1
INTRODUCTION

1.0 BACKGROUND

Virtually unheard of two decades ago, HIV/AIDS has become one of the worst feared and one of the most featured diseases in agendas around the world. The first diagnosed case of HIV/AIDS was in June 1981. From the outset HIV/AIDS was stigmatised, its first known bearers being gay men and sex workers from Western Europe and North America. This allowed those who did not belong to these "high risk" groups to imagine that they were immune from infection. The people who were infected were believed to be victims of their own immoral behaviour. This was also the case in South Africa. When the first HIV/AIDS cases were reported in 1983, the "high risk groups" were once again powerfully stigmatised.

Warning lights, however, started to flash in the late 1980's, when several South African migrant workers tested HIV-positive. The first of a series of annual national surveys conducted in 1989 found an HIV/AIDS prevalence of 0.8 per cent among antenatal clinic attendees (Schneider, 1998). By 1991, this figure had doubled to 1.5 per cent, and it became clear that South Africa was in the early stages of a rapidly growing HIV/AIDS epidemic. It also became clear that unlike in Western Europe and North America where the epidemic was largely transmitted through homosexual sex, in the Southern African region the HIV/AIDS epidemic was mainly transmitted through heterosexual sex. Subsequently, attention began to shift more towards sexual culture and high-risk behaviours (as opposed to high-risk groups).

In South Africa, socio-cultural norms of gender inequality, sexual violence and pressures to prove fertility contribute to a high-risk environment (Leclerc-Madlala, 2001). This sexual culture is an important dimension of the HIV/AIDS pandemic. Understanding it contributes to our knowledge of HIV/AIDS transmission and the challenges faced by interventions designed to change behaviour. The centrality of culture and the urgent need to transform it is key to HIV/AIDS prevention. However in South Africa this can be a difficult task, particularly when it comes to transforming

sexual relationships in a context where men are expected to have multiple partners, and women are accredited an inferior status in society.

Unfortunately, this sexual culture in which both men and women are locked in exposes them to HIV/AIDS infection. South Africa has more people living with HIV/AIDS than any other developing country (see table 1). By the end of 1998, an estimated 2.8 million people were living with HIV/AIDS in the country. By 1999, this figure had increased to 3.5 million and at the end of 2000 it had increased again to 4.7 million (CHSD, 2002; Walker *et al*, 2004). Not all observers and analysts, however, agree with this figure and many believe it is an underestimate of the real picture. The Actuarial Society of South Africa puts the total number of people infected in South Africa at the end of 2000 at 5.3 million (600 000 more than the official figure of the Department of Health). Other sources put this figure as high as 6 million (SAIRR, 2001).

Table 1: Counties with largest number of HIV/AIDS infections and highest adult HIV-positive prevalence rate in December 2000 (adapted from UNAIDS 2001)

NUMBER OF INFECTIONS (MILLIONS)	**ADULT PREVALENCE RATE %***
South Africa (4.7)	Botswana (36)
India (3.7)	Swaziland (25)
Ethiopia (3.0)	Zimbabwe (25)
Nigeria (2.7)	Lesotho (24)
Kenya (2.1)	**South Africa (22)**
Zimbabwe (1.5)	Zambia (20)
Tanzania (1.3)	Namibia (20)
Mozambique (1.2)	Malawi (16)
DRC (1.1)	Kenya (14)
Zambia (0.87)	Central African Republic (14)
USA (0.85)	Mozambique (13)

*The percentage of the population between the ages of 15 and 49 who are HIV-positive.

Recent projections of HIV-positive individuals indicate that these figures could reach 7.5 million by 2010 (CASE, 2002). This represents a fifth of the population. In the same year, the World Health Organization (WHO) estimates that life expectancy in South Africa will be 43 years, that is seventeen years less than it would have been before the epidemic. According to CHSD (2002) in the period 2000 to 2010 between

four and seven million South Africans may die of AIDS related illnesses. The number of AIDS deaths will be much larger than the number of deaths due to any other single cause. It will be almost double the number of deaths from other causes combined over that period (Dorrington, 2001). These figures are overwhelming and reveal the massive social and economic impact that HIV/AIDS will have in the future. As leading South African scientist Professor Malegapuru Makgoba has said, "if we had been involved in a major war, that would be the only other thing that could explain the high numbers of young men and women who are dying in our country" (Sunday Times Newspaper, 07 September 2000).

