

CENTRE FOR
SOCIAL SCIENCE RESEARCH

Aids and Society Research Unit

**HIV ILLNESS MEANINGS AND
COLLABORATIVE HEALING
STRATEGIES IN SOUTH AFRICA**

Elizabeth Mills

CSSR Working Paper No. 157

May 2006

Elizabeth Mills holds an Honours degree in Social Anthropology from the University of Cape Town and is currently completing her Masters degree in Development Studies at the University of Cambridge.

This working paper is a forthcoming article in *Social Dynamics*, vol. 31, no. 2.

HIV Illness Meanings and Collaborative Healing Strategies in South Africa¹

Abstract

Traditional health care practices were formally recognised and advocated by the World Health Organisation (WHO) in 1978. The implications of the WHO's directive have been diverse, and have shifted over the subsequent three decades of international health care. Similarly, the landscape of disease and illness, within and beyond South Africa, has been significantly influenced by the burgeoning international and regional HIV-epidemic. In South Africa the move to democracy was coupled with a decentralisation of the National Health System (NHS), increasing rates of HIV-infection, and a political desire to recast traditional healing as an African cultural practice deserving of state endorsement. This paper considers the multiple illness meanings and treatment strategies employed by HIV-positive people and traditional healers living in Cape Town, South Africa. In order to offer an understanding of treatment strategies that move between the biomedical and traditional healing, this paper draws on the distinction between the psychosocial aspects of illness and the biological disorder of disease. The first section of the paper presents a case study of an HIV-positive woman's experiences of the illness and the disease of HIV, and explores her concomitant health care strategies based on her shifting conceptions and experiences of HIV. The subsequent section moves into a detailed analysis of interviews conducted with a sample of traditional healers. This section highlights the traditional healers' overlapping and also divergent views on the causation and treatment of HIV and AIDS-related illnesses amongst their HIV-positive clientele. Finally, this paper places traditional healing practices and practitioners within the context of South Africa's NHS in order to suggest some of the potential benefits and limitations around collaboration between biomedical and traditional health care paradigms.

Introduction

The majority of people living in resource-poor settings in Africa depend on traditional healers for psychosocial counseling and health care. In South Africa, it has been estimated that over 300 000 traditional healers ply their trade, that is, approximately fifteen times more than the number of medical practitioners (Liddella, Barret and Bydawell, 2005). Given the current AIDS epidemic, in which over five million people have become HIV-positive in South Africa (UNAIDS/WHO, 2005), there is a strong argument for mobilising both

biomedical and traditional health practitioners to address the complex psychosocial and physical nature of HIV-infection and AIDS-related illnesses.

The World Health Organisation initially marked the importance of formally recognising traditional healers as public health care providers at an international level in 1978 at the Alma Ata International Conference on Primary Health Care. In 2002 the WHO renewed this commitment to increasing the role of traditional healers in primary health care provision; this commitment was also taken up by the African Union through the declaration of the decade of African Traditional Medicine from 2001 to 2010 (www.africa-union.org). The urgency behind the WHO's call for the inclusion of traditional healers in public health care in 1978 differs to that which prompted the latter call by the African Union in 2001:

Earlier, the inclusion was motivated by the problems of shortage of personnel in the modern sector, the self-reliant character of traditional medicine, its cultural sensitivity and its therapeutic value. Presently, while the above reasons remain valid, the increasing social devastations by the AIDS pandemic in poorly performing health care systems confirm the need of involving the traditional health sector. (Kaboru, Falkenberg, Ndulo, Muchimbac, Solo and Faxelid, 2005: 2).

The debate on intersectoral collaboration between biomedical and traditional healers mainly has focussed on the risks and feasibility associated with collaboration from a policy (top-down) perspective; frequently critiques centred on the pros and cons of including traditional healers in the formal health care system (see Green, 1994; Kaboru *et al.*, 2005). Irrespective of whether collaboration is feasible or even desirable, it is important to gain a better understanding of the way that traditional healers and their clients move between the different healing paradigms. This paper takes a few steps towards extending our knowledge of this issue by means of an ethnographic study of the way that traditional healers are responding to HIV/AIDS and the way that HIV positive people may be negotiating their way between biomedical and traditional healing strategies.

The first section presents a case study of an HIV-positive woman's health seeking behaviour, which includes drawing on healing strategies that range from using traditional medicine, allopathic drugs and spiritual healing. This case study underlines Kleinman's (1988) distinction between the psychosocial aspects of *illness* and the brute materiality of physical disorder, namely *disease*, arguing therefore that different health care options fulfil idiosyncratic and differing needs of HIV-positive people. Following this consideration of the fluid nature of health seeking behaviour, the subsequent section explores a range of illness meanings and treatment perspectives held by a sample of traditional healers who work in the Western Cape.

As demonstrated through the case study and qualitative research with traditional healers, it can be seen that traditional healers adopt a range of healing practices and sometimes encourage their clients to use a combination of biomedical and traditional treatments that would best serve their various psychosocial and physical needs. The final section of this paper explores the attitudes of traditional healers towards collaboration with biomedical practitioners in the area of HIV/AIDS prevention and treatment.

The research that forms the basis of this paper was conducted between May and August 2005 amongst people living in informal shack settlements on the border of Cape Town's central business district.² The author and assistant researcher, Busi Magazi, used semi-structured informal in-depth interviews in order to explore pre-determined themes and, importantly, to allow space for new themes to emerge in the course of the interview. Access to traditional healers was by no means straightforward, and carefully formulated information and consent forms were distributed in order to allay some of the traditional healers' concerns that the researchers were acting on behalf of an antagonistic government wishing to discredit their work. Fortunately, however, in many cases, following the interview, the traditional healer would suggest a colleague or friend who would be willing to collaborate with the researchers and we would then move on to set up a meeting with the next traditional healer. This research does not aim to represent the views of all traditional healers living in South Africa, but to put forward, and make sense of, the perspectives of those traditional healers involved in this research project.

A Contentious Term

The term 'traditional healing' falls into a terrain of contested discourses, and at times has conjured up images of ancient healing methods rooted in a particular history and place. This paper concurs with Wreford's (2005:3) assertion that it is important to understand that traditional healers are not fixed relics of Africa's history, but actors in a complex and dynamic world in which they find ways to thrive and adapt to constant change. To make matters more complex, traditional healers can occupy multiple social roles. As Green states:

traditional healers are priests, religious ritual specialists, family and community therapists, moral and social philosophers, teachers, visionaries, empirical scientists, and perhaps political leaders in addition to being healers in the more restricted Western sense (1994: 36).

Traditional healers should thus not be understood as forming and stemming from a united and generic body of healing practices and beliefs.

Furthermore, as Mary Douglas asserts, science and (bio)medicine also ‘can be seen as cosmologies: as systems of natural symbols which we today can make sense of our existence in the world’ (in Jones, 2004: 705). This paper demonstrates how people are able to move between, and often straddle, multiple treatment cosmologies. Working with bounded dichotomies in which ‘traditional’ and ‘biomedical’ knowledge systems are rooted in ‘local’ or ‘global’ epistemologies respectively is thus misleading. This paper recognises the problematic use of the term ‘traditional healing’ whereby these false dichotomies are reinforced, and it works actively to challenge these perceptions by illustrating the multiple ways in which traditional healers and their patients have accommodated and responded to the shifting terrain of health care in South Africa.

Illness Meanings and Healing Strategies: A Case Study

In the human context of illness, experience is created out of the dialectic between cultural category and personal signification on the one side, and the brute materiality of disordered biological processes on the other. (Kleinman, 1988: 55).

The way in which illness is understood and experienced, whether it is through personal signification, cultural category, biological disorder or a combination of the above, informs the kind of treatment that is sought to heal the illness. However, the way in which one understands illness is itself informed by numerous factors, not least public policy, the media and epistemologies drawn on by health practitioners to support their various forms of health care practices. Therefore, the epistemology that informs and supports a particular form of treatment will in turn reproduce, or challenge the individual’s understanding of his or her illness, continuing or reconstituting the cycle.

Kleinman (1998) argues that *illness* should be understood as the psychosocial and cultural aspect of *disease*. The differentiation between *illness* and *disease* is significant in this discussion because it challenges biomedical discourse to move beyond pathologising the individual to a deeper understanding of the complex factors that coalesce to create the experience of *illness*. In turn, this calls for a redefinition of ‘suffering’ as an interpersonal and intersubjective experience that extends beyond the individual into their social environment. In line with this notion of ‘social suffering’, the chronic illness of an individual can be understood as influencing and influenced by the individual’s social environment, thus possessing a social history. Both the biological *disease* and the psychosocial *illness* of HIV play out in various ways for HIV-positive people and their social environments. Networks of treatment options are drawn on, as

demonstrated in the vignette below, in order to access both physical health care and psychosocial care at various stages of the disease. As demonstrated below, ontological beliefs around HIV affect the way in which it is experienced and treated by the HIV-positive individual. As a result, numerous sources of health care are drawn on in order to treat different aspects of HIV, as both an *illness* and a *disease*.

