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GOVERNMENT, THE BIOMEDICAL SECTOR AND TRADITIONAL HEALERS

4.0 Introduction

The scope and scale of the HIV/AIDS epidemic in South Africa is almost beyond belief. The human tragedy and the hugeness of the challenge facing South Africa as a result of the epidemic cannot be captured by simply using statistical models (Walker *et al*, 2004). Instead of these models, there is a real need to look at people (real lives) behind the statistics (Skhosana, 2001). In that case, effective intervention from government, NGOs and local communities becomes a matter of unprecedented urgency (Walker *et al*, 2004). Ironically, efforts to combat the spread of the HIV/AIDS epidemic in South Africa have not resulted in smooth cooperation between different sectors of society. Instead they have reinforced existing social problems and divisions, as is evident in the way government policy differs from government practice and the on-going conflict between government and NGOs over the implementation of preventative strategies. The stakeholders/actors that government has chosen to work closely with in the area of HIV/AIDS prevention is highly contested, as is the extent to which such actors can inform government policy (ibid). This chapter is about how government and the biomedical sector act as obstacles and enablers to the realisation of the role of traditional healers in the prevention and treatment of HIV/AIDS.

One of the conclusions to be drawn from the preceding paragraph is that one of the major obstacles to an effective prevention and treatment programme in South Africa lies in government policies. While other countries such as Uganda and Mozambique have taken a different course to combat HIV/AIDS by using traditional knowledge systems to improve public awareness and health, South Africa has depended solely on biomedical explanations of the disease. The acceptance of such explanations and understandings of HIV/AIDS in South Africa has been foregrounded to the extent that other understandings have been subdued (Heald, 2002). The assumption that IECs, which are based on western experiences (condom use, promoting abstinence and monogamy), can be generalised to different situations cannot be held true in a country with many cultural belief systems impacting on how people understand and respond

to illness. The result has been that despite knowing how HIV/AIDS is transmitted, people still engage in high-risk sexual behaviour. While it is true that the practice of traditional healing is unregulated and relies on spiritual, unobservable phenomena (Walker *et al, 2004*), there is danger in following an exclusively biomedical approach, which, according to Heald (2002), tells just one side if the story, while there are other voices that need to be heard. A shift in terms of policy and approach is therefore needed.

4.1 Government and traditional healers

Lack of decisiveness and clarity in government policy, and the failure to induce commitment at all levels have a profound effect on the growth of the HIV/AIDS pandemic in South Africa. While national AIDS policies such as the Strategic Plan do attempt to create the mechanism for integrated response, they still remain somewhat generalised in terms of what needs to be done (Grimwood, 2000). To be effective against HIV/AIDS, government should move beyond simply involving more relevant role players such as traditional healers, but the voices of these role players need to be strengthened.

4.1.1 The Strategic Plan: IECs and the need for cultural sensitivity

The adoption of the Strategic Plan implies that government has come to recognise that for IECs to be more effective, they need to be more culturally sensitive.

> *By now everybody here has seen an advert (in the radio/TV, poster, newspaper) providing information about HIV/AIDS. People here know that HIV/AIDS is transmitted during sexual intercourse and that they should remain faithful to their partners or use condoms to prevent it. Many people also know that HIV/AIDS is incurable* (Interview, traditional healer, September 2004).

The mere fact that people continue to practise unsafe sex suggests that knowledge about HIV/AIDS is much more complex than what people see in the media (use condoms, HIV/AIDS is incurable and many more). People's knowledge about HIV/AIDS is embedded within a range of doubts and uncertainties, which serve to blunt the message imparted by the IECs (Green, 1994). People don't simply accept HIV/AIDS education messages because they compete with other cultural beliefs and experiences that are more compelling than the information that the nurse/doctor/health educator seeks to impart. According to one healer,

> *Even though people have heard of HIV/AIDS, some of them remain unsure about its existence since they have never seen anyone suffering from it…some people still*

believe that we (traditional healers) can cure the disease (Interview, traditional healer, July, 2004).

