The role of practitioners of traditional medicine in the treatment, care and support of people living with HIV/AIDS

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This thesis is being submitted in accordance with the requirements for the degree **PHILOSOPHIAE DOCTOR** in the Faculty of Humanities, Department of Sociology at the University of the Free State.

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May 2005

DECLARATION

I declare that the thesis hereby submitted by me for the Philosophiae Doctor Degree at the University of the Free State is my own independent work and has not previously been submitted by me at another university/faculty. I furthermore cede copyright of the thesis in favour of the University of the Free State.

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Joy Violet Summerton
May 2005

for Sheila, my mom

ACKNOWLEDGEMENTS

In humble gratitude I wish to express my thanks to the following people:

- Professor HCJ van Rensburg for his incessant patience and faith in me, for being a role model, compassionate mentor and parent figure throughout my career at the Centre for Health Systems Research & Development. Your achievements and meticulous critical eye have been an inspiration, and will continue to be. (If wisdom comes with age, I look forward to aging).
- Professors Engela Pretorius and Charles Ngwena for their incessant guidance and support, and for sharing their invaluable knowledge about the fields of HIV/AIDS and traditional healing.
- Sheila Summerton (mommy) for her patience, understanding and genuine encouragement throughout the duration of this research. Thank you for allowing me to achieve my goals even if it meant not being there when you needed me most.
- My gratitude also goes to Ruby, Lizo, Nombeko, "Sista", Niana and Latoya for not disowning me as a sister, sister-in-law, "daughter" and aunt when I neglected you completely throughout this endeavour.
- A heartfelt thanks goes to all the staff of the Centre for Health Systems Research & Development, whose support, excellent advice and friendly encouragement carried me through.
- To Hlengiwe Hlope for lending a shoulder to cry on and emotional support when the weight became difficult to bear.
- To Kobus Meyer for being a dear friend and confidante, and for the excellent technical editing of this thesis and giving the lay-out a professional appearance.
- My most sincere gratitude goes to all the traditional and western health practitioners who participated in the study as respondents, for giving their consent to participate in the study and for their willingness to share their invaluable knowledge and experience for the purpose of this research. May you be richly blessed! "*Nangomso"*
- I also wish to thank all the individuals from the Eastern Cape and Free State provincial and local government who have directly or indirectly shaped the outcome of this research.
- To the Andrew Mellon Foundation for making this research possible through their devoted financial and technical support throughout the duration of this study.
- Finally, I thank God, who once again made me realise that with Him, nothing is impossible.

JOY VIOLET SUMMERTON
MAY 2005

LIST OF ACRONYMS

AACHRD	African Advisory Committee for Health Research and Development
AIC	African Independent Churches
AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ARV	Antiretroviral
CBO	Community based organization
Contralesa	Congress of Traditional Leaders in South Africa
CSIR	Council for Scientific and Industrial Research
DOT	Directly Observed Treatment
DTHPF	District Traditional Health Practitioners Forum
DWB	Doctors Without Borders
EC REP	Eastern Cape representative
ECTHPF	Eastern Cape Traditional Health Practitioners Forum
FBO	Faith based organization
FS REP	Free State representative
GAU REP	Gauteng representative
GCIS	Government Communication and Information System
GIFTS	Global Initiative for Traditional Systems
HIV	Human Immunodeficiency Virus
ICCTHP	Interim Coordinating Committee for Traditional Health Practitioners
IFP	Inkatha Freedom Party
IKS	Indigenous Knowledge Systems
KZN REP	KwaZulu-Natal representative
LP REP	Limpopo representative
LSA	Local Service Area
MCC	Medicines Control Council
MEC	Member of the Executive Council
MP REP	Mpumalanga representative
MRC	Medical Research Council
MSF	Médecins Sans Frontiéres
NACOSA	National AIDS Convention of South Africa
NC REP	Northern Cape representative
NCOP	National Council of Provinces
NEHAWU	National Educational Health and Allied Workers Union
NEPAD	New Partnership for Africa's Development
NGO	Non governmental organization
NPPHCN	National Progressive Primary Health Care Network
NRCATM	National Reference Centre for African Traditional Medicines
NTHPF	National Traditional Health Practitioners Forum
NW REP	North West representative

PDC	Provincial Disciplinary Committee
PEC	Provincial Executive Committee
PWAs	People living with HIV/AIDS
PWC	Provincial Working Committee
RDP	Reconstruction and Development Plan
SABC	South African Broadcasting Corporation
STD	Sexually transmitted disease
STI	Sexually transmitted illnesses
TAC	Treatment Action Campaign
TASO	The AIDS Support Organisation
TAWG	Tanga AIDS Working Group
TB	Tuberculosis
THETA	Traditional and Modern Practitioners Together Against AIDS
THO	Traditional Healers Organisation
THP	Traditional health practitioner
TM	Traditional medicine
TRAMED	Traditional Medicines Database
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WC REP	Western Cape representative
WHO	World Health Organisation
WHP	Western health practitioner

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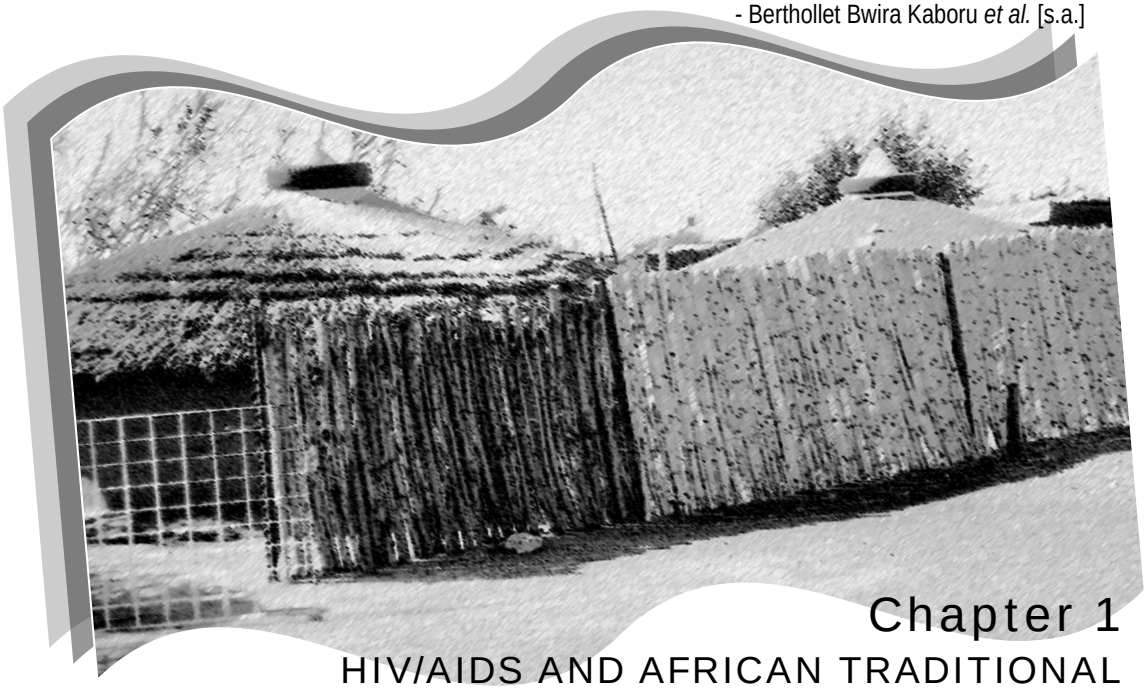
GENERAL INTRODUCTION TO THE STUDY

"Providing comprehensive care to the millions of patients in remote rural areas and overcrowded slums in cities is a major challenge for African health care systems. Shortage of staff and insufficient skills for the available personnel, and lack of other resources have motivated increased international call for integrating traditional healers in delivering care to STI/HIV/AIDS patients."

- Berthollet Bwira Kaboru *et al.* [s.a.]



Chapter 1
HIV/AIDS AND AFRICAN TRADITIONAL HEALING: AN INTERFACE

In many societies at least two prominent health care systems co-exist, namely the western health care system and the traditional healing system. Traditional healing systems are, however, very often regarded as out-dated and ineffective (Williams 2002). Nevertheless, an estimated 80% of Africans, and 70-85% of South Africans utilise traditional medicines to help meet their health care needs (International Council of Nurses 2002; Munk 1996; Njanji 1999; NPPHCN 1997; WHO 2000). The need for collaboration between traditional and western health care systems towards improving the quality and accessibility of health care has been acknowledged globally. This is especially evident in policy frameworks developed by the international community to promote the integration of traditional health practitioners into national health care systems, as well as selected programmes to combat epidemics such as HIV/AIDS and tuberculosis (Pillsbury 1982). Two policy frameworks, namely the *STD/HIV/AIDS Strategic Plan for South Africa 2000*-2005 (Strategic Plan) and the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa 2003* (Operational Plan), are evidently the pillars of South Africa's

response to the HIV/AIDS epidemic (Department of Health 2000; 2003). Both documents refer to traditional health practitioners as partners in the national response to the disease.

Several decades ago, the World Health Organisation (WHO) recognised that although traditional healing has its shortcomings, it also has advantages, especially in dealing with psychosocial problems which are based on culture-specific worldviews. In 1978 the Declaration of Alma-Ata (WHO 1978) on primary health care recommended, among others, that traditional health practitioners be integrated, where needed, into primary health care services in order to respond to the expressed health needs of communities. The WHO has since then repeatedly emphasised the necessity to ensure respect, recognition and collaboration among practitioners of the various health care systems concerned. In South Africa, the *Traditional Health Practitioners Act, 2004* (Republic of South Africa 2005) is by far the most significant breakthrough in attempts to legalise and legislate traditional healing in this society. In 2004, the Bill was unanimously approved in Parliament and was enacted on 11 February 2005. However, various obstacles threaten the successful implementation of the Act, as revealed by this thesis.

Despite evidence of the use of traditional health practitioners and traditional healing by millions of Africans as an important source of health care in their communities, for the most part, it is a role sidelined in the corridors of western medicine (Clark 2002). Various obstacles, other than the critical view of western health practitioners, hinder the process of integrating traditional and western health care systems, such as disunity amongst African traditional health practitioners, the lack of professionalisation and institutionalisation of traditional health care systems, as well as lack of knowledge by one system of the other.

In the light of the fact that a large majority of Africans utilise the services of traditional health practitioners, as well as the challenges associated with providing access to antiretroviral therapy, this study analyses the value of integrating traditional health practitioners into national health care systems *per se*, but with specific reference to programmes aimed at providing treatment, care and support to those individuals living with the virus.

1.1. A catastrophic divide in the midst of an HIV/AIDS epidemic

In societies which contain both traditional and western health care systems, the western health care system is more often than not the official and perceived superior of the two systems. It receives greater recognition in the professional sector than the traditional healing system, despite the acceptance of the latter system by a significantly large proportion of the population especially in developing countries. The South African health care system is a case in point, where the traditional healing system has, until recently (February 2005), lacked official recognition and legal representation, despite its widespread client base. In South Africa, an estimated 70-85% of the population uses traditional medicines to help meet their health care needs and approximately 60% of South African babies are delivered by traditional birth attendants (International Council of Nurses 2002; Munk 1996; Njanji 1999; WHO 2000). The high utilisation rate of traditional medicine in developing countries may be attributed to (i) its historic accessibility and affordability in comparison to western medicine, and (ii) it being firmly embedded within wider belief systems (WHO 2000).

In most countries, western medical practitioners form the only group of practitioners whose positions are upheld by law (Helman 1990). In South Africa, traditional health practitioners have thus far not been officially integrated into the

official health care system, but efforts are underway in the form of the *Traditional Health Practitioners Act, 2004* (Republic of South Africa 2005). The utilisation of African traditional medicines by a significantly large proportion of the South African population (an estimated 70-85%), as their choice of health care, and the proposed high costs associated with providing equitable antiretroviral therapy in the midst of an HIV/AIDS epidemic, point towards an urgent need for a more vigorous approach towards the inclusion of traditional health practitioners in the official health care system of the country. The AIDS epidemic in South Africa continues to threaten social and economic developments through its adverse effects, such as shortened life expectancy, burdened public health care services, poor quality of life, and escalating number of AIDS orphans due to maternal and paternal AIDS-related deaths. Hence, the traditional healing system is an important health resource in South Africa, and efforts to position it in the mainstream of health care are vital.

1.2. Contextualising the research challenge

1.2.1. Collaboration between traditional and western health practitioners in Africa and South Africa

Strides have been made in an attempt to narrow the gap between traditional and western health care systems, towards integrating traditional health practitioners into national health programmes to combat priority diseases, such as HIV/AIDS, tuberculosis and malaria. One such attempt is the promotion of collaboration between the two systems at various levels of health care in Africa. However, at a global and a national level, these efforts appear ad hoc and unregulated, even lacking the necessary guidelines and policies to facilitate such collaboration.

Various African countries have embarked upon initiatives to promote collaboration between traditional and western health care systems. Tanzania and Uganda have been highlighted by the Joint United Nations Programme on HIV/AIDS (UNAIDS) as portraying significant success in collaboration between traditional and western medicine in curbing the effects of HIV/AIDS. In these countries task groups have been established specifically for coordinating and enhancing collaborative efforts between traditional and western practitioners in HIV/AIDS prevention and care. The Tanga AIDS Working Group (TAWG) in Tanzania has seen traditional and western practitioners synergistically join forces to combat HIV/AIDS by treating people living with HIV/AIDS (PWAs) with traditional medicine. TAWG's primary activity is treating PWAs in the hospital and at home with medicinal plants. Some of the proclaimed benefits of these medicinal plants include: they are low-cost; they effectively treat selected opportunistic infections; they are readily available; they are provided to patients free of charge; and if given in the correct form and dosage, they are very safe. TAWG's treatment programme for PWAs is viewed as a low cost-effective alternative to expensive imported antiretrovirals, which are not affordable to a large majority of the population of rural districts in Tanzania, such as the Tanga District (Scheinman 2002). The Traditional and Modern Practitioners Together Against AIDS (THETA) Project in Uganda is primarily involved in researching herbal remedies for HIV/AIDS as well as initiating and facilitating dialogue and collaboration between traditional and western practitioners. Clinical evaluations conducted by THETA have revealed comparable results between traditional and western therapies for HIV/AIDS, with herbal therapies, in some cases, even portraying better results than some western therapies (Engle 1998). An elaborate discussion of the objectives, outcomes, and perceived strengths of these initiatives, as well as success factors of other collaborative initiatives cited in literature follows in chapter four.

Treating patients with HIV/AIDS-related symptoms extends longevity and improves the quality of their lives. More importantly, effective treatment of opportunistic infections amongst PWAs stunts the production of AIDS orphans as a result of increased life expectancy of parents. Hence, the importance of integrating and utilising all available resources to enhance health care for PWAs.

1.2.2. Traditional and western health practitioners: challenges in finding common ground

The WHO (2000) advocates for integrated health care systems in countries which portray pluralism of health care, and with consumers who are pluralistic in their health care needs. Integrated health care systems require integration at all levels of health care which include research, training, education, as well as practice. Hammond-Tooke (1989) attributes the difficulty in integrating western and traditional medicine to the prejudicial notion that traditional African beliefs and practices are 'primitive' and 'savage'. Gumede (1990) further reiterates this notion by pointing to the fact that western health practitioners' critical view of traditional medicine is based on the following notions, which perceive traditional health practitioners as posing a danger to the health of their patients:

- indigenous healing is criticised for its over-reliance on magic;
- time used for ineffective traditional therapies/medicine creates a diagnostic and treatment delay, which may prove fatal; and
- some medicines are claimed to be detrimental to patients.

The critical view of western health practitioners is not the only obstacle in the process of integrating traditional and western health care systems. The lack of a unified traditional healing sector, the absence of the regulation of traditional healing practices, and lack of accurate knowledge by one system of the other are further hindrances to integrating the two health care systems. Furthermore, the absence of unequivocally delineated guidelines on collaboration between the two traditions of practitioners and an integration policy serve as additional obstacles to achieving an integrated health system. These obstacles are discussed in greater depth in subsequent chapters (two and three), and are further substantiated by the findings of the empirical study undertaken (chapters eight and nine).

1.2.3. Western medicine and traditional healing – some differences and similarities

Many Africans use the traditional healing system, even though it is criticised by many practitioners of the biomedical-based western health care system for its lack of scientific cognisance. There are an estimated 300 000 to 493 000 traditional health practitioners in South Africa, of which 200 000 are registered with the national Traditional Health Practitioners Association affiliated to the Department of Health (Matomela 2004; Pelesa 2004; Roberts 1999). The International Council of Nurses (2002) argues that the traditional and western health care systems may differ in the approaches that they use, however, they share the same basic elements. The biomedical model of disease, on the one hand, which is the more accepted approach in the western world, is based on a naturalistic understanding of the body. Biomedicine is based on the medical identification of symptoms, using technological investigations, and then treating such symptoms using biomedicine. The African traditional healing system, on the other hand, is based on the identification of symptoms using the guidance of ancestors, and, thus, treating these symptoms with traditional

medicines. These two systems differ further in their approach in diagnosing a specific illness. Whereas the biomedical approach is based on the manifestation of physiological irregularities in the patient, the indigenous approach is based on a holistic view of the individual. In other words, traditional healing does not cater for the physical condition only, but also for the psychological, spiritual and social aspects of individuals, families and communities. This holistic approach to illness is the keynote of African traditional healing (Abdool Karim *et al.* 1994).

The biomedical model of disease also recognises the relationship between biology and psychology through the disciplines of psychology and psychiatry. However, its approach in diagnosing and treating illness and disease remains fragmented. This is often viewed as one of the limitations of the biomedical model of disease. In essence, the practitioner of biomedicine aims to heal the body and alleviate physical suffering, whereas the practitioner of traditional medicine adopts a more holistic approach to health care with the aim to restore balance. Furthermore, whilst the biomedical approach leans heavily on technology and drugs, the traditional healing approach characteristically treats patients exclusively within the community setting, with the direct involvement of family and significant others in diagnosis and treatment of illness playing a vital role (International Council of Nurses 2002). The apparent difference in worldviews and disease aetiologies between western medicine and traditional healing poses major difficulties for collaboration between practitioners of the two health care systems in the provision of health care services.

It is apparent that both models of healing have strengths and limitations. The intention of this study is not to argue in favour of one approach over the other. Rather, the traditional healing approach is put forward as necessary to complement the biomedical approach in the treatment and care of illnesses, since it encompasses far more than alleviating physical symptoms of illness and disease. It extends its scope to include cultural connotations of illness causality and treatment, as perceived and understood by the individual experiencing the symptoms of disease and illness. Hewson (1998) believes that African traditional healing techniques can complement western medical practice since traditional health practitioners focus on the psychological, social and spiritual factors contributing to illness, which is perceived as a very effective approach.

It is in this light that this study highlights the strengths and limitations of the traditional healing system, especially in the treatment and care of PWAs. This is done with a view to informing stakeholders, such as government, whose national priorities point towards a need to enhance the quality and accessibility of treatment and care for those South Africans living with HIV/AIDS.

1.2.4. Interpreting disease causation from an African traditional healing approach

A large proportion of South Africans, both rural and urban, hold strong traditional cultural beliefs and practices, which have been found to have a significant influence on their reactions to illness. According to Rukobo (1992), it is the belief system that determines views of health, illness and disease. In traditional societies the view of the world is one in which all elements of society are linked and functionally integrated. Consequently, medicine, illness, disease and death are understood within the context of religion and sometimes myth and mysticism. In the conception of illness there is a basic distinction between theories of natural and supernatural causation, which forms the cornerstone of traditional cosmological, religious, social and moral worldviews of health and illness (Abdool Karim *et*

al. 1994). In the context of biomedicine, when an individual becomes ill, the question of causation pertains to 'what' caused the illness and 'how' it was caused. The traditional African worldview of causation believes that, in addition, the question of 'who' caused it and 'why', must also be addressed. This is an essential part of returning the body to its healthy state (healing process). As a result, any form of treatment/therapeutic mechanism given without this understanding may confuse the patient and render the treatment less effective, and even unacceptable in some instances (Abdool Karim *et al.* 1994). The medication given by a traditional health practitioner may not alleviate the symptoms of illness, but the reassurance and the psychological effect of the consultation on the patient play a vital role in restoring overall wellness. Similarly, the medication given by the medical practitioner may not provide psychological and spiritual comfort, but may alleviate the physical discomfort of illness. This is indicative of the interdependent and complementary role that biomedicine and traditional healing play in the healing process.

Chapter three provides an elaborate description of the African traditional healing system, with specific reference to the African cosmology and belief systems which influence the interpretation of health and ill-health.

1.2.5. Treating and curing HIV/AIDS from a traditional healing approach

The mainstream of traditional health practitioners admit that they may appear to cure diseases such as AIDS, but acknowledge that they in actual fact offer potential symptomatic relief from HIV-related infections, and enhance spiritual and psychological well-being, rather than combating the virus itself (Roberts 1999). Reported claims of the ability to cure HIV/AIDS by some traditional health practitioners have received strong criticism, not only from the western medical fraternity, but also from some authorities of the traditional healing sector. Traditional health practitioners who are striving to receive recognition in the official health care system of South Africa view these unsubstantiated claims as contributing towards the scepticism and discrediting of traditional healing as a legitimate profession, thus, reversing fundamental strides made in integrating traditional health practitioners into the mainstream of health care (Feni 2002).

Despite criticism, the belief that HIV/AIDS can be cured by traditional medicines is sustained amongst many traditional practitioners, as is revealed by the empirical findings of the research undertaken, reported in chapter eight of this thesis. Conceptualising the cause of HIV/AIDS and various theories of a possible traditional cure is further discussed in depth in chapter three of this thesis.

1.3. The South African context

Efforts to include traditional health practitioners in the official health care system appear to be more advanced in other African countries than in South Africa. Sadly so, considering that health services in South Africa still reflect the injustices and irrationality of apartheid. South Africa requires the provision of equitable health care which should be guided by the aspirations of the population, and the principles which reflect Traditional Health Care and the Primary Health Care Approach adopted by the WHO and UNICEF at Alma-Ata in 1978 (Rakolota 1992; WHO 1978). The Alma-Ata Declaration emanates from the International Conference on Primary Health Care, which took place in September 1978 to express the need for urgent action by all governments, health and development workers, as well as the world community, to protect and promote the health of all people worldwide.

South Africa finds itself in the wake of the devastating effects of the HIV/AIDS epidemic on all of its sectors. After much debate and controversy surrounding the provision of quality health care to individuals living with HIV/AIDS, the South African government has finally taken up the challenge of including antiretroviral therapy as part of providing comprehensive health care services. However, on the one hand, South Africa finds itself in a disadvantaged position to provide access to life-long antiretroviral therapy to the entire population that is in need, due to the high costs associated in doing so. South Africa, therefore, has to resort to other means to reduce AIDS-related morbidity and mortality, especially among the segment of the population that lives below the poverty line and is plagued by malnutrition and other factors that exacerbate the onset of full-blown AIDS. On the other hand, health care is belief-sensitive. The African belief system and the western belief system, stand divided in their interpretation of illness and health. Ideologies which form the foundation of each belief system, determine the diagnosis, prognosis and treatment of illness. Therefore, the South African government bears the responsibility of accommodating the health care needs of all South Africans in a non-biased manner, which includes those individuals who opt for the traditional healing system as their choice of health care.

The Government's commitment to address the basic needs of all South Africans is illustrated in the Bill of Rights, which enshrines the rights of all South Africans and affirms the democratic values of human dignity, equality and freedom. Two such rights are: (i) the right to freedom of conscience, religion, thought, belief and opinion; and (ii) the right to have access to health care services (Republic of South Africa, 1996). With reference to health care, upholding these two rights would, in part, require pulling together all available health care sources towards improving the health care of all South Africans.

South Africa, although at a less rapid pace compared with other African countries such as Uganda (THETA) and Tanzania (TAWG) (cf. paragraph 1.2.1), also portrays signs of moving towards integrating traditional health practitioners into certain primary health care programmes, rather than the coexistence of the two systems. The *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa 2003* (Operational Plan) (Department of Health 2003) refers to traditional health practitioners as an essential and irreplaceable component of the continuum of care developed for the HIV/AIDS care and treatment programme in South Africa. Furthermore, the Operational Plan acknowledges the importance of the role played by traditional health practitioners in treating and caring for PWAs, especially in the expanding of the official HIV/AIDS care and treatment programme throughout the nine provinces. The South African Government has reiterated the need to integrate traditional health practitioners into the national health care system. However, lack of clearly delineated policy guidelines for collaboration and translating policy into practice in many instances undermines Government efforts. Government, therefore, needs to adopt a stern approach and stringent measures to implement policies and decisions taken to integrate traditional and western health care systems. This includes consistent researching of patient needs and perceived benefits of traditional health care, and monitoring the implementation of policies and guidelines related to the traditional health care system, as well as collaboration between traditional and western health practitioners. The South African government's national plan to combat HIV/AIDS, and the anticipated role of traditional health practitioners in this plan are discussed in chapter two.

1.4. Aim and objectives of the study

The aim of this study is to explore the perceived role of the traditional health practitioner in the treatment and care of people living with HIV/AIDS, with a view to informing policies and initiatives aimed at integrating traditional health practitioners into official health care programmes, services and systems.

This aim will be achieved through the execution of the following objectives:

1) to provide an overview of the national response to the HIV/AIDS epidemic in South Africa, with specific reference to the strengths and weaknesses of the response;
2) to provide an introductory overview of the African traditional healing system in South Africa, and global and national policy frameworks related to African traditional medicine;
3) to give a description of lessons learnt from initiatives in Africa and Asia in their quest to enhance collaboration between traditional and western health practitioners towards an integrated national health care system;
4) to provide a descriptive overview of the structure of the traditional healing system in the Eastern Cape, with specific reference to Buffalo City;
5) to ascertain the knowledge, attitudes, practice and beliefs of traditional health practitioners about HIV/AIDS;
6) to determine the views and attitudes of traditional health practitioners about their role in the treatment and care of people living with HIV/AIDS in the context of the existing official health care system;
7) to determine the views and attitudes of western health practitioners about the role of traditional health practitioners in the treatment and care of people living with HIV/AIDS in the context of the existing official health care system;
8) to propose recommendations, based on the findings of the research undertaken, to optimise collaboration between traditional and western health practitioners in South Africa.

1.5. Research design and structure of thesis

The research essentially comprises two distinct parts, namely part one, which takes the form of a literature study (chapters 2 to 4), and part two which constitutes the exploratory empirical study (chapters 5 to 10). The literature study explores past and current developments in the field of HIV/AIDS and traditional healing. It serves to inform the research methodology adopted for the empirical study, and provides a conceptual and contextual framework to analyse and interpret the findings of the empirical study. Part two provides new knowledge to enhance insights about traditional healing and HIV/AIDS within the South African context, and with relevance to policy developments. An outline of the chapters that comprise the thesis follows:

Chapter 1 introduces the research topic, conceptualises the research problem and rationale for this study, and highlights the literature which is to be discussed for contextualising and interpreting the research findings.

PART 1
LITERATURE STUDY

Chapter 2 provides an overview of the national response adopted by the South African government to address the HIV/AIDS epidemic, as well as the current and envisaged role of the traditional healing system within the official health care system and selected programmes.

Chapter 3 is an introductory overview of the African traditional healing system. The various types of traditional health practitioners are described, with specific emphasis on the three categories of traditional health practitioners under study, namely diviners, herbalists and spiritual healers.

Chapter 4 gives a summative analysis of the strengths and weaknesses of efforts embarked upon by selected protagonists and governments to promote collaboration between the western and traditional health care systems as case studies in point. Lessons learnt from the integration of Chinese medicine into national health care systems in Asia are highlighted.

PART 2
EMPIRICAL STUDY

Chapter 5 describes the research approach and design adopted for this study, as well as the sampling and data collection process followed. Challenges posed by the research design are discussed, as well as problems encountered in collecting data. The data analysis procedure is also outlined.

Chapter 6 is the orientation to the study population. It includes an overview of selected geographical and socio-demographic characteristics. Also included is the availability of health care and health care utilisation trends, as well as an analysis of the organisational structure of the traditional healing system at a national, provincial and Local Service Area (LSA) level.

Chapters 7 is a discussion of the main findings of the research undertaken pertaining to the knowledge, attitudes, beliefs and practices of traditional health practitioners about HIV/AIDS in the research area.

Chapter 8 discusses the main findings of the research pertaining to the organisational structure of the traditional healing system in the research area, and views about the legalisation and professionalisation of traditional health practitioners.

Chapter 9 gives the main findings of the research undertaken concerning the views of traditional and western practitioners about current and prospective collaboration between the two groups of practitioners. Included in this chapter are perceived impediments to collaboration.

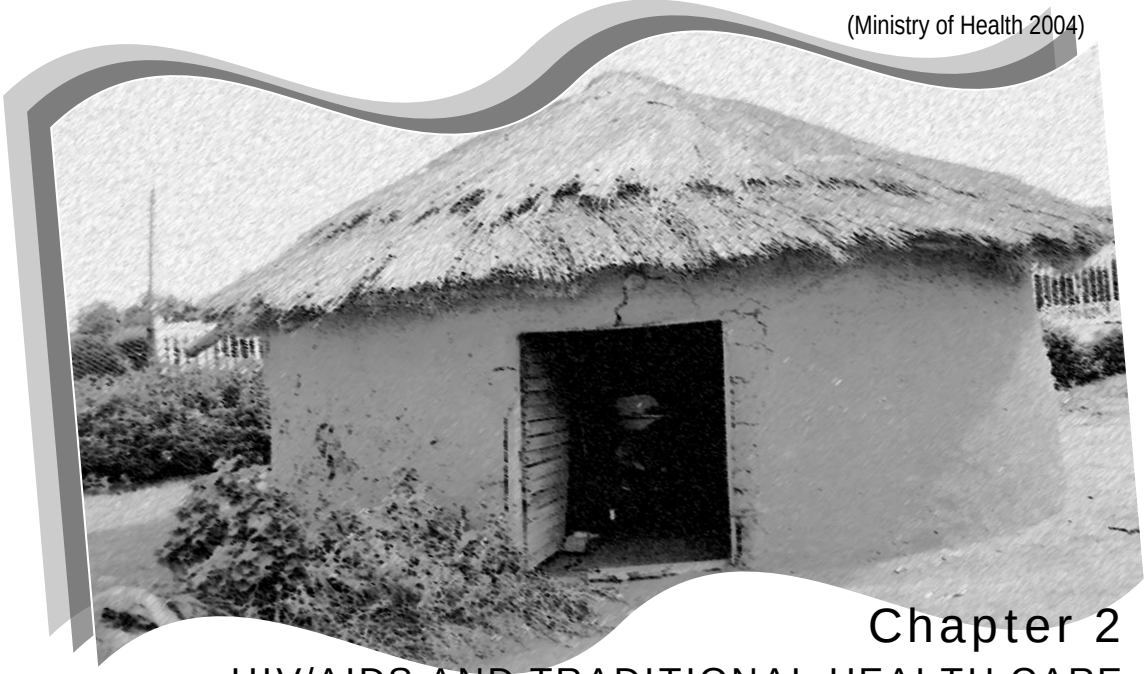
Chapter 10 highlights the major conclusions of the research findings against the stipulated objectives of the study. Recommendations are proposed based on the main findings of the research and guided by the literature study in part one of the thesis. Recommendations are aimed at informing all levels of government, traditional and western health practitioners in developing policies and programmes to integrate traditional health practitioners into HIV/AIDS and other health-related programmes.

PART ONE
LITERATURE STUDY

"It is absolutely important that we reiterate in unequivocal terms our commitment and determination, as a department and partners, including all stakeholders, to mobilise resources from all quarters to ensure that traditional medicines and the practice thereof enjoy, for the first time in our history, the full recognition and support they have always deserved".

-Manto Tshabalala-Msimang (Minister of Health)

(Ministry of Health 2004)



Chapter 2
HIV/AIDS AND TRADITIONAL HEALTH CARE IN SOUTH AFRICA

South Africa is reportedly the hardest hit by the AIDS epidemic of all the countries globally (Global AIDS Foundation 2004). The current impact of HIV/AIDS on all sectors of South Africa remains adverse, and future projections of the effects of the unperturbed disease portray an unfavourable impression. Sustained high HIV infection rates at a national and provincial level have evoked a renewed urgency to prevent new infections, as well as to address the health care needs of those individuals who are already living with HIV/AIDS - hence, the development and implementation of an expanded national comprehensive HIV/AIDS prevention, treatment and care programme, which has been endorsed and supported by the international community. The programme strategically focuses on the provision of antiretroviral therapy to reduce HIV/AIDS-related morbidity and mortality. Limitations and challenges of western health care in providing appropriate treatment to people living with HIV/AIDS has prompted individuals to consult traditional health practitioners in the hope of finding a cure. However, progress towards fully exploring the

traditional healing sector and its benefits to people living with HIV/AIDS has been rather slow. This chapter provides an overview of the relationship between HIV/AIDS and the traditional healing sector in South Africa.

2.1. Contextualising HIV/AIDS in South Africa

2.1.1. HIV incidence and prevalence

The HIV/AIDS epidemic in South Africa is characterised by escalating HIV infection rates, and resultant increased morbidity and mortality of especially the economically active segment of society. Sub-Saharan Africa is home to 71% of people living with HIV/AIDS in the world, and in 1998, half (50%) of all new cases of HIV infections in sub-Saharan Africa occurred in South Africa (Giarelli & Jacobs 2003). The prevalence rate among pregnant women attending public antenatal clinics in South Africa increased by 2.1% between 1998 and 1999 (from 22.4% to 24.5%). A decrease in HIV prevalence rates was evident between 1999 (24.5%) and 2001 (15.4%), which may point towards success in prevention programmes and campaigns in the country, but may also be attributed to decreased fertility rates. In 2002 HIV-prevalence peaked at an estimated 26.5%. An estimated 6 million of the total 43 million South Africans (one in seven) are living with HIV/AIDS with 550 000 people infected annually. It is reported that an average of 70 000 infants are born HIV-positive in South Africa annually (150 infants per day) (Giarelli & Jacobs 2003; Institute of Science in Society 2004; Sibiya 2000). In 2002 alone, 91 271 infants were born HIV-positive (Global AIDS Foundation 2004).

2.1.2. Effects of HIV/AIDS on life expectancy, mortality and population growth

On average, the AIDS epidemic lags between 9-11 years behind the HIV epidemic, in the absence of treatment (WHO 2004). In South Africa, the time period between infection and death is estimated to be 6 to 8 years (Sibiya 2000). The evidently shorter time lapse between time of HIV infection and time of HIV-related death among South Africans may primarily be attributed to the poor socio-economic conditions of the population worst affected by the epidemic. In other words, poverty exacerbates the onset of full-blown AIDS.

The most dramatic effect of the HIV/AIDS holocaust manifests itself in demographic trends such as adult and child mortality, life expectancy and population growth. Adult and child mortality is expected to continue increasing, whilst life expectancy and population growth will continue to decline. An estimated 600 South Africans die of AIDS-related illnesses daily and 6 million South Africans are expected to lose their lives to an AIDS-related illness over the next 10 years (2004-2014). Mortality rates for men aged between 20 and 40 years have almost doubled since 1998, and even greater increases are evident for women between 20 and 35 years. As a result of the AIDS epidemic, the life expectancy of South Africans is expected to drop from over 60 years to below 50 years in the period 2000-2005, and further plummet to below 40 years by 2010 (Giarelli & Jacobs 2003; Global AIDS Foundation 2004; WHO 2004). In the absence of AIDS, the population growth rate in Southern Africa would have been between 1% and 3%. The population growth rate for South Africa currently hovers just over 0% (0,1%-0,3%) due to decreased fertility rates. In 2002, the death rate due to AIDS in KwaZulu-Natal exceeded the birth rate (Giarelli & Jacobs 2003; Sibiya 2000). A controversial report released by the Medical Research Council (MRC) in 2001 predicts that if the HIV/AIDS tide is not effectively stemmed in South Africa, the end of this decade will be marked by a three-fold increase in deaths among

children aged 1-5 years; AIDS-related deaths will account for twice as many deaths as all other causes combined; and population growth will be stunted. (Dorrington *et al*. 2001; Pelser *et al.* 2003).

2.2. The wrath of the HIV/AIDS epidemic

The projected journey of the inexorable epidemic reveals sustained HIV infections, and HIV-related morbidity and mortality, which translate into continued adverse consequences and, thus, hampered development targets. The manifestations of the non-discriminatory epidemic are evident in all sectors of society. However, the impact varies from one sector to another, with poor households in South Africa bearing the greatest brunt of the epidemic. Comparatively, the health, education and business sectors are also hardest hit by the impact of the HIV/AIDS epidemic (Pelser *et al.* 2003). The impact of the HIV/AIDS epidemic on the health sector only, will be dealt with for purposes of relevance to the topic under study, namely treatment, care and support for persons living with HIV/AIDS, and who are pluralistic in their health care utilisation.

2.2.1. Impact on the public health sector

The health sector, among other sectors, bears the brunt of the epidemic as a result of increased AIDS-related morbidity. Health care for HIV/AIDS patients is more expensive than for most other conditions, primarily due to the repetitive nature of HIV/AIDS-related illnesses, as well as lengthened hospitalisation for HIV/AIDS patients in relation to HIV-negative patients. A study conducted by the Human Sciences Research Council (HSRC) found that HIV-positive patients tended to be hospitalised for an average period of 13 days compared with eight days for patients who are HIV negative (South African Broadcasting Corporation 2004a). According to Gilbert *et al.* (2002), 80% of South Africans rely on publicly funded hospitals and the primary health care system in relation to the official private health sector, which is mainly funded by employment-related health insurance schemes (Pelser *et al.* 2003). The implementation of the primary health care system has resulted in a redirection of resources from public hospitals towards primary health care facilities. Thus, the AIDS epidemic places a phenomenal burden on the public hospital system by rendering it unable to cope with the present demands, and will continue to do so if alternate options of care are not explored and adopted to complement the public hospital system.

According to the South African Institute of Race Relations (2001), as of 2004 the increase in demand for health services due to HIV/AIDS will exceed 5% per year and rise to 11% each year from 2010. Between 26% and 70% of hospital beds at public hospitals in South Africa are occupied by adult AIDS patients, and between 26% to 30% of beds are occupied by children (Global AIDS Foundation 2004). A case in point is one hospital in KwaZulu-Natal which reported that 40% of adult in-patients were admitted with HIV-related conditions in 1997. One other hospital in Gauteng reported that 30% of children younger than six years admitted to the hospital were HIV positive (Bollinger & Stover 1999). According to the findings of a study conducted by the HSRC, 46% of patients in public hospitals were HIV positive in 2002, and an increase of between 40% and 45% in AIDS patients at public hospitals is predicted by 2007 (South African Broadcasting Corporation 2004a). Increased expenditure on the health care needs of HIV-positive patients places unbearable strain on an already strained health care budget and human resources. All the more reason to explore and invest in other health care resources to reduce the burden on the current official health care system.

2.3. South Africa retaliates to a ravaging disease (HIV/AIDS)

The HIV/AIDS epidemic in South Africa first manifested in the early 1980s (Pelser *et al.* 2003). South Africa's response to the AIDS epidemic was slow to start with, but is fast gaining momentum, simultaneous with the devastating aftermath of the epidemic in the country. Responses to HIV/AIDS in South Africa have primarily taken the form of policy development and implementation to reduce HIV infections and provide treatment, care and support to those already living with the virus. However, these efforts have been ad hoc, inconsistent, lacked coordination, and the amalgamation of all available resources and role players necessary to yield significant results. Since, Government's approach has evolved into a multisectoral and comprehensive approach which attempts to harness all available resources to combat the HIV/AIDS epidemic.

Before the inception of the democratic government in 1994, the national response to the HIV/AIDS epidemic in South Africa was fragmented and largely Department of Health-oriented, although both Government and civil society shared a common goal, namely to address the impact of the disease on society. In 1994, the *National AIDS Plan* was developed by the National AIDS Convention of South Africa (NACOSA). The *AIDS Plan* aimed to achieve three fundamental objectives, namely (a) prevent HIV transmission; (b) reduce the personal and social impact of HIV infection; and (c) mobilise and unify local, provincial, national and international resources to address the epidemic. The Government of National Unity adopted the *National AIDS Plan* as the national strategy to combat the HIV/AIDS epidemic, but renamed it the *HIV/AIDS and STD Programme 1995-1996*. In principle, the programme was more inclusive by acknowledging the importance of involving civil society, especially communities and people living with HIV/AIDS, in prevention and care initiatives. A critique of the strategy found it still to be largely Department of Health-centered and lacking sufficient implementation. The findings and recommendations of a review of the programme, which took place in 1997, led to subsequent revisions in the national approach to HIV/AIDS. One major development, which emanated from the review, was the evolution of the *HIV/AIDS and STD Programme 1995-1996* into an expanded national strategic plan designed to guide the country as a whole (not merely the health sector), both within and outside Government, thus, rendering it more devolved. The strategy was implemented at the national level in the form of the *HIV/AIDS and STD Strategic Plan for South Africa 2000-2005* (Department of Health 2000; Pelser *et al.* 2003).

2.4. The national HIV/AIDS strategy

The *HIV/AIDS and STD Strategic Plan for South Africa 2000-2005* (Strategic Plan) was an advancement of the country's response to the HIV/AIDS epidemic, following recommendations from a review conducted in 1997 to identify shortcomings of the national response to the epidemic. The Strategic Plan provides a broad policy framework for all sectors of society, which include government, NGOs, CBOs, business, labour and women, in developing sector-specific plans based on their role in society, their activities, and their specific strengths. The multisectoral undertone of the Strategic Plan is indicative of the shift from a health-centred to an integrated national-based strategy in South Africa's response to HIV/AIDS. The realisation of the need for a broad-based, multisectoral approach towards fighting the disease was evident when the then Deputy President Thabo Mbeki launched the Partnership Against AIDS in 1998, which was formalised in 2000 by the formation of the South African National AIDS Council (Department of Health 2000).

Reducing new HIV-infections, especially among the youth, as well as reducing the impact of HIV/AIDS on individuals, families and communities, form the core goals of the Strategic Plan. Improving care and treatment for people living with HIV/AIDS, in order to promote a better quality of life and limit the need for hospital care, is one of four general strategies highlighted in the Strategic Plan, towards achieving its goals. The Strategic Plan is built around four priority areas, namely (i) prevention; (ii) treatment, care and support; (iii) human and legal rights; and (iv) monitoring, research and evaluation. A total of 15 goals have been set to address the four priority areas. Each goal has stipulated objectives and associated strategies for accomplishing the stated objectives. One important goal of the Strategic Plan is to investigate treatment and care options for people living with HIV/AIDS by, *inter alia* conducting research on the effectiveness of traditional medicines (Department of Health 2000). The Strategic Plan provides a broad framework for a multisectoral response to the HIV/AIDS epidemic, including provision of treatment and care.

2.4.1. Treatment and care

Until recently, the issue of treatment has been the most neglected element in most developing countries (WHO 2004). The South African Government's initial antagonism to the provision of antiretroviral therapy received much criticism from the general public, and more so from pressure groups lobbying for people living with HIV/AIDS. The basis of Government's antagonistic stance on antiretroviral therapy was concerns about the exorbitant costs of antiretroviral drugs, as well as the toxicity of such drugs (Pelser *et al.* 2000). The Treatment Action Campaign (TAC) is one of South Africa's leading pressure groups which defend the rights of people infected with, and affected by HIV/AIDS. Its national struggle for access to antiretroviral therapy for all people living with HIV/AIDS led to the Pan-African Treatment Action Movement, launched in August 2002 (WHO 2004). In November 2003, the South African Government finally approved a national drug treatment programme to deal with HIV/AIDS (SABC 2004a).

2.4.2. Moving towards an expanded global response to HIV/AIDS

A comprehensive approach to HIV/AIDS integrates prevention, treatment and long-term care and support for people living with the virus (WHO 2004). In view of the fact that treatment has received the least attention in the fight against HIV/AIDS in developing countries, urgency in rapidly expanding this neglected facet in countries hardest hit by the pandemic is vital, in conjunction with accelerated prevention efforts. Antiretroviral therapy has hit the world by storm and is put forward as one of the most feasible treatments to provide in the poorest settings. In 2003, only 400 000 people in the developing world were receiving treatment for HIV/AIDS. A study conducted in South Africa revealed that treating the most serious HIV-compromised South Africans could prolong between 500 000 to 1.7 million lives over a 5-year period. In September 2003, the dire lack of access to AIDS treatment with antiretroviral drugs prompted WHO, UNAIDS and the Global Fund to declare it a global health emergency. In response to this emergency, the three afore-mentioned organisations, together with their partners, launched the *WHO 3 by 5 Plan*. The 3 by 5 plan is an initiative aimed at providing 3 million people in developing countries with antiretroviral therapy by 2005 (Global AIDS Foundation 2004; WHO 2004).

One of the major obstacles to reaching the goals of the 3 by 5 plan is that for the most part, HIV/AIDS has struck hardest in countries with already compromised health systems. These countries, therefore face significant deficits in areas such as health sector human resources, HIV counselling and testing, drug procurement and supply

management, health information systems, and laboratory capacity. To overcome these challenges and to achieve the 3 by 5 target necessitate building partnerships between national governments, international organisations, civil society and communities. The importance of drawing on the strengths of each of the above sectors cannot be overemphasised, nor can the fundamental role of all spheres of government in devising mechanisms to harness indigenous resources within communities.

August 2003 marked the South African government's landmark decision to integrate antiretroviral therapy into its HIV-treatment and -care response, when the Cabinet requested the Ministry of Health to develop a detailed operational plan for a national antiretroviral treatment programme. A task team, the National HIV/AIDS Treatment Task Team, was appointed to coordinate the process of developing the operational plan which was completed November 2003. The antiretroviral treatment programme was developed within the broad framework of the Strategic Plan, and is intended to intensify and expand the *HIV/AIDS and STI Strategic Plan for South Africa 2000-2005*. The development of the comprehensive strategy has received support from the international community in the form of technical assistance, funding and monitoring. The Pangaea Global AIDS Foundation worked closely with the South African government as it developed a comprehensive strategy to make ARV treatment available to all people living with HIV/AIDS. Experts from the Clinton Foundation AIDS Initiative collaborated with the Pangaea clinical advisory team to render support to the South African National HIV/AIDS Treatment Task Team in developing the national plan for a comprehensive strategy to provide HIV treatment and care, including access to antiretroviral drugs throughout the country. South Africa has embarked on an unprecedented and formidable challenge by attempting to provide accessible, comprehensive antiretroviral treatment and care to the entire population in need (GCIS 2002; Global AIDS Foundation 2004; Tshabalala-Msimang 2003). A noble attempt no doubt, but with questionable feasibility, taking into account the large number of people living with HIV/AIDS (6 million) and the cost implications thereof in a resource-poor country such as South Africa.

2.5. The dawn of a new era: Comprehensive HIV and AIDS Care, Management and Treatment for South Africa

Three months of extensive meetings, numerous discussions with representatives of all nine provinces, including meetings with provincial Health MECs, consultations with a wide range of stakeholders, including NGOs, professional associations, trade associations, labour organisations, research institutions, and HIV/AIDS clinicians, bore fruit in the form of the *National Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (Operational Plan) (Department of Health 2003). The Operational Plan aims to achieve two interrelated goals, namely (i) to provide comprehensive care and treatment for people living with HIV/AIDS; and (ii) to facilitate the strengthening of the national health system in South Africa. The development of the Operational Plan was the responsibility of the assigned National HIV/AIDS Treatment Task Team, with the assistance of the Pangaea Global AIDS Foundation and the Clinton Foundation AIDS Initiative.

The development of the Operational Plan was guided by thirteen fundamental principles, one of which is the promotion of individual choice of treatment by encouraging all South Africans to make their own informed choices about the types of treatment they wish to seek. Therefore, the comprehensive HIV/AIDS programme proposes to offer a wide range of options, such as advice on general health maintenance strategies, positive living, exercise,

nutrition, antiretroviral therapy, as well as traditional and complementary medicines. In the same breath, the comprehensive programme is committed to ensuring the safe use of medicines, which entails monitoring patient safety, emphasising the safe use of medicines, and the importance of adherence to treatment. The Operational Plan places emphasis on antiretroviral therapy in its commitment to ensure the safe use of medicines, although the comprehensive programme also promotes the use of traditional and complementary medicines. It is of utmost importance that the use of traditional and complementary medicines also be monitored for patient safety, in the best interest of those individuals who opt for this form of treatment as by informed choice. A discussion on the safety and efficacy of traditional medicines in South Africa follows in paragraph 2.14.

The Operational Plan sets out clear tasks that must be accomplished, which includes a detailed schedule and timeframes in which all tasks must be completed for the Operational Plan to be effective. Broadly, the Operational Plan envisages to provide care to 3 million of the more than 5 million South Africans living with HIV/AIDS, and to provide antiretroviral therapy to between 900 000 and 1.2 million of the 3 million by 2007 (Global AIDS Foundation 2004). The Operational Plan has, however, been faced with numerous challenges and unforeseen obstacles which have impeded the plan reaching the set targets within the specified timeframes. These challenges are discussed in paragraph 2.6.

The implementation of the Operational Plan has taken effect in each of the nine provinces in South Africa, in what is commonly referred to as the comprehensive roll-out plan. The provincial roll-out plans are being implemented in accordance with the readiness of each province to do so. The comprehensive roll-out plan for the Eastern Cape was launched on 14 May 2004, and targed an estimated 2 700 beneficiaries in the first six months of its implementation. The Eastern Cape provincial government allocated an annual budget of R40.8 million for the roll-out campaign of the Operational Plan for 2004/2005(SABC 2004b).

2.6. Challenges of the Operational Plan

The implementation of the Operational Plan, both at a national and provincial level, has not taken place glitch free. Numerous obstacles have been in play and more are anticipated. Factors that pose the gravest threat to the effective implementation of the Operational Plan are (i) human resources; (ii) goals and targets of plan; and (iii) non-adherence to treatment regimens.

2.6.1. Human resources

Human resource development is increasingly being recognised as a fundamental aspect of health sector development especially in primary health care delivery. In the absence of primary health care staffing standards, 25 patients per nurse per day is regarded as the acceptable workload for primary health care facilities in South Africa (Lehmann *et al.* 2002). In many public health care facilities in South Africa, nurse workloads by far surpass this norm. Staff shortage at primary health care facilities is one of the major hindrances to effective service delivery. To make matters worse, HIV/AIDS arguably poses the greatest challenge to human resource development in the health sector. Not only does the health sector have to cope with the burden of increased morbidity and mortality amongst health staff, in addition, it also has to shoulder the impact of a rapidly increasing disease burden in the general

population (Lehmann *et al.* 2002). This leads to the question: Will public health care staff cope with the additional responsibilities necessitated by the comprehensive programme in the light of the existing staff shortage nationally, and existing high patient workloads? This is one of the challenges faced by the Operational Plan.

2.6.2. Goals and targets

The goals and targets of the plan, in themselves, pose great challenges. If one or two necessary steps are not completed on time, the entire programme may be jeopardised, although measures have been taken to minimise risk to patients in the event that individual tasks are not completed on time (Stevens *et al.* 2004). The Operational Plan has set two targets, namely (a) establishing a minimum of one ARV treatment service point in every health district in South Africa by the end of the first year of implementation, and (b) providing all South Africans who require comprehensive care and treatment for HIV/AIDS equitable access to this programme within their local municipalities within a period of five years (2005-2009). It is estimated that by 2009, 1.4 million South Africans will require ARV therapy (Department of Health 2003). The stipulated goals can only be attained with the necessary human resources and appropriate infrastructure to deliver the services stipulated by the programme. The challenge is putting in place these prerequisites in time for the attainment of the Operational Plan's goals within the specified timeframes.

2.6.3. Non-adherence to treatment regimens

With the exception of lack of available trained human resources, which may delay the attainment of the goals of the plan in the anticipated timeframes, non-adherence of patients to antiretroviral treatment regimens pose an even greater threat to the success of the Operational Plan. Antiretroviral drugs suppress virus replication, which contains the HIV in the human body. Failure to adhere strictly to therapy regimens results in drug resistance. Even sub-optimal adherence has proven less than effective, since failure to completely suppress virus replication has been shown to result in the development of resistance even at high levels of adherence (>92%). Moreover, drug resistant virus strains are transmissible and pathogenic. Therefore, drug resistance is not only of concern for the infected individual whose therapy fails as a consequence, but also for the health care system. The higher the incidence of HIV infection, the more rapidly resistant variants spread (Stevens *et al.* 2004).

Evidence suggests low drug adherence rates in Africa compared with industrialised countries. A case in point is the suboptimal treatment adherence of 60-70% of Malaria cases in Africa, while treatment completion rates for TB cases range from a low 37% to a moderate 78% (Stevens *et al.* 2004). In view of sub-optimal adherence levels of less than 92% resulting in the development of resistance to antiretroviral drugs, as well as sustained high HIV-infection rates, South Africa can brace itself for the grim fate of high rates of resistance to antiretroviral drugs among the population living with HIV/AIDS, as well as the rapid transmission of drug resistant viral strains within the population at large. It is, therefore, imperative that stringent measures be adopted to ensure that the distribution of antiretroviral drugs occurs in the context of policies, practices and procedures that promote rational antiretroviral drug use, and most importantly, to encourage and maximise patient adherence. This will require a conflation of activities applied consecutively, namely, constant and consistent monitoring and evaluation of the implementation of the Operational Plan, as well as routine monitoring of viral load in patients (to detect non-responsiveness to antiretroviral drug combinations), and identifying and addressing factors contributing to non-adherence to antiretroviral therapy.

2.7. Turning to traditional healing

The rapid spread of HIV/AIDS, combined with the challenges of obtaining western medicine, including antiretroviral drugs, is forcing more PWAs to turn to traditional health practitioners in search of a cure. However, there is a dire lack of concrete measures in place to benefit from the large pool of knowledge of traditional health practitioners in treating and curing various ailments including HIV-related illnesses. Policies and laws that relate to the practice of traditional healing have evolved over time. After the settlement of Europeans in Africa, the missionary influence, as well as repressive political ideologies, the colonial administrators outlawed African medical practises by condemning them as '*heathen', 'primitive', 'barbaric'* and *'uncivilised'* (Pretorius 2004). This colonial view of traditional healing as part of a barbaric civilisation was widely held. Although traditional health practitioners were permitted to practise their "trade" undeterred, officially, the use of traditional health practitioners in South Africa was outlawed by the 1974 Health Act, which forbid practitioners not registered with the then South African Medical and Dental Council (amended in 1982 to include those not registered with the South African Associated Health Services Professions Board) from practising medicine (Freeman 1992; Freeman & Motsei 1992). Traditional health practitioners only gained legal recognition in South Africa in February 2005 through the Traditional Health Practitioners Act 2004.

An overview of international and national policy frameworks, in respect of traditional healing, are discussed with a view to contextualise the current status and role of traditional health practitioners, especially in the global and national response to the onslaught of the HIV/AIDS epidemic.

2.7.1. Legalising and legitimising traditional healing in health care systems

The WHO (2002) defines four types of health systems to describe the relationship between western and traditional medicine in respect of the status and position of traditional healing systems in societies. An exclusive (monopolistic) system recognises only the practice of allopathic medicine, and illegalises or severely restricts all other forms of healing including traditional healing. In countries with a tolerant system, the national health care system is based entirely on allopathic medicine, with certain practices of traditional healing tolerated by law. An inclusive system recognises traditional healing, but has not yet integrated it into all aspects of health care (i.e. delivery, training, education, or regulation) (WHO 2002). This system may also be referred to as a parallel system since more than one system of health care coexists within a country (Pretorius 2004). Typical of an inclusive system, traditional healing may not be available at all health care levels; health insurance may not cover treatment with traditional medicine; official education and training in traditional healing may not be available at tertiary level; and regulation of providers and products of traditional medicine may be lacking or only partial. This system is evident in both developed and developing countries such as Zimbabwe, Guinea, Nigeria, Mali, Ghana, India, Sri Lanka, Indonesia, Japan, Austria, and South Africa, to mention just a few (Pretorius 2004; WHO 2002).

There has been a global consciousness regarding the necessity to move away from exclusive, tolerant and inclusive systems towards integrated systems characterised by the amalgamation of all health care systems available in a society, for purposes of optimising health care for all. The WHO has played a significant role in initiating an unprecedented global upsurge of interest in traditional medical systems, and driving the incorporation of this system into national health care systems. Traditional healing systems serve a significant proportion of Africans, and

should thus be recognised as an official health care system. The WHO (2002) refers to an integrative system, whereby traditional healing is officially recognised and incorporated into all areas of health care provision. This entails (i) including traditional medicine in the relevant country's national drug policy; (ii) registering and regulating providers and products of traditional healing; (iii) providing traditional healing at both public and private hospitals and clinics; (iv) reimbursing treatment with traditional medicine under health insurance; (v) undertaking relevant research in traditional healing; and (vi) making education in traditional healing available. Several developing countries in Africa, Asia and Latin America have attempted to unite traditional and western health care systems into a single national health care network. However, to date, only China, the Democratic People's Republic of Korea, the Republic of Korea and Viet Nam have arguably attained an integrated health care system (WHO 2002).