A Case Study of Nana's Treatment Strategies

Nana is 28 years old, and lives in Khayelitsha, Cape Town's largest informal settlement. She has a one-year old child, and because she works as a full time office assistant, she leaves the child in the care of her sister during the week. In March 2001 Nana tested positive for HIV, and started taking antiretroviral treatment in February 2002. Unlike most other unemployed people, she was able to access antiretroviral therapy by participating in the pilot antiretroviral treatment project operated by Medecins Sans Frontieres and the Western Cape Provincial Government. During the time between her positive diagnosis and going on treatment, recurring skin rashes and other ailments concerned her family and, unaware of her HIV status, they encouraged her to see an *Igquirha* (isiXhosa name for *isangoma*) in order to ascertain why she was 'always so sick'. Although Nana knew that she was HIV-positive, she also felt that there might be a mystical reason why she had contracted HIV, and continued to suffer from a painful skin rash and other recurring ailments. In the eleven months between March 2001 and February 2002, Nana visited a total of three traditional healers in order to ascertain the metaphysical aetiology and necessary treatment of her HIV-seropositivity and recurring illnesses.

Each of the traditional healers confirmed Nana's belief that her illnesses were not simply a cause of a physical 'disorder': Nana had been bewitched. The traditional healers claimed that a person, or group of people, in Nana's community were jealous of her because she was young and educated. The third and main traditional healer that Nana consulted said that Nana's main complaint, a serious skin rash, was a result of having been cursed by a witchdoctor to be a reptile, like a frog or a snake. Her skin, Nana said, was peeling in a similar way to that of a snake shedding its skin. Henderson suggests that the skin is deeply symbolic of the body's envelope, and when it erupts or is no longer smooth, highlights the 'failure of the bodies to hold, to maintain a modicum of coherence' which in turn 'is externalised and mirrors (the) experience of collapsing sociality' (2004: 5). Nana's diagnosis, and Henderson's description of the symbolic nature of the human body's skin, highlights Bergland's contention that illness is not simply related to physical disease but to social disruption and conflict; in turn, health is not simply a state of physical well-

being but also one in which the individual moves in a social context free from malevolent forces or social conflict (1976).

Significantly, Nana did not inform any of the traditional healers that she was HIV-positive; she felt that they should be able to tell her if she was indeed HIV-positive. On the one hand Nana wanted to test the proficiency of the traditional healers she visited, and on the other hand Nana felt ambiguous about her HIV-status and partly believed that both its symptoms and the virus itself could be addressed by traditional healers. When Nana discovered that she was HIV-positive she had a limited understanding of the virus but a clear understanding of the potential stigma she would be exposed to if she disclosed her status (see Mills, 2004; Ratele and Shefer, 2002). The traditional healers' diagnosis of bewitchment due to jealousy mitigated, to an extent, Nana's distress at being HIV-positive and concern over its possible social ramifications, like HIV-related stigma:

If mystical forces dominate human experience, then believing that these are rational forces brings a sense of order to unfortunate events. (Liddela, Barrett and Bydowell, 2005: 684)

The affirmation that Nana's illnesses were a result of someone's jealousy highlighted positive aspects of Nana's life, her professional success and education, rather than what she felt was a deeply discrediting attribute: her HIV-positive status.

The diagnosis of bewitchment deflected Nana's immediate focus on what she might have done in order to contract HIV onto the role that jealous neighbours may have played in making her ill. On the one hand, Nana's mortification at being HIV-positive was partially allayed by the traditional healers' diagnosis. On the other hand, however, the diagnosis of bewitchment contributed towards social disruption and distrust between Nana and the people suspected of bewitching her. Nana said that she believed she had been bewitched, and could understand why people in her community may have been jealous of her because she was beautiful and intelligent. She recalls having a visceral reaction to the 'evil atmosphere' of the community in which she had been living, and decided to move from her home to a different location once she had recovered from her 'bewitchment'. Nana said that each of the traditional healers were careful not to disclose any names of the people responsible for bewitching her. Although this protected the identity of individuals, the diagnosis of bewitchment resulted in Nana's general mistrust of her community, which indicates a possible negative impact of diagnoses that label people, albeit generally, within the sick individual's social environment as malevolent.

In considering Nana's range of treatment choices, this paper draws on Green's work (1994) in which he argues that a lexicon of proximate and ultimate illness

causes encompass and stimulate multiple aetiologies and healing options. The notion of 'proximate illness causes' relate to the physical symptoms of the disease, whereas 'ultimate illness causes' are considered to lie in the mystical and spiritual realm. For example, Green (1994) explains that a Swazi mother will concede that her sick child has diarrhoea because flies settled on its food (proximate cause) but will also want to ascertain who was responsible for sending the flies to make her child ill (ultimate cause). Both the proximate and ultimate causes of illness require treatment: the proximate cause can be treated by medical personnel whereas treatment for ultimate causes of illness, which lies primarily in the spiritual and mystical domain, is sought from traditional healers or diviners (Green, 1994; Liddella *et al.*, 2005).

Nana initially consulted a traditional healer because she wanted to establish the ultimate cause of her recurring skin rash. Her family supported this decision because they felt that the recurring nature of her ailment was inexplicable and unsuited to biomedical intervention. Each of the three traditional healers attempted to treat both the 'bewitchment' itself, the 'ultimate' cause, as well as the physical manifestation of the 'bewitchment', which took the form of her skin rash. The third traditional healer that Nana visited performed an extensive cleansing ritual, lasting seven days, in order to address Nana's bewitchment. As part of her treatment with this traditional healer, Nana moved into the traditional healer's home and spent the majority of the day inhaling steam infused with particular medicine. As part of the final climax in Nana's treatment, she was taken into 'the bush' in order to banish the curse that she had been placed under.

The traditional healer lived in a shack settlement in Cape Town away from large areas of vegetation, and therefore, 'the bush' that Nana refers to was, in reality, a small plot of trees in the vicinity of the traditional healer's house. Once in the bush, Nana was told to take off all of her clothes. The traditional healer had pre-selected a chicken, which had particular symbolic significance in counter-acting the malevolence of the curse that Nana was under. The chicken was killed by slitting its throat, and the traditional healer collected the chicken's blood in a small container. Nana was instructed to drink a mixture of the chicken's blood with brandy. After Nana had drunk the blood and brandy mixture, the traditional healer explained that death had been put inside her body, and that in order to release the death, she needed to cut open the black spots on Nana's skin. As Nana told me about this procedure, she pointed to the freckles on my arm, saying that they were the equivalent of the black spots on her body. Nana's black spots were cut open with a razor, and the 'bad blood' was drained out of them. The traditional healer proceeded to rub a mixture of medicine into the wounds in order to prevent any 'evil or death' from re-entering them. Thereafter, Nana was instructed to place the chicken in the ground and to address the chicken as if it was the person responsible for her bewitchment, saying 'My

name is Nana, and you must stop hurting me.’ In this way, the death of the chicken symbolised the termination of Nana’s bewitchment.

This ritual, as described by Nana, represents a complex healing cosmology in which social affairs are represented and managed through ritual in order to reinstate social and individual health (see Bolle, 1983; van Baal, 1976). The presence of ‘evil’ in the ‘bad blood’ beneath Nana’s dark spots echoes medical anthropological research into the symbolic interpretations of the body and its fluids; Benedict Ingstad, for example, describes Tswana medical beliefs that operate on two levels of causality, namely the origin and immediate cause of illness (1990). Blood, which is seen as one of the most critical life essences, is used frequently in Tswana aetiology in order to explain the immediate cause of sickness. In turn, cleansing of ‘dirty blood’ is a concomitant aspect of the healing of sickness. The death of the chicken represents the symbolic death of the Nana’s ‘bewitchment’ and the commencement of her healing. This ritual affords Nana an opportunity to address the perpetrators, albeit figuratively, and to reach a sense of closure and resolution. Nana’s description of the ritual and its symbolic value suggests that it occupied the dual space of resolving and sealing off (social and physical) malignancy and opening up a future of health in Nana’s physical body and social environment. Nana returned to the traditional healer’s home, and was cared for by the traditional healer for a further two days until she was fit enough to return to her family. After seeing this traditional healer Nana felt that she was getting better, and she recalls being pleased with the traditional healer’s treatment.

However, after a couple of weeks, Nana became even more ill, marked by significant weight loss, than she had been prior to visiting this traditional healer. With her life in danger, Nana decided to visit a medical doctor. She had felt that the traditional healer had been effective in addressing the ‘ultimate’ cause of her illness, namely the bewitchment, but the ‘brute materiality’ of what had developed into AIDS prompted her to seek biomedical treatment in order to address the ‘proximate’ symptoms of her illness.

