g. chicken pox. In the case of HIV and truck drivers the public health messages and literature seems to have ignored the reality of the driver’s way of life. These are people who are most likely highly traditional who have their homes in rural areas, the research did not consider the political, spiritual and traditional environments in which they were being asked to introduce blood testing, condoms, monogamous unions e.t.c. Also there seems to be unfair value judgements and dangerous misinformation in a public health message which seems to promise a ‘blanket cover’ from HIV infection from those especially women and men who are not ‘promiscuous’ and are married. Again Schoepf, Schoepf and Millen [2000] put it more succinctly:

“Many married women were disarmed by public health advice that assured people that marital fidelity would protect them from AIDS. However, most married women throughout Africa infected with HIV acquired the disease from husbands who had multiple sex partners and failed to use condom protection. Nevertheless, when men fall sick, their wives are often to blame” [Schoepf, Schoepf and Millen: 2000, pg 127]

The point I would like to add to this argument is that this is also true for married men. They may think their own fidelity in their own marriages is a blanket insurance against being infected by ‘loose unmarried’ women. Whereas the truth is they will never know for sure what their ‘spouses’ get up to, when out of sight.

Further, there is a considerable amount of religious literature which reflects on the linkage between health and religion especially in both traditional communities and the developed world. Whereby people believe a way of life e.g. pollution (westerners) on the one hand or disrespect of ancestors/cultures (traditionalists) on the other can bring illness and social ill

respectively. That one's action in a religious way or in a scientific paradigm can be a direct cause of distress and or illness [Benn C.: 2002]. This literature in fact seems to suggest that peoples of the world can control and change their 'lifeworld' [Cochrane 2006] to meet new demands or control new epidemics, new phenomena in their 'healthworld'.

Why alternative healing?

There seems to be agreement in the literature that in many developing societies one system of healing may not be adequate to cover all the health needs of the entire population. Helman [2001] writes that medical pluralism is also a creation of need for survival, a primal instinct. Human nature seeks healing and survival. He writes that because of the need for healing in most rural and developing communities in India, China and Africa, traditional medicine seems to take priority over modern medicine mainly due to its accessibility and availability. Islam [2005], Foster [1973] seems to be suggesting that among rural folk traditional medicine takes priority over bio-medicine also because rural folk are generally bound to it by strong cultural traditions. Within these communities traditional healers are often times more well known than bio-medical healers. Younger folk are introduced to local healers by their older folk, they quickly learn of local healing methods within the extended family as well as the community. These are local social healing traditions is the point the literature seems to suggest over and above financial and political reasons for making this choice. Ausherman [1998] explains that it is an issue of how humanity has survived through the ages more than a conflict of modernity and traditionalism.

On the question of public health the literature seems to indicate that in many countries of the developing world the government's public health messages seem to be in direct conflict with local traditions and culture e.g. widow inheritance, *levirate* and the question of HI virus transmission Morell [2001]. In a study by Ebrahim and Ranken *et al* [1988] on Primary Health Care in Peru, they concluded that a people's traditional belief system should be considered as a core factor in Health Care Planning because inevitably people will associate their wellness or illness with the good will of a 'supreme' being up there more than they will associate it with public health messages with a visible sometimes loved and sometimes hated central government. They argue:

‘The links between development and health are complex but fairly well known. It is the links between development, health and Faith/Religion that still have to be studied. In developed countries, the communicable diseases which were the main cause of mortality were controlled more by improvements in general living conditions, improved nutritional status, sanitation and health behaviour than by major discoveries for their cure and treatment. However, in developing countries improvement in health is closely linked with meeting all the basic needs of the population including raising educational level and improving opportunities for economic opportunities and the development of locally grown treatments and cures as believed by the practicing local healers’ [Ebrahim and Ranken et al 1988: pg 130].

They explain that strategies for national development that takes into consideration the people’s belief systems can influence a country’s health situation. Further, they can correct many of the biases between urban and rural areas.

Self Diagnosis, self medication and home remedies

A number of studies have reflected on the issue of self-medication and home ‘brewed’ remedies in African traditional societies as well as in other developing communities. Poverty challenges are an integral part of the health seeking ways of these communities. In South Africa the types of illnesses and health problems referred to both traditional healers and bio-medical practices are well documented Cocks & Dold [2006]. Unfortunately, there is very little literature available on self-diagnosis, self medication or sources of the medicines used for self medication. Cocks and Dold [2006] suggest that the reason for this bias in the literature is that a lot of researchers focus on the far end of the medication process; at the later stages of the illness and referral system when treatment is sought from a specialist for symptoms which have not responded to forms of self medication. To the result that health care studies have documented the more exceptional exotic healing rituals and culturally bound syndromes of a particular society or community, and not discussed the more ordinary practices of self medication of everyday illness.

Lack of tolerance

Some of the literary comments on the traditional health system seem downright derogatory, critical of certain population groups and judgemental. Wreford (2008) suggests that all the unsavoury comments and statements that are critical of the practices of traditional healers reflect the uneasy interaction generally prevailing between the traditional and biomedical paradigms in South Africa. She asserts that these negative attitudes towards traditional medicine practitioners dampen and undermine the possibility and buoyancy of collaborative medical efforts against HIV and AIDS between bio-medical practitioners and traditional healers; and thereby undermine the possibilities of improving both traditional and biomedical interventions in dealing with the HIV and AIDS pandemic in South Africa; and indeed elsewhere in the developing world. This negative attitude seems to be in line with the notion of promoting bio-medicines as an exclusive all round treatment for AIDS related illnesses, a quest for the 'magic bullet'. Wreford puts it more succinctly:

“The attitude of medical doctors towards traditional practitioners in South Africa is generally characterised by indifference and suspicion, even occasionally animosity. This standoff produces a relationship at a remove, such that, although some bio-medical practitioners acknowledge the potential advantage of collaboration with the traditional sector, examples of collaborations have been few... this bias is particularly evident in the debate about treatment for HIV and AIDS, where academic and medical coverage displays a resolute determination to promote an exclusively biomedical solution to the pandemic”
[Wreford: 2008 pg 14]

There is considerable amount of literature that places this bias, tension and conflict between bio-medicine and traditional medical systems in a historical context. Cocks and Dold [2006] explain that historically entangled with the processes of colonization came the 'forceful penetration' of Western medicines and religious cultures. Colonial and post colonial rulers who favoured the interests of the rich west and their western 'scientific' medicines; had a strong and racist influence as they sought to discredit traditional medicinal systems as primitive and backwards. Cocks and Dold explain that at the same time though, there was positive contact in rural areas between European settlers and the black African population,

resulting in familiarity and appreciation of each other's home remedies. Not all the health problems in Africa are as a result of 'settlers'. Schoepf, Schoepf and Millen (2000) make the observation:

"Africa's ills are, of course, not only externally derived. Unable to achieve economic independence, many leaders of new states acquired a vested interest in maintaining the old relations of domination. In order to accumulate capital and enjoy lifestyles commensurate with ruling classes elsewhere, they squeezed poor producers and plundered their economies" [Schoepf, Schoepf and Millen: 2000, pg 124].

The Treatment Action Campaign

There is quite a number of documents and literature that have been produced by the TAC (Treatment Action Campaign), a South African pressure group whose main focus is to advocate for AIDS treatment for all. Their main success in my opinion is in how they have managed to interpret medical terminology into everyday language so that people will understand what is happening in their bodies as they consider ART (Anti-retroviral Therapy) treatment. However, I do wonder if the TAC has not ignored the reality of medical pluralism in a society such as South Africa in their research. Wreford [2008] makes an important observation and makes the argument that organisations such as the TAC are to be appreciated for their mobilisation of a national grassroots campaign; asking for timeous treatment for all South Africans living with AIDS. She observes that it is not surprising that the TAC only sees western medicines i.e. ARVs as the exclusively correct treatment that should be made available by government. She writes:

'However, in the light of South Africa's pluralistic health system, their singular endorsement of 'proven' western medicines against 'untested substances' is peculiarly myopic' [Wreford: 2008 pg 15].

Other literature seem to support this argument Digby [2005] makes the point that any public health messages that have in their core an attitude of undermining the local people's belief systems and their instincts for survival tends to be summarily dismissed and ignored by the said people as a personal and at times 'insensitive, racist attack, contrary to the age old quest

for wellness which crosses all human boundaries' an attack on their very being. Wreford makes the argument even clearer:

"... Even in the context of an environment more hegemonically biomedical, rhetoric that implies restraints on the patient's freedom to choose treatment would be questionable. In the plural context of South Africa, where traditional practitioners continue to provide a vibrant and parallel service to the majority, including those living with HIV and AIDS; it appears to threaten the rights of patients to make their own treatment decisions based on their understanding of health and illness" [Wreford: 2008 pg 15].

In current and contemporary medical history of southern Africa there is a huge emerging market for Chinese medicines, including herbal teas, special ointments, ingestive capsules and tablets. In my own country Swaziland, as well as many other neighbouring countries in the southern Africa region; there is a recent aggressive mushrooming of Chinese shops selling various medicines and remedies. There are medicines for all kinds of ailments including AIDS symptoms, high blood pressure, Anaemia, diabetes, insomnia, weight management e.t.c [<http://www.healthpromotionjournal.com/>].

Unfortunately, there is not much literature that is being written on a sound analysis of this occurrence. Cocks and Dold [2006] seem to suggest that the arrival of such medicines from Asia is as a result of the coexistence of diverse cultural groups in South Africa, which has influenced the range of medicinal services and products offered. They make the example of remedies and treatments associated with Dutch, Chinese and Indian influences have become widely accepted by other cultural groups. They explain that these remedies are in such great demand that, today, there are large manufacturing companies in southern Africa (some by foreign investors of Asian origin) producing these medicines and supplying them to private health care distributors and chain stores all over southern Africa.

Conclusion

Perhaps to conclude this chapter it is befitting to cite the comments of Kaseje et al (2005):

“A major issue facing Africa is its inability to appropriately quantify and analyze the health care issues it faces continually with credible data. Few research and technical institutions exist in African countries or as regional organizations that keep and monitor the performances of the health system, traditional or bio-medical as well as accurate health records and the health status of the citizens”[Kaseje 2005: pg s-51]

Of course there are countries that are doing a bit better such as South Africa, where there is reportedly a number of credible and fairly well funded Research Councils. The lack of literature drawn from credible data undermines the ability for sound and informed decision making. Kaseje et al (2005), makes the point that cross-national and regional information on the health status of people in southern Africa requires a mix of manual peripheral systems blending with more sophisticated, computerised systems at the local district level, country level as well as southern Africa regional level linked to the entire public health care system.

The literature shows that a number of researchers have attempted to define what public health is, as seen by both traditional and bio-medical healers, and the consensus seems to be that both see it as a communal effort to mobilise biological and chemical resources to solve minor and major health problems affecting society. Others see it as the health status of population, the extent to which they are free from disease and premature death [Kaseje et al (2005). That, it is a philosophy of interventions aimed at protecting and promoting the health of the population. Perhaps, because their purpose for existence is so fundamentally same for both traditional and bio-medical healers the idea of a conflict and a tension is more influenced by personalities, political ideology, and history of conflict between social classes than in the actual practise of healing. McFarland (2005) arrives at the conclusion that public health is multi-disciplinary as well as interdisciplinary, an all hands on the deck ‘call’. That at its roots it is social, economic and political and a subversive. This seems to suggest to me that the literature is pointing towards a multi-tradition kind of science. Where all sources of knowledge of non-harmful healing methods should be considered. The literature could

benefit from paying attention to the possibility that not all bio-medical procedures are accident free or without harmful sometimes even fatal side effects.

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CHAPTER 3

Research Methodology

Introduction

This is a qualitative research project. The qualitative research methodology is the preferred research strategy because of its flexibility, sensitivity and open endedness. HIV and AIDS is inevitably linked to people's sexuality and their socio-economic status. Therefore, the researcher makes the assumption that people are more likely to speak freely about sexual health messages in a given situation if the research technique is seen to be flexible, sensitive to the context and open ended. In other words there is no right and wrong answer it is more of a discussion than an interrogation or an examination for level of knowledge.

The interest is mainly in the opinion, understanding, interpretation and attitude towards a specific issue rather than a measurement of how much knowledge the interviewee has. May T. [1997], argues that the qualitative research approach removes from both the respondent and the interviewer the burden of how many times incidences occur and focuses attention on how the people feel about a specific issue and on what they wish, want or think can be done to change or improve the situation.

Qualitative social research relies largely on the interpretative and critical approaches to social science. Neuman's conclusion could not be truer for this research project when he says:

“Qualitative researchers emphasize the importance of social context for understanding the social world. They hold that the meaning of a social action or statement depends, in an important way, on the context in which it appears. When an event, social action, answer to a question, or conversation is removed from the social context in which it appears, or the context is ignored, its social meaning and significance can become distorted.” [Neuman: 1994, p 319]

The focus of this research project is in the respondent's opinion on public health messages in the context of Swaziland where we have both traditional health care and bio-medical care realities. In other words the researcher prefers this approach in the belief that it will allow the data to interact in an observable pattern and result in the construction of an explainable theory [Bryman, 2001]. Neuman explains this research reality further and argues that a qualitative researcher begins with a research question and little else. Theory develops during the data collection process. This more inductive method means that theory is built from data or grounded in the data. Conceptualization and operationalization occur at the same time as data collection and preliminary data analysis. Qualitative researchers remain open to the unexpected, are willing to change the direction or focus of a research project and may rephrase the original research question during the course of the research project [Neuman 1994].

Mason adds to the discussion and explains that:

“Through qualitative research we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants, the way that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate..... Qualitative methodologies celebrate the richness, depth, nuance, context, multi-dimensionality and complexity rather than being embarrassed or inconvenienced by them. Instead of editing these elements out in search of the general picture or the average, qualitative research factors them directly into its analyses and explanations” [Mason: 2002, p11]

Because of the diversity and the wide variety of issues associated with health, the impact of the HIV and AIDS epidemic on public health messages and the range of context in which these messages are received the researcher has chosen to employ the qualitative research approach in order to cover all the elements of the primary research question. I also think that research can easily be ignored by other readers if they hear more the researchers language than the language used in the real daily lives of the respondents. Therefore I have chosen the qualitative research method because it allows the voice of the interviewees to be

heard answering or reflecting on an open ended question in their own words. This method will also allow me 'the respondents verbatim' from the tapes as well as actual field notes as quotes in the research report.

