2
LITERATURE REVIEW

The twentieth century has seen what has been termed 'the conquest of epidemic disease' in the western world. Although this term was coined before the outbreak of the HIV/AIDS epidemic, its implications for issues concerning health and disease remain valid. In most of the developed world, the pattern of causes of death has shifted dramatically from the predominance of infectious diseases in the nineteenth century to that of chronic diseases today (Gilbert *et* al, 2002). This shift in patterns of disease is linked to a change in the concept of causation of disease. The monocausal model of disease, which was associated with the germ theory, has been replaced by a multi-causal model approach. According to this new approach, the majority of diseases are caused by a multiplicity of factors and complex interrelationships between them. This shift represents components of a more general shift in the dominant framework of thinking in medicine. This has been the shift from the sole emphasis on the 'biomedical model' to a more comprehensive 'psycho-socio-environmental' model of health and disease.

2.1 SOCIOLOGICAL PERSPECTIVE ON HEALTH

Two models predominate thinking on health: the biomedical and psycho-socio-environmental models. While the two models represent different ways of thinking, and emphasise different aspects of health and disease, the two models provide complementary explanations rather than competing ones (Gilbert *et al,* 2002). Using these models helps broaden our understanding of health and disease in society and the role of health professionals in it (ibid).

2.1.1 Biomedical Model

This term was given to the scientific mode of thinking in medicine (Gilbert *et al,* 2002). According to Nettleton (1995) this model is based on four assumptions. First, that all diseases can be traced to a specific origin such as a virus, parasite or bacterium. Second, that the body can be repaired like a machine and in this case medicine adopts a mechanical metaphor presuming that doctors can act like engineers to mend that which is dysfunctioning. Third, the focus of this model is on treatment, a belief that medical knowledge and skills are sufficient to make the patient's body better. Finally, biomedicine is reductionist in that explanations of disease focus

biological changes to the relative neglect of social and psychological factors. These assumptions created a link between health and the medical care system, and maintained the powerful image of the role of medicine in improving health (Fenyves, 1994; Gilbert *et al*, 2002). The biomedical model resulted in an emphasis on treatment of disease (rather than maintenance of health), based on technologies or chemical means organised around medical specialities. The biomedical model also emphasises the role of the doctor, medical specialist and other specialised medical technicians. There is at best very little acknowledgement of any other health care players.

However, during the last three decades the institution of medicine and the biomedical model have increasingly been challenged by critiques emerging from both popular and academic sources. Two of these challenges are discussed here. First, striking at the heart of biomedicine is the challenge of its effectiveness (Nettleton, 1995). Many people argue that medicine's efficacy has been overplayed (Ngubane, 1992; Dauskardt, 1994; Ogunniyi, 2002). For example, historical demographic studies show that the decline in mortality which has occurred within the Western societies has had more to do with nutrition, hygiene and patterns of reproduction than it has with vaccinations, treatments or other modes of medical interventions (McKeown, 1976).

A second criticism of the biomedical model is that it fails to locate the body within its socio-environmental context. By focusing on biological changes within the body, biomedicine has underestimated the links between people's material circumstances and illness. Sociologists and medical anthropologists have repeatedly demonstrated that health and disease are socially patterned. Peoples' health statuses are related to social structures and vary according to gender, social class, race and age. Thus the biomedical model fails to account for social inequalities in health.

2.1.2 Psycho-socio-environmental Model
The second model represents a shift in the thinking mode about health, disease and the role of medicine in improving and maintaining health. While the biomedical model emphasises the impact of medicine on the elimination of disease, the psycho-socio-environmental model focuses on promotion and maintenance of health through socio-environmental and behavioural changes (Gilbert *et al,* 2002). It emphasises the

role of people's behaviour, what work they do and how and where they live their lives, in determining their health status. This model is of paramount importance if one wants to analyse health holistically. The development and growth of the HIV/AIDS epidemic in South Africa and the government's response to it provides an excellent example of the significance of the psycho-socio-environmental model as it illustrates how political and social structures are linked to a particular disease pattern. In Jeppestown these factors are found in the effects of migrant labour, unemployment, poor housing and gender, which all interrelate to produce a population that is susceptible to HIV/AIDS. Furthermore, unlike the biomedical model, in the psycho-socio-environmental model, a range of different players are involved in disease intervention. Potentially traditional healers, birth attendants, prophets and social workers can all be involved in disease intervention. The role of traditional healers is of particular importance since they often act as health workers, advisors and counsellors and are trusted by their communities.

2.2 CULTURE AND HEALTH

For health care professionals to be more effective in their work, it is important that they situate patients within their social context (Gilbert *et al*, 2002). This involves the exploration of concepts such as culture in order to develop a comprehensive understanding of health and disease (ibid). This concept of culture is a particularly relevant one for those working within the psycho-socio-environmental model.

Geertz (1973) defines culture as a socially established pattern of meaning that is responsible for controlling, shaping and ordering people's emotions, behaviour, and thinking. Based on this "control mechanism" view of culture, experiences like illness and healing can be seen as enterprises that are constructed in social situations and according to the premises of cultural hegemonies (Fipaza, 2003). Culture shapes people's behaviour and is closely linked to traditions, customs and beliefs (Gilbert *et al*, 2002). Culture is normative: beliefs may be viewed as normal by people practising them, but bizarre and strange by people from a different culture (this will become apparent when looking at the relationship between traditional healers and doctors).

In summary, culture influences all aspects of people's lives and behaviour. Furthermore, the concept of culture is very significant when dealing with health. It

shapes the way in which people make sense of the causes and manifestations of health, disease and illness (Gilbert *et al,* 2002). It shapes people's perceptions of healing and recovery. For example, the decision whether to consult a traditional healer or a doctor is informed by culture. More important for this research, all communities understand health in terms of their culture.

To illustrate how culture shapes experiences, understandings and perceptions of health and disease, consider an example of how prevailing concepts about nature and cause of health and disease differ from society to society. A person struck by lightning may be the victim of a scientific/natural event by one society but a magic/spiritual explanation will be given by another society. Accordingly, in each case the dominant prevailing concepts reflect the dominant orientation in that particular culture (Walker *et al,* 2004). It is important at this stage to state that many different cultures and sub-cultures can co-exist within any particular society. Arising from this are a number of different medical systems or ways of diagnosing and treating illness and disease, a concept called medical pluralism (Harding, 1990). Even though these medical systems co-exist they are often based on entirely different premises and worldviews. There are also different degrees of interaction between the different systems, although for the most part these different medical systems have little to do with each other. Frequently, any medical care not associated with the biomedical model is relegated a secondary "complementary" status.