At this point in Nana’s illness trajectory, she realised that she needed to address the ‘brute materiality and disordered biological processes’ of being HIV-positive. In Nana’s mind this was not antithetical to the aetiology that she had at first attributed to the symptoms of her disease. In this way, Nana’s experience confirms Kleinman’s statement that ‘experience is created out of the dialectic between cultural category and personal signification on the one side, and the brute materiality of disordered biological processes on the other.’ (1988: 55). Nana decided to not only address the *illness* of HIV, namely bewitchment caused by jealous neighbours, but also the physical manifestations of the *disease* of HIV, in this case, a radically diminished CD4 count.

In consultation with a biomedical doctor, Nana decided to take antiretroviral treatment (ARV). Nana said that the doctor had spent a long time explaining the causation and treatment of HIV and AIDS-related illnesses to her, and that this had allayed her concerns about taking ARVs. Aside from her realisation that ARVs were necessary to improve her health, Nana was influenced by her HIV-positive brother's positive experience of taking ARVs after he had been seriously ill with AIDS-related illnesses. A third reason, according to Nana, was that she felt sure that she was going to die, and after trying a range of non-allopathic treatments, she felt that she might as well try taking ARVs.

Nana's CD4 count increased over time, and she was gradually able to restore her health and re-enter the formal employment market. In 2004 Nana decided that she wanted to have a child. She explained to me that she experienced a large amount of criticism from other HIV-positive people for her decision to become pregnant. This is connected, according to Nana, to two main reasons. Firstly, she ran the risk of transmitting HIV to a child through childbirth, or breastfeeding, and secondly, she may not be able to raise her child if she died prematurely with AIDS-related illnesses. Despite these concerns, Nana explained that it was her right and legitimate desire to have a child. She consulted with her doctor and was told that the ARVs had reduced her viral load to such an extent that the risk of passing on HIV to her child was extremely low. Her child was born HIV-negative, which Nana attributed to the ARVs, and this played a critical role in Nana's ongoing active support for South Africa's antiretroviral roll-out.

This case study highlights the way in which Nana sought out different healing strategies in line with her shifting experience of HIV as an *illness* and as a *disease* and ties into Engel's (1960 in Viljoen, Panzer, Roos and Bodemer, 2003) biopsychosocial model which affirms that

social, biological and psychological factors comprise a complex system of interactions which determines the individual's health and vulnerability, as well as reactions, to disease. The biopsychosocial model challenged the single domain approach of the biomedical paradigm. (Viljoen *et al.*, 2003: 332).

According to this logic, health, or disease, can be seen as the product of perpetual interactions between each of the above-mentioned factors. Similarly,

the onslaught on health can therefore be from various entry points or even from various interactions. Interventions can similarly, within obvious limits, be performed at any of the interacting domains or even from a combination of entry points. (Viljoen *et al.*, 2003: 332)

Nana's treatment strategies were not understood by Nana to be exclusive or antithetical to each other, but rather that they were appropriate for treating

different aspects of HIV. Furthermore, Nana says that her beliefs about traditional healers fluctuate: 'Sometimes I do and sometimes I don't believe in *izangoma*.' Five years after Nana was first diagnosed with HIV she continues to draw on a range of healing professionals, like traditional healers, medical doctors and spiritual healers. For example at the time of her interviews for this study, Nana and her partner were seeing a spiritual healer in order to strengthen their relationship. In addition to seeing a spiritual healer, Nana has begun to attend church services. She said that she believes her relationship with her partner will only become stronger if she has a stronger faith in God.

This vignette highlights the myriad ways in which Nana experienced and treated both the *illness*, expressed through the diagnosis of bewitchment, and the *disease* of HIV, expressed through her dramatic weight loss and diminished immune system. Nana concurred with the traditional healers' belief that she had been bewitched and this did not undermine the medical doctor's prognosis that she needed to start taking ARVs. In his study of the Azande, Evans-Pritchard (1937) described their dual theory of causation, which made an implicit distinction between the how and the why of events. This is in line with Green's (1994) distinction between proximate and ultimate causes of illness respectively. The 'how' relates to the 'proximate' cause of disease, for example, a child is ill because s/he has eaten food contaminated by flies. The 'why' went into the local eschatology; it used empirical observation, and also the unseen or 'mystical' factors at work such as witchcraft. For example, the flies were sent through witchcraft to contaminate the child's food, causing the child to be ill. There was no contradiction in Azande visiting a western doctor to treat the manifest symptoms and still believing that the real reason for the illness lay elsewhere (Evans-Pritchard, 1937; Heald, 2003). This is in line with Nana's multiple approaches to the manifest expressions and metaphysical causation of her illness. In her understanding of HIV, she did not feel it necessary to choose between either traditional healing or biomedical care; she used multiple forms of treatment at different stages in her experience of the disease.

Nana's case study resonates with an international trend for HIV-positive people to draw on a range of complementary, alternative and biomedical treatment. Pawluch, Cain and Gillett (2000), for example, conducted a qualitative study in North America in order to assess 66 HIV-positive people's decision to draw on a range of health therapies. They argue that the interviewee's decisions to draw on complementary and alternative medicines (CAM) relate to, amongst other things, a desire to mitigate the side-effects of allopathic drug therapy and as a strategy for coping and maximising quality of life. Furthermore, and in line with the argument made through Nana's case study, these authors argue that beliefs about and experiences of health and illness significantly impacted the respondent's decision to access CAM. However, Pawluch *et al.* (2000) assert that these beliefs and choices are not mutually exclusive or fixed, and appeal to

the respondents on different levels and at different times over the course of their life.

Nana's initial approach to healing her ailments were informed, in part, by her social environment, especially her family, who encouraged her to see traditional healers for healing. However, as discussed above, Nana came to distrust the people in her community (beyond her family), and this eventually led to her moving to a different part of the country in order to avoid further bewitchments. The brute fact of continued ill health and severe weight loss, despite her work with traditional healers, motivated Nana to try an alternative health source: the clinic. In turn, her experience of taking antiretroviral treatment has also shifted her understanding of HIV-related illness, as well as her belief that it is possible for HIV-positive mothers to give birth to HIV-negative children. Nana continues to access a range of alternative, complementary and allopathic health care services, but draws mainly on allopathic medicine to treat what she understands to be AIDS-related illnesses. Having considered the demand for a range of health services through the lens of Nana's case study, the following section moves on to discuss a sample of traditional healer's understanding of illness and practices of healing in relation to HIV and AIDS.

Some Traditional Healers' Understandings of Illness and Practices of Healing

A striking aspect of Nana's case study relates to the belief that she was ill because 'death' and 'evil' had been 'put' into her body. Nana indicated that the traditional healers she visited viewed her healing as concomitant with purging and removing this pollution and death from her body. The notion of pollution as a cause of AIDS, and of illness in general, emerged as a dominant theme in the interviews with the traditional healers that participated in this study. In particular, the traditional healers spoke about getting the pollution from the inside of the person's body to the outside. Once the pollution was on the outside, in the form of pimples or (vaginal/penile) discharge, it could be treated topically.

Diso, a 35-year old woman who describes herself as a Christian and a traditional healer, believes that traditional medicine plays an important role in cleansing HIV-positive people's bodies. She associates spiritual healing with Christianity, and defines it as using blessed 'holy water' to provide spiritual healing and cleansing, on behalf, and in service, of God. Although she has not officially trained to be a traditional healer, she derives her knowledge of traditional medicines and healing through her dreams and communication with her ancestors. Diso said the following about the role of traditional medicines in cleansing HIV-positive people's bodies of pollution:

(Traditional medicines) bring out the dirt (from) inside, they cleanse the inside. People who have HIV have a collection of diseases. So the moment they take in traditional medicines if the blood was dirty, they will first feel the itching on the outside then they will develop big pimples, have vaginal/penile discharge and the eyes will be stuffed with white discharge. The medicines cleanse the whole body and the client can see that. (Interview with Diso, 2005).

Diso's statement also indicates the notion that sickness is moved from the inside of a person's body to the outside, through discharge, at which point the sickness can be topically treated and removed from the body. Similarly, the third traditional healer that Nana consulted insisted that Nana's 'black spots' marked the location where 'death and evil' inhabited her body, and therefore cut open these spots in order to remove the death from Nana's body.

Mnguni, an *inyanga* (isiZulu word for herbalist) and trainer for initiates, also believes in the value of moving the sickness out of his ill clients' bodies. In his work, Mnguni uses candles to facilitate divination, but sometimes he intuitively feels the state of his client's health when they enter his consulting room: "I feel it the moment the person steps in. I experience all his or her feelings" (Interview with Mnguni, 2003). Mnguni, like Diso, did not undergo official training as an initiate, and also draws on his ancestors for knowledge about traditional medicines and healing practices. Both Diso and Mnguni fulfil a number of roles that range from traditional healing to spiritual healing, to divination and training of other initiates who are entering the traditional healing profession.