Selected initiatives in various countries aimed at integrating traditional and western medicine are discussed in chapter four.

2.8. Traditional healing globally: policies and proclamations

National legal and policy frameworks for the inclusion of traditional healing in the mainstream of health care in South Africa are guided by international standards and trends for the integration of traditional health practitioners into official health care systems. The ultimate goal is to attain an integrated system of health care as defined by the WHO (WHO 2003). Whether or not this is achievable, or whether it would be to the benefit, or to the detriment of the traditional healing system, remains debatable in the light of the differences in paradigms and ideologies between the traditional and western health care systems.

One view is that a parallel system is more appropriate, where the two health care systems function independently, with mutual recognition and respect between the two. This view is based on a fear that one of the two systems may be over-compromised in the process of integration (WHO Kobe Centre 2002). The fear of traditional health practitioners being suppressed in the process of integrating the two health systems was reiterated by traditional health practitioners that participated in the research undertaken. Be it as it may, partial integration of traditional health practitioners into national health programmes and systems is necessary to provide comprehensive and holistic health care to a population that utilises both western and traditional healing systems. Inclusive or parallel health systems do not sufficiently cater for individuals who are pluralistic in their health care needs, as health care services for this segment of the population is largely fragmented. This is currently the case in South Africa, although efforts are underway to move towards partial integration. It is of the utmost importance to engage both traditional and western health practitioners in the decision-making process pertaining to the extent and nature of integration of the two health care systems, to ensure mutual understanding and cooperation between practitioners of both health systems. Thus, an integrated health care system, as referred to in this thesis, should be understood as integration at a level that enhances health care for individuals that utilise both traditional and western health practitioners, yet preventing over-compromising one system.

Traditional health practitioners in South Africa only started gaining recognition in the nineties of the previous century. Surprisingly so, taking into account that the inclusion of traditional health practitioners in formal health care

systems was endorsed by the international community as early as 1977.[1] In 1977 the Thirtieth World Health Assembly of the WHO passed a resolution promoting development of training and research in traditional systems of medicine. Additional resolutions supporting the utilisation of indigenous practitioners in government-sponsored health care systems were passed in 1978 at the International Conference on Primary Health Care held in Alma-Ata. In fact, a goal was set 26 years ago at the international conference, namely that there would be primary health care for all by 2000. The Alma-Ata Declaration, 1978, specifically stated that the mobilisation of traditional medicines would be the only way in which health for all could be a reality (Seneviratne 2000; WHO 1978). The implication by no means being that the integration of traditional medicine into a national health care system is without obstacles. One such obstacle is the difficulty in trying to evaluate the efficacy of traditional medicine, and to safeguard and promote quality of care. Another major obstacle is attaining equitable distribution of power among different medical systems' providers to control health care systems and medical resources (Chi 1994). Nonetheless, it is imperative that these, and other obstacles alike, do not deter the inclusion of traditional health practitioners into national health care systems in the quest to provide health care for all.

The WHO has played a pivotal role in propagating a global interest in traditional medical systems and promoting the inclusion of traditional health practitioners in national and donor-specific health programmes. Following the Alma-Ata Declaration, other international donor organisations, such as the UNAIDS, shortly followed suit by adopting similar policies, which indicated acceptance of the utilisation of traditional practitioners in health care programmes financed by the respective organisations (Pillsbury 1982). In the subsequent more than two decades, the WHO spearheaded initiatives aimed at improving the status of traditional healing systems. The basis of these initiatives was to assist countries to formulate policies on traditional healing; to study the usefulness of traditional medicines; to upgrade the knowledge of practitioners; and to educate the public about proven traditional health practices (Pretorius 2004). Many other organisations and government agencies have also called for closer collaboration between traditional and western medicine throughout the past decade. The African Union, for one, declared the period 2001-2010 as the Decade of African Traditional Medicine, and the New Partnership for Africa's Development (NEPAD) has noted traditional medicine as an important strategy in its plan. Despite these declarations, legalising and officially recognising traditional health practitioners have been characteristically slow in the legislatures of African countries (Gbodossou *et al.* s.a). In the South African Government's defense, Ndaki (2004) points out two factors which have contributed to the lengthy process of drafting the current legislation for traditional health practitioners, namely, that there was very little interest in structuring this sector prior to 1994; and the enormous size of the traditional healing profession.

2.9. Traditional healing nationally: South African policies and proclamations

In many instances, the relationship between traditional and western health practitioners is one of coexistence rather than collaboration. South Africa is a case in point, where government has accepted the existence and institutions of traditional health practitioners. However, this acceptance is based more on allowing traditional health

[1] In 1974, the WHO Regional Committee for Africa decided that the topic for the technical discussions at its 26th Session would be *Traditional medicine and its role in the development of health services in Africa.* This was followed in 1977 by the adoption of a resolution on the promotion of training and research related to traditional medicine (Pretorius 2003). A year later at Alma-Ata, it was declared that African traditional healers should be part of the primary health care team (WHO 1978).

practitioners to coexist in a pluralism of health care systems, rather than to incorporate traditional practitioners in the official national health care system (Pillsbury 1982). Government's policy on the transformation of the National Health Service (the *White Paper for the Transformation of the Health System in South Africa 1997*) states that "traditional practitioners and traditional birth attendants should not, at this stage, form part of the public health service, but should be recognised as an important component of the broader primary health team[2]" (Ministry of Health 1997: 34). In the same breath, there has been a growing consciousness of the dire need for integration of traditional healing into the national health care system, as compared to coexistence of the two health care systems, although the former has as yet not been achieved.

Before the election of the democratic government in 1994, the African National Congress (ANC) made a proposition in its health plan. It proposed to include traditional health practitioners as an integral and recognised part of health care in South Africa. It claimed that consumers would be granted the right to consult a provider of their choice for their health care, and that legislation would be changed to facilitate controlled use of traditional practitioners (ANC 1994; Peltzer 2000). The *White Paper for the Transformation of the Health System in South Africa 1997* states: "the regulation and control of traditional healers should be investigated for their legal empowerment. Criteria outlining standards of practice and an ethical code of conduct for traditional practitioners should be developed to facilitate their registration[3]" (Ministry of Health 1997: 34).

There is an apparent national shift towards initiating closer collaboration between traditional and western health practitioners in the provision of health care. This move is based on two principal tenets, namely (i) that people have the right of access to traditional health practitioners because of their cultural heritage and belief system, and (ii) that there are numerous advantages in cooperation and liaison between western and traditional health practitioners. The South African government's stance on recognising traditional practitioners in the national health care system is evident in the policy objectives and principles which a unified health care system in South Africa is to be based upon, as stipulated in the *White Paper for the Transformation of the Health System in South Africa 1997*. Furthermore, the South African Constitution provides the framework for accommodating the traditional health care system in the Bill of Rights [s15(1), s27(1a) and s31(1)][4] (Republic of South African 1996). For one, it is a basic human right for individuals to consult practitioners of their choice to meet their health care needs. Second, traditional health practitioners have the right to choose and practise their trade, occupation or profession freely, provided that they are subject to legal regulation (Pretorius 2004).

A visible shift in legislation has been marked by the recent enactment of the Traditional Health Practitioners Bill in South Africa (Republic of South Africa 2005). The Act was initiated in an attempt to recognise and regulate the practices of traditional health practitioners in South Africa. The *Traditional Health Practitioners Act 2004* is the product of a lengthy consultative process. A discussion of this process and the Act follows in paragraphs 2.11 and 2.12.

[2] Chapter four, paragraph 4.1.1 (a) vii.
[3] Chapter four, paragraph 4.1.1 (a) vii.
[4] Chapter two – Bill of Rights - states:
15 (1) Everyone has the right to freedom of conscience, religion, thought, belief and opinion.
27 (1) a. Everyone has the right to have access to health care services, including reproductive health care.
31 (1) Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community:
a. to enjoy their culture, practise their religion and use their language; and
b. to inform, join and maintain cultural, religious and linguistic associations and other organs of civil society.

2.10. Taking the lead: a WHO policy framework

In view of the fact that a large proportion of the African population utilises the services of traditional health practitioners, it is surprising that traditional medicine still remains illegal in many African countries. In addition, no African country exemplifies an integrated health care system (Gbodossou *et al.* s.a). In 2000 the WHO Regional Committee for Africa adopted a resolution in 2000, which recognised the value and potential of traditional medicine for the achievement of health for all in the African Region. The resolution recommended the acceleration of the development of locally-produced traditional medicines. The resolution further urged member states to translate the proposed strategy into realistic national traditional medicine policies, supported by appropriate legislation and plans for specific interventions at national and local levels, and to collaborate actively with all partners in its implementation and evaluation (WHO 2000). The WHO's most recent global policy framework for traditional medicine systems is a five year strategic plan which highlights five key priorities, namely:

- Policy, safety, access and rational use of traditional medicines;
- Prioritising integration of traditional medicine into official health care systems;
- Building global information resource on integration medicines (knowledge base);
- Formulating guidelines on regulatory and quality assurance standards for traditional healing;
- Building evidence base through comparative research for tackling priority diseases such as HIV/AIDS (Bodeker s.a.; WHO 2003).

The *WHO Traditional Medicine Strategy 2002-2005* (WHO 2003) has outlined four key objectives to promote the inclusion of traditional medicine in plans for improving health status. Table 1 outlines each objective aligned with components, and expected outcomes for each.

International policies are important in that a great proportion of financial and technical resources are provided by donor organisations to enable developing countries to extend national health care services. For most developing countries the existence of supportive international policy is a major facilitator in moving ahead. However, as important a role international policy plays in facilitating the adoption of a particular strategy, such as the utilisation of traditional health practitioners, it by no means assures that this will happen (Pillsbury 1982). As it stands, very few countries have developed a national traditional medicine policy. These policies are imperative for defining the role of traditional medicine in national health care systems, and how it can contribute to health sector reform. National traditional medicine policies also play an important role in ensuring that the necessary regulatory and legal mechanisms are in place for promoting and maintaining good practice; that access to traditional medicine is equitable; and that the authenticity, safety and efficacy of traditional medicine therapies used are assured. In the absence of national traditional medicine policies, traditional medicine is practised without regulation and, thus, without patient/consumer protection (WHO 2002).

Table 1: The WHO Traditional Medicine Strategy and Plan of Action 2000-2005 for promoting the inclusion of traditional medicine

Objective	Components	Expected outcomes
Policy – Integrate traditional medicine (TM)[5] into national health care systems, as appropriate, by developing and implementing national TM policies and programmes	**Recognition of TM** – Help countries to develop national policies and programmes on TM	▪ Increased government support for TM, through comprehensive national policies on TM ▪ Relevant TM integrated into national health care services
	Protection and preservation of indigenous TM knowledge relating to health – Help countries to develop strategies to protect their indigenous TM knowledge	▪ Increased recording and preservation of indigenous knowledge of TM, including development of digital TM libraries
Safety, efficacy and quality – promote the safety, efficacy and quality of TM by expanding the knowledge-base on TM, and by providing guidance on regulatory and quality assurance standards	**Evidence-base for TM** – Increase access to and extent of knowledge of the safety, efficacy and quality of TM, with an emphasis on priority health problems such as malaria and HIV/AIDS	▪ Increased access to and extent of knowledge of accurate information ▪ Technical reviews of research on use of TM for prevention, treatment and management of common diseases and conditions ▪ Selective support for clinical research into use of TM for priority health problems such as malaria and HIV/AIDS, and common diseases
	Regulation of herbal medicines – Support countries to establish effective regulatory systems for registration and quality assurance of herbal medicines	▪ National regulation of herbal medicines, including registration, establishment and implementation ▪ Safety monitoring of herbal medicines and other TM products and therapies
	Guidelines on safety, efficacy and quality – develop and support implementation of technical guidelines for ensuring the safety, efficacy and quality control of herbal medicines and other TM products and therapies	▪ Technical guidelines and methodology for evaluating safety, efficacy and quality of TM ▪ Criteria for evidence-based data on safety, efficacy and quality of TM therapies
Access – Increase the availability and affordability of TM, as appropriate[6], with an emphasis on access for poor populations	**Recognition of role of TM practitioners in health care** – Promote recognition of role of TM practitioners in health care by encouraging interaction and dialogue between TM practitioners and western practitioners	▪ Criteria and indicators, where possible, to measure cost-effectiveness and equitable access to TM ▪ Increased provision of appropriate TM through national health services ▪ Increased number of national organisations of TM providers
	Protection of medicinal plants – promote sustainable use and cultivation of medicinal plants	▪ Guidelines for good agriculture practice in relation to medicinal plants. ▪ Sustainable use of medicinal plant resources
Rational use – Promote therapeutically sound use of appropriate TM by providers and consumers	**Proper use of TM by providers** – Increase capacity of TM providers to make proper use of TM products and therapies	▪ Basic training in commonly used TM therapies for western practitioners ▪ Basic training in primary health care for TM practitioners
	Proper use of TM by consumers – Increase capacity of consumers to make informed decisions about use of TM products and therapies	▪ Reliable information for consumers on proper use of TM therapies ▪ Improved communication between western practitioners and their patients concerning use of TM.

Source: WHO 2002

2.11. Traditional health practitioners and the fight against HIV/AIDS in South Africa

Considering that a significant proportion of South Africans utilise traditional health practitioners, the care that they receive from these traditional health practitioners must be factored into the national health care system. Efforts are

[5] The WHO makes use of the comprehensive term "traditional medicine" (TM) to refer to traditional medicine systems and various forms of indigenous medicine in Africa, Latin America, South-East Asia, and the Western Pacific (WHO 2002).

[6] "Appropriate" refers to TM health care that does not cost more and which is no less safe and efficacious than recommended western health care for the disease or health problem (WHO 2002).

currently underway to include traditional medicine in the realm of health care through legislation, albeit gradually. Integrating traditional medicines into western health care systems require nothing short of appropriate policies of integration. Although a national integration policy has not come into play as yet, traditional medicine has been factored into policies aimed at combating some priority diseases such as TB, STIs and HIV/AIDS. Two policy frameworks, namely the *STD/HIV/AIDS Strategic Plan for South Africa 2000*-2005 (Strategic Plan) and the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa 2003* (Operational Plan), are evidently the pillars of South Africa's response to the HIV/AIDS epidemic (Department of Health 2000; 2003). Both documents refer to traditional health practitioners as partners in the national response to the HIV/AIDS pandemic.

2.11.1. The Operational Plan and traditional healing

Recognition of the significant role of traditional health practitioners in the health care sector at large, and more specifically, in the implementation of the Operational Plan, is based on two premises. It is estimated that 70-85% of South Africans consult traditional health practitioners, and up to 97% of people living with HIV/AIDS first use complementary or traditional medicines (Department of Health 2003; Matomela 2004). For these reasons, the Department of Health recognises traditional health practitioners as essential for enhancing the implementation of the HIV/AIDS Operational Plan. The Operational Plan envisages traditional health practitioners fulfilling the following benevolent functions in enhancing the implementation of the antiretroviral therapy component of the plan (Department of Health 2003):

- Mobilise communities;
- Draw patients into testing programmes;
- Promote adherence to drug regimens;
- Monitor side effects;
- Share their expertise in patient communication with biomedical practitioners, and vice versa; and
- Continue improving patient well-being and quality of life.

The anticipated contributory functions of traditional health practitioners in the implementation of the Operational Plan should not be that of traditional practitioners taking on the role of assistant western health personnel or community health workers. There should be a drive towards utilising the rich knowledge and skills of traditional health practitioners in treating and caring for people living with HIV/AIDS, so as to optomise the effectiveness of the comprehensive treatment, care and support programme. It is vital that traditional health practitioners are utilised with a view to provide treatment, care and support to all South Africans, including those people living with HIV/AIDS and who opt for traditional healing and medicine by choice. The findings of the research undertaken (cf. chapters eight and nine) reveal contrasting views between traditional and western health practitioners about the role of traditional practitioners in the treatment and care of people living with HIV/AIDS. Western health practitioners tend to perceive traditional health practitioners as providing secondary health care to supplement and support western health care services, whereas traditional practitioners regard their role in the fight against HIV/AIDS as equally important, at times even more important than western medicine.

The Operational Plan has taken cognisance of the need to promote collaboration between traditional and western health practitioners in the successful implementation of the comprehensive treatment and care programme. To this end, it has highlighted five fundamental steps to ensure collaboration between the two cadres of practitioners in the Operational Plan. The essence of these steps is to develop protocols and guidelines for the nature of collaboration between traditional and western health practitioners in the implementation of the comprehensive programme, as well as to address the needs of PWAs and South Africans in general. This entails, *inter alia:* defining the role of traditional health practitioners within the care and treatment programme; defining the level of interest of traditional health practitioners in participating in the treatment programme; assessing community infrastructure and special skills offered by traditional health practitioners; assessing the expectations of traditional and western health practitioners in collaborating with each other; formalising quality assurance methods for traditional medicine as it relates to the treatment programme; and providing bi-directional training to educate traditional health practitioners about ARVs and HIV care, on the one hand, and to educate western health practitioners about the role and method of traditional practice, particularly their communication skills with patients, on the other (Department of Health 2003).

Discussions about initiating collaboration between traditional and western health practitioners in provincial HIV/AIDS programmes have been and are still taking place. Proclamations to this effect, such as the Operational Plan, have reached the ears of many traditional health practitioners, who have largely reacted with enthusiasm. However, progress in actualising these proclamations, has been less than satisfactory for traditional health practitioners. The slow pace at which plans to include traditional practitioners into the mainstream of HIV/AIDS programmes, and inevitably health care *per se* in South Africa, has resulted in traditional health practitioners questioning Government's commitment to their sector, and has simultaneously evoked a sense of mistrust among traditional health practitioners of the western health care fraternity's intentions. Despondency among traditional practitioners could seriously hamper forthcoming endeavours aimed at collaboration between traditional and western health practitioners. Traditional health practitioners are an essential part of the continuum of care, and they are generally enthusiastic about contributing to the well-being of South Africans, and more especially in efforts to expand treatment and care for people living with HIV/AIDS. However, fundamental hindrances from the side of both traditional and western health practitioners stand in the way of including traditional practitioners into the mainstream of health care, particularly in national HIV/AIDS programmes. One such hindrance of note is the absence of a unified traditional healing system in South Africa.

Seemingly, traditional health practitioner organisations are viewed as an important catalyst for collaboration between traditional and western health practitioners through coordinating the participation of traditional health practitioners in health care issues and programmes. According to the Department of Health (2003) several traditional health practitioner organisations have been in discussions with government concerning various health care programmes to which traditional health practitioners have already begun to contribute. However, heterogeneity and lack of organisation of traditional health practitioners renders it difficult for governments to collaborate with them, thus hindering the enhancement of the quality of traditional health care (World Bank s.a.).

2.11.2. A fragmented traditional healing system

It is of concern that traditional health practitioners in South Africa still lack the organisational unity required as a prerequisite for a fully accountable and legitimate traditional health care system. In the 1970s, in an attempt to facilitate their registration and licensing, traditional practitioners in KwaZulu-Natal were encouraged to form associations. A number of traditional health practitioner associations now exist throughout South Africa, however, a common code of conduct and standards for training are still lacking (NPPHCN 1997). In South Africa, it is estimated that traditional health practitioners are organised and "licensed" by 100 traditional health practitioner associations which are registered under the Companies Act, and not as health care providers. These associations function independently of one another, and portray internal disunity, division, and rivalry among traditional practitioners in the country. Since 1994, Government has made various attempts to facilitate a process of collaboration and networking among traditional health practitioners. These attempts are aimed at attaining organisational unity, but fall short of attaining this goal (Ndaki 2004; Pretorius 2004). However, progress has been made in reducing the number of traditional health practitioner associations registered under the Companies Act, through lobbying for the merge of all associations into a national government-affiliated association for traditional health practitioners. At present, the Traditional Healers Organisation (THO) is the largest umbrella organisation for traditional health practitioners in South Africa. It represents 69 000 traditional health practitioners in Southern Africa, of which 25 000 reside in South Africa. The THO has provincial branches in five[7] of the nine provinces with the head office in Johannesburg. One other umbrella body for traditional practitioners is the South African Traditional Healers Health Care Group, which focuses specifically on home-based care, Directly Observed Treatment (DOT) support for people with tuberculosis, Voluntary Counselling and Testing (VCT) and education on HIV/AIDS, and 'street counselling' (Richter 2003). Various other traditional health practitioner organisations, some of which remain undocumented, exist, further demonstrating the lack of organisational unity and sufficient coordination in the traditional healing sector in South Africa.

The *Traditional Health Practitioners Act 2004* may be evidence of a breakthrough in the South African Government's efforts to regulate and legislate traditional healing, and to integrate it into the national health care system. The Act emanates from a consultative process initiated by the South African government in 1995. Provincial governments were required to conduct public hearings on the viability of traditional health care. The hearings were aimed at obtaining comments about three pertinent issues, namely (i) a statutory council for traditional health practitioners; (ii) the issuing of medical certificates by traditional health practitioners; and (iii) the medical aid coverage of care provided by traditional health practitioners (NPPHCN 1997). The outcome of these hearings was a report presented by the National Council of Provinces (NCOP) to the National Assembly Portfolio Committee on Health in 1997. Based on the findings of the provincial public hearings[8], the report recommended that a statutory council for traditional health practitioners be instituted. Subsequent to this report, in 1998 public hearings for national stakeholders were conducted by the Portfolio Committee on Health with a view to making recommendations to Parliament that would effect legislation. National stakeholders who took part in this process included the National Health Committee of the ANC, several traditional health practitioner associations, The Inkatha Freedom Party (IFP),

[7] Mpumalanga, Limpopo, KwaZulu-Natal, North West and Gauteng provinces (Richter 2003).
[8] Reports were received from seven of the nine provinces. Northern Cape and North West Province did not submit reports.

NEHAWU, the National Progressive Primary Health Care Network (NPPHCN), and Doctors for Life. The recommendations that were put forward included:

1) the legal recognition of traditional health practitioners;
2) the establishment of a Forum to ensure the inclusion of all relevant parties; and
3) the establishment of an Interim Council for traditional health practitioners.

Also included in these recommendations were the composition and functions of the Interim Council, and the categories of traditional health practitioners to be included in the jurisdiction of the Council (Pretorius 1999; 2004).

2.12. The Traditional Health Practitioners Act of South Africa

Antiquated laws, which are remnants of European colonisation, technically, still outlaw the practice of traditional healing in some African countries. However, these laws are often overlooked and traditional healing practices are, thus, accepted and tolerated throughout the African continent. Traditional health practitioners in South Africa were recently (February 2005) officially recognised as health care personnel. Prior to the Traditional Health Practitioners Act, the Witchcraft Suppression Act of 1957 was the only legislation which related to traditional health practitioners, albeit indirectly. This Act sought to outlaw the practice of traditional healing (Gbodossou *et al*. s.a; NPPHCN 1997). The Traditional Health Practitioners Act may be documented as the most significant breakthrough in attempts to legalise and legislate traditional healing in South Africa. Disunity among traditional health practitioners has sabotaged previous attempts to unite the various traditional health practitioner associations into a single governing body for purposes of regulating the training, registration and practices of traditional health practitioners, which are prerequisites for a legitimate profession. The Traditional Health Practitioners Act 35 of 2004 (Republic of South Africa 2005) proclaims to:

- provide for the establishment of the Interim Traditional Health Practitioners Council of the Republic of South Africa;
- provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services;
- provide for control over the registration, training and practice of traditional health practitioners; and
- provide for matters incidental thereto.

The Interim Traditional Health Practitioners Council of South Africa will consist of a maximum of 25 members appointed by the Minister of Health. The Council proposes to play a regulatory role through the implementation of the Traditional Health Practitioners Act. The chairperson will be a registered health practitioner appointed by the Minister of Health, and the vice-chairperson will be elected by the members of the Council, from amongst themselves. The nine provincial representatives will be traditional health practitioners from each of the nine provinces, who have been actively practising as such for a minimum of five years (Republic of South Africa 2005). The Interim Statutory Council will pave the way for a fully-fledged Council. In other words, it will exist for a period of three years during which it will make proposals for the character and composition of a permanent council, and supporting legislature (Pretorius 1999).

The *Traditional Health Practitioners Act, 2004* commits to enhancing the quality and credibility of the traditional health system in South Africa through the execution of numerous objectives and functions, some of which are in line with international resolutions and frameworks promoting the development of training and research in traditional systems of medicine, such as the *Alma-Ata Declaration* and the *WHO Traditional Medicine Strategy and Plan of Action 2000-2005*. To mention just a few of the proposed functions of the Interim Traditional Health Practitioners Council as illustrations in point, and as outlined in the Act, it proposes to (Republic of South Africa 2005):

(a) assist in the promotion of the health of the population of the Republic of South Africa;

(g) promote and develop traditional health practice by encouraging research, education and training in traditional health practice;

(h) promote liaison in the field of training in traditional health practice in the Republic of South Africa, and to promote the standards of such training;

(j) promote traditional health practice which complies with universally accepted health care norms and values with a view to improving the quality of life of patients and the general public.

2.13. Grey areas of the Traditional Health Practitioners Act

Based on the findings of the research undertaken, legislation to regulate the practice of traditional healing in South Africa is welcomed by many traditional and western health practitioners. However, such support remains conditional. Traditional health practitioners view the Act as progressive only if it is designed to promote and support traditional practitioners and not to restrict and oppress them. The findings of the research undertaken point towards a lack of sufficient knowledge and comprehension of the content and purpose of the Act, amongst traditional health practitioners in particular. Considering that the Act has already been subjected to comments and amendments prior to its enactment, it would appear that such an Act will be subjected to further criticism by the very traditional health practitioners which it is intended to legalise and legitimise, once the implications of its content are fully known to them. One potential dispute-evoking area is the inconsistency between one of the stipulations in the Act, and the role that traditional health practitioners view themselves playing in combating illnesses. According to the Act, traditional health practitioners not registered as such will not be permitted to diagnose, treat, or prescribe any form of treatment for prescribed terminal illnesses, such as cancer and HIV/AIDS. Anyone found guilty will face a fine or imprisonment of up to twelve months [s49(1) and s49(4)][9] (Matomela 2004; Ndaki 2004; Republic of South Africa 2005). At present, very few traditional health practitioners, of the total number of practicing traditional practitioners in South Africa, are registered with the national Traditional Health Practitioners Association (cf. paragraphs 6.4 and 6.7). Various reasons, some of which are valid, are given by traditional health practitioners for their non-registration and reluctance to register with the national association (cf. paragraph 8.1.3). Based on the fact that only a small proportion of

[9] Chapter five – Offences – states:
49 (1) A person who is not registered as a traditional health practitioner or as a student in terms of this Act is guilty of an offence if he or she –
(g) i. diagnoses, treats or offers to treat, or prescribes treatment or any cure for cancer, HIV and AIDS or any other prescribed terminal disease;
ii. holds himself or herself out to be able to treat or cure cancer, HIV and AIDS or any other prescribed terminal or to prescribe treatment therefore; or
iii. holds out that any article, compound, traditional medicine or apparatus is or may be of value for the alleviation, curing or treatment of cancer, HIV and AIDS or any other prescribed terminal disease.
(4) A person found guilty of an offence in terms of this section is liable on conviction to a fine or to imprisonment for a period not exceeding 12 months or to both a fine and such imprisonment.

practising traditional practitioners are registered with the national association, section 49 of the Act is, thus, in direct contradiction to the views held by many traditional health practitioners pertaining to their role in the fight against diseases such as cancer and HIV/AIDS. The fundamental discrepancies between the proposed legislation and perceptions of traditional health practitioners is best expressed in the statement of the national organiser of the Congress of Traditional Leaders in South Africa (Contralesa) in response to the approval of the then Traditional Health Practitioners Bill by Parliament: "We are excited about the latest developments, but western medical practitioners should not say we must not claim to have a cure for HIV/AIDS. Through our own research, we can find a cure for HIV/AIDS, and let's hope that Government involvement will not westernise our profession." (Pelesa 2004: 1). This expression of caution by traditional health practitioners of legislation is further substantiated by the findings of the research undertaken (cf. chapter eight). The discrepancy between the Act and traditional health practitioners' expectations of the Act, points towards the absence of a fully consultative process in the development of the Bill. This, thus, has serious implications for the implementation of the Act, since such implementation requires the support of the primary stakeholders and role players, namely traditional health practitioners. Support will be determined to a large extent by the degree to which the Act addresses the perceived needs of traditional health practitioners *vis-á-vis* the perceived needs of western health practitioners and government. In other words, if the Act is perceived to oppress traditional health practitioners, support of the Act will not be forthcoming from this group of practitioners.

Also of concern is one of the mandates of the Interim Traditional Health Practitioners Council, namely to enforce minimum requirements and standards of practice required for the recognition and licensing of traditional health practitioners. The Act, however, fails to clearly delineate a set of criteria for granting a licence, such as what the minimum requirements are, or what training and practice standards need to be met, as well as mechanisms to monitor traditional health practitioners. At present, an open-door licensing system has been adopted, where recognised traditional health practitioners use their discretion in determining the minimum requirements for qualification of a traditional practitioner, in addition to peers attesting to the capacity of traditional health practitioners, at the hand of empirical evidence of performance. This mechanism of determining qualification, and issuing of licences leans heavily towards subjectivity and bias (Cartillier 2004; Ndaki 2004; Pelesa 2004; Republic of South Africa 2005). This type of licensing system was evident from the findings of the research undertaken, whereby the provincial and Local Service Area (LSA) traditional health practitioner coordinators were responsible for evaluating the authenticity of traditional health practitioners before issuing of licences. The two coordinators relied solely on their discretion, without any standardised guidelines or formal criteria, to assess the legitimacy of traditional practitioners. Of concern is the fact that the two traditional health practitioners were not well versed in all the categories of traditional healing, namely herbalists, diviners, spiritual healers, etc. Therefore, they are not fully competent to assess the legitimacy of all the categories of traditional healing, thus casting doubt on the quality of licensed traditional health practitioners in the Buffalo City Municipality.

Two impacts of the legislation have undoubtedly sparked the most controversy, namely, the issuing of medical certificates by traditional health practitioners, and the recognition of traditional health practitioners by medical aid schemes. Licensed traditional practitioners will be issued with registration numbers as proof of registration to employers, before accepting medical certificates. Traditional health practitioners, licensed or not, have already been issuing medical certificates. The Act will weed out less *bona fide* traditional health practitioners who issue medical

certificates. Traditional health practitioners will also be recognised by medical aid schemes, although this has been met with weary reactions from medical aid schemes, who anticipate an escalation in premiums and related costs as a result of this legislation. However, the benefits to the patients are invaluable, since patients will now finally have a choice of health care provider to consult, and will be protected by law against charlatan traditional health practitioners (Ndaki 2004; Republic of South Africa 2005). The challenge is for medical aid schemes to devise mechanisms that will both contain the costs associated with premiums, as well as ensure that all clients receive equal medical cover irrespective of their choice of health care provider.

2.14. Tapping into a reservoir of indigenous resources (traditional medicines)

Traditional health practitioners are very often only utilised for HIV/AIDS prevention. However, it is equally important to explore the value of traditional healing in HIV/AIDS treatment and care with a view to complement western interventions. According to Gbodossou *et al.* (s.a), scientific research into the efficacy of African traditional medicines is imperative. This research will not only, with the appropriate intellectual property rights protection, provide answers to the age old question of whether traditional medicine actually works, but it will also contribute significantly to eliminating charlatans that are perpetuated under the guise of traditional healing practices. Applying western scientific research principles to African traditional healing practices, such as divination, is rather complex, to say the least. However, these principles are an appropriate measurement of herbal medication efficacy.

In 2002, the African Advisory Committee for Health Research and Development (AACHRD) passed a resolution calling for enhanced research into traditional medicine in the African Region. It also prepared a working document which outlined current research activities (AACHRD 2002). It is highly disappointing that only 21 of 46 African countries have research institutions which conduct research into traditional medicine. Equally disappointing is that the majority of African universities, medical schools and research institutions have not significantly embraced traditional medicine research, although there are a few exceptions (Gbodossou *et al.* s.a). The South African Government has invested an estimated R6 million into research on traditional medicines, especially for the treatment of HIV/AIDS, and the Department of Health has demonstrated commitment to traditional medicines by developing the National Drug Policy, 1996. The Policy is aimed at investigating the use of effective and safe traditional medicines at a primary care level (Department of Health *et al.* 2003; Pelesa 2004).

A number of institutions in South Africa have developed programmes to promote the use of safe, effective and high quality traditional medicines; to promote the documentation and scientific validation of traditional medicines; to contribute to primary health care by providing appropriate information to traditional health practitioners; to support industrial development in the traditional medicine sector; and to contribute to the training of traditional health practitioners. However, a partnership between tertiary academic institutions and the Department of Education has the potential to yield phenomenal results in setting up training programmes and infrastructure in traditional medicine. Institutions which have undertaken research into traditional medicines include selected university departments (e.g. University of Cape Town: Department of Pharmacology; University of Western Cape: School of Pharmacy), government departments (e.g. Department of Health), and research institutions (e.g. MRC; CSIR). Nonetheless,

these efforts remain minimal and leave ample room for greater involvement of, especially, research and academic institutions.

Conducting scientific research into traditional medicines which satisfy international standards, is both a complicated and costly undertaking for traditional health practitioners. Western pharmaceutical companies have to consider the cost: benefit ratio in supporting such research – low cost herbal remedies translate to undercuts in the lucrative market for antiretroviral drugs, especially if these herbal remedies are accessible to large markets in developed countries. This dilemma points to conflicting interests between the objectives of pharmaceutical companies and according traditional medicines priority and identity for their speedy development. This, in turn, raises eyebrows in respect of pharmaceutical companies as partners or collaborators in investigating the efficacy of traditional medicines (Department of Health *et al.* 2003). Hence, it is of the utmost importance that Government and national research and academic institutions adopt a more active and prominent role than is currently evident, in the areas of training, and research and clinical study of traditional medicines.

In response to the WHO's (2002) reported concern that the quantity and quality of data on the safety and efficacy of traditional medicine did not meet the criteria to support its use globally, the South African Government launched the National Reference Centre for African Traditional Medicines (NRCATM) in August 2003. The NRCATM is an independent unit coordinated by the Council for Scientific and Industrial Research (CSIR), the MRC, and the Department of Health. The NRCATM's core function is research into African traditional medicines. It is estimated that one third of the 700 plant species traded in South Africa have medicinal effects (Ndaki 2004). The NRCATM is guided by the stringent criteria of the Medicines Control Council (MCC) for the registration of a product or compound. The MCC is the medicine regulator of South Africa with its primary focus on safety, quality and efficacy of medicines; it has established an expert committee on African tradition medicines to advise it on the regulation, registration and control of traditional medicines. The main concerns and challenges of the MCC, currently, are the herbal medicines that are pre-packed and sold in shops, as well as herbs being sold on the pavements across the country (Department of Health *et al.* 2003). African countries need to fully grasp the urgency to develop adequate and acceptable research methods for evaluating the safety, efficacy and quality of traditional medicines. The WHO (2002) draws attention to the vast amount of published and unpublished data on research in traditional medicine, in various African countries, but which require further research in safety and efficacy to qualify for registration and official utilisation in health care systems.

2.15. In conclusion…

Judging from the current and projected impact of HIV/AIDS, the social and economic devastation of the inexorable epidemic continues to grow. In the absence of effective efforts to curb the epidemic, developing countries such as South Africa face economic collapse. Reinforced prevention is vital to safeguard future generations, however, expanded treatment for those already living with the virus is equally essential to protect the stability and security of communities, and to strengthen the foundation of future developments. South Africa has embarked on an unprecedented quest to combat the world's most urgent public health challenge, namely effectively addressing HIV/AIDS in the country. The development of a comprehensive HIV/AIDS prevention, treatment, care and support plan, within the framework of the WHO 3 by 5 Plan, is a step in the right direction. The 3 by 5 plan adapts lessons

from HIV/AIDS programmes in developed countries, and draws from the best practices of developing countries such as Botswana, Brazil, Senegal and Thailand in scaling up antiretroviral treatment (WHO 2004).

One key success factor to ensure the effective delivery of comprehensive HIV/AIDS treatment and care is strengthening the capacity of the national health system as a whole. This remains a challenge in developing countries with fragile health systems. Hence, expanding comprehensive treatment and care to people living with HIV/AIDS in South Africa will require a collaborative approach. Community involvement is an essential part of any comprehensive approach to HIV/AIDS. Furthermore, the challenges posed by the comprehensive HIV/AIDS treatment and care programme in South Africa, necessitates community involvement towards a strengthened health system.

Traditional health practitioners are an integral part of communities and are viewed as important providers of health care by community members. Therefore, their integration into official health care systems is supported and encouraged by the international community. The WHO has played a significant role in developing policy frameworks to guide the integration of traditional healing into the realm of health care systems in especially developing countries. However, obstacles such as the lack of unity of the traditional healing sector in South Africa renders it unregulated, thus making it difficult for Government to propagate collaboration between traditional and western health practitioners. According to Hirst (1999) the regulation of traditional health practitioners will not only serve a practical purpose, but also to some extent short-circuit witchcraft accusations by harnessing the assistance of registered health practitioners, and devising mechanisms to oust charlatans. Generally, traditional health practitioners have given the “thumbs up” for governments to include traditional medicine in health regulation legislature. This entails the medico-legal recognition of the traditional healing sector. The South African government has made its stance on traditional healing clear by including them as allies in fighting epidemics such as TB and HIV/AIDS, as well as granting them legal status. Success of the Government’s drive to integrate traditional health practitioners into the mainstream of health care will require the utilisation of international policy frameworks as guidelines in developing a national generic integration policy. Despite breakthroughs in legislating traditional healing, the real challenge lies in effecting change at the grassroots level. Regulating the traditional healing system in its entirety, and implementing legislation will require more than policies and laws on paper. It will require soliciting changes in budgetary, personnel and time allocations in all spheres of government (national, provincial and local).

"I want to know what components of their medicine neutralises or deals with the virus. I want to see laboratory tests. I want to see patients' histories, prognosis, diagnosis, treatment, everything that is needed to validate a treatment."

Dr Francis Kasolo (Head of Virology Laboratory)

"What proof? The proof of the efficacy of traditional medicine is in the numbers of people with HIV who swarm traditional healers' clinics. What further testimony do you need than numbers flocking to your clinic? If we were quacks, then people would have stopped coming to us a long time ago."

Goings Nhkula (Herbalist)

(PLUSNEWS 2002)

Chapter 3

AFRICAN TRADITIONAL HEALING IN BRIEF

This chapter provides an introductory overview of the African traditional healing system with specific reference to the categories of traditional health practitioners classified as diagnosticians and therapists (diviners and herbalists). Reference is also made to the category of traditional health practitioners known as spiritual healers, who have fast gained recognition in African societies, despite their omission from the officially recognised group of traditional health practitioners in South Africa. Diviners, herbalists and spiritual healers are the main providers of traditional health care for especially HIV/AIDS-related illnesses in South Africa. According to Friedman (1998) knowledge about the cosmology, or belief system, of African traditional healing is a prerequisite to understanding the role of the African traditional health practitioner - hence an overview of African traditional healing and health practitioners to provide a conceptual framework for interpreting the findings of the research undertaken (chapters eight and nine). Traditional surgeons, who perform male circumcisions, and traditional birth attendants are also officially recognised traditional health practitioners. However, direct reference to these groups of traditional health practitioners will not be made in this report. This is due to the less profound role that they play in diagnosing and treating individuals who present with HIV/AIDS-related illnesses.

3.1. African cosmology and belief systems

Disease, according to the *Oxford Dictionary*, is defined as "a serious derangement of health or the disordered state of an organism or organ". This definition strictly limits disease to biological etiology. *Illness* is more encompassing by referring to the subjective response of a patient, and of those around him/her, to his/her being ill. In particular, it refers to the patient's interpretation (influenced by his/her social and cultural environment) of the origin and significance of his/her experience of being ill; how it effects his/her behaviour and relationship with others; and the various measures he/she takes to remedy the situation. The Xhosa and Zulu refer to both disease and illness as "*isifo*". *Isifo* encompasses far more than physiological disorders. This concept applies to disease that is manifested not only in the body, but also in the form of misfortune and states of vulnerability. This concept of illness recognises physiological aspects, as well as disturbances in the environment in which the individual lives, as playing a role in illness (Friedman 1998; Helman 1990). Therefore, understanding how people interpret their ill-health as well as how they respond to it, is of the utmost importance in health care planning and provisioning.

Two types of African belief systems exist which explain the cause of illness and misfortune. The first, namely the ancestral system, is based on ancestral spirits as controlling illness and misfortune, whilst the second, the magical system, attributes illness and misfortune to evil forces (Pretorius 2004). The two systems are, more often than not, used interchangeably and simultaneously to explain both illness and misfortune. According to Gumede (1990) it is difficult to understand traditional healing, and, thus, African belief systems, without first understanding African traditional religion. In accordance with Gumede's view, Chavunduka (1999) eludes to the difficulty in separating African medicine from African religion. According to Chavunduka (1999) religion forms the backbone of the African way of life. The difficulty in separating the two is attributed mainly to African theories of illness, which include African theology. In other words, theory to explain illness and disease also attempts to explain the relations between God and the universe. Africans believe in a supreme being which they cannot see. He is known as *Tixo* (among the Xhosa), or *Tilo* (among the Tsonga), or *Modimo* (among the Sotho), or *Umvelinqangi* (among the Zulu). This supreme being is perceived as the creator of the universe. The African cosmology shows that the universe comprises two worlds, namely the world in which man lives, and the world in which the ancestral spirits of the departed ones exist. The ancestral spirits, also referred to as *izinyanya* (among the Xhosa), or a*madlosi* (among the Zulu) keep in touch with their families through an interdependent bond between the living and the dead. It is mandatory to continuously make sacrifices to the dead to maintain this bond of friendship. Failure to make sacrifices to the ancestors is marked by ancestral visitations to their offspring, which take the form of ill-health, misfortune, ill-luck, disease, or even the death of a family member. These consequences are not viewed as deliberate malevolent actions, but rather as corrective measures (Gumede 1990).

Since the ancestors are perceived as benevolent and bestowed with supportive attributes, they cannot be blamed for all the evil which befalls humans. The presence of magical views can thus be interpreted as serving to explain evil in society. Evil explicitly refers to negative emotions such as jealousy, envy, and anger. It is believed that certain people possess the inherent ability to cause illness, death and misfortune through either changing their form so that they are invisible, or by making use of familiars[10]. This type of magic is referred to as witchcraft, and is practised by

[10] Familiars are instruments or bearers of magic powers (usually animals) sent by witches to cause harm to others.

witches. Sorcery constitutes another form of magic, where unscrupulous people make use of special medicines to deliberately cause harm or kill from a distance. This form of magic is practised by sorcerers. Both forms of magic are referred to as black magic (*ubuthakathi* in Zulu/Xhosa), or malevolent sorcery, in juxtaposition to white, or benevolent magic[11] (Friedman 1998; Pretorius 2004).

3.2. African cosmology: an equilibrium

Based on the African belief system, health and ill-health are held in a state of equilibrium by the friendship or bond between the living and the dead (ancestors), which is maintained through constant sacrifices to the dead. *Tixo* (God in Xhosa) is perceived to be too distant to be directly concerned and involved with the personal affairs of individuals. Therefore, *izinyanya* (ancestral spirits in Xhosa) communicate with him on behalf of the people (Gumede 1990). Chavunduka (1999) emphasises the importance of understanding that African religion does not encourage people to venerate their ancestors instead of worshipping God. Members of African religion talk to their ancestors, but worship God. God is perceived to be concerned with matters of national and international importance, while ancestral spirits are concerned with the day-to-day affairs of their descendants. Ancestral spirits are, thus, intermediaries between the living and God.

In essence, the significance of the ancestors lies in their taking a lively interest in the lives of their descendents. They are essentially concerned with maintaining law and order in society through sanctioning socially unacceptable behaviour, and reinforcing behaviour that is in accordance with social norms. Their actions are generally benevolent, and they act as protectors against especially the malevolent actions of witches and sorcerers. Rituals are performed to ancestors in recognition of their guidance, protection and bearers of good fortune. However, they are dissatisfied when rituals are not observed. This dissatisfaction is made known in two ways, namely (i) through dreams, or (ii) through the onset of illness (Pretorius 2004). Although the ancestors do not generally 'send' illness or misfortune, they may abandon their protective function, which results in illness or misfortune. Hence, the Xhosa/Zulu saying "*abaphantsi basifulathele"* - which translates to "the ancestors have turned their backs on us" – is often uttered when the ancestors are believed to have withdrawn their protection and gifts of good fortune from erring descendants (Friedman 1998). This is regarded as a corrective measure rather than a punitive one. Thus, the ancestral spirits are responsible for guiding and caring for their descendants, and have the welfare of their descendants at heart.

Both the ancestral and the magical belief systems maintain that natural and social forces must be restored to a state of equilibrium in which a good relationship between the gods, nature and one's fellow human beings is established. Illness, adversity, misfortune, and so forth are associated with a disturbance in this equilibrium (Pretorius 2004). Thus, a traditional health practitioner's power lies in the ability to apply an understanding of the intricate relationship between the patient and the world around him or her. The traditional health practitioner looks for the cause of the patient's misfortune or illness in the relationship between the patient and his or her social, natural, and spiritual environment (De Smet 2000). This is indicative of the fundamentally important role community involvement plays in the traditional healing system. If one member of a community suffers from illness, then all members of the community suffer, since illness is indicative of disharmony in the cosmic forces which ensure good health and

[11] White or benevolent magic is used by traditional health practitioners to protect the community whereas black magic or malevolent sorcery is used by witches and sorcerers to cause harm to people.

fortune. Therefore, illness is viewed as being derived from a broken society. Thus, communities become the starting point for individual diagnosis, prognosis and treatment. This makes traditional healing an essentially interactive process. The traditional concept of 'individual' is described as "I am because we are, and since we are, therefore I am" (*Umntu ngumntu ngabantu* in Xhosa*)*, which is in contrast to Descartes' dictum which describes the individual as "I think, therefore I am". According to the traditional concept, individualism is an abomination. Belonging, participating and sharing life with others leads to wholeness and guarantees integral health (Ngong Teh 1998).

3.3. The hierarchy of cosmic forces

The presence of natural and supernatural forces and, more importantly, maintaining harmony between these cosmic life forces, point towards a system of influence exhibited by each force. The highest force which permeates the entire universe is that of the creator of mankind, God. Ancestral spirits, which explain the destiny of mankind, have access to this force. However, not all human beings can access this force. Only a select few, namely priests and traditional health practitioners are believed to hold the power to manipulate this force to the benefit, or detriment of society. Pretorius (2004), following others, thus, proposes a hierarchy of force endowment in which God is the most powerfully endowed, followed by the ancestral spirits, living people, animals, plants and objects.

3.4. Categorising diseases

According to African conception, individuals do not exist in isolation. Health is perceived as a balanced relationship between individual and individual, individual and nature, and individual and the supernatural world (Helman 1990). It is for this reason that etiology and symptomatology of ill health are seldom viewed as isolated phenomena. It is thus that the African ontology of disease and health focuses on harmony or balance between the cosmic life forces (Pretorius 2004). In the same breath, some diseases are, however, attributed largely to either natural or supernatural causes. Two categories of diseases are, therefore, identifiable based on the degree of causality, namely natural diseases (*umkhuhlane),* and supernatural diseases (*ukufa kwabantu*) (Munk 1996). A descriptive distinction of the two categories follows.

3.4.1. Natural diseases

It is accepted that diseases can be caused by infection, even if the infection agent remains unknown. The Xhosa, like many other ethnic groups of Africa, believe that human beings are subject to ill health, and that each disease can be cured with the appropriate remedy. It is when a disease appears to be unusual that knowledge about the cause of the disease becomes imperative in determining the appropriate treatment. The decisive factor in determining whether an illness episode is due to a natural cause lies in the progression of the disease, and not so much the symptoms. In other words, natural diseases do not last long, do not recur repetitively, and do not form part of a series of misfortunes (Pretorius 2004).

On the one hand, natural diseases, such as colds, are cured purely through pharmaceutical remedies, without any rituals being performed. Treatment requires a specialist in symptomatic treatment, which may be either a traditional health practitioner, such as a herbalist, or a western health practitioner. Therefore, remedies for natural diseases

may be western medicine, as well as traditional medical concoctions. Supernatural diseases, on the other hand, are cured according to their cause (*unobangela* in Xhosa) (Munk 1996; Pretorius 2004).

3.4.2. Supernatural diseases

In the case of supernatural diseases, the symptoms are in themselves an indication of a discourse in the metaphysical environment. This may be either one of three things, namely the ancestors being angry, or the patient being exposed to witchcraft, or the cause of affliction may be ritual pollution (Friedman 1998; Munk 1996). Supernatural explanations for disease causation serve to answer the question of why a particular person suffers disease or misfortune. In western thought the concept of chance is applied, whereas the African worldview makes little provision for accident or chance. For example, a patient who believes in the biomedical model of disease will accept that tuberculosis is caused by the tuberculosis bacillus, whereas, a patient who believes in the African traditional model of disease will not be satisfied by this explanation - despite seeing the bacillus under a microscope - or acknowledge its existence. This explanation fails to answer the two key questions of 'why' and 'who', namely (i) 'why' the bacillus is active now, or 'why' it is active in his/her lungs and not someone else's, and (ii) 'who' has caused the bacillus to be active in his/her body. In societies where supernatural etiological views prevail, disease or misfortune is ascribed to the active, purposeful intervention of an agent which can be either human (witch or sorcerer), or non-human (ancestral spirit). Only traditional health practitioners are perceived to be equipped with the necessary knowledge and skills to treat supernatural diseases (Pretorius 2004).

3.5. Conceptualising disease causation

The process of conceptualising the cause of disease is largely determined by sociocultural factors which describe patterns of symptoms and signs that are perceived as abnormal. On the one side of the coin, an individual's interpretation of disease causation may be based on the biomedical model of disease, whilst on the other side, another individual's interpretation of the cause of the exact same disease may be based on the African traditional healing model of disease. Thus, the process of conceptualising disease causation is far from simple. It is a multifaceted process that is influenced by beliefs about disease etiologies, as well as situational factors. Figure 1 illustrates this point. Scenario 1 depicts the interpretation of disease as being caused purely by natural causes, where no supernatural forces are associated with the onset of disease. Scenario 2 illustrates the process of interpreting disease causation within the context of supernatural forces. The latter interpretation of disease, prompts the questions 'why?' and 'who?'. A purely biomedical explanation, which only focuses on the causal relationship between physiological entities, does not suffice in providing answers to 'why?' the disease has befallen a particular individual, and 'who?' is the person (dead or alive) responsible for the ill person's fate.

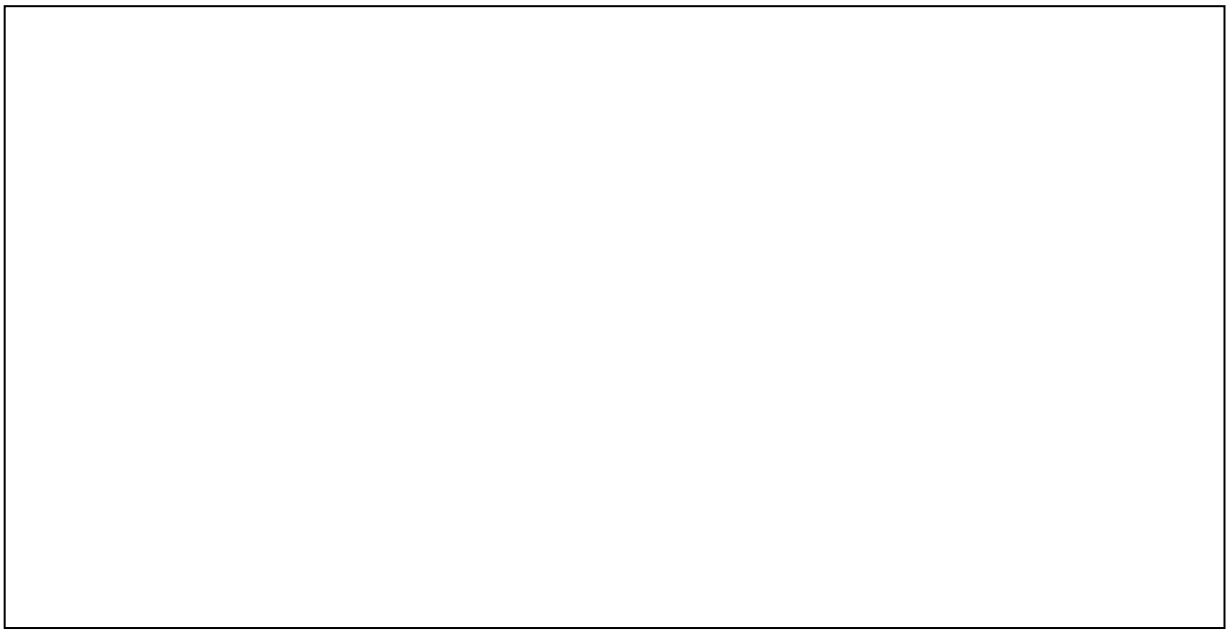


Figure 1: Conceptualisation of disease causation

Only traditional health practitioners are perceived as being able to treat supernatural diseases. This notion is based on the theories of illness and health which form the pillars of the traditional healing system.

3.6. STI/HIV/AIDS: A traditional health practitioner's view

HIV/AIDS has puzzled many traditional health practitioners. They have various explanations for its cause, thereby, experimenting with a cure. On the one hand, AIDS is seen as either the development of an untreated syphilis, or to be *ncunsula* (gonorrhea). On the other hand, it is associated with pollution, by being compared with a culture-specific syndrome, which existed during Shaka's reign, called *izembe*, or by being compared to *ilumbo*. *Izembe* was contracted by warriors who had killed somebody in battle, but were not properly cleansed in the rituals that followed, thus, they were polluted. The warrior himself would not show any signs of the disease. However, any man who had sexual intercourse with the warrior's wife would over time become weak and very ill (Munk 1996). *Ilumbo* occurs when a jealous husband drinks a particular medicine, then has sexual intercourse with his wife so that she will pass it on to her other sexual partner(s) without showing any of the symptoms herself. However, other women can be infected by engaging in sexual intercourse with the wife's sexual partner(s) (Munk 1998).

Also related to pollution is the belief that AIDS is spread through *umeqo*. This occurs when a witch, or someone who wishes to bewitch another, places a polluting substance on the ground. When the target walks over the *eqo*, it immediately enters the body, and may lead to death, unless it is treated by a traditional health practitioner. The symptoms of *izembe, umeqo, ilumbo* and *ncunsula* are all undoubtedly identical to those of AIDS, namely the patient will lose weight, be very weak, and prone to all kinds of minor ailments, including genital sores and malodorous secretion (Munk 1996; 1998). Despite differences in understanding among traditional health practitioners regarding the cause of HIV/AIDS, the concepts behind most of their explanations are similar. According to King (2002), HIV/AIDS is generally attributed to taboos related to pregnancy, birth, marriage and death. There are, however, some traditional health practitioners who associate the symptoms of HIV/AIDS with the calling to be a traditional

practitioner. This interpretation of the cause of HIV/AIDS transpired from the findings of the research undertaken, and is further discussed in chapter eight.

The perceived ability to cure HIV/AIDS is a topical issue which is creating an ever increasing rift, not only between traditional health practitioners and their western counterparts, but also among traditional practitioners themselves. A study conducted in South Africa in 1992 revealed that 40% of traditional health practitioners who participated in the study believed that AIDS could be cured by either traditional or western medicine (Giarelli *et al.* 2003). Although the mainstream of traditional health practitioners denounce claims that AIDS can be cured by traditional medicines, claims by some traditional health practitioners of traditional "cures" prevail. The Eastern Cape serves as a case in point where the Eastern Cape Traditional Health Practitioners Forum, and the National Interim Coordinating Committee for Traditional Health Practitioners (ICCTHP) publicly dissociated themselves from claims by some traditional practitioners that they can cure AIDS (Feni 2002). The findings of the research undertaken reveal that the belief that HIV/AIDS can be cured is prevalent among traditional health practitioners in the Eastern Cape, despite denounces of this claim.

