AFRICAN INDIGENOUS METHODS OF HEALTH PROMOTION AND HIV/AIDS PREVENTION

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ABSTRACT

HIV/AIDS is the current century's challenge that stares humanity in the eye. The socio-political, economic, spiritual and philosophical dimensions of our society have to face up to this challenge. This brings one to the conclusion that HIV/AIDS is a national disaster and should be dealt with as such. In other words, interventions geared towards combating this epidemic should address all the spheres mentioned above. The main purpose of this study then was to investigate the role of indigenous healers in combating HIV and AIDS.

The rationale for looking at the role of indigenous healers was to ensure that their role is highlighted for a joint effort that is necessary for the advocacy, awareness, education, care and medical intervention which is necessary to combat the HIV/AIDS crisis. This challenge goes as far as involving non-medical professionals and stakeholders in the fight against HIV/AIDS.

Focus group interviews and individual interviews were conducted with indigenous healers in the Gauteng and North West provinces. The results were analysed thematically. The results are presented in relation to the questions which were posed.

The results reflected that traditional healers have demonstrated that they can make a very important contribution to the treatment of HIV/AIDS. However, they feel that they are not receiving a fair opportunity to

demonstrate their knowledge and expertise in treating HIV and AIDS. They also lack support from the public, from government policy, and from the modern medical fraternity.

There have been efforts by the Minister of Health to incorporate traditional healing and traditional medicine as part of a holistic approach to the treatment and containment of HIV. This strengthens holistic health care ensuring the advocacy, awareness, education, care and medical intervention which is necessary to combat the HIV/AIDS crisis.

Traditional healers need support and recognition from the public, the government and the modern medical fraternity. It was also evident from the results that the indigenous healers were very willing to co-operate with biomedical practitioners as shown in the statement below.

Traditional healers reported that they did not routinely test their patients for HIV as they had no means of doing that. They were legally required to send their patients for testing through modern medical procedures. Most healers also said that they preferred their patients to be checked using modern medicine, and thereafter they would treat them accordingly. This is because they currently relied only on their ancestors to show them when the patient was positive. What is important to note is that these healers said that the disease was not presented to their bones as HIV/AIDS, but

that they were only shown the known symptoms of HIV and then were able to deduce that the person was HIV positive.

DECLARATION

I declare that this dissertation is my own unaided work. It is submitted in partial completion for the degree of PhD in Community Psychology in the University of Zululand, KWADLANGEZWA. It has not been submitted before for any other degree or examination in any other university.

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Busisiwe Precious Dlamini

_____ day of _____, 2006

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Contents

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BDSA	Development Bank of Southern Africa
HIV	Human Immunodeficiency Virus
IKS	Indigenous Knowledge Systems
NGO	Non-Governmental Organisation
SANTA	South African National Tuberculosis Association
VCT	Voluntary Testing and Counselling

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

HIV/AIDS is the current century's challenge that stares humanity in the eye. The socio-political, economic, spiritual and philosophical dimensions of our society have to face up to this challenge. In a local meeting in Majaneng Village, in the north part of Pretoria, community members came to the conclusion that HIV/AIDS is a national disaster and should be dealt with as such. In other words, interventions geared towards combating this epidemic should address all the spheres mentioned above.

Arguably, the fight against HIV/AIDS should become a joint effort. One is reminded of PROMETRA, an international organisation that aims to promote traditional medicine. Its logo, a clay calabash with small holes the size of a finger, conveys the idea that one needs many fingers to close the calabash. This shows that a joint effort is necessary for the advocacy, awareness, education, care and medical intervention necessary to combat the HIV/AIDS crisis. The challenge goes as far as involving non-medical professionals and stakeholders in the fight against HIV/AIDS. An

increasing number of people are becoming infected or affected. The impact stretches to families, workplaces and the broader community.

This assertion points to a need to develop practically oriented strategies to sustain those who are HIV-negative, to ensure longevity for those already infected and to explore other methods of health promotion and HIV/AIDS prevention. Broadly speaking, a communally based approach is needed for this. Health care in South Africa is such that it encompasses various healing systems – the so-called western system based on science, traditional healing based on indigenous knowledge systems, and a holistic approach to health care.

Holdstock (1979:121) argues that indigenous healers represent an enormous mental health workforce among African people in both cities and rural areas. One has to note the complexities and subtleties of this medical practice, given its long history of forced silences and absences. Much of the latter had to do with the impact of colonialism. In support of this assertion, Baleta (1998:556) states that one has to remember that South African traditional healers were ousted by "white men's medicine" during the apartheid years. Indigenous African medicine in South Africa takes into account the cosmological framework in dealing with illnesses. This would suggest a different manner of understanding HIV and AIDS than the current knowledge frame to which the mainstream health care

sector adheres. Obviously, most Africans share different perspectives on HIV/AIDS from the above, premised on African health idiomisation and healing expression which are based on their language and belief systems.