In South Africa, and elsewhere, traditional healing practice is growing despite the achievements of the orthodox medical system. This increasing popularity and acceptance of traditional healing has brought to light the need to examine the role of culture in medicine (Gilbert *et al,* 2002). In South Africa alone, more than 70 per cent of the population consults traditional healers. The question to ask then is what do traditional healers offer which is lacking in western medicine. The answer to this question is very complex and the empirical chapters will engage with this question in more depth.

In the context of the popularity of traditional healers, it is somewhat perturbing that in South Africa traditional practices are still not formally recognised by the western medical sector (Cooks, 2002). With such a high rate of HIV/AIDS infection in South

Africa and the failure of the modern-medical sector to lower this rate, it becomes interesting to note that western-based medical ideas still primarily control medical theories of disease causation and how medical knowledge is organised, evaluated and controlled. Western doctors, despite their belief in the 'openness' of science to alternative theories, appear not to be so open-minded when it comes to the overall theoretical assumptions that guide their professional work (Green, 1996). They tend to distance themselves from some of the theoretical premises upheld by traditional healers. Traditional healers' emphasis on metaphysical knowledge and their use traditional herbs seems far removed from the clinical procedures and language of western medicine and is therefore ruled out by western doctors. In doing so and without even thinking about it, western doctors are disallowing traditional knowledge to penetrate into scientific language. Hammond-Tooke (1989:46) summarises this point succinctly when he writes, **"**the medical profession is notorious for its conservatism". The emphasis on the biomedical model in HIV/AIDS campaigns in South Africa has undermined the role of traditional healers, both in the prevention of HIV/AIDS and in providing care and support to those who are infected. However, the nature of the HIV/AIDS epidemic in South Africa requires a multicultural strategy, such as the one used in Uganda (see box 1 on page 31).

2.3 THE DYNAMICS OF HIV/AIDS IN SOUTH AFRICA

During the last six to seven years, South Africa has experienced an alarming growth in HIV/AIDS infections. The HIV/AIDS prevalence rate among adults has risen from 12 per cent in 1997 to 20 per cent in 1999 (CHSD, 2002). Most data on HIV/AIDS in South Africa is obtained from the national sentinel surveillance of antenatal state clinic attendees. The survey is limited to pregnant women attending state antenatal clinics, and as a result there is still a debate as to whether data gathered this way is representative of the broader situation in South Africa. However, some case studies suggest that antenatal clinic surveys can indeed be considered representative of the broader population (Whiteside and Sunter, 2000). These surveys are helpful because they allow researchers to track HIV/AIDS prevalence in different provinces and age groups, thus identifying trends over time. Levels of HIV/AIDS prevalence in South Africa reflects large geographical variations between affected provinces, with Kwa-Zulu Natal, Mpumalanga and Gauteng being the most affected provinces (see table 2). Kwa-Zulu and Gauteng are also the only two provinces where a statistically

significant increase in HIV/AIDS prevalence has been experienced between 1999 and 2000.

Table 2: Provincial and national prevalence-antenatal attendees between 1995 and 2000 (Department of Health, 2001).

Province	% HIV+ 1995	% HIV+ 1996	% HIV+ 1997	% HIV+ 1998	% HIV+ 1999	% HIV+ 2000
Natal	18.2	19.9	26.9	32.5	32.54	36.2
Mpumalanga	16.2	15.8	22.6	30.0	27.3	29.7
Gauteng	12.0	15.5	17.1	22.5	23.9	29.4
Free State	11.0	17.5	20.0	22.8	27.9	27.9
North West	8.3	25.1	18.1	21.3	23.0	22.9
Eastern Cape	6.0	8.1	12.6	15.9	18.0	20.2
Limpopo	4.9	8.0	8.2	11.5	11.4	13.3
Northern Cape	5.2	6.5	8.6	9.9	10.1	11.2
Western Cape	1.7	3.1	6.3	5.2	7.1	8.7
National	**10.4**	**14.2**	**17.0**	**22.8**	**22.4**	**24.5**

In light of these figures, awareness and prevention campaigns are of crucial importance to decrease the rate of HIV/AIDS infection. Before moving any further with the discussion on awareness and prevention, it is necessary to examine the constellation of forces that gave rise to conditions of risk in which HIV/AIDS has so devastatingly thrived (Setel, 1999; Walker *et al* 2004). There is no doubt that socio-cultural and social dynamics in the country have colluded to foster the progress of HIV/AIDS and block effective intervention (CHSD, 2002).

2.3.1 Gender Inequality

Throughout the world, gender inequalities are a major driving force behind the spread of HIV/AIDS. Inequalities in relationships in particular, often disempower people, making them unable to act on what they know (Jewkes, 2001). Very often gender inequalities overlap with socio-cultural and economic inequalities between men and women. In many cases these inequalities render women vulnerable to HIV/AIDS infection since the different roles and attributes that society assigns to women and men profoundly affect women's ability to protect themselves against HIV/AIDS infection (CHSD, 2002).

There are many factors that increase the vulnerability of women to HIV/AIDS but here I discuss only two: social norms that deny women sexual health knowledge and cultural practices that prevent them from controlling their bodies. Many South African women are still brought up to be subservient to men, especially in matters of sexual relationships (Jewkes, 2001). This enhanced culture of male-dominance renders women profoundly powerless even though they may want to protect themselves. Added to this is the fact that many South African women play a key role in ensuring economic security of their families (CHSD, 2002).

Cultural practices such as *Lobola* (bridewealth) – a long-standing tradition among South African black communities whereby a husband gives cows and/or money in exchange for a wife – also makes it difficult for a woman to leave her husband since this will require that the bridewealth be paid back. The wife is therefore obliged by tradition to sustain the relationship with her husband even if she knows that the husband is cheating on her. Moreover, trust and intimacy are seen as an important part of marriage (Walker *et al,* 2004). In many cases the status of the relationship is measured by the willingness of the partners to take risks and practise unsafe sex. Hence in South Africa it is not uncommon for a man to beat his female partner if she refuses intercourse or requests a condom (CHSD, 2002).