The recognition that the production of theories is a historical phenomenon, and as such, a critical account of the historical and cultural conditions both personal and social on which the researcher's own intellectual conclusions are formed is necessary. It should be understood as a continuous critical re-examination of concepts and ideas. Selikow 2005; advises that while not resorting to extreme relativism, critical realist theory draws on historical arguments, acknowledging the context and conditions in which particular research findings are produced. A critical engagement of the researcher's social world, recognising that the existing state of affairs is a product of some actions but does not exhaust all possibilities, and offering positive implications for social action based on an open minded gathering of information.

My main attraction to critical theory is in that it seems to re-affirm human agency in that it assigns a key role to text generated from the very essence of being; some have argued that it is an emancipatory theory in that it is a vision for realizing a better society embedded in the idea of understanding 'what is'; and then working towards 'what ought', Kushner, Morrow, Brown and Usher as cited by Selikow 2005. They argue that the use of the word 'critical' in critical theory should not be confused with the common sense understanding of this word should not be read in the pejorative; rather critical refers to an analysis of society that aims to uncover beliefs and practices that impose limits and delimits to human well being and human freedoms.

Traditionally, qualitative researchers have been cautious about getting bogged down in the arguments about whether or not their work is scientific. This should not be seen as a rejection of science. Qualitative research does draw a lot of data using natural science cultures. There is hardly any evidence of a form of knowledge that is not arbitrary, subjective and biased by interests. Murphy and Dingwall 2003; explain that some qualitative researchers have gone on from this to conclude that they should give up any claim to be doing science and adopt some form of relativism. Relativists assert that we decide what

counts as 'real' through the linguistic and cultural resources of the groups to which we belong, which frame our interaction with the world. They argue:

“Consequently, it is possible for many different realities to exist or even for there to be as many realities as there are persons to exist. Individual realities may contradict one another and yet still be equally true for those living within them.” [Smith 1984: as cited by Murphy and Dingwall 2005: pg 273]

Murphy and Dingwall [2005] further give the example of witchcraft and psychotherapy to illustrate the difficulties that result. Relativists cannot distinguish between psychotherapy and witchcraft as means of dealing with strange behaviour. That the prior decision whether to believe in witchcraft or psychotherapy, shapes the very perception of what behaviour will be counted as strange and how it can be properly explained. Claims about the world are only true, if the idea of the truth has meaning at all, within the frameworks adopted by those who make the claims. In that sense all claims to truth are arbitrary [Murphy and Dingwall 2005:11]

The problematic issue with the realist perception of qualitative research is that it seems to suggest that researchers can only do their work effectively only in cultures, communities and places to and in which they belong. This is problematic because a number of qualitative researchers have done extensive, long term high quality research projects in far away countries where they hardly spoke the local language or languages. Realists seem to suggest that one can not understand another's reality or even more strangely that people's different realities are somehow always in conflict. There are of course problems whereby foreign scholars will interpret local realities incorrectly or make outright wrong assumptions. However, this is no worse than a local researcher ignoring important text just because they have seen it so many times and may have grown certain insensitivities.

Research area

The main guide to choosing the research area was intended to be an area that would be considered not over researched in Swaziland, unlike the townships surrounding the urban

centres and yet at the same time be able to make a meaningful contribution to all the past and on-going research efforts on HIV and AIDS in Swaziland. The field site and the research question had to be bound in relevance and practicality. I considered accessibility as well as the researcher's limited resources to carry out the task. This area whilst quite rural has easy access to at least two urban centres, Piggs Peak to the North of Swaziland and Mbabane which lies North-West of Swaziland. It is a highly populated community and has both private owned industry e.g. the nearby Malolotja Game Reserve, as well as public social welfare centres e.g. the clinic and the farmers' market. I felt that I would be accepted easier in this area since I have worked with a youth project before and it remains relatively successful. The people will take me seriously. I also hope that my previous relationship with the youth of this area will make it easier for them to trust me and have confidence in the research process. I am also hoping that this research can be of some benefit to the youth project and build on its previous and on-going achievements. It is however a new project and independent of any previous work I have done in this community and I will explain that to all participants.

The research will be conducted in Motshane a peri-urban community about 34 km from the city of Mbabane. The reason this community was chosen was mainly that it represents all the basic community health assets that are found in the rest of Swaziland. It is also a community that represents a fair reflection of the socio economic status of many Swazi families; in that some members of the same extended family will have very good access to resources and own a lot of productive assets and yet others will be so poor it is hard to believe they are related to each other at all. In an almost similar fashion it is not unusual to find members of an extended family fighting over which treatment to pursue when a child, dependent parent or grandparent falls sick. Motshane like many other communities in Swaziland; is geographically well placed to access both traditional medical care as well as government public health centres.

Rationale for research focus

A huge part of the factors that aggravate the stigma associated with HIV and AIDS is grounded on cultural and traditional beliefs. I am making the assumption that knowledge

comes from experience and evidence, that knowledge and evidence are contextual, situational and interactive; sometimes this research approach is referred to as the deductive research strategy. Blaikie [2002] argues that the deductive research strategy derives its ontological and epistemological assumptions from 'critical rationalism', that it shares some aspects of positivism's ontological assumptions but rejects its epistemological assumptions. Nature and social life are regarded as consisting of essential uniformities, i.e. patterns of events. The aim of social science research is to first of all find these patterns and then to make universal conclusions that are reasonable, rationale and true; because they correspond to the facts of nature, to give a description of the observed states of affairs. Data collection occurs against the background of certain expectations about what exists and how it behaves.

Blaikie [2002] explains that rather than physical scientists waiting for the social world to reveal its regularities social scientists must impose theories on the world, and by a process of trial and error use data to reject wrong theories or adopt 'correct' ones. He argues further that all knowledge is tentative and subject to ongoing critical enquiry and evaluation. There are a number of weaknesses and problems with this theory for one it seems to suggest that even when we know we may not know; an endless cycle of critical examination sounds schizophrenic to say the least. It also leaves out the issue of group knowledge which may not necessarily be scientific knowledge, when does it become true? For instance Jesus was a Jew; whilst we do not have DNA to prove this, surely we 'know' he was born to a family of Israeli natives.

It is for this reason that the researcher decided that this project should involve people who will have had some experience and some understanding of the differences between the traditional health messages and will have an opinion on how they may or not be in conflict with the bio-medical public health policies.

The primary focus of the research will be people living in Motshane above the age of 14. The researcher reasons that, at that age, people are likely to come across more health messages in their everyday lives, they are able to read and write and count fairly well. The research

assumes that people below this age range are not likely to be taking health decisions on their own or formulating meaningful health opinions without the influence of parents and or guardians. The research further assumes that in general people above this age range will have had some level of interaction with the public health system; and be willing to share their experiences given a safe discussion/interview environment. They will also make a meaningful contribution to the discussion on how they perceive the interaction between traditional African public health practices in view of the western linked public health regimes. However, the study does not exclude the possibility of unique public health experiences of children below the age of 14.

The Research Question

In 1994 the government of Swaziland and the King declared HIV and AIDS a National Disaster and an Emergency, according to the Africa Mayors Initiative to Combat Aids at Community Level [AMICAAL] 2006 annual report. As a result of this decision, the government of Swaziland, supported by the United Nations Swaziland country office, resolved to establish the National Emergency Response Committee for HIV and AIDS, [NERCHA]. NERCHA has since served as the main and lead organisation (committee sometimes referred to as a commission) in the national fight against HIV and AIDS. The structure of this committee is organised around three thematic areas, HIV and AIDS Prevention, HIV and AIDS Management, which includes disease control and HIV and AIDS Mitigation, which includes community development. Under each theme a national office was established to coordinate and give support to activities undertaken by either government HIV/AIDS centres or Non Government Offices(NGOs) including community based development NGOs working within the HIV and AIDS sector. There are some privately run NGOs and Foundations that have received support from NERCHA. NERCHA as an organisation does not implement programmes but rather gives fiscal as well as human resource support such as consultants to ongoing HIV and AIDS programmes nationally. They also serve as the lead organisation when it comes to research, documentation and publications.

This research concerns itself more with the HIV and AIDS prevention theme. The HIV and AIDS prevention theme is organised into three departments; education, awareness and communication. This is the theme that produces what is generally referred to as IEC [information education and communication] materials. These can be roadside billboards (huge board adverts), fliers, newspapers, magazines, radio and television adverts. Some HIV and AIDS prevention activists have been innovative enough to draw pictures on top of huge stones on mountains along side major national bus routes e.g. the red ribbon.

In a progress/status report on the HIV and Aids situation by Whiteside et al, [2004], he makes major observations on the possible reasons why the HIV and AIDS situation in Swaziland is not improving; and why infact it seems to continue to deteriorate in spite of the huge nationwide HIV/AIDS prevention campaigns. He writes:

“There is no doubt that the country is under siege from an epidemic that has been spreading silently over the years. So far national efforts to address this challenge have only yielded heightened awareness of the problem but have failed to stimulate levels of sexual behaviour change that are necessary for turning the epidemic around. As a result, the epidemic has continued to grow to a point that it has become generalized, mature and very deeply entrenched” [Whiteside et al, 2004 pg 54].

The reference to sexual behaviour change is mainly an allusion to the lack of treatment of other prevalent; yet treatable sexually transmitted infections as well as to the lacklustre use of condoms; that this behaviour is irresponsible and that it does not reflect the level of knowledge that the population have; that the information, education and the communication materials do not seem to bring about the expected transformation in the population. The reality is that statistics from the Family Life Association of Swaziland [FLAS], 2006, a PEPFAR funded NGO, tell us that the number of condoms distributed, is not a reflection of a number of condoms used. Their study concluded that people take condoms out but do not use them correctly or consistently. There is a lot of starting and stopping in view of the statistics they gather from their distribution centres.

There are many new 'collectors' who do not make return visits, or when they do return it is way beyond the estimated time of when their supply would have run out. Also the number of condoms taken out; do not reflect the number of possible sexual encounters that may likely be infectious incidences in a given distribution centre given its attendant demography. A number of social science researchers in Swaziland in particular within the NGO sector are beginning to wonder if the problem is in understanding how the people understand, accept, believe or do not understand, accept, and believe the messages.

The main thrust of this research project will therefore be an examination of the social, cultural and religious/faith beliefs that influences people's attitude in how they respond to and receive to public health messages, specifically HIV and AIDS information on prevention campaigns. The overarching influence of economic status and faith and religion in what may be referred to as normal health seeking behaviours will not be overlooked. The researcher is in this case making the assumption that the general public may probably be responding to public health messages in terms of what they think is accessible, affordable, swazi i.e. culturally acceptable such as the use of condoms, religiously non alienating and perhaps to a certain extent scientifically credible. Writing about the similarities of health seeking ways among various world communities Benn C. (2002), proposes that social science researchers should first and foremost understand that all people are influenced to some degree by atleast three different paradigms; the scientific, the religious and the traditional and cultural one. The research makes the assumption that the people of Swaziland are no different.

On the question of condoms, the researcher is aware that there could be any number of reasons why people may choose to or not to use condoms. For teenagers the fact that they are young may make them feel embarrassed and ashamed to be admitting to be engaging in pre-marital sex perhaps due to their knowledge and understanding of Swazi culture and custom; or they may be Catholics submitting to Vatican instruction which forbids the use of condoms. Possibly, a couple that wants to have a baby may not use condoms or they may consider themselves faithful to each other. There are a number of reports that seem to suggest that there are people who believe that using a condom interferes with their sexual

pleasure and they do not like condoms. Some people may not even know how to use condoms correctly and therefore may decide to leave them out of their sexual incidences.

Other reasons may be that the people may feel that using condoms implies they have more than one sex partner; that they sleep around with a lot of people. Even though the condom is useful for preventing other sexually transmitted diseases it has inadvertently been advocated more for the prevention of HIV transmission, people who doubt the existence of the virus or who may believe there is a traditional cure for it from may ignore or refuse to use condoms. The study will investigate these questions in Swaziland, drawing from comparative literature from other African countries with high prevalence of HIV to refine and examine the hypothesis and assumptions. It will then investigate the relevant questions through a systematic research project within the Motshane community and other relevant in-depth literature review.

Background preparation

The researcher has previously worked with the youth of this community. It is hoped that it will be easy to build on the previous relationships and add on the already existing contacts. The researcher will try and get copies or pictures of existing public health messages or adverts to prompt and focus the discussion especially with the focus group interview. For the in-depth interview the researcher will make telephone contact with the interviewees and explain the key study question before the day of the sit down interview. It is hoped that by doing things this way the participant can have time to think about examples they would like to discuss and will be encouraged to bring whatever adverts e.g. newspaper clips they have seen to enhance the discussion. The researcher will have a standard letter in both languages to send to all participants explaining the research purpose and its goals and also asking them if they can participate and what logistics e.g. time and venue factors they may want to consider.

Research Size

The intended number of interviewees is 18 people in total with one focus group consisting of eight youths between 14 and 24 year olds. There will be five adults who are in professional jobs within the community [3 teachers and 2 nurses from the local clinic and local school respectively]. The reason for targeting the teachers and nurses is that in almost every community throughout Swaziland, there will be a community clinic and a local school, and perhaps because they are seen as educated people or even civil servants or health practitioners the nurses get consulted on almost everything to do with health and the teachers get equally consulted for most things to do with government.

It is not unusual for rural people to take tablets or medicines from the hospital to an educated relative or neighbour and ask again what it is for and whether or not it is safe to drink. One way or another in rural Swaziland educated people become reluctant 'authorities' on a number of areas from banking, medicine, accounting, taxation, scholarships, choosing careers, travelling, buying and selling cars e.t.c. They become an important source for researchers because when strategically interviewed without perpetuating the myth that educated people know everything they can be a fair reflection of general community health issues. They will also be a fair indication of what the local discourse on a topic is likely to be. They influence local knowledge and attitudes.

It will also include four adults who may be accessed easily within the community both male and female. One pastor will be interviewed, because the local church and vicarage is in a way also a health centre to which a number of the local people go to be prayed for over a number of ailments. It will be interesting to find out how the decision is made on which health provider is approached for which illness and why. It is hoped that I will also be able to have an interview with the Chief's runner or their representative who can give an in-depth insight into the traditional side of public health practises. I will also interview one well known herbalist in the area who I hope will assist in explaining the spiritual side of healing and give a broader view of what messages are out there and how she perceives them.