The HIV/AIDS epidemic has not only had a devastating impact (in terms of the number of people infected) since it appearance 20 years ago, but it has also posed a major challenge to previous medical accomplishments. Despite extraordinary accomplishments in disease control, the medical profession has yet to provide an adequate prevention or control strategy. Dr. Letlape – Chairperson of the South African Medical Association, for example, has commented that "the South African medical profession has failed dismally in embracing its duty towards the HIV/AIDS pandemic"(Mail and Guardian Newspaper, 8 August 2002). The HIV/AIDS epidemic may turn out to be the single most important challenge to any future government and health service in this country (Skhosana, 2001).

There is no doubt that South Africa has failed to slow down the spread of HIV/AIDS. However, it is important to note that the HIV/AIDS epidemic in South Africa is a complex one since there is no single explanation for the epidemic, but a unique combination of factors which influence the pattern and profile of the epidemic. The combination of poverty, sexual violence, unsafe sexual practices, and a secretive approach to sexual dialogue, rapid political change, migrancy and sexual networks have created an environment in which HIV/AIDS is spreading at an unprecedented rate (Walker *et al,* 2004).

Besides these factors, one other important reason why South Africa has failed to slow down the spread of the HIV/AIDS is that initial research on the epidemic has been largely confined to the biomedical sciences (Grimwood *et al*, 2000). Public health programmes on HIV/AIDS in South Africa have tended to focus more on the

need to change sexual behaviour and use condoms as a safer sex practice. This narrow scientific reasoning which sees individual sexual behaviour as the major cause of transmission has resulted in intervention programmes/campaigns targeting individual behavioural change and condom use. Needless to say, this approach has not produced any significant results as is evident in the increasing number of people becoming infected with the HIV/AIDS virus in South Africa. HIV/AIDS is a social epidemic and as such, in understanding the HIV/AIDS epidemic, other factors that influence sexual behaviour need to be taken into consideration (Reid, 1997). Furthermore, the role of key organisations/institutions influencing people's behaviour need to be assessed. One such institution is traditional healing. It is argued in this research report that traditional healers, because they are trusted by their communities and because they are culturally powerful, they can play a role in fostering safer sexual behaviour especially in men who, according to Walker *et al* (2004), are drivers of the HIV/AIDS epidemic.

The main aim of this research project will be to assess the role that can be played by traditional healers in preventing HIV/AIDS. Two key issues will be examined:

- What are the implications of traditional healers' attitudes towards sex, sex education and Sexually Transmitted Infections (STIs) for the development of an effective preventive strategy?
- What are the prospects and constraints to collaboration between traditional healers and the biomedical profession in Jeppestown?

At the World Health Organization (WHO) and UNICEF Alma-Ata Conference held in 1978, the inability of the Western-based medical sector to provide sufficient health care in the developing world countries was noted. It was resolved at this conference that the developing countries of the world had to turn their attention to promote and develop existing health care resources (Dauskardt, 1994). This was a very important move for developing countries since health is often used as a world development indicator to assess the developmental status of a country (Dauskardt, 1990). It took South Africa sixteen years to adopt a similar policy, which was eventually adopted by the African National Congress in 1994. In their policy, the ANC stated that, "traditional healing will become an integral and recognized part of health care in South Africa" (ANC, 1994:5).