3.7. Categories of traditional health practitioners available to South African consumers

The WHO (2003a: 1) defines traditional medicine as:

> *"health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being".*

In the past traditional health practitioners could be clearly differentiated into distinct categories according to their functions, which are in accordance with their calling, training, knowledge and practices. However, over the years, there has been an overlap in the functions of traditional health practitioners, thus, making their classification all the more complicated. So much so, that the traditional health practitioners selected for the research study undertaken were multiskilled in terms of their training and practice methods in various categories of traditional healing. In fact, very few traditional health practitioners adhere to the methodologies and practices of only one category of traditional healing. This was evident from the findings of the present study when traditional health practitioners responded with difficulty to the question relating to the category of traditional practitioner to which they are affiliated. Many of them responded, after some hesitation, as belonging to more than one category. For example, a traditional health practitioner may have started off as a spiritual healer, but thereafter received the calling to be a diviner, or else a diviner may decide to also become a herbalist, or, in some instances, a traditional health practitioner may have qualified in all three categories of traditional healing. In addition, traditional health practitioners are increasingly changing their methods of diagnoses and treatment to suit modern and technological advancements (Freeman & Motsei 1992). The ever fading differential lines between the various categories of traditional healing have received mixed views from traditional health practitioners themselves. Some traditional practitioners view this trend as a progression in the art and skill of traditional healing, whereas other traditional practitioners view it as a deterioration of the quality and credibility of the traditional healing profession (cf. paragraph 8.1.6c).

Historically, traditional health practitioners were classified into the following most common categories (cf. Table 2).

Table 2: Classification of Zulu traditional health practitioners

Description	Category	
Destructive and evil	*Abathakathi* (witches and wizards)	
	Sorcerers[12]	
Diagnosticians or diviners	*Izangoma/amagqira* (diviners)	
	Izanusi (smellers)	
	Abalozi (ventriloquists)	
	Amandiki	
	Amandawu	
Therapeuticians	*Izingedla* (medicine men)	
	Izinyanga/amaxhwele (herbalists)	
Specialists	*Izinyanga zezulu* (skyherds)	
	Izinyanga zemvula (rainmakers)	
	Izinyanga zempi (military doctor)	
	Disease specialists	Chief special physicians
		Heart specialists
		Kidney specialists
		Chest specialists

Source: Gumede 1990

The rapid evolution of African societies, especially pertaining to technological advancements and the influence of western thought, has been matched by a transformation in the structure and practices of the African traditional healing system. In South Africa many categories of traditional health practitioners have merged to form broader categories. This is most evident in the umbrella title of diviners, who do not necessarily identify with any one of the five original categories of diviners/diagnosticians (cf. table 2). Similarly, medicine men and herbalists are now collectively referred to as herbalists (cf. table 2). There is an apparent discrepancy between literature about the structure and functions of traditional health practitioners and their actual structure and functions. This points towards outdated literature about the South African traditional healing system, and a need for more current research to update the literature.

The most prevalent categories of traditional health practitioners in South Africa at present are diviners, herbalists, spiritual healers, traditional birth attendants and traditional surgeons. However, only four categories of traditional health practitioners are officially recognised in South Africa, namely diviners, herbalists, traditional birth attendants and traditional surgeons. Only two of the four categories of traditional health practitioners recognised by the Parliamentary Portfolio Committee on Health of South Africa will be further explored, namely diviners and herbalists[13] (Pretorius 2004). Spiritual healers are not officially recognised as traditional health practitioners as yet, however, due to the increasing number of people who utilise their services for HIV/AIDS-related illnesses, they are included in this thesis. Traditional surgeons and traditional birth attendants constitute the remaining two categories of traditional practitioners recognised by the Parliamentary Portfolio Committee on Health. However, due to their highly specialised functions, direct reference needs not be made to these two categories of traditional health practitioners. Reference to them will be made in as far as they comprise the broader category of traditional practitioners and, therefore, share common theories of disease and illness.

Clarifying the distinction between traditional health practitioner and witchdoctor is an important step in a study of this nature. Many traditional healing antagonists are of the belief that traditional health practitioners are synonymous with witchdoctors. This is one of the misconceptions which contribute to the negative connotation attached to traditional healing in western societies. Witchdoctors (*abathakathi)* possess powers of black magic which they tap at their own will for purely malevolent purposes. In contrast to traditional practitioners who are the bearers of good health and prosperity, witchdoctors cause ill-health and death (Gumede 1990). As a traditional health practitioner

[12] There is no clearly defined distinction between witches, wizards and sorcerers. They are collectively referred to as *abathakathi.* Distinctions are made in the methods they use to cause harm.

[13] The Portfolio Committee on Health, in its recommendations to Parliament, proposed that four categories of traditional healers be recognised and overseen by the Interim Council for Traditional Healers, namely diviners, herbalists, traditional surgeons (conduct male circumcisions) and traditional birth attendants.

from Swaziland puts it: "*By the rules of the ancestors who invest power in us, a healer cannot use the right hand to cure a person then use that same hand to kill. If that happens, the power goes away immediately after such a harmful act is committed. The powers to heal are taken away forever*" (Campbell 1995).

For the purpose of relevance to the aim of the study, namely to explore the benevolent role of traditional health practitioners, the focus will be on practitioners, and not witchdoctors.

3.7.1. Diviners

Diviners generally are the diagnosticians of traditional health practitioners. Their primary function is to diagnose mysteries. They do this by analysing causes of specific events, and then interpreting the messages of the ancestral spirits. They are consulted to answer the "why?" of events, occurrences or non-occurrences. In essence, they provide answers to why anything goes wrong (Gumede 1990).

Diviners diagnose illness mostly by divination. Divination refers to the art of throwing either bones, shells, sticks or any other special objects in order to interpret the message of the ancestors (Motsieloa 1998). The most popular diviners are *izangoma* (plural). The cult of being *isangoma* (singular) is not hereditary, however, it is possible to have more than one person in a family with similar inclinations and becoming *isangoma*, but this is not necessarily the norm (Gumede 1990). In addition to diagnosing illness through divination, diviners are also called upon to interpret misfortune, and to perform family rituals to secure the protection and guidance of ancestors.

Historically, diviners were differentiated into specific categories based on the methods and objects of divination used. These categories included *izangoma zamathambo* (bone throwers), *izangoma zehlombe* (hand clappers), *izangoma zezabhulo* (stick diviners) and *izangoma zezithupha* (thumb diviners) (Gumede 1990). *Izangoma* learnt their trainer's method of divination while under training. The differentiation between *izangoma* has disintegrated to a large extent. The tendency is for diviners to integrate various divination skills and diagnostic methods in their respective practices, as opposed to specialising in one of the historic fields of divination. This trend of amalgamating the various categories of diviners into one umbrella category of diviners has received mixed views from traditional health practitioners. Although some view it as progressive, others perceive it as misguided and a deterioration of the quality of traditional healing, as illustrated by the findings of the research undertaken (cf. paragraph 8.1.6c).

3.7.2. Herbalists

Herbalists and medicine men are collectively referred to as herbalists (*izinyanga),* and they practise the art of healing. Their function is to diagnose and prescribe medication for ordinary ailments and diseases, to prevent and alleviate misfortune and disaster, to provide protection against sorcery and misfortune, and to promote good fortune and happiness (Pretorius 2004). They master the use of roots, barks, leaves, fats, mineral matter, etc., for healing purposes (Gumede 1990). Empirical knowledge, as well as magical techniques, are pivotal in herbalists' healing procedures. They have the ability to diagnose certain diseases accurately and to prescribe healing herbal remedies. Almost all their medicines are believed to contain ingredients charged with magical powers (Pretorius 2004). This is the reason why some traditional health practitioners believe that the ingredients of their traditional medicines are of

no use to western practitioners without the magical power to heal, which is bestowed upon an individual by the ancestral spirits (cf. chapter eight).

Herbalists are more than likely males, but can be females, who are well respected by the community (Freeman & Motsei 1992; Gumede 1990; Hammond-Tooke 1993). Unlike diviners, herbalists are not called upon by ancestral spirits. They voluntarily decide to undergo training with an established herbalist, and then practise on their own (Motsieloa 1998). Various methods are used to administer medicines, which include, *inter alia,* oral consumption, infusion, decoction, steaming, to smoke out, fomentation, cupping, sniffing and emesis (Gumede 1990). Although these methods are primarily utilised by herbalists by virtue of their specialising in traditional medicines, the impermeable lines of differentiation between the various categories of traditional health practitioners have resulted in these methods also being used by traditional health practitioners in other categories. A summation of the various methods of administering medication is presented in Table 3.

Table 3: Methods of administering traditional medicines[14]

Method	Description
Oral	Medicines are taken by mouth and swallowed. Can be a single herb or a mixture.
Infusion (Isichocho)	Afresh mixture of herbs is crushed and mixed with cold water. A strainer is used to separate the liquid medicine from the solid matter.
Decoction *(impeko)*	A fresh mixture of herbs is crushed and then boiled. Some poisonous medicines are crushed into a powder, then boiled with milk to remove the poisonous ingredients leaving only the healing parts.
Steaming (ukugquma)	Suitable medicines are boiled. The boiling mixture is removed from the fire. The patient is covered with a blanket and steamed up. He/she then sweats out *isidina*[15] as heating opens up the pores of the skin and lets the dirt out.
Smoke out (ukushunqisela)	This treatment is administered to the newly born. A three-legged pot is placed upside-down on hot coal and the appropriate herbs and other medicinal substances are placed on the hot lid. As smoke rises, the new born baby is passed over the fumes a few times. This is to prevent allergic reactions at a later stage.
Incisions *(ukuzawula*)[16]	This method is the African mode of injection. It entails making incisions into the skin and rubbing medicinal powders into the incisions. The medicine goes directly into the bloodstream at the site of the pain. Therefore, it is believed to be very effective.
Fomentation *(ukuthoba)*	Medicine is brought to the boil and allowed to cool so as not to scald the patient. The medicine is applied directly to the affected part. This method is used for painful parts such as sprains, swollen joints, early boils, abscesses and carbuncles.
Cupping (Ukulumeka)	Small incisions are made on the temple. Then, the larger end of a cupping horn (open at both ends) is placed against the incisions and blood is drawn out. This method is used in cases of severe headaches.
Sniffing (ukuhogela)	A method used to relieve headaches. Clematis brachiata (*idlonzo*) leaves are crushed and rubbed between the two palms to emit a strong pungent smell which the patient sniffs.
Emesis (ukuphalaza)	This method entails instigating vomiting. Either, medicine is taken orally together with copious amounts of water or the anti-peristaltic action is started off by tickling the throat with a feather or finger. This method is common for treating pulmonary tuberculosis (*idliso*). The rationale is to reverse the process. *Idliso*[17] is believed to enter through the mouth by eating the poison. Hence, vomiting it out. This method is also used simply for luck or to cleanse oneself.
Ukucinda	Medicine on a three-legged pot lid heated over a fire is licked up with the fingers.
Ukuqqaba/ukushweza	The herbalist prepares medicine to enhance dignity and personality. The medicine is rubbed over the eyebrows on the day of the confrontation with the enemy. For example, if a client is accused and has to appear in court, he/she rubs the medicine on his/her brow just before court. The moment the client appears in front of the magistrate, the magistrate will not see the correct files clearly and the case will be repeatedly remanded till it is dismissed.
Ukuchela intelezi	These are protective medicines which are sprinkled in the yard to protect the homestead against witchcraft (witches and sorcerers).
Ukubethela	These are protective medicines used specifically for protecting the homestead against lightning. In earlier days this method was used by skyherds (*izinyanga zezulu)*.

Source: Gumede 1990

Izinyanga have accumulated extensive knowledge of the use of plants and herbs for medicinal and nutritional purposes. Some drugs are used as placebos, others for sympathetic magic, but most have a definite medicinal value (Gumede 1990). *Izinyanga* have an extensive phamaceutical codex. Table 4 presents a list of some of the medicines used by *izinyanga,* which have therapeutic value.

[14] These were the most commonly used methods of administering medicines by Zulu herbalists. The same methods would apply to herbalists from other cultural groups in South Africa. Many other methods exist which were used by witchdoctors and sorcerers to cause harm.
[15] Skin conditions of especially the face, e.g. acne.
[16] This is one of the oldest means of administering medicines and is also the most demanded among African patients due to its immediate effects.
[17] *Idliso* refers to being poisoned. Tuberculosis is, thus, synonymous with being poisoned.

Other plants commonly used by herbalists include Agothosma betulina (*ibuchu),* Aloe ferox (*ikhala)* and Salix mucronata (*umngcunube*). *Ibuchu* has been widely used to treat kidney and urinary tract diseases. It is also applied locally to bruises and rheumatic pains, chewed to relieve stomach complaints, or infusions are used against fever, tiredness and congestion of the chest, as well as to strengthen the body. The fresh leaf juice of *ikhala* is used to treat conjunctivitis. The powder ground from its charred leaves is applied to venereal sores, or used for snuff. *Ikhala* is also traditionally used to treat arthritis, eczema and hypertension, or applied externally to treat skin irritations, burns and bruises. *Umngcunube* is traditionally used to treat rheumatism and fever (Iziko museums of

Table 4: Medicines of therapeutic value used by herbalists

Purpose of medicine	Indigenous Xhosa/Zulu term	Scientific term
Drugs used to expel worms	*Uxhaphozi*	Ranunculus pinatus
	Umqoqongo	Clerodendron glabrum
	Isidende/Umaguqu	Maesa speciosum
	Izintanga	Pumpkin
	Ishabelo/Isikhomakhoma	Male fern/Filicis mas
Aphrodisiacs	*Ubhangalala*	Eriosema salignum
	Umzimuka	Argyrolobium speciosum
	Inhlamvu	Orchidaceae:Habenaria speciosum
	Umhlabankunzi	Eriosema cordatum
Drugs used for women only	*Icena*	Bulbinella carnosa – Green star lily
	Ihlamvu	Gloriosa virescens Lindi
	Uhlunguhlungu	Vernonia corymbosa less
	Ugobho	Gunerra perpensa Ibid
	Ubani	Agapanthus minor/Agapanthus umbellatus
	Isidala	Lobelia coronopifolia
	Insangansanga	Senecio buple roides – yellow starwort
	Isihlambezo	Streptocarpus speciosum – cow's tongue
	Usikisiki Olumhlophe	Sutera Kraussiana
	Usikisiki Lwehlathi	Sutera Floribunda
Drugs used for chest complaints	*Iboza*	Iboza riparis
	Isisinini	Senecio quinquelobus
	Umathunga	Kniphafia natalensis
	Icwaningi	Capparis tomantosa
	Insangu	Cannabis sativa
	Imunyane	Leonotis leonurus
	Umhlaza	Ipomoea batatas
	Umhlonyane	Artemisa Afra
	Izimbiza	A mixture of several medicinal extracts such as the following used for blood poisoning or pulmonary tuberculosis: ▪ Aster erigoroides (*Uxaphozi*) ▪ Strychnos (*Umhlali*) ▪ Barleria ovata (*Umathanjana*) ▪ Cissampelos lolurosa (*Umthombo*) ▪ Rawolfia natalensis (*Umhlambamanzi*) ▪ Gunnera perpensa (*Ugobho*) ▪ Chlorophylum modestum (*Umathunga*) In certain areas of the Eastern Cape *uthangazana* (Cucumis africanis) and *umthumana* (Solanum capense) are added to this mixture specifically for tuberculosis.
Medicines used for external application	*Umthuma*	Solanum sodomeum
	Umthunduluka	Ximenia caffra
	Inkomfe	Authericinia gerrardi
	Uqonsi	Eriosema salignum
	Icebethwane	Aristea cognate
	Icishamlilo	Pentanesia variabilis
	Usikisiki lwentaba	Selago racemosa
	Ibohlololo	Kalanchoe hirta
	Isidikili Esimhlophe	Arthrosolen calocephalus
	Umadolwana	Pelargonium speciosum

Source: Gumede 1990

Cape Town 2003). *Inongwe,* more commonly known as the African Potato, has become renowned for its immune strengthening effect, and is especially recommended for people living with HIV/AIDS who suffer from a compromised immune system. The Sutherlandia Frutescens, found in KwaZulu-Natal and regions of the western and eastern coast of Africa, is used by traditional health practitioners to make tonics, teas, tablets and creams. The benefits of these remedies include improved appetite, weight gain, exercise tolerance, and an overall sense of well-being. In the absence of easy access to antiretroviral drugs, many such herbal remedies are used as the first line of defense to combat HIV/AIDS-related symptoms (Institute of Science in Society 2004). Only a select few of the medicines used by traditional health practitioners have been noted.

According to Gumede (1990), in many cases, the medicines used by traditional and western health practitioners are the same substance, for example, Filicis mas for tapeworms, the only difference being that the herbalist may prefer the raw root, while the modern practitioner prefers to extract the juice so as to have better control over the dosages. In essence, medicine originates from barks and roots, and would, therefore, not exist were there no herbs. Thus, medicine is synthetic, whilst herbs are authentic.

3.7.3. African spiritual healers/faith healers

The vital role of ancestor spirits in the daily lives of African people has been discussed. So too has the ways in which ancestors communicate with their offspring. The most common mode of communication is through dreams. Ordinary human beings are often unable to interpret the messages of their ancestor spirits, thus, the necessity to consult those who have the skill to do so. The spiritual healer and diviner are two such people who serve as mediums, and provide a telepathic bridge between the ancestral spirits and the population at large (Gumede 1990).

Spiritual healers are directly related to the African Independent Churches (AICs)[18], and they function within this framework (Pretorius 2004). AICs are believed to have emerged as a result of disagreements between African Christians and western missionaries over the extent to which traditional African practices were permissible. An example in point is the issue of polygamy where many AICs permit polygamy following the Old Testament, and which the New Testament does not reject. This practice is condemned by most mission churches (African Christianity s.a.[a]).

Religious sects, cults, and church groups of all origins emerge yearly. Recurrent words in the naming of these churches, such as *'African', 'National', 'New Jerusalem', 'Independent', 'Free'*, etc., express the desire to escape from a restrictive western religion that does not meet the everyday needs of the African (African Christianity s.a.[a]). Bhengu (in Gumede 1990) states: "We are called to face these people with the Gospel of Christ. People with empty stomachs, empty brains, empty everything, a workless, homeless, hopeless people who see no future apart from day to day living". This depicts the fundamental social, economic and political characteristics of the South African society for years. It is these politico-socio-economic[19] pressures on the Black man/woman which are deemed responsible for producing spiritual healers by the hundreds. Communities in South Africa are plagued by problems which emanate from the process of adjusting to new social conditions. Thus, the spiritual healer fulfils a vital role. He/she generates

[18] African Independent Churches are also referred to as African Initiated Churches, African Instituted Churches or African Indigenous Churches (African Christianity s.a.[a]).

[19] Gumede (1990) refers to politico-socio-economic pressures such as substance abuse, child abuse, hypertension, mental confusion states, schizophrenia, etc.

an atmosphere of comfort in prayer, song, and the words of the oracle from the ancestral spirits. This role was particularly relevant as a new volatile Africa was emerging and urban complexities appearing, leaving large numbers of people confused by new situations and unsettled by new expectations (Gumede 1990). In this day and age, the plight of the HIV/AIDS epidemic is one of the most prominent politico-socio-economic problems facing Africans.

One of the best known and outstanding African spiritual healers is Isaiah Shembe[20]. Shembe made a profound contribution to the development of African Christianity through making use of dancing, singing, prayer, ritual, healing the sick, testimony and confession as instruments of worship in his theology. African spiritual healers are said to be looking for a ritual with a familiar frame of reference, for example, dance, sacrifices, and singing as the spirits move the believers. This form of ritual is often lacking in Christian churches which originate from the western world. Spontaneous joyful worship is more evident in the Zionest movements (Gumede 1990). Zionism has mission origins, but found itself on a par with African ways of thinking, to the extent that it blended itself into traditional African culture within a generation. The Zionist church is characterised by a commitment to faith-healing, river baptism, and to the Pentecostalist gift of speaking in tongues (African Christianity s.a.[b]). Maphitini Mfene Thusi, better known as Mfene, is one other renowned spiritual healer. Mfene's place was built in Malukazi (KwaZulu-Natal) and was named *Emakhehleni*. He adopted the Zulu code of living and social hierarchy structure in his church, which included his adherents incorporating various traditional African practices in their daily living. One such practice is the *Isibaya*, which traditionally is the area where the Zulu pray to the ancestor spirits. All adherents to the *Emakhehleni* spiritual healing church are required to wear a small Zulu shield as a badge, which serves as an insignia. They pray and address their problems[21], small or large, to the Patron Saint, King Shaka (Gumede 1990).

What transpired from the research undertaken, is that spiritual healers are differentiated into two distinct categories, namely spiritual healers who heal by virtue of prayer and water alone, and spiritual healers who combine prayer and water with the use of traditional medicines and rituals. According to the Department of Health of South Africa, spiritual healers who do not make use of traditional medicines and rituals are not regarded as traditional health practitioners. In other words, inclusion of traditional rituals and medicines in the healing process, has earned the latter group of spiritual healers inclusion in the pool of traditional health practitioners, while excluding the former group of spiritual healers from the pool. Spiritual healers themselves express different views about the legitimacy of spiritual healers based on calling and supernatural source of communication. One group of spiritual healers has visions related to God and so-called heaven as their calling. This group also communicates directly with God in the healing process and does not make use of roots and other raw plant material to make traditional medicines. Instead, they use water and processed herbs to heal. Contrary to this, the second group of spiritual healers has visions of objects and people as their calling (similar to diviners). Furthermore, this group of healers communicates with ancestors in the healing process, and they utilise raw plant material to make medicinal remedies in their healing practices. Each of the two groups of spiritual healers views themselves as legitimate healers, whilst viewing the other as illegitimate. Hence, spiritual healers stand divided based on their beliefs.

[20] Shembe lived in Ekuphakameni (KwaZulu-Natal), within a kilometre from Mahatma Ghandi and the reverend John Langalibalele Dube, who were both also well known religious leaders. He died in May 1935 at Kwambonambi (KwaZulu-Natal). Shembe produced 242 hymns with his son in which he often expressed the significance of the Nazarite sacred dance.

[21] Problems included why a calf does not suckle, why a baby is crying all night, why *umakoti* (daughter-in-law) has been married for five years and yet has not produced any offspring, or why *umakoti* has given birth to three lovely daughters but no son?

Of interest is that even the faith healers who are regarded as traditional health practitioners have been omitted from the categories of traditional practitioners that have been recommended to the Statutory Portfolio Committee for the Department of Health, in 1998. Reasons given for their omission include their use of western practices, namely prayer; the lack of knowledge about their practice; and the inability to measure their practice. However, the issue on the inclusion of spiritual healers has not been closed. It is noted that submissions in this regard will be considered by the relevant authorities, and that spiritual healers may be accorded due recognition by law if representations can satisfactorily argue that this cadre of healers fulfill the basic criteria of a traditional health practitioner (Parliamentary Monitoring Group 2003). The findings of the research undertaken, suggest that spiritual healers are more than likely also diviners. This was deduced from evidence which points towards all the spiritual healers who participated as respondents in the research, also practising as diviners, either before becoming spiritual healers, or shortly after practising as spiritual healers. Assuming that this trend is portrayed nationally, it can be concluded that spiritual healers are inevitably included as traditional health practitioners, albeit indirectly, in the Traditional Health Practitioners Act by virtue of also practising as diviners. However, spiritual healers who are excluded from the category of traditional health practitioners because they do not utilise traditional medicines and rituals in their practice, are also excluded in the Act.

3.8. In conclusion…

African traditional healing is best understood in the context of the African worldview, as opposed to the Western worldview, and it is linked to religion. The African worldview is characterised by a holistic and anthropocentric ontology that places man at the centre of the universe (Minnie *et al.* 2002). The universe comprises three inseparable and inter-related cosmic forces, namely man (including nature), ancestral spirits, and God. Health and good fortune are maintained through a harmonious relationship between the cosmic forces. Illness and misfortune are attributed to a disturbance in the equilibrium of cosmic forces. The onset of illness, thus, prompts the questions 'why?' and 'who?'. Corrective measures aimed at alleviating illness depend on the answer to these two pertinent questions. Traditional health practitioners are viewed as interpreters of the 'why?' and 'who?' associated with illness, by serving as mediums between the living and those who are guiding and protecting the living, namely ancestor spirits and God.

Although African traditional health practitioners have evolved somewhat from practising exclusively within a specific field (i.e. herbalists, diviners, etc.) to including practices of other categories of traditional healing in their methods of diagnosing and treating, these categories of specialisation remain intact. Furthermore, the roles and responsibilities of traditional health practitioners encompass far more than maintaining good health through the elimination of physical symptoms of disease. They play a pivotal role in maintaining harmony between individuals, their environment, and God. This harmonic relationship is what facilitates good health and fortune. In essence, traditional medicine's value lies not in its materials, but in the methods and concepts underlying its use. In other words, the key feature of traditional medicine/healing is its ability to provide meaningful answers to the practitioner, the patient and the patient's family (Ngong Teh 1998). To this end, acknowledging the African worldview provides a 'wide-angled lens' to view health and illness, *per se,* and will highlight the multidimentionality of epidemics, such as AIDS, in Africa.

"It is not policy or just massaging the issue that will resolve this impasse, common sense and necessity will have to prevail so that both these sectors begin to work with each other rather than against."

- Musa Mabandlha (University researcher)

(PLUSNEWS 2002)

Chapter 4

COLLABORATION BETWEEN TRADITIONAL AND WESTERN HEALTH PRACTTIONERS: LESSONS LEARNT FROM DEVELOPING COUNTRIES

The WHO has been in the forefront of an unprecedented drive towards incorporating traditional healing systems into national health care systems, thus attaining integrated health systems especially in developing countries (WHO 2002). However, very few countries exhibit integrative health care systems as described by the WHO. The feasibility of integrated health care systems as defined by the WHO remains debatable, including within the South African health sector. However, the need for integrating traditional health practitioners into official health programmes and health care systems is undeniable. The extent and nature of integration should be country-specific and determined by the health-care needs and health-seeking behaviour of a society. Effective collaboration between practitioners of western and traditional healing systems is a first step on the road to integration. Many traditional and western health practitioners have voiced the need for closer cooperation between the two in order to combat diseases such as HIV/AIDS (Baggaley *et al.* 1995; Coleman 1996; King 2002; Roberts 1999). With the realisation of the interdependent relationship between the traditional and western healing systems, a number of collaborative projects were initiated as early as the late 1980s (King 2000). Initiatives that have attempted collaboration between traditional and western health practitioners, with specific reference to HIV/AIDS prevention, counselling and care, will be reviewed. Reference is made to HIV/AIDS-related collaboration between traditional and western health practitioners in Africa for two reasons, namely (i) Africa is the region most affected by HIV/AIDS and (ii) it has the least available resources (King 2002). To date, no African country has attained an integrated health care system. Thus, invaluable insights are

drawn from the experiences of Asia in formalising and integrating traditional medicine into the national health care system.

4.1. Collaboration between traditional and western health practitioners in Africa

4.1.1. Traditional and western health practitioners: Finding common ground

The AIDS epidemic sparked a renewed wave of interest in collaboration between western and traditional medicine, in the hope of finding more appropriate and effective means of fighting the epidemic. It is a common belief that for a health education message to be understood, and for health seeking behaviour to be positively modified, two things are required, namely, the correct message, and the correct messenger. In developing countries, the traditional health practitioner remains the correct messenger for millions of citizens. Traditional health practitioners are a major health human resource due to their accessibility and their being a preferred source of health care for large segments of populations in developing countries. They are respected members of their communities due to the major role that they play in the fields of health, governance, family disputes, marriage/divorce, sexuality/infertility, and socialisation of children. They also play a prominent role in enforcing appropriate normative behaviour, and sanctioning behaviour that is inconsistent with socio-cultural norms and expectations. The influence of traditional health practitioners is evident in community members seeking, believing and acting upon their advice. It, thus, only follows logically to use the messenger that is most trusted and respected by a population to transmit a health message to the population in question. Similarly, it is most logical to enlist the assistance of those with great influence in order to influence health-seeking behaviour. For an estimated 80 – 85% of the population in sub-Saharan Africa, this agent is the African traditional health practitioner (Gbodossou *et al.* s.a).

The fact that traditional health practitioners are culturally accepted and respected, and are more universally located in African countries, prompted the development of various efforts aimed at utilising traditional health practitioners as agents of HIV/AIDS awareness and education. Such efforts have been based mainly on a trainer-trainee approach, where traditional health practitioners are trained about the basic facts of HIV/AIDS transmission and prevention so that they can, in turn, train their peers and clients. These initiatives have also encouraged traditional health practitioners to empower and provide emotional support to clients that are living with HIV/AIDS (King 2000). According to Pretorius (1999), a dramatic multiplier effect is evident when this training reaches those traditional health practitioners who regularly teach initiates. King (2000) documented initiatives within sub-Saharan Africa which were identified by the Joint United Nations Programme on HIV/AIDS (UNAIDS) as depicting best practices in collaboration between traditional and western health practitioners in HIV/AIDS prevention and care. King (2000) further highlights selected initiatives from these identified by UNAIDS, as flagship projects. These initiatives are discussed in Table 5 against the backdrop of their objectives, activities and outcomes. Table 5, however, is not an exhaustive list of initiatives to date. It merely highlights initiatives between the mid-80s and mid-90s which portray effective collaboration between traditional and western health practitioners in the area of HIV/AIDS prevention, counselling and treatment.

Table 5: Collaboration between traditional and western health practitioners in sub-Saharan Africa

Country	Project/initiative	Objectives	Outcomes
Botswana	Botswana Dingaka AIDS awareness and training programme (1991-1993)	▪ Provide a forum for exchange of information and experiences between traditional and biomedical health practitioners ▪ Promoting cooperation and collaboration for health services ▪ Creating awareness on AIDS among traditional health practitioners ▪ Training core trainers who will, in turn, pass on the information to other traditional health practitioners in selected pilot areas	▪ Twelve trained traditional health practitioners trained, on average, 45 other traditional practitioners per district (six districts) in two years ▪ 72% of traditional health practitioners said they had changed something in their practice in relation to AIDS training ▪ 80% of traditional health practitioners said they recommended condoms to their clients ▪ 31 of the 32 traditional health practitioners said that they had referred HIV/AIDS patients to clinics or to a hospital ▪ a great majority of the nurses who participated in the project said that they had referred patients to traditional health practitioners ▪ a flip chart addressing practices of traditional health practitioners was produced
Central African Republic	Action to Define, Broaden, and Strengthen the Role of Traditional Practitioners (ADERT) (1995)	▪ To identify and reinforce aspects of traditional medicine believed to promote public health, while discouraging those that have negative health impacts ▪ To enable traditional health practitioners to deliver preventive messages, support persons living with HIV/AIDS and modify their own risk practices	▪ Traditional health practitioners' knowledge improved, except with regard to their own risk practices.
Ghana	Unit for traditional medicine established in Ministry of Health (1990)	▪ To involve traditional health practitioners in primary health care	▪ To involve traditional health practitioners in primary health care
Guinea	Ministry of Health, traditional medicine unit. Integration of traditional health practitioners into health activities (1985)	▪ To identify the factors within traditional medicine that can increase the effectiveness of the fight against AIDS in Guinea ▪ To increase traditional health practitioners' knowledge of modes of HIV transmission and prevention, clinical manifestations, care and support	▪ Traditional health practitioners are registered with the Ministry of Health ▪ Research on 898 traditional health practitioners since the beginning of the programme found that increasing numbers of traditional healers refer to health centres, hospitals and other traditional practitioners, using a referral form, for diagnosis and treatment ▪ Biomedical health providers also refer to traditional health practitioners ▪ Traditional health practitioners keep records on number of cases and treatment given
Malawi	Training on AIDS for traditional health practitioners (1992)	▪ To better understand the practices and roles of practitioners in their communities ▪ To promote greater communication between traditional health practitioners and the formal health care sector ▪ To educate traditional health practitioners about HIV/AIDS and STD transmission and prevention ▪ To encourage community-based HIV/AIDS prevention and care by traditional health practitioners	▪ Increase in community education, condom distribution, and patient counselling activities
Mozambique	Anthropological research on traditional medicine (1995)	▪ To improve intersectoral cooperation in the prevention and treatment of STDs ▪ To identify and reinforce aspects of traditional medicine believed to promote public health, while discouraging those believed to have negative health impacts	▪ Developed a culturally appropriate strategy for the National AIDS Control Programme (NACP) involving traditional health practitioners in STD control ▪ Eight clients of traditional health practitioners were interviewed and showed increased knowledge on HIV transmission, condom use and promotion

Table 5: Collaboration between traditional and western health practitioners in sub-Saharan Africa

Country	Project/initiative	Objectives	Outcomes
South Africa	Training of trainers for practitioners (1992)	▪ To engage traditional health practitioners in combating HIV/AIDS in South Africa through training other health practitioners and incorporating HIV/AIDS prevention into their practices	▪ 630 traditional health practitioners were trained by 28 trained traditional practitioners on basic AIDS facts including death and dying ▪ After a seven month follow-up, more than 80% of the trained traditional health practitioners had retained correct STD/AIDS information and practised counselling
	Training programme for traditional health practitioners in KwaZulu-Natal (1994)	▪ To increase AIDS prevention, education and management in KwaZulu-Natal by providing training and resources to traditional health practitioners ▪ To help trained traditional health practitioners become accepted by the biomedical system in KwaZulu-Natal	▪ Traditional health practitioners were able to identify signs and symptoms of AIDS after training ▪ Traditional health practitioners identified a need for rural AIDS hospices and trained home-care personnel to care for persons living with HIV/AIDS ▪ 75% of traditional health practitioners believed that they could cure AIDS before training whereas none believed they could after training
Uganda	Traditional and Modern Health Practitioners Together against AIDS (THETA) (1992)	▪ To provide training for traditional health practitioners in community counselling and HIV/AIDS education, basic clinical diagnosis and patient management ▪ To provide a resource center for information sharing on traditional medicine and AIDS ▪ To advocate for traditional medicine among health professionals and other scientists in order to build a true collaboration	▪ Increased counselling and AIDS education by trained traditional healers and increased knowledge and condom use among clients of trained traditional health practitioners ▪ Over 120 traditional health practitioners trained and more than 96 000 persons benefited in two years ▪ Collected a wide variety of materials on traditional medicine and AIDS ▪ Produced two videos in Uganda and English for educational and informational use
	Community-based home care (1993)	▪ To train volunteers to provide care and support to the sick using a primary care herbal kit developed by the project ▪ To disseminate information on herbs and disease	▪ Traditional health practitioners trained 68 volunteers involved in home care and distributing herbs for common AIDS-related symptoms
Tanzania	Tanga AIDS Working Group (TAWG) (1990)	▪ To raise HIV/AIDS/STD awareness among traditional practitioners in three districts with a view to safeguard both practitioners and clients from being infected during practices ▪ To train traditional health practitioners as community-based HIV/AIDS/STD educators and home-based care providers for people living with HIV/AIDS and their families ▪ To promote community-based condom distribution	▪ 160 traditional health practitioners were trained in HIV/AIDS and health information ▪ healers are involved in collaborative clinical work, AIDS education, counselling, home visits and village theatre groups ▪ training manual produced
Zambia	AIDS research, training and follow-up (1994-1996)	▪ To educate traditional health practitioners about HIV/AIDS and STD transmission, prevention and care ▪ To enable traditional health practitioners to educate their patients about these issues and motivate them to avoid high-risk behaviour	▪ 2000 traditional health practitioners were trained on AIDS facts and 120 traditional practitioners were trained in community education ▪ knowledge increased, traditional health practitioners started selling condoms through a social marketing programme

Source: King 2000

The majority of initiatives have focused on integrating traditional health practitioners in HIV-prevention and counselling programmes. As evident from the selected initiatives presented in table 5, the role of traditional health practitioners in the battle against HIV/AIDS encompasses far more than merely prevention. It is equally important to explore and understand the role that they play in the treatment of HIV/AIDS. Integrating traditional practitioners in treatment and care programmes has only recently gained momentum in sub-Saharan Africa. Initiatives most worthy of mention are, *inter alia,* the Tanga AIDS Working Group (TAWG) in Tanzania, and the Traditional and Modern Health Practitioners Together against AIDS (THETA) project in Uganda. Although these are not the only initiatives embarked upon, they are exemplary of successful collaboration between the traditional and biomedical health care systems in providing treatment and care to people living with HIV/AIDS. An overview of TAWG and THETA, as thriving examples of collaboration between western medical doctors and traditional health practitioners in an African setting, follows.

4.1.2. Tanga AIDS Working Group (TAWG)

TAWG is a multidisciplinary NGO situated in the public regional hospital of the Tanga District in Tanzania. The Tanga District consists of 670 traditional health practitioners of which 337 are in Tanga Urban District and 333 are in Tanga Rural District. The traditional health practitioners in Tanga mostly comprise of herbalists, diviners, mediums, traditional surgeons, traditional birth attendants and traditional psychiatrists. The traditional practitioner:resident ratio in Tanga is 1:343, and the western practitioner:resident ratio is 1:33 000. TAWG realised that the war against HIV/AIDS could only be won by including traditional practitioners as active partners in the health care system. TAWG's main goal is to bridge the gap between traditional and western biomedicine by treating PWAs with traditional medicine. This goal is achieved through knitting together local expertise and resources, namely traditional practitioners, physicians and health workers, botanists, social scientists, and people living with HIV/AIDS.

TAWG evolved from the realisation by health workers in 1990 that many patients in the Tanga District were concurrently visiting both the regional hospital and traditional health practitioners. This realisation prompted the need to make contact with local traditional practitioners in hopes of initiating a referral network. Traditional health practitioners responded enthusiastically to this initiative, which they (traditional practitioners) interpreted as an indication of being taken seriously, and treated like fellow professionals. This network evolved into TAWG. TAWG was officially registered with the Ministry of Home Affairs in 1994 and is currently the leading HIV/AIDS NGO in the Tanga District. TAWG's main activity is treating PWAs in the hospital or at home with medicinal plants. These medicines are low cost, effectively treat selected opportunistic infections, are readily available, and are provided to patients free of charge (Scheinman 2002). TAWG buys the medicines from traditional health practitioners for $1.5 per patient's supply and then administers them in public hospitals and at the homes of PWAs (Agence France-Presse 2000). The medicines provided have been laboratory tested and shown to have curative properties (Plastow 2002). The medicines provided by TAWG serve the following functions, which essentially is indicative of a strengthened immune system: increase appetite; help patients gain weight; stop diarrhoea; reduce fever; clear up oral thrush; resolve skin rashes and fungal infections; treat herpes zoster; and clear ulcers (Plastow 2002; Scheinman *et al.* 2003).

Since TAWG was founded in 1990, they have treated over 2 000 AIDS patients with herbs prescribed by traditional health practitioners (Scheinman 2002; UN Integrated Regional Information World Bank 2001). The impact of TAWG includes the extension of PWAs lives, improvement in their quality of life, and a reduced number of AIDS orphans since parents remain alive longer. It is reported that some patients treated by TAWG have lived longer by up to five years (World Bank 2001). TAWG's treatment programme exemplifies the positive results which can be achieved when traditional and western health practitioners synergistically combine forces to provide effective low cost treatment for people living with HIV/AIDS (Scheinman 2002).

4.1.3. Traditional and Modern Practitioners Together Against AIDS (THETA)

The THETA Project is based in Kampala, Uganda, and has been involved in extensive efforts to determine how traditional and western health practitioners can work together against AIDS. THETA was founded by members of Doctors Without Borders[22] (DWB) and The AIDS Support Organisation of Uganda (TASO) in 1992, when western doctors in Mulago discovered that some of their HIV/AIDS patients also consulted traditional healers. Out of curiosity, these western doctors wanted to determine the effectiveness of the treatment of traditional health practitioners. This led to the birth of THETA, which embarked upon conducting clinical evaluations to compare the outcomes of patients treated with traditional herbal remedies with the outcomes of patients treated with available biomedical drugs at the national hospital in Kampala. This entailed evaluating treatments for diarrhoea, herpes zoster and wasting. The phase one and phase two tests found comparable results between the two types of therapy with herbal therapies, in some cases, even portraying better results than those achieved by the more sophisticated biomedical drugs. The treatment facet of the project was supplemented by an education and counselling skills component in the form of a two-year project. The follow-up of the latter project revealed that the trained traditional practitioners had increased the focus of their educational campaigns to the community at large, and welcomed affiliations with western doctors and hospitals. A key success factor of the THETA project is its ability to gain the trust of traditional health practitioners through respecting the practitioners' rights of ownership over their herbal formulas (Engle 1998). Also attributable to the success of the project, are the complementary workshops that are conducted to demystify traditional medicine for western health personnel. This has facilitated and encouraged the referral of patients by western doctors to traditional health practitioners if hospital treatments are not producing the desired results (International Federation of Red Cross and Red Crescent Societies 2000).

In essence, THETA's primary activities are to research herbal remedies as well as nurture dialogue and cooperation between traditional practitioners and western health workers. The project has the full support of Uganda's Ministry of Health, which is evident in the Ministry assisting traditional health practitioners to process and package their products for wider distribution (International Federation of Red Cross and Red Crescent Societies 2000).

[22] Doctors Without Borders, also internationally known as Médecins Sans Frontiéres (MSF), is a nonprofit organisation that provides emergency medical relief to populations threatened by war, civil strife, epidemics, or natural disasters (Engle 1998).

4.1.4. Summary of factors key to successful collaboration

Traditional health practitioners have an unmistakable and crucial role to play in building the health care systems of African countries, and strengthening and supporting a global response to HIV/AIDS. The projects identified by UNAIDS as flagship projects (cf. table 5) in the area of collaboration between traditional and western health care systems portray key factors as attributes to the success of the respective projects, and should be heeded by other collaborating initiatives. In addition, key contributing factors to successful collaboration between traditional and western health practitioners are also cited in literature elsewhere. The following success factors are extrapolated from table 5, as well as supportive literature consulted:

- *Repetitive rather than single training model is more effective* (King 2000). It is important to sustain knowledge and good traditional practices through continuous and consistent training. This will also serve as a quality control mechanism. Each training session should be followed by a session of assimilation to ensure that the training material is well assimilated.
- *First generation of trained traditional health practitioners select and train their peers more effectively than the western-trained trainers of the first generation* (King 2000). The reason for this is that the traditional health practitioners' selection is less politically directed and the training is more culturally appropriate (King 2000). It is of the utmost importance that the educational messages of training reinforce, and not contradict, traditional concepts of illness in order to gain the interest and trust of traditional health practitioners.
- *The ability to gain the trust of traditional health practitioners through respecting the practitioners' rights of ownership over their herbal formulas* (King 2000). Research has been conducted among traditional health practitioners about traditional medicinal plants and medicine, which has resulted in biopiracy and the exploitation of intellectual property rights of traditional health practitioners (Rukangira 1998). This is detrimental to relations between traditional and western health practitioners, since the latter are deemed untrustworthy by the former, when trust is an integral prerequisite to collaboration between two parties.
- *Complementary workshops to demystify traditional medicine for western health personnel* (King 2000). There is a need for practitioners from both traditional and western health systems to overcome the barriers of suspicion that exists between them. Workshops which afford researchers, academics, traditional and western health practitioners the opportunity to jointly deliberate on issues of concern to all of them, results in a better understanding of the concerns of each of the sectors represented (Rukangira 1998).
- *Active participation of western health practitioners in projects and initiatives to transform the health care system through the inclusion of traditional health practitioners* (King 2000). It is imperative that all role players are involved in the integration of traditional health practitioners into national health systems so as to ensure cooperation towards collaboration. One-sided participation on the part of traditional health practitioners will not suffice since it requires western health practitioners to accommodate traditional health practitioners into the official health sector to achieve successful integration.
- *Registration of all traditional health practitioners with one national body*. Heterogeneity and lack of organisation of traditional health practitioners renders it difficult for government to collaborate with them. This

is especially evident from the research undertaken where traditional health practitioners are segregated into groups by various traditional health practitioner associations or by affiliation and non-affiliation to a traditional practitioner association. Animosity between the various groups of traditional practitioners makes it increasingly difficult for government to work with them as they are fragmented and dispersed instead of a unified entity.

- *Institutionalisation of core practices of traditional health practitioners*. Institutionalising traditional healing requires standardising certain aspects of traditional health practitioners' training and practices. Standardised traditional healing practices, thus eases the process of integrating traditional healing into training programmes for western health practitioners. Standardisation also facilitates the regulation and monitoring of the traditional healing sector, therefore maintaining the quality of traditional healing services.
- *Traditional health care information system for record keeping purposes (regulation)*. Developing and implementing a record keeping system for the traditional healing system not only regulates the system, but also serves the purpose of easing collaboration between traditional and western health practitioners. A traditional health care information system will facilitate a bilateral referral system between the two groups of health practitioners, as well as ensure appropriate traditional and western treatment for patients who opt for both systems to meet their health care needs. This will also minimise negative effects associated with combining traditional and western medicine, such as drug interactions, which is one of the major obstacles to effective collaboration expressed by respondents of the research undertaken.
- *Researching traditional healing and medicine, and the perceived role of traditional health practitioners*. According to Richter (2003) urgent research is needed into traditional medicine and healing, especially with regard to HIV/AIDS. Research should be geared towards understanding the conditions that facilitate traditional health practitioners purporting to cure AIDS, the profile of clients that consult traditional health practitioners, and the costs and benefits of traditional medicine. Research should be aimed at including traditional health practitioners in ongoing AIDS information, education and counselling programmes.

4.2. South Africa: collaboration in HIV/AIDS

A number of collaborations between traditional and western health practitioners in the field of HIV/AIDS have been embarked upon in South Africa. As is the case with most collaborative initiatives elsewhere, the focus of collaboration has been on educating traditional health practitioners about HIV prevention and counselling. The drive to train traditional health practitioners has yielded positive results in terms of increasing traditional practitioners' knowledge about HIV symptoms, modes of transmission and prevention. However, one concern conjured up by this predominantly one-way approach to collaboration, namely imposing only western knowledge about HIV/AIDS, is the risk of losing the strength and unique contributions of traditional healing. Western health practitioners still have difficulty acknowledging the value of traditional practitioners. The reluctance of western practitioners to acknowledge the role of traditional practitioners creates an illusion that western medicine holds all the answers to the challenges posed by the AIDS epidemic in developing countries and should, thus, charter the way forward (King 2000). It is of the utmost importance that training in collaborative health care provision include both western and traditional practitioners. Training should also be geared towards promoting the exchange of information between the two groups of practitioners and a bilateral (two-way) referral system.

Ignoring, marginalising or criticising traditional health practitioners have not, and will not prevent people from utilising their services. Therefore, it is imperative that traditional health practitioners be included in the realm of health care so as to evaluate and determine harmful and useful practices, including evaluating the safety and efficacy of traditional remedies.

4.2.1. Validation of traditional medicines in South Africa

The South African Traditional Medicines Research Unit, which was launched in 1993, is a collaboration between the Medical Research Council (MRC), the Department of Pharmacology at the University of Cape Town, the School of Pharmacy at the University of the Western Cape and several traditional health practitioners. The main objective of this Unit is to scientifically establish the effectiveness, safety and quality of traditional medicines with the aim to protect people from unscrupulous conduct and unproven medical claims within the traditional healing sector. The Unit's main activities include registration of provisional patents, research into various medicinal plants, and research training of postgraduate students. In 1997, the Unit developed a comprehensive manual on primary health care as a practical guide for traditional health practitioners. One of the major outputs of the Unit is the compilation of the Traditional Medicines Database (TRAMED III) in 2000 (Mavasa 2003; Ndaki 2004; Pretorius 1999; Richter 2003).

It is unfortunate that research bodies specifically established to ascertain the validity and efficacy of traditional medicines, are still unaware of traditional medicines in South Africa which have clinically been proven to be effective in the treatment of HIV/AIDS. According to Richter (2003), representatives of TRAMED III and Global Initiative for Traditional Systems (GIFTS of Life) reported being unaware of any clinical data of an African traditional treatment for HIV-related illnesses. These statements followed one year after reports of preliminary positive research outcomes on the efficacy of African traditional therapies in HIV/AIDS, and other prevalent illnesses in the African Region, were presented at the XIV International AIDS Conference in July 2002. Included in the literature presented at the conference, is the positive impact of the traditional medicinal plant, 'Sutherlandia' (*Unwele* in isiXhosa/isiZulu). Both literature as well as personal accounts of people living with HIV/AIDS have demonstrated diminishing opportunistic infections and increased quality of life. A study conducted by Phyto Nova, a South African-based company that researches, promotes and distributes natural traditional medicines from indigenous African plants, found that 4000 people living with HIV/AIDS, and who were using 'Sutherlandia' in place of antiretroviral therapy, showed evidence of an improvement in appetite, exercise tolerance, mood and sense of well-being. Weight gain within six weeks of commencing treatment in the majority of emaciated patients, and decreased diarrhoea were also reported. Studies conducted by the MRC revealed no toxicity. Reports of such findings provide affirmation and assurance of the beneficial role of traditional medicines in the global fight against the AIDS epidemic. However, these observations still need to be validated and quantified by an independent controlled clinical trial to meet international and national standards of safety and efficacy, and requirements for registration (Gbodossou *et al.* s.a; Richter 2003).

Following concerns noted by the WHO regarding the quality and quantity of the safety and efficacy data on traditional medicines as insufficient to meet the criteria for its worldwide use, the South African Government launched the National Reference Centre for African Traditional Medicines (NRCATM) in August 2003 (Ministry of Health 2004; Ndaki 2004). At the launch of the Western Cape provincial Reference Centre for African Traditional Medicines, the

Minister of Health stated: "*The need for scientific validation and production of high quality, safe medicines based on African traditional medicines cannot be overemphasised*" (Ministry of Health 2004).

4.3. Respecting intellectual property rights of traditional health practitioners

Ethnopharmacology refers to the process of utilising western science to bring to light which traditional plants are effective and safe for incorporation into the official health care system. Seemingly, many western practitioners are interested in collaborating with traditional practitioners in good faith. However, caution is drawn to those initiatives which practise biopiracy[23].

Rees (1999) believes that many traditional health practitioners are exploited for their ethno-botanical knowledge. He refers to some cases where traditional health practitioners have individually been paid a small fee for their ancestral wisdom which could lead to the development of a drug and eventual market. Rees (1999) describes some of the contracts entered into by traditional health practitioners and pharmaceutical companies, or institutions, as an insult to the indigenous population. Exploitation of traditional practitioners is reiterated by Mayeng (in Warren-Brown & Krali 1999), who is both a traditional practitioner and western trained medicinal and biological chemist. Mayeng believes that the intellectual property rights of some traditional health practitioners are violated by large profit-driven multinational pharmaceutical companies. This has resulted in some traditional health practitioners who have been able to help AIDS patients, but are wary of being exploited, to share the knowledge of their remedies only with trusted colleagues, thus, hampering efforts for collaboration with the western health sector.

Sustaining traditional medicines and indigenous knowledge is dependent on prompt action, at every possible level (local initiatives, support from NGOs, scientific research and governmental support), for all agreements between traditional health practitioners and companies or institutions to protect intellectual property rights as stipulated in the Convention on Biological Diversity (De Smet 2000). The MRC has established a Medical Innovations Centre to offer advice on intellectual property rights. Thus far, the procedure which the Centre has developed for purposes of protecting the intellectual property rights of traditional health practitioners that the MRC collaborates with, entails the signing of an agreement between the unit and the practitioner, after consent is obtained to disclose how a sample remedy has been prepared, and prior to testing of the sample. If the sample remedy looks promising and further tests are required which may lead to the development of a drug cure, a further agreement would have to be signed by the two parties (Warren-Brown & Krali 1999). Although these agreements may be entered into in good faith, it would be advisable for Government to oversee such agreements. Traditional health practitioners may not have the required legal knowledge, nor have the means to acquire such knowledge, in order to make informed decisions which will ensure that they are not exploited. Therefore, the proposed Interim Council for Traditional Health Practitioners will play a vital role in standardising and regulating such agreements to ensure the protection of intellectual property rights of traditional health practitioners.

The South African Government intends introducing new laws which will allow traditional medicines to enjoy the same patent rights as expensively developed pharmaceuticals. According to the former Minister of Arts, Culture,

[23] Biopiracy is defined as the use of intellectual property laws (patents, plant breeders' rights) to gain exclusive monopoly control over generic resources that are based on the knowledge and innovation of indigenous people (Rees 1999).

Science and Technology, a model for the new patent law, which will be tailor-made for the South African context, is under development (Standley 1999). The current Department of Science and Technology proposed an Indigenous Knowledge Systems (IKS) Policy to protect the rights of traditional health practitioners (Department of Health *et al.* 2003). The Policy was adopted by cabinet in November 2004, and provides a framework to stimulate and strengthen the contribution of indigenous knowledge to social and economic development in South Africa (Department of Science and Technology 2004).

Research shows that many traditional health practitioners are willing to learn more about western medicine and to cooperate to some extent with their biomedical counterparts (De Smet 2000). However, sustained controversy surrounding disclosing the content and nature of traditional medicines to western practitioners, could significantly hamper efforts to promote collaboration between traditional and western health practitioners. According to Gbodossou *et al.* (s.a), the absence of legislation to protect intellectual property places the traditional knowledge of African scientists and traditional health practitioners at risk of being stolen, misappropriated and shrouded in secrecy.

4.4. Integrated national health systems: lessons from Asia

The use and promotion of traditional medicines is not unique to South Africa and the African continent. Traditional medicines have a long and rich history in non-African countries such as India, China and Thailand. Some countries have progressed further than the mere use and practice of traditional healing to develop appropriate and practical regulatory frameworks for traditional healing (Ministry of Health 2004). It would be unjustified to exclude insights acquired by countries that have made significant strides in integrating traditional medicine into modern health care systems. Taking cognisance of such insights will enhance the capacity of governments to develop appropriate policies of integration, rather than of coexistence. Asia has witnessed the most progress in incorporating its traditional health systems into national health policy. The experiences of Chinese medicine's encounter with western medicine in China and Taiwan, and their integration policies may provide invaluable insights and guidance for other countries.

Chinese medicine, as has been the case with African traditional medicine, has survived subordination from western medicine. The process of integrating Chinese medicine into the national health system in China stems back to the late 1950s. It was essentially in response to national planning requirements to provide comprehensive health care services. Noteworthy are five salient elements in the integration strategy in China, which undoubtedly and unmistakably contributed to the successful integration of Chinese medicine into the national health system. These contributing factors include western health officials guiding the integration process; clearly setting the harmonisation of Chinese and western medicine as the goal of integration from the outset; a science-based approach to education and training in Chinese medicine; emphasis on research into Chinese medicine; and a substantial organisational infrastructure to support education, training and research into Chinese medicine (WHO Kobe Centre 2002).

Although Taiwan reportedly has an integrated national health system, Chi (1994) argues that the health system, in reality, is more characteristic of a tolerant system, where traditional health practitioners are permitted to practise in an unofficial capacity. This argument is based on three apparent observations, namely (i) limited participation of Chinese medicine practitioners in public health policy development and programmes; (ii) the small proportion of government

medical resources allocated to the training, research and practice of Chinese medicine; and (iii) the open-door licensure system for Chinese medical practitioners. After the Chinese Nationalist government came into power in Taiwan in 1945, it modified Japanese policy on Chinese medicine by allowing Chinese medicine to coexist with western medicine. The notion was to modernise Chinese medicine based on the scientific paradigm. The number of licensed Chinese medical practitioners in Taiwan increased from less than twenty in 1945 when the Chinese Nationalist government took over, to 1 545 practitioners in 1954. This rapid increase in the number of Chinese medical practitioners was viewed as a blessing, but also raised concern. Concern was conjured up by the open-door licensure system which was not based on educational or training requirements. This discredited the licensure system, thus also reducing the trust placed in Chinese medical practitioners due to the lack of regulation on the quality of practitioners (Chi 1994; WHO Kobe Centre 2002).

The following recommendations are deduced, mainly from the experiences of Taiwan in formulating its integration policy. These recommendations may be used by countries with pluralist health systems, such as South Africa, to inform and guide effective integration.

1. Promote communication and mutual understanding among traditional and western medical systems that exist in a society

   Often, attempts at integrating traditional medicine into a western health care system follow a unidirectional approach which requires traditional medicine to acquire an understanding of western medicine. The result is a unidirectional understanding, which may be partly responsible for western practitioners despising traditional practitioners. Mutual understanding of the two systems by the two groups of practitioners, paves the way for successful integration. This is achieved by education and training programmes to promote mutual understanding as well as complementary communication at all levels of practice and research (Chi 1994).

2. Evaluate traditional medicine in its totality

   A common approach is to conduct physiological, pharmacological and biochemical research on the curative value of traditional medicinal plants. The WHO also advocates the application of scientific knowledge and techniques in evaluating traditional medicine in contrast to using western scientific paradigm to evaluate traditional medicine's worldview and philosophy. This approach is more acceptable to both traditional health practitioners, as well as the scientific community. However, this process should go beyond evaluating medicinal plants, since traditional healing encompasses more than herbal drugs. The holistic approach towards health is one of the special strengths of the traditional healing system (Chi 1994). Bodeker (s.a.) affirms that self-regulation of traditional practices by traditional health practitioners is central to the establishment and maintenance of standards of best practice.