However, violence does not only occur inside the home but outside as well. The high level of sexual abuse in South Africa shows that violence against women is endemic (Walker *et* al, 2004). There is growing evidence that a substantial number of new cases of HIV/AIDS infection are due to sexual violence (UNAIDS 2001). A significant proportion of rape cases go unreported every year, according to the South African Institute of Race Relations; nationally, there was an increase of seven per cent in the number of reported rape cases over the period 1994-1998 (see table three). This should be compared with an average of one per cent in the twenty most serious crimes over the same period (Department of Health, 1998). During rape there is a great deal of vaginal tearing which increases the risk of infection if the rapist or rapists are infected with HIV/AIDS. In addition, a woman may be hesitant in negotiating safer sex in an environment where she fears a violent response. A study done by UCSF (2001) found that 57 per cent of women in the Eastern Cape believed that they could not refuse sex with their partner.

Table 3: Provincial breakdown of reported rape cases for 1994, 1998 and 1999 (adapted from SAIRR, 2001)

Province	1994	1998	1999
Gauteng	10 813	11 808	12 132
Mpumalanga	2 472	3 034	3 286
Free State	3 553	3 496	3 472
Eastern Cape	5 499	6 514	6 862
Kwa-Zulu Natal	7 028	8525	8 875
North West	3 750	4 461	4 572
Northern Cape	1 326	1 438	1 478
Limpopo	2 617	3 800	3 912
Western Cape	5 317	6 204	6 600
South Africa	**42 429**	**49 280**	**51 249**

This high level of sexual violence in South Africa reflects a pervasive gender inequality within South African society. This inequality is typified by a low valuation of women's needs, dignity and lives, while men's power over women is viewed as normative (UCSF, 2001). Most of these gender inequalities are seemingly deeply embedded in culture. Case studies undertaken in South Africa identify dominant behaviour in men, which includes having multiple sexual partners, exercising control over women and coercive sex. Despite knowing about HIV/AIDS, some men still express their masculinity by having sex with many different partners. For example, a study conducted in Kwa-Zulu Natal found that although 98 per cent of men knew about HIV/AIDS transmission modes and 84 per cent knew about the protective effect of condoms, 46 per cent of these men had more than one partner, 55 per cent had a history of STIS. Only 35 per cent of these men used condoms and only 38 per cent believed they were at risk of becoming HIV/AIDS infected (UCSF, 2001). Nine out of ten men interviewed believed it was common for men to have more than one sexual partner at the same time, and two out of three men believed that women did not have the right to insist on condom use or refuse sex if their partner refused to adopt safer sex practices (UCSF, 2001).

For many men, coercion is part of sexual interaction. It is a means of asserting sexual control over women (Walker *et al*, 2004). Authority and control over women appears to be a key feature of masculinity in South Africa and many men see themselves as having undisputed power over their girlfriends/wives (Nduna *et al*, 2001). The roots

of this behaviour can be seen in women's position in society. Regretfully, the ways in which men achieve masculinity have an impact on the spread of HIV/AIDS. It is therefore important to understand men's attitudes towards condom use, safer sex options, trust, intimacy and responsibility in order to develop a successful preventative strategy.

In many societies, sexual practices are regulated through a set of taboos and conventions (Walker *et al*, 2004). Transgression of these conventions can lead to misfortune and disaster. This is also a very common belief among many South Africans who believe that HIV/AIDS is caused by a loss of culture; the most common evidence of this loss of culture being found in the inappropriate modes of sexual behaviour that people are engaging in (Hunter, 2001). Forbidden sexual behaviour is potentially polluting and contaminating and it results in an STI. Thornton (2002) elaborates on the ways in which Africans believe that appropriate flows of blood and bodily fluids between men and women ensure health and physical well-being. Engaging in a forbidden sexual act such as sex during menstruation results in polluted blood, which when passed to another person will result in ill health. But according to Douglas (1970), pollution is not likely to occur except where the rules of social structures and conventions are clearly defined. It follows then that a polluting person is in the wrong. He/she has broken the taboos that are meant to protect. But blaming HIV/AIDS on breaking sexual taboos is indirectly blaming it on women, since in many societies they are the source of pollutants (Walker *et al*, 2004). Once again the onus of responsibility rests on women. They are the ones who must maintain their virginity, not have sex during their monthly periods and for a period of three months after childbirth or for a year after the death of a spouse (ibid). Cultural perceptions such as this need to be examined carefully as they provoke responses that perpetuate the inferior position of women.

Culture enters and inflates itself as a barrier that many professionals working in the area of HIV/AIDS confront (Herdt, 1996). Culture serves as the explanation for failures to effectively fight the epidemic, but for other professions such as anthropology, culture is an asset which defines much of the world in which people situate themselves and live. If researchers and policy-makers do not enter and attempt to understand this world, their efforts to convince and change others will be

ineffective or even harmful (Schoepf, 1996). Take as an example the 'loverboy tradition' (*isoka)*; a sexual culture that contributes to the spread of HIV/AIDS. In Zulu tradition loverboys were sexually vigorous men who were known to be good lovers (Delius and Glaser, 2002a). They were much admired both in their peer group and among the older generation. The latter regarded loverboys as respectable, and as such they were sought after as future sons-in-law. Contrary to the loverboy, being *isishimane* (one with one girlfriend) and *isigwadi* (one without a girlfriend) was unacceptable. Such a person was not a real man (Leclerc-Madlala, 1997). Nowadays men, to justify multiple partners, often use the loverboy tradition. It is also used to justify behaviour that is contrary to public health messages about HIV/AIDS.

But such a notion of culture is a static one. It does not accept that culture is dynamic and forever changing in response to internal pressures and external circumstances. Furthermore, culture is romantically invoked and draws on largely fictitious re-imaginings of the past (Walker *et al*, 2004). For example, a historical study of socialisation among South African youth by Delius and Glaser (2002b) showed that African communities were relatively open about sexual matters and adolescent sexuality was recognised as being particularly powerful and potentially destructive. As such even though loverboys were widely accepted, regulatory and control measures were taken whenever a sexual activity was performed. A young man was not allowed to have penetrative sex with his girlfriends. Instead, other non-penetrative forms of sex such as thigh sex were socially sanctioned. Virginity testings were performed regularly on young girls and those found to have broken the rule were heavily fined, both the girl and the boy.

With modernity and the introduction of Christianity, such patterns of sexuality have been altered, with the result of loosened pre-existing sexual sanctions and an increase in pre-marital sex (Horwitz, 2001). The extent of this breakdown of parental authority and lack of control over adolescents is evident in the way youth are most at risk of infection (Preston-Whyte, 1996; Walker *et al*, 2004). In that case, a return to traditional customs such as virginity testing is an attempt to take control over young bodies, sexuality and reproductive health. This report will show that traditional

healers have a huge role to play in re-inventing culture in accordance with the changing circumstances such as HIV/AIDS.