The failure of the Western-based medical sector to lower the rate of HIV/AIDS infection in South Africa has, however, only recently caused many people to start looking at the potential role that could be played by traditional health systems in South Africa's multicultural environment. It has been recognized that there is a need for a multi-disciplinary team approach to HIV/AIDS prevention, and traditional healers form an important component of this. With the above points in mind it is necessary to understand and explore the potential contribution of traditional knowledge systems to local development. The protection of traditional knowledge systems and its utilisation for the benefit of its owners and communities where it is practiced needs to be researched. Up until now traditional knowledge systems have been ignored by science and their status has been suppressed. However, researchers such as Green, 1994; Pretorius, 1999; Thornton, 2002 and Walker *et al*, 2004 among others, have started to see that traditional knowledge systems such as traditional healing can be used for the well being of the people who practise them. There is therefore a need for traditional knowledge systems to be brought into the mainstream of knowledge in order to establish its place within the larger body of knowledge.

1.1 JEPPESTOWN: A PROFILE

The research was conducted in the area of Jeppestown, south of Johannesburg. Situated in Region Eight in the inner city, Jeppestown is a predominantly black "suburb" and is experiencing a high level of HIV/AIDS infection (Interview, senior nurse at Jeppestown clinic, June 2002). The estimated population in this region is 200 000 but the number of people living in the inner city on a temporary basis is unknown (Johannesburg News Agency, 2003). There has been gradual shift of the population profile in this region as higher-income residents and Whites have moved away and been replaced by the lower-income population of Blacks.

Before 1994, Jeppestown used to be an industrial area and the Wolhuter Men's hostel was one of the few places of residence for black people at that time. Most of the factories have been closed and abandoned buildings turned into informal housing. These 'shacks' are not visible from outside since they are located inside the abandoned factory buildings. The majority of people living here have no fixed income and those that do, still live below the poverty line with bad nourishment and low self-esteem (Thomas, 2002).

Poverty, unemployment and poor social and physical conditions (such as lack of access to safe drinking water, sanitation and poor housing) have had a direct impact on the susceptibility[*] of communities in Jeppestown (Annual Report on the City of Johannesburg, 2002/2003). This risk environment in Jeppestown coupled with the low status of women makes Jeppestown an ideal setting for the spread of STIs and the risk of HIV/AIDS infection.

About 98 per cent of inhabitants of Jeppestown are low-income immigrants from Kwa-Zulu Natal (Beavon, 2004). Most of them are men who stay in Wolhuters Men's Hostel, also situated in Jeppestown. When this hostel was built in the late 1960's, men were prevented by migrancy laws from bringing their families to Johannesburg. The legacy of the migrant labour system as is evident in Jeppestown has resulted in at least two things. First, there is a breakdown of the African traditional family values. As men migrate and are separated from their families, women are left to raise children alone.

Second, within the context of single sex hostels in Johannesburg, a thriving commercial sex industry has sprung up, with women coming to Johannesburg from impoverished rural areas both in South Africa and neighbouring countries and finding accommodation in informal shack settlements (Campbell, 2000). Research on this topic has shown that most men staying in Wolhuters Men's hostel indulge in casual unprotected sex with multiple partners (Ndingi, 2001). This research has also shown a high level of co-habitation in the shacks, where men as young as 20 years live together with women as young as 16 years, in the informal shack settlements of Jeppestown. These men in turn have other partners. Such sexual behaviour is risky and many lead to one getting infected with HIV/AIDS. Researchers like Green (1994), Schneider (1998) and Skhosana (2001) also concur that the South African migrant labour system is the major contributing factor of STIs and HIV/AIDS. Migrant labour leads to imbalances in the male/female population of urban areas, giving rise to a demand for paid sex. Sex workers and their clients then become "the core of disease transmitters". Many women in Jeppestown are unable to find paid

[*] Whiteside (2000:15) defines susceptibility as "the chance of an individual becoming infected".

work, and thus support themselves by offering sexual favours to a series of lovers in return for material support (Ndingi, 2001).

Coupled with the risk of migrancy, Jeppestown residents also face a problem of inadequate health care facilities. To date, there is only one clinic in Jeppestown situated at 34 Fox Street. The clinic 'strives' to provide a comprehensive health care service, which includes maternity, child health, immunisation, family planning, STIs, (TB) and curative care. However, the clinic is understaffed with only six professional nurses. As early as seven o'clock in the morning, patients can be seen standing in a queue outside the clinic waiting for it to open at eight o'clock. This is because consultation with nurses is done on a 'first come first served basis' with only 50 patients getting treatment in any one given day and the rest are sent back home (Interview, Resident, June 2002). In addition, nurses are frequently judgemental towards men who present themselves with STIs and, in search for a more 'effective' form of treatment these men consult with traditional healers (ibid).