Locating the IEC programmes within a complex and detailed web of ideas concerning health, sexuality, traditional values and traditional systems is very important if these programmes are to be successful (Campbell 2003). The role of a traditional healer in this regard is an undeniable one. The Strategic Plan shows a particular strength in this regard, as it attempts to create an integrated response so that it is not only the government that is responsible for implementation and delivery, but other sectors as well (Grimwood *et al,* 2000). This shift in policy has significant implications for traditional healers:

We have been ignored for many years. We were called names, such as primitive, uneducated and many other hurtful names…Through it all, our patients were our strength. I have seen people who were brought to me half dead and having treated them they became well and went to live happily with their families. I've treated people suffering from epilepsy, stroke, heart failure, STI's and TB and they always get well…Even though I don't have a cure for AIDS, my herbs and prayers help my patients keep strong and live longer (Interview, traditional healer, July 2004).

Finally, educated people have come to accept my culture. The acceptance of my culture as a healer implies the acceptance of my patients. We share the same cultural belief otherwise they would not come to me for help. I always tell them (my patients) to observe traditional beliefs. This is very important if they want to live good and healthy lives… but I also advise them about the dangers of AIDS. They cannot live restlessly. They must be wise…I am very glad that government is now appreciating the work we do. We do a great work here in Jeppestown and government cannot afford to ignore us (Interview, traditional healer, August 2004).

The Strategic Plan, however, lacks concrete and measurable outcomes, with clear time schedules for monitoring and evaluating results. As a result, five years after the Strategic Plan was adopted, HIV/AIDS and STI control programmes are still planned and managed by the biomedical sector. This further demonstrates a discrepancy in government policy and government practice. Such a discrepancy has serious implications for HIV/AIDS and STI awareness programmes in particular, since when it comes to traditional healing, STIs are often regarded as one area of particular competence by South African healers and their clients (Chavunduka, 1994). As such, traditional healers need to be more visible in STI awareness campaigns and government policies should reflect and recognise this need.

4.1.2 The appointment of traditional healers in SANAC

It is worth emphasizing that government, and in particular the national department of health, has a leading role, not only in implementing the strategies against HIV/AIDS but also in appointing representatives to government structures dealing with HIV/AIDS. As a result, even though the involvement of traditional healers in the SANAC shows some commitment on the part of the government to stick to its goals, the manner in which these healers were appointed raises a number of questions. First, none of the healers interviewed in Jeppestown know how the representatives were appointed. They were never involved in the procedure of nominating candidates, nor do they know who the representatives are. Second and most importantly, there is no interaction/link between the healers in the SANAC and the healers on the ground:

> *We don't know what they do or talk about and I really wonder if our views are really being represented. How can they know our views and needs if they have not even spoken to us* (Interview, traditional healer, July 2004).

> *I don't even know what SANAC is and I have never heard of such a word. The government just chooses a few healers without consulting with us. The assumption is that these healers, whom we don't even know will represent us all…*(Interview, traditional healer, July 2004).

The result is that the role of traditional healers and other representatives in SANAC is not well established, thus undermining the credibility of SANAC and the Strategic Plan as a whole (Grimwood *et al*, 2000). One possible reason for the lack of meaningful representation by healers in SANAC is that traditional healers remain largely unorganised. They don't have sufficient structures, except for the THO (and not all healers belong to this organisation), which can be a platform for such interaction (Pretorious, 1999).

4.1.3 Role of government in providing support for traditional healers

WHO recommends that 'training' of healers be preceded by the establishment of an official government policy regarding healers (WHO, 1984). According to a WHO report, traditional healers must be involved in all stages of planning themselves, and programmes involving healers should be carried out in a way that does not destroy their individualility and authenticity. In South Africa, after years of negotiation between government and traditional healers, government approved the Traditional Health Practitioners Bill in September 2004. This bill creates a broad profession called "Traditional Health Practitioner (THP), which includes *izinyanga, izangoma,*

traditional birth attendants and traditional surgeons (those involved in the initiation of young boys and girls). The bill demonstrates government's commitment to the National Health Plan, where there is provision to involve traditional healing in the official health care service. Traditional healers welcomed this bill because,

> *Official acceptance of our practice as an important health service, and regulating it is good news for us as traditional healers because we will be recognized alongside medical doctors. Moreover, regulation will help do away with the many 'illegal healers' who are not officially trained. Such healers should be locked in prison* (Interview, traditional healer, July 2004).