Further, Morris (2001:1190) maintains that "indigenous knowledge that encompasses traditional healing and folklore remedies is actually bearing the brunt of HIV/AIDS care and support in Africa". This is so because there are many people in the country who subscribe to indigenous healing. In addition, Morris (2001) states that acceptance of indigenous knowledge requires a realisation that technology is not the exclusive property of industrialised societies.

With the above statements in mind, indigenous African healers become important in providing a perspective on the HIV/AIDS pandemic, debates and discussions due to the fact that the great majority of people still adhere to Indigenous African practices and belief systems. Notably, indigenous African healers who live among the people have an advantage in their command of the indigenous language (both verbal and non-verbal). These healers are in an advantageous position because they understand the rural community and the local people. As a result, their observations, linked with western health care, can provide a better assessment of the community needs (Egbertin, 1979:47).

One is able to draw these conclusions because, in the African context, health is viewed not as an isolated phenomenon within the culture, but as a product of critical social dimensions. This ensures that the health care delivery service is evaluated with the attitudes of the providers in mind without ignoring the attitudes of the consumers. According to Mankazana (1979:1004), indigenous healers and traditional remedies meet a genuine need.

Based on the above, it becomes important that the Department of Health finds a strategic approach that strives for a complementary relationship between wellness behaviour and the cultural context of individuals affected by HIV and AIDS.

Thus, the researcher aims to find out what indigenous African healers can offer in an attempt to promote health and prevent diseases in this HIV/ AIDS era.

1.2 AIMS OF THE STUDY

The aims of the study are as follows:

- Establish the level of contribution that indigenous African healers make in the treatment and combating of HIV and AIDS.
- Determine and indicate the support structures that indigenous African healers require in order to streamline mainstream indigenous health care services.
- Determine and indicate any factors that hinder promotion and development of indigenous health care services.
- Determine the extent of the use of indigenous medicine or treatment by HIV-infected people.

1.3 RESEARCH QUESTIONS

In order to realize the abovementioned aims, the thesis was concerned with a qualitative study where indigenous healers will be interviewed and asked to respond to the following questions

- What is your experience in working with HIV/AIDS?
- What methods do you use to promote health?
- What methods do you use to prevent illness?
- How do you perceive your contribution to the fight against HIV/AIDS?

- Which support is key in ensuring that indigenous health becomes a mainstream form of health care as is the current biomedical approach?
- What problems do you encounter in your work and what could be a solution to your problem?
- Would you be prepared to share your success stories relating to the treatment of infected people?

1.4 CHAPTER OUTLINE

1. Introduction
2. Review of literature, discussions and debates
3. Research Methodology
4. Perspectives on Indigenous Healing (to cover questions such as: What is indigenous knowledge and related systems? Who is an indigenous knowledge practitioner? How do indigenous healing practitioners fit within the current scheme of healing and medicine?
5. An integrated approach or attempt – Is this possible? How can it work? Who should make it work?
6. Representations from the fieldwork – data collected will be presented, analysed, interpreted and suggestions and recommendations will be presented.
7. Conclusions

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews indigenous methods of healing. In order to be able to investigate and understand the role of indigenous African healers in the fight against HIV/AIDS, it is necessary first to examine their approach in providing treatment. However, before the indigenous healing system can be discussed, one has to look at the theorists who provided the basis of our understanding of the indigenous healing system.

2.2 THEORETICAL BACKGROUND

2.2.1 Carl Gustav Jung

Most indigenous healing systems are linked to a system of beliefs. The basic belief is that there is a link between the science of healing and the prevailing power of the ancestors and God. Monnig (1969), when he describes the Pedi people, says that one cannot understand them without

a clear concept of the supernatural which is reflected in all their behaviour. All aspects of their life – their economic activities, the socialisation of individuals, their political organisation, the functioning of their legal system – are so interpenetrated with ritual that nothing can be properly understood without understanding their religious significance.

Carl Jung was a clinician, and was among the first to be interested in studying various phenomena from a psychiatric perspective. He brought a spiritual approach to his studies of American spirituality, yoga and African Shamanism.

He came to the following conclusions:

- A human's psychological development should consider higher levels of consciousness.
- Transcendence is contained within an individual.
- Healing and growth emanate from symbolic imagery that cannot be obtained through rationalism (Scotton, 1996).