There are more than one hundred traditional healers practising in Jeppestown. A small proportion of these are housed in the Mai-Mai Bazaar, which is the oldest market dedicated to traditional healing and is also the best-known source of traditional medicine in the area. Situated on the corner of Anderson and Berea streets in the city centre, the bazaar serves as a cultural enclave for traditional healing in the city of Johannesburg.

Following many years of neglect, the bazaar has now begun to regenerate. Moves are underway to restore the market and promote it as a prime tourist destination in the city (Johannesburg News Agency, 2003). This bazaar is described as *'Afrocentric', catering for indigenous needs and practices, and indeed, it is here that some spiritual and cultural elements of indigenous knowledge have been reworked and preserved"* (Interview, manager of the Bazaar, July 2004).

A study done by Williams (1997) revealed that about more than 40 herb traders and traditional healers clustered in the bazaar in 1996. There are currently 176 units in the bazaar, all of them dedicated to traditional healing, which is why the bazaar is often described as a "mall of *muthi"*. Mai-Mai is also a home to some 600 people, many of

whom have lived in the complex for decades. Dance competitions featuring dancing troupes from hostels across the city are a regular feature of the bazaar (Johannesburg News Agency, 2003). Within the walls of the complex, traditional healers, mainly female Zulu *sangomas,* trade in traditional medicines alongside healers of other cultural groups. Each healer is the keeper of plants and knowledge specific to their cultural groups, and they usually attract patients and customers with similar affiliations (Williams, 1997).

This research report will show that a high proportion of residents in Jeppestown consult with traditional healers in the Mai-Mai Bazaar. According to Thomas (2002) people come to traditional healers suffering from different diseases, many of which can be dealt with at the clinic. However, their first point of contact for primary health care is the traditional healer, not the clinic nurse. As a result attempts made by the City of Johannesburg to deal with HIV/AIDS in Jeppestown are less successful than envisioned and there is an obvious need to include traditional healers in prevention strategies. For example, less than ten per cent of the inner city hostel dwellers attend the awareness and outreach campaigns that are organised by the City of Johannesburg in conjunction with the clinic staff (Interview, nurse at clinic, June 2004). Even the review of the clinic's patient register for the period between June 2002 to June 2003 revealed that less than 20 per cent of people with STIs who come to the clinic are men (Interview, nurse at clinic, August 2004). It is therefore argued in this research report that there is a need to start reaching men where they are i.e. at traditional healers. One way of doing this is to get traditional healers more involved in HIV/AIDS prevention campaigns so that men receive all the relevant information about HIV/AIDS from traditional healers.

1.2 METHODOLOGY

Qualitative research methods were used in this research since greater depth of understanding was required. The term "qualitative" indicates an approach that deals with depth of engagement and interaction. The development of qualitative research methods in human geography stemmed from a multi-disciplinary concern that sought to bring to the forefront the everyday experiences of marginalised groups of society. A core feature of qualitative research is that satisfactory explanations of social activities such as traditional healing require substantial appreciation of the

perspectives, culture and worldviews of the actors involved. Qualitative research methods describe and explore the culture and behaviour being studied from the point of view of those studied (Neuman, 1997). According to Allan (1991:178) "the researched are not seen as objects with given properties…which can be measured, but as actors whose own frame of reference needs detailed explanations before their actions can be adequately interpreted and explained." Thus qualitative methods were used in this study to gain insight into, and a better analytical understanding of the dynamics and relationships involved in traditional healing.