Like Diso, Mnguni argued that traditional healers need to cleanse HIV-positive people because only once one can see the sickness on the outside of the client's body can the disease start to leave the body:

So when you as the healer are going to treat AIDS, you need to get some medicine for him to cleanse and get rid of the inflammations, after that he/she will get rid of the evil spirit. When that spirit is out, the sores or pimples will start showing on the outside. Then you need to cleanse that person inside. The person must steam. After the patient has done that and the pimples and sores show, he must continue using the medicines to burn the sores. When the sores have burned out you need to give him some topical medicines. (Interview with Mnguni, 2005)

Aside from the belief that disease is a symptom of pollution inside the client's body, there are also numerous understandings of the cause of HIV, and AIDS-related illnesses. Just as particular beliefs about illness influenced Nana's choice of health care (and vice versa), so too do they affect the manner in which traditional healers treat their HIV-positive clients.

Mnguni's approach to diagnosing HIV-positive people reflects his belief in the importance of cleansing for maintaining optimal health. He argues that he can tell if a client is HIV-positive because he can feel that their blood is cold, and can see that it is black. The latter is, according to Mnguni, a sign of the presence of impurities in the blood. In addition to this form of diagnosis, Mnguni argues that one of the principle causes of HIV relates to the use and behavioural implications of contraceptives like Depo Provera³.

The reason, the main cause of AIDS, if you recall in the olden days there was not as much prevention as we see these days. Many people use prevention, that is the cause of the spread of this disease. Many people have become careless. They say no, I won't get pregnant because I use the protective injection. (Interview with Mnguni, 2005).

Like Mnguni, Magagulu, a 38 year old male traditional healer, believes that he is able to diagnose a person's HIV-positive status during their consultation with him. Magagulu initially trained to be a spiritual healer, but unlike Diso, he rejected spiritual healing in favour of traditional healing after he was advised through his dreams to become a traditional healer. This is perhaps related to the extensive training that he underwent, which took place over 15 months, in order to become formally recognised as a traditional healer.

Magagulu shares Mnguni's belief that the use of Depo Provera is one of the principle causes of HIV. However, in contrast with Mnguni, Magagulu had a different understanding of why Depo Provera might facilitate HIV transmission. Of particular interest, is the notion that this contraceptive encourages people to move away from 'traditional norms', which, according to Magagula, include women menstruating every month.

I suspect it's because of the prevention that is used by women especially Depo Provera. I think it causes AIDS because it stops ovulation. It's natural that the blood should come out so if that does not happen, its likely to cause diseases because I think that poison is very strong ... We have also talked about this in our workshops with THO (Traditional Healers Organisation) that AIDS is caused by prevention. ... Something is not suitable for you if its stops ovulation for instance some people are abnormally big. That is the blood! It's all over the body because it does not come out. Some have bad varicose veins. It's the blood that is all over the body. So I am trying to say contraceptives are the cause of AIDS. (Interview with Magagula, 2005).

Magagula's assertion that women should menstruate each month is supported by his belief that women retain menstrual blood in their bodies and, because of this abnormal amount of blood, are therefore more susceptible to contracting and

transmitting HIV. In line with this assertion, Henderson highlights the asymmetry of pollution assignment which often highlights the woman as the 'transmitter' of pollution: "the acknowledgement of contamination as a two-way process demands a sexual symmetry missing in patriarchal structures" (2004: 19)⁴. Body fluids, it should be noted, are understood in different ways and are not necessarily viewed as generic pollutants. For example, Zulu epistemology attributes value to women's blood and men's semen as creating and nurturing the growing embryo (Berglund, 1976).

The biomedical search for a cure for HIV and AIDS is also reflected in traditional healing practices. Mnguni said that his patients were despondent about biomedical treatment of AIDS because they did not see clinics healing HIV-positive people. Unlike medical doctors, traditional healers can, according to Mnguni, offer a cure for HIV and AIDS. Given the traditional healer's concern to protect their knowledge, they were unwilling to elaborate on or justify this assertion. Mnguni's belief that traditional healers can offer a cure for HIV and AIDS might relate to his perception that his clients are cured when their health improves. Curing illness, therefore, is measured through visual and experienced improvement in health, as seen by the traditional healer and reported by the client. The potential disjuncture between biomedical and traditional practitioner's perceptions of 'cure' warrants further research as it has significant implications on the way in which HIV-positive people perceive the need for continuing with either, or both, biomedical and traditional healing methods.

Like Mnguni, Magagula also believed that there is a cure for AIDS and HIV. He states:

I think besides using traditional medicines, I believe that there is a medical cure for AIDS but the government does not want to give it. What I am trying to say is our government does not care about black people. (Interview with Magagula, 2005).

In treating HIV-positive people, Magagulu first looks at their clinic card to find out what stage the client is in. He believes that traditional medicine is much stronger than allopathic medicine, and that it is not advisable for ill HIV-positive people to use traditional medicine as it might make them even more ill. If he can see that a client is going to die, or if he finds them to be in the last stage of AIDS, he advises them to get treatment at the local clinic. He is concerned that people with AIDS might die soon after visiting his practice, which would convey a message to his clientele that his treatment was potentially lethal.

In line with his belief that the government is withholding the AIDS cure, Magagulu is also suspicious of government issued condoms, arguing that health practitioners encourage condom use, even if the condoms have already expired:

When you open these condoms, and it has exposed to air you find that it has expired and it has bugs and these bugs cause AIDS. The condoms that are good are the ones you buy from the chemist because they have done carefully because the manufacturers know they are going to benefit from sales. The ones that are supplied by the government have done carelessly. I can say maybe it's the chemical they use on the condoms. Just like free contraceptives from government facilities causes problems in peoples bodies. The right contraceptives you get are the ones you pay for. Sometimes if you are literate you can see from the packet that the medication or condom had expired. But the health practitioners tell you to use that medication. (Interview with Magagulu, 2005).

Magagulu's distrust in government issued condoms raises a number of potential problems in terms of HIV-prevention and opposition to the free condoms that are aimed at precisely those people who cannot afford to buy condoms.

Like Magagulu, Diso also believes in the value of knowing the HIV-positive client's CD4 count in order to assess what kind of treatment to administer because some forms of traditional medicine can be too strong for an HIV-positive person. In the interview Diso underlined the value of traditional healers as counsellors; like Mnguni, Diso recognises that many people who come to her for healing are not only looking for medicine:

Some illnesses don't need to be treated by medicines, sometimes you just need to talk to the client... To counsel them and ask what is bothering them for instance the woman I said she told me that she was HIV positive I realised that besides being positive she was also depressed. I asked her about her problem. She opened up and said she was hurt because she was raped and it's hard to forgive and forget about it. Sometimes you can see by looking at the clients or feel what they feel. So some problems need the healer to sit and talk to clients but you also need to approach them in the right way. I told her to forgive because the person died and she was the one who was suffering. (Interview with Diso, 2005).

In addition to Diso's assertion that client's sometimes need counselling for traumatic events or relationships, Diso believes that HIV can be transmitted in a number of ways, many of which conform her belief that illness is caused through evil spirits:

I don't think people get the disease through sexual intercourse. I think there are different ways that a person can be infected, through evil spirits not only sexual intercourse. Yes people get it through sexual intercourse, by dreaming about eating because we sometimes dream

about eating and you are actually being poisoned. By having wet dreams sometimes you do get infection. I think there are opportunistic evil spirits that infect people with the disease. (Interview with Diso, 2005).

As mentioned above, Diso describes herself as a Christian and as a traditional healer. Her belief that evil spirits can infect a person with HIV is contrasted with her conviction that an HIV-positive person can be cured if they are Christian:

I think people can be cured if they are dedicated Christians, they pray to God. I am an example. ... I don't think it's a curse. We, the people, are failing somewhere because there are people who get cured because they are converted Christians... (Interview with Diso, 2005).

Zima, a 55 year-old female traditional healer, concurs with Diso's belief that illnesses like HIV can be caused by evil spirits. Unlike Diso, however, Zima is HIV-positive. Zima said that she finds it difficult to believe that she could be HIV-positive because she describes herself as healthy and fat:

It's confusing, you can see that I am fat and healthy but found out that I have HIV. I think our youth cannot see who has the virus because young men see a cute and healthy young lady, approach her and it happens that the lady is HIV positive and she does not disclose her status. And our young men do not condomise. They appreciate girls and want flesh to flesh, you see. (Interview with Zima, 2005).

Additionally, Zima argues, HIV is a punishment inflicted by ancestors because of the move away from traditional values:

I think people moved away from traditional way of life like, boys and girls can't maintain their virginity. In our times we did not have sexual intercourse... Those days young men did it on thighs and never had vaginal intercourse. That practice was abandoned by our children; they want flesh to flesh. I think the disease, although I don't know how it came about, but I think that's how it gets spread. It's a punishment by ancestors because we abandoned our traditional ways of life. It's not wise these days even if a person is disciplined and celibate. A guy would approach her and, unknown to her, that is the guy who has the virus... (Interview with Zima, 2005).