The researcher systematically chose the participants with the concern that it should be reflective of the community and include all possible age groups. Hence the involvement of both young and old, educated and people who never went to school, traditional, spiritual and biomedical practitioners.

Study design framework

Participants	Research technique	comment
8 youths between 14-24	Focus group	
4 adults	Semi structured interview with Public health officers	
1 church pastor or deacon	In depth-interview	
5 semi-professional community members	In depth-interview the 2 nurses and 2 teachers Semi structured interview	
1 traditional leader/and or 1 herbalist	In depth-interview	
Total planned 18 Total interviewed 22	There were about 4 more incidental interviews with people recommended by those in the original plan	

Key definition

The researcher assumes that whilst there might a few fundamental differences in the way that traditionalists and bio-medical health practitioners manage public health; they all agree that public health is a way to improve, manage and promote public health. Even though there may be conflict in the actual methods and tools that they use to do their jobs; it is imperative to acknowledge that essentially for both traditionalists and bio-medical practitioners the main issue is that they are both concerned with both the individual's health and the health of the community and state as a whole (Nutbeam & Harris 2001). I also think that key to public health is accessing health resources, especially the procurement of medicine and health implements. Therefore the term public health will be used in this research project to refer to

this process or processes of managing health assets locally and internationally to solve and eliminate health problems. A philosophy of activities aimed at promoting health and socio-biological welfare of the population [Tones and Tilford 2001].

Research techniques

This project will employ a multi-method research strategy. It will employ three main research techniques; the semi-structured interview, the focus group interview as well as the in-depth interview. All interviews will be tape recorded and the interviewer will be taking hand notes to counter a recording failure. Both records and notes will be reviewed within 48 hours of the interview meeting to guard against memory loss.

The Semi structured interview

HIV and AIDS as a topic still remains a relatively sensitive topic for discussion. All the participants are assured that all data deemed too personal or too sensitive will be handled confidentially and anonymously and where appropriate the names, age and occupation of the person giving the information will not be disclosed in the research report. This research technique was chosen because of its flexibility in that there is no really fixed question and answer sequence. The aim is to discuss specific issues and topic on public health message e.g. a conflicting policy or guideline on birth control more in general terms to find out the respondents perspective on an issue. The main strength of this technique is that it is open enough to allow 'expert' interviewees to add on extra information that the researcher may not be necessarily asking for or aware of. As Bryman [2001] explains this research technique is empowering for the interviewee in that it positions her/him in such a way that he/she is an integral part of the research process. He/she has some control and expert authority in ensuring that the interview covers all the relevant parts thus helping the data generation process.

There are limitations to the semi structured interview technique. It has a loose structure in order to guard against straying from the key questions and generating less relevant data even when it is valuable to the HIV sector in general. It is these very qualities that can make the interviewee feel like they are discussing the 'boring' side of a given topic. Because it has no

sequential questioning route it can easily lead to the respondent dwelling more on issues that she or he is more comfortable with and some issues that are critical to the research project may be ignored. Bryman [2001] explain further that this research technique calls upon the interviewer to be on guard to make sure that there is no unnecessary repetition of data that has already been covered. It also puts the interviewer under pressure to always listen out for those topics that the interviewee may be glossing over and be able to probe the responses in order to get to whatever information the interviewee may not be overexcited to speak about.

The Focus group interview

The focus group is a highly effective method of qualitative research because it involves a more communal debate on a specific issue; with a predetermined selected group of people, who have a known or perceivable interest on the topic under discussion. Hennink advises that the focus group interview research method is suitable:

“To identify a range of views and experiences, to provoke discussion and explanation of issues, to identify new issues and generate hypotheses, to seek broad information about a community, for less sensitive topics, to understand group interaction and decision making”[Hennink: 2007, p10-11]

I think this is a good research tool for this project because it will give us a good picture of community level as well as individual level public health perspectives and experiences. It will also give us a good understanding of social behaviour, cultural values and community opinion on a range of public health messages.

I think that the main strength of the focus group interview is that it can generate a wide range of information in a relatively short period of time. It also happens in a setting that more or less represents the way that the participants would discuss issues in their everyday lives i.e. with their peers or with individuals who have a mutual interest in the topic under discussion.

Hennink puts it more succinctly:

“The focus group method emerged due to the limitations of traditional forms of interviewing, such as the artificial nature of standard interview procedures, the influence of an interviewer on a respondent’s comments and the limitations of pre-determined close questioning on enabling spontaneous responses or identifying new issues..... The function of non-directive interviewing is to shift the attention away from the dominance of an interviewer to focus on generating a discussion between participants on certain topics” [Hennink: 2007, p4].

It appears to me that the main thrust of the focus group interview could be the prominent use of the groups’ dynamics; and its interaction to produce data and insights that would be less accessible without the spontaneity encouraged by the group’s peerhood. The interactive nature of a group discussion also influences the quality of the data collected. The respondents are less likely to get creative in their responses and down play or exaggerate the ‘story’. They will immediately be corrected and challenged by their peers in terms of factual information as well as perspective which may always be debatable even in a group of peers. Ritchie and Lewis [2002] as cited by Hennink [2007] seem to concur that the comments of others in the group may lead to reflection, refinement or justification of points raised; as well as a spontaneous debate where there is a sharp difference of opinion. This can lead to deeper insight into issues raised and context in which these issues are experienced.

There are some limitations to using the focus group research interview. This is mainly because people are not the same even if they may be a group from the same interest area. Some participants may be more talkative than others and may try to dominate the discussions. It may also be technically difficult to hear everybody should the debate get heated. The researcher plans to encourage the group to set up a few friendly ground rules at the start of the discussion e.g. to let one person speak at a time by listening to each other and let the speaker finish before we respond. The researcher will take hand notes to reflect the groups body language e.g. when people are frowning, suddenly quiet or laughing out loud. At the same time when people are looking uncomfortable with the question the researcher will repeat the question starting with you seem quiet or you are laughing or you seem

uncomfortable with this question can you tell us how it makes you feel. That way it will be captured.

To enhance accuracy of the data capturing the researcher will also use a tape recorder as well as take field notes. If there are participants who are too quiet in the group the researcher will ask them direct questions and address them by name where appropriate without making them feel like they are facing an examiner. The researcher will also manage the group dynamics by not allowing the extroverts to dominate the discussion by encouraging dissenting views.

In-depth interview

This technique is sometimes referred to as the purposeful conversation research technique. Hennink [2007] puts it more concisely that this research technique is more suitable for more complex and sensitive topics to identify personal perspective, to generate data on personal experience and opinion, for detailed in-depth information and for descriptive process information e.g. life course issues such as a migration process. It is mainly preferred in this project because it allows probing without making the interviewee feel like she or he is being put on a 'hot' seat. The nature of the interview requires that the researcher should as much as possible be able to listen more than ask questions; and yet at the same be able to manage the interview process to remain relevant. I will accomplish this by use of the reflective listening skills.

For this research project this research technique is suitable because the researcher will need to talk to 'expert officers' to get a lot of data from one on one interviews. The interview environment is respectful without being intimidating. Both the researcher and the interviewee can rephrase questions or answers in order to enhance clarity. It is immediate and the data generated is original and unique to this interview situation. There are no predetermined response categories; but there are topics to which the interviewee is required to give personal views and opinions as well as felt interpretations.

There are a few limitations to this research technique. Tones and Tilford (2001) explain the because it consists of only two people in a meeting, the interviewee may have a heightened awareness of the tape recorder as well as the researcher taking notes no matter how discreetly. There is no reason for any researcher to be totally ignorant of what responses she or he may generate during the interview. However, some participants in this type of situation may go on long very technical responses that may be a bit difficult to follow. The strategy for this project is that if that should happen the respondent will be asked to give a summary of the response without using any technical terms. Alternatively and depending on the time frame the respondent will be asked to explain any jargon [technical language] because that in and of itself may be educational to the researcher and may enrich the data with better insight. All the same the researcher has good and well practised listening skills and; has good interpersonal skills. The researcher is also aware that this technique will require very sharp question forming and gentle probing for elaboration.

Ethical considerations and power relations

This research will be carried out with respect to ethical principles and practices of research. All the respondents will be given an opportunity to reflect on the primary aim of the research project before they are asked to participate. There will be a consent form [both in English and siSwati]. The researcher will read it line by line with participants and ensure that people are not coerced into signing and are free to take it home if they want to and discuss with family and friends overnight before they sign it. The aim of the project is also to make the people understand that they are not in trouble with anyone if they choose not to participant. In the focus group, participants will be asked to treat personal information confidentially. The researcher will allow participants to stop an interview any time they wish to do so. There will be no negative consequence if participants choose to withdraw consent during the interview process. All participants are above 18 years old. Before the start of the interview the researcher will report to the Chief's indlunkhulu (*sometimes referred to as the homestead of the first wife and it used to be where the chief's kraal is in historical Swaziland*).

[The chief of this area does not keep his cows in this community due to the very cold weather and heavy rains of this area. More and more chiefs are choosing not to keep cattle at all for practical purposes since they may be working and living in urban areas.]

The research will be sensitive to cultural, traditional and spiritual values and respectful to the community in all stages of the research project. The ministry of health requires ethical clearance if the study involves giving the participants anything to inject, ingest or any sort of physical contact by either respondents or researchers. Otherwise for this level of research project a Chief's or Chief's representative clearance will be sought as a matter of courtesy.

Conclusion

Research whether qualitative or quantitative is in some sense political. Most researchers feel an immediate need to deny this. Any queries on the status of the health of a population do attract political attention. There is a variety of ways in which research can be said to have taken on certain political flavours. Murphy and Dingwall [2005] argue that social research always involves power relationships with those who are being researched and those who are conducting the research. It would be too simplistic to assume that as the initiators of the process the researchers are the ones who always have more power. Research participants can derail a research project if the power relations are not managed and negotiated firmly at the very onset of the project. Research participants have considerable scope for exerting power over researchers. In the same way the choice of which topic to do the research on can be a power relations minefield. The goals and priorities of the research may not necessarily be of urgent interest to the community in which the research project is to be carried out. The researcher is under no obligation to respond to the political agendas, goals and priorities of the research community or any of its leaders. And yet on the other hand the community is under no obligation to respond urgently to meet the deadlines of the researcher. It is for this reason that for this project, a consent form will be included that will clarify expectations for all parties.

CHAPTER 4

Findings and Discussion

Introduction

The conflict and tension between biomedical treatment regimens and the African traditional medicinal practices is as experienced and felt by the people who live in the rural areas as it is by the people who live in urban areas albeit at slightly different angles [<http://www.publichealthpromotionsjournal.com>]. At the main market in Mbabane traditional medicine is sold and practised at a dark corner in a little house at the back of the market; away from the mainstream market activity. On the other hand in the rural areas people who visit traditional healers are often times less apologetic about using traditional medicines.

However there are still many people even in rural areas who hide whatever medicines they may have been given by a traditional healer for fear of being judged as backward and unsophisticated. In extreme cases people found in possession of traditional medicines have been labelled as witches. This research also found that unlike in South Africa where one may find herbalist and traditionalist proudly selling their wares in broad daylight on any busy street this is not necessarily the case in Swaziland. In Swaziland traditional medicine though wildly practised and not considered illegal activity, except where human body parts are involved is relatively secretive business. The seeking and practise of traditional healing methods is still considered primitive and not something 'Christians' practise openly. The reasons for this reality seem to vary from person to person, family to family and indeed from community to community. As one informant told me:

“My child in this homestead I am a daughter in law, I can not do as I please even though I know that these timphandze (medicinal roots) are what is holding my soul. They think these roots are what I am using to control my husband and keep other women away from him ... make myself strong. The other sisters (other wives to her husband's brothers) are saying they won't hide it they have a right to look after their own health since in this family nobody contributes when you need to go to Mbabane (government hospital in this context) but once

you die they all want to be seen and they contribute and buy you a white (glamorous, or beautiful) coffin ... they are just showing off to their friends from Mbabane (town)”

[Interview notes with a female member of community].

It became very clear from the onset of this research project that people felt a bit self-conscious and judged for their beliefs in traditional medicine regardless of what they were using it for. This is quite true for Swaziland and possibly for other southern African countries as well where sometimes patients have to hide the fact that they have been using alternative medicines for fear of being laughed at by the nurses or even worse annoying the medical doctor. They seem to have a feeling of being embarrassed by their way of health seeking perhaps feeling that it is deemed backward and primitive.

However, the opposite seems to be true for rural areas whereby traditional healers hold a much respected position and command a lot of respect in the rural areas, where they seem to freely practise their ‘healing ministries’. Over 80% of the people interviewed said they would consult a traditional healer if they felt biomedicine was not helping them recover from an illness. Over 50% of those who said they have never been to a traditional healer said they would agree to go if their parents or spouse told or advised them to go. This chapter seeks to discuss all the main findings of this research in terms of where and how the conflict and tension between African traditional healing methods and western modes of medicine may be seen or perceived to manifest as observed by the people in the Motshane community.

The study also found that there are people who say that they do not use traditional medicine because they doubt its effectiveness, question its hygienic ‘standards’, that it is unscientifically proven therefore open to the abuse of con artists and fraudsters. Nonetheless, there is still considerable evidence [Mahlaba 2001: 7-11] to show that indeed close to 80% of the Swazi population consults traditional healers or use one form or another of traditional medicine, including none traditional remedies and herbs such as lemons and garlic for instance. That at least 1 in every 3 families use traditional healers exclusively even more so in those families where there is a traditional healer within the extended family. With an equal level of suspicion towards traditional healers; there are people who do not trust western medical doctors and their medicines. At least more than 3 interviews during the course of this

research revealed that communities think medical doctors especially those in private practise make their profits through giving you drugs; whether duly required or not. That in cohort with pharmaceutical companies, medical doctors are pushing for the exclusive use of ARVs to create exclusive dependency for their own profit. One respondent said

“When I grew up my grandfather would treat all illnesses in the family, I never went to hospital until I was there to have my child. He used local herbs but he often added insangu (dagga) to most of his herbs, especially if you were going to smoke it.” The respondent then jokingly added *“The only side-effect we suffered is that none of us, the children who were brought by him like to get tipsy or feeling light-headed; we will always associate it with being sick”* [researcher’s field notes and transcripts].