2.3.2 Poverty, economic deprivation and HIV/AIDS

Although South Africa has undergone a dramatic socio-political transition since 1994, many of the dynamics and distortions introduced in the previous political dispensation continue to reproduce poverty and perpetuate inequalities in health care and health status (CHSD, 2002). There is growing evidence that in South Africa HIV/AIDS has followed the social fault lines in society, with marginalised groups being disproportionately vulnerable (Van Donk, 2002). The socio-economic indicators shown in table four reflect disparities in how different groups are affected by poverty. For example, approximately a quarter of all blacks were officially unemployed in 1999, while the corresponding figure for whites was 4.4 per cent.

Table 4: Selected socio-economic indicators fro South Africa (adapted from SSS, 2000

Population group	% Unemployment rate (1999)	% Poverty rate (1995)[*]
South Africa overall	23.3	56.9
Black	24.5	67.8
Coloured	13.4	35.3
Indian	14.5	14.3
White	4.4	8.4
Gender		
Black men	24.5	
Black women	35.0	
White men	4.4	
White women	4.7	

These sharp divisions between the rich and the poor in South Africa, puts the poor in a more deprived position when it comes to access to health care. Increasingly, HIV/AIDS is becoming the disease of the poor: they are infected most frequently and are most affected by the epidemic because of their life conditions (Skhosana, 2001). South African urban areas have always attracted people who expect that there will be improved access to better quality of services such as housing, health and welfare facilities. Yet current public services are also not sufficient to address the apartheid

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[*] Poverty levels (expressed as a percentage) were estimated using minimum living levels i.e. minimum financial requirements of a family if they are to maintain their health and have acceptable standards of hygiene and sufficient clothing for their needs.

legacy of inequitable service provision. Moreover, the higher cost of living in urban areas means that poor people are often unable to take advantage of public services. (van Donk, 2002). As a result those who are in need receive the least treatment. For example, of an estimated 4.7 million infected in South Africa, only 20 000 to 30 000 are receiving HIV/AIDS treatment in the health sector (Walker *et al*, 2004). This problem is further exacerbated by the discrepancies in health expenditure by the South African government. The money allocated for HIV/AIDS programmes has increased from R125 million in 2001/02 to R275 million 2003/04 (SAIRR, 2001). However, the provinces with the highest numbers of people with HIV/AIDS are not receiving the largest share of these grants. For example, Gauteng receives only R12.3 million (11 %) of the total available HIV/AIDS grants funds but contains an estimated 19.7 per cent of the HIV/AIDS population in South Africa. By comparison, the Northern Cape receives six per cent of the grant while the Western Cape receives nine per cent. Yet, respectively only 0.99 per cent and 2.4 per cent of the country's HIV/AIDS population live in these two provinces (Hickey and Whelan, 2001).

Poverty and unemployment aggravate the engagement in high-risk sexual behaviour for economic survival reasons. In South Africa women are especially hard-hit by HIV/AIDS, not only because of skewed power relations which favour men but, because of economic dependency on these men. In table four it is shown that compared to men, there are many women who are unemployed. Many times these women are forced to participate in the sexual economy whereby they engage in sex with men while expecting money and favours from these men. In this case HIV/AIDS becomes a self-perpetuating cycle, with the poor being forced into high-risk survival strategies, such as commercial sex, with HIV/AIDS pushing people deeper into poverty as households lose breadwinners to the disease, and whatever money that is available being consumed by the cost of health care and funerals (Booysens, 2001). This occurs despite the implementation of national poverty alleviation strategies by the South African government.

2.3.3 Migration, high levels of STIs and HIV/AIDS infection
In South Africa migration has been an important contributing factor to the spread of infectious diseases such as STIs and HIV/AIDS (Campbell, 2000). Several studies have shown that migrant labourers are at greater risk of infection with HIV/AIDS and

other STIs than non-migrant labourers (Jochelson, 1991; Luner, 2000). The rate of infection among migrant labourers is 50 per cent higher than among their non-migrant counterparts (Evian, 1995).

Even though the link between migrant labour and high-risk sexual behaviour has not been explored in detail in South Africa, it is quite clear that the migrant's frequent and lengthy absences from home are likely to disrupt their stable sexual relationships (Jochelson, 1991). The long-term separation of migrant men from their wives/girlfriends, and families, along with the ever-present dangers of high-risk and low-paid jobs (if they are lucky to have one), leads to a sense of powerlessness (having no control over important aspects of one's life). This powerlessness is an important determinant of health-related behaviour. It helps foster aggressive masculinities and sexualities among migrants (Campbell, 2003; Walker *et al*, 2004). This was evident in a survey that was conducted in Wolhuter Hostel where 90 per cent of men acknowledged that they did not live with their immediate families (wives and girlfriends) and that they were also involved in casual sexual relations (Ndingi, 2001). Migration therefore provides an avenue for a complex set of sexual networks in which migrant workers are at risk of contacting STIs and HIV/AIDS.

There is a complex link between HIV/AIDS prevalence and the factors associated with its spread in South Africa. Based on this link, three main observations can be made about HIV/AIDS in South Africa. First, gender inequality is a major obstacle to women trying to protect themselves from infection, especially since it is often manifested in sexual violence. Second, the high levels of poverty in South Africa causes poor people to be more vulnerable to exclusion from reproductive health services and third, the legacy of migrant labour continues to render migrant workers vulnerable to HIV/AIDS infection. Based on these observations, does the response to the epidemic address the real issues surrounding HIV/AIDS? Are policies that are developed and implemented as a response to HIV/AIDS yielding any results and if not, why?

2.4 HIV/AIDS INTERVENTION POLICIES IN SOUTH AFRICA
A fair indictment of the South African response to the HIV/AIDS epidemic is summarised by Budlender (2000:115) in the following way:

Responses to the epidemic in the government and NGO sectors emerged slowly, increased in the late 1980's, faltered in the post-election period and may be gathering momentum once again. Overall the response has been characterised by poor co-ordination, limited intersectoral collaboration and variable commitment from role players.

Currently there are three tiers of policy which engage with the treatment and prevention of HIV/AIDS.

2.4.1 The National AIDS Plan

In the early stages of the epidemic, the National AIDS Convention of South Africa (NACOSA) spearheaded the South African response to HIV/AIDS. NACOSA was launched in 1992, in response to a conference that was convened jointly by the National Department of Health and the African National Congress. NACOSA was an umbrella body that was charged with coordinating the national AIDS response. Through a consultative approach among the ANC, unions, religious groups and AIDS organisations, and with assistance of international donor agencies, NACOSA launched the National AIDS Plan (Crewe, 2000; Mohale, 2003).