As the above healer has correctly put it, one of the aims of registering and regulating traditional healers is to do away with charlatans who have a huge impact on the quality of health care in the traditional sector. It is calculated that of the 80 000 persons practising traditional healing in South Africa, only about ten per cent are *bone fide* healers: those who abide by the strict code of traditional healing (Pretorious, 1999). The bill is also a major breakthrough for traditional healers as their official acceptance means breaking away from the many stereotypes which see healers as backward and uncivilised. This attitude, mainly by those in authority, has resulted in many prejudices against healers. As one member of the board that came up with the bill commented,

> *Whenever a patient died at the hands of a traditional healer or traditional surgeon, the first person to knock on the door was an aggressive policeman to arrest the healer. However, that involvement has never been the case with western medicine doctors. They just filed a report and were left in peace. That's the kind of protection we want* (Interview, traditional healer, July 2004).

The government is therefore committed to re-establishing traditional knowledge systems in the quest for improved human health. It does so by providing support for traditional medicine research as well as promoting other fields of inquiry in traditional knowledge systems. According to Minister of Health, Dr. Manto Tshabalala-Msimang, "The study of traditional knowledge systems is not simply a scientific endeavour. It provides an opportunity to reclaim our scientific and socio-cultural rights" (Sunday Times, February 2006).

The data presented above presents a complex relationship between government and traditional healers. In its policies, government is committed both to working together with healers and promoting traditional healing as a whole. Yet these policies rely heavily on the biomedical theories and the role of traditional healers in such policies

remains unclear. In relation to the bill, other healers were sceptical. They believe that public statements made by government officials, *"are only meant to raise our hopes that something will be done to improve our practice. After that we wait and wait and nothing happens"* (Interview, traditional healer, August 2004). Could this be the case with the above statement by the Minister of Health?

Whatever the answer to the above question is, the reality is that the current government policy on HIV/AIDS has got some important implications to the planning and implementation of IECs in South Africa. Government efforts to deal with HIV/AIDS have been confronted with many challenges. Traditional healers continue to treat and counsel many patients with STI, compared to the clinic. This means that even if the South African government were to launch a major campaign to try and deal with STIs, such as the Strategic Plan, as long as it is the clinics which run these campaigns, many people will miss out because, they don't go to the clinic for their sexual problems but to traditional healers. There should therefore be a shift in the approach and policy. Sticking to the biomedical approach has proven itself to be limited and other strategies should be developed which take into consideration factors such as culture and gender.

4.2 The biomedical sector and traditional healers

4.2.1Collaboration between traditional healers and clinic

The preceding section has reported on detailed accounts of the nature of the relationship between traditional healers and government in South Africa. It is apparent that traditional healers function largely under an unregulated and unsupported environment. Yet they continue to treat more patients with STIs than the clinic. This section of the report assesses the collaborative projects that are in place in Jeppestown. The rationale for collaboration rests on the insight that HIV/AIDS is an extraordinary event that arises because attempts to promote health or treat the disease are inappropriate or inadequate (Campbell, 2003).

Traditional healers in Jeppestown have voiced a concern about the number of people dying of preventable and curable diseases, which they can treat. At the same time biomedical doctors are also worried about the number of treatable cases that are being taken to traditional healers and only reach hospitals when it is too late to save patients. This calls for a partnership between the two sectors. Collaborative

programmes between the two healing systems should, however, not only allow patients to be referred from one healing system to another also offer the possibility for an in-depth understanding of the way in which the epidemic is spreading in Jeppestown.

Ideally, this in-depth understanding has the potential to develop informed attempts which can reshape the local context through which HIV/AIDS is spreading in such a way that might limit its spread. Undoubtedly, this requires commitment from other stakeholders as well. According to traditional healers collaborative programmes should not be only between nurses and themselves (healers), but should unite local people and other sectors of government.