This statement is reflective of life in general for many families based in the rural areas. I was not that surprised to hear this statement. I was myself brought up by my grandparents and indeed my own grandfather had a number of dagga plants growing scattered all over the homestead and at his fields to evade the police. My own first contact with medicine was with his various herbal concoctions even though I had been born at a hospital and I was never taken back there for any illness. Keeping quiet about my own experience I asked the respondent which medicine does she personally have more faith in. She told me that if she has a major illness e.g. bronchitis she will definitely go to her family and friends first and try local remedies and if they can not help then she will seek the help of a ‘proper’ hospital.

Use of Traditional Medicines

In a Nepad (The New Partnership for Africa’s Development) 2009 initiative Kalua Fetson et al (2009) makes the observation that in most African countries, traditional medicine is used by nearly 70-80 percent of the indigenous populations to deal with their basic health care needs. He explains that there is scientific evidence that over 120 pharmaceutical products were derived from plants and that 74% of them were first used within indigenous cultures as traditional medicines before being patented in the West and Northern countries. Most African countries recognise the need to employ science and technology to innovate

traditional medicines to meet the increasing health burden. It is the financial commitment by African governments towards these kinds of research that seems to be lacking.

This chapter also discusses the opportunities and potential for lessening the tension and the possibilities for increasing the levels of cooperation, understanding and mutual respect for the two medical traditions. Writing for the journal of General Internal Medicine Kripalani et al (2007) explains that cultural competence programs have proliferated in U.S. medical schools in response to increasing national health needs, diversity; training programs, she argues we all share common goals of improving physician-patient communication and reducing health disparities between the haves and the have nots, illiterate and educated. She argues further that in addition to improving communication, greater appreciation now exists for the impact of culture on health care and health disparities.

Health seeking behaviours are hugely affected by cultural norms, traditional values and practices. As the Motshane chief's runner (secretary) explained to me:

“My child as a Swazi this AIDS disease is confusing (swazi word he used can also mean unbelievable), because what we as Swazis know is that even before a child is born her/his conception is reported to the elders (ancestors) by her/his grandparents by burning of the right family trees (the dried bark of that tree), when a child is taking a wife or going away to be a wife, culture tells us all the procedures and rituals that are performed ... until the person dies and at the funeral we Swazis also know what to do. There are known medicines to treat a person through out their lives ... this story that now they tell you that even when you have no illness, they can look at your blood and tell you have an illness that will kill you ... is a new story... it must be coming with development and they will have to tell us when this is (or it is) finished ... in siSwati the field, or veld (possibly Afrikaner word for the wild area or undeveloped country site) has medicines for all illnesses without going to hospitals”[field notes from interview with chief's runner]

This argument seems to be in line with the observations of a number of anthropologists including Schoepf B. G. (2001) who says that traditional healers (were) are already there way

before bio-medicines reach indigenous communities. The potency of their treatment is discussed and shared between neighbours and between generations for many years. He says:

“An estimated 70% of Africans have no other recourse than traditional healers because biomedical care of a reasonable standard is neither accessible nor affordable. In a Situation without choice between alternatives, discourse about reliance on traditional healers is a hegemonic ploy that anthropologists should not facilitate” [Schoepf 2001: pg 352]

Leclerc Madlala (2001) makes the point more succinctly, she opines that AIDS is truly a disease of the global system and that its symbolic emblem in the South is more telling in communities with deepening poverty, hunger, deteriorating health infrastructure, bodies weakened by malnutrition as well as other epidemics such as malaria and TB, war and violence. She explains that there are increasing socio-cultural linkages on how poor communities and poor families react to the epidemic; making their dependency on traditional medicines not a question of choice but that of the sheer need to survive. That many anthropological studies have revealed some cultural particularisms but much regularity in the social production of disease especially among poor people and how indigenous knowledge systems try to grapple with this phenomenon. This seems to be in agreement with Schoepf argument:

“Focus on Africa, where the heterosexual epidemic has attained catastrophic proportions reveals the global inequalities of class, gender and ethnicity as poverty, powerlessness, and stigma propels the spread of the HIV. The bodies on which states and wealthy leaders inscribe both their power and their powerlessness are those of women, youth and poor men” [Schoepf 2001: pg 354]

In one of many reports by the South African media on the conflicting messages by medical doctors and a former Minister of Health, The Sunday Times of October 12, 2008, in a page 5 story ‘HIV patients trust in traditional remedies’ by Bongani Mthethwa; reports on a study by Shandir Ramlagan, a senior researcher at the HSRC, (Human Sciences Research Council), found that among 484 hospitalised HIV patients, very close to one out two of HIV positive persons in Kwa-Zulu Natal believes that traditional medicines are safer than Western

medicines. More than 66% believe that they would not be able to live without traditional medicines. More than 60% believe that herbs control their HIV rather than ARVs and 96% of these participants believe that doctors prescribe too many medicines. The study was conducted in three hospitals approved for providing antiretrovirals. According to Mthethwa's article, the TAC responded to these findings by blaming the former minister of health for sending mixed messages to the public. Ramlagan as quoted by this article concluded these findings by making the observation that some traditional medicines could be counter productive if taken simultaneously with ARV treatment. That in rural communities such as Motshane; the subject of this research can not be ignored and their fears of western medicines which continue to cloud the success of the programmes designed to distribute ARVs needs to be addressed properly. Where I do not agree with his opinion is when he seems to suggest that somehow the minister of health should make political statements condemning the use of traditional medicines; further, he seems to suggest that the government of South Africa should 'enforce' the use of ARVs; and patient's right to choose treatment should be less important in pushing a public health 'policy'. I do however think that more research needs to be done into what happens when a doctor prescribes ARVs for a minor child and surviving grandparents or guardians feel that the child should not take ARVs. They have power over her and may infact decide not to give her the treatment. I guess the question is who should take ultimate responsibility for the minor? Is it the Government perhaps?

Health care systems and public health promotional messages

The size of Swaziland makes it easy for public health promotional messages to reach everyone. As emphasized by several key informants primary (basic) health care education is provided through all the government supported media services as well as some of the privately owned printing press. The radio based primary health care education seems to be more popular in the rural areas. Radio reportedly reached 100% area coverage in 2004 which makes it easy for government to be within reach of everyone through this medium. The infrastructure of the health care system in Swaziland is relatively strong in comparison to that of other countries in the region. The system includes public, mission and private facilities that operate at three different levels: 162 health clinics, 12 health centres (different from

clinics since they offer some limited admission facilities between 26-34 beds), 8 public health units (these will offer a daily outreach mobile clinic unit to hard to reach peri-urban communities but are themselves based in town where they offer outpatient care); and 7 major hospitals [HDA & JTK Associates, 2005]. Primary health care is also provided through outreach services and Rural Health Motivators in communities. The study found that access to health care is good, with 80% of the population living within 8km of a health care facility, but transport and financial obstacles remain a challenge particularly for the chronically ill living in rural areas [HDA & JTK Associates, 2005].

Unsurprisingly, there are still more health professionals especially doctors working in the private health institutions in Swaziland than all those in the public health centre put together. More than 80% informants thought money was not the only attraction but governance was also driving a number of health professionals out of government facilities. The impact of HIV and AIDS on the health care system is most evident in the sharp rise in demand for care for AIDS-related conditions, and the health care burden has increased heavily over the past few years [Whiteside et al: 2006]. The survey by HDA & JTK Associates in 2005 particularly concluded that in four regional hospitals at least 45.9% admitted patients were infected with HIV. Health workers reported that morbidity due to HIV and AIDS has undeniably led to significant increases in patient loads at all levels of the health system. This has been accompanied by an increase in overcrowding in wards, longer hospital stays, and higher mortality rates, which together have put a strain on the health care system. Whiteside et al concludes:

“...signs of the expanding burden are evident elsewhere, particularly when looking at admissions and bed occupancy rates for opportunistic infections that are strongly associated with HIV and AIDS such as TB. Whilst rates of TB patients had been falling prior to 1990, rates have risen substantially with an almost fourfold increase between 1990 and 2004, from 210 to 820 per 100 000 population. This is indicative of the rising health care burden due to AIDS as the incidence of TB driven by HIV. In 2004 it was estimated by WHO that 80% of the adults in Swaziland with TB were HIV positive [WHO: 2004]. Rising TB admissions in hospitals present a particular challenge because of the length of stay, in comparison with other major conditions. Escalating needs of HIV/AIDS patients and the diversions of staff to

deal with these also threaten to ‘crowd out’ care for other patients, and health statistics and reports from health workers suggest that this is indeed already happening” [Whiteside, Andrade, Arrehag, Dlamini, Ginindza and Parikh 2006: pgs 51-52].

According to this research it is believed that over 80% Swazis seek services from traditional or alternative health practitioners prior to turning to the western health care system, so the study predicted that from 2005 the demand for health care was still going to rise. One of my key informants agreed and thought this prediction was on the money that at fourfold in 2005, today she can agree that it is at least ten times worse. Hospitals do turn admission patients away due to lack of bed spaces and patient in admission not recovering for longer periods of time. This results in people opting for traditional and faith healers.

Traditional Spiritual Healing

During the course of this research I often drove pass a Zionist Prophet’s house and there was a daily stream of people coming from and going to his house for prayers as I was told and also saw for myself. Upon further probing (snowball effect interview 1), it was explained to me that even though he makes Christian prayers for healing over his clients and patients; he also practises traditional African healing methods such as ‘*kufutsa*’ steaming the whole body with very hot or even boiling water whilst covered with blankets sometimes involves bathing the whole body with hot water into which various herbs have been added, ‘*kucatseka*’ anema, ‘*kubhemisa*’ smoking of traditional herbs, ‘*kukhotsisa*’ or sometimes referred to as ‘*kucaphisa*’ licking small portions of burnt traditional herbs mainly mixed with ash and a little water. A young man by the name of Sibusiso (a blessing) who works as a senior assistant to the Prophet proudly told me:

“This man of God does not look down upon nature, he uses what God has provided and then he will pray upon it, sometimes he just prays upon river water and when you drink it you feel better, even when you are looking for a job he prays for you. He follows the traditions of our ancestors. Who are closer to God and know more about our health and give us the (luck) to live longer in this earth” [researcher’s field notes and transcripts]

One distinguishing feature according to the focus group participants between the traditional healer and the Zionist prophet, or other faith healers is that for the prophet the whole treatment is free. Some prophets will take an offering but there is no stipulation that it has to be money, patients can take firewood, vegetables, a two litre bottle of soda or they can just show up empty handed especially if they are coming from afar.

“The prophet does not like to be paid, but you can thank him with a small offering or gift, for us, he is different from the hospital or the traditional healer he talks to God; and when he talks to God you can see things happening.” [Researcher’s field notes and transcripts]

Whereas, with the traditional healer there is almost always a stipulated price, and then there may be extras for instance if you want the healer to come to your home and perform certain rituals. These fees can be quite exorbitant sometimes. And peculiarly, if you bring a patient to the traditional healer’s place and your patient dies within his premises, there is a fee for that as well. The traditional healer is entitled to a cow for cleansing his or her homestead from the spirit of the dead person. The cow fee can be exchanged for Cash of up to a thousand Emalangeni (E1 lilangeni = R1 South African rand).

“In siSwati when a person is very sick and you suspect they may die you do not enter the premises of the inyanga with your person but instead you leave them at the outskirts and one of you must go to the inyanga and explain your situation. If he is a kind person or when the patient is related (same ancestral roots) to the traditional healer, the traditional healer may come to the patient and administer treatment, but normally the traditional healer will give you the treatment and explain to you how to use it” [field notes from interview with adult community member].

The explanation is that traditional healing is embedded with ancestor worship and the traditional healer’s ancestors will conflict with the spirit of the unknown dead person, therefore the cow fee is to appease them and buy the patient’s protection and acceptance by the departed elders of the healer’s family. The cow is then slaughtered in a ceremony so that the dead patient’s spirit can leave the Inyanga’s place and return to his own ancestors. If this is not done it is believed that the spirit can hang around and be in constant conflict with the

Inyanga's powers thereby weakening his powers to heal.

It also became clear during the research that whilst bio-medical doctors, traditional healers and divine healers refer to everyone who visits them as patients 'tigulane'; Zionist prophets and other prayer healers make the distinction between patients and clients, sometimes referred to as brethren because they explain that not everyone who comes to see them is sick and therefore a patient, that a huge number of people consult them for luck finding a job, a wife, a husband, for safety when travelling and just for other prayers and portions to make them stronger etc. Even more importantly the Zionist priests and prophets are often times church Pastors. Therefore, when people come to see them they are not just their patients but are in a way, actually church members, or their relatives or people who are just visiting the church for regular church services or specifically to be prayed for.

Even though more than 80% of the people who were interviewed had at least a high school education they all concurred that they had at least more than once consulted a traditional healer or a Zionist prophet for an illness. This reality is a pointer to the fact that traditional healing is not necessarily for backward or illiterate people. At least half of the participants claim to consult traditional healers out of desperation and also just so that they can try everything and anything. They are also more often than not under pressure and duress from elderly relatives and neighbours and of course from the pain of the illness itself. About 75% of the informants showed to have more faith in the healing powers of traditional herbalists as opposed to traditional healers. A young lady from the focus group who looked quite polished to me, she wore jewellery that looked quite good (not cheap by researchers estimate/view), had lipstick on and her clothes were more fashionable e.g. a colourful top with pretty straps for sleeves told me:

“My sister there is a difference between the traditional herbalist (lugedla) and a traditional healer (inyanga). Luggedla is just someone who is very knowledgeable on which traditional muti is used for what. They have a vast knowledge of the veld and managing, harvesting and mixing of the traditional plants. They will know which plants and herbs are used for any illness, but unlike the traditional healer, they have no spiritual calling by the ancestors to be healers, they just help people like us and the community”. [Researcher's field notes]

Upon further probing the community nurses (placed by government at Motshane clinic) and the other biomedicine practising participants explained that even more than the lack of scientific proofing and measurement of traditional medicine it was mostly the spiritual part of the healing that some health workers had a problem with. This conflicted with their own spiritual commitment and belief in the omniscient one God. On the other hand the general consensus seemed to be that there are some people who doubt the authenticity of the whole idea of being possessed by ancestors who then give directions on which medicine the patient should take. Even more doubtful is the ability to tell not only what the illness is but also who has cast a spell on the patient to cause the illness. This argument seems to be in agreement with Sumaya Mall's [2008] research findings from a group of respondents who had never accessed a traditional healer. She writes:

“There are patients in this group who do not trust traditional healers. They believe that traditional healers are merely entrepreneurs who promote their healing practices for purposes of profits... some patients said as the importance of traditional healing had not been instilled during their childhoods, they had no need to access these services during adulthood...they spoke of the healing strategies they had engaged with as children as significant influences in moulding their adult behaviour...traditional healers who falsely claim to have the ability for healing HIV/AIDS seemed to have been an important influence in shaping the health seeking strategies of some of the patients in this group...that traditional healing methods are not really appropriate when it comes to HIV/AIDS care... patients were aware of the necessity of scientific evaluation of all drugs. As traditional medicine has never been scientifically evaluated, many patients queried its therapeutic quality or credibility”

[Mall 2008: pgs 8, 9, 10 and 11]

Mall explains that health seeking behaviours of HIV patients is complex especially when trying to understand why they make certain choices of treatment over another. For instance she explains that from her research project the group of respondents who had accessed a traditional healer expressed more positive opinions of traditional healing services while others are much more sceptical of traditional healing. There are patients who had indeed been healed or felt healed of some symptoms. Her overview of the findings are worth noting as she concludes from her study that the patients who have ties with traditional healing

practice themselves, e.g. those who are *tangoma* themselves or closely related to one, demonstrate particularly interesting healing strategies. They claim they do not use untested traditional treatment on HIV positive patients or to take this treatment themselves. They also claim they encourage clients to access VCT services at local clinics and in the event of an HIV positive diagnosis to adhere to ARV treatment [Mall 2008: 17].