In 1994, the AIDS Plan was adopted and the HIV/AIDS epidemic was then declared a "Presidential Lead Project" (Schneider, 1998). The objectives of the plan were to prevent the spread of the epidemic; to reduce the personal and social impacts of HIV/AIDS and to mobilise and unify local, provincial, national and international resources to prevent and reduce the impacts of HIV/AIDS (NACOSA, 1994). The AIDS Plan also sought to achieve an intersectoral approach through the development of national and provincial programmes. However, only government departments such as health, education and welfare were identified as key sectors through which to implement the programme. Other sectors were excluded.

The AIDS plan assigned a central role to government, as leader, funder and implementer of a comprehensive response to HIV/AIDS. The National AIDS Director was appointed during the same year and was placed within the Department of Health (NACOSA, 1994). Provincial governments followed the lead of the national government in placing responsibility for AIDS within the health department; the provincial AIDS managers were reassigned from positions in the old structures (rather than recruited from the network of HIV/AIDS activists), and appointed at

relatively low levels of power and influence (CHSD, 2002; Nattrass, 2004). Placed within a biomedical framework, staffed mostly from old civil service, and having little power or connection with policy processes and networks prior to 1994, the AIDS plan met with many obstacles, both nationally and provisionally (Mohale, 2003).

NACOSA's AIDS Plan was later renamed 'HIV/AIDS and STDs Programme 1995-1996' by the Department of Health. This new Programme sought to ensure a strong and mutually collaborative relationship with NACOSA. The Programme committed itself to ten principles as listed in the CHSD (2002) report. The most relevant to this report are as follows:

- ➢ The vulnerable position of women in society will be addressed to ensure that in all aspects they do not suffer discrimination, nor remain unable to take effective measures to remain uninfected.
- ➢ Education, counselling and health care will be sensible to culture, language and social circumstances of all people at all times.
- ➢ Full community participation in prevention and care will be developed and fostered.
- ➢ All intervention and health care strategies will be subject to critical evaluation and assessment.
- ➢ All sectors of government will be involved in the fight against AIDS and HIV/AIDS education, prevention and care will be viewed in a broad context

Though the programme secured some important goals, such as securing a high level of commitment from the Department of Health, initiating collaboration intersectorally and substantially improving accessibility to treatment for STIs at clinic level, it has not generally been regarded as a success by organisations working in the field of HIV/AIDS (CHSD, 2002). Part of the failure can be attributed to lagging behind when it came to implementation. There were also infrastructural constraints which had an influence on how the programme's goals and objectives were met.

2.4.2 The HIV/AIDS and STI Strategic Plan 2000-2005

Established in 1999, the HIV/AIDS and STI Strategic Plan for South Africa 2000-2005 is a current national strategy that aims to deal with the epidemic. It is considered a milestone in policy development because it draws not only on government, but all sectors and HIV/AIDS stakeholders. It is structured around four main areas, namely: prevention; treatment; care and support; human and legal rights as well as monitoring,

research and surveillance (CHSD, 2002). The Strategic Plan emphasises effective and culturally appropriate information, education and counselling.

The Strategic Plan gave way to the establishment of The South African AIDS Council (SANAC), a structure that advises the government on HIV/AIDS policies. Representatives in SANAC include traditional healers, youth, religious organisations and PLWA. The worrying aspect of the Strategic Plan is that government appoints all members of SANAC. There is controversy surrounding the way representatives are appointed (CHSD, 2002) and there is general feeling that the arch critics of government policy on HIV/AIDS, the AIDS Consortium, have deliberately been marginalised in the appointments. This is a huge problem since the AIDS Consortium represents more than 160 organisations working in the fields of HIV/AIDS (Nattrass, 2004).

The Strategic Plan further fails to pay attention to the greater vulnerability of women in HIV/AIDS transmission and the concrete steps needed to address this vulnerability (CHSD, 2002). There still exists a need for a concerted effort/strategy to deal with the main factors that are known to exacerbate the epidemic, including poverty, migration and the vulnerable position of women. Lack of co-ordination between the structures created under the Strategic Plan makes it impossible for such a strategy to be developed.

South Africa seems to be very progressive in terms of policy formulating. Yet these policies and strategies always fall short when it comes to implementation. Evidence from this report will show that most of these policies just look good on paper but in reality there is very little evidence of success. Instead of acting efficiently to solve the implementation problem, the South African government engages in 'quick-fix' solutions such as encouraging condom use (Nattrass, 2004). The real issues surrounding HIV/AIDS receive less attention. Gender inequality continues to be a major contributing factor to the spread of HIV/AIDS. Education and prevention campaigns continue to be biomedically orientated and the concept of culture to health is not receiving as much attention as it deserves. Moreover, only the biomedical sector is visible in the fight against HIV/AIDS. Other sectors such as traditional healers are ignored. The result is that HIV/AIDS prevalence continues to soar,

suggesting a discrepancy between policy-making and the impact thereof (CHSD, 2002). Also, despite promoting a national strategy against HIV/AIDS, government from time to time undermines its own credibility through inconsistencies in policy and controversies such as Sarafina II, the Viroden 'cure' for HIV/AIDS and the infamous denialism of President Mbeki (Whiteside and Sunter, 2000).

With an effective vaccine unlikely to be available for at least ten years, prevention of transmission through education and behaviour change remains the only option that can slow the spread of the epidemic (Green 1994; Joubert, 1990). Studies around the world have shown that behaviour interventions including information, education and communication programmes (IECs), condom promotion and behaviour change initiatives that encourage people to reduce the number of their sexual partners can bring about a reduction in high-risk sexual behaviour (CASE, 2000; CHSD, 2002; Harrison, 2000). A number of these programmes have also been implemented in South Africa by national and provincial governments as part of policy.

2.4.3 Information, Education and Communication Programmes (IECs)

The National Aids Plan gave rise to IECs. These IECs typically form the starting point for HIV prevention activities, and in South Africa, have been crucial in raising awareness about HIV/AIDS. While South Africa has been criticised for the slowness of the response to the epidemic, a high level of awareness exists among the general population. In particular, the mass media has publicized HIV/AIDS through television programmes such as *Soul City*, a weekly drama series covering a range of health issues, thus disseminating basic information about the epidemic and its consequences. Radio has also been an important medium for HIV/AIDS education, particularly through community radio stations.