3. Integration should take place at the theoretical and practical level

   Many integration policies are nothing more than policies of tolerating traditional medicine by promoting coexistence of different medical systems. These types of policies are evident in Taiwan, Hong-Kong, Singapore, and India, where their official policies are that of integration but in practice are policies of coexistence. A common feature of these policies is the lack of sufficient mechanisms for integrating training, education, practice and research of both traditional and western medicine. A genuine integration policy should

promote the integration of medical systems at both the theoretical and practical levels of research, training, education and practice of medicine. Such an approach both promotes the contribution of traditional medicine to the national health care system, and also improves the traditional medical system (Chi 1994).

Bodeker (s.a.) highlights the need to promote comparative research, where modern and traditional approaches to managing the same conditions are compared in terms of clinical outcomes and cost. This will be achieved through channeling mainstream research funds towards research into traditional means for treating specific conditions.

4. Equitable distribution of resources between traditional and western medicine

   In many countries, the health budget for the public sector allocates a disproportionately smaller portion to traditional medicine than to western medicine, if at all the budget includes traditional medicine. In Taiwan, although one-third of outpatient visits were reported to occur in Chinese medical practitioners clinics, far less than one-third of government resources were allocated to Chinese medicine. This disproportionate allocation of medical resources is not unique to Taiwan, but is also evident in countries such as South Africa. According to Chi (1994), a country's commitment to an integration policy is evident when traditional and western medical practitioners jointly determine the definition and allocation of its medical resources. This is especially important when a significant proportion of the population utilises the services of traditional healers. Participation of both traditional and western medical practitioners in policy making should be promoted at both national, provincial and district level. Lessons from Taiwan suggest the establishment of medical associations that include both traditional and western medical systems, and by establishing referral systems between the two medical systems.

5. An integrated training and educational programme for both traditional and western medicine

   Chi (1994) proposes a unified medical educational system, which trains medical students to practise integrated medical care, as the ultimate goal of integration. Admittedly, this goal will be difficult to attain, and will take a long time to achieve. However, mutual understanding and respect between the traditional and western medical systems should be enhanced by incorporating the medical curricula of one system into another. In the absence of a standardised training and educational programme for traditional medical healers, the question arises as to how best this programme will be integrated into the western medical curricula. Nonetheless, mutual understanding between practitioners of the two systems about each other's medical systems, will provide an environment conducive for increased tolerance, as well as cooperation between the two systems.

6. A national drug policy that includes traditional drugs

   Pharmaceuticals make up a large proportion of medical resources, especially in developing countries. Thus, it is crucial that an Essential Drug Policy also includes traditional drugs. Furthermore, traditional drugs have the potential to expand medical resources without straining a country's finances because they are usually available domestically (Chi 1994). The Indian government has added ten medicines from the Ayurvedic and Unani systems into its national family welfare programme (Bodeker s.a.).

4.5. In conclusion…

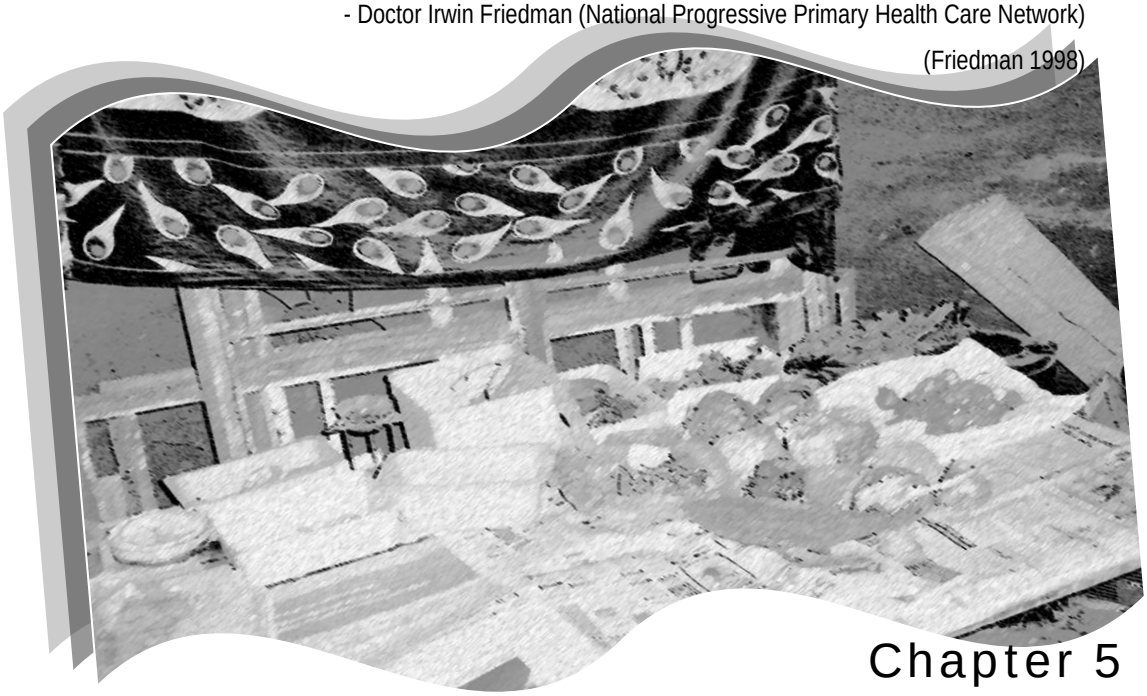
The benefits of promoting collaboration and cooperation between different health care systems are diverse. One such benefit of note is the resultant progression in health care in an open medical system. This progression is brought about by the expansion of medical resources at a country's disposal to improve the quality and efficiency of health care services (Chi 1994). Taking cognisance of experiences and lessons learnt from both African and non-African countries with a pluralism of health care, and a population that is pluralistic in their health care utilisation, will assist countries to fast-track policy development and implementation aimed at integrating traditional health practitioners into national health care systems. At present, progress *is* being made, albeit slowly, toward developing collaboration among traditional and western health practitioners. It is important to note that, although such relationships take time to build, the future of HIV/AIDS prevention and care in South Africa largely depends on the success of these efforts.

PART TWO
EMPIRICAL STUDY

"If we have been trained in the paradigm of the conventional western-oriented health sciences, then, whether we are white or black, before we are ready to fully appreciate the role of traditional practitioners and other healers and enter into a partnership, we must be prepared to suspend our scientific judgements long enough to be able to truly listen and learn. This is the first step and most vital step of a methodology aimed at achieving partnership."

- Doctor Irwin Friedman (National Progressive Primary Health Care Network)

(Friedman 1998)



Chapter 5
RESEARCH DESIGN AND METHODOLOGY

Scientific inquiry, or "finding out", requires a well-defined plan which will ultimately lead to the production of credible and accurate answers to the research question under study. This chapter provides an elaborate discussion of the research approach and design selected for the empirical study. The research strategy adopted to select the research area and research participants, collect, analyse and interpret the data is further discussed in detail. Included in the discussion are challenges encountered during the collection of data, as well as action taken to overcome these challenges. The purpose of this chapter is to describe and motivate the methodology applied for the empirical study.

5.1. Study design and research approach

The study is both descriptive and exploratory in nature since it provides an overview of the nature and scope of the African traditional healing system (descriptive), as well as providing insight and comprehension into the perceived

role of traditional health practitioners in the provision of treatment and care for people living with HIV/AIDS (exploratory). The traditional healing approach in the treatment and care of people living with HIV/AIDS was explored to determine the perceived strengths and weaknesses of this health care system from the perspectives of both the traditional and western health practitioners. Also explored was the current nature of collaboration between the two groups of practitioners, as well as perceived ideal collaboration as envisaged by each group of practitioners.

The empirical study (part two) entails the systematic collection and presentation of data about the perceived role of traditional healing/medicine in the treatment and care of men, women and children living with HIV/AIDS in an urban settlement in the Eastern Cape (Buffalo City). The data collected focus on exploring the knowledge, beliefs, attitudes and practices of traditional health practitioners in relation to the health care needs of people living with HIV/AIDS. Furthermore, data collection also focuses on exploring views about the potentially complementary role of traditional medicine within a western-based health care system, from the perspectives of both traditional and western health practitioners, with specific reference to HIV/AIDS treatment and care.

Qualitative research methods were applied due to the nature of the study, namely, to obtain a contextual understanding of the research question, which is to enquire about traditional healing as a health care option for people living with HIV/AIDS. Qualitative research methods, in relation to quantitative methods, are flexible in that they allow the researcher to develop concepts during data collection. Hence, as data are collected the researcher may reflect on the data collection process and develop new ideas. This ensures continual interaction between data and existing ideas during data collection. In other words, as the researcher gathers data, he/she uses some pre-existing constructs to assist in data collection, and then incorporates the existing ideas with new ideas that are developed from the data (Neuman 2000).

This entailed following an ideographic research strategy[24] to understand the role played by traditional health practitioners within the context of health care for people living with HIV/AIDS in Buffalo City. In more elaborative terms, the ideographic strategy involved subjectively interpreting traditional healing within the cultural context of the traditional health practitioners (Babbie & Mouton 2001). Hence, the researcher, from the outset, understood the role of traditional health practitioners as health care providers in the research area. This resulted in the development and building of deductively-based new interpretations of primary descriptions of behaviours, actions and events, as reported by the research respondents.

5.2. Selection of research area and research participants

5.2.1. Research area

The Eastern Cape has the sixth highest HIV-prevalence rate (23.6%) of the nine provinces in South Africa (Department of Health 2002). Although not the poorest of the nine provinces, the Eastern Cape exhibits one of the worst cases of inequity in the provision of services, especially health care. Geographically, the Eastern Cape can be sub-divided into three parts, two of which were previously homelands, namely the former Transkei (towards the KwaZulu-Natal border), and the former Ciskei. As homelands, tribal authorities were venerated, and traditional leaders played a prominent role in maintaining social order by preserving traditional cultural beliefs, norms and

[24] Understanding a particular and specific event or case within its own context (Babbie & Mouton 2001).

practices. This was achieved through negatively sanctioning culturally inappropriate behaviour, and reinforcing behaviour which was deemed culturally appropriate. A substantial proportion of the population in the Eastern Cape still maintain strong traditional cultural beliefs, expectations and practices. One such traditional practice is the use of traditional health practitioners for health care. Although the official western health care system is also utilised, a large number of South Africans also consult traditional health practitioners. This is due to the venerable nature of traditional health practitioners in certain communities, as well as the historic accessibility of this group of practitioners in remote rural areas in relation to western health practitioners. These factors, in conjunction with the researcher's affiliation to the culture and vernacular of the research respondents, served as strong motivators in selecting the Eastern Cape as the research area.

The research participants were selected from Buffalo City Local Service Area (LSA)/Local Municipality in the Amatole District Municipality. Preliminary investigations conducted in preparation for the research undertaken, revealed that the organisation and regulation of traditional health practitioners are more problematic in urban than in rural settlements. This argument is based on one important regulatory mechanism, namely that traditional health practitioners in rural settlements are well known by the traditional authorities, as well as community members, thus, they are closely monitored and sanctioned. Contrary to this, traditional health practitioners in urban settlements are larger in numbers, are not always known by community members, thus, they are not closely monitored and sanctioned. It was mainly for this reason that the research was conducted in an urban rather than a rural population. Five urban areas were selected as the research sites, namely Mdantsane, Duncan Village, Gompo Town, Potsdam and Fort Jackson. A geographic and demographic profile of the research sites is given in chapter six.

5.2.2. Selection of research participants

In the light of the study being qualitative in nature, qualitative sampling methods were used to select respondents (Laws *et al.* 2003; Neuman 2000). Three broad categories of respondents were identified to obtain a comprehensive and close to exhaustive overview of the perceived role played by traditional health practitioners in treating and caring for people living with HIV/AIDS in Buffalo City. The categories of respondents included (a) traditional health practitioners (20 respondents); (b) western health practitioners (23 respondents); and (c) managers of the provincial Department of Health (3 respondents).

(a) Traditional health practitioners

The purpose of the research was to gain in-depth understanding of the role of diviners, herbalists and spiritual healers in the official health care system, and specifically in the treatment and care of people living with HIV/AIDS. Thus, non-probability sampling methods were used to select traditional health practitioners, whereby the relevance of respondents to the research topic, rather than their representativeness, determined their selection (Flick 1998 in Neuman 2000). The most appropriate non-probability sampling techniques were used, namely, sequential and snowball sampling (Laws *et al.* 2003; Neuman 2000).

Snowball sampling is a multistage technique. It starts off with one, or a few, respondents, and expands on the basis of links to the initial respondents. Usually, the researcher asks the initial respondents to refer to him/her others who share characteristics with them. The key feature of snowball sampling is that each respondent is

connected with another respondent through a direct or indirect linkage. Therefore, as a whole, the respondents are either directly or indirectly an interconnected web of linkages (Laws *et al.* 2003; Neuman 2000). The Provincial Traditional Health Practitioners coordinator of the Eastern Cape referred the researcher to two traditional health practitioners situated in various areas of Buffalo City. One of the traditional health practitioners was the designated Buffalo City LSA coordinator for traditional health practitioners, and, thus, registered with the national Traditional Health Practitioners Association, whereas the other traditional health practitioner was not registered with this association. Through the assistance of the LSA coordinator, as well as the non-registered traditional health practitioner, traditional health practitioners from three categories of practitioners were selected, namely diviners, herbalists and faith healers. The process of snowball sampling resulted in the selection of traditional health practitioners who were registered with the national Traditional Health Practitioners Association, traditional health practitioners not registered with this association, as well as traditional health practitioners registered with a traditional health practitioners association other than the national one. This process facilitated the attainment of a potentially exhaustive list of factors that hindered collaboration both between traditional and western health practitioners, as well as amongst traditional health practitioners themselves. As far as it was possible, representation of the three categories of traditional health practitioners under study (diviners, herbalists and spiritual healers), age and gender were strived for.

The initial selection of traditional health practitioners, utilising the method of snowball sampling, was complemented by the application of sequential sampling. Sequential sampling entails gathering respondents until the amount of new information or diversity of respondents is filled. The principle is to collect information until a saturation point is reached (Neuman 2000). The point of data saturation was reached after the twentieth interview, when the incremental value for additional respondents dropped significantly. This method of sampling required that the researcher continuously transcribe and evaluate the collected data, throughout data collection (as opposed to doing so after completion of data collection), so as to establish a point of saturation.

(b) Western health practitioners

Purposive and sequential sampling was used to select 23 western health practitioners from primary health care facilities (community health centres/day hospitals and fixed clinics) in two of the selected study sites, namely Duncan Village and Gompo Town. According to Laws *et al.* (2003), purposive refers to selection linked to the purpose of the research. Purposive sampling is most appropriate in three situations, namely to select unique cases that are especially informative; to select members of a difficult-to-reach, specialised population; and to identify particular types of cases for in-depth investigation (Neuman 2000). Purposive sampling was, thus, appropriate since the group of respondents was selected according to their involvement in treating and caring for PWAs at a primary health care level. In other words, the most informative respondents were selected. The researcher, with the assistance of representatives of the Buffalo City Municipality management, selected individuals from various strata of primary health care, namely professional nurses, HIV/AIDS counsellors, home-based caregivers, and medical doctors. Selection of respondents continued up until a point of data saturation was reached, namely 23 interviews (sequential sampling).

(c) Managers of the Provincial Department of Health

Similarly, the third group of respondents, namely managers of the provincial Department of Health, was selected through purposive sampling. Respondents were selected according to their participation in decision-making in initiatives related to the traditional healing system in Buffalo City and South Africa, for in-depth investigation.

5.3. Data collection techniques and instruments

Being an exploratory study, qualitative data collection methods were used. This necessitated an emic perspective in collecting data from especially two categories of respondents, namely traditional and western health practitioners. The term "emic" is derived from anthropological literature and refers to the perspective of the insider. In other words, it is the perspective of the subject being observed or studied (Babbie & Mouton 2001). Thus, the data collection techniques used, ensured the collection of a rich, detailed description of specifics (qualitative approach) as opposed to summative, standardised descriptions (quantitative approach). This was achieved through the utilisation of qualitative data collection techniques, namely semi-structured and indepth interviews. Interviews are most appropriate under the following circumstances (Laws *et al.* 2003):

- Need to know about individuals' experiences or views in some depth.
- Possible to rely on information from a fairly small number of respondents.
- Respondents would not be able to express themselves fully through a written questionnaire.

Furthermore, individual interviews, as opposed to group discussions, were opted for due to the following reasons:

- Traditional healing is still shrouded with negative connotations, such as illiteracy, barbarism, and death. Individual interviews made it possible for respondents to openly and honestly express their views and beliefs about traditional healing without fear of being judged, or criticised by fellow respondents.
- Individual interviews with traditional health practitioners created an environment conducive for traditional health practitioners to comfortably express their views about charlatans in their profession without fear of malevolent action befalling them as a result thereof. Also, it provided an indifferent environment which allowed perceived charlatans to share knowledge about the nature of their training, practice and role in treating PWAs. This may not have been possible in a group discussion.
- Western health practitioners, who also supported the use of traditional healing, were able to express their views about traditional health practitioners openly and honestly without fear of criticism, and subsequent discriminatory action by colleagues who oppose the use of traditional medicines.
- Both traditional and western health practitioners could disclose their views about obstacles that hindered effective collaboration between the two systems, without the risk of offending their colleagues, or their counterparts.

A combination of semi-structured and in-depth (depth) interviews, as well direct observations were utilised to collect data. The following are characteristics of semi-structured and in-depth interviews in juxtaposition (Laws *et al.* 2003):

Semi-structured	In-depth/unstructured
▪ Useful where some quantitative and some qualitative information is needed	▪ Useful to help set the research focus, or to explore new or sensitive topics in depth
▪ Questions may be asked in different ways, but some questions can be standard	▪ More like a conversation – no standard questions, just topic areas
▪ Questions can be left out and others added	▪ Follow (or ask) the respondent to establish what is important to discuss
▪ Include a mix of types of questions - some open and some closed	▪ Avoid questions which can be answered by 'yes' or 'no'

Utilising both semi-structured and unstructured interview techniques resulted in interview schedules that contained broad topic areas, as well as specific probing questions. Also, the interview schedules allowed for questions to be added and omitted based on the responses of each interviewee, which guided the interview process. The interview schedules followed the structure for field research interviewing, namely they constituted three types of questions: descriptive, structural and contrast questions. Field research, also referred to as *ethnography,* is a qualitative technique in which the researcher directly observes and participates in small-scale social settings in the present time and within a specific culture. It is most appropriate when the research question involves learning about, understanding, or describing a group of interacting people (Neuman 2000).

In field research, the researcher first asks descriptive questions to explore the setting and acquire knowledge about respondents. Next, the researcher uses structural questions after starting to analyse data. This takes place after the researcher has organised specific field events, situations and discussions into conceptual categories. Last, the researcher uses contrast questions to build on the analysis that has been verified by structural questions. Contrast questions focus on similarities or differences between elements in categories or between categories as the researcher asks respondents to verify similarities and differences (Neuman 2000). Essentially, the first two to three interviews with traditional and western health practitioners mainly comprised descriptive questions. After transcribing the interviews and systematising the data, the researcher adapted the interview schedules by increasing the number of structural questions based on emergent concepts from the first two to three interviews. This also served as verification of data. Thereafter, contrast questions were added to further verify data amongst traditional health practitioners and western health practitioners respectively, as well as between the two categories of practitioners. Therefore, the interview schedules developed prior to data collection were administered loosely, where the sequence of topics, the type of probing questions, and the structure of questions were determined by the responses of respondents. In addition, new issues that transpired from each interview, and that were relevant to the research objectives, were included in subsequent interviews. Hence, the interview schedules were adapted in accordance with the progression of each interview.

5.4. Phasing the data collection process

Data collection constituted three phases. Phase 1 of data collection entailed conducting in-depth individual interviews with 20 traditional health practitioners utilising a semi-structured interview schedule (cf. Appendix A). The interviews focused on the following areas:

- Demographic information about respondents
- Knowledge, attitudes, practice and beliefs about HIV/AIDS

- The organisation of the traditional healing sector
- Collaboration between traditional and western health practitioners
- Legalising and professionalising the traditional healing sector

Phase 2 entailed conducting in-depth individual interviews with 23 western health practitioners from public primary health care facilities, utilising a semi-structured interview schedule (cf. Appendix B). The interviews focused on the following issues:

- Perceived role, value and disadvantages of traditional health practitioners, with specific reference to HIV/AIDS
- Collaboration between traditional and western health practitioners
- Integration of traditional health practitioners into the official health care system
- Legalising and professionalising the traditional healing sector

Phase 3 comprised the collection of primary and secondary data from various individuals from the provincial Department of Health and Buffalo City Local Municipality. Individual interviews were conducted with three respondents utilising semi-structured interview schedules (cf. Appendix C). The interviews primarily focused on the following:

- The organisation of traditional health practitioners, nationally, provincially and locally
- Policy guidelines and legislation for traditional health practitioners
- Demographic, geographic and socio-economic data of the research area

PHASE 1

5.4.1. Interviews with traditional health practitioners

The 20 selected traditional health practitioners were located and verbal consent was obtained from them prior to data collection. As soon as consent was obtained, the researcher interviewed the respondents in their natural environment, namely their home or their place of practice ("consultation room").

In the majority of cases, traditional health practitioners selected to participate in the study were accessed and interviewed on the first visit. Very few traditional health practitioners were not available to be interviewed on the initial visit. In such cases where selected traditional health practitioners were unable to be located after the second visit, they were substituted with another practitioner. To their credit, not one traditional health practitioner selected to participate in the study refused to do so. On the contrary, colleagues of selected traditional health practitioners who were present at the time of the interviews, often voluntarily provided the researcher with information upon hearing about the nature of the study.

The duration of interviews varied from one traditional health practitioner to another. Some interviews lasted a mere hour, whilst others were conducted over a period of two days due to the exhausting length of the interviews, which could stretch up to five hours. The duration of the interviews was determined by both the ability of traditional health practitioners to focus responses and discussions strictly within the scope of the research topic, as well as whether or not a traditional health practitioner had treated a patient that was living with HIV/AIDS. Interviews with traditional

health practitioners who were least side-tracked, and had not treated a patient who was living with HIV/AIDS, tended to be shorter in duration than interviews with traditional health practitioners who presented the contrary.

PHASE 2

5.4.2. Interviews with western health practitioners

The selected 23 respondents were contacted and located with the assistance of local and provincial Department of Health personnel. As far as it was possible, appointments were made prior to being interviewed. Where such prior arrangement was not possible, interviews were conducted as soon as a respondent was located. Verbal consent was obtained from all respondents prior to being interviewed.

Once written authorisation was obtained to conduct interviews with western health practitioners, western practitioners at the selected primary health care facilities were informed and briefed about the study through the respective district health offices. Although appointments were made prior to interviews, difficulty was experienced in finding an appropriate time to conduct interviews with some of the staff, due to their high workloads. This was especially the case with doctors and nurses, as compared to the other categories of health practitioners. The least busy days (minimal expected workloads), and times were selected for conducting interviews, in order to cause the least disruption in the operation of the health care facilities, as well as the respondents' work schedules. This tactic proved successful, although some interviews were rescheduled nonetheless. The duration of the interviews varied between one hour and two hours.

PHASE 3

5.4.3. Interviews with managers of the Department of Health

Individual semi-structured interviews were conducted with three respondents from the Department of Health. Arrangements were made prior to the interviews with all the respondents. Interviews were conducted periodically with the same respondents. This was necessitated by the need to clarify and verify data from interviews with traditional and western health practitioners, as well as secondary data from relevant documents and sources.

Both written notes and tape recordings were utilised in interviews with all three categories of respondents (5.4.1 – 5.4.3). Consent was obtained from respondents for the use of a tape recorder. Notes were taken to record researcher observations relevant to the research. They served as a detailed description of what the researcher heard and saw in concrete, specific terms. Inferences were made based on the researcher's observations and these inferences are used to enrich the research findings (cf chapters 8-9).

5.5. Challenges and limitations

Although the research strategy and approach selected and applied for the empirical study facilitated collection of data of a high quality and standard, various challenges were, nonetheless, experienced along the way. The following posed the main challenges:

- Authorisation – Due to incidences of so-called traditional health practitioner exploitation by researchers in the Eastern Cape, both traditional health practitioners and health officials were cautious in providing authorisation for the research. Hence, the process of securing authorisation from the relevant officials to conduct interviews with traditional health practitioners was a lengthy one, and delayed the onset of data collection. In addition, was important that authorisation be obtained from all relevant authorities, namely provincial and local government, as failure to do so creates further delays in accessing respondents.
- Traditional health practitioner interviews – Interviews with traditional health practitioners were, generally, of a longer duration than anticipated by the researcher. This was mainly due to the traditional health practitioners' pride in their work and wanting to share as much information about their work as possible with the researcher, even if such information was not relevant to the nature and purpose of the research. In some instances, much of the interviews were dominated by information sharing about the history of traditional healing and specifics about traditional health practitioner experiences pertaining to their calling. Thus, the length of interviews often necessitated the return of the researcher to the same traditional health practitioner twice to ensure that all the relevant information was collected.
- Western health practitioner interviews – Enquiring about the least busy working days and times of western health practitioners prior to data collection assisted in securing interviews and causing the least interruption both with interviews as well as the work schedules of respondents. However, the most problematic respondents, in terms of securing time for interviews, were medical doctors who had to be interviewed during their tea and lunch breaks.
- Researcher bias – Extra caution should be taken to avoid researcher bias towards respondents. The researcher, time and again, fell into the trap of losing objectivity during data analysis by adopting subjective views in favour of one group of practitioners. Discipline had to be applied to ensure that the researcher maintained objectivity throughout the process of analysis.

5.6. Data analysis

All tape-recorded interviews were translated from Xhosa to English and transcribed verbatim. Qualitative data analysis techniques were utilised, which entailed organising the transcribed data into categories on the basis of conceptual themes. According to Neuman (2000), concept formulation is an integral part of data analysis and it begins during data collection. New concepts were, thus, developed and conceptual definitions formulated throughout data collection. Coding is an essential procedure in qualitative analysis. According to Strauss (1987) the excellence of the research rests in large part on the excellence of the coding. Open coding brings to the fore themes from deep within the data. Open coding was utilised to condense the large volume of data into conceptual themes. This entailed coding the data by closely scrutinising the transcribed material, line by line and word by word, and extrapolating the essence of words, phrases and sentences so as to attach a relevant code. Furthermore, associated subcategories which were reflected either in the same sentence, or other sentences within the same or different interview were also coded. Initially the codes were crude. However, as the process of scrutinisation of transcripts continued, so codes became saturated and, thus, modified and elaborated. Thematic codes were, thus, created and changed throughout the process of analysis. It is important that codes do not remain mere descriptions, but rather to be analytical by

giving meaning to data. The data were summarised into the created conceptual themes. Findings were inferred from the summarised data, and quotations were used to highlight, substantiate and illustrate points. Conclusions were drawn from the findings, and recommendations for initiatives aimed at promoting collaboration between traditional and western health practitioners in Buffalo City are based on the conclusions.

5.7. Ethical considerations

HIV/AIDS and traditional healing share a common trait, namely they both evoke or bear the label of stigmatisation. HIV/AIDS is still associated with sexual promiscuity, thus, many people do not wish to disclose their status. Furthermore, the association between HIV/AIDS and sexual behaviour in many communities makes it a difficult and sensitive topic to discuss, more especially in traditional communities, where traditional cultural values and norms about sex and sexuality are deeply entrenched.

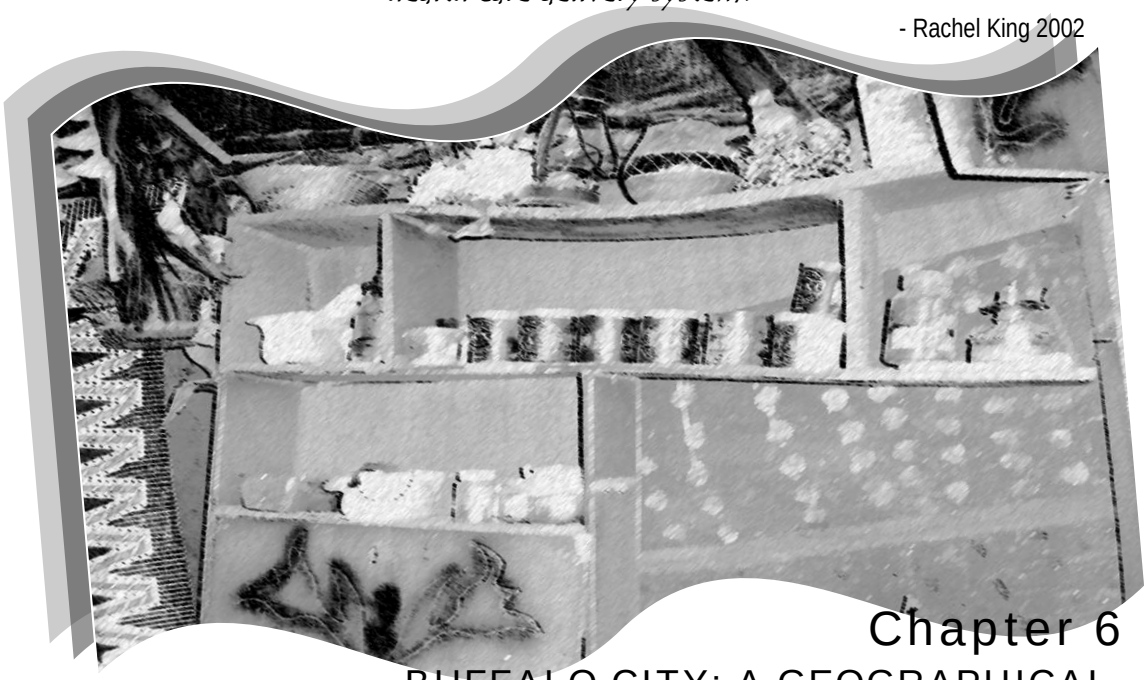
Also, traditional healing and medicine is disparaged by many scientism-minded South Africans for its lack of scientific substance. Traditional health practitioners are very often associated with witchcraft and sorcery, ignorance and illiteracy, as well as with harmful practices. These negative associations have conjured up suspicion and mistrust among traditional health practitioners of researchers and the media. Furthermore, regulations limiting traditional health practitioners from disclosing information about their profession have been put in place in an attempt to prevent the exploitation of this cadre of practitioners.

These obstacles and challenges were acknowledged in the field research, and stringent procedures were adhered to in obtaining authorisation to conduct the research in the selected study sites, and with the selected research populations (traditional and western health practitioners). Written authorisation was obtained from both provincial and local authorities of the Department of Health, and the relevant authorities in the traditional healing sector. Developing good rapport with the respondents, although time consuming, facilitated the collection of rich, trustworthy and quality data.

Confidentiality of all research respondents was ensured at all times and trust relationships established by various organisations and initiatives in the research sites were honoured.

"As in the rest of sub-Saharan Africa, in South Africa, 80-85% of Black South Africans make use of traditional healers' services in both rural and urban areas. Traditional healers tend to be the first "professionals" consulted by people with an STD, including HIV. Healers are more accessible geographically and provide a culturally accepted treatment. They have credibility, acceptance, and respect among the population they serve, thus form a critical part of the health care delivery system."

- Rachel King 2002



Chapter 6

BUFFALO CITY: A GEOGRAPHICAL, DEMOGRAPHIC AND TRADITIONAL HEALTH CARE PROFILE

This chapter serves as an introduction and orientation to the selected research area and population. Secondary data and statistics were collected from relevant documents to provide a descriptive analysis of demographic and geographical features of Buffalo City, within the context of the Amatole District Municipality, and against the backdrop of the impact of HIV/AIDS. Primary data collected by interviews with relevant officials of the Department of Health are analysed according to the process described in chapter five (paragraph 5.5) and findings inferred are included in this chapter. Buffalo City is referred to as Buffalo City Municipality by the local government, and as Buffalo City LSA by the provincial government. These two terms are used interchangeably in this chapter, although, to remain neutral, the study area is referred to as Buffalo City, wherever possible.

6.1. Demographic and geographical features of the Amatole District Municipality

The Eastern Cape comprises a total of six health districts and one metropole. The Amatole District Municipality (DC12) constitutes one of the six health districts and consists of eight local municipalities, namely Mbhashe (EC121), Mnquma (EC122), Great Kei (EC123), Amahlathi (EC124), Buffalo City (EC125), Ngqushwa (EC126), Nkonkobe (EC127) and Nxuba (EC128). Buffalo City municipality is the third smallest in geographical size, namely 2 515 km^2, yet it has the largest population by far of all eight local municipalities/LSAs in the Amatole District Municipality (Municipal Demarcation Board 2003). Table 6 gives a geographical and population breakdown of the Amatole District Municipality by LSA, and figure 3 provides a proportionate presentation of the Amatole District Municipality population by LSA.

Table 6: Geographical and population profile of the Amatole District Municipality (DC12)

Local municipality	Geographic size (km^2)	Total population	% Black of total population
Mbhashe	3 030	487 655	50
Mnquma	3 323	290 881	99
Great Kei	1 735	40 116	92
Amahlathi	4 266	137 618	96
Buffalo City	2 515	682 287[25]	82
Ngqushwa	2 245	93 997	99
Nkonkobe	3 725	143 167	95
Nxuba	2 734	24 801	72
Total	23 573	1 900 522	79

Source: Municipal Demarcation Board 2003.

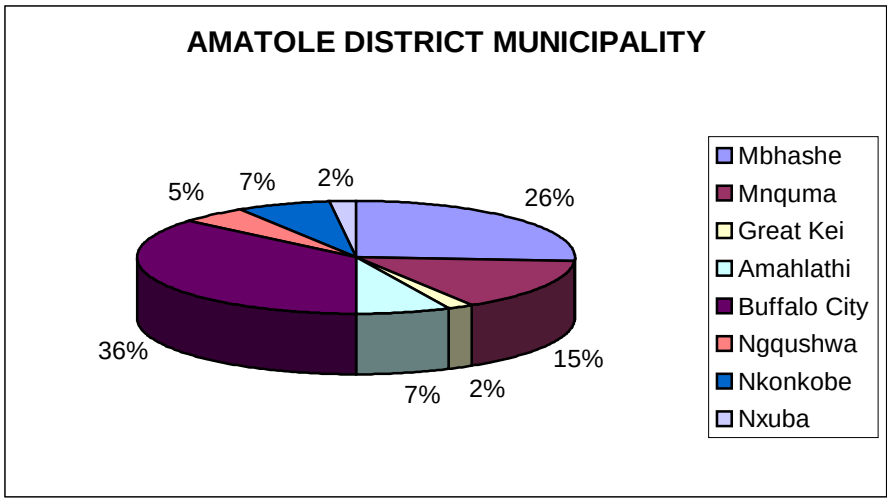


Figure 2: Population segmentation of DC12 by local municipality/LSA

6.2. Demographic features of Buffalo City (EC125)

Buffalo City consists of two towns, namely East London and King Williams Town/Bisho, and comprises a total of 45 wards. The majority of the Buffalo City population is urban with only a 20% rural population, as opposed to a majority rural population in most of the remaining local municipalities/LSAs that constitute the Amatole District Municipality. More than half of the Buffalo City population is female (52%), although the gender ratio varies with residential area and age. Detailed analyses indicate that there are more males than females in Duncan Village, which

[25] Estimated population figures for Buffalo City vary. The estimated total population for Buffalo City for 1999 was 888 000 as stipulated in the Buffalo City IDP (Buffalo City Municipality 2002: 35-36)

is characteristically inhabited by a large number of migrant workers and individuals seeking employment (Buffalo City Municipality 2002; Municipal Demarcation Board 2003). Selected demographic indicators are used to give an overview of the typical profile of the Buffalo City population.

6.2.1. Population size and composition

(a) Total population of Buffalo City

At the end of 2001 the estimated total population of Buffalo City was 888 000. East London urban constituted 533 164 (60%) and King Williams Town urban constituted 174 000 (20%) of the total population. The remaining 180 836 (20%) individuals comprised the rural population of Buffalo City. Figure 3 gives a proportionate illustration of the Buffalo City population by geographical area.

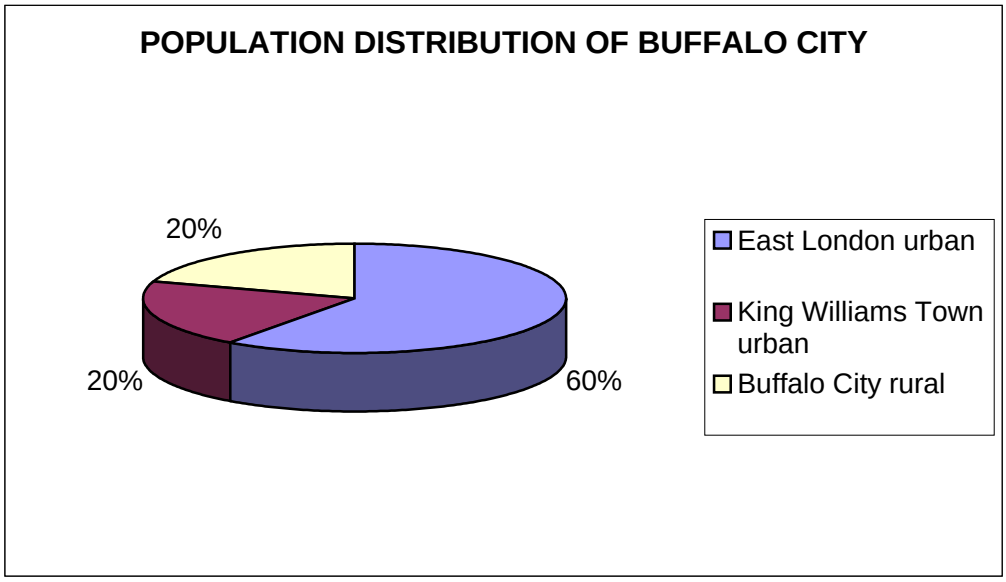


Figure 3: Population estimates by geographical area - 1999

Source: Buffalo City Municipality 2002

HIV/AIDS morbidity and mortality is expected to dramatically change Buffalo City population estimates within the next ten years and more. It is projected that the average annual growth rate in Buffalo City will decrease from 3.87% in 2001 to 1.77% in 2011, and reach a mere 0.28% in 2021 (Buffalo City Municipality 2002).

(b) Age and gender distribution

In South Africa, young adults aged 20–24 years have the highest HIV prevalence rate (25.6%). HIV prevalence is higher among females than males. The HIV prevalence rate among 15-19 year old females is 16% compared with 3% prevalence among males in this age group. Therefore, an estimated 1 in 5 learners is assumed HIV-positive. At the end of 2001, South Africa was home to 660 000 AIDS orphans. It is projected that AIDS orphans will reach 1 million in 2005 (UNAIDS/WHO 2002). Table 7 presents the age profile, by gender, of the population of Buffalo City. Based on the above projections and estimates of the impact of HIV/AIDS, one can roughly deduce what the implications are for the population of Buffalo City, in terms of the section of the population that will be most affected by the AIDS epidemic. By 2005, 30% of the Buffalo City population (children between 0-14 years) may be severely affected by the loss of both parents to HIV/AIDS. Also, 10% of the population (20-24 year age group) is estimated to currently have the highest HIV prevalence rate of 25.6%, and among the 15-19 year age group (11% of the total population) an estimated 1 in 5 women is living with HIV/AIDS.

Table 7: Age and gender distribution of Buffalo City

Age	Male	Female	Total
0-14	134 000	135 000	269 000
15-19	48 000	50 000	98 000
20-24	45 000	47 000	92 000
25-49	143 000	165 000	308 000
50-59	25 000	30 000	55 000
60-69	15 000	23 000	38 000
70-79	8 000	12 000	20 000
80+	3 000	5 000	8 000
Total	421 000	465 000	888 000

Source: Buffalo City Municipality 2002

The age profile of the Buffalo City population is expected to change largely due to the HIV/AIDS epidemic, as well as other factors such as poverty and poor living conditions which all impact negatively on life expectancy. It is projected that life expectancy at birth for the Buffalo City population will decline from 50 years between 2001 and 2006 to 48 years between 2006 and 2011, and further decline to 45 years between 2011 and 2016, to reach only 40 years by 2021 (Buffalo City Municipality 2002).

6.3. Traditional health care utilisation trends in East London

The research population was selected from five urban settlements in the East London area, namely Duncan Village, Mdantsane, Gompo Town, Potsdam and Fort Jackson. The five areas, although urban, are largely impoverished, and some still lack formal housing, appropriate water and sanitation facilities. More than 90% of the inhabitants in all of the five settlements are black. An estimated 70-85% of South Africans use traditional medicines to help meet their health care needs, and approximately 60% of South African babies are delivered by traditional birth attendants (Cartillier 2004; International Council of Nurses 2002; Matomela 2004; Munk 1996; NPPHCN 1997; Njanji 1999; WHO 2002). The assumption is that the majority of blacks have an African worldview, due to their upbringing and socialisation. The African worldview and cosmology form the backbone of the traditional

Table 8: A population breakdown by research site and race

Geographic area	Total population	Percent (%) black of total population
Duncan Village	56 108	99
Mdantsane	1 559[26]	96
Gompo Town	1 410	99
Potsdam	1766	100
Fort Jackson	53	100

Source: Demarcation Board 2003

[26] The figure for Mdantsane should be interpreted with caution as Mdantsane is expected to have the largest population of all five research sites.

healing system. Based on this assumption, it can be deduced that between 70-85% of individuals in the research sites (Duncan Village, Mdantsane, Gompo Town, Potsdam and Fort Jackson) utilise the services of traditional health practitioners for their health care needs, even if not exclusively.

6.4. Provision of health care in Buffalo City

Public health care services in Buffalo City are officially provided by two spheres of government, namely the Eastern Cape Provincial Government and the Buffalo City Municipality. The Eastern Cape Provincial Government as well as the Buffalo City Municipality offer similar services, but the responsibility and accountability fall with each respective authority under which the health care facilities resort. Health care services are segregated along three levels, namely primary health care, secondary health care and tertiary health care. Primary health care services are provided by all fixed clinics, satellite clinics, mobile clinics and community health centres/day hospitals. Unfortunately, the poor condition of roads and road infrastructure in both urban and rural areas impacts negatively on the accessibility of health care services.

Community mobilisation and participation is vital to provide adequate service delivery. However, there is a dire lack of structures in Buffalo City communities to facilitate such participation (e.g. community health committees). As example in point, only one of the five primary health care facilities included in the research undertaken had an active community health committee at the time of the research.

One of the burning issues faced by Buffalo City health services is a critical shortage of health care personnel. This is a common problem shared by many other districts and provinces nationally. South Africa has as yet not developed national norms for professional nurse:patient ratios. According to the WHO the average professional nurse:patient ratio is 1:25. Findings from studies conducted in the Free State have shown that 35 to 40 patients per nurse per day is the average workload.[27] This norm has seemingly been adopted in other provinces. In 2000, the national average nurse clinical workload at fixed clinics was 19.8 (Viljoen *et al.* 2000). In 2002 professional nurses in Buffalo City were consulting an average of 60 patients per nurse per day (Buffalo City Municipality 2002). Based on the above average workloads per nurse per day, it is clear that primary health care facilities in Buffalo City are grossly under-staffed.

On 6 October 2004[28], 584 traditional health practitioners (i.e. diviners, herbalists, spiritual healers[29], traditional surgeons and traditional birth attendants) were registered with the Department of Health in the Eastern Cape. Of all practising traditional health practitioners in Buffalo City, only 20 were registered with the national Traditional Health Practitioners Association (Mtyeku 2004). Although the registration process is ongoing, the rather sluggish pace, especially in Buffalo City, is of concern in the light of the estimated large number of practising traditional health practitioners. It is not uncommon to find an average of three traditional health practitioners within a 2km radius, or more than one practising traditional health practitioner residing in one household. This was a common trend observed during the fieldwork of the research undertaken.

[27] In one national survey, health managers reported between 20 and 35 patients per nurse per day as the ideal nurse clinical workload (Viljoen *et al.* 2000).
[28] Telephonic interview conducted with the Eastern Cape Traditional Health Practitioners coordinator.
[29] Although spiritual healers are as yet not officially regarded as traditional health practitioners, they are, nonetheless, registered as such in the Eastern Cape, on condition that they utilise traditional medicines and rituals in their practice. Furthermore, spiritual healers are more than likely also diviners, which automatically includes them in the category of officially recognised traditional health practitioners.

6.5. Traditional health practitioners in the provincial response to HIV/AIDS

The *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa 2003* (Operational Plan) (Department of Health 2003) commenced to be rolled out in the Eastern Cape in May 2004. The Operational Plan aims to provide treatment and care to all South Africans living with HIV/AIDS by 2008. The Eastern Cape is home to an estimated 530 000 people living with HIV/AIDS. Seven sites have been accredited by the province to dispense antiretroviral therapy, namely Port Elizabeth Hospital Complex, East London, Umtata Hospital Complex, Mlamli Hospital, Frontier Hospital, Settlers Hospital and Rietvlei Hospital (SABC 2004b). The Operational Plan has set out to involve traditional health practitioners as an essential and irreplaceable component of the comprehensive care provided. Three pertinent questions which are immediately conjured up are: (i) What is the exact nature of involvement (unequivocally delineated)? (ii) Have both traditional and western health practitioners been prepared for such involvement? (iii) Have the necessary structures been established, and mechanisms devised and put in place to facilitate collaboration between traditional and western health practitioners to achieve the objectives of the Operational Plan?

Responses of representatives of the traditional healing sector in the Eastern Cape point to a lack of knowledge and clarity about the nature of involvement of traditional health practitioners in the Operational Plan. The findings of the research undertaken (chapters eight and nine) reveal that both traditional and western health practitioners are not clear on the exact role of traditional health practitioners in the provincial HIV/AIDS programme, and of more concern is the fact that traditional health practitioners view collaboration between the two groups of health practitioners as far more of a reciprocal nature than western health practitioners views on collaboration between the two groups. This raises an eyebrow or two about the consultative process followed, which includes the representativeness of the decision-makers, in formulating the Operational Plan.

The findings of the research reveal a hiatus between intentions to include traditional health practitioners in the mainstream of health care, and the availability of clear guidelines and structures to support collaboration between traditional and western health practitioners in Buffalo City. If plans to redress this discrepancy are still being deliberated, it is vital that certain prerequisites for collaboration be factored into such plans. First, a careful assessment of potential benefits and obstacles should be conducted, prior to commencing collaborative efforts between traditional and western health practitioners. Second, health services utilisation patterns of the Buffalo City population should be ascertained, and the specific role of traditional health practitioners should be considered. Third, the ideas and suggestions of traditional health practitioners about possible collaboration should be given high priority (Boerma & Baya in WHO Kobe Centre 2002).

6.6. Creating awareness about the Traditional Health Practitioners' Act amongst traditional health practitioners

The consultative process followed in the Eastern Cape to obtain comments from traditional health practitioners pertaining to the Act, appears to have been far less than satisfactory. The Traditional Health Practitioners Bill was tabled in Parliament in April 2003, circulated nationally for comments, approved by Parliament in September 2004, and finally enacted in February 2005. The purpose of circulation was for all stakeholders and roleplayers to

familiarise themselves with the content of the Bill, and thereafter contribute to the finalisation of the Bill before its enactment by the President of South Africa.

To this end, the approach adopted by the Eastern Cape government entailed conducting workshops in all the health districts in the province towards soliciting the contributions of all the relevant stakeholders, namely traditional health practitioners, councillors, CBOs, NGOs, FBOs, etc. in the drafting of the Bill. Of major concern is that only one workshop was conducted, namely in the OR Tambo District Municipality, with resounding success. The workshop prepared traditional health practitioners for their expected role once the Bill is enacted. Furthermore, it availed the opportunity for traditional health practitioners to raise issues in the Bill that were of concern to them, or that were not to their satisfaction. Issues that were raised were either addressed during the workshop, where possibly, or they were documented and submitted to the relevant authority for the revisit of the Bill (Mtyeku 2004).

Subjecting a Bill to wide-based scrutiny and comments from relevant stakeholders and role players serves the purpose of enriching the quality, ultimate effectiveness and accessibility of the consequent Act. The lack of success of the Eastern Cape government's consultative process in finalising the Traditional Health Practitioners Bill can primarily be attributed to the absence of sufficient coordination and cooperation between the provincial and local governments. According to protocol, district activities are funded by the respective District Municipalities. It is reported that the provincial Department of Health distributed letters stating the approach to be adopted in the consultative process to all District Municipalities in the Eastern Cape. The use of workshops to achieve the goal of the consultative process was made clear, so too was the responsibility of each municipality in preparing for, and financing the workshop. However, only OR Tambo District Municipality (Community Services) responded, and, thus, financed the workshop which was deemed successful (Mtyeku 2004). One of the reasons which rendered the workshop successful was the clarifying of issues related to the Bill which would have hindered the effective implementation of the current Act in the OR Tambo District Municipality. This has negative implications for the implementation of the Traditional Health Practitioners Act in the districts where workshops to create awareness about the Act, and clarify issues of concern among the stakeholders, namely traditional health practitioners, did not take place.

6.7. Organisational structure of traditional health practitioners[30]

Traditional health practitioners in Buffalo City are one of the main providers of health care services. This category of health care providers still lacks organisational unity. Structures have been put in place at the national, provincial and district levels in an attempt to organise traditional health practitioners into a legitimate and organised sector. To this end, traditional health practitioners have been urged and encouraged to register with the national Traditional Health Practitioners Association and, thus, receive a license to practise legitimately. An estimated 200 000 traditional health practitioners are already registered in South Africa (Cartillier 2004; Matomela 2004; Pelesa 2004). Although this process of registration and licensing of traditional practitioners is underway, it is still a far cry from ensuring that all practising traditional practitioners are registered under one body. Factors associated with traditional health practitioners' non-registration and reluctance to register with the national association in Buffalo City, are discussed in chapter eight (cf. paragraph 8.1.3a).

[30] Individual interview conducted with the Eastern Cape traditional health practitioners' coordinator.

At a national level, all nine provinces are affiliated to the National Traditional Health Practitioners Forum, which comprise representatives from each province. At a provincial level, organisational structures for traditional health practitioners differ from one province to another. An overview of the Eastern Cape provincial and district structures for traditional health practitioners follows.

6.7.1. Provincial and district structures for traditional health practitioners in the Eastern Cape

Traditional health practitioners in the province are represented by the Eastern Cape Traditional Health Practitioners Forum, which is affiliated to the national body. Within the government sphere, traditional health practitioners are monitored and coordinated through the Traditional Health Practitioners Programme, which forms part of non-personal primary health care services. The provincial coordinator of the Traditional Health Practitioners Programme, herself, is a part-time practising traditional health practitioner. Various committees have been established with a view to coordinate the unification and regulation of traditional health practitioners in the province. One such committee is the National Interim Coordinating Committee for Traditional Health Practitioners (ICCTHP). This committee was specifically mandated to facilitate the development of the Traditional Health Practitioners Bill 2003. The ICCTHP fulfilled its mandate with the unanimous approval of the Bill, by parliament, and its subsequent enactment. Although the ICCTHP has achieved its set goals, is has not been disbanded as yet. Three additional committees have been established in the Eastern Cape, namely the Provincial Executive Committee (PEC), the Provincial Working Committee (PWC), and the Provincial Disciplinary Committee (PDC). The three committees have been allocated tasks in response to the requirements for the implementation of the Act. One such requirement is the drafting of regulations for traditional health practitioners (Mtyeku 2004).

The Traditional Health Practitioners Programme, in close consultation with relevant representatives of the traditional healing sector, developed a structure aimed at organising and institutionalising the traditional healing sector in the Eastern Cape, in preparation for the implementation of legislation, namely the Traditional Health Practitioners Act. The structure is also viewed as an important channel of communication in the devolution of national policies and decisions, related to traditional healing, to a grassroots level. The structure consists of four spheres. The first sphere is the National Traditional Health Practitioners Forum (NTHPF), which consists of one representative from each of the nine provinces in South Africa. The second sphere is the Eastern Cape Traditional Health Practitioners Forum (ECTHPF), which constitutes the coordinators of the six health districts and one metropole in the province. The Forum is chaired by the provincial representative of the National Traditional Health Practitioners Forum. The third sphere is the District Traditional Health Practitioners Forum (DTHPF), which comprises the coordinators of each LSA within each district and metropole. The fourth sphere simply comprises all traditional practitioners within a LSA that are registered with the national Traditional Health Practitioners Association. Figure 4 is an illustration of the proposed structure for traditional health practitioners. The structure is in the process of being rolled out by health district, and utilising a phased approach. Through this structure, the coordination and regulation of traditional healing practices are decentralised to a community level.

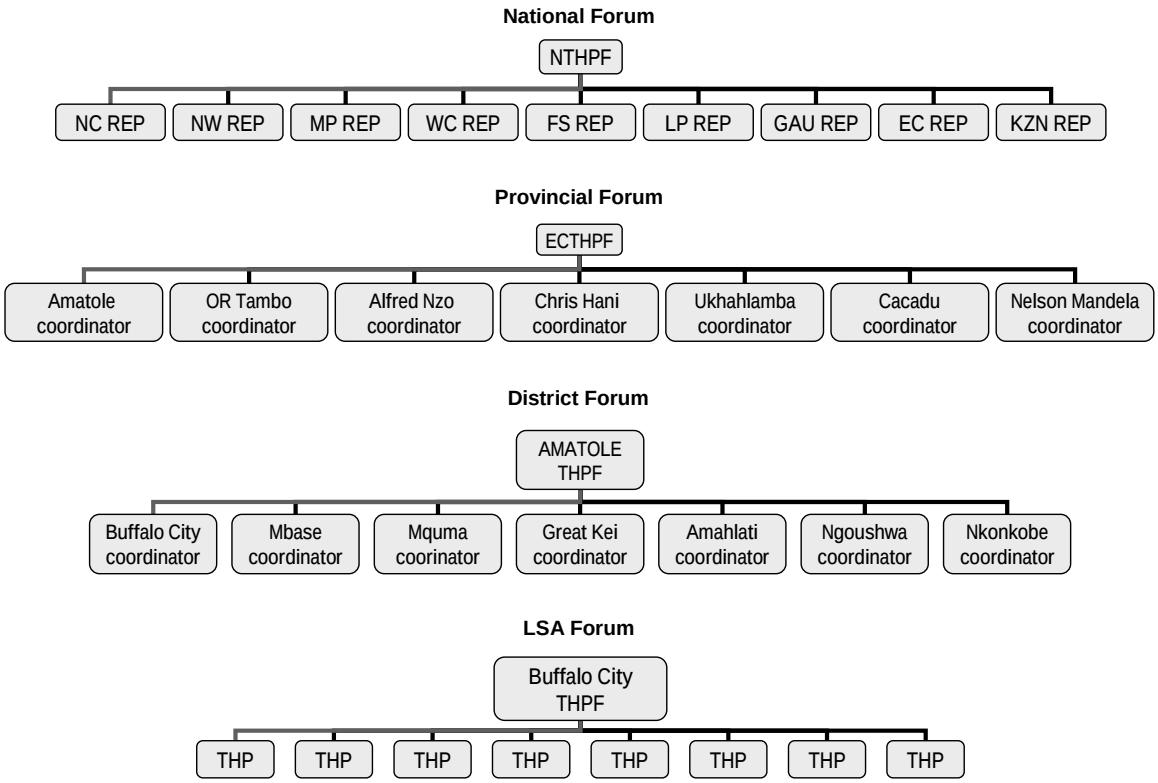


Figure 4: The organisational structure of traditional health practitioners in the Eastern Cape

A phased approach has been utilised in the Eastern Cape to implement the organisational structure presented in figure 4. The National Traditional Health Practitioners Forum and the Eastern Cape Traditional Health Practitioners Forum already exist. Establishing District and LSA Forums follows next. Characteristically, the local service area (LSA) forums are implemented first. Thus far, LSA forums have been launched in three districts, namely the Nyandeni LSA Forum (OR Thambo District Municipality), the Umzimkhulu LSA Forum (Alfred Nzo District Municipality) and the Qaqadu LSA Forum (Western District Municipality). At the time of data collection for the research undertaken, the Buffalo City LSA Forum had not yet been established. As soon as all the LSA Forums have been established and operationalised, the final phase will comprise establishing and operationalising the District Forums.

At present, each LSA in the province has been assigned a coordinator, however, the absence of LSA and district forums has limited the functions and responsibilities of LSA coordinators to that of a messenger between the provincial coordinator and traditional health practitioners in the communities, at best. At worst, the coordinator's duties are limited to ad hoc administrative tasks, such as ensuring that registered traditional health practitioners receive their license cards. Undoubtedly, the proposed organisational structure for traditional health practitioners in the Easter Cape will play an important role in unifying and organising traditional health practitioners, thus, facilitating their active participation in decision-making about health care at a community level.