Reported Risks

I found the common claims that are generally made by researchers and public health practitioners to the effect that traditional healing strategies that include blades and cutting are dangerous to be well founded to an extent. I gathered that even though there are so many public health messages on radio, newsprint, television e.t.c [National Coordinated Communication Strategy for HIV/AIDS, 2002] on informing and educating the public about the dangers of sharing needles and cutting blades; there still remain quite a remarkable number of traditional healers and family herbalists who still continue to ignore these messages. The reasons for this vary from the blades are expensive, they only share blades within families or blades are cleaned first before borrowed out to the next user. With some air of ‘sheepish’ annoyance one informant told me:

“If the government is truly concerned about ‘kugata’ (cutting) of patients they will give us blades and stop telling us even when we wash the blades with spirit (methylated) they are still unsafe to use” [Researcher’s field notes]

Conflicting Spirits?

The issue of spiritual guidance and ‘divine sight’ seems to point to another conflict of interest between public health care systems and traditional healing systems. However, some participants made the point that traditional healers would not necessarily be working along the understanding that they are dealing with a person infected with an incurable virus, instead their focus would be at this point on the presenting symptoms e.g. sores on the body, tiredness, headaches, night fever etc. They felt that if the patient explained to the traditional

healer or indeed disclosed their sero status it is doubtful that there would be any conflict, notwithstanding the fact that a number of traditional healers in Swaziland seem to argue vehemently that the HIV and AIDS virus is not in fact a new 'disease'. This is understandable from the point of view that the symptoms presented by HIV positive patients are symptoms of old illnesses. Therefore, it is harder for public health workers to convince people that this is a new incurable syndrome when in fact they can treat some of the symptoms even when the patient may die later on they feel convinced that it is of other natural causes than AIDS. This is not a conflict between spirituality and science but rather a difference in a people health seeking ways in an apparent pluralistic health care environment. There is however a broader sociological challenge to study further the various forms of 'African' perspectives of healing and illness in the historical context of indigenous medicinal healing methods. A smaller number 20% of respondents felt that even getting infected with HIV is just bad luck that other people can wish or cast on you; about 65% felt it could be a combination of bad luck and bad behaviour. Some pointing at the king's many wives, and how he seems to be HIV 'free'.

However, not all traditional medicine is foretold by ancestors or refers merely to a recent spiritual encounter of any nature. Jo Wreford [2005] explains that the term traditional itself is in many academic literature and discourse used with the understanding that it refers to age old and ancient healing practices and medical understandings of Africa. Traditional healers themselves acknowledge the implicit longevity of the indigenous healing knowledge of Africa; practiced way before the arrival of white colonialism and of white rule in Africa. African traditional healing methods have been thriving and adaptive through out history. Most traditional herbalist, *tingedla*, as opposed to *tinyanga*, traditional healers and *tangoma*, spiritual foretellers, do not claim any spiritual visitations by ancestors. Instead they are trained as apprentices, *ludzibi* usually by parents or grandparents. The training involves showing the young apprentice which medicine to use for which ailment, including the processing, where and how to get the traditional herbs. A major part of the training involves showing the *ludzibi* how to harvest traditional medicines in a sustainable manner. Respect of the soil, stones, trees and flowers is entrenched, complete and wholesome interdependence of humanity on and with the environment and vice versa.

Wreford [2005] explains that the title of 'sangoma' in southern Africa encompasses healing skills which includes those of the diviner, herbalist, psychotherapist and community counsellor, not to mention artist, detective, mediator and sensor. There seems to be some variation between sangomas in Swaziland and South Africa even though I am made to believe that a number of South African sangomas are trained in or by Swazi healing and divinity schools. However these are minor differences for instance during the study I was told that a real, 'organic' and genuine sangoma does not necessarily practise medicine herself but she will give a 'diagnosis' in the sense of explaining why the illness has occurred, and sometimes not always how the 'spell' was cast upon the patient; and a 'prescription' of how it can be treated. For example she will tell the patient what rituals needs to be performed and how; in other words the nature of the herbs and *muti* that needs to be involved in order for healing to take place.

It is then incumbent on the patient to find the right herbs and people who will help her perform that ritual. It appears that every family or local community e.g. neighbours will usually have a person or two who will have specific indigenous knowledge of how to perform the ritual to treat a specific symptom. Buhrmann V. a South African specialist psychotherapist who studied Xhosa diviners, as cited by Wreford [2005], explains that the concept of ancestors can be spiritually understood in the sense and notion of 'collective unconscious' an ancestral unconsciousness which acts as motor, motivator, operator and actor in the here/now and the after world of the living. This understanding of the unconscious understanding of wellness and wellbeing is important in the understanding of how people will react to a virus such as HIV and AIDS which seem to threaten the very existence of humanity. To the result that a community may begin to look to beyond the here and now in finding ways and means of surviving a 'species' threatening, incurable, and overwhelming virus. The very fear of death itself makes anyone of us look urgently to means beyond explainable bio medicine for help.

It seems to me that the very urgency of these circumstances is an origin of a number of the confusion where by indeed traditional healing methods may treat successfully some symptoms in people living with HIV and AIDS; thereby causing this huge debate about whether or not traditional medicines are effective treatment for HIV and AIDS. That even if

they are effective in treating only the symptoms; there is still need to look at how then can the public health system ensure a smooth, professional and mutually respectful relationship between indigenous health care system and 'modern' western science medicines. The reality is that for poor countries like Swaziland the public health care systems are enormously overloaded as a result of the HIV and AIDS pandemic; to the result that in a number of people finding it more expedient to completely rely on the traditional health systems. It is however also important to note that health seeking behaviour in southern Africa as indeed is the case in the rest of the developing world is highly constrained by accessibility. Schoepf G., Schoepf C. and Millen V give the explanation:

“The lack of health provider discretion and the imposition of user fees, however, are not the only barriers confronting poor Africans who seek biomedical health care. A person’s ability to reach a health care facility, to be treated by a health care provider, or to obtain needed medicine is dependent on many factors, including proximity to the facility, transportation costs, ability to pay service and medicine fees, and socio-cultural factors such as language, class and gender. Generally, the more numerous and widely dispersed health facilities and health care providers are, the greater people’s access to health care. This is especially true in Africa where the majority of poor people live in rural villages far from urban centres. In remote areas, distance is the most crucial determinant factor of health care access” [Schoepf G., Schoepf C. and Millen V: 2000 pg 109].

There seems to be an urgent need for all health care providers and the general public to increase the level of understanding of how each health care system can help mitigate the overload. To consider potential for collaboration. Wreford observes:

“The ravages of HIV/AIDS have exacerbated demands on public health care systems across the African continent. In South Africa, the health system post apartheid continues to be sharply stratified: an elite multiracial clientele avails itself of biomedical health care at its most mechanised and sophisticated, while at the other end of the spectrum a creaking public health service endeavours to fulfil its ministry to the majority black population. Reports suggest that the pandemic is putting an already overburdened system under immense strain. Meanwhile, reports suggest that between 60 and 80% of the South African population

continues to make the traditional health practitioners its first point of call for diagnosis and treatment. This preference is especially true in the case of STDs and HIV/AIDS. In this context, the possibility of co-operation between traditional practitioners and bio-medical doctors obviously needs revisiting” [Wreford 2005: pg 7].

The Burden on Grandparents

From an accidental interview with a lady to whom I had given a lift just at the outskirts of Mbabane one morning on my way to the research site I also learnt that there is a tendency for the western public health system to ask patients and their guardians to take on more legal responsibility for a patient's treatment procedures than seems fair. This lady (Thabi) related to me as we were driving towards Motshane that she had a grand daughter who had tested HIV positive. The child's mother had died of TB. Thabi is her paternal grand mother. Upon the mother's death the girl had been sent to live with her father's family hence my passenger's guardianship of the young girl. When the girl arrived at Thabi's house she was already sick, she had sores in her head. Thabi explained to me that she had asked the mother's family how their daughter had died and they explained she died from TB; they suspected that she had been infected with TB due to looking after her uncle who had also died from the TB. They never made any connection or reference to AIDS [at least not to Thoko].

From a researcher's point of view several issues about the public health system are raised in this discussion. Firstly, the requirement/pressure for families to look after their own sick relatives raises a number of questions. Assuming that indeed this child's mother did die as a result of contracting TB from looking after a relative what can the family do to prevent this from happening to other relatives living within that homestead. More importantly, what do they think they need in order to prevent this from happening to surviving members of the family? Secondly, I asked myself if this was a family in denial. Is everything just being explained away in terms of 'Oh she died from TB' or did they not suspect that a treatable disease such as TB could be aided by e.g. a weakened immune system to be terminal. Was the family aware that even if their relative was HIV positive they did not need to die from Tuberculosis? Further discussion with the grandmother revealed that she herself felt they were just scared of the truth.

Coming to her own dilemma Thabi explained to me that as a result of some sores in her granddaughter's head she had taken her to the clinic. The nurses had encouraged her to have the child tested for HIV. Since she got the sero positive result, the nurses were putting her under enormous pressure to bring her son (the girl's father) also to be tested. Her son is a twenty year old high school going boy. The nurses are telling her the best way for them in providing HIV/AIDS services at the clinic is to look after the whole family. They do not want to isolate the child and treat just her alone. They understand the mother died but they want a meeting with the father.

To me as an outsider looking in, the nurses have a point; however I can understand the fear of a twenty year old high school going child, and the dilemma of the young grandmother (At the time, I had not had the opportunity to ask her to fill the bio data form but she looked no more than forty years old). The boy (Thabi's son) is clearly terrified of a sero-positive result. Coming from a rural background boys his age hardly have anything to do with clinics let alone HIV and AIDS voluntary counselling and testing centres. I could not help but wonder as to how many of our youths as Thabi's son; are also lost in a similar maze.

It is however remarkable that Thabi thought her son's 'in-laws' were being less than honest about the dying from TB story. She understood that TB could be terminal but told me she herself had heard, seen, and read a number of public health messages on the connection between TB and HIV and AIDS. Thabi showed understanding that if a person was HIV positive and have TB they should go to the clinic and get help. Asked whether she thought the in-laws were treating the TB with traditional medicines she told me that at the mother's funeral there was mention of her being taken to a number of 'people' looking for healing. She doubted that they would have had any money to go to a doctor or clinic. Even though this was an accidental interview it yielded so much information and during the trip it was just natural for me to ask to meet her again. Even though meeting the young girl would be of no value to the research it seemed to make the grandmother happy when I asked to see her. Like the clinic nurses I brought with me small gifts for the whole family, bread, tea bags, milk, sugar and a list of phone numbers for NGOs who offer assistance to HIV orphans e.g. food, school fees, clothes etc.

I especially wanted this second interview even though it was unplanned because I wanted to probe further into the treatment issues for the girl. It was hard not to start offering her my opinion but I went away with the feeling that the interview offered her an opportunity to also reflect deeply what her options might be and the acceptance of the reality that she did have to make a few difficult decisions. The interview itself revealed a few things for this research project. Firstly, the bio-medical health care system does treat HIV and AIDS related illnesses differently from other diseases despite what they say on their health promotion bill boards.

In this case after the child tested HIV-positive, the nurses immediately tell the grandmother ‘if you want her to start taking ARVs we can give you’ but they further explain that the child ‘looks’ (I assume they based this on the child’s blood test and CD4 count but grandma is not psychic) good and healthy and if she (grandmother) gives the child good health foods she can delay the need to be on ARVs until the child is a bit older. If this were any other illness nurses would have issued clearer instructions, and not rushed to push responsibility of treatment choice and course to grandmother. For instance an anaemic child would have been given iron tablets and grandmother would have been told give her spinach also etc.

Possibly, the nurses can not help the treachery of a mutating virus such as the HI virus, but all the same an attempt could be made to give the guardian more information and clarity than to say to her the choice is yours, find the child ‘good’ food or we give her ARVs. Where really is the choice one may ask? Instead it appears that they explained to grandmother that if she chooses to give the child ARVs she must be prepared to remember to give her at the same time everyday after the child has eaten. This seems to be her major concern. She asked me:

“How am I supposed to do this? I have to leave home at 7 every morning to go to work (grandma is a labourer/cleaner at a nearby nature reserve Malolotja) I only come home at 6 in the evening. They told me that I have to decide whether I give her the pills at 6 or 7 and I must give her again at 6 or 7 in the evening. But she has to eat first. This child when I leave at 7 she is usually still sleeping. I only see her in the evening and then she falls asleep soon after supper” [Researcher’s field notes].