Before pursuing this point further, it is important to make a distinction between cooperation and integration. On the one hand, "cooperation implies a better working relationship between traditional and biomedical health sectors whereby appropriate referrals between the two sectors are developed and become routine" (Green, 1994:19). When there is cooperation, certain of the traditional healer's skills are upgraded, and the cultural sensitivity of nurses and doctors is increased to the point of learning about the more effective traditional healing practices, and even using these in their practice. In the literature, collaboration is used synonymously with cooperation, although collaboration implies cooperation between *equal* partners (Cooks, 2001).

Integration, on the other hand, implies a fundamental alteration in both healing systems and in the roles of the respective practitioners, although in practice it is the traditional healer who is expected to change. The danger here is that the traditional healer may become a second-rate paramedical worker and thereby cease to carry out his or her important duties in the local community (a function that has social, psychological, and spiritual as well as bodily health dimensions (Ngubane, 1992; Green, 2004), as one healer commented, *We don't want to be integrated to the western medical system but would prefer to maintain our authenticity. We can work together and share knowledge with doctors and nurses but we don't want to be integrated into their system" (*Interview, traditional healer, July 2004).

Training always precedes integration. It turns out that many healers in Jeppestown believe that training is a condescending word as it implies that traditional healers are somewhat deficient, but once they are trained by some method that only doctors and nurses can recommend, they can be enlightened and their practice improved. These healers believe that,

> *Such an approach ignores the great extent to which we (traditional healers) can educate nurses and doctors. We have a lot to offer in terms of how to treat some illnesses such as STIs; how to develop trust with patients; how to counsel patients and their families and much more. Yet, when there is training, facilitators always promote western medicine and techniques over traditional medicine* (Interview, traditional healer, July 2004).

Such an approach could be disruptive in many ways. Firstly, it undermines traditional healers' authenticity and authority. The ability of healers to solve their community's problems is downplayed. Secondly, it reinforces power relations between doctors/nurses and traditional healers. These power relations are such that traditional healers have little authority to insist that their practices be recognised in the biomedical framework. Hence the term 'collaboration' is used in this report.

The most recent collaborative programme in Jeppestown is the *Mpilonhle/Mpilonde* Programme, a three-year programme, which started in February 2004. According to the programme organisers, *Mpilonhle/Mpilonde* Programme is divided into three phases/rounds, each running for one year. The healers who participated in this study were part of the first phase (Round 1 Recruitment).

Round 1 Recruitment phase of the *Mpilonhle/Mpilonde*Programme saw the establishment of Quality Life Clubs (groups of about 10 residents) throughout Jeppestown. Quality Life Clubs act as a vehicle for community directed change,

> *Enabling residents to increase confidence and regain control over their lives. Our aim as organisers of this project is to see everybody being part of a club. We make sure that every community structure is represented in the club e.g. nurses, business people, youth, churches, traditional healers and women's organisations* (Interview, Programme Organiser, February 2006).

Clubs meet together once/twice a week, over a period of six months under the supervision of a qualified facilitator. During this period they study modules covering a range of community identified needs including healthy environment, food and nutrition, gender and violence as well as HIV/AIDS. After six months a graduation

ceremony is held where each participant is issued with an attendance certificate. The remaining six months is spent on follow-ups of clubs. During this period participants are also trained as facilitators so that they can pass on the knowledge to other residents. Most healers believe that round one of the *Mpilonhle/Mpilonde* Project was a huge success.

> *The project brought together a number of stakeholders such as women, men living in the hostel, youth, nurses from the clinic and traditional healers. We did door-to-door campaigns in the area making people aware of the disease and also encouraging to get tested for HIV* (Interview, traditional healer, September 2004).

> *There were many activities and workshops aimed at addressing issues surrounding HIV/AIDS. There were workshops on women and youth empowerment. For the first time we had police officers coming to address us. They talked a lot about gender violence and what help is available for victims* (Interview, traditional healer, August 2004)

> *Many people came forward to be tested for HIV. They were counselled and assured that the results would remain confidential. They were told where to go for help should the results come back positive* (Interview, traditional healer, July 2004).