Although both Zima and Diso's understanding of HIV and AIDS aetiology differs from biomedical descriptions of how HIV is transmitted, they advise their clients to go to the clinic if their treatment has not yielded significantly positive results. Additionally, Diso advises clients who she thinks may be HIV-positive to go for an HIV test. She claims that it is important for her to know what stage her client is in order to ascertain the strength of the client's body.

This in turn affects the kind of treatment that she administers to her HIV-positive clients.

In contrast to the above-mentioned healers, Gogo (a female traditional healer who draws on bone-throwing and divination) and Ntswampi (a male traditional healer who grew up in a family of traditional healers) believe that HIV is not caused through failure to appease one's ancestors or perform certain cultural rituals. In the course of the interview, Gogo (2005) said, "If a person is positive, s/he is positive. It has nothing to do with rituals." Rhayi, a 56 year old male traditional healer, asserts that HIV is a new disease and one which he cannot treat because he does not know what the symptoms are. He does, however, advocate collaboration between biomedical practitioners and traditional healers in order for each group of healers to share their knowledge and skills (Interview with Rhayi, 2005).

Nana's perception of illness informed her decisions around accessing health care for both the psychosocial and physical aspects of the illness. Similarly, the traditional healers' perceptions of illness played a role in the way they treated their clients. A significant aspect of their treatment, which is also mirrored in Nana's case study, relates to the cleansing of pollution from their clients' bodies. This form of treatment highlights some of the traditional healers' perception that HIV is a pollutant. This 'pollutant' could be transmitted by women experiencing what the traditional healers describe as excessive blood retention because they did not menstruate every month. HIV infection was also attributed to HIV-positive clients' failure to appease their ancestors. The shift away from cultural values that revere spiritual ancestors and adhere to strict sexual codes of practice is perceived by Zima to be a principle cause in the high rates of transmission of HIV. However, biomedical explanations of HIV transmission are also drawn on by traditional healers, like Gogo and Ntswampi. This understanding of HIV also prompts these healers to encourage their clients to draw on biomedical resources and tests in order to monitor the development of the disease. The following section draws on the traditional healers' arguments around the practicalities of collaboration in the light of current traditional healing practices and health seeking behaviour that suggests the boundaries between biomedicine and traditional healing are fluid and in constant flux.

Exploring Networks of Collaboration in the Context of South Africa's Public Health Care System

The most critical issue facing health care systems is the shortage of the people who make them work. Although this crisis is greatest in

developing countries, particularly in sub-Saharan Africa, it affects all nations. It severely constrains the response to the AIDS treatment emergency and the development of health systems driven by primary health care, even as AIDS reduces the available workforce. (WHO, 2003: 7).

As defined by the WHO (2003) primary health care is predicated on community participation, intersectoral health care approaches, universal access to care and commitment to health equity. In recognition of its inability to provide formal state health care to all those people who require it, South Africa's Department of Health (DOH) has advocated a Community and Home-based care (CBC and HBC respectively) approach to providing primary health care (ANC, 2001). Traditional healers are included in the DOH's CBC policy, but this commitment to the inclusion and utilisation of alternative health care providers like traditional healers is not necessarily reflected in practice through policy implementation. This section sketches government policy and practice regarding traditional healers and explores the perspectives of the interviewed traditional healers on the value and possibility of more meaningful collaboration with the NHS within the field of HIV in South Africa.

South Africa's National Health Policy on HBC and CBC is supported (perhaps unwittingly) by a two-pronged argument. One aspect of the argument relates to the limited resources in the health care system, and the need for informal organisations, community-based carers and NGOs to fill 'the void created by neglect of health care needs in underserved populations.' (ANC, 1994: 63). On the other hand, the argument refers to the government's assertion that democracy should empower people to take care of their needs because it is "undesirable, patronizing and promotes dependence if the state does it for them". (ANC, 2001: 75). Thus, in the context of post-1994 South Africa, community participation, including that of traditional healers, in health care is presented on the one hand as a 'so-called' extension of democracy and on the other, as a viable alternative of care when the state cannot afford to provide sufficient health care for people dependent on state resources.

As with the two-pronged argument supporting the notion of 'care for the community by the community', so too is there similar rationale supporting the inclusion of traditional healers in South Africa's NHS. Minister of Health, Dr Manto Tshabalala-Msimang, had the following to say in a closing remark at the end of the First International Conference on Natural Products and Molecular Therapy held at the University of Cape Town in January 2005.

The study of Indigenous Knowledge Systems is not simply a scientific endeavour, but an opportunity to reclaim Africa's scientific and socio-cultural heritage which was stigmatised and discredited as primitive

rituals and witchcraft by colonialism and apartheid. (quoted in Mngadi, 2005: N.P.)

In short, the discourse supporting community-based care in general, and the inclusion of traditional healers as community health providers in particular, is underpinned on the one hand by the dire need for informal health care providers, and advocated on the other hand as ‘democratic’ and ‘empowering’ to communities that had been discriminated against through colonialism and Apartheid.

In line with this bivariate rationale, the Department of Health (DOH) has developed a policy framework regarding the use of traditional and complementary medicines in South Africa. This framework includes the Traditional Health Practitioners Act and the National Drug Policy (www.doh.gov.za). The objectives of the Act are to establish the Interim Traditional Health Practitioners Council of South Africa; to make provision for control of the registration, training and practices of traditional health practitioners in South Africa; and to serve and protect the interests of members of the public who use the services of traditional health practitioners (Pefile, 2005). A significant critique of this Act is that it does not propose concrete measures through which to implement its objectives. The National Drug Policy refers to the need to investigate traditional medicines for safety, efficacy and quality with the aim to integrate their use into the NHS (www.doh.gov.za). This is envisaged to be achieved through: working more closely with traditional healers to compile and develop a code of practice; establishing a National Reference Centre for African Traditional Medicines; and providing for the registration and control of marketed traditional medicines. In addition to developing the National Drug Policy, the DOH has put R4.5 million into the Medicine Research Council’s Traditional Medicine unit to facilitate the testing of the components and efficacy of various traditional medicines (Pefile, 2005).

Each of the traditional healers that were interviewed in this study argued strongly for collaboration between the traditional healers and biomedical practitioners. Their reasoning was predicated on their belief that these forms of healing were not necessarily exclusive, and that some aspects of the *illness*, and the *disease*, of HIV were better treated by either traditional healers or biomedical practitioners or a combination of both. This reasoning is supported by Nana’s case study which highlights the fact that a range of healing professionals can address different aspects of HIV and AIDS. This is further exemplified in Magagula’s statement below:

The person who has motivated me is Manto Tshabalala. She has spoken in favour of traditional healers and said there is a need for traditional healers and doctors to work together to curb the AIDS pandemic. Yes, there are many diseases that need a dual treatment

from doctors and traditional healers. And it depends on what kind of illness is being treated. As I practice here, I know that there are people who are sick and those that are not sick, they just have personal problems that need to be attended to. So with sick people, there are illnesses, for instance, traditional healers do not have a drip.

What I see as a shortfall in South Africa or amongst us traditional healers, we need to work together and form an organisation. When we are organised we can invite the department of health. I think we can gain something from working with them because there are illnesses that need to be treated by both doctors and traditional healers. I said there are people who need a drip before taking traditional medicine or we can give our homemade drip like water with salt and sugar as we were told, to give them energy. (Interview with Magagula, 2005).

Gogo, a traditional healer who works primarily with people who have cancer, AIDS and mental illnesses, also referred to the value of a drip in order to counteract malnutrition and dehydration:

... traditional healers don't have drips. Sometimes the client is dehydrated because of diarrhoea so they need to go to clinic to a drip. Then the patient can be boosted by drip only. (Interview with Gogo, 2005).

Magagulu also asserts that the government has failed South Africans because if they had involved traditional healers in its response to HIV earlier, the traditional healers could have intervened faster to control HIV. He argues that the Traditional Healers Organisation (THO) has trained traditional healers to impart knowledge of HIV and prevention to their clients, and they have also provided traditional healers with knowledge about HIV and AIDS-related illnesses and ways of labelling and preserving their medicines:

The THO showed us how to treat a person who has diarrhea which is a problem in areas where people get water from the stream. They told us ... to educate our clients that they should boil or purify the water before consumption. They also taught us about AIDS. At that time condom use was fairly new; there were people who were taught how to use a condom, they came back and demonstrated to us so that we could educate our clients. We were also taught about hygiene and cleanliness. Every traditional healer should keep his working place clean. We also talked about some traditional healers who pile up their medicines and do not label them. To know what medicine it is they smell or chew it, we were told that was not acceptable. We need to label our medicines so that we don't confuse them.