This is a dilemma because she does not want to do anything that may jeopardise the health of her grand child. Thabi realises that once she puts the child on ARVs it will have to be a lifetime commitment. She feels that if maybe the child was older she could teach her how to take the medicine and the child would have to take some responsibility. There are other older children in the family who might help but Thabi worries that in order to get the other children to help she has to explain the seriousness of her grand daughter's illness. She worries about how the other children would feel about that; even more importantly she worries that children can be cruel and has no idea how they will treat her. Does she have to explain why the child has to take these medicines? Will they understand the importance of not skipping or taking the medicine same time every day, these are the worrying and real issues she has to deal with. She muses:

"I feel like I am risking the life of my grandchild by giving her the medicine I am still risking her life by not giving her the medicine, it is the same. She has no parents; I must be everything her father is a child. He has nothing [very long pause] ...whatever I do or do not do is very dangerous for her. Maybe the nurses should tell me what I must do, they are educated than me and know this disease that I have never seen even from my own parents". [Researcher's field notes].

To the contrary a traditional healer would have been more forthcoming in terms of what treatment would heal the girl and how. Rightly or wrongly this would take off a heavy load of psychological pressure from Thabi. This perhaps is the conundrum of many a grandparent of a developing world.

The psycho-social construction of illness

The plurality of medicine in Africa seems to be thicker on the ground than any western form of medical intervention. There are more people depending on a mix of the medical regimes than those completely dependant on any Western form of health care [Herek G.1990]. The circumstances in which people who have an illness make the decision on which medicines to take is largely guided by their social construction of what their illness is all about; more than on the moment feelings of the pain of the illness itself. For instance if the patient has sores on the body

and they are not painful she or he has the time to wait and see if whatever ointment or tablets they may be taking is helping with the healing. However, where there is pain e.g. severe headache or any other illness presenting with extreme pain and severe discomfort the treatment especially when it is self administered becomes frantic if at times even reckless.

Even at such desperate times I heard from many respondents that it all depended on what he or she associates the illness with. At times this is associated with the stigma of illness as well as the anxieties brought about by the natural fear of death. Those who are 'well' in the community seem to be worried about being associated with the sickness especially HIV and AIDS. Many times my informants would talk in terms of 'oh those with this illness' or 'those who already have it'. This showed me that a whole community can create certain social reference to the 'other', as a result of perception, its not just individuals. Herek G. puts it more clearly, he:

Argues:

"A disease is no absolute physical entity but a complex intellectual construct, an amalgam of biological state and social definition. In other words, illnesses are socially constructed. Symptoms are noticed, correlated and categorized as related or unrelated to the illness; the disease is labelled; theories of cause, transmission, prevention and cure are formulated, promulgated, criticised and revised. This is done at both individual and community level" [Herek: 1990 pg 5].

Even though this is a larger discussion and not a focus of this research project, it is important to understand how individuals and communities understand and construct social meanings of illness; in order to see what affects their health seeking behaviours and constraints thereof. Herek [1990] makes a good observation that in addition to identifying symptoms and giving the disease a name but that further four components of the construction of disease follow. These include:

- The *origin* of the disease is isolated and identified
- Often as knowledge and understanding of the sickness grows, systems of causes are articulated and in the process *responsibility* for the disease is assigned
- At the same time the *victim* or patient's identity is constructed as guilty or innocent, dangerous or benign, heroic or pitiful.

- Lastly, *responsibility for cure* is assigned

Herek [1990] makes the point that a community and individuals driven by fear will be quick to find specific sources of the disease and its origins or evolutionary origins. He writes:

“Responsibility is assigned to individuals for their own illness and to groups for bringing this disease into the community or society. Cultural images develop of individual patients as well as communities of victims. Responsibility for an individual’s cure as well as responsibility for eradicating the illness from society are assigned” Herek: 1990 pg 5].

This is true and seems to be sustained by many a politician’s obsession of finding a ‘magic bullet’ transnational solution and explanation for AIDS. This seems to be driven by fear of losing control and not knowing how to explain the relentless failures of the many campaigns and interventions put forward to combat HIV and AIDS. There seems to be on the one hand the moralistic versus secular dimension of the construction of illness and on the other; a conflicting and pervading sense of identifying the sick person as offender or defendant in terms of how they should be treated, and cared for by the community or quarantined as dangerous, contagious others.

Regrets and Reasons

Even in less desperate illnesses, people seem to get more radical if the illness is taking too long without the patient getting any better. The only HIV positive, (she already had full blown AIDS) informant who gave consent to be interviewed had an interesting story to tell describing how she controls her illness: For purposes of this project she is referred to as Liza and she told me:

“I spend most of my mornings here this side of the house (where there is sunshine) most of the time just sitting and leaning on the wall, if it is raining I stay inside, sometimes I sleep when I feel tired. But when the pain starts it drives me mad ... at that time I will take any medicine, all the medicines that I have sometimes more than the nurse said instead of two painkillers I take up to four because of the pain. Then when my mother notices that the pain has started she asks me if I want to smoke it (dagga), I wait a little to see if the pain killer is working most of the time it makes little difference then I tell her I want to smoke. But sometimes if my uncle comes to see (or check on)

me he brings some herbs. His herbs are good they are different I think my body is not used to them, the ARVs instead make me lose my breath, more tired, and forget things” [transcripts from tape recorded interview, I had been advised not to take too many notes or be seen to be writing everything down].

Of all the interviews this was the most hostile family set up I ever walked into, and I walked into 18 homesteads during this project. To some I went more than once. Liza’s people were angry, they were not very welcoming, to anyone who seemed even remotely connected to the government public health system. Liza is 44 years old; she had been kept at the government TB centre for over a year. I suspected after listening to their story that she had either deserted the programme at times or; she had the treatment resistant TB-MDR (Multi Drug Resistance, other public health literature refers to this type of TB as TB-XR, X=Multiple Drug Resistance); or that she had defaulted her treatment so many times she had grown resistance to the treatment. In their view it is doubtful that she ever had TB prior to being admitted to the TB centre. They suspect a wrong diagnosis or that she actually got infected at the TB centre, they explain that her illness got worse the longer she was kept there.

I also gathered that she herself, also felt very angry not only with the government’s handling of her illness but also with the father of her child, who had deserted her and did not even show up for his child’s funeral. I am no psychiatrist but wondered later on as I listened to the tape if all this anger was not just plain pain of desertion, anguish at the prospect of such a painful death and the regret of some decisions. This was perhaps the most depressing part of this project. I soldiered on as emotionlessly as possible. I also gathered that even though her mother was really her most supportive crutch, she felt guilty that she was now a burden on her and that perhaps she should be the one looking after her mother now instead of the other way round. She said:

“My mother did not give birth to many children its only my sister and our older brother, people are blaming her they are saying she spoilt us... are they laughing at her because she has to look after me... its not her fault” [transcripts from tape recorded interview]

Some of her regrets come from decisions such as not using condoms even to prevent getting pregnant. Her responses reflected to me that there are perhaps conflicting views and public health messages on the promotion of condom usage especially for sexually active school going teenagers. My informant says even though she knew about condoms and that her boyfriend (also school going) at the time was not opposed to them they both felt shy to look for them. They were afraid and a bit embarrassed to admit that they were sexually active. To the result that they used them off and on, depending on whether or not they could find them. The second National Multi-sectoral HIV and AIDS Strategic Plan [2006-08] admits that condoms are generally not accepted by traditionalists, especially within the school system. Traditionalists and the religious establishment sometimes issue negative statements about condom usage even for adults, contrary to government's position. Such conflicting messages about condom usage can potentially confuse the public, especially young people and hinder their wide acceptability and use. Myths, misconceptions and concern related to quality issues fuel unacceptability of condoms. I also gathered from this interview that the advent of antiretroviral therapy is sometimes seen as a substitute for condom use, and that the ARVs are seen as preventive medicines for getting any more infections. The informant's mother said:

“If my child gets better, it is better to keep taking the pills and forget the condoms, because she will never know when she meets a new young person whether or not he has the disease, it is better if she just continues the pills maybe they can protect her”. [Transcripts from tape recorded interview]

It was revealing and interesting to hear the views of the interviewees who were on ongoing treatment, 4 were people who were openly living with HIV (but did not have any major illnesses or any full blown AIDS symptoms) and 2 of them were already taking ARVs, the other 2 were alternatively seeking various traditional healing methods as well as visiting public health centres whenever they felt unwell. The people who had tested HIV positive but were not yet on ARVs felt that firstly, the traditional medicines would help them remain strong for longer before needing ARVs (the public health system in Swaziland still advises health centres to give ARVs to people with a CD4 count below 200). Secondly, they all felt that where as the ARVs had terrible side effects the traditional medicines could easily be

taken without fear of ‘overdosing’ or getting any bad side effects that even if the side effects were there they were bearable and manageable. Ironically most of the older interviewees and the siSwati speaking ones described being HIV positive as having ‘dirt’ in the blood; or they would say her or his blood has been found to be ‘dirty’ in almost the sense of being polluted. They would therefore continue to talk about medicines that would ‘clean’ the blood and make it ‘strong’. At times my impression was that the general understanding was that ARVs did not clean out the ‘dirt’ but rather covered it and kept it somewhere in the body in a less lethal form. But that on the other hand, traditional healing methods which involved ‘*kuhlanta*’, self induced vomiting, ‘threw out’ or washed out the ‘dirt’ and therefore cleansed the blood system is how I understood them to be explaining to me.

I was intrigued by one of the 4 respondents who were HIV positive, I will call him Siphoh. Even though there are a number of people who speak openly about living with the virus a majority of them are women. Siphoh seemed very eager, for a man, to talk about his ‘journey’ with HIV, he has been used by government public health officers in their workshops to give talks about his status and how he is ‘living positively’. He talks about how his family especially his father, still does not want to believe that Siphoh has HIV. Instead his father sees the whole thing as an issue of bad luck, over and above that Siphoh explained that his father has made the whole thing to be about himself and not about Siphoh or HIV. In as far as Siphoh’s father can see it is the ancestors who have turned their backs on him and thereby making Siphoh vulnerable to a strange illness. The whole thing has nothing to do with Siphoh’s sexual activity a virus etc. He himself has slept with a countless number of women, says Siphoh, it never made his blood sick, to the contrary he slept with many women as a sign of his health [I read virility].

Even though Siphoh has participated in a number of health promotion events, he still is vehemently opposed to ARVs. Claiming they shorten the life span of the ‘body soldiers’ which fight off illness and delay the onset of AIDS. He would rather eat healthy foods and take traditional treatments to strengthen him including praying and having faith. Hesitantly, I asked to see his test card. [I had found out a few days earlier from another informant that all people who test HIV positive are given a government issue card by every clinic, and they must come for CD4 count (and full blood analysis) every three months. He happily showed

me and actually taught me how to read it and what it all meant. Two things stood out for me. Firstly, even though the card looked quite officious and complicated he understood it competently; Siphon himself told me the nurses spent a long time patiently explaining everything to him.

Siphon's understanding of the whole situation said to me that despite popular criticism it does look like the government is serious about this epidemic. They know what they are doing, and they are consistent and more organised than I had been made to believe. The second issue that stood out to me was Siphon's CD4 count and his understanding of what it means and implies for his survival. It read over 700; Siphon understood the consequences of what it meant. He told me it is not good but it is not too bad. This made me realize that if his CD4 should go down and with all the attendant issues that that will bring he has all the information he needs to make his own decision. He knows the deal. Whatever decision he makes he has been given all the tools to take an informed decision and we can assume he understands his responsibilities and wishes better than all of us. I found it hard though to remain neutral and not try to influence him one way or another, somehow even though I left with a heavy heart, I felt confident in his intelligence. I thought his internal conflict between his beliefs and the science presented by his blood analysis was one experienced by many other people living with HIV and AIDS in southern Africa.

Scepticism, Faiths and Trust

Even though the research found that there seems to be a general hesitancy about mixing both traditional and biomedical treatments, this study found that there are very few people who only used and completely depended on one health care system, less than 10% was my estimate. The consensus amongst this minority ranged from saying that it would cause confusion because the patient would not know which medicine was helping her, to spiritual reasons; one family belonged to the 'Universal Church of Christ' and participants explained that this family rejects all forms of medicine believing only prayer can heal. Those who depended and relied more on traditional medicine generally seemed to opine that traditional

medicines were cheap, none poisonous (no toxins) and easily accessible within the community. Therefore the patient would not have to spend money travelling out of her community to get treatment.

One defining feature of accessing traditional medical care for many respondents was that for the inyanga to issue out a prescription or give the actual medicine there was no need for the patient to be always physically present for diagnosis and treatment. So if the patient was very sick and could not walk to the healer's homestead, relatives and friends could go on her behalf, explain her illness to the traditional healer and she would get help. This seems to be in direct conflict with western model of treatment where in order for the doctor to issue a diagnosis they need to examine the patient first. For people in rural areas this brings into sharp focus the issue of trust.

Many respondents explained that for the western doctor insists on seeing the patient to them this means he or she thinks they are lying. They are being treated as criminals otherwise why then does the doctor not take their word for it. Why would they come and report a sick person and her symptoms if there was no sick person. This is their relative or friend they know better than anyone what is happening. Clearly the thinking patterns are parallel. It appears that for the western healer honesty is issuing out prescription only after examining a patient anything else is fraudulent. S/He is not just being difficult and unhelpful he too has a different honest protocol to follow. S/He is indeed being professional in the traditions and cultures of her/his field.

Writing for AVERT (Alternative, Complimentary and Traditional Medicine and HIV) Noble R. concludes that in Sub-Saharan Africa, on average, traditional healers outnumber western medical doctors by eighty to one. Due to their proximity to the community they usually provide immediate treatment, whereas clinics may be distant, have long waiting lists and unpredictable reception awaits an incoming patient especially one with an acute illness. He argues, in relation to HIV, alternative therapies are also commonly used in areas where it is difficult to access western medicine. In the absence of anti-retroviral treatment, people seek other ways to delay the onset of AIDS, or to treat opportunistic infections. He writes:

“Most people living with HIV in developed countries have ready access to antiretroviral therapy and conventional treatments for opportunistic infections. Because these treatments are so effective, there is less demand for alternative HIV medicine, except perhaps for addressing relatively minor infections or when antiretroviral treatment cannot any longer be taken, for example because of drug resistance. Many instead look to complementary medicine as a way to prevent or relieve AIDS treatment side effects, some of which are not easily treatable with conventional medicine. There is also demand for complementary therapies that might boost immunity, relieve stress, or improve general health and well-being”.