6.8. In conclusion…

Buffalo City has the largest population of all eight local municipalities in the Amatole District, and the majority of the population is urban. Traditional health practitioners comprise one of the categories of health care providers

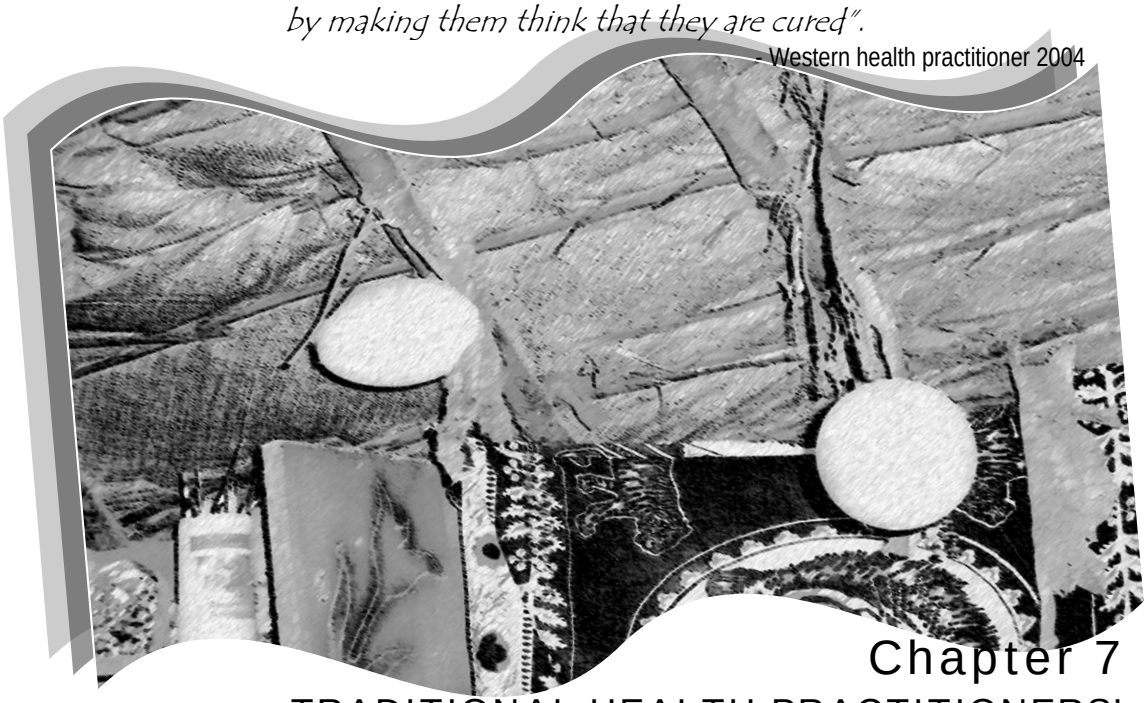
commonly utilised by the Buffalo City population. However, traditional health practitioners in Buffalo City still lack unification and organisation in order to regulate their practices and, thus, enhance the quality of traditional health care utilised by a large proportion of the population. A provincial organisational structure has been proposed and implemented using a phased approach. The organisational structure is aimed at facilitating the implementation of the Traditional Health Practitioners Act, as well as to decentralise the coordination and regulation of traditional healing practices to an LSA level. However, a very small proportion of traditional health practitioners in Buffalo City are registered with the national Traditional Health Practitioners Association, despite evidence that a large proportion of traditional health practitioners are practising as such. This has negative implications for the regulation and monitoring of traditional health practitioners, and leaves ample breeding room for charlatan traditional health practitioners. In view of the conduciveness of the environment for charlatans to thrive, and the high utilisation rate of the traditional healing sector, Buffalo City is a hot spot for urgent interventions to legitimise and professionalise this health care sector.

"We traditional healers would be able to cure HIV/AIDS, because what we would be able to do is to ask our ancestors what we should use to cure it. We are sometimes shown in our sleep what medicine we should use, and where the medicine is, and we can picture that place. So we would be able to cure AIDS".

Traditional health practitioner 2004

"What I see is that these herbs that they claim cure HIV/AIDS are in actual fact boosting the immune system, because patients come to them weak and frail, and then they become stronger after getting treatment from them. However, they give them (patients) false hope by making them think that they are cured".

- Western health practitioner 2004



Chapter 7

TRADITIONAL HEALTH PRACTITIONERS' KNOWLEDGE, BELIEFS AND PRACTICES REGARDING HIV/AIDS: VIEWS OF TRADITIONAL AND WESTERN PRACTITIONERS

Essentially, the analysed data are discussed in two parts. First, data from interviews with management of the provincial Department of Health are systematised and summarised, then discussed in chapter six (paragraph 6.7 - 6.9). Second, the data analysis process described in chapter five (paragraph 5.5) is followed to analyse data collected from the individual interviews with traditional health practitioners and western health practitioners. Repetitive themes are identified and the data are discussed according to these themes in chapters seven to nine. Comparisons are made between the data of individual interviews, as well as between data from interviews with the two groups of respondents, to identify significant differences and similarities, as well as contradictions of note in the data. The discussion of findings from the two groups of respondents are presented in two sections, namely

A – Views of traditional health practitioners

B – Views of western health practitioners

A – VIEWS OF TRADITIONAL HEALTH PRACTITIONERS

Individual in-depth interviews were conducted with the twenty selected traditional health practitioners in the Buffalo City LSA/Local Municipality. All interviews were conducted in the respondents' first language, namely *isiXhosa.* The interviews related to the role that traditional health practitioners perceived themselves playing in providing health care especially to people living with HIV/AIDS, as well as views about the current and future status of the traditional healing system. These views expressed by traditional health practitioners will be discussed at the hand of emergent themes, and illustrated and supported by direct quotations from the interviews where relevant (the quotations were translated into English by the researcher).

7.1. Discussion of findings

7.1.1. Classification and gender profile of traditional health practitioners

It was established by the research that spiritual healers, more often than not, undergo training as a diviner prior to, or immediately after completing training in the field of spiritual healing. Seemingly, divination is a prerequisite for spiritual healers. Thus, the category of spiritual healers was in fact diviners who also practised as spiritual healers. One respondent reported: "*they must also include spiritual healers because spiritual healers and diviners are one and the same thing. Their training comes from the same beads".* Furthermore, in most instances the differential line between herbalists and diviners was permeable. Many respondents answered that they were merely traditional health practitioners when questioned about the classification of their practices, namely whether they were diviners, herbalists or spiritual healers. The classification of traditional health practitioners into more than one historical category (i.e. diviners, herbalists, spiritual healers, etc.), points towards the transformation of the traditional healing system from traditional health practitioner specialists to multi-skilled practitioners (general practitioners).

Table 9 is a profile of the traditional health practitioners that participated in the research.

Table 9: Age, gender and category profile of traditional health practitioners

Category	Gender		Age (Yrs)				
	F	M	20-29	30-39	40-49	50-59	60+
Diviner	6				3	1	2
Herbalist		3				3	
Diviner/spiritual healer	4	1			2	3	
Diviner/herbalist	3	1		1	1		2
Diviner/herbalist/spiritual healer		2	1			1	
Total	13	7	1	1	6	8	4

The majority of traditional health practitioners interviewed were female, with all the "pure" diviners being female and the "pure" herbalists being male ("pure" refers to only being qualified in one category of traditional healing). This is in line with the historical tendency for diviners to be predominantly female and herbalists predominantly male (Freeman & Motsei 1992; Friedman 1998; Gumede 1990; Hammond-Tooke 1993). The number of years that the traditional health practitioners had been practising as such ranged between four and thirty-eight years. Although all the traditional health

practitioners who were interviewed were qualified in at least one category of traditional healing, some practitioners were still undergoing training in one other category of healing.

7.1.2. Knowledge about HIV/AIDS

Knowledge about HIV/AIDS among traditional health practitioners may be described as conflicting and contradictory, with uncertainty the undertone. In the main, traditional health practitioners' knowledge about HIV/AIDS portrays a combination of western thought and superstitious beliefs. The scope of knowledge about HIV/AIDS differs from one traditional health practitioner to another, and leaves behind a trail of a dire lack of knowledge about the specific symptoms and the transmission of the disease. Three most salient aspects of knowledge about HIV/AIDS among traditional health practitioners include the following:

(a) Source of information about HIV/AIDS

Many of the traditional health practitioners who claimed that they had some knowledge about the signs and symptoms of HIV/AIDS reported to have acquired their knowledge informally through the media or word of mouth. Very few traditional health practitioners reported having acquired knowledge about HIV/AIDS formally or through an appropriate source such as a western health practitioner or any other official of the Department of Health. The following statements are case in point:

THP[31] 1: - "We as traditional healers know some of the symptoms of HIV/AIDS through attending some workshops where we were told that this is how we will recognise someone who has HIV … that is how we managed to have the little knowledge that we have about the disease. We don't all go to the workshops. Some go and then they tell the others".

THP 2: - "We as traditional healers do our own thing, but because I am employed I hear about things that we should do to protect ourselves from HIV/AIDS. We hear that it is contagious. This information helps us to be of better help especially on how we should administer our medicines because we cannot say we will not touch a patient".

Only two of the twenty traditional health practitioners interviewed had attended a formal workshop or training session about HIV/AIDS.

(b) Uncertainty about the signs and symptoms of HIV/AIDS

Traditional health practitioners appear to be uncertain about the signs and symptoms of HIV/AIDS, although they claim to have the ability to diagnose HIV/AIDS. The following statement points towards confusion and uncertainty about the signs and symptoms of HIV/AIDS: "*Someone with HIV/AIDS does not have genital sores, is that not so? That is exactly how it is. Someone with HIV/AIDS loses energy and they get sores around the mouth and then their eyes look like … unusually white".*

The need for confirmation of the signs and symptoms viewed as indicative of HIV infection, further points to a lack of sufficient knowledge about HIV/AIDS amongst traditional health practitioners.

[31] THP = Traditional health practitioner

(c) Misperceptions about HIV/AIDS transmission

Of gravest concern regarding traditional health practitioners' knowledge about HIV/AIDS, are prevailing misperceptions about HIV/AIDS transmission. A traditional healer, referring to patients living with HIV/AIDS, reported "*Our problem is that we don't have places which we can use when someone comes to us with AIDS. Where are we going to admit them? Because, when this person arrives, we must have a place where this person can sleep. Why? This person is not going to use your bed, he/she is not going to use your linen, he/she is not going to use your toilet or your things to wash with".* Misperceptions about HIV/AIDS transmission are detrimental to the fight against the stigmatisation of people living with HIV/AIDS, and once again, is indicative of a lack of knowledge about HIV/AIDS amongst traditional health practitioners.

It is apparent that there is a dire lack of accurate knowledge about HIV/AIDS amongst traditional health practitioners in Buffalo City. This lack of knowledge was reiterated by the traditional health practitioners themselves. One traditional health practitioner reported, "*My weakness would be my lack of knowledge about AIDS and HIV".* Furthermore, they expressed a need for the acquisition of such knowledge, as was evident by the statement: "*We are still waiting to be trained, because in other places they* (traditional health practitioners) *have received training in TB and HIV/AIDS"*. However, imparting knowledge about HIV/AIDS to traditional health practitioners is far from simple, in that the methodology used should be sensitive to the needs of traditional health practitioners, so as not to undermine indigenous knowledge and traditional practices.

7.1.3. Diagnosing HIV/AIDS

Traditional health practitioners, in general, rely on the limited knowledge that they have acquired either through the media, word of mouth or formal training, in conjunction with the guidance of their ancestors to diagnose HIV/AIDS. Spiritual healers and diviners, in particular, are more inclined to use divination to "see" whether or not a patient has HIV/AIDS. Herbalists, who do not possess the ability to divine, rely on the patient to inform them of his/her HIV status. However, even those traditional health practitioners who reportedly are able to diagnose HIV/AIDS require the confirmation of a clinical blood test administered by a western medical practitioner, to confirm their diagnosis. The following statements by various traditional health practitioners are indicative of the perceived efficacy to diagnose HIV/AIDS:

Diviner: "The person that came to me with HIV told me that he was diagnosed as such. I asked to see his folder and it said so. I told him that he could be cured … that western doctors saw that what he had was HIV/AIDS whilst when I looked at him, I saw that he had 'igchushuwa' (gonorrhea) which can be cured".

Herbalist: "I have as yet not treated someone with HIV/AIDS. I know the signs and symptoms from what I have heard … that if you see such and such symptoms then that person has HIV/AIDS, so you will refer that person to a clinic … but I, myself, have not yet had a client who had these symptoms".

Diviner/Spiritual healer: "I haven't treated someone who has HIV/AIDS, but I can diagnose it. I can see when someone has HIV/AIDS. My ability to see it started now that I'm part of the church. But I wouldn't be able to say to them that they are HIV. I usually ask them to get tested at a hospital and then return to tell me what they have said. For example, a young bride with her mother and neighbour arrived at my home one morning when it was raining heavily. The young bride was very sick. I was still in the bath washing when they arrived. I then came

out of the bathroom and saw that these people appear desperate. So, I hurriedly got dressed so that I could attend to them quickly. So, I walked into the lounge and they were seated. I exclaimed "No people! Take her to the hospital … I can't cure HIV/AIDS". Then the mother replied that no, no, no she didn't have it. They just wanted me to examine her. I quickly said that I was joking and asked for forgiveness and I decided to hold back after that. But when I examined her, I saw that she had the symptoms of it, and then I gave them taxi money and asked the mother to please take her to the day hospital immediately and ask for the young lady to be tested, and then return to me to tell me what was said. Then the mother retorted that at the clinic in their village, one of the nurses said that she has HIV/AIDS, but they didn't believe it, because this child is being chased".

Diviner/Herbalist/Spiritual Healer: "I diagnose HIV/AIDS myself because people come to me to be examined. Then after I have diagnosed them as HIV-positive, I send them to get tested to prove what I am saying".

Herbalist: "No-one has come to me to say that they have this disease (HIV/AIDS)".

Herbalist: "No, I don't diagnose HIV/AIDS. People tell me that they have it, then I give them medicines".

Diviner: "I cannot diagnose it (HIV/AIDS) and no-one has come to me saying that they have HIV/AIDS".

Diviner/Spiritual healer: "I had people in 2002 who came to me with HIV/AIDS. I diagnosed them with HIV/AIDS and they also confirmed that their western doctor said that they had HIV/AIDS. What I know about HIV/AIDS is what I see when I examine a person. It's the symptoms that we are told about by people outside … symptoms of HIV/AIDS".

Diviner: "I can also examine a person and see for myself that they have HIV/AIDS. A person with HIV/AIDS is the same as someone with TB".

Generally, traditional health practitioners are not overly confident about their ability to diagnose HIV/AIDS. This may be attributed to the perception of the disease as being a fairly new phenomenon. Reportedly, even the ancestors who are called upon for assistance in diagnosing HIV/AIDS are sometimes caught at a loss. The following response was made by a traditional health practitioner who had called upon her ancestors for assistance with a patient that was diagnosed HIV-positive at a western health care facility, "*I've had someone come to me with HIV/AIDS, and I had no idea where it came from, nor where it was going. I called her family and told them that I work with the river. My ancestors live under the water. I took this girl to the river and said to my ancestors, grandfather, here is a girl that the doctors say has AIDS. My grandfather* (ancestor) *replied by saying that he doesn't know what this is. All that he could see was that this child is being called to become an underwater diviner by two elderly women".*

It is apparent from the perceived efficacy of traditional health practitioners to diagnose HIV/AIDS that their knowledge (inherent and learned) falls short of being adequate.

7.1.4. Determining the cause of HIV/AIDS

Traditional health practitioners exude more confidence in their ability to determine the cause of HIV/AIDS than diagnosing the actual symptoms, as is the case with any disturbance in an individual's state of health. In their view, determining the cause of any illness bears fundamental importance in the treatment and healing process than simply diagnosing the symptoms of illness, as is the case in western medicine. This logic is based on the interdependence

between cause and cure. In other words, accurately determining the cause of a disturbance in an individual's environment will lead to the appropriate corrective measures being taken to restore the balance in the individual's environment and, thus, return the individual to his/her "normal" state of health (absence of illness). This conviction is best captured in the response of one traditional health practitioner. He reports: "*In 1979, I thought I had TB, but it was in actual fact my calling. I finished my TB treatment and I was cured of TB, but the symptoms of the calling remained. So, what appeared to be TB was actually my calling. At the time, it was a sign that I should not think that I was cured by the TB treatment. If I had ignored the signs of the calling, I would have continued having TB and never had been cured even if I was taking my TB treatment. For instance, I have hypertension now … it is still this illness".*

The saying "*unobangela*" - 'the cause' - is often uttered by traditional health practitioners in describing their core concern and focus when treating a patient, as illustrated by the following responses:

THP 1: - , "The success of the treatment (for HIV/AIDS) also depends on whether or not you can trace the cause of you being HIV-positive".

THP 2: - "… our main concern is 'unobangela' (the cause)".

THP 3: - "I treat all my clients by finding out what the cause of the problem/illness is first".

THP 4: - "A person will go to the clinic and be diagnosed with high-blood pressure (hypertension). I see that high-blood pressure a different way. I see the reason behind the high-blood pressure".

Traditional health practitioners who are aware that HIV/AIDS is transmitted via blood, for example through sexual intercourse, still attribute a supernatural explanation to this western-based cause of HIV/AIDS. One traditional health practitioner reported, "*People who are HIV-positive who come to me, I find out the cause of the illness. They (*western practitioners) *say it is transmitted through sexual intercourse. So, I will ask who did you have sex with? Bring that person to me so that I can treat both of you. I cannot treat only one of you if the cause lies with both of you. I will treat both of you in the same way". "An individual must be in sync with both maternal and paternal families, and the relationship between a mother and father are responsible for the offspring's well-being – physical, psychological, spiritual. In divination, I try to establish the cause of illness through the parents. Ill-health is largely attributed to either instability in the parents' relationship or to instability in the mother or father's family".*

It is apparent that traditional health practitioners place grave emphasis on the cause of illness –*unobangela* - including HIV/AIDS, which is traced back to a disturbance in the patient's social and physical environment. This is an important consideration in efforts to educate traditional health practitioners about HIV/AIDS. "*Unobangela"* is at the core of the traditional healing process, and any effort to improve such practices should be aligned with this notion.

7.1.5. Curing HIV/AIDS

The majority of the traditional health practitioners interviewed believe that HIV/AIDS can be cured. This belief is primarily based on the assumption that recurrent illnesses/diseases have a supernatural cause. In other words, the symptoms of a recurrent illness/disease is a manifestation of a message from the ancestral spirits. Thus, the correct interpretation of the message or cause of the symptoms of HIV/AIDS will reveal the necessary corrective measures which need to be adopted to alleviate the symptoms. Once such action is taken, it is believed that the symptoms will be alleviated and, thus, the patient cured. The following responses point towards this belief:

THP 1: - "I believe HIV/AIDS can be cured if we could collaborate with western doctors, because it is the western doctors who say that AIDS cannot be cured. It has gone as far as even nurses now believe that it cannot be cured. Even the volunteers now believe that AIDS cannot be cured. You will tell a volunteer that this person can be cured and they will tell you that 'no' it is said that it can't be cured; you must just accept it and continue with that nagging feeling that you are going to die".

THP 2: - "I will say that those traditional healers who say that they can cure AIDS based on the fact that a person whose blood test was positive before treatment and then negative after treatment, can treat it".

THP 3: - "I can't diagnose HIV/AIDS and no-one has come to me saying that they have HIV/AIDS. I believe that it can be cured though".

THP 4: - "We treat everything and anything that a person comes with to us. Yes, we use medicine, but more importantly we talk. We talk to your ancestors. There is no disease which cannot be cured. The reason why a disease defeats western doctors is because it is a traditional disease … it is a person's natural illness".

THP 5: - "We traditional healers would be able to cure HIV/AIDS, because what we would be able to do is to ask our ancestors what we should use to cure it. We are sometimes shown in our sleep what medicine we should use, and where the medicine is, and we can picture that place. So we would be able to cure AIDS".

THP 6: - "You know that someone with AIDS becomes weak and fragile, and there is nothing that they can do. That is what that girl was like when she came to me. The day after I treated her, she got up and did things for herself, her family was shocked. Time went by and she gained weight. What was left now was for her family to come to me so that we could continue with these people that gave this girl the calling. They didn't return. The girl stayed at home and gained more and more weight, and was happy. Because this whole thing was from the ancestors, death returned and said I'm here! If this girl and her family had followed the route that they were meant to follow, she would have been cured. She would have been HIV-negative".

THP 7: - "Now you see this AIDS … it arrived saying it cannot be cured. Our belief is that there is no disease that cannot be cured".

Only one interviewed traditional health practitioner believed that HIV/AIDS could not be cured using traditional medicines. This was evident in the following response: "*… then the mother exclaims that at the clinic in the village, one of the nurses said that she (*daughter) *has HIV/AIDS, but they don't believe it because this child is being chased* (bewitched)*. She even gave the name of the person that is chasing her. So I said that if the nurse said so, then they should please return to another nurse to be tested. If the child is indeed being chased, then the results of the second test will be negative. Then they left. That young girl was very ill and I'm pretty sure that she is not alive anymore if she didn't get help from people who are knowledgeable about HIV/AIDS, such as western doctors".* The same traditional health practitioner is also of the opinion that certain illnesses cannot be cured through traditional healing interventions, but only through western medicine, as is evident from the response: "*I can diagnose HIV/AIDS but I can't cure it. I do not treat people who come to me with HIV/AIDS. I immediately refer them to a clinic or hospital. I ask them to go to the nearest clinic or hospital in their residential area to be tested. I believe that if you cannot treat something, refer that person to someone who is knowledgeable about that illness, especially with diseases that I know cannot be cured with traditional medicines*". This opinion is in the large minority since the majority of the traditional health practitioners interviewed believe that traditional healing has the ability to cure all illnesses.

Although the majority of traditional health practitioners interviewed believe that HIV/AIDS could be cured through the correct diagnosis of the cause and subsequent application of the appropriate corrective measures as per guidance of and consultation with the ancestors, only three traditional health practitioners claimed to have concrete proof that they can indeed cure HIV/AIDS. Their claim to have the ability to cure HIV/AIDS is based on pre- and post-HIV test results. It is alleged that the traditional health practitioners' clients who are clinically diagnosed as HIV-positive, are clinically diagnosed as HIV-negative after completing the prescribed treatment of the traditional healers in question.

THP 1: - "When I was in Cape Town people did go to get tested after using my treatment, and they would return saying that the tests are negative when they were positive at first. But now the problem is that when they are on treatment, they do not have the courage to go back to be tested".

THP 2: - "I can cure AIDS to the extent that there is nothing left of it in the body. Even if that person had to go to a doctor the blood results would come back negative".

THP 3: - "… he came saying that he went to a western doctor and was diagnosed with HIV/AIDS. He went to the doctor again and was diagnosed with HIV/AIDS. My nephew, who he works with, advised him to come to me. Because it was still in the beginning stages it took me only two months to treat him. I then referred him to a western doctor to check what progress he was making. He went the first time and he came back saying they didn't see anything. I told him to take my medicine again. I told him to go to the doctor for the second time to see that things were still fine. This was in the second month of treatment. He went, and they said that there was no sign of HIV/AIDS, and they (doctors) had no idea how it came about that he was told he had HIV/AIDS".

The belief to cure HIV/AIDS among the other traditional health practitioners that were interviewed was not supported by claims of evidence to such an effect. This may be attributed to traditional health practitioners' remedies alleviating the symptoms of HIV/AIDS, which they interpret as "curing" HIV/AIDS. The following statements are examples in point:

THP 1: - "We are not saying that we cannot cure AIDS. What we are saying is that we are at least making progress in terms of making sure that it does not kill an individual".

THP 2: - "Someone who has HIV/AIDS may be using western medicines for this HIV/AIDS and then come to me. I will see that this person's health is not improving. Once he/she comes to me and uses traditional medicines, then you see their health improving. That is something that they say … something straight from their own mouths. You then also see this. Sometimes they arrive weak … another one will say they have lost their appetite, they can't eat anymore, they have lost weight and can't do anything … but once I give them these traditional medicines then you see them improving to the extent that they come back for more medicines".

THP 3: - "The medicine that I give them helps kill HIV completely so that it is no longer in the body. The problem is that these patients do not return after I have given them their treatment. There is one from the rural areas who returned to tell me that they are feeling much better. Then his mother came back to me with other people who had HIV/AIDS. I am not saying that if someone was HIV-positive they then become HIV-negative after taking my treatment. What I am saying is that they come to me weak, unable to eat, the mouth red, their hands very pale, then I boost them so that they can eat, get up and work. That is all".

THP 4: - "We are not sure whether our medicines cure HIV/AIDS or not, because we have not had a patient who has been tested after taking our medicines. But we want to say that we can treat them. Those traditional healers who say that they can cure AIDS … if they are sure that they can, then that is right. We had someone who had HIV/AIDS who came to us in a critical state. I mixed a medicine for him. We gave it to the person and he returned saying that he was feeling much better. He was very critical when he came to us. He is still alive and comes to us every now and again for this and that ailment. He came to us recently to see what his condition is like, and when we examined him we found that his condition had improved tremendously even though he is not 100% better".

THP 5: - "I cannot speak on behalf of all traditional healers, because we are all given different means of healing and medicines by our ancestors, but the person that I treated who had HIV/AIDS is still alive and well after he/she was flat on their back when they came to me. But, it has not been said that the virus is gone, that they are HIV-negative".

The belief that AIDS can be cured, based on personal claims to do so or based purely on belief systems, is prevalent amongst traditional health practitioners in Buffalo City. This is a direct contradiction to public denouncements of this belief by provincial and national bodies/structures of traditional health practitioners. This is a matter of concern which needs to be addressed with urgency in the quest to integrate traditional health practitioners into the mainstream of health care in South Africa.

7.1.6. Treating HIV/AIDS

Treatment for patients with HIV/AIDS by traditional health practitioners predominantly comprises three practices/activities, namely, (a) inducing vomiting and/or diarrhoea (anemas), (b) consuming/applying traditional medicines and (c) performing rituals.

(a) Inducing diarrhoea and vomiting

It was apparent from the treatment regimens described by the traditional health practitioners, that HIV/AIDS is associated with contamination of either the stomach or the blood, and, thus, the actions of inducing vomiting and diarrhoea are symbolic of excreting this toxic substance from the body. This is best described by the following responses:

THP 1: - "Someone with HIV/AIDS, you give them medicine to vomit and then make them have diarrhoea to clean their bodies". "… the doctor had told her that she had AIDS and she was receiving treatment from one of the clinics. She had a fever, and her hair had fallen out, and she was not eating". "… then I gave her medicine to vomit. I did not make her vomit a lot. Just enough for the medicine to work. She then really got that 'xakaxa' out".

THP 2: - "What I do is that I do not make someone who has AIDS vomit. I give them a bottle (medicine) then I induce diarrhoea. I take it that this thing (HIV/AIDS) forms eggs inside your body and it is these eggs that we must remove from inside of you. So, you (traditional health practitioner) will think that you have completed treating a person meanwhile you haven't because you haven't removed the eggs inside".

(b) Consuming/applying traditional medicines

The use of traditional medicines either for consumption or topical use is seemingly administered in conjunction with the practice of inducing diarrhoea and vomiting, although not necessarily. Traditional medicines are consumed/applied to strengthen and protect the body from further attack by the toxins. These actions are merely to relieve the physiological manifestations of illness or disease, so that the individual may return to their normal state of physical health, as is evident in the following statements:

THP 1: - "Someone with HIV/AIDS, you first fix their bodies by putting medicines on their bodies".

THP 2: - "… what I did to her was to first apply medicine to her body so that her body could at least gain strength. Then I made her 'futha' (steaming) just for a few minutes, just for her to get the warmth of the steam, because I could see that she was very weak".

THP 3: - "I give them a bottle of traditional medicine to help them inside, then I also give them medicine to wash with on the outside. The medicine that I give them helps kill HIV completely so that it is no longer in the body".

THP 4: - "We had someone that had HIV/AIDS who came to us in a critical state. I mixed a medicine for him. The herb that we use is green and found in the forest. We gave it to him, and he returned saying that he was feeling much better. He was very critical when he came to us. He is still alive and comes to us every now and again for this and that ailment. He came to us recently to see what his condition is like, and when we examined him we found that his condition had improved tremendously even though he is not 100% better".

THP 5: - "I take it as though I am working with someone that has 'igchushuwa' (gonorrhea). Someone with 'igchushuwa', you must clean their genital area. That is the area that caused that dirtiness. I treated him that way, but I made sure that his things were separate from those of people with other diseases. His things were separate".

Traditional medicines are believed to be "powerful" in terms of their reaction. Traditional health practitioners view the strength of traditional medicines as an important advantage of the traditional healing system, whereas, western health care practitioners view it as a disadvantage (cf. paragraph 9.2.3c).

(c) Performing rituals

Inducing diarrhoea and vomiting is done so as to cleanse the body of the HI virus, whilst consuming/applying traditional medicines is to strengthen the body so as to counteract the effects of HIV/AIDS. However, addressing the cause of illness is as important a part of the treatment repertoire as alleviating the physical symptoms of illness. The patient's family forms an integral part of the treatment process. It is within the patient's interpersonal relationships that the root cause of illness is found. Hence, the importance of ensuring the participation of the family in treating a patient. One respondent said, "*I cannot cure you if I have not come into contact with your family. I need your family in order to cure you. If the family refuses to come to me, 'ndigoba ityolo'* – (continue without their consent)*. I then treat you and when you are cured I will ask if you are still fine. You are now mine, because I cured you and you have built new friendships while you were with me. I'll take you back to your family and ask them what they have to say now that you have been cured and you have built new relationships. That is when the family has to provide me with a cow".*

THP 2: - "… if they come to me or ask me to go to the hospital to help a person with HIV/AIDS, what I am going to do when I get to the hospital is to find out where that person's family is. If that person's family permits me to take this person to the river to go ask my grandfather what to do".

7.1.7. Benefits of traditional medicine for PWAs

It is reported that treatment of HIV/AIDS patients results in an increase in appetite, weight-gain, regaining of strength, and regaining of the ability to perform daily activities which may have been disturbed/prohibited as a result of illness. These manifestations, which are alleged to be a direct consequence of traditional medicines, are related to a strengthened immune system. The perceived curative effects of traditional medicines and healing are presented in the following statements:

THP 1: - "Traditional medicines prevent people from dying and they give people strength so that they can regain their strength again even if they were weak. Someone who has HIV/AIDS may be using western medicines for his/her HIV/AIDS and then come to me. I will see that this person's health is not improving. Once he/she comes to me then you see their health improving. That is something that they say … something that comes straight from their own mouths. You then also see this. Sometimes they arrive weak … another will say that they have lost their appetite, they do not eat anymore, and they tell you that they have also lost weight and cannot do anything … but once I give them these traditional medicines then you see them improving to the extent that they come back for more medicines".

THP 2: - "On the third day she came back to me dressed like you … a sleeveless garment and her face looked pretty. She was still thin though. I told her to stay with me for three to four days and I fed her porridge. My medicine has no problems. You drink it when you feel the need to drink it. This child gained weight, and when she went to the clinic they kept asking her why she looked so well".

THP 3: - "When someone has HIV/AIDS and they are weak, we help them gain strength so that they can be up and about again".

THP 4: - "We had someone that had HIV/AIDS who came to us in a critical state. I mixed a medicine for him. The herb that we use is green and found in the forest. We gave it to the person and he returned saying that he was feeling much better. He was very critical when he came to us. He came to us recently and we found that his condition had improved tremendously even though he is not 100% better".

THP 5: - "What I am saying is that they come to me very weak, unable to eat, the mouth red, their hands very pale, then I boost them so that they can eat, get up and work".

Thus, many traditional health practitioners are of the opinion that they cure HIV/AIDS, since the symptoms of illness associated with HIV/AIDS are alleviated, and the patient returns to his/her normal state of health. In other words, patients living with HIV/AIDS show improvement in their physical appearance (indicative of improved health), and resume their daily activities after receiving traditional medicines. Very few traditional health practitioners reported an inability to treat HIV/AIDS. Even traditional health practitioners who had as yet not been granted the opportunity to treat a patient that was living with HIV/AIDS reported that they were confident that they would be able to treat them successfully if the opportunity arose.

7.1.8. Stage of illness when treating HIV/AIDS

The ability to successfully treat HIV/AIDS is also related to the status of the patient's health at the time of seeking traditional health care. Some traditional health practitioners are of the opinion that the success rate for treating HIV/AIDS is higher when still in the "beginning stage". The "beginning stage" refers to a patient who has recently been infected with HIV, and whose health has not severely deteriorated as yet. The following statements serve as evidence of this notion:

THP 1: - "… then you can help that person because it is still in the beginning stages. I have not seen anyone who has had HIV/AIDS for a long time yet. I have only seen those who have just contracted it".

THP 2: - "The second one … as I told you I only had two cases of HIV/AIDS … the second one was slightly problematic because she had already had it for quite a long time. She was going to the doctors back and forth being given those tablets".

THP 3: - "Here is another case right here in front of me. This young man had a wife who was also a diviner, but not the type of diviner that I know. She was a diviner in her own way. The wife died. She died telling people that they have HIV/AIDS and are getting a grant for it. So she had no problem. Last week the husband started getting ill. He had 'iphika' (breathlessness). If he had come to me at that stage that I had told him to come, he would have been better by now. I am absolutely and utterly certain about that. Someone must not come when they are already flat on the ground. Because if they are flat on the ground the flesh has already gone off (rotten) and there is nothing more that can be done to save that person. See, they must come at that stage when a person is still walking".

THP 4: - "The way I see it, AIDS is not a problem if a person is taking their treatment. The difficult cases are the people who are already weak and frail and unable to stand on their own two feet. The person must at least have the energy to withstand our treatment".

Although traditional health practitioners were not knowledgeable about the clinical stages of HIV/AIDS, or the western distinction between HIV and AIDS, they were aware that the success of treatment is higher when the individual's state of health has not deteriorated severely. Deterioration of health is indicative of a longstanding illness, which decreases the effectiveness of traditional medicines.

7.1.9. Reasons for failure to cure HIV/AIDS

Various reasons are given for failure to cure HIV/AIDS, none of which bear any relation to the inability for HIV/AIDS to be cured. The reasons reported include, (a) the failure of traditional health practitioners to accurately determine the cause of HIV/AIDS; (b) non-adherence of patients to the prescribed traditional treatment regimens and associated corrective action; and (c) charlatan traditional health practitioners whose so-called traditional medicines have no curative powers.

(a) Inaccurate diagnosis of the cause of HIV/AIDS

Determining '*unobangela*' - the cause – is an important aspect of the treatment process for any recurrent illness such as those related to HIV/AIDS. Thus, it is imperative that traditional health practitioners accurately determine the cause of illness in order to prescribe the appropriate treatment and accompanying rituals to correct the imbalance in

the patient's environment, thereby restoring health and eliminating ill-health. Traditional health practitioners who prescribe the incorrect corrective action, based on an inaccurate diagnosis of the cause, reportedly results in failure to cure an illness, including HIV/AIDS.

THP 1: - "For example, when I became ill, my leg was swollen and sore, and I went to all types of doctors, clinics and traditional healers but I was never healed. Then I realised that what I really needed was something small. I just needed 'ukufa kwasekhaya' (family ritual). It is when I came here to my trainer that the cause of my illness was revealed and I was healed".

THP 2: - "I would really also like to know about these doctors that come from other countries that claim to be traditional healers. How do they treat you if they know nothing about your family's rituals and customs? How can you be a Rhodesian, a Tanzanian, a Malawian and not know the Xhosa rituals and customs?"

THP 3: - "A diviner will come here from another area after he/she has been trained and graduated, and it so happens that they have not been trained the way that their ancestors would have liked them to be trained. The trainer merely used the method that they were trained with which is not necessarily the method which the trainee was supposed to be trained with. That is not how diviners should be trained. As I told you, I was only cured of my illness after the third traditional healer trained me".

(b) Non-adherence of patients to prescribed treatment regimens

The most reported reason for failure to cure HIV/AIDS was non-adherence to treatment regimens. The non-adherence of patients to prescribed traditional medicines and corrective measures is attributed to four reasons, namely economic gain (social grants provided to individuals living with AIDS); defaulting prescribed treatment regimens due to the unpleasant taste of traditional medicines; misperception that improved state of health prior to completion of treatment is indicative of being cured; and avoiding payment of traditional health practitioners by not returning for follow-up examinations after the initial visit to the traditional practitioner. The following statements are examples of these perceived reasons:

THP 1: - "One person was sent to me very sick, unable to walk, he was carried to me. I treated him and he walked back home. I told him to go for a check-up at a clinic, but the problem was money. He was receiving a grant for being HIV-positive, therefore he did not want to forfeit this money. He was still going to get the money even if he was better. Because of this dependency on the grant, he did not continue his treatment with me. I also experience patients who default. As soon as the pain subsides they think that they are cured and stop treatment".

THP 2: - "Other times you give a patient medicine and tell them to use it in a specific way. When the medicine does not taste nice to the patient they will stop taking it, leave it there, and just keep looking at it instead of taking it as instructed. Then they go around saying that they were not cured".

THP 3: - "We have many defaulters because our medicines do not taste nice".

THP 4: - "The AIDS was not completely gone because I was still in the process of treating her. What happened is that this child saw that she was looking and feeling well, so she went back to her home town where she found her boyfriend thin and frail. She tried to convince him to come to me, but he refused. So, she went on and found herself another boyfriend and decided for herself that she was well and did not need to come back to me. In other words, she did not finish my treatment".

THP 5: - "The child with AIDS was cured by my medicines even though her aunt, who was a nurse, told her not to use traditional medicines because our medicines are dirty. The mother did not want to leave her alone with me. So, I let both of them stay and fed them both. They left because the child needed an ID to get a government grant for having HIV/AIDS. They did not have the money, so I gave them enough money to get one after which they did not return to complete the treatment. I heard now during December that that child has died".

THP 6: - "What happened is that she was bathed at the river with mud and was also given mud water to drink. We, thereafter, made her a bottle (medicine) and she was fine after that. The ancestors told her that what has happened to her is a sign that she must wear 'iintsimbi' (beads - calling). She moved away to Johannesburg, because she was running away from wearing 'iintsimbi'. She thought that 'iintsimbi' would lower her status. When she returned from Johannesburg she was back to square one again. When she left she had gained weight. She returned thin again and then died".

(c) Charlatan traditional health practitioners

Charlatan traditional health practitioners are viewed as bearers of death since they have not been bestowed with the power to heal by their ancestors. Therefore, their medicines are believed not to possess curative properties which are responsible for curing illnesses. As a result, their perceived ineffectiveness is associated with failure to cure illnesses, such as HIV/AIDS, with traditional medicines. The following statements are examples in point:

THP 1: - "There are too many charlatans in the traditional healing profession. When someone comes to me for help and tells me that they were being treated by a specific traditional healer, I immediately tell them to forget about that traditional healer because his/her money is lost".

THP 2: - "A lot of people have gone to traditional healers and paid a lot of money only not to be helped. There are many charlatan traditional healers. One lady came to me when I was preparing to send three initiates to Swaziland to be trained. She was in an abusive relationship with her husband. The other initiates had already left to start training but I decided to let her follow. I then told her that I entered into an agreement with the parents of the three initiates whereby the parents would give me the money for the training and I would pay the trainer myself to avoid me arriving in Swaziland only to find that the parents have not deposited the required money for the training. This women insisted that her husband would deposit the money into her bank account, and she would withdraw it in Swaziland and pay the trainer herself. Unfortunately, the husband did not make the deposit. We made arrangements for her to return to South Africa to sort out the problem with her husband and then return to complete her training. She did not return to Swaziland and I discovered that she was in actual fact practising as a trained traditional healer in the community, claiming that she had completed her training".

THP 3: - "Also, some people will go to a traditional healer, observe what the traditional healer does to, for instance, cure a headache, then pretend that they too have the ability to cure. That is the person that kills people, because they see that a medicine is mixed in a specific way meanwhile they have not grasped the measurement specifications. These are the things we are constantly telling people … because you must not fake traditional healing, because you are going to kill people".

THP 4: - "There are many charlatan traditional healers. Some traditional healers get their 'itshoba' (cow's tail received upon graduating as a traditional health practitioner) from a nearby abattoir where they ask for a slaughtered cow's tail and then they pretend that they are a traditional healer. You cannot see them based on their appearance. You can only see in their behaviour. I once had two male traditional healers who came to me to

assist me with a ritual that I had to perform at a specific home. We then proceeded to a river where we were to perform the ritual. As fully-fledged diviners I gave them specific tasks to perform in order to assist me. They then refused to assist me without giving me any valid reason. I had to ask the initiates that I was with to help me while the two so-called fully-fledged diviners stood aside holding their cows' tails in their hands. I completed the rituals and we set off on our way home. On the way home they started discussing things that they had seen at the place where we had performed the ritual. That is where I discovered that these two traditional healers never graduated. That is how we see charlatans. We see in their behaviour at rituals".

THP 5: - "Those people who sell traditional medicines on the streets are charlatans, because you cannot put medicines in a place where everyone passes by. That medicine is not respected in that case and will therefore not work".

It is apparent from the reasons for failure to cure HIV/AIDS that the belief that HIV/AIDS can be cured is still firmly entrenched in the belief systems of traditional health practitioners in Buffalo City. This belief has severe negative implications for collaboration between traditional health practitioners and western health practitioners who believe the contrary, namely that HIV/AIDS still remains incurable. The apparent abundance of charlatan traditional health practitioners further complicates collaboration between the two health care systems through the harnessing of ineffective traditional healing practices and medicines within the traditional healing system, which contribute towards ill-health and unforced deaths in communities that utilise the services of traditional health practitioners. This compounds evidence for the urgent regulation of traditional health practitioners.

7.1.10. Perceived strengths of traditional health practitioners

The role of the ancestors in the healing process appears to be the acclaimed strength of traditional healing over western medicine. Ancestors are associated with supernatural powers. Thus, traditional health practitioners, who are bestowed with the ability to communicate with ancestors, believe that it is within this relationship with ancestors that they are granted the ability to determine the cause of illness, and thereafter prescribe corrective measures and traditional treatment to successfully eliminate ill-health and misfortune.

Generally, the traditional health practitioners who were interviewed believed that all illnesses and diseases are curable if the cause is accurately diagnosed and the appropriate treatment and corrective measures are followed. However, traditional health practitioners differed in their perceived efficacy to treat all illnesses. Seemingly, traditional health practitioners' evaluation of their own competency to cure illnesses is based on personal experiences in treating various illnesses. Some traditional health practitioners believe that they specialise in treating specific illnesses based either on their success rate at treating those illnesses, or based on the belief that they were only bestowed with the ability to treat specific illnesses by their ancestors, as reported by the following traditional health practitioners:

THP 1: - "My strengths as a traditional healer are treating 'idliso' (poisoning), 'amafufunyane' (a type of possession of an evil spirit caused by sorcery) and 'ukuxhuzula' (epilepsy). See, these illnesses which are related to the family, I am very good in those. Where this person must be taken to a river, this person must be taken to the sea, this person must be taken to the forest … those areas, I'm excellent in. I also specialise in homes which have been visited by bees, because bees speak to black people. They (patients) will arrive and not say anything. I will be the

one to tell that they have been visited by bees. They will agree then ask me 'why'? I will then explain why and what should be done".

THP 2: - "I do not want to say I can or cannot treat AIDS, because I have not had someone with AIDS come to me before so that I can see if I can treat it or not, because I use my medicines, but do not know whether I can use my medicines for AIDS. People that come to me are people with epilepsy, swollen legs, mad people, cancer. These are the people who come to me and that I deal with. As a traditional healer, I have not been given the ability to treat all diseases. There are certain diseases that I cannot treat".

THP 3: - "With traditional healers, you are given specific diseases by the ancestors … diseases that you can treat. You will never be given the gift to treat all diseases".

Other traditional health practitioners are of the belief that they have the ability to treat and cure all illnesses with the correct and accurate diagnosis of causation. This conviction is best illustrated by the response of one traditional health practitioner, namely "*Traditional healers do not have any weaknesses or illnesses that they cannot cure or treat. My reason for saying so is because people come from clinics and hospitals to be treated by us".* One other traditional health practitioner supported this view in responding that "*We treat everything and anything that a person comes with to us".*

Only one traditional health practitioner believes that certain illnesses can only be successfully treated by western medicine and not traditional healing, as she reported: "*I believe that if you cannot treat something, refer that person to someone who is knowledgeable about that illness. Especially with diseases that I know cannot be cured with traditional medicines. For example, way before I became a traditional healer, my son suffered from epilepsy. I took him to traditional healers who could not successfully cure his condition. Then, when he was thirteen years old, I was already a traditional healer, I took him to a hospital where the doctors said that he had a brain tumor. I did not then take him back to traditional healers for treatment, because I knew that they could not treat a brain tumor. So, I kept him in hospital where he was eventually cured in Cape Town. So, I do have people who come to me where I can see that their illness does not need a diviner or herbalist. I do not become jealous. I tell them that what they have is not a traditional illness, but a mere physical problem in your body which needs the intervention of western medicine".*

This view was in contradiction to the views of other traditional health practitioners who leaned strongly towards the ability for traditional healing as a whole to cure all illnesses. The ability for traditional health practitioners to divine is viewed as a significant strength of traditional healing over western medicine, which relies on the client's reporting of signs and symptoms of illness. The ability to ascertain the cause of illness, rather than merely treating the symptoms, is viewed as an important ingredient in the recipe for curing illnesses. This conviction is evident in the following statements:

THP 1: - "People consult traditional healers to find out why they are ill. Western doctors will ask you where it hurts. I, on the other hand, will explain why this arm is sore and try to rectify the cause of the sore arm. Western doctors will merely give you medicine to treat the sore arm".

THP 2: - "A person will go to the clinic and be diagnosed with high-blood pressure (hypertension). I see that high-blood pressure a different way. I see the reason behind the high-blood pressure. People prefer to come to us traditional healers, because they do not get help at the clinics and hospitals. They get help from us. Their illnesses are not cured by western doctors, but by us traditional healers. A person will go to a western doctor and receive an

injection. This injection will merely take away the pain, but what is really wrong in that person's body will continue. I will treat that person so that whatever is in that person's body goes away completely".

THP 3: - "With our type of healing, it is more than just the medicine. I can tell someone to mix a specific herb with a specific plant, but what may actually cure that person is my healing hand. It is the combination between the two. We are not business people; we are healers. We receive our healing powers from our ancestors, and this happens everyday".

THP 4: - "The difference between western doctors and traditional healers is that western doctors ask you 'what is wrong with you'. They will ask you 'what is wrong with you', and you will say that you have a cough and they will treat that. They will ask you 'where the pain is' and then treat that pain. We see what is wrong with you, and treat the cause not just the symptoms".

Interestingly, many traditional health practitioners reported a higher rate of success in treating cancer with traditional medicines compared with western medicine. This notion was supported by information from interviews with western health practitioners (cf. paragraph 7.2.2). The following responses are examples in point:

THP 1: - "There was this one lady who had cancer. She worked at a factory and was constantly bleeding because of the cancer. I treated her, then referred her to the doctor for a check-up. The doctor found that there was only a small portion of the cancer left. The doctor further advised her to remain in hospital until the rest of the cancer was cured. In her stupidity she remained in hospital until the rest of the cancer was cured. My question is, how was the cancer cured? Because, when she came to me she said that she had cancer. If she had returned to me, I would have a say. But now that she was admitted to hospital, will the doctor claim that he cured her? I do specialise in cancer. It only takes three days for me to cure you".

THP 2: - "As a traditional healer you can run a hospital on your own because we can cure traditional illnesses as well as western illnesses such as cancer".

It would appear from the aforementioned responses and underlying acclamations that the ability to determine the cause of illness through the guidance of ancestral spirits, who possess supernatural powers, is the cornerstone of the traditional healing system, as well as a key attribute to their acclaimed success at treating and curing illnesses of both a western and traditional origin. This reported strength of the traditional healing system is also viewed as a contributing factor to the high utilisation rate of traditional health practitioners. In the light of efforts aimed at integrating traditional health practitioners into the realm of health care, this strength of the traditional healing system needs to be explored and capitalised upon.

7.1.11.Perceived weaknesses/shortcomings of traditional health practitioners

Traditional health practitioners reported not having any weaknesses when directly questioned about their weaknesses as traditional health practitioners (cf. paragraph 7.1.10). However, direct observations made by the researcher, as well as responses of the traditional health practitioners themselves to questions indirectly related to their weaknesses, pointed towards incompetence and lack of ability to treat certain conditions.

(a) Direct observations

An interesting observation which transpired during one of the interviews was a clear indication of a degree of incompetence of traditional health practitioners in treating certain illnesses, despite their reported ability to cure all illnesses. One traditional health practitioner responded when questioned about her weaknesses as a traditional health practitioner: "*I do not refer to other traditional healers or western health care professionals. When someone comes to me, in any state, I treat them"*. At the time of the interview, a three year old foster child of the traditional health practitioner was lying next to the practitioner on a bed. The child was reportedly ill, although the practitioner did not elaborate on the child's condition. Whilst providing the above response, the child started crying. After a quick examination, the practitioner retorted with a tone of concern that the child was extremely hot (high body temperature). She hastily beckoned one of her initiates to help her prepare to take the child to a western doctor nearby. Whilst the initiate was preparing to take the child to the doctor, the practitioner accompanied the child to the toilet first. After their return from the toilet, the practitioner examined the child again then reported that the child's temperature had dropped. She explained that the child's high temperature was caused by his need for a bowl movement. The trip to the western doctor was thus cancelled.

(b) Indirect reference to weaknesses

Many of the traditional health practitioners revealed that they themselves were suffering from an illness or disease for which they were receiving western medical treatment, such as hypertension, diabetes and painful joints. The discrepancy between perceived ability to cure all illnesses and diseases, and the use of western medical health care for certain illnesses, portrays an un-admitted shortcoming that even traditional healing fails to escape. The underlying shortcoming of traditional healing may be best summarised by the response of one traditional health practitioner, namely: "*Now, if a patient of ours is very ill, we traditional healers do not see what is inside. Whereas, western doctors have things which they use to see inside. We just mix our medicines which we have been blessed with and give our patients, but we cannot see the extent of the danger of this thing* (illness/disease). *Western doctors can see and judge the danger of this thing to determine whether it is possible for this person to be healed. We just treat and heal, but do not have anything to see the extent of something* (illnesses)".

The reliance of traditional health practitioners on the ancestors and the absence of equipment to observe physiological changes within the human body may be an area of weakness which renders a partnership between traditional health practitioners and western health practitioners complementary and ultimately beneficial to patients.

Further shortcomings of traditional healing, which were indirectly expressed by traditional health practitioners, were the use of western medicines in treatment regimens for certain patients, as well as the referring of dehydrated patients to hospitals for intravenous rehydration, which traditional health practitioners indirectly admitted to being unable to treat. Traditional medicines fail to have the desired effect if the body does not have the adequate strength to allow the traditional medicines to react, which is the case in dehydrated patients. The required state in which the body ought to be in order for traditional medicines to trigger the desired effect may shed light on the strength of traditional medicines. The following response serves as example in point: "*So, if someone arrives here at my place and I see that this person … I will not be able to induce diarrhoea nor will I be able to make them vomit because they are too weak … then I will be able to write a note saying that I am referring this person to the hospital because*

he/she is weak. So, I will not be able to work on them. You (hospital) *will see what you can do … maybe put them on a drip, because he/she is weak. So, this person must first start there with you. Once they have regained their strength then you* (hospital) *must refer them back to me, because I cannot work on a weak person since I will kill them if I do".*

The strength of traditional medicines is one area of concern raised by western health practitioners in combining traditional and western medicine. A discussion of the views of western health practitioners on this matter follows in chapter nine. On the whole, traditional health practitioners believe that all illnesses can be cured/treated within the traditional healing sector, even if individual traditional health practitioners do not have the ability to treat and cure all illnesses.

7.1.12. Training in western medicine

When directly asked, all the traditional health practitioners claimed not to have received training in western medicine. However, upon probing, two traditional health practitioners reported attending at least one workshop organised and presented by western health care professionals. The following responses are indicative of the nature of the training received, as well as views about the training:

THP 1: - "I underwent training at the Regent Hotel last year October (2003) on HIV/AIDS, pregnant women, breast feeding, helping AIDS orphans, and helping people that have HIV/AIDS. This training was very helpful to me, because it gave me a lot of information and knowledge. I was the only traditional healer who could make it to this training".

THP 2: - "There is not much training that we receive from the western side other than getting advice from them, because our training is within us. We use the skills and knowledge given to us by our ancestors. What they (western doctors) advise us on is that when we are treating people with HIV/AIDS we need to wear gloves, so that the person's blood does not mix with mine, thus infecting me. This information and advice is given to us at these meetings we usually have with western doctors at the City Hall. They do not tell us how to treat HIV/AIDS. We use our own ways of treating".

The views of traditional health practitioners on the issue of receiving training in western medicine were somewhat ambiguous. On the one hand, traditional health practitioners expressed a need to acquire knowledge about aspects of western medicine, but only in as far as it will improve their own diagnostic and treatment practices. The expression of interest to acquire knowledge from western medicine is deduced from the following responses:

THP 1: - "We are still waiting to be trained, because in other places they have received training in TB and HIV/AIDS. We as traditional healers know the signs and symptoms of HIV/AIDS through attending some workshops where we are told that this is how we will recognise someone who has HIV … that is how we managed to have the little knowledge that we have about the disease. We do not all go to these workshops. Some go and then they tell the others".

THP 2: - "I have not received training in western medicine. We are only called to attend workshops every now and again. They are very scarce, however. It is something that I have voiced at the Amatole District Municipality. It appeared as though they would put me in touch with someone who would come train our traditional healers on

AIDS and TB. It did take place in Port Alfred, but it has not reached East London yet. We are still waiting for this training".

THP 3: - "I have no knowledge about how to treat HIV/AIDS. I have been told about 'inongwe' (African potato) which is an immune booster drink. So, I give my patients this when they arrive at my place then refer them to a clinic or hospital, because I have no idea what else to do for them. I think that there is a need for traditional healers to know more about these diseases. We should not be too distant from western doctors. We must be able to share information so that I as a traditional healer can go to a clinic, hospital or social workers and get information about these diseases".

THP 4: - "Traditional healers need training in how hospitalisation works. We only know how to work from home. If we are going to work in hospitals, we need to be trained in how hospitals function, such as how to register patients and so forth, so that when we have to go work in hospitals, we know what to do. For example, we induce diarrhoea while a person is in bed whereas perhaps there is a different procedure that they use in hospital. We need to know how that procedure works so that we can adopt that one. We also need to be trained in neatness, because we as traditional healers have been trained in different ways by our trainers. Neatness is very important when dealing with patients".

On the other hand, traditional health practitioners are cautious about adopting western treatment practices. This latter view may be associated with caution to avoid sending out the incorrect message, namely an affirmation that western medicine is the superior and effective form of health care in juxtaposition to traditional medicine. Therefore, training in western medicine should complement and supplement the traditional healing system rather than undermine its value and effectiveness. This approach to training of traditional health practitioners about western medicine will, for one, render the content of such training acceptable and, thus, adoptable in the traditional healing sector. Second, it will minimise resistance of traditional health practitioners to utilising information that will serve to improve the quality of traditional health care.

B - VIEWS OF WESTERN HEALTH PRACTITIONERS

Individual interviews were conducted with twenty-three western health practitioners representing four categories of staff, namely doctor (6 respondents), professional nurse (7 respondents), HIV/AIDS counsellor (5 respondents) and community health worker (5 respondents). The majority of respondents were female (20 respondents). The findings of the interviews are discussed at the hand of emergent themes. Although attitudes and views expressed by western health practitioners differed from one individual to another, similarities in views were evident within, as well as between categories of staff. Reference is made to such similarities and differences where relevant, and substantiated and illustrated by direct quotations from respondents.

7.2. Discussion of findings

7.2.1. Reasons for consulting traditional health practitioners

Western health practitioners had various notions as to why they believe patients opt to consult traditional health practitioners, irrespective of the accessibility of western health care facilities and practitioners. The following reasons are attributed to individuals utilising the services of traditional health practitioners:

- Belief and trust in traditional health practitioners;
- Historical accessibility of traditional health practitioners;
- Lack of sufficient knowledge and understanding about HIV/AIDS among patients;
- Privacy offered by traditional health practitioners;
- Negative attitudes of western health practitioners towards patients;
- Promise of a traditional cure for AIDS;
- Inefficient western health care referral system; and
- Shared worldview and traditional theories of disease causation.

Two of the aforementioned attributes to the utilisation of traditional health practitioners were more prominent than others. These are further elaborated upon.