> *I learnt a lot in my club. We had people from the Greenhouse Project coming to teach about food and nutrition. They taught us about different fruits and vegetables and the nutritional value of each….I enjoyed the teaching on herbs especially because most of them act as immune boosters. Since I started using these herbs I feel very strong. My stress level has gone down and I am very energetic…I liked the fact that we received hands-on training on how to make our own food gardens. It saves me a lot of money because I don't have buy vegetables anymore….Later we had facilitators from Soul City teaching on gender and violence and HIV/AIDS. It was quite a learning experience….My eyes were opened…"* (Interview, Club member, February 2006).

During the first phase of the project people in Jeppestown were working together for the very first time. The many activities that were planned and organised during that time increased people's awareness of many community issues such as HIV/AIDS. Moreover, people learnt where to go for help in cases such as abuse and social grants. Traditional healers believe that the project was a success because through the workshops done during the project, people's knowledge about HIV/AIDS has improved. Examples of community directed action included community clean-up campaigns, gardening programmes, holding councillors accountable to community needs and club performances using music, dance, poetry and theatre to present issues related to the quality of life and HIV/AIDS.

Some healers, however, voiced a concern about the project. They believe that the project was not 'sustainable' as:

> *For eight months, we have not heard anything from the organisers of the project. They have not even given us the report (results of the project) which they promised to give…even if they did give that report it will be of no use to us since it will be written in English and many of us cannot read English* (Interview, traditional healer, August 2004).

> *I believe that such a project should be done on an on-going basis. Just one project is not enough…I wish more workshops could be done which target men in this area. These men are playing with their lives and when they die they cause a lot of pain to their loved ones…there should also be more on poverty alleviation strategies and women empowerment* (Interview, traditional healer, July 2004).

> *Our club does not meet anymore. Our mentor (facilitator) has since promised to come and do follow-ups on how we are doing and he has never come. The last time we saw him was during the graduation ceremony* (Interview, traditional healer, November 2004).

This lack of continuity reflects stakeholders' lack of understanding of the rationale for collaboration and poor project management on the part of the organisers. Hence after the project, rather than working together to develop new frameworks of understanding and action, participants simply continue to implement approaches that they had used before, with nurses in clinic working on their own. Nobody knows what is happening to other clubs and stakeholders such as women, men and youth.

4.2.2 Relationship between traditional healers and medical doctors

The myths and misconceptions surrounding HIV/AIDS are exacerbated by lack of trust between healers and doctors/nurses. This is indicated in the observation by one of the traditional healers that doctors can also inject people with HIV/AIDS. One of the healers alleged that, "*some doctors draw HIV/AIDS-infected blood from AIDS patients, keep the blood in syringes, and then use these to infect people who come to clinics and hospitals*" (Interview, traditional healer, September 2004). The same healer also believed that the lubrication oils of condoms contained HIV/AIDS. "*Should one place the condoms in hot water, one could see 'AIDS worms' floating about*" (Interview, traditional healer, 2004). It turns out that this particular healer has always discouraged his patients to go to clinic because he believes that nurses are of no use. He also refused to be part of the *Mpilonhle/Mpilonde* project. He is also not liked by other traditional healers because of controversial statements that he often makes.

Other healers however, dismissed these allegations as fictitious:

> *You have to be a fool to believe such nonsense. Traditional healers who make these statements must be blamed for the number of people dying with HIV/AIDS here in Jeppestown. They don't read newspapers; they don't listen to the news. No wonder they are so ignorant…It is a known fact that the HIV/AIDS virus cannot survive a long time 'outside' a human being…This is all crazy* (Interview, traditional healer, August 2004)

Nonetheless, such statements capture the fears of the potential misuse of biomedicine. According to Jonsson (2000), perceptions such as this one are not only due to ignorance, but traditional healers often actively resist the pronouncement of biomedicine and western science over traditional medicine. They see western doctors as neither superior nor inferior as one of the traditional healers asserted,

> *What is different is the way western doctors diagnose, identify and treat sickness, but the result is the same. All of us cure people regardless of whether we use western medicine or traditional herbs* (Interview, traditional healer, August 2004).