<http://www.avert.org/alternative-medicine-hiv.htm>. Accessed 26/02/09

There still remains a fair amount of people who distrust western medicine and will avoid using it at all cost. At Motshane my interview with the chief’s runner revealed that they have a huge problem of people who refuse to register even for government issued food supplements such as the e-pap. E-pap is a form of mealie-meal which has been vitamin enhanced initially meant for distribution to mothers of HIV positive children in poor families. Due to problems to do with stigmatization the government decided to distribute to the whole community with a focus on child headed households and poor families. For the very reason that clinic nurses and social welfare officers were in the for front of the distribution of the e-pap some traditionalists were throwing it away or giving it to pigs in fear that it had western ‘injections’ that would make them sick forcing them into western hospitalization and clinical care.

Are we all medically pluralistic?

In contemporary public health literature medical pluralism is defined as a ‘synchronic’ existence in society of more than one medicine system grounded in different principles or based on different world views [Jansen G, 2001]. Citing Bhardwaj [1980], Jansen explains that pluralism describes a situation in the world societies where choices can be made between several competing models, values and religion. Such an open ended explanation of medical pluralism makes it easy to see how each community and especially individuals within communities might

actually tell you they do not use traditional medicines; or that they do not believe traditional medicines are effective whereas in reality they do use traditional medicines e.g. garlic for flu, as an alternative to bio-medical antibiotics or lemon and honey in the flu season. It might be that because traditional herbs such as eucalyptus, mint and lemon are readily available to rural communities such a normal part of the everyday lives people have stopped seeing them as medicines and yet they are continually and traditionally used for medicinal purposes.

Certainly, during this research projects many respondent's reaction to an illness appeared to follow an observable pattern. First they feel unwell; some will drink water with a pain killer if it is available or any other over the counter (OTC) medicines, but if there is no pain killer they will drink *siwasho*, this is an age old swazi if not southern African concoction that virtually every household can make within minutes. I myself have made it and used it for everybody in my house; my own mother used it as did her parents. It is a simple mix of water and ash (usually this is from the general household cooking fire). It is also used for cooking, the best way I can describe what it does to food is that it has an almost cream of tartar effect. It mainly aids digestion and helps avoid indigestion. Very effective for colic babies is my experience. Naturally there is concern for its hygiene qualities, but people in rural area without tapped water will boil the water first before making the mix. There is no scientific proof that this mix is effective, but equally there is no scientific proof that it is harmful or ineffective. To the contrary there are several hundreds of generations of people who have used it successfully to control a number of ailments. It seems to be generally understood that it is effective for moderate symptoms only.

Unfortunately a number of medical anthropology studies tend to focus on much later stages of health seeking behaviours where the sick person is already being diagnosed and treated by 'professional' healers or medical doctors at a much more severe stage of an illness. I think a look at the health seeking behaviour patterns would reveal that a major part of health care is family based. There is a lot of plural medical treatments that come out of the family unit than is currently understood. Nazrul Islam puts it more succinctly:

"In looking at any complex society, one can identify three overlapping and interconnected sectors of health care; the 'popular' sector, the 'folk' sector and the

'professional' sector. The popular sector includes all the therapeutic options that people utilize, without any payment and without consulting either folk healers or medical practitioners. Among these options are: self-treatment or self-medication, advice or treatment given by a relative, friend, neighbour, workmate or consultation with another lay person who has had experience of a particular disorder. These healers are neither part of the 'professional' traditional healing system nor that of the Western medical systems" [Islam: 2005 pg 4]

In severe cases people know that the OTC medicines and *siwasho* and painkillers from friends and family; are the kind of medicines one takes en route to a bigger health facility, biomedical or otherwise. Secondly, after the pain killer or *siwasho* then respondents explained that they would usually report the illness to a second person, might be a spouse, parent, neighbour or friend etc. It is at this point that sometimes the second person would either give his or her own pain killer or *siwasho*; but if the illness persists relatives, parents and friends or the sick individual herself will then make a decision to either go to the clinic, or visit a traditional healer, prophet, or other faith based healers.

The third phase is a more telling one and it can last anything from a few days to a few years. This is a stage at which the duration of the illness and its severity is key. The illness might be long but if it is not acute the reaction will be different. But if it turns out to be a long illness e.g. diarrhoea and does not seem to abate due to available treatment then the family or sometimes the nurses at the clinic might urge the patient to take a test e.g. HIV test or in very traditional families they may decide to visit sangoma, the divine foreteller, to find out the root cause of the illness. Surprisingly a high number of the respondents in the focus group and in the semi-structured interviews indicated that if they suspected they were HIV positive they would first take traditional herbs to make them physically strong in the hope that the nurses would not put them on ARTs (Anti Retroviral Therapies) immediately. Their argument was essentially that once you are on ARVs, you will grow a dependency and 'that is the end of you', one participant said:

"... the truth is that a person was not made to take pills everyday. Food every day but pills can become poison. Even food except for water they tell us can become

poison. Once you take the pills for a week if you stop the next week you become sick, not because you are HIV positive but your body has been taught to be lazy, it has forgotten how to fight... to stand... for itself. Like a baby if you give it formula milk it looks down on the breast milk, the bottle is easy is less work and ... it has sugar or is sweet” [Researcher’s field notes]

Several people in the focus group felt that is a form of preventive behaviour not to take ARVs immediately, because you are giving your body a chance to reconstruct and recover. Tellingly almost all group members felt since people taking ARVs also die the pressure for people to test and then be on treatment is a ruse. That government was just issuing out ARVs so that they may be seen to be doing something instead of dealing with the real problems presented by the disease. The feeling was that public health messages are deceptive; they sell ARVs as if it were the ‘magic bullet’, the all assorted solution to the disease. That public health messages play down the side effects of ARVs, public health messages play down the reality that if a patient is going to be on ARVs, then that person needs a constant supply or source of nourishing meals, and health food.

Can the Government Cope?

On the other hand, a number of informants/participants in the focus group expressed worry and concern over government’s financial ability to keep a constant supply of ARVs. One participant asked a telling question:

“If what the government is saying is true that over 42% of the people in Swaziland are estimated to be HIV positive, does that not mean that in a way about the same number of people will in time need ARVs, this government struggles to treat flu ... you go to hospital and they tell you they only have vitamin C and panado, they have run out of cough mixture, how are they going to afford these ARVs if they can not afford cough mixture which costs ten Emalangi at the chemist”[focus group transcripts and field notes].

As she was making her comments the group burst out laughing with one of them saying “*we will all die from the flu even before AIDS gets to us*”. I noted from their facial expressions and shaking of heads by some that even though they were laughing this situation worried them a lot. The reality of southern Africa is that almost everyone including the researcher, has either lost a close friend, relative, neighbour, work colleague through this pandemic and sometimes the laughter and sense of humour is there as a survival tool instead of grief and tears. Instead of crying the people might choose to laugh, it does not mean they are not afraid it means they are terrified.

These sentiments seem to be sustained by newspaper reports that patients on anti-retroviral therapies were being turned away at health centres because the ‘pills’ had still not arrived from South Africa, thereby being forced by the inconsistent supply to not comply with their prescribed dosages. The statistics on how many people are on ARVs in Swaziland remain weak and unreliable because they are based on a new patient information data collection system that has recently [2007] been put in place, however even these statistics give an idea that a large scale up from an estimated 600 people in 1998 to over 30 000 in 2004 [Whiteside et al: 2005] is occurring. They also show an encouraging level of adherence especially with those patients who are being cared for in the private health care system e.g. company clinics and private doctors.

Unfortunately information from the traditional health care system is even harder to come across; and yet there is no doubt that there are more HIV positive patients depending on this system than there are people in the bio-medical health care system. Informants within the public health care system feel that information from traditional healers on their numbers of HIV positive patients is possible to obtain with proper training of all registered traditional healers. Naturally traditional healers are secretive and perhaps confidential as well about their healing formulae and strategies but they would share information in general none specific terms.

Several informants working within the civil service including teachers voiced strong concerns about the ability of government to finance ARTs sustainably, without compromising provision for other non-AIDS related health care needs such as malaria,

anaemia, child birth and immunisation programmes. It appears that whatever public health message government sends, out people tend to receive it with remarkable scepticism because of lack of trust in the government in its performances and general integrity. There continues to be public concern over corruption in the procurement of medicines and drugs by government officials; and that due to this mismanagement people feel that financing health care will not be a reliable and consistent service offered by this government. The impact of good governance on HIV and AIDS related programmes seems to be another area of social science that needs to be researched more in the sociology of Swaziland. Governance seems to have a resonant impact on accessing health care Whiteside et al cautions:

“On the other hand, ART has the potential to ease hospital inpatient loads and some of the challenges presented by the dual health care systems in Swaziland, both the bio-medical and the traditional. The need for inpatient services, TB care services, and home based care needs are not projected to drop” [Whiteside et al 2006: pgs 54].

Whiteside makes the point that the effects of a struggling health care system will reverberate throughout the country over the long term and that in order to prevent this committed actions on how to monitor this needs to be made now within both the traditional and bio-medical public health messages. That in the long term; the increasing demand for health care service and the decreasing ability of the government to provide it will translate into a substantial drop in service quality and health system effectiveness. HIV and AIDS is already commonly perceived to have played a large role in compromising the quality of care as a result of rising patient loads with complex HIV/AIDS related illnesses, in combination with staff shortages and low morale and even lower faith in the government [Whiteside et al: 2006]. The capacity of the family based and government based health care system to persevere in the face of HIV/AIDS is what will, to a large degree, determine the impact of the epidemic on the rest of the economy and the rest of the society

Factors for Accessibility and Availability

Fetson et al (2009) makes the point that there are a number of factors that hamper ARV access in Africa related both to distribution but also production. Citing Medecins Sans Frontieres [2006] he explains that these factors include:

- Shortage of health workers and the high costs charged to patients for the drugs and clinic visits;
- Too few children receiving ARVs because of the lack of diagnosis and treatment tools as well as the lack of strategies to prevent mother to child transmission;
- Failure to coordinate TB and HIV control programmes and a lack of tools to diagnose and treat TB in HIV patients and;
- Newer formulations and combinations of drugs are often not available or registered in developing countries resulting in a lack of access to the best drugs that are available.

I think he makes a valid observation that availability and costs of ARVs is a major threat to the health of many people in the developing world especially Africa; where some countries as a result of HIV and AIDS are actually showing signs of losing any developmental gains ever made prior to the arrival of the pandemic. Even where governments are able to help the lack of viable roll-out strategies is often times a huge impediment. Whether or not people want to listen to public health messages advising them to test for HIV and begin ARV treatment if they need to a great number of people in the developing world have to ignore these messages and instead continue to rely on the steadier supply and care of traditional health medicines and practitioners. Fetson makes the conclusion that:

“Addressing the problems of public health in Africa will heavily depend on the public health messages growing out of the people’s perceived realities and not super imposing ‘enlightened thinking’ on the people. This will also depend on the structure and scope of funding for health communication research, communication development infrastructure, health development and health product development programmes. Although investment in health research is increasing, evidence suggests that African countries have not met targets”
[Fetson et al: 2009 pg 4].

There are countries like Swaziland who are totally dependent on neighbouring South Africa for procuring drugs and medicines. Swaziland has no drugs and medicines council of their own even to decide which drug and medicine to accept and what standards to even use making that decision. These countries are certainly a long way from developing their own medicines, except for traditional medicines. Dependence on traditional medicines is not a choice for many Swazis even when the public health messages try and explain their unsafety and lack of suitability. There is some evidence to show that South Africa and Egypt are involved in some level in developing health product in scientifically controlled programmes. However, these programmes are heavily dependent on foreign donor funding, this makes their sustainability worrisome. Governments need to be the bigger contributors to increase the fiscal viability of these programmes.

The Nepad's monograph (Fetson: 2009) shows an example of an innovative south-south cooperation where there is more government involvement:

“An innovative focus pervades South-South initiatives such as Brazil’s work with Mozambique and Angola to build stronger clinical research capacity. Brazil is to help strengthen Portuguese speaking African countries’ public health research activities through educational linkages. Fiocruz is to coordinate a project which sees Brazilian researchers support a Masters course in public health research to be run at the Angola National School of Public Health. If successful the project will be rolled out to Mozambique and other African Portuguese speaking countries. The project, supported by the Angolan government and Capes, Brazil’s federal research funding agency, allows Brazilian researchers to teach on the two year Masters course in Angola and for Angolan students to spend three months of their second year in Brazil doing research and writing their dissertations at Fiocruz” Fetson et

al: 2009 pg 41]

It seems to me that this could be a good way to innovate public health research and make the science work for people's wellness. The whole idea of this project is to encourage students to use everyday medicines found locally in Angola or Mozambique in creating formulae which are scientifically proven into cures or make meaning contribution resulting in making public health and traditional local construction of illness meet each other somewhere and in mutual respect.

Conclusion

I should conclude this chapter by looking at a few examples of the most popular public health messages given by the study participants and what they may seem to reflect. The first one was popular among men more than women. I found its interpretation highly controversial. This is a public health message sponsored by PEPFAR for male circumcision. It is almost 100% based on radio, there are no pictures, no skit (short educative play) and is not advert promoted. Instead they got together a group of popular radio DJs including a few from South Africa, had a no rules discussion about protection from HIV infection as an open ended topic. Basically in this message circumcision is highlighted as one of many ways by which a man can protect himself against getting infected with HIV. Of concern to me however, was the fact that the long ques at family life centre clinics are there because people have decided that if this is one of many ways to 'prevent' getting infected it is the better option to having to deal with using condoms every day.

One informant, who is a male teacher at Motshane High School explained that the truth is that a number of young men in Swaziland have more than one girlfriend whether they are married or not and that these relationships are not only concurrent but they are long term. Instead of choosing to use condoms with one or both it is easier to get circumcised and live

life as if HIV was no issue. Confounding. Upon further probing on my part, he explained that in the absence of exciting job prospects or any reason to be hopeful for the future, sexual activity becomes the only self affirming, affordable and accessible source of pleasure and excitement, whether or not he is in love with one or more girls.