THO taught about condom use, how to use a drip, about AIDS and its causes and about cleanliness. They told us that white people are not in favor of working with healers who use certain animal parts to make medicines. If someone used animal parts he/she should find a place far away from other people. So, they emphasised on cleanliness, there are people who use animal bones and sometimes they smell bad. That could also cause diseases, so we are talking about cleanliness, they emphasised that someone who is working with people needs to be clean. So they said you must three different working areas, like examination room, treatment room and storage for your medicines. Because of the lack of space and money it's not feasible to have these three places, there are few people who can afford that. (At this point Magagula pointed to his shelves of medicine in the room in which the interview was taking place) ... But cleanliness is very important and I think before you leave you can have a look at my medicines that side to make sure what I am talking about. (Interview with Magagula, 2005).

Magagula's statement above indicates an awareness and willingness on behalf of the THO to train traditional healers to conform to particular standards of hygiene and medical practice, including teaching clients how to purify water to prevent diarrhoea and how to use condoms to reduce HIV transmission. This statement also contrasts with the views expressed by Magagula and Mnguni in the above section in which Depo Provera was accorded responsibility for high rates of transmission. This raises a number of questions that can and perhaps should be explored in future research. Firstly, Depo Provera may be thought to be dangerous because it might deter women from using condoms with their partners. A second interpretation is that these traditional healers condone condoms used by men but do not believe that women should use oral or injected contraceptives because it interferes with their ability to bear children.

Aside from the THO's encouragement of traditional healers to educate their clients about HIV, the benefits of collaboration are articulated and advocated through the DOH's 'continuum of care' model, the National Drug Policy, the Traditional Health Practitioners Act and the CBC policy. However, concrete steps have not been taken by the state to implement this legislation. Perhaps this relates to what Homsy, King, Tenywa, Kyeyune, Opio and Balaba (2004) describe as distrust by clinical professionals of traditional healers and traditional medicine. This may also relate to the fact that some traditional healing practices operate outside the rational legal paradigm in which biomedicine acts, which in turn may inform clinicians perception that that traditional healers do not have sufficient information to treat HIV-positive people. It is argued that traditional treatments have

never been rigorously evaluated, are not always properly prepared or standardized, and are frequently poorly packaged and preserved, limiting⁵ their usefulness and accessibility to the immediate production site (Rukangira, 2001 in Homsy *et al.*, 2004: 905).

Efforts, however, have been made by traditional and complementary healers in Africa to establish regulations regarding traditional healer's treatment of HIV-positive people. For example, a Ugandan NGO, Traditional and Modern Health Practitioners Together against AIDS and Other Diseases (THETA), spearheaded a regional initiative to define the standards of practice regarding the involvement of traditional healers and traditional medicine in HIV and AIDS prevention, care and treatment. These standards represent the first regional and participatory attempt to boost the validity and credibility of African traditional healing while seeking to maintain its diversity. THETA calls for rigorous testing and evaluation of traditional medicine, standardisation of traditional healing practices with HIV-positive people, and the provision of education, counselling and referral sources to HIV-positive clients. (Homsy *et al.*, 2004).

The drive to include traditional healers in HIV education, prevention and treatment programmes has also been taken up some NGOs and CBOs in South Africa. For example, the AIDS Foundation of South Africa partnered up with local traditional healer associations and launched an HIV/AIDS training program for traditional healers. In the period 1995-2001, over 6000 traditional healers were trained through this programme to dispel myths that propagate stigma, to identify signs and symptoms of HIV, to observe infection control procedures, to promote HIV and AIDS education in their communities and to establish formal referral networks with medical clinics and hospitals (www.aids.org.za). This example illustrates the range of services that traditional healers can offer HIV-positive people who visit them for palliative and psychosocial care. These training programmes are not implemented throughout South Africa, but only through a small number of organisations committed to moving the HIV health agenda, as set out by the government, forward through participatory programmes with traditional healers.

However, it should be noted that collaboration between these two health care paradigms should not entail a seamless mapping of one onto the other. The biomedical assumption, highlighted by some of the above-mentioned programmes that encourage collaboration, that traditional healers are useful only if they conform to and work within an overarching biomedical framework is also problematic. Green (1994) explores the dynamics of potential collaboration between traditional healers and biomedical practitioners in Southern Africa, and suggests the relative value of each of these practices asserting the importance of noting disjuncture as well as correlation between these healing paradigms. For example, Green notes that traditional healers are sought out for treatment of

sexually transmitted diseases, which if treated correctly, can drastically reduce the chances of transmitting or contracting HIV through unprotected sex (1994). Furthermore, as indicated through the analysis of Nana's treatment strategies, various healers are drawn on in order to heal the psychosocial and physical aspects of the illness and disease of HIV respectively. Nana's case study also points to the complementarity and difference between traditional and biomedical healing paradigms. This paper asserts that while it is useful to explore routes of collaboration between traditional healers and biomedicine, particularly in the field of HIV, it is also important to recognise that these healing paradigms also have different qualities to offer HIV-positive people.

In addition to the above caution regarding collaboration, formalisation of traditional healing practices as a precondition for collaboration between biomedical practitioners and traditional healers can potentially create a hierarchy of HIV health care options that are formally sanctioned by the state. This hierarchy already exists between different groups of health care providers, and collaboration will not necessarily address or undermine this deeply entrenched hierarchy. Furthermore, some of the traditional healers who participated in this study also suggested that there is value in prioritising biomedical treatment over traditional medicine, particularly when the client was in the last stage of AIDS, or if their health had not improved following the traditional healers' treatment. Some traditional healers, like Magagulu, felt that the doctors were perceived to be more 'legitimate' because of their formal recognition by the state as medical healers:

The reasons people go to doctors is that they want to know if the disease is under control or not, no matter they feel pains or no pains. If we can be registered as we have planned in the workshops in Johannesburg, we planned that iNyangas should be given their time to work with AIDS patients to give them traditional medicines in the hospital wards. (Interview with Magagula, 2005)

According to Magagulu traditional healers often play a role in the HIV-positive patient's recovery, but because the patient uses numerous methods of health care, including clinical treatment, the doctor does not necessarily recognise the traditional healer's work. In his view, this can serve to perpetuate the hierarchy of biomedical practitioners over traditional healers in the field of HIV diagnosis and treatment:

We (traditional healers) work in the dark because most of the time the patients come to me and go to hospital. When the person gets better the doctor who has attended the patient will get a promotion while the patients used traditional healing as well. ... The doctors asked them what they have been taking. When they tell the doctors about traditional medicines they would say, 'nonsense why did you use

witchdoctors' medicines'. They are treated badly and told not to use our medicines. And AIDS patients don't have the courage to defend themselves. (Interview with Magagula, 2005).

The above statement also indicates Magagulu's distrust of medical doctors and his belief that HIV-positive clients are treated badly by their doctors if they acknowledge that they are using traditional medicine. Whether or not this is the case, Magagulu's statement underlines the fact that a hierarchy of healing practices exists in which the clinician is at the pinnacle, under which traditional healers, complementary health care practitioners and the ill client fall (but not necessarily in this order, see Baer, Singer and Johnson, 1986).

Magagulu's statement also indicates frustration with the medical profession for dismissing the contribution of traditional healers by falsely conflating traditional healers with 'witchdoctors'. Similarly, Diso believes that one of the main reasons why traditional healers are not taken seriously by the biomedical profession is because of their association with witchdoctors. This may be a result of what Green (1986 in Wreford, 2004) describes as the equation of traditional healers with witchdoctors through the intentional misapplication of the latter term to traditional healers by missionaries in the early years of colonialism. In most cases, however, traditional healers assert that they are only connected with witchdoctors inasmuch as they are responsible for healing the 'witchcraft' inflicted through witchdoctors' work (Green, 1986 and Niehaus, 2001 in Wreford, 2004). Magagulu's frustration with doctors' conflation of traditional healers with witchdoctors is underlined by Wreford, who suggests that doctors may use the term 'witchdoctor' to legitimate their own misunderstanding of traditional healers; the negative associations connected with 'witchdoctors' maybe used by doctors to justify their disrespect or dismissal of traditional healers. The dismissal of 'witchcraft', and the concomitant traditional healers who are drawn on in order to heal bewitchment, poses a significant challenge to biomedicine:

If biomedicine continues to prefer ignorance, it may have to accept that patients will continue to take the unfinished business of their illnesses, the moral concerns which underpin them, to a *sangoma*, for only there will they receive 'real' healing. (Wreford, 2004: 5).