1.2.1 SAMPLE

The study sample consisted of ten traditional healers practising in the Mai-Mai Bazaar. An important part of data collection process in qualitative research is the rapport established between the researcher and the participant. Not only does rapport create an environment based on trust and mutual respect, but it also allows the researcher to solicit important information one had hardly bargained for. Rapport and intimacy was easy to establish with the participants since I was a local resident of Jeppestown who could appeal to common ground and conceptions of space, community, history and culture at a variety of levels. This "insider" status related importantly to the amount, depth and richness of information collected.

Criteria for the inclusion in the study were that healers must have come into contact with patients suffering from STIs. Five participants were men and the other five were women. In addition, the leaders of Traditional Healers Organisation (THO), which has an office in Marshalltown, offered some valuable information required during the study. Interviews were also conducted with the senior nurse at the Jeppestown clinic to find out about collaborative measures between the clinic and healers.

1.2.2 INSTRUMENT

The researcher conducted one-on-one in-depth structured interviews that lasted between forty-five minutes to an hour on average. Interviews were conducted in Zulu language, and tape-recorded with permission of the participants. Notes were also jotted down during the course of the interview to safeguard against faulty tape-recording. These face-to-face interviews helped to ensure a relatively high response rate and provided the interviewer a chance to observe the surroundings. Each interview followed almost the same format. This helped maintain considerable

direction, controlled the topics discussed and kept the discussion from wandering too far. Each interview was conducted following a specially designed interview schedule with open-ended questions. The open-ended questions allowed the researcher to reveal unpredicted linkages and themes. They also allowed participants to express thoughts in their own words without limiting the type of response they could give.

1.2. 3 DATA ANALYSIS

The process of data analysis is a stage where the vast amount of data that was collected is organised into coherent units, which can be analysed. After the interviews had been transcribed, thematic content analysis was used to identify, categorise and elaborate themes on the basis of systematic scrutiny of the interview transcripts. The useful and important factor in thematic content analysis is the reduction of data into coherent and manageable categories. These in turn allow for the identification and clarification of central issues within the study (Berg, 1995). Through the construction of themes and categories, I was able to see which segments were important (based on frequency) and developed a corresponding categorisation system. Representative statements or quotes were selected from the interview transcripts to illustrate these categories after which an interpretation was developed.

1.3 Organisation of the report

This research report is divided into two sections, a theoretical section and an empirical section. Chapter two provides a review of the literature on HIV/AIDS in South Africa. This chapter stresses the need to move away from a biomedical perspective on health to a psycho-socio-environmental perspective. The latter is very important as it introduces the concept of culture to health management. Culture is an important concept to consider when looking at health issues, as it shapes the way people think about illnesses and health. In South Africa, the relevance of culture to health is demonstrated by the presence of traditional healers. Chapter two also reveals that in South Africa, even though many people consult traditional healers, western-based medical ideas still control medical theories of disease causation, and how medical knowledge is organised, evaluated and controlled. HIV/AIDS prevention strategies in South Africa are also discussed in this chapter and the argument is made that these have had little impact as they leave out other key potential players in HIV/AIDS, including traditional healers. Case studies where traditional healers have

been involved in HIV/AIDS prevention are then given and it is recommended that the same strategies be used for Jeppestown as well.

Three empirical chapters follow. In chapter three I provide different scenarios/cases where traditional healers can play a role in HIV/AIDS prevention. This chapter highlights the special relationship that healers have with their client. The empirical evidence presented in this chapter demonstrates a strong need for traditional healers to be involved in the provision of primary health care in the inner city, both as health care providers and as community health care workers.

Chapter four looks at government, the biomedical sector and traditional healers. The chapter highlights the lack of support towards traditional healers both by government and the biomedical sector. As a result it becomes difficult for traditional healers and medical doctors to collaborate in the fight against HIV/AIDS. Mistrust between the two sectors also adds to the constraints to collaboration.

Chapter five explores the traditional healers' attitudes towards sex, sex education and STI for the development of an effective preventive strategy. 'Preventive strategies' such as virginity testing and male circumcision are discussed. The chapter shows that old customs as virginity testing are used by traditional healers to encourage young girls not to be sexually active before they get married. There are, however, a number of problems associated with these practices and they are discussed in this chapter.