The second frequently cited example of public health messages is one also co-funded by government and USAID (United States Aid for Development) through Pefar. This one is called Believe, Begin and Become. This is mainly popular among teenagers especially girls, it is mainly based on the newsprint and its main thrust is on encouraging young people to have trust in themselves. To believe in themselves, begin to change how they make decisions and then become a self confident generation. It has no particular drama except that it seems to have gone a long way in attracting the attention of a number of schools who have signed up and sent the career guidance teacher for training in order to introduce and run the programme in each school. Its upbeat outlook seems to resonate with the youth. The fact that it does not directly engage them with talk about sex was cited as one good thing about it. One informant explained that as young people they feel like they are over bombarded with sex-talk (sex-education), that it sometimes feel like they are being accused and blamed for all sexual ills of Swazi society. Words like 'the fact is we are sexual', 'it is not a sin to be sexual', 'parents and teachers have a problem accepting we are who we are' were used quite often.

The third public health message that seemed to be also among the popular was the WALK campaign. This campaign was initiated by the Ministry of Health, Adolescent Health and AIDS department. The W is for Wait, the A is for Ask and the L is for Learn and the K is for Know. Even though I could not confirm it this is not a new campaign, however the coordinator explained that young people liked this one because of the upbeat tempo. It was mainly based on poster boards, which can be seen in a number of schools, youth centres even at the university campuses. Even though this campaign seem to have no major conflict with traditional understanding of public health I thought save for the pretty, colourful pictures it really has no strong message about HIV and AIDS. This is a good message for education as a sector but says very little about adolescent health or teenage HIV and AIDS issues.

The last public health message which seems to be more popular among health professionals themselves is the one about prevention of mother to child infection. This one is a number of huge wall pictures, charts and billboards basically flow charting the decision on whether to breastfeed or not to breastfeed for HIV positive mothers. It is meant to explain the 'forced' testing of pregnant women and also encourage them to use Nevirapine to prevent infecting their babies, especially at the birthing process. It seems to me that there is some tension and confusion on whether or not to breastfeed under these circumstances. Traditionally nurses and doctors have encouraged exclusive breastfeeding for a certain period of time especially at infancy; Swazi culture itself frowns at women who do not breastfeed their babies. However, with the advent of HIV and AIDS public health messages are at pains trying to give advice on what to do for HIV positive women. Some health professionals are unhappy with the very idea of 'encouraging' HIV positive women to fall pregnant in the first place.

According to popular public health education the risks associated with pregnancy are worsened by a weakened immune system they argue. The focus of these posters seem to be in telling the mother which ever way she decides the life of her baby and her own will be threatened and may be put in jeopardy by her actions. This seems to raise all kinds of tensions including human rights issues. The sociological question becomes to what extent should medical regimes and institutions interfere as well as asking about the extent of the government's liability to protect lives. A nurse at Motshane clinic made the comment that:

“As far as I can see pregnancy signifies, unprotected sex by an HIV positive female, something we should not even be talking about at this point in time. Even if the child is born HIV negative, the chances are we have a new potential orphan in our hands, worse if the baby is born HIV positive, who will look after it once the parents die. If they are positive and having unprotected sex, what are the chances that any one will convince them to take ARVs consistently?” [Researcher's field notes]

CHAPTER 5

CONCLUSION

Development projects and programs that succeed are based on understanding of local practise and preferences, rather than on internationally 'generalized models' of how people or villages should behave and what they should want... Health promotions strategies need to be put into place to better engage and support families and communities in preventing disease, optimize caring, creating the demand for services and holding service providers to account. This approach changes the emphasis from the content of the message to the characteristics of a community's organisations and institutions" [Chopra and Ford: 2005, pg 1].

The study came across a lot of evidence that there is a lot of personal strife as a result of people seeking the best health care they can find for themselves and their families. There also seems to be a general consensus that it is best practise to avoid the 'cookie cutter' approach in sending out public health messages. Chopra and Ford (2005) make the point that in view of the fact that there is increasing evidence that even when high levels of knowledge are attained through behaviour change messages, individual practise may not change accordingly. Further, they make the conclusion that if we are to make an impact we must find a way of working alongside entrenched cultural and societal norms, values and beliefs that have such an important impact on the effectiveness of health programmes. We need to find an approach which changes the emphasis from the content of the message to an analysis of the realities of the society we are communicating in.

Community enhancement programmes and public health officers engaging the population at a highly inconsistent pace seems to be the major source of conflict and suspicion. Public health programmes seem to be heavily donor driven and whatever is the priority for the donor of the day, month or year is quickly prioritized for the public. Forgetting that the communities have on-going health concerns that are daily being addressed through

indigenous health care systems. In the end there are two systems and health ideologies fighting over the same community and population. On the one hand there is the 'bio-medical' public health messages which are brought into the communities by 'visiting' health education officers. On the other there is the traditional and cultural health seeking ways which are passed on from neighbour to relative, to friend, to child to sibling on a more consistent if not daily method. It is this 'opposition' that leaves many a community vulnerable to epidemics such as Malaria, Tuberculosis and HIV and AIDS. Chopra and Ford (2005) put it more eloquently:

"In this conceptual framework, health promotion is acknowledged as an ongoing activity within a community – unlike campaign - style communication, which is seen as a distinct activity carried out by professionals. People communicate constantly as they make daily decisions, explore strategies for surviving and coping, discuss norms and standards to apply in their communities, absorb and apply new information and experience and affirm themselves"[Chopra and Ford: 2005 pg 4].

I agree a lot with their conclusion, people adapt and change their survival and coping strategies as the communication around them makes new information available, or places it in a different context. They assess and analyse their situations continuously. Through out the study I was confronted by the interviewees' feelings of being objectified by public health programmes that are meant to shepherd them into change for 'appropriate' behaviour. Programmes that are supposedly made to make them stronger as a community must for some reason start by knocking down their sense of who they are. A blatant disrespect and dissing of their traditions led to the source of tension and feelings of mistrust towards a number of well meaning public health messages. Chopra and Ford (2005) make the argument clear that the task of engaging community members in any development agenda; especially to do with their health seeking ways, becomes more an exercise in facilitation rather than one of designing and delivering messages for change. Whether or not the change is a desired one becomes irrelevant.

It became evident to me the more I worked on this research project that for any public health initiative to be welcomed without suspicion within traditional communities principles of identifying with poor people should apply. Health education officers should pay more attention to the people's natural instinct to pursue self-determination. Great effort need to be made to ensure that the processes of community involvement are respectful of local norms and values, systematic and consistent and inclusive of the different world views. In Motshane and possibly in the rest of Swaziland there is a notable breakdown in the closeness between traditional leadership and virtually all government departments. The Chief's secretary told me:

“My child the people from Mbabane, (civil servants and NGO workers) come here to search (word used could also mean fault finding mission) us and see if we have lice. When they call a meeting they are worried about numbers because they must report us to government, if they come and they do not like the attendance, they talk to you as if the whole community is just children, naughty children who will put their fingers into a fire unknowingly. Their tone changes quickly and they start making statement like if you do not use a condom you will die. I ask myself that in this community we have buried a number of people, none of them died because they did not use a condom, where were the condoms when these people died” [researcher's field notes].

Even though statements like these are reportedly common in other communities through out the nation they do reflect weariness on the part of the people of the many NGO and government driven public health education exercises. There is a clear need for more research into how a more nurturing and more inclusive public health system could be engendered; in consultation with both the bio-medicine practitioners and traditional healers. There is also a need for more research by African or Africa based social scientists into what are the innovative possibilities of collaborative work between the traditional healing systems as well as the western healing strategies. Fetson Kalua et al (2009) puts more succinctly:

“There is need for a common and shared understanding of what can be done in order to tap science, technology and innovation tools to address Africa's current huge burden

of disease. First African countries and research institutions in Africa have to show the qualities of leadership necessary for generating and utilizing technology and innovations in health in order to address disease trends that are peculiar to this continent. It is evident that these diseases are not being adequately addressed by the global scientific community for reasons which need no enumerating here” [Fetson Kalua et al: 2009 pg 2].

Other public health workers I spoke to called for more decentralization of some of the functions of the Ministry of Health, such as the social welfare and public health units. The Chief’s secretary’s comments also left me with a feeling that people also feel that there is a political agenda attendant with the visits by government agencies. They want to ‘report us’ somewhere. In other words even though we have our own elders here they are making us feel like ‘children’; because they draw power from elsewhere. The public health message is lost in the superimposition, and overbearing approach presented by how the message is delivered. The powerless relations can be very well improved by taking on a more respectful and human rights based approach.

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APPENDICES

Appendix (1)

Researcher greets the interviewee and asks to make a tape record of the discussion. Researcher goes through the consent protocol and when consent is given she switches on the tape. *The researcher will explain the purpose of the meeting and give background information on the study.*

In-depth interview guide

Date of Interview:..... Interview no:.....

Name of Participant:.....

AgeOccupation.....

Contact address and tele/cellphone.....

{Mr} {Ms} {Mrs} please tick accordingly

1. What is your major source of information on health?

.....
.....
.....

2. When you feel ill, emotional, physical or mental

who do you go and see.....

3. When you realise you have an illness or are not feeling well in general what do you do to deal with your illness e.g. stomach ache, pain in the ear or cold and flu?

.....
.....
.....

3. Can you tell me of one or more public health message, television, radio or newspaper advert, billboard, radio jingle, sms, church, school or home advice on health that you can think of?

.....
.....
.....

5. Why does it stand out for you? What other public health messages can you think of?

.....
.....

.....
.....
6. What do you think of public health messages in general? (*researcher will show samples of messages to enhance discussion*)

.....
.....
.....

7. Do you think the government/traditional public health messages are mutually supportive or in conflict? Please explain.

.....
.....
.....
.....

8. If in conflict (to no.7) what do you think needs to be done to bring in a mutually inclusive public health message? How?

.....
.....
.....
.....

9. There are traditional healers in this area. Can we talk about them? How many are you aware of? What do you think of traditional healers? Do you ever consulted them and how often? Please explain your reasons?

10. Are there any other issues that you would like to discuss?

.....
.....
.....
.....

Interview ends {Switch off recorder}

Interviewer thanks participant and gives opportunity to reflect on the interview experience

Focus Group Questionnaire

*The researcher will explain the purpose of the meeting and give background information on the study. **The recorder is switched on.***

Date of Interview:.....

Interview no:.....

Names of participants:

Contact address and tele/cellphone

.....
.....
.....
.....
.....
.....
.....
.....
.....

1. Please introduce yourself and tell the group how you would like everybody to address you during the course of this discussion.
2. What do you think of the public health information, education and communication (IEC) on HIV and AIDS in general?
3. Do you see any conflict with traditional and cultural health practices and norms? Explain and give examples.
4. How should these differences (if any) be reconciled?
5. Are there any other issues that you would like to discuss about the conflict between public health messages and cultural and traditional health practises?
6. Thank you for participating. ***The recorder is switched off.***

Semi-Structured Interview Guide

Date of Interview:.....

Interview no:.....

Name of Participant:.....

Contact address and tele/cellphone.....

{Mr} {Ms} {Mrs} please tick accordingly

Researcher greets the interviewee and asks to make a tape record of the discussion. Researcher goes through the consent protocol and when consent is given she switches on the tape.

The researcher gives a brief overview of the research project and its primary aim and then gives the respondent an opportunity to seek clarity on the topic.

1. What do you think of this topic?
2. Do you have any concerns about the state of public health messages and how they are received by the people in your area, and or nationally.
3. What would you like to see happening between public health promotions by the ministry of health and those health messages from the traditionalists.
4. Are there any other issues that you would like to discuss?

The researcher switches off the tape recorder and thanks the participant for time spent on the interview and gives an opportunity to the respondent to chat or ask any process related questions e.g. when the study will be published or who else is being interviewed. The reason for this is that it may create a snowball opportunity in case the respondent knows of somebody who may have extra information on any part of the topic.

Appendix 2

CONSENT FORM_(*FOCUS GROUP*)

I, _____ (name and surname), agree to participate in this research project on public health messages about HIV/AIDS; that is being conducted by Geinekile Dlamini an MPhil student from the University of Cape Town, UCT.

I understand that the purpose of the study is to hold a group interview to find out about the people of my area's attitudes and perceptions around this topic.

I understand that the study involves a focus group interview that lasts an hour or less, which will be audio taped, transcribed and later on analyzed.

I understand that my participation in this study is entirely voluntary, and that if I wish to withdraw from the study or to leave, I may do so at any time, and that I do not need to give any reasons or explanations for doing so. If I withdraw from the study, I understand that this will have no effect on my relationship with any of the individuals involved, the researcher or with UCT.

I understand that there will be no violations of my own and others' privacy. I therefore undertake not to talk or write about any part of the interviewees' private experiences and or contributions that would be considered too personal, embarrassing and or humiliating.

I understand that all the information I give will be kept anonymously to the extent permitted by my consent, and that the names of all the people in the study may be kept anonymously where appropriate or where they have asked the researcher to do so.

I also understand that I have an obligation to respect the privacy of other members of the group by not disclosing any personal information that they share during the discussion.

I understand that I may not receive any direct benefit from participating in this study, but that my participation may help others in the future.

The researcher has offered to answer any questions I may have about the study and what I am expected to do. I also understand that I may withdraw my consent anytime during the course of this research project.

I have read and understand this information and:

I agree to take part in the study

I do not agree to take part in this study.....

Signature: _____ Date: _____

Signature: _____

University of Cape Town

CONSENT FORM (*semi-structured and In-depth interview*)

I, _____ (name and surname), agree to participate in this research project on public health messages on HIV/AIDS; that is being conducted by Gcinekile Dlamini an Mphil student from the University of Cape Town, UCT.

I understand that the purpose of the study is to hold an interview to find out about my attitudes and perceptions around this topic.

I understand that the study involves an interview that lasts an hour or less, which will be audio taped.

I understand that my participation in this study is entirely voluntary, and that if I wish to withdraw from the study or to leave, I may do so at any time, and that I do not need to give any reasons or explanations for doing so. If I withdraw from the study, I understand that this will have no effect on my relationship with any of the individuals involved in the project, the researcher or with UCT.

I understand that because of this study, there could be no violations of my own and others' privacy. I have been asked not to talk about any of my own or others' private experiences that I would consider too personal.

I understand that all the information I give will be kept confidential to the extent permitted by law, and that the names of all the people in the study may be kept confidential where appropriate or where the researcher has been asked to do so.

I understand that I may not receive any direct benefit from participating in this study, but that my participation may help others in the future.

The researcher has offered to answer any questions I may have about the study and what I am expected to do.

I have read and understand this information and I agree to take part in the study.

Date: _____

Signature: _____