Other IEC campaigns focus on knowledge of HIV/AIDS and specific risks, which must precede behaviour change (Hornik, 1993). For example, the Department of Health's *Beyond Awareness* campaign addresses HIV/AIDS and its prevention through popular media, widespread promotion of condoms, encouraging open dialogue on the disease and sponsoring HIV/AIDS-related activities (Department of Health, 1998). Other notable IEC efforts in South Africa have included youth magazines such as *Laduma*, produced in comic form and *Lovelife*: a national youth

sexual health initiative, which has started a mass media campaign using billboards, newspaper advertisements, radio and other outlets to address sexual health issues, as well as underlying causes of HIV/AIDS including gender issues and sexual coercion (NASHI, 1999).

Targeting youth in HIV/AIDS awareness is a response to the finding that young people are the most likely sector of the population to be involved in activities associated with HIV/AIDS. A study conducted by CASE (2000) showed that black youth are likely to become sexually active before the age of 16. Moreover, only 52 per cent of the youth had ever asked a partner to use a condom. There therefore exists a need to provide HIV/AIDS information and education to the youth. This early socialisation phase is crucial in forming youth's attitudes towards sexuality and yet there is still little research in this regard. It is here that the role of traditional healer as a custodian of traditional culture and knowledge comes to play.

2.5 TRADITIONAL KNOWLEDGE SYSTEMS AND THE WORK OF THE WHO

Continued reliance on the developed countries has left Africa with a legacy of unsustainable development and a growing sense of dependence (Lebakeng, 2003). Scientific research is driven globally by the needs of the developed countries, which set the agenda and decide on the directions which research should take. Thus in developing countries, promoting scientific research often means buying into the agenda of the developed countries. As a result, problems of the developing countries are often not sufficiently addressed. This has led to the preoccupation with the promotion, protection and utilization of traditional knowledge. Odora-Hoppers (2002:6) defines traditional knowledge systems as:

> That knowledge that is held and used by a people who identify themselves as
> indigenous of a place based on a combination of cultural distinctiveness and prior
> territorial occupancy relative to a more recently arrived population with its own
> distinct and subsequent dominant culture.

In the 1970's, critical changes in the perception of, and the status accorded to traditional healing began to take place. For example, the Organization of African Unity (OAU) and the French Organization for Educational Development began to explore the use of herbs by traditional healers in African countries (Fehher, 1997).

This was partly because the WHO began to see that meeting even basic health requirements was beyond the capabilities of western medical practitioners. Since then, the WHO has "spearheaded an ideological rethink of the role that the traditional medical systems could play in health care coverage" (Chavunduka, 1994: 32). It also encouraged planners and governments in developing countries to reassess traditional medicines as a potential health care resource.

The WHO also promoted policy-oriented research for collaboration between western and traditional medicine. This has been successful in countries like northern Ghana and northeast Tanzania where traditional healers have successfully been incorporated into the health care provision without losing their own status and autonomy (Fenyves, 1994). Another example is that of China's *barefoot doctors.* By the mid-1980's, China had more than 1100 traditional medical hospitals, as well as traditional medical departments in 90 per cent of all other hospitals, with almost 500 000 traditional medical practitioners (Dauskardt, 1990).

The 1970's were also the time when development planners and policy makers who sought to promote sustainable human development began to see the need to build on knowledge resources and insights existing in communities (Luiz, 1994). South Africa has a rich resource of such knowledge. However, traditional beliefs and practices are still largely equated with ignorance and backwardness. There is recognition by development planners and government agencies that people or communities need to be stimulated in a manner that builds on what they have. This includes the knowledge, skills and competencies, which they acquired through indigenous methods (Beeker, 1998). Thus in dealing with the HIV/AIDS pandemic, many health departments in countries such as Mozambique, Ghana and Zimbabwe are now building upon traditional knowledge systems by finding the fit between what already exists and what they wish to promote in the interest of public health (Green, 1996).

BOX 1: THE UGANDAN CASE

Uganda has managed to control its HIV epidemic during the past 15 years. According to the United Nations Programme (UNP) on HIV/AIDS, the national HIV/AIDS prevalence peaked at around 15 per cent in 1991, and has fallen to five per cent as of 2001 (Green, 2002). Uganda's falling HIV prevalence can be attributed to a number of behavioural changes that have been identified in several surveys and qualitative studies. In 1986, Uganda's new head of state, President Yower Museveni, responded to HIV/AIDS with a proactive approach that has continued to the present moment. This early high-level support fostered a multi-sectoral response, prioritising and enlisting a wide variety of national participants in the war against HIV/AIDS. As of 2001, there were reportedly at least 700 agencies working on HIV/AIDS issues across all districts in Uganda (Green, 2002).

In 1986, Uganda launched an aggressive public media campaign that included print materials, radio, billboards and most importantly, community mobilization for a grass-roots involvement in HIV/AIDS intervention programmes (South Africa lacks this last part). The STD/AIDS Control Programme established in 1994 has since trained thousands of community-based AIDS councillors, health educators and peer educators. Rather than putting emphasis on information and education, more emphasis was placed on a behaviour change-based approach to preventing HIV/AIDS. Interestingly enough, Uganda's approach to behaviour change communication has relied more on non-electronic mass communication, which was community-based, face-to-face and culturally appropriate. The use of a participatory approach in Uganda led to the sensitisation and subsequent involvement in HIV/AIDS awareness and education of not only health personnel, but also other influential people such as traditional healers and religious leaders.

2.6 TRADITIONAL HEALERS IN SOUTH AFRICA

South Africans who require medical attention have both western-trained physicians and indigenous/traditional healers available to them. From the patient's point of view, choosing between western and African forms of medical treatment entails rather more than differences in assumption about the causes of illness and the appropriate mode of cure (Ngubane, 1992). In most parts of southern Africa (including South Africa) the two kinds of practice contrast strikingly: in western practice the patient is expected to give the history of the illness and describe the symptoms before being examined by the doctor, while in traditional healing the healer consults with the ancestors and tells the patient what the problem is.

The first people to practise traditional healing were the Egyptian Africans (Norman, 1996). Thereafter traditional healing started to extend to the Bantu people. When these Bantu clans headed south on the African continent, they had no doctors with them. Even though they developed different classes and religions, they all believed in

one thing: their ancestral spirits (Norman, 1996). Even today it is impossible to understand traditional healing without understanding the culture, customs, traditional religion and the role of the ancestral spirits in the lives of the healers and patients (Ngubane, 1992; Norman, 1996; Schuster, 1998).