(a) A traditional cure for HIV/AIDS

Western health practitioners are of the opinion that PWAs are mainly lured to the consultation rooms of traditional health practitioners because of the hope of a "miracle cure", as opposed to the "no cure" message reiterated in the corridors of western health care facilities. On the one hand, traditional health practitioners believe that illnesses are curable through the correct diagnosis of the cause, which is often associated with supernatural phenomena. This belief leaves ample room for hope that, with the correct diagnosis of the cause of HIV/AIDS, one may be cured. On the other hand, western health practitioners unequivocally and unambiguously state that HIV/AIDS still remains incurable. Faced with two contradictory views about HIV/AIDS, PWAs are believed to opt for the practitioner that offers some glimmer of hope that they will return to their normal state of health (HIV-negative).

(b) Inefficient western health care system

The reported absence of an intermediary level of care (district hospital) between primary health care clinics/community health centres and the tertiary hospital in Buffalo City, is perceived to contribute to the influx of patients to traditional health practitioners, who are perceived as the only other alternate health care providers. According to national referral policies, the typical referral chain consists of three levels of care, namely primary (clinic/community health centre/day hospital), secondary (district hospital) and tertiary (provincial hospital). The reported absence of a district hospital in Buffalo City interrupts the referral chain, with negative repercussions for patients. In other words, patients who suffer from an HIV/AIDS-related illness, but cannot receive the appropriate care and treatment at a primary health care facility, are typically not referred to the tertiary hospital, because they will reportedly not receive the necessary treatment and care due to their HIV status. Therefore, failure to receive appropriate treatment and care from the western health care system, often results in patients choosing to go to traditional health practitioners as their next best option.

The limited competence of and resources available to primary health practitioners in the absence of an intermediary referral facility (between primary health care facilities and the provincial hospital), diminishes a patient's health care options drastically, thus, driving patients to traditional health practitioners.

The negative attitudes of western health practitioners, privacy and unlimited time offered by traditional health practitioners per consultation were reiterated as contributing factors to the high utilisation rate of traditional health practitioners. The following response serves as example in point:

WHP[32] 1: - "Patients get to traditional healers and find that the atmosphere is so conducive and they feel comfortable. If we (western practitioners) could change our attitudes … how we treat our people … the way we speak to them, we can win society in that way".

7.2.2. Traditional healing: beneficial or not?

Western health practitioners are divided in their stance on whether or not traditional healing has any benefits, as well as on the nature of benefits. By and large, the benefits of traditional healing are perceived to be directly proportionate to an individual's belief in traditional healing, more especially in the theories of disease causation upon which the traditional healing system is founded. Some western health practitioners believe that traditional healing is beneficial only in addressing psychosomatic and psychological aspects of illness, as opposed to providing scientifically significant physiological changes in the health of patients. This notion is evident in the following responses:

WHP 1: - "Definitely, psychologically it does help a lot, because clients get the attention from a traditional healer that they want. That in itself is of value, in addition to their little concoctions. There is something called the placebo effect which means something will always work as long as you believe that it does".

WHP 2: - "It's what you believe in that heals you. I believe that panado works, but my husband will say that I should not give him panado, because it doesn't work".

WHP 3: - "People believe in traditional healing. It's all about psychology. I am sure that if we could come together and for there to be intersectoral collaboration, not so many people will die, because they will get more comprehensive help".

Other practitioners believe that traditional healing has the ability to effect physiological changes to the benefit of patients. This notion is based on scientifically unexplained physiological relief of the symptoms of illness in some patients. At the same time, some western health practitioners are of the opinion that traditional medicine is more effective in treating certain illnesses, such as cancer, than western medicine. The following responses are examples in point:

WHP 1: - "You will find that from time to time you meet a patient who will tell you that they had certain symptoms and that they went to a traditional healer and this and this happened. And you cannot explain it either, but you will find that this person did get a cure for whatever he/she had. I even remember a patient of mine who had breast cancer. She said that she had been to doctors, hospitals … wherever, wherever, and they couldn't see anything wrong with her. She went to a traditional healer who diagnosed her with breast cancer and treated her. When she came to me …

[32] WHP = Western health practitioner

not that the traditional healer had cured her, but she had less severe symptoms … she had a sepsis and this big ulcer which was evident that she had cancer".

WHP 2: - "What I see is that these herbs that they claim cure HIV/AIDS are in actual fact boosting the immune system, because patients come to them weak and frail, and then they become stronger after getting treatment from them. However, they give them (patients) false hope by making them think that they are cured".

WHP 3: - "In my view, cancer is mostly treated best by traditional healers, which is why we should collaborate with them. Sometimes, western doctors do not see what is wrong with a patient. They will tell you that they have looked and looked and looked, but cannot see anything wrong. But, when that person goes to a traditional healer, the healer will diagnose him/her with cancer and treat them thereafter. This does happen sometimes. This is why they need to get together and collaborate".

In summary, traditional healing is seen as beneficial only in as far as it provides some sort of psychological relief for patients who believe in traditional healing, more especially in the theories of causation pertaining to illness and health, which form the backbone of the traditional healing system. However, observations have been made, which point towards evidence of immune boosting effects of traditional medicine, which have not been clinically substantiated.

7.2.3. Disadvantages of traditional healing

A lack of sufficient knowledge about HIV/AIDS amongst both traditional health practitioners and PWAs who consult traditional health practitioners appears to be the most salient problem associated with the traditional healing system in Buffalo City. Harmful treatment regimens and delaying seeking appropriate health care when prescribed traditional medicines do not produce the desired results are two of the most severe consequences of insufficient knowledge about HIV/AIDS among traditional health practitioners, followed by psychological torment when clients are made to believe that they can be cured through traditional healing, and thereby increasing the workload of primary health care practitioners, as well as destroying interpersonal relationships of patients who need a strong social support system.

(a) Harmful treatment regimens

The typical traditional treatment regimen for patients who present with an HIV/AIDS-related illness (diagnosed as HIV-positive either by a western practitioner, or traditional health practitioner), is the use of enemas and inducing vomiting (cf. paragraph 7.1.6), as reiterated in the following response: *"There are a group of people who believe very much in traditional healers, in so much that they undermine western medicine. They will say that traditional medicines will cure them and they will be healed, because those medicines are good and they are strong because they make them vomit and have diarrhoea, which will excrete the illness in them"*. The danger of this treatment method is that it exacerbates dehydration in already emaciated patients, thus, causing more harm than good. Furthermore, some of the traditional medicines used by traditional health practitioners further destroy the immune system of HIV/AIDS patients due to the strength of their reaction. Some traditional health practitioners are also

accused of discouraging patients from using western medicines once they have started traditional treatment. As a result, the patient's health deteriorates to the extent whereby either the traditional health practitioner refers the patient to a western health care facility, or the patient refers himself/herself to such a facility as a last resort. Unfortunately, this referral often takes place once the patient is in the final stages of illness when the chances of successful treatment have been minimised drastically. This problem is best expressed by the following responses:

WHP 1: - "They keep their patients even while their patients are deteriorating, instead of bringing them to clinics or hospitals, until the patient dies. Or else, they only bring the patient to a clinic or hospital once the patient is obviously dying".

WHP 2: - "I've seen patients who have been emaciated badly, and when I ask them where they have been, they say that they were in this sangoma's hut for the past two months and now they have given up. They come here as a last resort. Patients who come here from traditional healers arrive here terminal".

WHP 3: - "Some children who are diagnosed as HIV-positive are under-age. Because they are under-age, and many parents are still from the old school of thought where traditional healers are believed to be the best source of help, they end up taking their children to traditional healers first, and that is where the children start experiencing problems. What happens is that by the time the parents find out that the children are HIV-positive, it is already too late. By then, time has gone by and the children's health has deteriorated too much".

(b) Delaying seeking appropriate health care

Prolonging seeking appropriate health care when traditional treatment does not produce the desired effect, can be perceived as a manifestation of a sense of denial of one's HIV status. This sense of denial is reportedly sustained and nurtured by traditional health practitioners' lack of sufficient knowledge of the complexity of HIV/AIDS. A sense of denial of one's HIV status creates room for the belief that one will return to one's natural state of health (absence of disease). This belief is supported and fuelled by the notion held by traditional health practitioners who participated in the study, namely that all recurrent illnesses/diseases have a supernatural cause. Based on the correct diagnosis and, thus, adherence to the appropriate treatment (corrective action), all diseases/illnesses are curable. The following responses are indicative of a fuelled sense of denial of HIV status by PWAs:

WHP 1: - "I know of a professional nurse who died at a traditional healer. She was my friend. For a professional nurse to run to a traditional healer means that they are in a state of denial where they do not want to admit that they are HIV-positive. They deny it up to the last end".

WHP 2: - "Sometimes patients are diagnosed as HIV-positive, but they do not even start to take the treatment and health/nutritional education that we give them after their diagnosis. Instead, they believe that they do not have HIV/AIDS, Instead, they see it as a sign that they should perform a ceremony to their ancestors – 'isiko'. Or else they say that they do not have a white (western) illness, but a family illness (traditional illness). That is why I say that patients run to herbalists, because they are in denial about their HIV status".

Also problematic, and related to traditional healing, is denial of the implications of being HIV-positive, namely having to live with the illness for the rest of one's life. Traditional health practitioners who propagate that all illnesses can be cured through the appropriate corrective action, provide a scapegoat for PWAs who are not willing to accept a life-long illness.

(c) Increased workloads and negative psychological effects

The adversity of claims of traditional cures for HIV/AIDS is evident in the number of patients who reportedly insist on multiple HIV tests after undergoing various traditional treatments to cure HIV/AIDS. In addition to increasing the workload of western health practitioners who have to repeatedly counsel and test the same patients, as insisted upon by the patients, and as advised by traditional health practitioners consulted, the psychological turmoil and emotional torment experienced by the patients upon receiving the same HIV-positive result after each test remains unparalleled. The following statement is case in point: "*For example, a person will be tested positive the first time, then they return for another test and again for a third test. When you ask them why they are repeating the test, they will tell you that they are testing repeatedly because they have heard that there is a specific herbalist that cures HIV/AID. So, they decided to go themselves. They will tell you that when they went to him, they told him that they were tested positive and even showed him their results. Now they have to come back for another test to confirm that they are cured, because they have completed his treatment. When you test them, the results come back positive again*".

(d) Destroying interpersonal relations

Traditional health practitioners are also said to compound volatile interpersonal relations within households, and between households in communities, by attributing the symptoms of HIV/AIDS to witchcraft or malevolent magic. In the case where witchcraft is the cause of illness, there is typically an accused who very often is someone known by the ill individual. During consultation with a traditional health practitioner, the identity of the accused is either revealed descriptively, or through course of events which implicate a specific individual. Attributing the cause of illness to witchcraft only serves the purpose of aggravating the emotional and psychological repercussions of HIV/AIDS, by straining relations between the person living with HIV/AIDS and his/her relatives, friends, neighbours and colleagues, who are usually implicated in the process of identifying the cause of illness. This adverse effect of traditional healing is best described by the following statement: "*Instead of people supporting each other, they end up looking at each other suspiciously, because they believe that some people bewitch others".* This finding is substantiated by literature about the interpretation of HIV/AIDS by traditional health practitioners. Very often, illness is believed to be a manifestation of witchcraft, and rituals are performed to cast away evil spirits. This results in strained human relations in communities, since neighbours and relatives are named as witches (Shabalala 2003).

In essence, the acclaimed physical and psychological benefits of traditional healing for individuals who utilise this health care system are matched with grave consequences. The identified negative repercussions of traditional healing are indicative of weaknesses in the traditional healing system, which often outweigh and ultimately undermine the benefits of this system. It is, therefore, imperative that these weaknesses are addressed urgently as a means to improve the standard and safety of traditional health care for those individuals who, by choice, utilise this health care system.

""There is a bit of a problem when it comes to us traditional healers collaborating, because we do not work the same way. We have all been trained in a different way. We will not be able to collaborate".

- Traditional health practitioner 2004

Chapter 8

TRADITIONAL HEALTH PRACTITIONERS: ORGANISATIONAL AND INFRASTRUCTURAL DIMENSIONS

This chapter reports on the organisation and infrastructure of the traditional healing system in the research area, with specific reference to impediments to the unification of traditional health practitioners into a legitimate and professional body. These findings bear fundamental importance for efforts aimed at integrating traditional health practitioners into official HIV/AIDS-related programmes and services. This chapter also reports on traditional health practitioner perceptions about their legalisation and professionalisation.

8.1. Discussion of findings

8.1.1. Collaboration between traditional health practitioners

The presence of collaboration between traditional health practitioners was mainly reported by practitioners who were registered with the national Traditional Health Practitioners Association. Traditional health practitioners who were not affiliated to a traditional health practitioners association did not perceive any collaboration taking place between traditional health practitioners, although the very same practitioners reportedly practised as a group, occasionally. Seemingly, three fragments of traditional health practitioners are identifiable, namely (i) traditional health practitioners who are registered with the national Traditional Health Practitioners Association of South Africa; (ii) traditional health practitioners who are not registered with the Traditional Health Practitioners Association of South Africa, but enjoy membership with another traditional health practitioners association; and (iii) traditional health practitioners who are neither registered with the Traditional Health Practitioners Association of South Africa, nor with

any other traditional health practitioners association. Of the twenty respondents who were interviewed for the study, nine traditional health practitioners were registered with the Traditional Health Practitioners Association of South Africa, ten traditional health practitioners were not registered with any traditional health practitioners association, and one traditional health practitioner was not registered with the Traditional Health Practitioners Association of South Africa, but enjoyed membership with another traditional health practitioners association. It is apparent from the negative responses expressed towards the other by both traditional health practitioners registered with the Traditional Health Practitioners Association of South Africa, and those who are not, that segregation and deep divides between the two groups remain intact. This deduction emanates from the following responses made by traditional health practitioners from all three segments of traditional health practitioners:

THP 1: - "The problem is that our traditional healers are fragmented. They move in cliques. There was a certain gentleman that was in the forefront of traditional healers here in the Eastern Cape. I tried to get closer to him and other traditional healers that were with him, but when I came to it they had disappeared. There is a lack of organisation and collaboration amongst traditional healers in the area. There is no action-plan that traditional healers have to try to improve the health status of their communities. I tried to start fund-raising initiatives which involved each traditional healer contributing a specific amount towards a fund that would be used for various community activities such as feeding and housing orphans, ill people, etc. They agreed but did not put the plan in action".

THP 2: - "Our association is called the Traditional Medical Practitioners Association. Here in the Eastern Cape, this is the only traditional healers association that there is. Any others are illegitimate. All the nine provinces belong to this association. It is something that we all came together for in 1995 in Umtata. Only people who belong to our association participate in events that we plan. Anyone who does not belong to our association does not succeed in anything. We do not include them in anything until they register with us".

THP 3: - "Traditional healers do collaborate well. We collaborate by, I speak for myself, if someone comes to me and I see that I will not be able to treat this person I take that person to another traditional healer instead of doing what I do not know. If I also do not know who would be able to assist a person, I tell them to rather consult someone else, because I cannot help them, nor do I know anyone who could. We tell each other at meetings … because we have meetings every Tuesday … that we must work together, because you cannot do something alone … you cannot cure and treat everything on your own. We talk about this continuously at our meetings. Traditional healers from our association (national) attend these meetings. Those who have not yet joined, do not".

THP 4: - "I am no longer a member of the national association because there is not really anything that associates me with it right now".

THP 5: - "There is no collaboration between traditional healers. We only put each other down, that is all. They (traditional health practitioners) come up with associations which say that we must come together, but you will discover that these associations of theirs are just formed. But they are of no use or assistance. Even now, they are in associations, but are still not working together. They are just putting each other down … in these associations".

THP 6: - "Traditional healers only collaborate when they have to go perform rituals somewhere. There is no other significant collaboration between them. These associations do not play any role. They are just a means for people to get certificates for practising traditional healing. These associations are encouraging the practice of

charlatans, because everyone joins so that they can get a certificate even if they do not know anything about traditional healing. So that they can have people who will confirm that they are really a traditional healer, because they have joined the association. The associations do not first evaluate the members before they issue certificates, because they are a business and certificates are sold".

THP 7: - "We do collaborate as traditional healers. For example, if I get a patient and I do not know what to do, I will go to another traditional healer and tell them. They will then advise me what to do. But this only happens amongst people who get along well and not amongst everyone".

THP 8: - "I would not say that there is collaboration between traditional healers in Buffalo City, because we have not met with them as yet. As you can see, the people that just left here are also diviners but have come to us for help. Yes, they may be some sort of collaboration, but not the type that we want".

THP 9: - "I have not seen much collaboration between traditional healers in Buffalo City. I would like to see it. I wish all traditional healers could come together so that we can come up with a medicine for HIV/AIDS that will be administered to people with HIV/AIDS".

THP 10: - "We as traditional healers collaborate very well. We ask each other for advice about how to treat our patients. We consult each other about medicines, especially those for treating HIV/AIDS".

THP 11: - "Traditional healers collaborate well. There isn't even jealousy amongst us. If one traditional healer is overcome by something they know that there is another traditional healer over there that they can go to and ask assistance and advice from. We do not only collaborate as members of the same association of traditional healers. If you know of a traditional healer who has specific strengths that you may not necessarily have, you approach him/her for advice. Or else, if you have been treating a client and you realise that you are not making any progress, you go to another traditional healer who you know will be better able to help that person. You then accompany your patient there and in private tell the other traditional healer what your situation is and that you have decided to refer that patient to him/her. Whether you are in an association or not in an association, we traditional healers work together".

THP 12: - "We as traditional healers collaborate in the sense that we, as human beings …we have not all been given the same gift … we do not all do things the same way. We may be doing the same thing, but doing it in different ways. So, we traditional healers here in Buffalo City help each other. We go to each other for advice about our clients and if you do not have s specific medicine you can go to another healer to get medicine".

THP 13: - "We traditional healers do not collaborate with each other. What we do is that everyone of us has their own family medicine".

It appears that adequate collaboration between traditional health practitioners is perceived by a minority of traditional health practitioners. Perceptions of the existence of collaboration is essentially based on personal experiences of collaboration between small groups of traditional health practitioners, who either know each other or are affiliated to the same traditional health practitioners association, rather than traditional health practitioners in general collaborating on a larger scale. Sustained segregation and deep-rooted divisions between traditional health practitioners hamper collaboration between traditional practitioners, thus, undermining efforts to unify traditional health practitioners into an organised and legitimate profession.

8.1.2. Impediments to collaboration between traditional health practitioners

The majority of traditional health practitioners viewed collaboration between traditional health practitioners as vital. However, various factors were identified as obstacles to effective collaboration between traditional health practitioners. These obstacles included (a) the unwillingness of traditional health practitioners to compromise and accommodate the practices of other traditional health practitioners; (b) the reluctance of traditional health practitioners to admit their inability to treat specific ailments, and, thus, to refer to a more competent practitioner; and (c) competition and mistrust amongst traditional health practitioners themselves. These obstacles to collaboration promote fragmentation and deep-rooted divisions amongst traditional health practitioners.

(a) Unwillingness and inability to accommodate different practices of traditional health practitioners

Traditional health practitioners are trained by various trainers. The tendency is for trainers to utilise varying healing techniques and methods in their training. Therefore, the absence of a standard training programme for all traditional health practitioners results in traditional health practitioners healing in ways that differ from one another, based on the knowledge and skills of healing that they have acquired from their trainer. Seemingly, traditional health practitioners perceive their own healing practices as correct and any other practices that may differ from their own as incorrect. It is this perception that serves as a barrier to traditional health practitioners collaborating with one another, by rendering traditional health practitioners less accommodative and accepting of other traditional health practitioners whose methods of healing differ from their own. This argument is illustrated and substantiated by the following response:

THP 1: - "Other traditional healers class us because we wear the red and white beads and not the plain white ones that they wear. So, they do not see themselves as being one with us. Also, these Xhosa traditional healers do not bring their patients to live with them. They treat their patients while they live at their own homes. Therefore, their patients will never get well".

THP 2: - "We as traditional healers cannot work together. It would be right if we could work on our own, because we do not work in the same way that they do. They merely take medicine and give it to you to drink. They give you a bottle (medicine). Another one sells medicine for R30 a bottle. I can work with the other traditional healers of my trainer and where we have our place where we can lodge our complaints because we experience problems even from them (Xhosa traditional health practitioners). You will find that they have no idea what we are talking about, and you end up having to teach them. Our rituals for divining are different. They do not know our way of performing rituals. Yes, our way of doing things is different, but I would like us to meet".

THP 3: - "There is a bit of a problem when it comes to us traditional healers collaborating, because we do not work the same way. We have all been trained in a different way. We will not be able to collaborate".

(b) Reluctance to admit the inability to treat specific ailments/illnesses

Traditional health practitioners, generally, are of the opinion that they can treat and cure all illnesses. However, some believe that traditional health practitioners are bestowed with the ability to cure certain illnesses and not all. This is one of the reasons cited by protagonists of collaboration amongst traditional health practitioners as indicative of a need for traditional health practitioners to work in collaboration with one another in treating and curing illnesses

(cf. paragraph 8.1.1). The following responses point towards a perceived reluctance amongst traditional health practitioners to admit an incompetence to treat all illnesses:

THP 1: - "Even us traditional healers are arrogant towards each other. The one does not want to come down to the level of another. They (traditional healers) have that problem. When someone does not know something they will say that they do just because they do not want to bring themselves to another's level".

THP 2: - "This diviner that came to me has his own trainer, but that trainer did not say to him that she should come to me. They do not want to say, 'no', they cannot help with something, therefore, go to someone else. This diviner came to me on his own".

(c) Competition and mistrust amongst traditional health practitioners

Commercialisation of traditional healing by some traditional health practitioners is viewed as one other major impediment to effective collaboration of practitioners in this sector. Traditional health practitioners who heal for purposes of generating income (profitability) are reportedly reluctant to refer patients that they are unable to treat to another traditional health practitioner due to the implications thereof, namely the loss of potential income that accompanies such a referral. Similarly, traditional health practitioners may not assist a fellow practitioner who will gain in monetary terms from his/her assistance. The following responses outline the presence of competitiveness amongst traditional health practitioners:

THP 1: - "We are competitive … it's a competition".

THP 2: - "For instance, you are a traditional healer, and you know that I am also a traditional healer. However, no-one comes to you for help. We know each other and we are on speaking terms. I come to you for help, but you know that I get patients (money), but you do not. You may have the herb that I need, but it will occur to you that you must not give it to me because I will be getting the money. You may even think that by not giving me the herb, that patient may even end up coming to you".

THP 3: - "There are certain diseases that I cannot treat. That is why we need to come together and work together as traditional healers, but the fact is that we do not, because you are suspicious of me. The thing is that you are suspicious of me, whilst I can be of assistance to you. We do not trust each other".

8.1.3. Registration of traditional health practitioners with the National Traditional Health Practitioners Association of South Africa

The main association for traditional health practitioners in the Eastern Cape is the Traditional Health Practitioners Association, which is affiliated to the Department of Health. The association aims at amalgamating all past associations into one reputable association to represent all traditional health practitioners recognised by the South African government. Traditional health practitioners are registered by the Local Service Area (LSA) coordinator of traditional health practitioners in each LSA and the provincial coordinator of traditional health practitioners in the Eastern Cape. The LSA coordinator for traditional health practitioners in Buffalo City describes the procedure for registration of traditional health practitioners as follows: "*Traditional healers have to register with me using this registration form. To make sure that they are legitimate healers, I ask them questions to make sure that they are really a diviner, that they are really a herbalist, that they are really a traditional surgeon".* Registered traditional health practitioners are issued with a certificate as well as a license as proof of registration. Due to the large number of

traditional health practitioners' associations which are registered under the Companies Act, certificates alone are no longer regarded as sufficient proof of legitimacy. Surprisingly, only nine of the twenty traditional health practitioners interviewed were registered with this association. According to the provincial coordinator of traditional health practitioners in the Eastern Cape, a mere 20 traditional health practitioners in Buffalo City were registered with the national association on 06 October 2004. This translates into a small proportion of the total population of practising traditional health practitioners in Buffalo City.

(a) Reasons for non-registration with the national association

Traditional health practitioners' reasons for not registering with the Department of Health varied. Reasons given pointed mainly towards a lack of knowledge and understanding about the Traditional Health Practitioners Association, especially the main aim of the association, as well as skepticism about the benefits and implications of membership to the association based on previous experiences with similar associations. The association is viewed, and referred to by many traditional health practitioners, as the 'new Traditional Healers Association' (*Umbutho omtsha wo qhirha bemveli)*.

Of concern is the divergent opinion that traditional health practitioner associations are either (i) cliques, or (ii) opportunities to elevate one's status, or (ii) non-effective organisations, or even (iii) havens for charlatans - in all cases then, a far cry from the essentials of a professional association. The national Traditional Health Practitioners Association is viewed by some traditional health practitioners as an opportunity/means for charlatan traditional health practitioners to gain access to certificates that permit them to practise as *bona fide* practitioners. The association is also viewed by other traditional health practitioners as a means for members to pursue their own personal agendas, such as to occupy leadership positions in the association which grant them superiority profiles, and, thus, promoting power struggles within the association. Other traditional health practitioners believe that their ancestors, who had bestowed them with healing powers, do not support their affiliation to an association. It would appear that the reason for ancestral condemnation of such affiliation of their descendants is based on a preempted conflict of interest between the guidance of ancestors and the guidance of an association. One other reason expressed for non-affiliation to the "new" association for traditional health practitioners is a delay in manifest progress by the association. In other words, some traditional health practitioners' decision to register with the "new" association for traditional health practitioners is pending on the visible outcomes of the association, which they report not to have witnessed as yet. The following responses substantiate the aforementioned views of traditional health practitioners not registered with the national association for traditional health practitioners:

THP 1: – "We do not know this national traditional healers association, so we cannot talk about it. We are not included in it. We have not been told anything about this association. We went to Bisho to speak to the MEC of Health, because we had nowhere else to go to report a problem that we had".

THP 2: – "I am not aware of any local or provincial traditional medical practitioners association other than the national association, namely the World African Herbalist Association of South Africa".

THP 3: - "They (traditional health practitioners) do come up with associations which say that we must come together, but you will discover that these associations of theirs are just formed, but they are of no use or assistance. Even now, they are in associations, but are still not working together. They are just putting each other down in these

associations. These associations do not play any role. They are just a means for people to get certificates for practising traditional healing. These associations are encouraging the practice of charlatans because everyone joins so that they can get a certificate, even if they do not know anything about traditional healing. The associations do not first evaluate the members before they issue certificates because they are a business and certificates are sold".

THP 4: - "The reason why we have not joined the national association for traditional healers is because it is still something that is being discussed. I am still waiting for the meeting that is supposed to take place in March to get more information about the association, such as how to join, what happens after joining, and so forth".

THP 5: - "I am not a member of this new association for traditional healers. I've only heard about it on radio. Us traditional healers are not hasty. We first want to hear from others how something really is. We are afraid of starting something that we cannot finish. We first want it to be clear and for us to see how it works".

THP 6: - "I've heard about this new law for traditional healers and discovered that my father and grandfather were also approached by these associations and they did not join".

THP 7: - "I am not a member of this association, because I have not seen anything that it has done as yet. This association has existed for quite a long time now, but I have not seen what it has done yet. I have not heard of a single traditional healer who is in parliament. I have not heard of any traditional healer who is part of the hospital staff. It is still quiet".

Traditional health practitioners' who are already registered with the national association are critical of traditional health practitioners who are not registered. Their views regarding the reasons for the non-registration of traditional health practitioners point towards the harbouring of charlatans within non-registration, as well as resistance to change, even if such change is to their benefit. These views fuel segregation and division amongst traditional health practitioners, and, thus, also further hampers collaboration amongst traditional health practitioners. The following statements best illustrate the negative views of traditional health practitioners towards their fellow practitioners who have as yet not registered with the national association for traditional health practitioners:

THP 1: - "Those traditional associations of the past are the ones that have delayed the progression of things for traditional healers. People are stubborn. They are still going by the rules and regulations of the old associations. There were many associations in the past. Someone would rock up from nowhere claiming that he is the president of an association … that was in the past during the apartheid era. Whites would tell these so-called presidents to come up with some form of draft for an association and then approve that association".

THP 2: - "People who have not registered with our association are stubborn. Others think that this association is the same as the past ones where they will be cheated of their money but that is not so. People are just stubborn. We keep telling them that not registering is going to get them into trouble".

THP 3: - "We are trying, especially here in the Eastern Cape, to encourage all traditional healers to join this association. But, you will find some traditional healers who will tell you that they were not trained by an association, but they were trained by 'amawethu' (ancestors). Others have a tendency to ignore things whilst they are still being attempted, and when the attempts bare fruit, then only do they join in".

(b) Reasons for registration with the national association

The most salient reasons given by traditional health practitioners for registration with the Traditional Health Practitioners Association include working towards the unification of traditional health practitioners into a professional and recognised body; avoiding legal action associated with the death of a patient; facilitating collaboration between traditional health practitioners and western health practitioners; and ousting charlatan traditional health practitioners from the mainstream of traditional health care. In the main, traditional health practitioners express a need for collaboration amongst themselves in order to improve the status and quality of traditional health care *per se*. In the light of identified impediments to collaboration amongst traditional health practitioners, and the negative implications thereof for effective collaboration between traditional health practitioners and western health practitioners, registration of all traditional health practitioners with one association that is monitored by government, is viewed positively by traditional health practitioners who have already registered with the national association. It would appear that traditional health practitioners registered with the national association exhibit an indepth comprehension about the aim and objectives of the national association. The main purpose of the national association, as perceived by traditional health practitioners who are affiliated to it, is expressed in the following responses:

THP 1: - "The traditional healers association that is affiliated to government is trying to unite all traditional healers, so that we know each other".

THP 2: - "For instance, someone will bring a patient to me and I can see that this person is dying, and nothing more can be done for him. The person that has brought the patient will beg me to help them saying that they know my healing powers. I, as a traditional healer, will mix water with anything to make it look like medicine just to please the person, because I know that there is almost no life left in the patient. I ask the patient to open his/her mouth and as he/she swallows he/she takes his/her last breath and dies. The person who brought the patient runs outside screaming that I have killed the patient. The police are called and the first thing they ask for is whether I have been registered. If I have not, I go straight to jail. The police must know whether you have been registered or not. The certificate is not sufficient proof of registration. You must have a card licence as proof of registration".

THP 3: - "Government is saying that we as traditional healers need to come together so that we can collaborate with western practitioners … so that we can have our own place. As soon as we are all registered and we have our licence numbers, they can be submitted to hospitals so that when they look on their list at the hospital, they can see that so and so can cure a specific illness and this person here is beyond us … we do not know what else to do … then that person can be sent to a specific traditional healer on the list".

THP 4: - "There are still many people who register traditional healers according to the old way and disregard what government says. They say to people "just give me R300 and I will give you a certificate". The problem is when a patient dies and the authorities want to see your certificate. If you do not have the one issued by the national association affiliated to government, you go straight to jail. Whereas, if you had joined the national association and followed the correct procedure, there would be no reason for you to go to jail, because that person would have died the same way that they would have had they been in hospital".

8.1.4. Views about the Traditional Health Practitioners Bill[33]

Traditional health practitioners expressed enthusiasm about the Traditional Health Practitioners Bill. However, their enthusiasm and support of the Bill was based on a perceived need for traditional health practitioners' rights to be protected and their profession legalised rather than on the actual content of the Bill itself. Knowledge about the stipulated objectives of the Bill and the implications thereof for traditional health practitioners were lacking, as illustrated by the following response: "*I see the new Act to legalise traditional healers as something good. I see it as something good even if I don't know what it is".* Seemingly, information about the Bill has not been disseminated utilising a planned and broad-based strategy. Knowledgeability about the Bill is more prominent amongst traditional health practitioners who are registered with the Traditional Health Practitioners Association than those who are not, as can be deduced from the following responses:

THP 1: (member of national association) - "We, who are registered, already know about the Traditional Medical Practitioners Bill and we are encouraging it. We are still trying to explain it to others who are not in the mainstream as yet".

THP 2: (member of national association) – "I do not have any objections regarding the new law for traditional healers. Even when they told us about it in Bisho, I saw it as a good thing. They called all traditional healers to this meeting in Bisho (mid 2003). There were people from Johannesburg as well. They were telling us about the new law and how it would work. Things such as what to do when you admit a patient. You shouldn't just take someone without first enquiring about who that person has consulted before coming to you. Perhaps the medication that that person has received from the other person that they consulted before coming to you is strong, or your medicine is stronger, and so forth. That person may die whilst with you and you did not enquire about these issues. You must first enquire about a person's history in terms of where he/she went to for health care and what he/she was given before coming to you, so that if the patient dies, you know what to do and you have a record of the type of help he has received before dying. This covers you legally. I liked what I was told about this law, because it opened up our minds about cases that often happen to traditional healers. These things make us more aware and cautious".

THP 3 (not member of national association) – "I've heard about the new law for traditional healers, but just on radio when they were talking about it".

THP 4: (not member of national association) - "We haven't heard about the new law for traditional healers. The problem is how does it guide traditional healers? It should be something that will improve, but I do not know how. We will agree with a law for traditional healers if that law is right. If it suites us".

THP 5: (member of national association) - "We have not heard about what the new law says … about how we are going to collaborate".

Two main perceptions about the value or advantage of the Bill[34] is that (a) it will grant traditional health practitioners legal status and (b) it will grant traditional health practitioners equal status with western health practitioners, thus facilitating collaboration between practitioners of the two genres of health care.

[33] At the time of data collection, the Traditional Health Practitioners Bill had not yet been enacted. Hence, reference to the Bill and not the Act.
[34] At the time of data collection, the Traditional Health Practitioners Bill had not yet been enacted. Hence, reference to the Bill and not the Act.

(a) Legal status through the legalisation of traditional health practitioners

Traditional health practitioners have practised as such without a legal framework to guide them or to uphold their rights as health practitioners. The absence of legislation in the traditional healing sector has resulted in various negative repercussions for traditional health practitioners, two of which are the inability to protect themselves in disputes related to their profession with both clients and society at large, and the inability to practise uninhibited. The Bill is also viewed as a mechanism to protect the indigenous knowledge of traditional health practitioners in collaborative relationships with western health practitioners. Hence, the Traditional Health Practitioners Bill[35] is viewed as emancipating traditional health practitioners. Responses of traditional health practitioners point towards anticipated benefits of the Bill for the traditional healing sector at large, as evident from the following statements:

THP 1: - "One of my problems which I need assistance with is clients who do not pay after they have been cured. The type of help that I require would be to be told to go to a certain place for help regarding this matter, because going to lawyers about an ill person … I do not want them to be arrested. Legalising traditional healers will help a lot with this matter, because you will know who to turn to … a shoulder to cry on. Because, really, to take someone who you are treating all the way to court is out of the question. If there is a council for traditional healers where you know that, if someone has paid you, you should go to that door, and then that council will take your statement and reach their conclusion after which they will approach your patient as a council for traditional healers and ask them to pay you what they owe you. I would accept such a council very much".

THP 2: - "This Bill is going to help us, because it is going to put an end to it being said that our medicines are dirty, because our medicines do not get processed or put into machines. It is also going to help us stop those people who are stealing our indigenous knowledge and selling it to outsiders".

THP 3: - "Legalising of traditional healers will be of great help to us. Because, if I'm walking next to a farm and I see a herb/root that will help me in my healing, I won't be able to pick that herb/root, because the owner of the farm will arrest me. Whereas, if there is a law that protects traditional healers, it will remove a lot of barriers that are in our way. If we could have legal standing even we will be able to do a lot more things, because right now our hands are tied. We cannot even say we are going over there to the forest to get medicines, because we fear being arrested".

THP 4: - "I think that the new Act for traditional health practitioners is a very good thing, because someone will come to you with a problem and you will treat them whichever way that you treat them, or whichever way that they need to be treated. Then the person is cured. Now, we have what is called 'imvula tasi' (opening of calabash/bag). You may, for instance, charge a person R100 for 'imvula tasi' so that they can register. Then you treat the person. Then, when the person feels better, you will find him/her walking around saying that they were cured here, there, and everywhere, knowing that you were the one that cured them. In that case, there is no place that we traditional healers can go to for assistance. All we can do is go to our consultation room and say to our ancestors that so-and-so came to us for treatment and we treated them, now they have run away with our cow (payment). This has happened to me many times. I would go to a home and spend the required number of days performing the necessary rituals. Thereafter, I would be thanked and then told that they do not have the money to pay me so it will follow at a later stage, which it never does. This is after the rituals have been

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completed successfully. There is nowhere where I can run to in such instances. I really wish this new Act could be put in place so that traditional healers can be protected".

THP 5: - "This new law for traditional healers is going to help us a lot. I once got a young man who was completely mad … he was good enough for Fort Beaufort. I took him and brought him to my trainer, because I was still working because I had to feed my children and send them to school. The young man's mother was not employed and was as poor as they come, but she wanted her child cured. When she heard what her child was suffering from and that it was the family illness - 'umsholoku', she decided that she also had to get involved and help her son. I took my last cents and brought her here to my trainer. She stayed a week and in the second week she got a job as a nurse. She is still a nurse as we speak and her son was cured, but we never saw a dirty cent for our work. Just think, for doing this type of ritual, you have to pay R2 000, not for the traditional healer, but to perform the ritual. This new law will help us a lot because there is no place for us to complain to. If you go to a lawyer you need money. The police … it's a long story … they do not want to get involved in a relationship between healer and patient. It's a disgrace! Police need proof of everything. Where is the proof going to come from. Where am I going to get money from … where am I going to get a brick to build a place for me to work from … who am I going to complain to, because I have no-one to defend me".

THP 6: - "Other traditional healers are exposed to dangerous situations such as having to collect medicinal plants in forests. Perhaps this new law and legislation of traditional healers will improve conditions for traditional healers".

(b) Equality between traditional and western health systems and practitioners

Traditional health practitioners do not share equal status with western health practitioners. The former are generally granted an inferior status relative to the latter due to the absence of professionalisation of the traditional health care system. This trait is long standing and has been to the detriment of the traditional health care system, which, as a result, has been frowned upon as ineffective and primitive. It is in this light that traditional health practitioners perceive the Bill[36] as a significant stride towards professionalising the traditional health care system and, thus, granting this cadre of health practitioners equal professional status as their counterparts, namely western health practitioners. The following responses substantiate this notion:

THP 1: - "We would like government to legalise and professionalise us, because there are a lot of things that we can treat that we are sure western doctors cannot treat".

THP 2: - "We are afraid of doing a lot of things, because we are afraid of being arrested. We cannot even register our patients in a file … this thing that western doctors do … because we are afraid of doing the wrong thing and being arrested".

THP 3: "In the years to come we will be free; free to heal people, because at the moment our hands are tied. Even when our ancestors have given us the gift to heal a specific disease, you will only get one such person, because the rest have been held up somewhere. Being held up, I mean that they are not told to go to traditional healers to get help. That is why we wish they would free our hands so that our role could be made visible. We are not thirsty for money. We are thirsty to help people. We must also be able to go into hospitals like western doctors. It must not be the case where we go into hospitals to volunteer and not get paid. We should also be paid, because we are

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providing a service. There are many traditional healers in this region who are thirsty to help people, but they are tied down because they are not known".

The introduction of legislation for and legalisation of the traditional healing sector is automatically associated with a support hub for traditional health practitioners. It is assumed that the Traditional Health Practitioners Bill will serve the needs of traditional health practitioners, and instill a sense of respect, dignity and professionalism for these practitioners amongst western health practitioners and society at large. Of concern is the fact that the perceived benefits of the Bill for traditional health practitioners are based on assumptions and not facts. Traditional health practitioners, generally, are not knowledgeable about the content and implications of the Bill. Seemingly, efforts to create awareness and educate traditional health practitioners about the Bill were either not embarked upon or did not have the intended effect. The researcher strongly anticipates major opposition to the Bill from traditional health practitioners once its content is fully disclosed to them. The content may even be viewed as contradicting the views of traditional health practitioners about the perceived benefit of the Bill for the traditional healing system. In other words, the Bill is viewed as an emancipation of traditional health practitioners who will, as a result, be able to practise uninhibited. However, the nature of the Bill is to regulate and control the traditional healing sector.

8.1.5. Traditional health practitioners views about Government

The so-called "new" government, which came into power in 1994, is generally regarded as supportive of traditional health practitioners. This view emanates from the various efforts which the ANC-led South African Government has embarked upon to include traditional health practitioners into the mainstream of health, such as the initiation of legislation for the traditional healing system, attempts to initiate collaboration between traditional health practitioners and western health practitioners, as well as national discussions and debates about traditional health practitioners, which currently feature on government agendas. These are perceived as positive changes introduced by the government of the new dispensation. Nevertheless, traditional health practitioners are still of the opinion that these government efforts are a far cry from what is required to ensure the full recognition of traditional health practitioners. The following responses are indicative of views about perceived changes, or lack thereof, introduced by the post-apartheid government in favour of traditional health practitioners:

THP 1: - "Before the new democratic government, traditional healers were not respected. They were not seen as people who help … people with knowledge. They were looked down upon. When the new government came into power, they saw that these people who heal according to the traditional way also have a contribution in the health of people. In the past, traditional healers used to be interrogated".

THP 2: - "There is a difference since the new government came into power, because before 1994, traditional healers were afraid to follow up on their patients who were hospitalised. Now, we can go into hospitals and see how our patients are doing, so that we can see if there is anything that we can give them to further help them. Whereas, in the past we were not allowed to go into hospitals at all. When the old government was still in power, western doctors and nurses did not see us as helpful or resourceful. At least now they are more accepting of us. I say so, because I was elected to be on the clinic committee in our community. That is where I was dealing with the clinic sister. The committee met twice a month and we discussed the issue of government wanting traditional healers to collaborate with western doctors".

THP 3: - "There is a big difference between the previous government and new government. The new government has spoken about traditional healers even though they have not given us a chance to prove ourselves yet. They have accepted traditional healers, and they have initiated an association for traditional healers. At least this government has made some change on the side of traditional healers".

THP 4: - "Ever since the new government came into power, and we are now moving towards us being allowed into hospitals, it is now that black people will get clarity on which direction they are moving in. I think traditional healers have a bright future".

THP 5: - "There is a difference in the way traditional healers are treated since our new government came into power. Our government is treating us well because we can stand up and speak for ourselves. We ask when we do not understand something, I can see a difference. A big one at that!".

THP 6: - "Things have changed since the new government. In the past traditional healers did their own thing. Now, we have to work together. We have to have our own association, and we have to work with government".

Despite the majority of traditional health practitioners' views on the positive changes brought about by the democratic government, some traditional healers beg to differ. Views to the contrary emanate from the perceived absence of measurable and visible support for traditional health practitioners from the side of Government. Seemingly, verbal support that is not translated into action does not suffice for some traditional health practitioners, as expressed by the following responses:

THP 1: - "I have not seen any difference in the situation of traditional healers since the new government came into power. We will say that there is a difference once we see them working and collaborating with us. They just keep calling us, but there is no difference. A difference will be if the things that we ask for are made visible. We should not ask for things and then nothing happens. Right now, it is all just talk, but no action. At times, the majority of us become despondent because we are constantly called upon to listen but nothing ever happens after that. Sometimes even when we are called now, we become disinterested".

THP 2: "There is no difference that I have seen for us traditional healers since the new government came into power in 1994".

THP 3: - "It appears as though government does not trust traditional healing. It is as if they prefer western medicine to traditional healing. Government says that they accept traditional healers, but they do not give us an opportunity to prove ourselves".

Although traditional health practitioners are not clear about the distinction between national, provincial and local government pertaining to their specific roles and responsibilities to traditional health practitioners, local government tends to be viewed as representing all three spheres of government. Generally, local government, represented by councillors, is viewed as unsupportive of traditional health practitioners. This notion is mainly based on views of councillors as expressing indifference to traditional health practitioners; failure to include traditional health practitioners in the health care referral chain, even if informally; failure to assist traditional health practitioners with infrastructural needs; and failure to effectively protect the rights of traditional health practitioners and eliminate their stigmatisation in certain communities. The following statements are an expression of traditional health practitioners' views of the role that Government is playing in rendering support to the traditional healing system:

THP 1: - "Traditional healers should be known even higher up and not only by the village people. It is slightly difficult in urban areas, because there are no traditional leaders. Even the councillors are difficult to work with. We tried to get the councillors together at one of the clinics here, but they did not come. Why? They have no interest in this thing. They are only interested in floating around being called councilors, but there is nothing that they are doing for the people. That is the problem that we still have here in the urban townships. In the rural villages, things are progressing, especially in the Transkei".

THP 2: - "We wish for a place where we can say, this place, especially for those who have HIV/AIDS. I went to the mayor of Buffalo City, but he still has not responded. I also went to one of the councillors in the Amatole District Municipality, but I am still waiting for a response. I also contacted someone from the Premier's office and he promised to call me, but I am still waiting".

THP 3: - "Yes, I know that government is waiting for us to combine as traditional healers, but it will help if government could push from behind for this to take place quickly. The reason why some people are still resistant/stubborn is because they do not hear government's footsteps from behind. In other places such as Cape Town and Durban, they all speak with one voice, but that is not so here in the Eastern Cape. Government should put pressure on people to do away with the past associations which took people's money and encourage them to join the national association that is affiliated to government. People are still part of other associations, because government is not firm about doing away with these associations".

THP 4: - "We should be experiencing democracy, but there are those people who are in the forefront who are taking everything for themselves and neglecting us. We are supposed to have received many things but cannot, because of these people that have been put in the forefront. We have no relationship with local government. I do not even know who my councillor is".

THP 5: - "In my view there is no collaboration between local government and traditional healers. There is nothing that links us to them. Local government does not show any interest in traditional healers. We do not want to be used by government for fun and entertainment purposes. What we want is to collaborate in healing people. Fun will follow".

Very few traditional health practitioners perceive Government as playing a facilitative role in promoting collaboration between traditional health practitioners and western health practitioners. Perceptions of Government playing a supportive role in this respect are mainly based on traditional health practitioners' involvement in clinic committees, and availing of public venues for traditional health practitioner meetings. The scarcity of active clinic committees in Buffalo City is of concern.

It is imperative that traditional health practitioners change their negative views of Government, which is represented by councillors. Government is the designated facilitator and coordinator of the process of integrating traditional health practitioners into the realm of health care through initiating successful collaboration between traditional health practitioners and western health practitioners. Hence, the importance for traditional health practitioners to view Government as supportive of their integration into the official health care system through both the promulgation of traditional health practitioners, and actualising their integration into the health care system itself. Endless discussions of integration without any visible action to this effect will in the long run jeopardise collaboration between traditional health practitioners and western health practitioners by rendering Government untrustworthy in

the eyes of traditional health practitioners, and also evoke sceptic views about Government's intentions for traditional health practitioners.

8.1.6. Perceived needs of traditional health practitioners

Traditional health practitioners reported various factors which they perceive to prohibit them from rendering traditional health care of a satisfactory standard. The most predominant impediments expressed by traditional health practitioners to effectively treating patients include a lack of (a) appropriate infrastructure to render traditional health care of a high quality and standard; (b) standardisation of traditional healing practices; and (c) information and training. An elaborate discussion of the perceived needs of traditional health practitioners towards improving the quality of traditional health care follows.

(a) Infrastructure

Three types of infrastructural needs were identified, namely traditional health care facilities; administration facilities for traditional health practitioners; and facilities for producing, processing and packaging traditional medicines.

- *Traditional health care facilities*

Adherence of patients to prescribed traditional treatment and medication is viewed as critical to successfully curing a diagnosed illness/disease. However, the tendency for patients to default from prescribed regimens, as well as the need for 24-hour traditional care for some of their patients hinder the success of traditional healing in many cases. Most traditional health practitioners do not have adequate facilities to render 24-hour care. Some traditional health practitioners reside in informal settlements plagued by overcrowding, lack of adequate sanitation and clean water, as well as insufficient space. The inability to "hospitalise" patients who require constant monitoring and care is a major concern for many traditional health practitioners. This concern is evident in the following responses:

THP 1: - "I do not give anyone medicine to take home with them. I make them stay here at my place and treat them while they are here, because I have to make their medicine and administer it to them there and then, and sometimes I change the medicine accordingly".

THP 2: - "Our problem is that we do not have places which we can use when someone comes to us with AIDS. Where are we going to admit them? Because when this person arrives we must have a place where this person can sleep. Why? This person is not going to use your bed, he/she is not going to use your toilet, or your things to wash with. That person must have his/her own place. Where are we going to get that place, because we do not have money and government does not give us anything. Because us traditional healers must be hygienic and tidy, but look at this place that I am living in. How can you be hygienic in a place like this? How can you let a sick person stay in a place like this? Because, if you let a sick person stay here other illnesses will enter him/her, more especially because it is damp here".

THP 3: - "Some traditional healers do not even have proper houses. The only reason why I have a proper house is because I am a teacher. Other traditional healers do not even have houses, because they do not charge much for their services. A traditional healer may ask for one cow … two hundred rand (R200) after bringing someone back from the dead. Then they have to spend that money on their children".

THP 4 - "Now we are trying to get a place where a patient can be admitted and treated so that the patient does not take his treatment/medication home, because sometimes when you tell the patient to take a spoonful of medicine, the patient will get home and think to himself that a spoonful is too little, and end up taking about three spoonfuls, which will end up killing him/her. Now, if a patient is admitted and there is someone, more especially those people who are HIV-positive, you can say to that person, look so-and-so, look after these people and give them their treatment at specific times. You cannot ensure this if you give patients their medicine to take home. Other times you give a patient medicine and tell them to use the medicine in a specific way. When the medicine does not taste nice to the patient, they will stop taking it, leave it there and just keep looking at it instead of taking it as instructed. Then they go around saying that they were not cured. If we had a place to treat our patients, we would wake them up and say, "here so-and-so … drink", and the patient will drink, and we will continue doing so until they are cured".

THP 5:- "Something else that we would like to see done for us … our houses are small. We do not have space for our patients to sleep, because some of our patients arrive very ill and unable to walk or do anything for themselves. We then have to give this person medication ourselves. What we would like is a place of our own, such as a hospital, so that we can admit our patients there and help each other there as traditional healers. We will all be there so that if I cannot treat a specific patient, I know that there is someone else that can treat them there at our hospital … so that we know that we do not keep our patients in our homes".

THP 6:- "In the past, I used to take people with HIV/AIDS to stay here with me. I would ask the patient to bring someone with them to guard them, because sometimes they say that people are raped and so forth by traditional healers. What people did, is that they would bring the ill person and then disappear, never to be seen again. Second, I need to have a proper place where people can stay. It is difficult, because I do not have money to build a place where patients can stay with beds. Because, people with HIV/AIDS need care, and at their homes, you will find that their household members get sick and tired. If the patient is here close to me, I can see that they are at a specific stage of the illness, and then change my treatment accordingly".

THP 7:- "Government should organise us a place of our own where we as traditional healers can work from. So that when they (western health practitioners) send their patients to us, we know that we have a place for these patients, to treat them from".

THP 8:- "The doctors must also fix up our places so that we have a proper place to work from, because if they see our places they will refuse to refer patients to us, because they are going to say "no, no, these places are dirty" and so-forth. Therefore, they cannot send their patients to us. We do not have money to build and fix up our places".

THP 9: - "These Xhosa traditional healers do not bring their patients to live with them. They treat their patients while they live at their own homes, therefore, their patients will never get well".

The severity of the consequences of inappropriate traditional health facilities is best illustrated by the following response:

THP 1: - "We really need proper infrastructure, such as water. We have to get water from far away. It so happens that our sick patients end up walking to fetch water. Even if I could get a two-roomed flat with a sink and a toilet … these are the things that we need".

- *Administration facilities*

Traditional health practitioners lack adequate administration facilities, which is a vital component in the effective functioning of any given health care system. The appropriate administration infrastructure will allow for, *inter alia,* the regulation of the traditional healing system by optomising its efficiency and effectiveness, and sidelining unqualified practitioners. The regulation of the traditional healing system is also a major prerequisite for collaboration between traditional health practitioners and western health practitioners towards mainstreaming the former into the official health care system. At a provincial and district level, the administrative infrastructure for the traditional healing system comprises two offices, namely one in Bisho and another in Umtata. The two offices are jointly responsible for the registration of traditional health practitioners in the Eastern Cape Province. However, the lack of appropriate technological support, as well as human and financial resources at especially a District/LSA level, has rendered this infrastructure inadequate and inefficient. The response of the District traditional health practitioners coordinator is clear indication of the inefficiency of the administration infrastructure for traditional health practitioners in the Buffalo City Local Municipality, thus failing to regulate the traditional healing system: "*We do not have an office as yet." "We do not have an office, but we need one where there will be traditional healers who represent all five categories of traditional healers. Because, a spiritual healer is known by another spiritual healer … what they are like when they have completed training. A traditional surgeon is known by another traditional surgeon … what he/she should be like when he/she has completed training. A herbalist is known by another herbalist what he/she should be like after completing training. A traditional birth attendant is known by other women that, yes, she is a traditional birth attendant, because we know how many children she has delivered. We do not have this office as yet. I am responsible for doing this here in Buffalo City".*

- *Facilities for producing, processing and packaging traditional medicines*

Traditional health practitioners produce their own medicines with the guidance of their ancestors. However, the medicinal plants which they utilise are not necessarily indigenous to their town, district or province. Some medicinal plants are, in actual fact, indigenous to other provinces or neighbouring countries, and are not easily obtainable due to their locality (e.g. in mountains, deep rural areas, etc.). Traditional health practitioners are, therefore, required to travel long distances to obtain certain medicinal plants, which proves costly and time consuming, as well as rendering the practitioners inaccessible to patients during their absence. It is in this light that traditional health practitioners perceive a need for demarcated land for growing medicinal plants which are indigenous to other provinces and countries.

The lack of appropriate facilities for the processing and packaging of traditional medicines is viewed as one other obstacle in the traditional healing system. Also, the procedure and conditions under which traditional medicines are processed and packaged has received much criticism for being unhygienic, and thus detrimental to patients who consume these medicines. This negative view of traditional medicines is shared by traditional health practitioners, western health practitioners and community members alike. The following responses of traditional health practitioners elude to this view:

THP 1 – "We do not have proper places to work from, because our medicines need proper storage places which are neat and clean. We do not have places, because we do not have the money to rent such places. Can you see in Johannesburg, they have built a complex there for traditional healers. They have been built a place … it is neat. I would like to see something like that happening in the Eastern Cape. Second, hygiene should be stressed,

because traditional healers are dirty. So now you are going to take a sick person to someone who himself/herself is dirty and the place they live in is dirty. These are the things that need to be rectified. They give us a bad name where people say that we are dirty and then people undermine us, more especially western doctors. I place this responsibility on government, because people are not honest. They should send people out even if it is once a month to inspect our places"

THP 2: - "It has been a difficult and long road. When we first started to initiate collaboration between traditional healers and western doctors, we called all community members to give us their views about why doctors and nurses did not want us to work with them. They (community members) voiced their views. They gave reasons such as we do not cook our medicines, we are dirty … this hurt me very much, but they were rectifying us here and there".

THP 3 – "Us black people have a tendency to belittle or look down upon one another. We will say that we will never use roots, because they are dirty. But, we will go to a western doctor and drink their medicines even if it means we have to keep changing doctors, because we are not getting the proper help. Meanwhile, it is those dirty roots that are going to heal you".

(b) Standardisation of traditional healing practices

The absence of clear guidelines and standards for the training of traditional health practitioners, and also to differentiate between the various categories of traditional health practitioners, is viewed as problematic for registration of traditional health practitioners and establishing an effective licensing system. The disintegration of impermeable lines between the various categories of traditional health practitioners over time has resulted in traditional health practitioners evolving from specialists to general practitioners who practise various types of healing. Thus, it becomes increasingly difficult to monitor and regulate practitioners in a training system that is not based on clearly delineated practice guidelines and standards for each category of traditional health practitioner. This is viewed as undermining the quality and integrity of the traditional healing system. This argument is best illustrated by the following response:

"Even western doctors have various departments. We traditional healers say that we do not have these departments, we are just traditional healers that's all. My grandfather told me that there are seven departments in traditional healing. Another traditional healer who says that they are qualified will tell you that this is news to them. I will tell you that the first department is 'isanusi', the river diviner … that is me. The second department is 'isangoma', that is the forest diviner. Then I will tell you about 'ighogho', which is the dream diviner. Then again I will tell you about the 'isaghogho', which is the head diviner who does not deal with evil medicines. Then I will tell you about 'itola', which is a herbalist that mixes evil medicines. Then I tell you about 'inthlangu', who is a person that uses water and candles, like myself. Then there is the 'phangu', who is a person that knows all seven of these healing methods. These departments have specific methods for training. Now, another traditional healer will not know what I am talking about when I say to them that they are 'isanusi' that has 'isaghogho'. It used to be this way in the past, but where was it lost? You will find now that someone will say that they can do everything from healing to killing. It doesn't work that way. These things are not clear anymore. Training of traditional healers needs to be standadised to some extent where traditional healers should know that there are specific types of traditional healers who must be trained in a specific way based on the guidance of the ancestors".