Mistrust between healers and nurses/doctors in Jeppestown hinders programmes aimed at addressing the issue of HIV/AIDS. Healers are afraid that,

> *The relationship with medical doctors could be exploitative. We fear that we might lose our herbs to western medicine…These medical doctors are only interested in control. They want to control traditional herbs for their own use and benefit* (Interview, traditional healer, August 2004).

One healer reported that for many years traditional healers have been using the 'African Potato' as a herbal treatment for HIV/AIDS-related diseases and other opportunistic ailments. The 'African Potato' helps people with HIV/AIDS because it improves their immune system. Once the medical sector discovered this, products which have the 'African Potato' as an ingredient have mushroomed (Equal Treatment, 1995). These products are now sold in chemists worldwide and traditional healers were not credited as people who discovered the use of the 'African Potato'. Healers believe that, "*our knowledge and medicines must be protected so that we can benefit from it"* (Interview, traditional healer, August 2004).

The use of herbal mixtures such as the 'African Potato' and recently *Ubhejane* (Rhino), a tradition medicine that is currently being researched by the University of Kwa-Zulu-Natal, however, poses a serious concern. This is largely because while healers see these herbs as immune boosters, many people are of the opinion that these herbs cure HIV/AIDS. A focus group of young men in Durban found evidence for

this myth (Tillotson and Maharaj, 2001). Such evidence speaks to the role of healers who should discourage such myths.

The medical profession has reacted aggressively on the use of traditional herbs by people infected with HIV/AIDS, describing these herbs as 'fake Aids cure that is produced by a backyard chemist' (medical doctor, Sunday Times, February 2006). This is despite the fact that such herbal mixtures have positive effects on patients with HIV/AIDS (medical doctor, Sunday Times, October 2002). Besides, other parts of the world are making progress in recognising the role of traditional medicine in the management of disease (Green, 1994). All these different opinions on the use of traditional herbs speak of the lack of trust and co-operation between doctors and traditional healers. This report argues that the first point of entry to build trust between the two sectors is to formulate government policies that support both healers and doctors. Without this, HIV/AIDS awareness will continue to be run by clinics and medical doctors and in so doing leave out thousands of people who are at risk of infection.

4.3. Conclusion

It is clear that in Jeppestown there is little attempt to develop forms of collaboration between local partners. Collaborative programmes in the area are constrained by a 'cultural distance', mistrust and power relations between traditional healers and western doctors. These power relations are exacerbated by lack of policy support for traditional healers. Government policies such as the ones in the Strategic Plan address the HIV/AIDS epidemic from the biomedical point of view. Yet this report has continually shown that such an approach fails to look at the socio-environmental factors that influence the spread of the epidemic. By not addressing these factors in HIV/AIDS prevention policies, government is disallowing other stakeholders such as traditional healers to participate in HIV/AIDS intervention programmes. Currently, the national department of health has a leading role in implementing strategies against HIV/AIDS. This 'total' control by government has serious implications for traditional healers as is evident in the manner in which they were appointed in SANAC. The healers' role in such structures remains unclear.

The introduction of the Traditional Health Practitioners Bill in 2004 is perhaps one way of recognising traditional healers by government. Yet this chapter has shown that the relationship between government and traditional healers is a very complex one. What is actually needed is a shift in approach to government policy. The biomedical approach does not allow for an in-depth understanding of HIV/AIDS, one that is much needed in the fight against HIV/AIDS. Such an understanding requires commitment from as many sectors/stakeholders as possible, as is the case with the *Mpilonhle/Mpilonde* Programme. The participation by healers in this programme shows their willingness to share their medicines and knowledge. On the contrary, medical doctors and nurses continue to actively disallow traditional healing in their health care practice. The Jeppestown experience, therefore, highlights the way in which HIV/AIDS intervention programmes are profoundly shaped and constrained by access to power. Traditional healers have different access to resources (that is funds and power to exercise their own practice). The Jeppestown experience also highlights the power of western doctors and nurses to support selectively or undermine other measures of preventing HIV/AIDS.