2.6.1 Traditional Healing Cosmology

Traditional healers in South Africa fall under three categories i.e. diviners (*sangomas),* herbalists (*inyangas*) and prophets (Gumede, 1992; Ngubane, 1992). Diagnosis is the primary function of the diviner (who is usually a female) while the herbalist (who is usually a male) uses herbs to cure illness. Prophets originate from Independent African Churches and they use "holy water" and prayer to heal the sick (Thornton, 2002). In the past an *inyanga* would visit patients at their homes, where he was told about the symptoms and he used to spend more than a day with one patient and the patient's family. This period gave him an opportunity to determine whether he understood the particular ailment and was capable of handling it, or whether the family needed to consult a diviner who would diagnose the cause of illness (Hammond-Tooke, 1989).

Contrary to the herbalist, a diviner is consulted by relatives of the sick, who remains at home (Ngubane, 1992). She is not given the history of the illness or symptoms as she was expected with her second sight to see beyond what ordinary people could perceive. She should be able to know who is ill, what the nature of the ailment was, and what caused it, and how it should be treated. Every diviner is able to enter a trance and communicate with ancestors through the throwing of bones (Hammond-Tooke, 1989). She then interprets their meaning according to how they fall. Some diviners have ancestral spirits who speak directly to her by whistling from the rafters of her house. This is the diviner of the highest grade and there are very few who reach this status.

Nowadays, the distinction between diviners and herbalists is often blurred. Some people claim to be both a diviner and a herbalist. Therefore for the purpose of this study the term traditional healer is used to refer to both the diviners and herbalists. Prophets are not included in this study as there is no current research that shows that

they are involved in HIV/AIDS prevention strategies and to do this is beyond the scope of this research project.

The close link between traditional healers and ancestors makes traditional healers indispensable members of the South African society (Hammond-Tooke, 1989; Schuster, 1998). This is because ancestors are believed by South Africans to be both the casual agents of misfortune and the means of its removal. The role of a traditional healer as a mediator between the people and the ancestors is therefore very important. In addition, traditional healers also play a role of combating the forces of evil that constantly threaten the lives and well-being of their patients (Ngubane, 1992). As a result, healers are accorded authority and prestige.

2.6.2 Traditional Healers and HIV/AIDS prevention
Insofar as the relationship between healers and their patients is concerned, there is no doubt that healers are greatly respected as a profession. This is evident in the number of people who consult them. According to Cocks (2002) 70 per cent of the South African population consult traditional healers. Moreover, traditional healing is holistic in nature, dealing with the psychological aspects of a disease as well as with the physical (Ngubane, 1992). People therefore choose whether to go to doctors or traditional healers, depending on the nature of illness that they have. In many cases, the choice is to consult a traditional healer who is not only familiar with the patient, but also understands the social matrix in which the patient lives (Hammond-Tooke, 1989; Thornton, 2002).

Traditional healers have a numerical advantage over all other forms of healing including the biomedical sector. For example the traditional healer to population ratio is roughly 1:200 in Mozambique (Green, 1996), 1:260 in Zimbabwe (Chavunduka, 1994), 1:210 in South Africa, 1:287 in Uganda and 1:215 in Swaziland (Green, 1988). Not only are traditional healers numerous, but they also apply their profession in the remotest parts of these countries. The insufficiency of western medical doctors in the above-mentioned countries coupled with their limited access has a profound impact on the health status of the poor. For example, it was mentioned in the introduction that Jeppestown residents are sometimes sent back home from the clinic due to lack of staff and resources. There is therefore a need to explore the possibility of utilising

the services of traditional healers who are numerous and are trusted by people. In fact, the high concentration of traditional healers in other parts of the Johannesburg further suggests that they are still frequently consulted, especially when hospitals and clinics are unavailable (Campbell, 2000).

The power and trust that traditional healers have in society can be useful in terms of HIV/AIDS prevention in South Africa. By now South Africans are fairly knowledgeable about HIV/AIDS (CHSD, 2002). This, in a sense, suggests that the HIV/AIDS campaigns discussed earlier have worked, yet the continuing increase in infection rates suggests that these efforts have been limited or perhaps not effective on a broad enough scale to achieve a significant impact on public health. In dealing with HIV/AIDS, it is important that all key organizations or institutions influencing people's behaviour are identified and traditional healers are among them. Many healers and organizations such as the Traditional Healers Organization for Africa (THO) and the University of Cape Town's Traditional Medicines Programme (TRAMED) have been involved in experimentation with herbal remedies for treating HIV/AIDS.

Many health departments in Africa have now started working closely with traditional healers in what is termed "collaborative programmes". Collaborative programmes mean a better working relationship between traditional healers and western health sectors whereby appropriate referrals between the two sectors are developed and become more routine (Green, 1994). This also means that certain of the traditional healer's skills are upgraded, and the cultural sensitivity of western health workers is increased to the point of learning about the more effective traditional healing practises, and even integrating these in their practice (Pillay, 2000). In South Africa, only the Kwa-Zulu Natal Province has shown some progress when it comes to collaborative programmes between traditional healers and western doctors.

2.7 SOUTH AFRICAN CASE STUDIES

Kwa-Zulu Natal (with 35 per cent of its population infected with HIV/AIDS) has developed an HIV/AIDS prevention strategy whereby small-scale projects are geared towards local communities where trained staff can translate the information in locally meaningful terms (Beeker, 1998). This has involved traditional healers being seen as

key role players. Two examples of such projects are the Aids Information and Communication Center (ATICC) and the Freedom Traditional Hospital

2.7.1 The Aids Information and Communication Centre

This centre is situated in Pietermaritzburg. A government Aids Counsellor and a traditional healer lead the ATICC. What is unique about this programme is that it accepts that traditional healers are vital to the success of the programme (Schuster, 1998). The strategy used by the Kwa-Zulu Natal Health Department, in partnership with ATICC, is to identify and reinforce those aspects of traditional medicine believed to promote public health. Those believed to have a negative health impact are discouraged, as shown in table 5.