Aside from the distrust that permeates the relationship between doctors and traditional healers, a distrust of the South African government emerged as a strong theme in the interviews. Broadly speaking, this refers to intellectual property rights around traditional medical knowledge. The DOH overtly acknowledges the value in 'reclaiming Africa's scientific and socio-cultural heritage' through the study of so-called 'indigenous knowledge systems'. However, the issue of sharing and owning 'indigenous knowledge' remains a contested issue, particularly in relation to the Medical Research Council's

testing of potential ‘indigenous’ medicinal plants for treating certain HIV-related illnesses. Ntswampi, for example, feels that the government is trying to find out about the components of their medicine, without recognising their right to be recognised as valuable partners in health care provision in South Africa:

I have seen some programmes on TV that on one side there is some help and the other side the healers are sabotaged ... what we don’t want is to be cheated because we are going to tell them about our medicines, they are going to write them down, but they are not going to tell us what antiretrovirals are made of. (Interview with Ntswampi, 2005).

Like Ntswampi, Diso argues that it is unfair that the government has started to use and recommend the African potato without acknowledging the genealogy of traditional healers’ knowledge of African medicinal plants and herbs. This suggests that collaboration is not necessarily viewed as having positive outcomes for each of the healing professions, but that sharing knowledge, and subsequent success, may be unidirectional, favouring biomedicine.

In addition to a concern over intellectual ownership of ‘indigenous’ medicinal solutions, the traditional healers expressed a belief that the government is not committed to providing non-discriminatory health care to all South Africans regardless of race:

The government said they don’t have money to pay those (pharmaceutical) companies, so that indicates that the government does not care about us. Diseases that affect black people are sometimes taken seriously and sometimes not. Yes, we have many other needs and the government is overpowered, but on the issue of AIDS I see that the government does not care enough. Some pharmaceutical companies have reduced their prices, for instance there is a pill that initially cost R200 each but now it costs R50. So they are trying to fight AIDS. ... In the previous government there was never a disease that killed so many people like this. These days the majority of people that are dying are blacks and very few whites are dying. If AIDS was killing many whites it would have been curbed long ago. (Interview with Magagula, 2005).

It is noteworthy that Magagulu feels that if the HIV epidemic affected white people to the same extent that it affects black people, it would have been more directly and quickly addressed. Perhaps this belief is part of the residue of Apartheid’s discriminatory health care, or perhaps this statement reflects dissatisfaction with the current government’s approach to addressing the HIV-epidemic. Additionally, Diso argues that the current government’s approach to treating HIV-positive people does not take into account the practical limitations

of providing biomedicine, like ARVs, to destitute HIV-positive people. Diso insists that the government find ways of incorporating food distribution into their antiretroviral roll-out in order to enhance the efficacy of antiretrovirals. The following statement also highlights Diso's awareness of the range of factors that contribute towards healing HIV-positive people beyond traditional or allopathic medicines:

I think the government is lacking in a big way because what's happening is that we are faced with unemployment. In the first place people with HIV/AIDS do not get nourishment. People need healthy food and the disability grant takes long. People get it when there are less chances of survival. I think that the government is lacking because people don't have jobs and they are sick. There is no support like food to nourish the body with. Some of the people I treat, I see sometimes that they need food. I think the government is not supportive. Even if people take antiretroviral, you cannot take medicines on an empty stomach or you are going to vomit. What are they going to eat? (Interview with Diso, 2005).

In addition to Diso, a number of traditional healers pointed out that antiretroviral therapy and some of their own treatments are rendered redundant when the treatment is not taken with food. This further underlines the value of holistic and collaborative approaches that move beyond biomedicine in order to provide maximal health care to HIV-positive people. As highlighted above, the traditional healers interviewed in this study asserted the importance of providing holistic treatment to their clients. Examples of this form of holistic treatment ranged from incorporation of biomedical practices, like encouraging seriously ill patients to attend the clinic for drips or other treatment rather than taking their medicine, to insisting on the importance of practical support, like food, in the administration of the ARV roll-out and of their own medicines, to the value of psychosocial support, like counselling.

The views expressed by the traditional healers in this study resonate with the observed practices of traditional healers involved in a study conducted in Hlabisa that explored the incorporation of traditional healers into a tuberculosis directly observable treatment (DOT) control programme. Between 1999 and 2000 in the three study sub-districts, 53 patients (13%) were supervised by traditional healers and 364 (87%) were supervised by clinic health workers or lay people.

Overall, 89% of those supervised by traditional healers completed treatment, compared with 67% of those supervised by others ($P = 0.002$). The mortality rate among those supervised by traditional healers was 6%, whereas it was 18% for those supervised by others ($P = 0.04$). Interestingly, none of the patients supervised by traditional

healers transferred out of the district during treatment, while 5% of those supervised by others did. (Colvin, Gumede, Grimwade and Wilkinson, 2001: N.P)

High levels of satisfaction were reported by the patients supervised by traditional healers, with all of the patients stating that traditional healers should be involved as supervisors for future DOT programmes. A major advantage, according to these patients, was that the traditional healers were easily accessible because they typically lived near to the patient. This is supported by Green (1994) who argues that traditional healers may also be visited more frequently because they live locally and may be more familiar with a client's social context than doctors and nurses working in a clinic. Other reasons for satisfaction, according to Colvin *et al.* (2001), related to the traditional healers' caring attitude and concern about the general well being of the patient they supervised. One patient stated: "They love their patients and treat them like family". This approach was also demonstrated by three traditional healers doing regular home visits to eighteen patients in the early phase of their treatment because the patients were too ill to leave their homes. Three patients in the study said that they had regularly received food from their supervisor during treatment consultations (Colvin *et al.*, 2001).

Qoli, a traditional healer who participated in the study for this paper, exemplifies the possibility of collaboration between traditional and biomedical healers. She works as a patient advocate with a team of clinicians involved with the antiretroviral roll out in Langa, a township in the Western Cape. Qoli describes how, in 1996, she became seriously ill and visited a traditional healer for treatment. This meeting, she said, was "like an electrical connection between me and my background – where my roots were coming from." During this meeting she realised that it was her destiny to become a traditional healer, and proceeded to undergo training in Mpumalanga in 1999. She describes her work as a patient advocate as 'hands on healing', and believes that she can integrate her knowledge of traditional healing with her commitment to care for the people starting ARVs through the Langa clinic.

Like Qoli, Mnguni believes that although collaboration may be difficult, and sometimes unnecessary, there is also potential for positive outcomes for HIV-positive clients. He suggests the following plan:

I have a request. I don't know how the government can help us. My request is, if the government wants to see AIDS control and treatment, they must not ask for the cure. They must refer AIDS patients to us, they must give us tenders to treat and cure AIDS patients. They must give us fixed quotas of patients; they must ask us how long we are going to take to treat these people. We would tell them and do as we promised. (Interview with Mnguni, 2005).

Ntswampi suggests that the government provide a hospital in which both medical and traditional healers work; he argues that this would facilitate better communication, and greater health care provision for the patients. Similarly, Rhayi regards collaboration as possible, and beneficial to the clients:

I don't think we cannot work together if we can negotiate and reach certain agreements. I think if we can work together we can control diseases. We can learn from each other, so I believe if we can share information we can protect many people...Medical doctors are good because they gained expert knowledge through learning about diseases. They are good and can be helpful in certain things we don't know and we can also help them with things they don't know. (Interview with Rhayi, 2005).

As mentioned above, distrust of traditional healing is not unfounded; the traditional healers themselves argue that witchdoctors and untrained people pretending to be traditional healers undermine the positive and valuable function that traditional healers perform. Additionally, they suggest that their knowledge of HIV is limited, and state unambiguously in the interviews that they would like to receive more training around HIV. However, as discussed above, collaboration does not infer the mapping of traditional healing onto biomedical practices, or vice versa, but should allow for places of divergence where each can offer relative and different resources to HIV-positive clients. As argued above, research with traditional healers and the HIV-positive clients, points to the importance of considering the value and practicalities of collaborative health care networks, while acknowledging that both biomedical and traditional practitioners offer independent, and sometimes overlapping, forms of care that address both the *illness* and *disease* experiences of HIV-positive people. This paper recognises the fact that a range of traditional healing practices exist in South Africa, and that similarly, all traditional healers do not necessarily share the views of the traditional healers represented in this paper.

Conclusion

The high number of traditional healers combined with a rapidly increasing HIV-epidemic in South Africa points to the value of researching illness meanings and healing strategies employed by both traditional healers and HIV-positive people in this country. Nana's case study highlights the value of a more nuanced understanding of HIV: one that recognises the psychosocial and also the material aspects of HIV and AIDS-related illnesses, and the forms of health seeking behaviour that are developed in response to these aspects of HIV and AIDS. The traditional healers who participated in this study offered a range of

beliefs around HIV causation and treatment, emphasising the range of beliefs that can be held under the broad term of ‘traditional healing’.