(c) Information and training

Although some traditional health practitioners sometimes perceive themselves as being able to cure all illnesses/diseases, they also expressed a need for information and training that would improve the quality of treatment and care that they render, rather than abandoning their traditional practices in favour of western practices. Mainly, information and training are required on specific illnesses which they perceive to lack, such as in the case of HIV/AIDS. Seemingly, such training is not easily accessible for various reasons. Two reasons given is the limited number of information and training workshops presented in Buffalo City, and the limited number of traditional health practitioners permitted to attend such workshops due to financial constraints. The following statements are examples in point:

THP 1: - "We are only called to attend workshops every now and again. They are very scarce, however. It is something that I have voiced at the Amatole District Municipality. It appeared as though they would put me in touch with someone who would come train our traditional healers on AIDS and TB. It did take place in Port Alfred, but it has not reached East London yet. We are still waiting for this training. I am still trying to get it this side as the coordinator of traditional healers in Buffalo City".

THP 2: - "We do not all go to these workshops. Some go and then they tell the others. They say that it is a waste for all of us to go, because then they have to feed all of us at the workshop … and also things like transport. Transport is a big problem, because we do not have transport".

It appears that traditional health practitioners who attend workshops are expected to, in turn, educate and train other traditional health practitioners, as indicated by the response of one traditional health practitioner, namely: "*At the end of 2003, it was said that traditional healers would receive training. Someone from provincial government came to us and said they need 15 traditional healers for the training, so that those 15 traditional healers can in turn train others".* This is a widely used education and training method, called training of trainers. However, division and fragmentation of traditional health practitioners in Buffalo City render this method of education and training less effective than desired. A prerequisite to utilising this method of training is the unification of traditional health practitioners.

One recommendation proposed by traditional health practitioners in response to addressing infrastructural needs, was that traditional health practitioners be provided with adequate facilities to improve the quality of care rendered to patients who choose traditional healing for their health care needs. A suggestion which was put forth by traditional health practitioners was the establishment of a hospital for traditional health practitioners (traditional medicine hospital), where traditional health practitioners registered with the national Traditional Health Practitioners Association (Department of Health) would admit their patients and administer their respective treatment regimens. Although many traditional health practitioners view this move as a solution to the problem of defaulting of clients from prescribed treatment regimens, as well as optimising the quality of traditional health care, concerns about this approach were raised nonetheless. Concerns were mainly based on the operational aspects of institutionalising traditional health practitioners and patients, such as synchronising the diversity of traditional healing methods characteristic not only between categories of traditional health practitioners (i.e. diviners, herbalists, spiritual healers), but also between individual practitioners within the same category. The following statement, made by one traditional health practitioner, highlights this concern: "*I don't think government giving traditional healers a place of their own,*

such as a hospital, to work from is a solution, because we will be given a hospital where we diagnose and treat our patients, but we don't diagnose and treat the same way, such as with western doctors. Some of us throw bones, others scream when they diagnose, and so forth, and this is going to result in us disturbing each other. So, everyone must do their own thing in their own place".

One of the proclaimed strengths of the integrated national health system in China is the availability of traditional medicine hospitals. In 1995, China boasted a total of 2 522 traditional medicine hospitals equipped with 353 373 staff, and 236 060 beds. In addition, 95% of general hospitals in China have traditional medicine departments which treat, on average, an estimated 20% of out-patients per day. In 1992, a World Bank financed programme to expand the number of hospital beds in China, included the provision of 20% of these beds in traditional medicine hospitals (WHO Kobe Centre 2002). It is important for traditional health practitioners to be equipped with an adequate infrastructure to provide traditional health care of a high quality and standard. However, the nature of this infrastructure should be deliberated at the hand of disadvantages and advantages before facilities are put in place. The decision-making process to address the infrastructural needs of traditional health practitioners should seriously consider the status and nature of the traditional healing sector in South Africa, and Buffalo City, as a key determinant. More so, the vast array of traditional healing methods characteristic of the South African traditional healing system, poses real challenges for initiatives aimed at developing the traditional healing system. The complexity thereof is best expressed by the response of one traditional health practitioner to the issue of infrastructural needs of traditional health practitioners: "*As a matter of fact, when we were told we are going to be moved from our informal settlements into proper houses, I said that I am not going anywhere. I get all types of patients, such as mental cases. I perform rituals which require beating drums all day, therefore, I will be making a noise for other people in formal settlements. I will not do that amongst other people. Therefore, I refuse to move. Piping or no piping* (water and sanitation)".

"A more complex collaborative relationship, such as a formal bilateral referral system between western doctors and traditional healers, is a bit farfetched."

- Western health practitioner 2004

Chapter 9
COLLABORATION BETWEEN TRADITIONAL AND WESTERN HEALTH PRACTITIONERS

This chapter reports on the findings of interviews with both traditional and western health practitioners on the issue of collaboration between the two groups of practitioners. Discussions focus on perceptions about current collaboration, as well as views on future collaboration. Both strengths and weaknesses of collaboration are explored and discussed. Discussions are presented in two sections, namely

Section A – Views of traditional health practitioners on collaboration

Section B – Views of western health practitioners on collaboration

SECTION A

9.1. Views of traditional health practitioners on collaboration

9.1.1. Collaboration between traditional health practitioners and western health care practitioners

The presence of collaboration between traditional and western health practitioners was reported by very few traditional health practitioners. In such cases, collaboration is interpreted as the unofficial referral of patients from traditional health practitioners to western health practitioners, subsequent or prior to the administration of traditional treatment regimens that yield positive results. This informal and unofficial unilateral (one-way) referral chain is perceived as a collaborative relationship by some traditional health practitioners. The following responses are examples in point:

THP 1: - "There is collaboration between traditional healers, and western doctors now. We collaborate with western doctors by telling our patients to consult western doctors, so that we can also get a full report. This gives us more power in terms of knowing how the person's condition is progressing, how he/she is feeling now that they are using your traditional medicine. So, I would say that traditional healers and western doctors do work together"

THP 2: - "We collaborate in the sense that, if we see that someone is very ill and is in no condition for you to treat them, then we refer them to a hospital first and hear what the doctor has to say".

THP 3: - "There is collaboration between traditional healers and western doctors. In the sense that, when someone has HIV/AIDS and they are weak, we help them to gain strength so that they can be up and about, then the western doctor comes in and uses injections which we don't have, and things like drips".

THP 4: - "I can diagnose HIV/AIDS, but I cannot cure it. I do not treat people who come to me with HIV/AIDS. I immediately refer them to a clinic or hospital. I ask them to go to the nearest clinic or hospital in their residential area to be tested".

Despite these isolated cases of collaboration, however, the majority of traditional health practitioners interviewed reported an absence of collaboration between traditional and western health practitioners in Buffalo City. This was viewed in a negative light due to the perceived need expressed by many traditional health practitioners for traditional and western health practitioners to join forces towards improving the status of health care available for the Buffalo City population. Seemingly, the unilateral and unofficial referral of patients from traditional health practitioners to western health practitioners does not qualify as collaboration by most traditional health practitioners. Lack of collaboration was mainly attributed to (a) a lack of recognition of traditional practitioners by their western counterparts; (b) undermining of and disrespect for traditional health practitioners by community members; (c) delaying of Government in effecting plans for the inclusion of traditional health practitioners into the official health care system; and (d) lack of commitment on the part of Government in unifying traditional health practitioners through enforcing their registration with the national Traditional Health Practitioners Association. A discussion of each of these perceived obstacles to collaboration follows.

(a) Lack of recognition of traditional health practitioners by western health practitioners

Generally, traditional health practitioners believe that western health practitioners are willing to collaborate with them. However, a few traditional health practitioners beg to differ. Instead, they are of the opinion, based on personal experiences, that western health practitioners have neither desire, nor the intention, to collaborate with them. This is largely attributed to western health practitioners failing to recognise and accept traditional health practitioners as equal partners in the quest to provide health care to those in need, as well as western health practitioners' perceived exploitation of traditional health practitioners. Some traditional health practitioners believe that western health practitioners' so-called need to collaborate with them is a disguise for reaping their indigenous knowledge and traditional medicines to the benefit of western medicine, and not towards mutual collaboration between the two healing traditions of practitioners. Seemingly, there is also an element of selective collaboration, whereby western health practitioners prefer to collaborate with certain traditional health practitioners and not others. This perceived lack of willingness for western health practitioners to collaborate with traditional health practitioners is illustrated by the following responses:

THP 1: - "There is no collaboration between traditional healers and western health care professionals. There is this old man who went to the hospital to undergo head surgery. The place where they had operated on was septic and full of maggots. They told him to wait for his check-up date before returning to hospital. After examining the man's condition, I went to the hospital and asked them how they can expect this man to wait for a check-up date in his condition. How will he be by then? I then went straight to Bisho to take the matter up with the Department of Health. Fortunately, or unfortunately - I am not sure if they were afraid because I went to Bisho to talk about them – they took him in, but they took him with difficulty, because they had that attitude of who do I think I am to go to Bisho about them. If this patient was being treated by me and I had taken him to the hospital in that condition, they would have blamed me and said that I prolonged him getting the correct treatment. I have washed him, managed to get gloves so that his wounds could be cleaned, and taken him to the hospital for treatment. The western health practitioners do not want to work with us. There may be collaboration between western health practitioners and their own traditional healers that they have selected, but on my side there has been no collaboration. It was a hassle for us to get gloves from the clinic for the man I was talking about. We had to go to the provincial coordinator for traditional healers in Bisho to ask her to help us get gloves. They then asked us why we went to the provincial coordinator for gloves and not to them. I asked them why they did not recognise the traditional healers that are affiliated to their clinics because there are. Otherwise, there is no collaboration that I can see with traditional healers and western health care professionals".

THP 2: - "I went to a doctor that was next to my surgery when I still had one at the highway. I sat down with him but I discovered that he was arrogant. Perhaps he didn't want me to get familiar with him. I told him that I wanted to collaborate with him and what things did he think I could gain from him to help in this matter of HIV/AIDS. He said that he wouldn't be able to because he only works with people who come to him. Now, I didn't know if that meant that there is no connection".

THP 3: - "There is no collaboration between traditional healers and western doctors, because western doctors do not want to admit that they cannot cure something".

THP 4: - "Collaboration between traditional healers and western doctors is a very sore issue because they (western doctors) do not want to come closer to us. That is their problem and that poses problems for us. We have been going to the City Hall to meet with western doctors there, and we discovered that they are sucking information from us about how we work, instead of them giving us an opportunity to prove ourselves by giving us patients to treat so that they can see for themselves how the condition of patients changes. They just keep telling us that we are going to work together and eventually end up working with them in hospitals. I have not seen a single movement in this direction. Nothing is happening. It has reached a stage where we have lost interest in what they are saying. There is no collaboration between us and western doctors".

(b) Undermining of traditional health practitioners by some community members

Traditional health practitioners are reportedly undermined and disrespected by some community members who do not recognise their contributory role in society. The undermining of traditional health practitioners by community members is associated with the lack of respect and recognition for traditional health practitioners by western health practitioners. The rationale behind this association is the belief that the views and attitudes of community members are influenced by people who they perceive to hold positions of high status, such as western health professionals. Therefore, the negative attitudes of western health practitioners towards traditional health practitioners are regarded

as partly responsible for the negative attitudes of community members towards traditional health practitioners. Similarly, traditional health practitioners believe that their value in society will be recognised, and they will thus gain the respect of communities through western health practitioners respecting and recognising the beneficial role that they play in society. This argument is substantiated by the following response:

THP 1: - "We as traditional healers are not respected by our community members. They down play our role and our rituals. They do not understand what we endure when we receive the calling. It is not a pleasant experience. You will not know what it is like if you have not experienced it. So, someone who sees you walking there in the street whilst you have this illness will think that you are a mad person. Therefore, traditional healers are viewed as mad people by others. We are not treated like human beings … with dignity. People have no respect for us and show no appreciation for what we do. They show this by what they say in your presence and also by the way they look at you when they see you wearing beads".

(c) Delay by Government in implementing plans for the inclusion of traditional health practitioners in the official health care system

The perceived lax manner in which the integration of traditional health practitioners into the mainstream of health care is progressing, is viewed as a hindrance to collaboration between practitioners of the two health care systems. This is mainly attributed to a lack of policy guidelines to facilitate such integration. Seemingly, efforts towards collaboration between traditional and western practitioners predominantly comprise on-going discussions and plans about the need for collaboration, as well as the education of traditional health practitioners about selected diseases, rather than the actual implementation of plans to this effect. The need for clear guidelines and policies to enforce collaboration was reported, as illustrated by the following statement:

THP 1: - "There is no collaboration between traditional health practitioners and western doctors. There is still nothing that binds us officially. The associations are still trying to bring us together, but there are still no policies which state that traditional health practitioners and western practitioners collaborate in specific ways. This is what we are still working towards. We come together at meetings when we discuss … us being made aware of these diseases such as AIDS, so that we can be one, but this has not happened yet. This is still being discussed".

(d) Lack of Government commitment in unifying traditional health practitioners

Traditional health practitioners acknowledge the unification of traditional health practitioners as a fundamental prerequisite to collaboration between traditional and western health practitioners. Government's failure to enforce the registration of all traditional health practitioners with the national Traditional Health Practitioners Association is viewed as a hindrance to collaboration between practitioners of the two health care systems, as indicated by the following response:

THP 1: - "Yes, I know that government is waiting for us to combine as traditional healers, but it will help if government could push from behind for this to take place quickly. The reason why some people are still resistant/stubborn, is because they do not hear government's footsteps from behind. Government should put pressure on people to do away with the past associations which took peoples money, and encourage them to join the national association that is affiliated with government. People are still part of other associations, because government is not firm about doing away with these associations. Government should make it very clear that only traditional healers

that are registered with the national association will be permitted to practise. There are still many people who register traditional healers according to the old way, and disregard what government says".

Interestingly, very few traditional health practitioners perceived western health practitioners as being a hindrance to collaboration between the two groups of practitioners, despite a high reported absence of collaboration. On the contrary, traditional health practitioners generally view western health practitioners, especially doctors, as accepting of them. This view is based on the perception amongst traditional health practitioners of self-proclaimed defeat by western health practitioners in single-handedly curing diseases such as cancer and HIV/AIDS. Furthermore, perceived acceptance of traditional health practitioners by western health practitioners is based on the premise that western medicines are derived from the exact same herbs and roots that comprise traditional medicines. Therefore, western health practitioners are, generally, not viewed by traditional health practitioners as posing a threat to efforts aimed at synergistically joining the western and traditional health care systems. The following responses of traditional health practitioners are indicative of this view:

THP 1: - "I think western practitioners approve of us collaborating with them. We attend meetings with them where we speak the same language".

THP 2: - "Even doctors and nurses end up coming to us diviners and herbalists for help".

THP 3: - "In my view, I believe that western practitioners trust traditional healers. I believe in this strongly because medicines used by western practitioners, whether they have been processed and packaged, are derived from herbs. So, I think that they trust traditional healers for the mere fact that they use the same roots and herbs that we use. I think that western doctors do accept us.

9.1.2. Perceived desirable/undesirable collaborative relationship between traditional and western health practitioners

The majority of traditional practitioners perceived a need to collaborate with western practitioners. However, ambivalent views were expressed regarding the ideal nature of collaboration between the two groups of health practitioners. Some traditional practitioners interpreted collaboration as traditional and western practitioners sharing information and knowledge regarding their methods of healing, as well as their medicines. Other traditional health practitioners were opposed to sharing of information about the contents of their medicines, due to the secrecy associated with their healing powers. The belief that healing powers are a gift bestowed upon them (traditional health practitioners) by their ancestors renders it impermissible to transfer such powers to another individual without the intervention and approval of the ancestral spirits themselves, as suggested by the following responses:

THP 1: - "We went to Port Elizabeth for research on traditional healers, and they wanted to know that if someone has a specific illness, what do we mix to cure that person? We do not agree to give that type of information at all. Why? With our type of healing, it is more than just the medicine. I can tell someone to mix a specific herb with a specific plant, but what may actually cure that person is my healing hand. It is the combination between the two. We are not business people, we are healers. This goes for collaboration. Traditional healers and western doctors should collaborate in the process of curing a sick person, not in finding out what we use to cure. We also do not want to know what they have mixed together for benylin, or for disprin, or any of their medicine. Therefore, they too should not be interested in our mixtures. We receive our healing powers from our ancestors, and this happens everyday".

THP 2: - "We cannot tell western doctors about our medicines. We do not just go outside and collect our roots. The root appears to me in a dream. It is shown to me by my ancestors. They tell me where to go to collect a specific root. How do I give that information away when it has been given to me by my ancestors?".

THP 3: - "Western doctors are trying to know our healing medicines. When government says we should come together, it does not mean we are going to give our medicines to western doctors. All we need to do is to share patients, not our medicines. It is not our traditional right to give our medicines to western practitioners". "However, where I disagree, is for us to stand at the same table and we have to give them our medicines".

THP 4: - "I do not agree with us giving western doctors our recipes for treating people, because they do not give us theirs. They just want to suck information from us. Our ancestors would take our healing powers away if we had to give away the gift that they have given to us to someone else who is going to gain a lot of money using that gift. I do not agree with this at all. They must leave us to work using our methods, and they must continue using the methods that they have learnt, and then we collaborate and work together. Not for them to want to know what we mix together to treat something".

On the other side of the coin, some traditional health practitioners argue that the ancestors bestow practitioners with healing powers in order for them to utilise this power to the benefit of society. Therefore, the sharing of insight into traditional medicines that have healing properties should be viewed as traditional health practitioners fulfilling their responsibility to society, since this information will be to the benefit of a larger proportion of end beneficiaries, namely the sick. However, this act of sharing information should be duly rewarded by the recipients of this information. The following responses best express these views:

THP 1: - "I do not agree with traditional healers who say that they will not be able to share their medicines with government or western doctors, because it is a gift given to them by their ancestors. That gift is given to you by your ancestors to help people. I do not say that traditional healers should say to government, here take my medicine and use it. They should first establish what government is going to give them in return for their medicine, because until when are they going to keep their medicines when people are busy dying".

The ideal collaborative relationship is described as traditional and western health practitioners administering their respective practices within a mutually accepting and respecting health care setting. Traditional health practitioners do not accept a unilateral (one-way) system of collaboration, which entails traditional health practitioners compromising their knowledge and practices for those of western medicine. Therefore, a unilateral referral system, where traditional health practitioners refer to western health facilities and practitioners, is unanimously and unquestionably unacceptable. Traditional health practitioners view their role in the official health care system as valuable and beneficial, hence the expectation that it should be viewed as such by Government and western health practitioners alike. It is in this light that traditional health practitioners propose the ideal collaboration between traditional and western health practitioners as the two groups of health practitioners consulting each other on specific patients and specific diseases. This consultation process between the two healing traditions is viewed as optomising the effectiveness of health care for patients who are in need of such care.

Also, traditional practitioners wish to collaborate with western practitioners in ascertaining which traditional medicines are most effective in treating various illnesses. However, this collaboration should be limited to western health practitioners observing the effectiveness of traditional medicines, rather than learning about the contents of

traditional medicines. Furthermore, some traditional health practitioners believe that they should be remunerated for traditional services rendered as partial fulfilment of western health care services. In other words, the official use of traditional health practitioners to supplement and complement western health care should be remunerated as per remuneration schedule for any other professional service. The following responses are indicative of the nature of collaboration envisaged by traditional health practitioners:

THP 1: - "We do not have referral forms as yet, but these forms are needed. We should have these forms. These forms should specify that I, the traditional healer, suspect that this person may be suffering from such-and-such, or else, I have no idea what is wrong with this person except that he/she is becoming increasingly ill. So, please place them on a drip and then refer him/her back to me. I was about to start treating him/her, but they arrived at my place very ill. So, please place them on a drip then send them back to me to continue treatment. We are still working on this, but as yet we do not have a form".

THP 2: - "We are still trying to get a referral system between western doctors and traditional healers, so that if someone arrives here at my place and I see that this person … I won't be able to induce diarrhoea, nor will I be able to make them vomit, because they are too weak. Then I will be able to write a note saying that I am referring this person to the hospital because he/she is weak, so I won't be able to work on them. You (hospital) will see what you can do, maybe put him/her on a drip because he/she is weak. So, this person must first start there with you. Once they have regained their strength, then you (hospital) must refer them back to me, because I cannot work on a weak person since I will kill them if I do. This arrangement is still being attempted, but it is not in place as yet".

THP 3: - "The type of collaborative relationship that should occur is that traditional healers should be able to refer patients that they are unable to cure to western doctors. And, western doctors should also be able to refer patients that they are unable to cure to traditional practitioners, especially diseases such as cancer. They tend to be better handled on the traditional healing side. On the western side, they appear not to be handled very well".

THP 4: - "We should all be working towards the same thing. What I do not know, is how this can be achieved, because western doctors are professional and heal in their own way, whereas traditional healers also heal, but in a different way. So, I do not know how this can take place. I would like to see it happen, but it must happen in a way that it does not oppress one side … this side of traditional healers. We should be equal".

THP 5: - "I wish western doctors could collaborate with us. If they could take my medicine for HIV/AIDS and give it to patients, then see what effect it has; and then take another traditional healers medicine and see what effect it has and so forth, until they see which traditional medicine works the best".

THP 6: - "I have no problem working with western doctors if they come to me, or ask me to go to the hospital to help a person with HIV/AIDS. What I am going to do when I get to the hospital is to find out where that person's family is. If that person's family permits me to take this person to the river to go ask my grandfather what to do, then I will. I wouldn't mind working together with western doctors if they could understand the way I operate, because I understand how they work. When I cannot manage someone here I send them to the hospital. My grandfather is not against western doctors because he knows I live on earth. So, the type of collaboration I wish to see is for western doctors to understand how we work"; "What I can say is that if I was told to go to a hospital to give a patient of mine traditional medicines in an effort to help western doctors, I wouldn't say no".

THP 7: - "We must also be able to go into hospitals like western doctors. It must not be the case where we go into hospitals to volunteer and not get paid. We should also be paid because we are providing a service".

THP 8: - "If doctors could be on the same boat as us, whereby they pay us if someone that they diagnose with HIV/AIDS … then they should refer them to us and know that once we have treated that person, they will pay us, so that I know that doctor so-and-so has sent his patients with HIV/AIDS to me and he is going to pay me so much".

However, some traditional health practitioners are of the opinion that traditional medicine and western medicine are two worlds apart, which cannot be reconciled or placed on a par with each other. This view is based on the perception that traditional medicine is the superior of the two types of medicine due to its ability to cure all types of illnesses based on the traditional laws of causation. Hence, traditional health practitioners who share this view are not willing to practise within an integrated health care system, namely side-by-side with western health practitioners. Rather, their proposition is a parallel health care system where traditional and western health practitioners practise independently of each other with minimal contact between the two practitioners. Very few traditional health practitioners shared this view. The following responses best illustrate this view:

THP 1: - "I do not see myself, as a traditional healer, collaborating with western health practitioners. I am what I am. I wake up with my medicine. I look at a person and see what they are suffering from, then I go to my stone and grind my medicine for that specific person"; "I support traditional healers collaborating and working together, because if I see that this is something that I cannot treat, I will refer to another traditional healer or ask another healer's advice. But, I will not refer them to a western practitioner. I will look at the person and see what is wrong with them first, then prepare medicine for them. I will not say to someone with a sore leg that they should go to a clinic. Sometimes a person will just lose their eye sight, and when a western doctor examines them they will be told to wear spectacles, or they will see that this person's eye should be removed. Meanwhile, that is not what the person needs. It will require me to treat them the way that I do. A western doctor will not see what I see, that this person needs to be treated in a traditional way. A person will go to the clinic and be diagnosed with high-blood pressure. I see that high-blood pressure a different way. I see the reason behind the blood-pressure". "Government should leave us to work independently as traditional healers. It should not try to get us to work side-by-side with western health practitioners. I agree that government should support traditional healers by giving us the legal right to work as such, but I do not agree with traditional healers working side-by-side with western health practitioners. I do not want to go work with western practitioners in hospitals and clinics. We just want our own place where we can work together as traditional healers".

In essence, most traditional health practitioners are in agreement about the necessity for collaboration between traditional and western health practitioners towards improving the health care available for South Africans. However, consensus needs to be reached pertaining to the extent and nature of collaboration. Reaching consensus regarding how traditional and western health practitioners should collaborate within an integrated health care system is of the utmost importance in as far as plans for integrating the two health care sectors will be informed by such decisions.

Some traditional health practitioners recommended that success factors from the collaborative relationship between traditional surgeons (*iincibi*) and western health practitioners should also be drawn upon in the development of guidelines for collaboration between other categories of traditional health practitioners and western health practitioners. The collaborative relationship between the two groups of practitioners was referred to as an example of successful integration of the two health care systems by a number of traditional health practitioners. This view was,

however, not unanimously expressed, as other traditional health practitioners differed on the issue of successful collaboration between traditional surgeons and western health practitioners. In other words, some traditional health practitioners viewed this collaboration as unsuccessful and portraying adverse effects, such as promoting deaths amongst young initiates.

9.1.3. Referral system between traditional health practitioners and western health practitioners

At the time of data collection, an informal one-way referral system (from traditional to western) was present between some traditional and western practitioners. It appeared as though the informal arrangement, whereby traditional health practitioners refer clients to western health practitioners, was prevalent amongst traditional practitioners who were registered with the national Traditional Health Practitioners Association, and who had attended at least one related workshop or meeting coordinated by Government. Seemingly, encouraging traditional health practitioners to refer patients to western health care facilities and practitioners is one of the predominant mechanisms utilised by the western health care system to promote collaboration between the two groups of health care providers, as indicated by the following response:

THP 1: - "I then referred him to a western doctor to check what progress he was making. I referred him, because I work according to the guidelines of the association for traditional healers (national Traditional Health Practitioners Association) which says that we must always check with western doctors to see how things are going"; "The same applies to people who have HIV/AIDS. I do not treat a person until they have had a check-up, since we are under this association for traditional healers".

A few traditional health practitioners were opposed to the referral of their clients to western health care practitioners. This opposition was mainly based on the premise that traditional healing had the ability to cure all ailments and diseases with the correct diagnosis and appropriate adherence to treatment regimens (corrective action). Therefore, referring clients to western health practitioners was viewed as contradictory to this belief. However, many of the traditional health practitioners who were opposed to referring clients to western health practitioners also reported using western medicine both for themselves, as well as in the treatment of their patients. An observation by the researcher during data collection further highlights this contradiction. One traditional health practitioner who voiced strong opposition to referring patients to western health practitioners (based on the perceived ability to cure all illnesses), reacted to an emergency which she was confronted with during her interview, by referring a patient to a western general practitioner after a brief examination of the patient. Concerted efforts are needed to address the negative shroud which engulfs the referral of patients from traditional health practitioners to western health practitioners. A strong sense of interdependence between the two types of health practitioner should be instilled, where a referral system is viewed as a strength, rather than a weakness of one system at the hand of another.

All traditional health practitioners who were in support of a referral system, reported that the referral system between traditional and western health practitioners should be of a bilateral (two-way) or reciprocal nature, where western doctors would refer patients who may not be suffering from a western disease to traditional health practitioners. Failure of western intervention to successfully treat a specific diagnosed disease is viewed by

traditional health practitioners as indicative of the disease being of a traditional nature. The following response by one traditional health practitioner is an example:

THP 1: - "The type of collaboration I wish to see between traditional healers and western practitioners would be, if someone at the hospital is continuously ill even after they have been receiving all sorts of treatment, they should refer them to us traditional healers. It could be that illness that that person has, does not need western intervention, but needs us. So, my wish is that if a doctor is unable to successfully treat a patient, he/she should refer them to us. Similarly, if we are unable to treat a patient we should refer that patient to western practitioners."

Generally, the referral system between traditional and western health practitioners has been largely one-way – from traditional to western health practitioner. The Traditional Health Practitioners Act could play a prominent role in effecting a more effective referral system between the two groups of health care providers. In other words, western health professionals must be educated to overcome their mistrust and suspicion of the traditional healing system (Ndaki 2004).

SECTION B

9.2. Views of western health practitioners on collaboration

9.2.1. Current collaboration between traditional and western health practitioners

Collaboration between the two groups of practitioners is seemingly lacking, and even reported cases of collaboration appear inadequate, taking into consideration the desirable nature of collaboration as perceived by traditional health practitioners (cf. paragraph 9.1.2). In the main, western health practitioners reported (a) an absence of collaboration; (b) informal and unregulated collaboration; (c) formal collaboration in the form of clinic committees; and (d) a preferred unilateral referral system. These salient aspects of collaboration are discussed below.

(a) Absence of collaboration

Not one respondent was aware of any form of formal collaboration between traditional and western health practitioners in the field of HIV/AIDS at their respective facilities, or anywhere else in Buffalo City, or even within the Eastern Cape Province. The following responses are indicative of the perceived absence of collaboration:

WHP 1: - "Collaboration between traditional healers and western health practitioners in this district is non-existent!"

WHP 2: - "We don't have any collaboration on the side of HIV/AIDS in our district as yet. They talk about it in Bisho when we go there for meetings … they say that they are bringing something to do with traditional healers, but we haven't seen anything yet here in the local service areas. It hasn't reached us yet, because if there was something we would know about it".

WHP 3: - "In my knowledge, there is no collaboration between traditional healers and western practitioners".

WHP 4: - "There is no formal collaboration between traditional healers and western health professionals in our area or district. We only see, sometimes, when we are sitting in our homes and we see on TV

that there are places where traditional healers and western doctors are collaborating, and have their own association, but here there is nothing of the sort".

WHP 5: - "So far, there is no collaboration between traditional healers and western health practitioners. In so much that I wouldn't be able to tell who the traditional healers here in Duncan Village are".

WHP 6: - "I do not know of any collaboration between traditional healers and western health practitioners".

(b) Informal and unregulated collaboration

Upon further probing, it became apparent that collaboration between traditional and western health practitioners did exist, to a degree. However, collaboration between the two health care systems is informal and very marginal, which could explain the unanimous response of there being no known collaboration. The informal, unregulated and unstandardised nature of collaboration is best illustrated by the following statements:

WHP 1: - "So far there have not been any traditional healers that we have interacted with. Though, when I used to work at the hospital, when a patient had a traditional medicine … for instance, in the case of HIV/AIDS, where a patient had consulted a traditional healer and was given traditional medicine to take, we would allow them to take it while they are in hospital, because it is not known what will heal the patient. Especially in the case of cancer, patients are allowed to continue using their traditional medicines, as well as the western medicines provided at the hospital. Here at primary health care there is nothing that brings us together with traditional healers, maybe at hospitals there is collaboration. I know for a fact that at hospitals, patients at a terminal stage of illness are allowed to use traditional medicines if they so wish. I do not think it is policy, but it is done because that patient believes in that medicine. So, if we say that they should stop using their traditional medicines, they will leave the hospital and become worse at home".

WHP 2: - "I must say, we also use a part of traditional healing, because there are herbs that we tell them (patients) about and that they should use. Things such as the African potato (Inongwe). We tell them (patients) to grate it and mix it with garlic, and so forth, and so forth. We tell them this mixture will not cure them, but it will boost their immune system".

WHP 3: - "We can also learn from them, because cough mixture has been stopped now. Instead, we tell people to use 'umhlonyane'. 'Umhlonyane' is their herb. We tell them to cook it and mix it with vinegar and sugar, and then drink it. These are their remedies".

One respondent reported that collaboration between traditional and western health practitioners was limited to traditional circumcisions. It appears that the relationship between traditional surgeons and western health practitioners is viewed as exemplary of the ideal collaboration between the two types of practitioners, as illustrated by the response:

WHP 1: - "Collaboration is only on the side of circumcision. See, they have won over traditional healers on the side of circumcisions, but we don't have any collaboration on the side of HIV/AIDS in our district as yet".

(c) Formal collaboration in the form of clinic committees

The most commonly reported collaboration is in the form of clinic committees. However, only one of the primary health care facilities selected for the research undertaken had an active clinic committee. Clinic committees evidently serve as forums conducive for initiating and facilitating collaboration between traditional and western health practitioners. The nature of collaboration, however, appeared to be limited to an informal unilateral referral system, where traditional health practitioners are encouraged to refer their patients to clinics. Although the perception was that traditional health practitioners viewed their participation in the clinic committees in a positive light, this participation was reportedly not sustained, as expressed by the following responses:

WHP 1: - "Last year, or year before last, I was on a clinic committee. I was nominated by SANCO to go represent my branch. There at that committee, we had traditional healers because we wanted them to be part of us, so that they could merge their knowledge with western knowledge about medicine. The traditional healers partook of the decision making by the committee. But now the committee dissolved, because some people could not make the meetings, and others thought that being on the committee meant that they would get some form of payment. And because they didn't, they lost interest and stopped attending meetings".

Unsustained participation of traditional health practitioners in clinic committees may be attributed to the traditional health practitioners' perceived lack of recognition of the contribution that they as health practitioners could make in the mainstream of health care, by western health practitioners, as well as Government (local and provincial). By and large, western health practitioners view the role of traditional health practitioners as mainly agents of western medicine, whereas, traditional health practitioners view themselves as resources from which western medicine can gain in the form of traditional knowledge and practices. Therefore, propagating the referral of patients from traditional health practitioners to clinics, on its own, is not a successful method of encouraging and sustaining collaboration.

(d) A preferred unilateral referral system

Referral of patients from western health practitioner/facility to traditional health practitioner was not reported by any of the respondents. Based on verbal, as well as non-verbal responses, the likelihood of such a referral system appears improbable, in at least the near future. The following statements are examples in point:

WHP 1: - "A more complex collaborative relationship, such as a formal bilateral referral system between western doctors and traditional healers, is a bit farfetched".

WHP 2: - "I do not see a bilateral referral system between traditional healers and western doctors. I can see them referring to us, but I do not think we can make a diagnosis one day and say, 'okay, this needs to go to a traditional healer'. I cannot come up with a condition where we will make a diagnosis and say 'go to a traditional doctor'".

WHP 3: - "Traditional healers can and should refer to health centres, but I do not see us referring to traditional healers".

Collaboration and interaction between traditional and western health practitioners is evidently perceived as non-existent, let alone lacking. This clearly points towards failure of efforts to promote collaboration between practitioners

of the two health care systems, despite global and national acknowledgement of the dire need for such collaboration in, especially, curbing the devastating impact of the HIV/AIDS epidemic. Factors such as unequivocally delineated guidelines for collaboration; developing and putting in place structures to promote collaboration; as well as monitoring the impact of such structures, need urgent attention in Buffalo City.

9.2.2. Western health practitioner attitudes towards patients who consult traditional practitioners

Western practitioners differed on their views about attitudes towards patients that also consult traditional health practitioners for their health care needs. Some respondents believe that western practitioners do not propagate the non-use of traditional medicines, whilst others believe that western practitioners overtly discourage patients from using traditional medicine. Therefore, two distinct and contradictory views prevail about the attitudes of western practitioners towards patients who utilise both traditional and western medicine, namely (a) indifference towards patients who consult traditional health practitioners; and (b) antagonism towards patients who consult traditional health practitioners.

(a) Indifference towards patients who consult traditional health practitioners

Despite western health practitioners' views regarding the referral of patients to traditional health practitioners, however, patients are reportedly not discouraged from consulting traditional practitioners. This decision is based on two prime tenets, namely that the vast majority of individuals in the communities that the respondents serve, are reported to believe in, and trust traditional health practitioners, and the need to respect the choice of health care provider opted for by their patients. The following statements are examples in point:

WHP 1: - "We cannot convince them not to consult traditional healers, because it is their choice and right to do so, and also because we can only advise and not dictate to our patients".

WHP 2: - "We do not discourage our clients from going to traditional healers, but we advise them on what they should do to avoid infections, and also to avoid infecting others such as taking a blade to a traditional healer if the traditional healer is going to make incisions (qatshulwa) on them".

WHP 3: - "We encourage people's beliefs. We believe that what you believe in is what will help you. Also, to avoid them becoming depressed, we let them go to traditional healers".

WHP 4: - "We do not discourage patients from using traditional healers. We tell them to use the medicines that we give them, then they can also go to traditional healers to satisfy their beliefs".

WHP 5: - "I also have this thing that says that if you believe in something you will be helped. That is why I do not agree in discouraging and criticising people who use traditional healers or traditional medicine, because I believe by doing that you are killing them, because it is their belief. After all, where do we come from? We come from traditional medicines, such as 'imihlonyane', which was given to us when we were young to induce vomiting. However, these practices have phased out to some extent because of the influence of westernisation".

(b) Antagonism towards patients who consult traditional health practitioners

Despite the majority of respondents reporting not to overtly discourage their patients from consulting traditional health practitioners, some traditional health practitioners pointed to the antagonistic attitudes and tactics of western health practitioners towards traditional health practitioners as a major contributor to patients refraining from seeking help from western health practitioners when they feel the need to do so. It appears that negative attitudes aimed at patients who consult traditional health practitioners prevail at some facilities as is evident in the following statements:

WHP 1: - "You will find some patients who will tell you that they were at a traditional healer, and the traditional healer told them to come to the clinic. Then, we scream at them and ask them why they went to the traditional healer in the first place, even though it is their belief".

WHP 2: - "We discourage our patients from going to these traditional healers. We tell them not to take those pamphlets that they hand out in the streets".

WHP 3: - "… because, really, a lot of people go to traditional healers and they do it in a 'backstreet' way, because we scream at them for going to traditional healers, which makes it seem as though it is an illegal thing".

9.2.3. A need for collaboration

The vast majority of western health practitioners interviewed expressed a need for collaboration between traditional and western health practitioners in, especially, providing treatment and care for people living with HIV/AIDS. The reported need for collaboration between the two groups of practitioners is based on both the perceived weaknesses and strengths of the traditional healing system. The following factors were viewed as necessitating collaboration between traditional and western health practitioners, namely (a) high utilisation rate of traditional health practitioners in communities served by western health practitioners; (b) insufficient knowledge among traditional health practitioners about HIV/AIDS; (c) immune system weakening properties and toxicity of some traditional medicines; (d) drug interactions caused by unknown traditional medicines which are used in conjunction with western medicines; (e) unhygienic traditional practices which exacerbate vulnerability of PWAs to infections; (f) immune boosting properties of some traditional medicines; and (g) substantiation of the authenticity of traditional healing methods and medicines.

(a) High utilisation rate of traditional health practitioners

Western health practitioners who were interviewed acknowledge the use of traditional health practitioners by a large proportion of the communities/catchment areas that they serve. The perceived high utilisation rate of traditional practitioners is associated with the fact that traditional practitioners share the worldview of these community members. This shared belief system between traditional health practitioners and community members is perceived as a strength of the traditional healing system, as illustrated by the following responses:

WHP 1: "Nurses live together with our people and they are well aware that our people believe in traditional healers".

WHP 2: "We know that a lot of our people believe in traditional healers and they (traditional healers) have more clients than western health care practitioners, especially when it comes to HIV/AIDS".

WHP 3: "More than 80% of our patients go to traditional healers before they come to us".

WHP 4: "I think traditional healers play a huge role, especially if you consider the community which we serve where, I would say, the majority of people believe in traditional healers and will opt for them".

(b) Insufficient knowledge among traditional health practitioners about HIV/AIDS

Western health practitioners are of the opinion that traditional health practitioners are not knowledgeable about HIV/AIDS, or at least about the appropriate treatment of HIV-related illnesses. This is one of the identified weaknesses of the traditional healing system which conjures up the need for collaboration in the form of western practitioners training and educating traditional practitioners about traditional treatment regimens that are harmful to PWAs, and identifying various symptoms and conditions related to HIV/AIDS. The following responses are indicative of the views held by western practitioners pertaining to traditional practitioners' knowledge about HIV/AIDS:

WHP 1: "Western doctors must not push traditional healers away, but should rather pull them closer so that they can be educated about HIV/AIDS".

WHP 2: "I think that traditional healers should be educated about HIV so that they can understand certain things better".

WHP 3: "Traditional healers need to be made aware about HIV/AIDS so that they know which cases they should take and which they should refer".

WHP 4: "There should be collaboration between traditional healers and western health care professionals so that the traditional healers can also get this health education that we give our clients".

WHP 5: "I think we need to accommodate traditional healers so that we do not take them away from what they do, because it is their gift as they put it. But we can enlighten them so that when they heal they know what not to do, for example, for them not to induce diarrhoea, because it makes the patient weak".

WHP 6: "Well, they know the signs and symptoms of HIV/AIDS, but they miss the mark in treating them. For instance, they do enemas and induce vomiting which makes patients more dehydrated. But if traditional healers can be workshopped, we would work well together. We wouldn't have so many HIV/AIDS related deaths".

WHP 7: "Collaboration is very important so that they know the signs and symptoms of diseases and not say that they know that this is 'ibekelo', but rather the signs and symptoms of HIV/AIDS and, therefore, I will treat this person psychologically in my own way and also refer this person to nurses at a clinic".

WHP 8: "They must be convinced that there is no cure for HIV/AIDS".

WHP 9: "We should work together, because at the end of the day our interest is the patient and helping the patient. Again I make example of dehydration, traditional healers are of no help to someone who is

dehydrated, because if someone is no longer consuming fluids and they have diarrhoea, surely that person has to come to a clinic or hospital for a drip. So, if a traditional healer has that knowledge and is aware of the signs and symptoms of dehydration, it will be easier for them to see these symptoms in a patient and then refer that patient to a clinic or hospital".

(c) Immune system weakening properties and toxicity of some traditional medicines

One of the main concerns raised by western practitioners is the negative reaction of certain traditional medicines, such as weakening of the immune system and herbal intoxication. These reactions are particularly of concern to PWAs who already suffer from a compromised immune system due to the nature of their illness. Therefore, some traditional medicines cause more harm than good for PWAs. The following statements are indicative of these concerns:

WHP 1: "Some of the medicines used by traditional healers are very strong, thus, further destroying the immune system of the patient that has HIV/AIDS. That is why I think collaboration is important".

WHP 2: "Some of the traditional medicines cause complications, such as herbal intoxication in babies due to high dosages. Traditional healers' medicines don't have any dosages".

(d) Drug interactions

The mystification of the traditional healing system, more especially the contents and dosages of traditional medicines, appears to be of concern to western practitioners. This concern mainly relates to fear of drug interactions which may occur between traditional and western medicines when used together. Although traditional practitioners are skeptical of disclosing the content of their traditional remedies and medicines to western practitioners, there appears to be a need, from the side of western practitioners, to acquire knowledge about traditional medicines for the purpose of avoiding drug interactions in patients that utilise both health care systems. This concern is expressed by the following responses:

WHP 1: "We have absolutely no idea what is in their concoctions or what dosages their clients take. Even with western drugs, there is always potential for drug interactions. So, we wouldn't know to what extent these traditional medicines are going to interact with the drugs we give patients".

WHP 2: "Sometimes patients come here and go to traditional healers … mixing the things up. They go to a traditional healer and get medication which I don't even know what it is, and then they come here and I want to give him/her other medication, and the disadvantage is that you cannot explain what traditional medication this person is on. They will tell you that they were given enemas or medicine to induce vomiting or whatever, and you may end up having drug interactions or side effects which present to you as an illness, meanwhile it is side effects of traditional medicine and western medicine mixed".

(e) Unhygienic traditional practices

The lack of hygiene in the processing and packaging of traditional medicines was reported by some traditional practitioners that were interviewed (cf. paragraph 8.1.6a). This issue was also raised by western practitioners. The lack of hygiene in preparing and packaging traditional medicines, as well as in diagnostic and treatment procedures,

exposes any individual to various infections. PWAs are at an even greater risk, since unhygienic traditional practices exacerbate their vulnerability to infections. According to western health practitioners, this risk factor deems collaboration necessary in order to educate traditional health practitioners about hygienic measures which they need to adopt. This notion is articulated in the following responses:

WHP 1: "I wish government would accommodate traditional healers in clinics and hospitals, such as having them in labs, so that they can see how medicines are made, so that they can learn about neatness and cleanliness. They must know that the container in which an ill person's medicine is put, must be clean … must be sterilised with boiling water. They will see for themselves how it should be done, instead of just rinsing containers under tap water which does not kill germs. I don't think traditional healers know all of this, which is why I say they should be brought closer to us".

WHP 2: "Sometimes you will see your clients in the community going to a traditional healer to induce diarrhoea and vomiting and you become very worried because, for one, you know that they use the same equipment to induce diarrhoea, which is not sterilised that much. You think to yourself that these people are at a great risk of picking up an infection, but there is nothing that you can do, so you worry until you stop worrying".

(f) Immune boosting properties of some traditional medicines

Based on direct observations by some western practitioners, as well as proclamations by patients, certain traditional medicines appear to have immune boosting properties. This is one other strength of the traditional healing system which western health practitioners view as necessitating collaboration between the two groups of practitioners towards improving the quality of health care for especially PWAs. The following responses substantiate this view:

WHP 1: "I think it is a very wise thing for us to accommodate our traditional healers so that we can teach them and also so that we have certain herbs that we can learn from them … so that we can improve our patients appetites, because some of our people do not like tablets. They believe that if you use tablets for a long time you will develop cancer … it is their beliefs. Perhaps by accommodating traditional healers there can be herbs that we can learn from them that will boost the appetites of our patients".

WHP 2: "I've had patients who have been down and out and then they suddenly pick up weight and they have enough energy to do things for themselves … I would see that there is something that they have received to boost their immune system and energy levels. There is this herb that traditional healers have, but it is difficult for us to know what it is, because we have not drawn them closer to us".

WHP 3: "Sometimes … it doesn't happen all the time … you hear that a traditional healer has a good medicine. He/she can give you a "bottle" that will boost you … those people that are HIV+. So I should think it is these "bottles" that result in a person that was bed ridden to get up and walk again".

WHP 4: "They need to be included, because some of them have very good medicines and we can gain something from them … some of them".

(g) Substantiate the authenticity of traditional healing methods and medicines

The need to substantiate the authenticity of traditional healing methods and medicines is associated with the belief that traditional healing has value and a role to play in the official health care system. Therefore, proof of authenticity will avail the opportunity for official collaboration between the two health care systems. The following statements illustrate the point:

WHP 1: "I think it's important that traditional healers be given the chance to prove themselves. They should bring to the forefront what they can do, and this should be researched and its authenticity established".

WHP 2: "Traditional healers should be included in the mainstream of health care so that they can be given a chance to prove themselves. They should prove what they can do, then only when there is proof can certain cases be referred to them".

WHP 3: "There should most definitely be collaboration between traditional healers and western health care practitioners. That is why they should be part of clinic committees, because we need their knowledge since we are all searching for a dish in the dark when it comes to HIV/AIDS".

9.2.4. Impediments to effective collaboration between traditional health practitioners and western health practitioners

Although the vast majority of western health practitioners indirectly and directly expressed a need for collaboration between traditional and western health practitioners, many obstacles appear to stand in the way of such collaboration. These obstacles mainly relate to the difference in interpretation and understanding of what collaboration between the practitioners of the two health care systems entails. The nature of collaboration envisaged by traditional health practitioners is detailed in paragraph 9.1.2. The following obstacles to collaboration were reported by western health practitioners, and are indicative of the nature of collaboration envisaged by western health practitioners in Buffalo City:

(a) Commercial gain and business in traditional healing (entrepreneurship)

Traditional health practitioners believe that their power to heal is a gift from their ancestors, and practising their skill is, thus, primarily a sense of duty to their communities and ancestors. However, most traditional health practitioners practice as such on a full-time basis without any other form of income. Since traditional health practitioners receive payment for services rendered, profit comes into play as much as making a living from their power to heal. It is this factor of traditional healing that is viewed as a possible impediment to successful collaboration between traditional and western health practitioners. This impediment is based on the notion that referral of a patient from a traditional to a western health practitioner translates into loss of income on the part of the traditional health practitioner. Thus, it is believed that traditional health practitioners will avoid referring patients to

western health practitioners as a means of preventing loss of current or potential income. This view is best illustrated by the following statements:

WHP 1 – "I see that they are more after business than the health of people".

WHP 2: - "They are in business. I do not think it will be easy for them to refer to us, because the patient pays for treatment and accommodation at the traditional healer. So, I do not think they will refer to us, because it will be like losing a patient. Even western doctors are like that. A GP will not refer to another GP and lose a patient".

WHP 3: - "Traditional healers are practising on private commercial basis. Not like us at the clinic. I have nothing to lose by referring a patient to another doctor, because it is for the patient's best interest".

WHP 4: - "Traditional healers make money from what they do. I do not see traditional healers sending a client presenting with HIV/AIDS symptoms away to a clinic when this person has come to them with R200 to be diagnosed/divined –'ukuvumisa'. Traditional healers are after this money. So, whether they are going to pull wool over the client's eyes or not, I do not see them sending that client away. They feel that they have to replace the monies that they spent being trained as traditional healers. This is all just a business to them. They are not interested in helping people".

(b) Fear of biopiracy

Traditional health practitioners regard their knowledge and skill to heal as a gift bestowed upon them by their ancestors. Therefore, their loyalty and respect to those who have given them the powers to heal is portrayed by the enshrinement of their healing practices, and the cloud of secrecy that engulfs the content of traditional medicines. It is this respect and loyalty to their ancestors, which western health practitioners believe may deter traditional health practitioners from collaborating with them. Collaboration may be interpreted by traditional health practitioners as the western health care system's attempt at stealing their gift to heal, through the process of sharing their traditional knowledge and medicines with western health practitioners. This fear of biopiracy is anticipated to result in traditional health practitioners distancing themselves from any form of collaboration attempted by Government and western health practitioners alike. This view is expressed by the following response:

WHP 1: - "There are those traditional healers that are very stubborn; who will not agree to collaborate. Perhaps if it is said that we should collaborate and speak with one voice to fight HIV/AIDS, they (traditional health practitioners) will think that government is trying to steal their knowledge or their medicines, and this makes them distance themselves. They will say that they were given their medicine or skill by their ancestors and, therefore, they would not be able to collaborate with western practitioners with medicine that was given to them by their ancestors".

(c) Absence of scientific formulae in preparing medicines and prescribing dosages

Preparation of traditional remedies and medicines is not based on strict scientific formulae. Instead, traditional medicines are typically prepared with the guidance of ancestors. This often takes place in the form of a dream or vision, whereby, the types of herbs and their quantities for making traditional medicines are determined by the

ancestors, and relayed to the traditional health practitioner. This translates into unfixed formulae for preparing traditional medicines. Western health practitioners view the lack of standardisation in the traditional healing system as problematic for collaboration. This argument is based on the fact that the unknown dosages and exact quantities of ingredients used in traditional medicines lead to uncertainty about which western medicines may be used to avoid drug interactions if western interventions are required in treating a patient. This concern is expressed by the following responses:

WHP 1: - "I don't think that there should be any collaboration between traditional healers and western health practitioners because their medicines are not tested. Although some of their medicines are used for making western medicines, but their dosages aren't … they just say 'take half a cup' or something like that … I'm saying that they have no formulae that are right. I do not think we will be able to collaborate with them".

WHP 2: - "Number one, traditional healers medicines do not have any dosages. Second, they cover everything. You know how they advertise their medicines, that this herb will cure hypertension, diabetes, blood pressure … everything all in one. Wonder drugs!".

WHP 3: - "How sure are they that the medicines they prescribe are really for the conditions that they describe? Where did they test their medicines and how? In western medicine everything is tested".

(d) Absence of technologically sound diagnostic methods

The western health care system, as opposed to the traditional healing system, relies to a large extent on technology to confirm any diagnosis. The absence of technology to substantiate a diagnosis is viewed as posing one of the most severe hindrances to collaboration between traditional and western health practitioners. The problem is, seemingly, compounded in the case of diagnosing and treating HIV/AIDS. First, in the western health care system, a diagnosis for HIV/AIDS requires clinical evidence of the HI virus in a patient's blood, whereas, in the traditional healing system, diagnosing HIV/AIDS is far more complex, where emphasis is placed on the cause of illness and corrective measures which need to be taken in order to return the patient's environment to a state of equilibrium, so as to return the patient's health to its normal state ("cure the illness"). Second, western treatment for HIV/AIDS, in particular antiretroviral therapy, is predetermined and based on clinical evidence, such as CD4 count and viral load, whereas, traditional treatment for HIV/AIDS-related illnesses is primarily determined by the cause of illness, with physical symptoms playing a secondary role in the treatment regimen.

Western health practitioners experience difficulty in accepting a diagnosis without scientific/clinical evidence. They admittedly attribute this to the principles and values instilled in them through their formal education in western medicine. Acceptance of a diagnosis without adhering to strict scientific procedure is viewed as a contradiction to western medical beliefs, which form the foundation of the western health profession. The following responses are indicative of this notion:

WHP 1: - "Being a western health practitioner and being interested in researching things, there has never been any scientific evidence that traditional medicines do work, which is why I will remain skeptical of it".

WHP 2: - "They (doctors) are skeptical of everything, especially if it is not in their traditional medical line of thinking. I see doctors' attitudes as an obstacle to collaboration between traditional healers and western health care practitioners. Western doctors are not liberal at all!".

WHP 3: - "We come from very different schools of thought. It will be very difficult for us, even if you are a black indigenous person, once you have been to medical school your mind changes completely. You look at the causes of diseases in a specific way. For us to get another view of disease, which is not scientific … it is almost like a compromise. Your mind will not allow you to do that. It will be as though you are not pure now. Our mindsets have been fixed".

This concern is of the utmost importance when taking into account national health programmes and plans. The Operational Plan proposes to include traditional health practitioners as partners in the provision of comprehensive treatment and care to all South Africans living with HIV/AIDS. In view of the fact that western health practitioners view treatment and therapy that does not meet with the approval of western scientific standards, as less than satisfactory, collaboration between traditional and western health practitioners in the implementation of comprehensive HIV/AIDS treatment and care is deemed unrealistic. The question of how to reconcile two seemingly diverse systems, appears to be at the root of concerns amongst western health practitioners, and further points towards confusion and lack of knowledge about the nature of traditional healing and the practice thereof. This was evident in the following response:

WHP 1: - "Concerning the inclusion of ARVs in the western health care system, I don't really see how traditional healers are going to fit in. First of all you have to have a diagnosis … identification of the virus in your blood. I don't know their system … how they take patient history, examination … I'm sure they don't do that. For a diagnosis you need CD4 count, you need viral load, and all of that stuff. I don't see how they can determine all of this, unless they try to follow our mainstream of health".

(e) Skilled versus unskilled

Western health practitioners, by virtue of undergoing formal training, which is accredited, internationally recognised, and officially endorsed, are perceived as skilled, as opposed to traditional health practitioners who are perceived as unskilled due to the lack of internationally acclaimed training, and official recognition of their profession, as was evident in the following response:

WHP 1: - "We would not be able to collaborate, because I have no idea where they were trained for their medicine. I know that they don't really have a place where they are trained other than the fact that their grandfathers did it and then told them how to do it".

Hence, western health care is viewed as superior and traditional healing as inferior. Western health practitioners who attach unequal status to the two professions are of the opinion that collaboration would not be possible -

understandably so, taking into consideration that the playing field would not be level in a relationship of this nature. It follows logically that western health practitioners would view their practices as effective, and those of traditional health practitioners as ineffective. This view is best expressed by the following responses:

WHP 1: - "It would be difficult from the side of western doctors to collaborate with traditional healers, because western doctors have learnt the skill of healing … they are professional. Traditional healers are unskilled. So now you cannot bring together a person that is skilled with a person that is not skilled. The skilled person will say that they know how to heal the correct way, because they have studied for it, whereas the unskilled person will say that they heal in a specific way, because it was shown to them by their ancestors. I don't think they would be able to collaborate because of this reason. They don't think the same way, although they both wish to heal people".

WHP 2: - "The way western doctors have been trained is unfortunately based around their egos, I think. We come out of medical school thinking we are God. Even as it is, a doctor will not refer to a homeopath or an acupuncturist. They are so sceptical of everything, especially if it is not in their traditional medical line of thinking".

(f) Lack of guidelines and leadership

The absence of policies to guide collaboration between the two groups of practitioners was voiced by traditional health practitioners as a major hindrance to collaboration (cf. paragraph 9.1.1c). This was further reiterated by western health practitioners. Although the vast majority of western health practitioners reported a need for collaboration, they were of the opinion that such collaboration would not be realised without a vehicle and driver to steer all the roleplayers ahead. Antagonistic attitudes of western health practitioners; lack of knowledge and understanding of the traditional healing system; and professional subjectivity or bias, were the most prominent constraints reported in the quest for traditional and western health practitioners finding common ground. Views expressed by respondents pointed towards an urgent need for a third independent party with sufficient clout, to act as a catalyst of change. Government was repeatedly, either directly or indirectly, commissioned to initiate and drive the process of collaboration. The following responses serve as examples in point:

WHP 1: - "The only way, I think, that collaboration between the two systems will be possible is at the highest levels of government. Because, given to individuals, there will be a lot of opposition that would retard the process. Opposition from the various practitioners … western. Various practitioners that will safeguard their own territories".