Three major themes emerge from the work of the ATICC. Firstly, there is the issue of condoms. Even though a great resistance to the use of condoms has been reported on the part of many African men, the ATICC found that some traditional healers already told their patients with STIs to avoid sexual intercourse during treatment or to use condoms. The ATICC then persuaded these traditional healers to provide their patients with condoms. The response of both healers and patients was positive (Shuster, 1998). Second, it was recognized that some traditional practices might contribute to the spread of AIDS and other diseases, for example, the use of unsterilized razor blades for making incisions for introducing medicine into the blood stream. The same razor may be used for several other patients. Traditional healers were encouraged to use only one razor per patient. Sometimes patients are required to bring their own razors to the healers. Third, is the issue of the modification of sexual behaviour, an issue that is very important in lowering the rate HIV/AIDS infection. As a means of modifying behaviour, people suffering from STIs are advised to refrain from intercourse until they are healed. They are also advised to bring their husbands, wives or other sexual partners to be treated as well and to avoid relations with partners suspected or known to have had many sexual partners.

Table 5: the proposed HIV/AIDS strategy as developed by ATICC in conjunction with traditional healers in Kwa- Zulu Natal (Schuster, 1998).

Introduce, Promote	Encourage, Reinforce	Discourage
Condom use and condom education.	Belief that sex with many partners can be a health hazard.	Healers having direct contact with blood.
Use of only one razor per client.	Belief that sex with a person with an STI is dangerous.	Use of traditional medicine if acceptable alternatives are available.
Appropriate referrals to hospitals.	The practice of sexual abstinence during STI treatment.	
Healers to discourage their clients from antibiotic self-treatment.	Belief that partners of a person with STI should be treated.	
	Traditional healers caring for AIDS patients and providing support to families.	
	Notions of sexual morality.	

What has been apparent through this programme is that traditional healers now seem to have a clear sense or understanding of what they can or cannot heal (Schuster, 1998). They now recognize that there are conditions for which western biomedical treatment is superior to traditional treatment. In cases where they cannot heal the patient and in cases of emergency, traditional healers send this patient to the hospital. For example, for STI treatments, traditional healers may first send the patients to medical doctors for antibiotics, so that they won't spread the disease. While patients are taking the antibiotics, they are also treated with complementary herbs.

Furthermore, the ATICC believes that traditional healers are the guardians of traditional culture and are also highly respected members of traditional society, and as such, they can stimulate certain cultural and traditional values, which may help to reduce HIV/AIDS. This can be done predominantly by helping people to internalise safe sexual practices. For example, in the past, traditional healers were very much involved in the sexual socialisation of adolescents in many South African communities. Adolescents received guidance on sexual matters during initiation rituals and traditional healers were an integral part of these rituals (Delius and Glaser 2002b). Urbanisation and modernity has undermined these customs, with negative implications for the spread of HIV/AIDS. That is why the role of traditional healers in

sexual socialisation among young people is now being re-evaluated in many communities and there is a trend to reinstitute a number of traditional customs such as male circumcision and virginity testing in urban areas.

In the past traditional healers used unsterilised razors on different patients, although it must be remembered that at that time traditional healers lacked knowledge of how the infection spread (Campbell, 2000). In addition they had no knowledge of alternatives, but when alternatives were offered to them, studies show that traditional healers were willing to incorporate these alternatives in their repertoire of techniques and abandon some of their practices if they are were shown to be harmful (Green, 1994). Thus, through programmes like the ATICC, healers now use surgical gloves, and sterilised razors are used only once and then thrown away to protect both the healer and the patient from spreading the virus any further. The Health Department, in partnership with the ATICC, runs a series of workshops where techniques like sterilisation are explained and demonstrated. Traditional healers are also involved in HIV/AIDS rallies at schools; they distribute and teach their clients how to use condoms. In addition, HIV/AIDS training is now part of training as a *sangoma* initiate.

2.7.2 The Freedom Traditional Hospital

The Freedom Traditional Hospital in Durban is another example of co-operation between traditional healers and western doctors. This hospital started in 1996 as a small clinic for patients and was also a place where groups of student nurses who wanted to learn about traditional medicine were taught. The hospital treats patients and trains health care workers. It receives many patients already infected with the HIV virus. The hospital employs trained HIV/AIDS counsellors who are also traditional healers. Nana (the leader) states, "I see my patient's symptoms of HIV/AIDS disappear over time but I can't say I have got a cure for anything since I do not have a proper testing facility" (in Campbell, 2000:104). Despite this, the traditional healers seem to be prolonging and improving the patient's quality of life through diet, herbal treatment and exercise. The most important contribution that these traditional healers make is psychological. They offer support and counselling, something that is lacking in clinics. As HIV/AIDS is associated with stigma, the very reputation of being HIV/AIDS positive adds to the suffering of those who are infected (Sontag, 1989). The feelings of shame aroused by HIV/AIDS cause people to conceal

their status from friends, families and even their partners. The Freedom Hospital therefore offers more than just diagnosis and treatment; the staff counsel both patient and family and this approach is receiving good results (Campbell, 2000). Their symbolic embedding in shared culture enables them to give their HIV patients hope. They are also able to suggest modifications in their life styles, which are better "heard" coming from a traditional healer i.e. someone who shares the culture, rather than being seen as an imposition by someone who does not "understand" (Schuster, 1998; Campbell, 2000).

2.8 Conclusion

Based on the above discussion, two general conclusions can be made. First, the concept of culture and disease is very much neglected in policy-making. The result is that the biomedical approach is getting more attention while other forms of treatment are being suppressed. The word culture is just mentioned in passing in many HIV/AIDS documents but there is no real engagement with the concept. Hence, even though the South African government has a fairly comprehensive national HIV/AIDS strategy, the implementation of policy is largely lagging behind. This is possibly because not all stakeholders and key role players have been identified. In dealing with a very sensitive and socio-cultural disease such as HIV/AIDS, there is no reason why traditional healers (as highly respected and much valued members of the society as they are) should be left out.

Second, HIV/AIDS is a complex disease with many interrelated factors fuelling its spread. Yet, the national government's response does not address these factors. For example, despite of the NACOSA AIDS Plan's commitment to addressing the vulnerable position of women in society, gender discrimination, sexual violence and oppression of women are still rife in South Africa. Surprisingly, given the strong perception that sexual behaviour and cultural notions held by men are mainly responsible for the epidemic and its impact on women, the extent of HIV/AIDS among men and their critical role in preventing its transmission have not been, comparatively, the focus of much research and policy response. Much more research needs to be devoted to determining barriers to HIV/AIDS prevention amongst men in general and adolescents in particular. The question why men continue to have unprotected sex while facing the likelihood of HIV/AIDS infection has not received

the attention it deserves. This literature review therefore raises the weakness and constraints in government policy-making and recommends that other players such as traditional healers be brought into the equation. Case studies of where traditional healers are involved in HIV/AIDS prevention and education campaigns show that indeed, there is more that traditional healers can offer in the fight against HIVAIDS.