The theme of pollution emerged throughout the interviews, highlighting the perception that HIV can be caused through contact with pollution, and that it can similarly be cured through cleansing the HIV-positive individual and bringing the pollution to the outside in the form of pimples or vaginal/penile discharge. Significantly, the traditional healers drew on and incorporated biomedical indicators of disease, like the CD4 count, and demonstrated a knowledge of the trajectory of HIV illness as shown through the various stages of disease defined by WHO and used in South Africa’s public health care system. Distrust in the government also emerged as a noteworthy theme in the subsequent section on collaborative possibilities and limitations between traditional healing and biomedicine. On the one hand many of the traditional healers advocated collaboration between themselves and doctors and nurses, and on the other hand, biomedical staff were viewed with distrust. This was particularly evident in the traditional healers’ insistence that knowledge sharing should be mutually beneficial, and that the traditional healers’ knowledge of various medicines should be formally acknowledged by medical bodies like the Medical Research Council in South Africa.

This paper therefore argues that South Africa’s legal and political rhetoric, which recognises the importance of incorporating traditional healers in the public health sector, be matched with a greater degree of empirical research into the practicalities and limitations of collaboration between traditional and biomedical healing practices. This is particularly important given the escalating rates of HIV-infection in South Africa, and the limitations of South Africa’s biomedical health care services in treating this growing HIV-population. Additionally, the nuanced nature of HIV, as a psychosocial illness and a biological disorder, plays a significant role in the health care decisions made by HIV-positive people and their families; this, in turn, calls for greater attention to be paid to the multiple and overlapping healing strategies developed by HIV-positive people, and supported by health care practitioners in South Africa. Following these recommendations, the shifting terrain of South Africa’s health care system is likely to undergo further transformations that will, with careful consideration of the interconnection between these healing paradigms, facilitate more effective and vital health care for people living with HIV and AIDS-related illnesses in South Africa.

Elizabeth Mills holds an Honours degree in Social Anthropology from the University of Cape Town and is currently completing her Masters degree in Development Studies at the University of Cambridge. Her research interests include gender and HIV, transitional justice, human security and the impact of the global political economy on access to HIV and AIDS treatment. Her email address is beamills@gmail.com.

References

- African National Congress, 1994. *A National Health Plan for South Africa*. African National Congress: Johannesburg.
- African National Congress, 2001. *A National Guideline on Home-Based Care and Community-Based Care*. African National Congress: Pretoria.
- Baer, H., Singer, M. and Johnson, J. 1986. "Introduction: Toward a Critical Medical Anthropology" in *Social Science and Medicine* 23(2): 95-98.
- Bergland, A-I. 1976. *Zulu Thought-Patterns and Symbolism*. Hurst and Company: London.
- Bolle, K. 1983. "A World of Sacrifice" in *History of Religions* (21): 126 – 155.
- Colvin, M., Gumede, L., Grimwade, K. and Wilkinson, D. 2001. "Integrating traditional healers into a tuberculosis control programme in Hlabisa, South Africa" in *MRC Policy Brief No 5*, December, www.mrc.ac.za, accessed July and August 2005.
- Elujoba, Odeleye and Ogunyemi. 2005. "Traditional medicine development for medical and dental primary health care delivery system in Africa" in *The Journal of Alternative and Complementary Medicine* 2 (1): 46-61.
- Evans-Pritchard, E. 1937. *Witchcraft, oracles and magic among the Azande*. Clarendon Press: Oxford.
- Green, E. 1994. *AIDS and STDs in Africa: Bridging the Gap between Traditional Healing and Modern Medicine*. Westview Press: Colorado.
- Heald, S. 2003. "An Absence of Anthropology: Critical Reflections on anthropology and AIDS policy and practice in Africa". In G. Ellison, M. Parker and C. Campbell (eds.) *Learning from HIV/AIDS: a Biosocial approach*. Cambridge University Press: Cambridge. pp. 210-237.
- Henderson, P. 2004. "The Vertiginous Body and Social Metamorphosis in a Context of HIV/AIDS" in *Anthropology Southern Africa* 27 (1&2): 43 – 53.
- Homsy, J., King, E., Tenywa, J., Kyeyune, P., Opio, A. and Balaba, D., 2004. "Defining Minimum Standards of Practice of Incorporating African Traditional Medicine into HIV/AIDS Prevention, Care and Support: A Regional Initiative in Eastern and Southern Africa." In *The Journal of Alternative and Complementary Medicine* (10) 5: 905 – 910.
- Ingstad, B. 1990. "The Cultural Construction of AIDS and Its Consequences for Prevention in Botswana" in *Medical Anthropology Quarterly*, 4 (1): 28 – 40.
- Jones, K. 2004. "Schism and heresy in the development of orthodox medicine: The threat to medical hegemony". *Social Science & Medicine* 58 (4): 703–712
- Kaboru, B., Falkenberg, T. Ndulo, J. Muchimbac, M. Solo, K. Fixelid, E. 2005. "Communities' views on prerequisites for collaboration between modern and traditional health sectors in relation to STI/HIV/AIDS care in Zambia" Health Policy (article in press)
- Kleinman, A. 1988. *The illness Narratives*. Basic Books: The United States of America.
- Kleinman, A. 1995. *Writing at the Margin: discourse between anthropology and medicine*. University of California Press: London.
- Liddella, C. Barrett, L. Bydawell, M. 2005. "Indigenous representations of illness and AIDS in Sub-Saharan Africa" in *Social Science & Medicine* (60): 691 – 700.
- Magubane, B. 1979. "The 'Native Reserves' (Bantustans) and the role of the migrant-labour system". *The political economy of race and class in South Africa*. Monthly Review Press: New York.
- Mills, E. 2004. "Beyond the Disease of Discrimination: A Critical Analysis of Stigma in KTC, Cape Town". *CSSR Working Paper* 100. Centre for Social Science Research: Cape Town.
- Mngadi, S. 2005. "International Scientists Support Traditional Medicines" in Department of Health, South Africa, www.doh.gov.za, accessed May, July and August 2005.
- Pefile, S. 2005. "South African legislation on traditional medicine" in *Science and Development Network*, <http://www.scidev.net/>, accessed May 2005
- Pawluch, D Cain, R., and Gillett, J. 2001. "Lay constructions of HIV and complementary therapy use" in *Social Science & Medicine* 51: 251-264.
- Ratele and Shefer, 2002. "Stigma and the social construction of sexually transmitted diseases" in *Psychopathology and social prejudice*. Hook, D and Eagle, G (eds). Landsdowne: University of Cape Town Press.
- UNAIDS/WHO. 2005. *AIDS Epidemic Update*: December.
- Van Baal. 1976. "Offering, Sacrifice and Gift." *Numen* (23): 161 – 178.
- Viljoen, M., Panzer, A., Roos, K.L. and Bodemer, W. 2003. "Psychoneuroimmunology: From philosophy, intuition, and folklore to a recognized science." In *The South African Journal of Science* (99): 332 – 336.

- Wilson, M. and Mafeje, A. 1963. *Langa: A study of social groups in an African township*. Oxford University Press: Cape Town.
- World Health Organisation. 2003. "Health Systems: principled integrated care" in *The World Health Report – Shaping the Future*. Accessed at <http://www.who.int/whr/2003/chapter7/en/> in 2005 and 2006.
- Wreford, 2005. 'We can help!' - A literature review of current practice involving traditional African healers in biomedical HIV/AIDS interventions in South Africa, *CSSR Working Paper* 108. Centre for Social Science Research: Cape Town.

Websites

- The African Union. www.africa-union.org, accessed January 2006.
- The AIDS Foundation of South Africa. www.aids.org.za, accessed June – August 2005.
- The WHO traditional medicine strategy 2002 – 2005. <http://www.who.int/medicines/library/trm/strategytrm.shtml>, accessed June and July 2005.

Notes

- ¹ The author is grateful to Busi Magazi for the significant contribution that she has made to this paper through her work as the assistant researcher on this project.
- ² These settlements are characterised by high unemployment and low incomes. This is largely a result of the residue of Apartheid laws that encouraged the development of a cheap non-white labour force on the periphery of central business and industrial areas (Wilson and Mafeje, 1963 and Magubane, 1979).
- ³ This perception might relate to Apartheid's misuse of this contraceptive in response to the perceived threat of black women's fertility. In many cases it was administered in an autocratic manner and without counseling or the full consent of the women involved (see http://popdev.hampshire.edu/projects/dt/dt32.php#_edn24 and <http://shr.aas.org/loa/pviod.htm> accessed in 2006).
- ⁴ This theme is also reflected in Ratele and Shefer's (2002) description of how women are accorded blame for transmitting HIV to their male partners.
- ⁵ Rigorous testing of traditional healers and medicine in South Africa is contested issue in South Africa. Commitment to rigorous testing is evinced by the award of R4 million to the Medical Research Council in South Africa from the Department of Health. However, the minister of Health has also supported certain forms of traditional medicine, like the African potato, without insisting that it be scientifically tested (www.tac.org.za; www.doh.gov.za).