WHP 2: - "There are no policy guidelines for collaboration between traditional healers and western health practitioners as yet".

(g) Resistance to change traditional healing practices

On the flip side of the coin, some western health practitioners anticipate that traditional health practitioners, themselves, will be the grim reapers of collaboration by opposing the exchange of traditional healing practices for western health care practices. This anticipated opposition is largely related to the biased notion towards western health care, namely as being the superior and effective health care system, rather than to perspectives attributing

equal status to the two health care systems. Based on this biased perspective towards western health care, collaboration is, thus, viewed as traditional health practitioners taking on the role of secondary western health practitioners. Adopting such a role will require traditional health practitioners to transform their belief system, especially as pertaining to theories of disease causation and cosmology, which form the core of the traditional healing system. Taking into consideration the magnitude of change which would be necessitated from the side of traditional health practitioners and the consequential implications thereof, it is only logical to anticipate that such change would be met with great resistance from the traditional healing sector.

This, once again, points towards a dire lack of clear guidelines for collaboration between western and traditional health practitioners, albeit the need to do so has been acknowledged, emphasised, and even stipulated in national policies, such as the *STD/HIV/AIDS Strategic Plan for South Africa 2000*-2005 (Strategic Plan), and the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa 2003* (Operational Plan) (Department of Health 2000; 2003).

(h) Lack of regulation and unification of traditional health practitioners

The absence of strict regulatory mechanisms for traditional health practitioners is a major stumbling block for any collaborative endeavour embarked upon. An unregulated industry undermines the calibre of professionals in the industry by reducing the standard of services rendered through failure to sanction unacceptable practices. This is currently the case with the traditional healing system in South Africa. Traditional health practitioners practise their profession fairly unperturbed. However, lack of regulatory standards within the traditional healing system has left ample room for charlatans to earn a living and, thus, tarnish the credibility of *bona fide* practitioners, as illustrated by the following response:

> *WHP 1: - "It would be very difficult to have traditional healers accommodated into a formal kind of system, in that what they do, does not have any form of yardstick in terms of them passing a formal exam. In fact, that would lead to a dilution factor in what they do, because that will be a gateway for anybody to just come in and claim to be a traditional healer. There should be an establishment of a standard that would effectively control the movements of the traditional healers".*

Furthermore, traditional health practitioners in Buffalo City are fragmented into cliques based on residence, training institutions, traditional health practitioners associations, and ethnicity. This translates into a system marked by disunity and questionable professionalism as a result of unregulated practices of practitioners of this profession. It would be a virtually futile task to initiate dialogue towards collaboration between traditional and western health practitioners without unification of each sector of practitioners as a foundation upon which to build a partnership. Only when internal unification and stability is achieved in each sector will the possibility for unification and stability between the two sectors be optomised.

9.2.5. Legalising and professionalising traditional health practitioners

Government's attempts to regulate and legalise the traditional healing sector is welcomed and supported by western health practitioners who share a sense of importance for collaboration. Efforts to this end are perceived beneficial for both traditional and western health practitioners, as well as the population that is pluralistic in health

care utilisation through ensuring the provision of traditional health care of a high quality and standard. The following responses are indicative of this perception:

WHP 1: - "Legalising and professionalising traditional healers will have great benefits. It will help a lot of people, and there will not be so many deaths, because now they will know that they have to work up to a specific standard. They will know that if a girl is dehydrated they must be referred to a government facility. I encourage this, because they will work according to certain guidelines".

WHP 2: - "I think that legalising them and professionalising them is a good thing, because you find many chance takers. So, if they are recognised and registered somewhere, it will prevent every Jack and Jill from healing, especially those who treat but cannot treat … abusing people. If they are legalised it will be easier to control them".

WHP 3: - "I view the legalisation and professionalisation of traditional healers as a good thing, because then there will be some form of monitoring of traditional healers. First of all, a client will have documents (patient card) which will state that this client was diagnosed with such and such an illness, and was seen by a western doctor and given a specific treatment. If the client goes to a traditional healer, it will also state in the records what treatment the client was given by the traditional healer, so that if something happens to the client and the records show that the client was suffering from a specific illness which required specific treatment, but the traditional healer gave the client their own thing, then government will be able to intervene on behalf of the client".

WHP 4: - "I'm very keen on formal collaboration, because, as it stands, they are not under any supervision or under any regulation. So, their ethics are, therefore, questionable. So, we need to embrace them as part of our health care system, because they are health care providers. In that way we will have some supervision and regulation over what they do, and they will be accountable for what they do. So, I agree 100% with government's move towards regulating and professionalising traditional healers".

WHP 5: - "I think the legalisation and professionalisation of traditional healers will have the advantage of getting rid of the 'boggas' traditional healers".

WHP 6: - "The legalising and professionalisation of traditional healers through the Traditional Health Practitioners Act is a step in the right direction. You must remember that the Government always envisages smooth running of systems, but it is always easier said than done. However, these are initiatives that should be taken, or else nothing comes into being without any such initiatives".

WHP 7: - "Perhaps if they are legalised and they have their own organisation, then people will know that they are not doing anything illegal by going to traditional healers. Because patients do not want to admit going to traditional healers now".

Very few western health practitioners opposed this endeavour. Perceptions of a total lack of value in traditional healing formed the basis of opposition. Legalising and legitimising traditional health practitioners is, therefore, viewed

as pivotal to opening up channels for collaborative relations between the western health care system and traditional healing system as envisaged by national policies.

9.3. Summary of findings from interviews with traditional and western health practitioners

Based on the discussion of the main findings of the research, the most salient factors, in view of the research objectives, are extrapolated and summarised below. The summation of the findings is aimed at highlighting insightful contradictions and similarities between data from traditional health practitioners and western health practitioners.

9.3.1. Perceptions about collaboration between traditional and western health practitioners

- Collaboration between traditional[37] and western health practitioners in Buffalo City is described as "non-existent" by both traditions of practitioners. Even the few reported incidents of so-called collaboration demonstrate scantiness, haphazardness, inconsistency, and a lack of standardisation and monitoring.
- The large majority of traditional and western health practitioners believe that collaboration between the two types of health care providers is of fundamental importance to improve the health status of their communities.
- Traditional and western health practitioners differ significantly in their views on the nature of collaboration between the two health care systems. These differences bear negative implications for collaborative prospects. On the one hand, traditional health practitioners envisage collaboration as encompassing a formal bilateral (two-way) referral system between traditional practitioners and western health care facilities; joint decision-making between traditional and western practitioners on specific patients and specific illnesses; and sharing of information and expertise between the two health care providers. On the other hand, western practitioners envisage collaboration as traditional practitioners receiving training in western health care; a formal unilateral (one-way) referral system from traditional health practitioners to western health care facilities; and sharing of information about the contents of traditional medicines/remedies which have demonstrated curative effects.
- Both western and traditional health practitioners referred to collaboration between traditional surgeons and western practitioners as exemplary of successful collaboration. However, fewer traditional practitioners than western practitioners were of this opinion. One traditional practitioner attributed the apparent increase in deaths amongst young initiates to inappropriate collaboration between traditional surgeons and western health practitioners.
- Very few western health practitioners, and even fewer traditional health practitioners, were opposed to collaboration between the two health practitioners. Opposition was mainly based on superiority/inferiority status attributed to the two health care systems, as well as an inability to comprehend the integration of two phenomenally diverse health care systems. Traditional practitioners who were opposed to collaboration based it on their belief that the traditional healing system is the superior of the two systems, and that all diseases and illnesses could be cured by traditional intervention. Based on this belief, collaboration is deemed futile.

[37] Traditional health practitioners mainly refer to diviners, herbalists and spiritual healers.

Similarly, opposition to collaboration among western practitioners is derived from the belief that western practitioners are skilled and professional, as opposed to traditional practitioners who are unskilled and unprofessional. Based on this perspective of unequal status, collaboration would appear impossible, since traditional healing is perceived as ineffective from the outset.

9.3.2. Impediments to collaboration between traditional and western health practitioners

- The belief in a traditional cure for HIV/AIDS appears to pose one of the gravest threats to collaboration between traditional and western health practitioners. The majority of traditional practitioners who participated in the research believe that HIV/AIDS can be cured. This belief is based on the traditional premise that all recurrent illnesses have a supernatural cause. The correct diagnosis of the cause, and adherence to the prescribed traditional treatment and medicine are believed to "cure" the illness. Contrary to this, western practitioners still firmly believe that HIV/AIDS cannot be cured at this point in time.
- Lack of knowledge about the nature of traditional healing, as well as traditional medicines, is an obstacle to integrating traditional and western medicine. Western health practitioners raised concerns about their lack of knowledge regarding traditional practices, more especially the content and dosages of prescribed traditional medicines. Fear of harmful reactions, such as drug interactions, which may result from combining traditional and western health care practices and medicines, is the most prominent concern.
- Lack of unification hampers any attempt at collaboration. Traditional health practitioners in Buffalo City form three broad segments, namely traditional practitioners who are registered with the national Traditional Health Practitioners Association of South Africa, traditional practitioners who are not registered with this association, but enjoy membership with another traditional health practitioners association, and traditional practitioners who are neither registered with the national association or any other traditional health practitioners association. Traditional health practitioners are also typically arranged into cliques based on affiliation to an association, residential area, trainer/mentor, and ethnicity. These cliques further segregate traditional health practitioners through the edge of animosity between them, thus, compounding the complexity of collaboration.
- Western health practitioners view commercial gain and business (entrepreneurship) in traditional healing as a deterrent to traditional health practitioners referring patients to western practitioners when the need arises. Based on this view, traditional practitioners use the cost/benefit ratio in decision-making about referring patients. Western practitioners believe that traditional practitioners weigh the personal cost of referring a patient to a western practitioner against the personal benefit of not doing so. If the cost of referring a patient (loss of income) outweighs the benefit of not referring the patient (potential/current income), then traditional practitioners will avoid referring patients to western practitioners. Traditional health practitioners also raised this concern. They reported that it would be difficult for some traditional practitioners to refer patients to western practitioners taking into consideration the implications of such a referral for the traditional practitioner (i.e. loss of income). It is reported that some traditional practitioners do not even refer patients to another traditional practitioner if the cost implication is a loss of current or potential income. This mentality and behaviour is condemned by traditional practitioners, and described as competitive and irresponsible.

- Both traditional and western health practitioners perceived the lack of recognition of traditional practitioners by western health practitioners as one of the obstacles to effective collaboration between the two health care practitioners. Surprisingly, only a few traditional practitioners perceived western practitioners as being opposed to collaboration. In fact, many traditional practitioners are of the opinion that western practitioners are more than willing to engage traditional practitioners as partners in fighting priority diseases, such as HIV/AIDS. On the flip side of the coin, the majority of western practitioners perceive the antagonistic attitudes of western practitioners as a major obstacle to effective collaboration.
- Lack of leadership was reported by both traditional and western health practitioners as a contributing factor to the lack of collaboration between the two groups of practitioners in Buffalo City. Traditional practitioners reported an absence of commitment on the part of Government in unifying traditional practitioners. Lack of government commitment is reportedly manifested in the small number of traditional practitioners registered with the national Traditional Health Practitioners Association, and delays in effecting plans for the inclusion of traditional practitioners in the official health care system. At the time of data collection, only 20 traditional practitioners in Buffalo City were registered with the national Traditional Health Practitioners Association. Western practitioners expressed a need for Government to act as a catalyst of change by adopting a far more vigorous and rigorous approach to enforcing collaboration between traditional and western practitioners, instead of leaving it up to practitioners of the two health care systems.

9.3.3. Perceived value of the traditional healing sector

- Both traditional and western health practitioners believe that traditional medicines have immune boosting properties. Traditional practitioners reported that HIV/AIDS patients treated with traditional remedies demonstrate an increase in appetite, weight-gain, regaining of strength, and the ability to perform daily activities which were disturbed due to illness.
- Successful treatment of certain diseases, such as cancer, by traditional healing methods, was reported by both traditional and western health practitioners.
- The psychological benefits of traditional healing are regarded as the most significant strength of this sector by western health practitioners. Traditional practitioners share the worldview of their patients, and provide answers to the 'why' and 'who' associated with illness. Therefore, the holistic approach of traditional healing is perceived to provide psychological and psychosomatic relief in patients.
- The reported absence of a district hospital in Buffalo City by some western health practitioners interrupts the official referral system, namely from primary level of care (clinic, community health centre/day hospital) to secondary level of care (district hospital), to tertiary level of care (provincial hospital). Therefore, HIV/AIDS patients who cannot receive the appropriate treatment and care at a primary health care facility, yet cannot be referred to the provincial hospital, often turn to traditional health practitioners for treatment and care, thus, acting as an alternate health care service for patients who would otherwise not have access to health care.
- One of the notable strengths of the traditional healing system, as perceived by western practitioners, is the privacy and unlimited time offered by traditional practitioners per consultation.

9.3.4. Weaknesses of the traditional healing sector

- Traditional health practitioners' treatment regimens for HIV/AIDS-related illnesses, which includes inducing diarrhoea and vomiting, promotes dehydration and the further emaciation of patients. Traditional practitioners need to understand the relationship between their healing practices and the effects thereof to the human immune system.
- Western health practitioners reported psychological turmoil and torment in patients who seek health care from traditional practitioners who claim to cure HIV/AIDS. These patients repeatedly undergo an HIV-test with the hope that they have been cured, and are distraught when the tests show a positive result each time. Traditional practitioners need to understand the relationship between traditional healing and emotional and psychological well-being.
- Traditional health practitioners believe that all diseases and illnesses can be treated within the traditional healing sector. However, traditional practitioners indirectly admit to fall short when it comes to treating dehydration. This shortcoming is evident in the referral of patients who are severely emaciated and weak to western practitioners for intravenous rehydration (drip), so that traditional medicines can trigger the desired positive effect. Further shortcomings of the traditional healing system were demonstrated by some traditional practitioners utilising the western health care system for their own ailments and chronic illnesses, as well as prescribing western medicines in conjunction with traditional medicines for their patients.
- Toxicity and severe reactions/complications of traditional medicines were reported by western health practitioners as major weaknesses of the traditional healing system.
- The most adverse impacts of traditional healing are attributed to a lack of sufficient and accurate knowledge about HIV/AIDS among traditional health practitioners. The typical traditional treatment regimen for HIV/AIDS-related illnesses includes inducing diarrhoea (enemas) and vomiting. Inducing vomiting and diarrhoea in already emaciated and severely dehydrated patients, aggravates their condition, even resulting in death. Additional adverse impacts associated with lack of knowledge about HIV/AIDS includes psychological and emotional torment when patients who are promised a traditional cure repeatedly test HIV-positive; burdening the PHC system due to nurses testing the same patients repeatedly for HIV/AIDS after receiving traditional treatment to "cure" HIV/AIDS; and destroying interpersonal relationships with accusations of witchcraft.
- Lack of hygiene in traditional healing practices, especially in preparing and storing traditional medicines, is perceived to increase the vulnerability of HIV/AIDS patients to infections.

9.3.5. Perceived needs of traditional health practitioners

- Both traditional and western health practitioners pointed towards a need for traditional practitioners to acquire knowledge about HIV/AIDS. Traditional practitioners perceive HIV/AIDS as a fairly new phenomena, which even the ancestors are not very knowledgeable about. However, the two groups of practitioners differ on the nature and content of training. Western practitioners are more of the opinion that training should be based on western ideologies and practices, whereas, traditional practitioners wish to strengthen and complement traditional practices, rather than substitute them for western practices.

- A disproportionately small proportion of traditional health practitioners in Buffalo City, and within the group of respondents, are registered with the national Traditional Health Practitioners Association, and are, thus, licensed to practise as such. A lack of sufficient knowledge about the provincial Traditional Health Practitioners Association appeared to be at the root of traditional practitioners' reluctance to register.
- Although both traditional and western health practitioners welcome the regulation and legislation of traditional practitioners nationally, it is apparent that knowledge about this process, namely the Traditional Health Practitioners Bill[38], is very scanty, inaccurate and inconsistent. Some traditional practitioners expressed weariness and cautiousness about the content of the Bill, which they were not knowledgeable about. Optimism about the new legislation is based on traditional practitioners' dire need for official recognition by their communities, as well as practitioners of the western health care system; need for legal status in the practise of their profession; need to practise their profession unhindered; and need to oust charlatans. It is believed that the Bill will address these needs to the satisfaction of traditional practitioners. Western practitioners perceive the Bill as a means to regulate and control traditional practitioners as they see fit, as well as to promote collaboration between the two groups of practitioners as desired by western practitioners.
- The main concerns raised by traditional health practitioners relate to the absence of the appropriate infrastructure to render traditional healing services of a high quality and standard. These include a lack of appropriate facilities to provide traditional treatment and care of a high standard; facilities for processing and packaging traditional medicines; demarcated land for planting medicinal plants; and legal protocols permitting traditional practitioners to collect medicinal plants on private property.

9.4. In conclusion…

Traditional and western health practitioners see value in traditional healing, but differ on the nature and extent of value. Traditional practitioners, on the one hand, perceive traditional healing as having the potential to cure all illnesses, including HIV/AIDS. On the other hand, western practitioners attribute the value of traditional healing to the ability of traditional practitioners to treat patients psychologically and relieve psychosomatic symptoms. However, the harmful practices of traditional practitioners, especially pertaining to the treatment regimens for patients that present with an HIV-related illness, and the belief that HIV/AIDS can be cured, undermine the perceived effectiveness of the traditional healing sector amongst western practitioners. It is both the perceived value and weaknesses of traditional healing that evokes consensus on a need for collaboration between the two groups of practitioners. However, the envisaged nature of collaboration differs significantly between traditional and western health practitioners. Traditional practitioners view their contribution to the health care of the population at large, and more specifically in the treatment and care of people living with HIV/AIDS, *as* fundamentally important as that of western medicine. The nature of collaboration envisaged by traditional practitioners include:

- A bilateral (two-way) referral system between traditional and western health care facilities/practitioners;
- Joint decision-making between traditional and western health practitioners regarding patients.
- Whereas, the nature of collaboration envisaged by western practitioners entails:

[38] At the time of data collection, the Traditional Health Practitioners Bill had not yet been enacted. Hence, reference to the Bill and not the Act.

- A unilateral (one-way) referral system from traditional to western health practitioners;
- Sharing of information about the content of traditional medicines which demonstrate curative effects;
- Educating traditional health practitioners about HIV/AIDS and other health issues based on the biomedical approach.

The legalisation and professionalisation of the traditional healing sector through legislation is viewed in a positive light by both traditional and western health practitioners. The main perceived advantage of the regulation of this system of health is the ousting of charlatans. However, the lack of knowledge about the content of the Traditional Health Practitioners Act amongst traditional practitioners manifests in skepticism and reservations about the benefits of the legislation for traditional practitioners.

"Arrogance is an ugly weed which destroys all wisdom."

Indian proverb

(Friedman 1998)

Chapter 10

CONCLUSIONS AND RECOMMENDATIONS

In this chapter the main findings of the research will be summarised and key conclusions which inform the main aim of the research will be inferred. Based on the findings, the role of traditional health practitioners in the treatment and care of people living with HIV/AIDS in Buffalo City will be identified, including impediments to effective collaboration between traditional and western health practitioners in the provision of health care. Thereafter, measures to enhance the benevolent capacity of traditional health practitioners in health care will be proposed.

10.1. Main conclusions

Based on the findings discussed in chapters seven, eight and nine, the most significant findings will be summarised and presented as the main conclusions of the study. The conclusions will be guided by the stipulated research objectives, and will be presented according to the most salient themes that emerged from the findings.

10.1.1. Knowledge about HIV/AIDS

Knowledge about HIV/AIDS among traditional health practitioners in Buffalo City is lacking, inaccurate, inconsistent and contradictory. Very few traditional practitioners reported receiving formal western education/training about the disease. Most traditional practitioners received their limited knowledge about HIV/AIDS informally through word of mouth, or through the media. Traditional health practitioners expressed a need for the acquisition of knowledge about the disease. However, they caution against imposing of western practices and beliefs to replace traditional practices and beliefs in the process of acquiring such knowledge.

Their lack of knowledge about HIV/AIDS is mainly attributed to the disease being a fairly new phenomenon, which even the ancestors are unfamiliar with.

10.1.2. Diagnosing, treating and curing HIV/AIDS

Traditional health practitioners' diagnosis of HIV/AIDS depends on the guidance of the ancestors, their limited knowledge about HIV/AIDS – acquired through formal western education/training, informally through word of mouth and the media – as well as a blood test for confirmation. The main focus of diagnosis is to determine the cause (*unobangela*) of HIV/AIDS, since this bears significant importance in prescribing the correct treatment and remedial action.

Treatment for HIV/AIDS typically entails three activities, namely inducing vomiting and diarrhoea (enemas) to eliminate the "toxic" substance from the body, consuming traditional medicines to strengthen and protect the body from further attack, and performing rituals which are determined by the cause of illness, to restore the balance in the patient's environment (corrective measures). Inducing vomiting and diarrhoea in already emaciated patients exacerbates dehydration, thus leading to further deterioration of health. It appears that traditional practitioners are not aware of the relationship between dehydration, vomiting and diarrhoea. However, traditional health practitioners admit that they lack the capacity to treat dehydration. Hence, they refer patients who they perceive as severely dehydrated to western health facilities for rehydration first, so that they can continue administering their traditional treatment regimens thereafter.

In general, traditional health practitioners in Buffalo City believe that HIV/AIDS can be cured, based on the traditional healing philosophy that all illnesses can be cured if the cause is accurately diagnosed, and the appropriate treatment and corrective measures are strictly adhered to. This belief is sustained despite public denouncements by authorities of the national Traditional Health Practitioners Association and affiliate bodies in the Eastern Cape, from claims of traditional cures for HIV/AIDS.

10.1.3. Perceived strengths of traditional health practitioners

Traditional health practitioners in Buffalo City perceive their most important strength to be the ability to cure all illnesses, within the traditional healing sector. However, traditional health practitioners differ in their perceived efficacy to treat illnesses. Some traditional health practitioners reported to have the ability to cure all illnesses, whilst others reported to have the ability to cure certain illnesses (specialists). The ability to successfully treat cancer with traditional remedies was reported by both traditional and western practitioners. Western practitioners based their responses on patient observations rather than clinical evidence/trials.

Western practitioners perceive traditional practitioners to be of most value in treating patients psychologically, and relieving psychosomatic symptoms. Seemingly, some traditional medicines have immune boosting effects, based on physical manifestations in HIV/AIDS patients treated by traditional practitioners. This observation was reported by both traditional and western practitioners. Some western health practitioners reportedly also prescribe certain traditional herbal concoctions which are alleged to be beneficial to people living with HIV/AIDS who suffer from a compromised immune system.

The availability of traditional health practitioners in the perceived absence of a secondary level of care (between primary health care and tertiary health care facilities) in the research site can be viewed as a strength of the traditional healing sector. Patients who are living with HIV/AIDS but cannot receive the required treatment and care

at a primary level of care, and do not necessarily qualify to receive treatment at a tertiary level of care, often resort to traditional health practitioners for treatment and care. Privacy and unlimited time offered by traditional practitioners per consultation are additional strengths of the traditional healing sector. These strengths of the traditional healing sector, in addition to the shared worldview between traditional health practitioners and their patients, are associated with the perceived high utilisation rate of traditional practitioners in Buffalo City, despite the wide availability of western health care facilities within communities in Buffalo City.

10.1.4. Perceived weaknesses of traditional health practitioners

Traditional health practitioners reported not to have any weaknesses when directly asked. However, through the process of probing, as well as observations made by the researcher, several shortcomings of traditional practitioners in Buffalo City emerged. Some traditional health practitioners were receiving western treatment for conditions such as diabetes, hypertension and painful joints. Other traditional practitioners were prescribing western medicine in conjunction with traditional remedies to their patients. This is indicative of the interdependence and mutual collaboration between traditional and western medicine, rather than the failure of one system against the victory of another in providing health care.

The most prominent weaknesses of traditional health practitioners reported by western health practitioners were:

- Harmful treatment regimens, such as inducing diarrhoea and vomiting in already dehydrated and severely emaciated HIV/AIDS patients.
- Strong reaction of some traditional medicines, which further destroy the immune system of patients living with HIV/AIDS.
- Sustaining and nurturing the belief that patients diagnosed as HIV-positive will become HIV-negative upon successful completion of prescribed traditional treatment regimens.
- Emotional and psychological torment when patients who are repeatedly tested after traditional treatment regimens reveal sustained HIV-positive results.
- Increase in western health practitioner workload as a result of repeated counseling and testing of the same HIV-positive patients after completion of prescribed traditional treatment regimens.
- Destroying interpersonal relationships of HIV/AIDS patients by attributing the cause of illness to witchcraft. Patients suspect family members, neighbours, friends or colleagues and, thus, results in strained human relations in communities.

In summary, the weaknesses of the traditional healing sector tend to undermine the perceived strengths.

10.1.5. Current collaboration

Collaboration among traditional health practitioners themselves, as well as between traditional and western health practitioners in Buffalo City is far from the global ideal, namely in line with universal standards set by the WHO for integrated health care systems (WHO 2000). Traditional health practitioners are segregated and divided as a result of affiliation/non-affiliation to an association; registration/non-registration with the national Traditional Health Practitioners Association; residency; ethnicity; and trainer/mentor.

Collaboration between traditional[39] and western health practitioners is informal, ad hoc, inconsistent, and lacks standardisation and monitoring. Clinic committees are viewed as ideal forums for encouraging and facilitating collaboration. However, these were lacking at the primary health care facilities that were selected for the research undertaken. The most prominent form of informal collaboration is a unilateral (one-way) referral system from traditional health practitioners to western health facilities/practitioners. This is both encouraged and commended by western health practitioners. Collaboration between traditional surgeons and western health practitioners was viewed as exemplary of successful collaboration by both traditional and western health practitioners, although a few traditional health practitioners begged to differ.

10.1.6. Envisaged collaboration

The need for more and closer collaboration was almost unanimously reported by both traditional and western health practitioners. Both cadres of practitioners pointed towards improving health care and decreasing mortality, especially amongst people living with HIV/AIDS, as the underlying reason or rationale for collaboration. However, differences in the nature of collaboration envisaged by the two, poses fundamental hindrances for effective collaboration. On the one hand, western health practitioners envisage a far more one-sided relationship than traditional health practitioners, where traditional practitioners are the recipients of western knowledge and practices. On the other hand, traditional health practitioners envisage a more reciprocal relationship characterised by mutual sharing of knowledge, skills and expertise between traditional and western health practitioners.

10.1.7. Impediments to effective collaboration

Impediments to effective collaboration between traditional and western health practitioners lie in both the traditional healing and western health systems. A number of hindrances were identified by traditional and western practitioners in current collaboration, as well as those threatening prospective collaboration. The following factors pose challenges to collaboration:

- The belief that HIV/AIDS can be cured by traditional medicines/interventions
- Lack of knowledge among western health practitioners about the traditional healing system (ideologies, practices, training, medicines, etc.)
- Fear of biopiracy
- Fragmentation/disunity of traditional health practitioners
- Entrepreneurship in traditional healing
- Lack of recognition of traditional health practitioners and their profession by western health practitioners
- Absence of legislation granting traditional health practitioners legal status
- Lack of a vigorous approach and leadership to propagate, initiate, steer and monitor collaboration.

Seemingly, various factors related to both the traditional healing system, as well as the western health system contribute to the lack of collaboration between the two systems.

[39] Traditional health practitioner mainly refers to diviners, herbalists and spiritual healers.

10.1.8. Views about legalising and regulating traditional health practitioners

Traditional health practitioners in Buffalo City lack sufficient knowledge about the most recently enacted Traditional Health Practitioners Bill. This is attributed to the absence of a workshop for all the relevant stakeholders in Buffalo City, aimed at creating awareness about the Bill, discussing the content of the Bill, clarifying concerns raised by stakeholders pertaining to the Bill, and securing the participation of all stakeholders in drafting the Bill.

Generally, traditional health practitioners are optimistic about gaining legal status and recognition through legislation. The perception amongst traditional health practitioners in Buffalo City is that legislation will place them on a par with western health practitioners and, thus, grant their profession formal recognition and dignity. However, their lack of knowledge about the content of the Bill conjures up concern pertaining to the beneficial nature of the Bill for traditional health practitioners *vis-á-vis* benefits for Government and western health practitioners. Western health practitioners in Buffalo City approve of legalising and regulating traditional health practitioners, although they too lack knowledge about the content of the Bill.

Both traditional and western health practitioners perceive the regulation and legalisation of traditional practitioners as serving two important functions, namely ousting charlatans from the mainstream of traditional healing, and facilitating communication between the practitioners of the two health systems towards effective collaboration.

10.1.9. Infrastructural needs of traditional health practitioners

Traditional health practitioners lack the appropriate infrastructure to provide traditional health care of a high quality and standard. Lack of sufficient water and sanitation, as well as accommodation for patients that need 24-hour traditional care was one of the main concerns of traditional health practitioners. The option of the institutionalisation of traditional health care, such as establishing traditional hospitals, is not without rational objections. Objections to this option of infrastructural development are mainly based on the lack of standardisation in traditional healing practices. The diversity in the practices of traditional health practitioners, both within the same category and between categories, is likely to result in conflict when the practices of some traditional health practitioners are perceived to impose on those of other traditional health practitioners within the confines of traditional hospitals.

Furthermore, infrastructural development is also required in the areas of planting medicinal plants, and processing and packaging traditional medicines.

10.2. Recommendations

Recommendations are proposed, each time based on the main conclusions deduced from the findings of the research, and within the theoretical framework of the literature study in part one of the document. Recommendations are aimed at enhancing the perceived benevolent role of traditional health practitioners with specific reference to the treatment and care of people living with HIV/AIDS.

10.2.1. Increase knowledge about HIV/AIDS by appropriate training

Traditional health practitioners in Buffalo City require more detailed knowledge about all aspects of HIV/AIDS. However, such knowledge needs to be culture-specific and profession-friendly, rather than strictly western-based.

The purpose of imparting detailed knowledge about HIV/AIDS should primarily be to assist traditional health practitioners to improve the quality of traditional health care and rid it of harmful effects. Training should be conducted within the traditional practitioners' natural environment, and should include traditional health practitioners as active participants, where traditional practitioners share their knowledge about HIV/AIDS and reconcile it with the detailed information of the training. Furthermore, traditional health practitioners should be encouraged to educate other traditional practitioners, and to ensure that such education is repetitive and continuous.

According to initiatives identified by the Joint United Nations Programme on HIV/AIDS (UNAIDS) as flagship projects in the area of collaboration between traditional and western health practitioners, two key success factors were evident in relation to educating traditional practitioners, namely repetitive rather than a single training model is more effective; and first generation of trained traditional health practitioners select and train their peers more effectively than the western-trained trainers of the first generation, because the traditional practitioners' selection is less politically directed and the training more culturally appropriate (King 2000).

10.2.2. Discuss the relationship between traditional healing practices and harmful reactions thereto

Formal deliberations about the relationship between traditional healing practices and harmful reactions thereto especially for people living with HIV/AIDS should be conducted. These discussions should focus specifically on the relationship between the immune system of people living with HIV/AIDS, enemas and vomiting. Once again, deliberations should be interactive and culture-specific as opposed to being authoritative and purely biomedically-based. Traditional health practitioners should be encouraged to adapt harmful traditional healing practices to the benefit of their patients in a non-judgemental and non-critical manner. Care should also be taken to avoid prescribing western practices as the superior and more effective form of treating people living with HIV/AIDS. This approach will merely deter traditional health practitioners from taking cognisance of any useful information that will benefit their patients.

10.2.3. Redefine traditional "cure" for HIV/AIDS

Traditional health practitioners need to be made aware of the psychological and emotional adversities experienced by patients who believe that HIV/AIDS can be cured through traditional healing intervention. The difference between relieving the symptoms of HIV-related illnesses and eliminating the virus from the body should be clarified to traditional health practitioners, so too should the intricate nature of the virus (viral mutation). It is vital that traditional health practitioners are not discouraged from believing that a traditional cure for HIV/AIDS is possible. Emphasis should be placed on the validation of traditional medicines that are believed to cure HIV/AIDS before patients are told of this effect, to prevent negative psychological and emotional repercussions for patients. In the same breath, propagating the validation of traditional medicines which are alleged to cure HIV/AIDS should be supported by efforts to this effect. This will entail developing the necessary infrastructure and programmes to avail traditional health practitioners opportunities to validate claims of traditional cures for HIV/AIDS.

At present, only a few selected tertiary institutions and organisations in South Africa are involved in the testing of traditional medicines for their validation and subsequent registration. In addition, such efforts appear to progress at a

less than satisfactory pace if viewed against escalating HIV/AIDS-related morbidity and mortality. Tertiary institutions, nationally, need to adopt a far more active role than is currently evident, in assisting traditional health practitioners to validate the effectiveness of traditional medicines that are alleged to cure HIV/AIDS. This is especially important in clarifying the difference between treating the symptoms of HIV/AIDS, on the one hand, and eliminating the HI virus from human blood, on the other, amongst traditional health practitioners.

Promoting the validation and registration of traditional medicines and initiatives embarked upon to this effect should be complemented by policies to protect the intellectual property rights of traditional health practitioners, and guard against biopiracy and their exploitation. Some traditional practitioners in Buffalo City are skeptical of sharing knowledge about the contents of their traditional medicines, which have acclaimed curative properties, with western practitioners. They do, however, express a need for opportunities to prove the authenticity of their medicines. It is of the utmost importance to gain the trust of traditional practitioners through respecting their rights of ownership over their herbal formulae, for the dual purpose of improving the traditional health care they provide to their clients, as well as for enhancing the status and standard of the traditional healing system.

10.2.4. Unify traditional health practitioners

A vigorous approach should be adopted for the registration of traditional health practitioners with the national Traditional Health Practitioners Association. Disunity amongst traditional health practitioners hampers efforts towards collaboration between traditional and western practitioners, as well as regulating and monitoring the practices of traditional practitioners. The most salient reason behind the small proportion of practising traditional practitioners currently registered with the national Traditional Health Practitioners Association is a lack of knowledge and clarity about the main aim and purpose of the so-called new association. Enforcing the registration of all traditional health practitioners with this association will facilitate the sifting of charlatans from *bona fide* traditional health practitioners, as well as organise traditional health practitioners into a professional body. However, there should be understanding and sensitivity for the reasons why some traditional practitioners opt not to affiliate with traditional health practitioner associations including the national association. Some of these reasons are valid.

Therefore, a succession of workshops should be conducted aimed at educating traditional health practitioners about the purpose and expectations of the national association for traditional health practitioners. These workshops should also accommodate queries and comments regarding the association. Thereafter, traditional health practitioners should be given a specified period in which to register with the national association in order for them to be included in the realm of health care. Complementary workshops should also be conducted with community members to educate them about the new association for traditional practitioners and the benefits of consulting traditional practitioners who are registered as opposed to those traditional practitioners who are not.

It is important that both traditional health practitioners and individuals who utilise the services of these practitioners are encouraged to support the registration of traditional practitioners with the national Traditional Health Practitioners Association towards enhancing the quality and status of the traditional healing system.

10.2.5. Create awareness about the content and implications of the Traditional Health Practitioners Bill

Lack of knowledge about the content and implications of the Bill among traditional health practitioners in Buffalo City, has resulted in fundamental discrepancies between perceptions of the Bill and certain clauses in the Bill. It can be assumed that the recently enacted Bill will be met with grave criticism and resistance once its contents and implications are fully known to traditional practitioners in Buffalo City. It was of the utmost importance that workshops be conducted to inform both traditional and western practitioners about the actual content of the Bill prior to its approval and subsequent enactment. These workshops should have been aimed at soliciting comments from both groups of practitioners, to clarify and address queries pertaining to the Bill, and to secure the support and participation of all stakeholders in the effective implementation of the proposed Act. A workshop to this effect was conducted in the OR Tambo District, which was deemed successful in terms of preparing stakeholders for the eventual implementation of the Bill once enacted. The Buffalo City Municipality, as part of the Amatole District, should urgently follow suit, even though the Bill has already been enacted.

10.2.6. Demystify traditional healing through dual training for traditional and western health practitioners

Joint workshops should be conducted for traditional and western health practitioners towards demystifying traditional healing methods. The nature of the workshops should be such that practitioners of both health systems are allowed to interact and clarify misconceptions and myths related to each profession. Workshops should also be conducted to educate traditional practitioners about the basic principles and theories of western medicine. In turn, western health practitioners should be educated about the basic principles and ideologies which form the backbone of the traditional healing system.

A structured training programme based on both the traditional and western health systems should be developed in close consultation with practitioners from the respective systems. The training programme should be mainstreamed into the training of both western practitioners, as well as traditional practitioners registered with the national Traditional Health Practitioners Association.

Lessons from Asia reveal that very often attempts at integrating traditional and western medicine follow a unidirectional approach where only traditional health practitioners are required to acquire an understanding of western medicine (Chi 1994). The result is sustained animosity towards traditional healing by western health practitioners. Therefore, mutual understanding and appreciation of the two systems by the two groups of practitioners are vital for successful integration.

10.2.7. Develop the traditional healing infrastructure

Infrastructural development to the benefit of traditional health practitioners needs to take place at the provincial, district and local service area level. The infrastructure should be geared towards providing traditional healing services of a high quality and standard to patients who choose to utilise this cadre of practitioners. Selection of the appropriate infrastructure should be a collaborative decision-making process amongst all the stakeholders concerned, namely traditional health practitioners, western health practitioners (including community health workers), representatives of

communities, provincial Department of Health, local authority, etc. At present, some traditional health practitioners live in informal settlements with less than satisfactory water and sanitation facilities, as well as a lack of twenty-four hour care facilities for patients who are in need. The infrastructural shortcomings of the traditional healing sector need urgent attention, especially in striving to provide quality health care for all South Africans based on their choice of health care.

10.2.8. Distribute resources more equitably between traditional and western health care

Of utmost importance is the allocation of meaningful resources for the development and facilitation of the traditional healing sector. According to Chi (1994), a country's commitment to an integration policy is evident when traditional and western health practitioners jointly determine the definition and allocation of its medical resources. This is especially important if a large proportion of the population utilises the services of traditional health practitioners. Hence, traditional health care should be factored into provincial and local government health care budgets. However, this may only take effect once the traditional healing sector is sufficiently organised and regulated.

10.2.9. Develop clearly delineated guidelines for collaboration

Collaboration in the field of HIV/AIDS between traditional and western health practitioners in Buffalo City is largely left to the discretion of individuals from the two health sectors. Government has acknowledged traditional health practitioners as important partners in the emasculation of the HIV/AIDS epidemic. Also, traditional health practitioners in Buffalo City have been informed, through various mediums, that they would be included in the official health care system. However, lack of policies for the effective implementation of such plans delay collaboration, thus, creating a sense of despondency among traditional practitioners. Unequivocally delineated policies at a national, provincial and local level are necessary to guide and facilitate collaboration between traditional and western practitioners. This is especially important for programmes that aim to combat the HIV/AIDS epidemic, such as the *HIV/AIDS and STD Strategic Plan for South Africa 2000-2005* (Department of Health 2000) and the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (Department of Health 2003).

10.2.10. Local government to take the lead

Local government can play a more active role in propagating, and initiating collaboration between traditional and western health practitioners, and facilitating the healing system at the grassroots level (primary health care). As the ears and eyes of Government in communities, local government should place more effort into initiating discussions between traditional and western health practitioners in order to reach joint decision-making between the two entities about how both health care practitioners can improve the health status of their respective communities in a collaborative relationship. Change must be effected at the grassroots level and not merely on paper. Not only should local government initiate collaboration, but it should also be the watchdog to ensure that collaboration is taking place in a mutually respectful and effective way.

10.3. To conclude …

The South African traditional healing system has survived illegality and has sustained itself in the absence of government funding for decades. As the saying goes, without a market, there can be no trade. Similarly, were there no need (market) for traditional healing, traditional health practitioners would not exist. The fact that traditional health practitioners are flourishing all over the country, even outnumbering western health practitioners, is evidence of the continuous need for their services amongst South Africans.

Realising that traditional healing is an integral part of the repertoire of many communities in South Africa, the South African government, since 1994, embarked on an unprecedented endeavour to legitimise and professionalise traditional health practitioners. This quest towards the recognition of practitioners of traditional medicine as health care providers was initiated in 1997, and these efforts bore fruit in the form of the Traditional Health Practitioners Act no 35 of 2004. The Act is a significant milestone towards the integration of traditional medicine into the realm of health care, as envisaged and advocated for by the World Health Organisation. However, it is still a far cry from attaining a fully integrated health care system. Numerous obstacles hinder the process of integration, including sustained suspicion of the other by practitioners of the two systems of health care (traditional and western); disunity amongst traditional health practitioners; absence of clearly delineated policy guidelines for collaboration, and the lack of an integration policy.

The need to place greater effort into the integration of traditional medicine into the mainstream of health care is most evident in the fight against HIV/AIDS, which requires a comprehensive approach and a multiskilled team of health care providers for those infected and affected by the disease. The International HIV/AIDS Conference, which was held in Bangkok in 2004, adopted as its slogan 'Access for All', which translates into governments ensuring that access to treatment is available to all, including those who prefer to use traditional medicines. To keep in line with this slogan as well as international proclamations to provide health care for all, the South African Government needs to urgently identify and address factors that impede collaboration between practitioners of the traditional and western health systems. Drawing on the strengths and weaknesses of initiatives in other countries that have made strides in collaboration between traditional and western health practitioners, and developing integration policies, will assist Government in developing generic collaboration and integration policies appropriate for the health care needs of the South African population. Equally important is ensuring that these policies are translated into action through their effective implementation and monitoring. After all, a policy on paper only is as good as no policy at all.

The importance of full participation of traditional health practitioners in charting the way forward for health care, particularly pertaining to their role in the fight against priority diseases such as HIV/AIDS, cannot be overemphasised. Their participation from the outset is a major contributing factor to the success of any initiative aiming to pull together all available resources to overcome diseases such as HIV/AIDS.

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SYNOPSIS

Key terms: HIV/AIDS, traditional healing, collaboration, pluralistic health care systems, Traditional Health Practitioners Bill, Buffalo City, African cosmology, HIV/AIDS treatment and care, traditional health practitioner, western health practitioner.

Synopsis

The ravaging impact of the HIV/AIDS epidemic on societies, especially in developing countries, has evoked a renewed urgency to consolidate all available resources to address the health needs of individuals living with HIV and AIDS. One such resource to the avail of many resource-ridden countries is the traditional healing system. Despite global proclamations and national policies that propagate the inclusion of traditional health practitioners into national health systems and priority programmes in order to address the health care needs of communities, in practice, traditional healing remains shadowed by its western health care counterpart. The South African government has declared traditional health practitioners partners in the national emasculation of the HIV/AIDS epidemic. However, significant results to this effect have not as yet been produced.

The lack of effective integration of traditional health practitioners into national health programmes, such as for HIV/AIDS in South Africa, points towards a discrepancy between policies and proclamations propagating the inclusion of traditional health practitioners into the mainstream of health care, and actual integration. It is in the light of this discrepancy that this study proposes the exploration of factors that hinder collaboration between practitioners of the traditional and western health care systems. Key factors to successful collaboration between traditional and western health practitioners are identified from various initiatives in Africa and Asia, and against the backdrop of the WHO suggested integrated health care systems. These success factors are used as a bench mark to analyse collaboration in the study area and propose recommendations towards successful and meaningful collaboration.

The study explores the perceived value and weaknesses of the traditional healing system in the treatment and care of people living with HIV/AIDS. This entailed ascertaining impediments to effective collaboration between traditional and western health practitioners for the purpose of informing the two categories of practitioners as well as policy developments aimed at integrating traditional and western health care. A literature study of the traditional healing system, international and national policies relating to HIV/AIDS and traditional healing, and lessons learnt from developed and developing countries on collaboration between the two health care systems informed the development of the research instruments and served as a conceptual framework for interpretation of the findings.

The study was conducted in five urban settlements in the Buffalo City Municipality, in the Eastern Cape Province. The Eastern Cape was selected due to the researcher's affiliation to the culture and vernacular of the research respondents, and due to the venerable nature of traditional health practitioners in many communities in the Eastern Cape. Preliminary investigations in preparation for the research revealed that the organisation and regulation of traditional health practitioners is more problematic in urban than in rural areas, thus the selection of an urban area to conduct the research. Due to the exploratory nature of the research, a qualitative research design was applied whereby indepth semi-structured individual interviews were conducted with 23 western health practitioners, 20 traditional health practitioners and three managers from the Department of Health. The focus of the interviews was to

explore the perceived strengths and weaknesses of traditional health practitioners; impediments to collaboration between traditional and western practitioners; the structure and organisation of the traditional healing system; and views about the legalisation and professionalisation of traditional health practitioners. Purposive, snowball and sequential sampling was applied to select respondents.

The main findings of the research points towards a dire need for closer collaboration between traditional and western health practitioners. The need for collaboration is based on both the perceived weaknesses and strengths of the traditional healing system. However, the nature of collaboration envisaged differs significantly between the two groups of practitioners. On the one hand, traditional practitioners envisage collaboration as entailing a bilateral (two-way) referral system between traditional and western practitioners, and joint decision making about certain patients and conditions between the two practitioners. On the other, western health practitioners envisage a far more unilateral collaboration which entails a one-way referral system from traditional to western practitioner, traditional practitioners receiving training in western medicine and traditional practitioners sharing information about the contents of proclaimed curative medicines/remedies. Furthermore, the absence of unequivocally delineated guidelines for collaboration is one other major hindrance to effective collaboration between the two traditions of practitioners. In general, the legalisation and professionalisation of traditional health practitioner is welcomed by both genres of practitioners. However, the lack of knowledge about the content and implications of the Traditional Health Practitioners Bill posses major threats to the successful implementation of the proposed Act.

Overall, the research indicates that traditional healing has a role to play in the provision of health care to people living with HIV/AIDS. However, the weaknesses of this system of health care, which undermine its value, need to be addressed. Furthermore, clearly delineated policies need to be developed in close collaboration with the major stakeholders, namely traditional and western practitioners, to guide effective collaboration as envisaged by both groups of practitioners. Local government should adopt a more active role in initiating collaboration as well as monitoring its effective and culture-sensitive implementation.

APPENDIX A:

INTERVIEW SCHEDULE FOR TRADITIONAL HEALTH PRACTITIONERS (THP) (Interview schedule 1)

CONTACT DETAILS and BIOGRAPHICAL INFORMATION				
Name			**Age**	
Gender			**Address**	
Type of THP			**Tel/Cell**	
No of years as THP			**Fax**	
Member of THP association (✓)	**Yes**	**No**	**Date of interview**	
Name of THP association	***(state whether national, provincial or local)***		**Duration of interview**	

INTERVIEW QUESTIONS

	TRAINING	
	Are you a full-time THP or do you also have another occupation? (no of days per week, hours per day if not full-time THP)	
	How did you become a THP (i.e. decision to become a TMP, calling, rituals, duration of training, etc.)	
	Which diseases are you able to treat?	

	What type/form of training have you received in western health care? (i.e. type of training, when training was received, who provided training, duration of training, etc.)	
	Have you received training specifically in HIV/AIDS? If yes, who trained you and what did the training entail?	
	What are your strengths as a THP?	
	What are your weaknesses as a THP?	

MEMBERSHIP TO A THPASSOCIATION		
	Are you a member of a THP association? If yes, name of association. If no, what are your reasons?	
	If not member of the national THP association, why?	

DIAGNOSES AND TREATMENT		
	What areas of traditional healing do you specialise in?	

	What is your knowledge about HIV/AIDS (i.e. its origin, transmission, prevention, etc.)	
	Do you believe HIV/AIDS can be cured. In other words, someone who is HIV-positive can become HIV-negative again? If yes, describe how this happens. If no, what do you think of some THPs who believe they can cure HIV/AIDS?	
	How do you know when your clients are HIV-positive? Describe your process of diagnosis.	
	The clients that you diagnose as HIV-positive, are you the first health care provider to tell them of their HIV-status?	
	Do the clients that you diagnose as HIV-positive come to you after they have already been diagnosed by another health care provider?	
	Do you advise the clients that you have diagnosed as HIV-positive to consult another health care provider for confirmation of their HIV status?	
	Who do you ask them to go to for confirmation of their HIV-positive status?	
	Describe how you treat and care for clients who are living with HIV/AIDS?	

	Do you only prescribe your type of traditional healing for your clients who are living with HIV/AIDS? Explain why.	
	Do you also refer your clients that are living with HIV/AIDS to other healers/health care providers? Explain (when, why, who, etc)	
	Describe some of the illnesses that are related to HIV/AIDS as well as your treatment for these illnesses	
	Discuss the treatment success rate for people living with HIV/AIDS that you treat.	
	Do some of your clients that are living with HIV/AIDS default? Explain (why, how, etc)	

COLLABORATION BETWEEN TRADITIONAL HEALTH PRACTITIONERS		
	Do you collaborate with other THPs? If yes, which other THPs do you collaborate with? If no, what are your reasons for not collaborating with other THPs?	
	Describe how you collaborate with other THPs? (i.e. how often, why, type of THP, etc.)	
	How would you describe the working relationship between THPs in the Amatole District Municipality/Buffalo City Local Municipalities (e.g. referral system, committees, forums, etc.)	

	What makes it difficult for THPs to work together in the Amatole District Municipality/Buffalo City Local Municipality	
	Are there THPs in the Amatole District Municipality who you think are not qualified to be THPs? If yes, what are your reasons for thinking that they are not qualified?	
	What problems do these "unqualified" THPs, cause by practising as THPs?	
	How can these "unqualified" THPs be stopped from practising as THPs?	
	How can the working relationship between THPs in the Amatole District Municipality/Buffalo City Local Municipality be strengthened?	

COLLABORATION BETWEEN TRADITIONAL AND WESTERN HEALTH PRACTITIONERS		
	How would you describe the working relationship between THPs and western health practitioners such as nurses and doctors in the Amatole District Municipality/Buffalo City Local Municipality? (e.g. referral system, committees, forums, etc)	
	How do you think western health care practitioners in the Amatole District Municipality view THPs?	

	What are your reservations about western methods of diagnoses and treatment, if any?	
	Do you collaborate with western health practitioners? If yes, which western health practitioners do you collaborate with? If no, what are your reasons for not collaborating with western health practitioners?	
	Describe how you collaborate with western health practitioners? (i.e. how often, why, type of practitioners, etc.)	
	How do you feel about working side by side with western health practitioners?	
	What are the advantages of collaboration between THPs and western health practitioners?	
	What are the disadvantages of collaboration between THPs and western health practitioners?	
	How could the collaborative relationship between THPs and western health practitioners (e.g. nurses and doctors) be strengthened	
	How can the services of THPs for people living with HIV/AIDS be improved?	

	How can health care services as a whole for people living with HIV/AIDS in the Amatole District Municipality be improved?	

TRADITIONAL HEALTH PRACTITIONERS AND THE OFFICIAL HEALTH CARE SYSTEM		
	Describe the relationship between THPs and local government in the Buffalo City Local Municipality	
	Describe the problems that exist between THPs and provincial government in the Buffalo City Local Municipality	
	How can the relationship between THPs and local government be strengthened?	
	How can the relationship between THPs and the provincial government be strengthened?	
	What role do you see THPs playing in the health care system of South Africa?	
	What positive and negative changes have government made since 1994 in the traditional healing system of South Africa?	
	What are your views regarding the regulation/legalisation and professionalisation of the traditional health care system by law (Traditional Health Practitioners Bill)?	

	What are the possible advantages of including THPs in the official health care system of South Africa?	
	What are the possible disadvantages of including THPs in the official health care system of South Africa?	
	How do you view the future of THPs in South Africa in the next year?	
	How do you view the future of THPs in South Africa in 5 years time?	

APPENDIX B:

INTERVIEW SCHEDULE FOR WESTERN HEALTH PRACTITIONERS (Interview schedule 2)

CONTACT DETAILS and BIOGRAPHICAL INFORMATION			
Name		**Tel**	
Occupation/position		**Cell**	
No of years in occupation/position		**Age**	
Name of organisation (clinic/hospital/etc.)		**Date of interview**	
Name of local service area		**Duration of interview**	

INTERVIEW QUESTIONS

ATTITUDES TOWARDS TRADITIONAL HEALTH PRACTITIONERS		
	Why do you think people consult traditional health practitioners for their health care needs?	
	What services do traditional health practitioners render for PWAs in the Amatole District Municipality?	
	How would you describe the value of these services?	
	What are the advantages of traditional healing for PWAs?	

	What are the disadvantages of traditional healing for PWAs?	

COLLABORATION BETWEEN TRADITIONAL AND WESTERN HEALTH PRACTITIONERS		
	How would you describe the collaborative relationship between western and traditional health practitioners in this district (e.g. referral system, forums, committees, etc.)**?**	
	Are there any formal and informal initiatives/projects/structures in the district where traditional and western health practitioners are collaborating? If yes, name these initiatives/projects/structures and briefly describe them.	
	When and how (in what respect) should traditional and western health practitioners collaborate in order to improve health care services?	
	What are your views on traditional and western health professionals collaborating in providing treatment and care to PWAs in the Amatole District Municipality?	
	What, in your opinion, are the major constraints in traditional and western health practitioners collaborating in providing treatment and care for PWAs in this district?	
	How can the collaborative relationship between traditional and western health practitioners in providing treatment and care for PWAs be strengthened in this district?	

TRADITIONAL HEALTH PRACTITIONERS AND THE OFFICIAL HEALTH CARE SYSTEM		
	Should THPs be accommodated/included in the official health care system of South Africa? If yes, how should they be accommodated/included?	

	What are your views on the legalisation and professionalisation of traditional health practitioners in South Africa? (i.e. the Traditional Medical Practitioners Bill)	
	Discuss both government and other professional policies that exist regarding collaboration between traditional and western health practitioners (i.e. objectives, strengths, weaknesses, etc.)	
	How can traditional health practitioners strengthen health care services as a whole in this district?	
	What are the possible disadvantages of including traditional health practitioners in the official health care system of South Africa?	
	What role do traditional health practitioners currently play in providing treatment and care for PWAs in this district?	
	How can traditional health practitioners strengthen health care services for PWAs in this district?	
	What are the possible disadvantages of including traditional health practitioners in official programmes rendering treatment and care for PWAs?	

APPENDIX C:

INTERVIEW SCHEDULE FOR MANAGEMENT (DEPARTMENT OF HEALTH/LOCAL AUTHORITY/PROVINCIAL AUTHORITY) (Interview schedule 3)

CONTACT DETAILS and BIOGRAPHICAL INFORMATION			
Name		**Tel**	
Authority (LA/PA/)		**Fax**	
Position/Post		**E/mail**	
No of years in post		**Cell**	

	TRADITIONAL HEALTH PRACTITIONERS IN THE AMATOLE DISTRICT MUNICIPALITY	
	How many THPs associations are there in the Amatole District Municipality and Buffalo City Local Municipality?	
	How many THPs are there in the Amatole District Municipality and Buffalo City Local Municipality?	
	Discuss the registration of traditional health practitioners with the national Traditional Health Practitioners Association	
	Discuss the Traditional Health Practitioners Bill and preparation for its implementation	
	Discuss both government and professional policies that exist to regulate THPs in the district (i.e. objectives, strengths, weaknesses, etc.)	

	Describe the organisation of traditional health practitioners in the Eastern Cape (national, provincial and district structures)?	
	Describe the infrastructure for traditional health practitioners in the Amatole District Municipality and Buffalo City Municipality	

COLLABORATION BETWEEN TRADITIONAL and WESTERN HEALTH PRACTITIONERS		
	Describe the collaborative relationship between THPs and western health practitioners in the Amatole District Municipality. (provide examples)	
	How can the collaborative relationship between THPs and western health practitioners be strengthened in this district?	
	What, in your opinion, are the major constraints in THPs and western health practitioners collaborating in providing treatment and care to PWAs in this district?	

TRADITIONAL HEALTH PRACTITIONERS AND THE OFFICIAL HEALTH CARE SYSTEM		
	What are your views on the legalisation and professionalisation of THPs in South Africa? (e.g. the Traditional Medical Practitioners Bill)	
	What is taking place in the Amatole District Municipality regarding legalisation and professionalisation of THPs in relation to national developments (i.e. policy documents, etc)**?**	

SOCIODEMOGRAPHIC and GEOGRAPHIC INFORMATION		
	Demographics (population size, population segmentation of Amatole District, geographic size, towns, gender breakdown, age breakdown, etc.)	
	Primary health care sources in Buffalo City (number and types)	