Jung's interest in this form of psychology emanated from his childhood, which was strongly dominated by transpersonal experiences which created a drift between him and his teacher. Through these experiences he later gained emotional release from pain, and began to understand how he came to be in conflict with his teacher. His own personal experiences led him to be more interested in transpersonal psychology. Through these

childhood transpersonal experiences, Jung gained healing symbolic meanings, which also helped him to deal with his own therapy clients (Goud, 2001). He made a significant contribution to the notion of spirituality by including religious aspects from African and Eastern perspectives. He believed that individuals have a growth tendency of striving towards integration and wholeness (Jung, 1953).

According to Suzuki (1968), many Eastern mystics and philosophical religious beliefs have shown commonalities with transpersonal psychology. Jung's inclusion of basic concepts of analytical psychology, such as complexes and archetypes, made another great contribution to the field of transpersonal psychology. These archetypes are the foundations of transpersonal experiences and are shared by all people (Meyer, Moore & Viljoen, 1997). According to Jung, people usually experience these archetypes indirectly through dreams, rituals and mystical experiences. Carl Jung strongly maintains that some symptoms of psychopathology and spiritual experiences are signs of mental health and relieve people from neurosis (Meyer *et al.*, 1997).

When asked what heals, traditional healers will talk about a spiritual healing power. When you ask Western physicians what heals, they will talk about medical technology such as kidney dialysis machines, or aspects of their technical training such as their knowledge of medications.

The concept of healing power has basic implications for contemporary practice. If, as clinical psychologists, we can realise that a healing power exists, we could go beyond a reliance on our own personal knowledge and techniques to draw on the broader healing powers that exist within the client, within her family, her community and her experienced universe (Peltzer & Ebigbo, 1989). As such, healing accounts for little if it does not benefit the whole community.

2.2.2 Abraham Maslow

Maslow is regarded as one of the prominent pioneers of humanistic psychology; he is also accredited with developing transpersonal psychology (Davis, 1996). He regards an individual as a spiritual being whose needs are hierachically explained in terms of motivations that complete themselves in spiritual self-realisation (Scotton, Chinnen & Battista, 1996). He considered humanistic psychology as the transitional preparation for the transpersonal, transhuman centred in the cosmos that goes beyond humaneness (Maslow, 1969). He also discovered that some self-actualising people had frequent transcendent experiences while others did not, which later pointed to a distinction between self-and social actualisation and transcendence. The motives of self-actualisation and self-esteem emerge when all the other deficiency needs have been met. This indicates that those who do not have experiences of transcendence are struggling with the lower levels of the hierarchy (Battista in Scotton *et*

al., 1996). This suggests that these experiences go beyond humanistic psychology to transpersonal psychology (Davis, 1996).

Moving the self from one state of consciousness to a more advanced state is an inner core of Maslow's philosophy. This knowledge of oneself is not only a path to a better value choice, but to knowledge of universal human nature (Pearson, 1994). Maslow would refer to the notion of holism, which recognises the interrelatedness of everything. Self-identity is tied not only to individual achievement, but also to a group, which imposes social pressures (Podeschi, 1986). Maslow (1962) recognises existential conflict between the self and others, which makes him regard self-actualisation both as self-concerned and concerned for others.

The self is the true teacher and can be accessed through creative work, deep exploration of the unconscious, rituals and experiential body work. The route to becoming a whole lies in uncovering one's own creation story, individual truth and expressions. When people find it difficult to express their uniqueness fully, they become sick and apathetic. The purpose of psycho-spiritual integration is to assist clients to become fully conscious and find their incentive spark to heal themselves. In the whole process the ego and the soul must be honoured (Maslow, 1968).

2.3 THE AFROCENTRIC WORLD VIEW

This section examines a generalised view of African culture and its conceptual system. It articulates a psychology evolving from the process of examining both African and western conceptual systems, in an attempt to understand the human consequences of each. Both individual and general experiences are taken into account. Such an understanding will aid individuals to gain greater sensitivity, awareness and understanding in terms of themselves and the rest of humankind.

The Afrocentric world view is based on particular belief systems of African people. Myers (1988:5) states that:

> these belief systems are structured by a conceptual system, the philosophical assumptions and principles on which one's beliefs are based. Often, these assumptions are not a part of a conscious awareness of the believers, yet they very much shape their beliefs.

She further states that this paradigm provides a theory of human nature in that it does three things:

- It makes claims about the universe as a whole.
- It describes the essential nature of the individual human being.

- It offers a diagnosis of what is basically wrong with humankind (Myers, 1988:22).

The universe is at once spiritual and material, and as such divinely ordered, the material being the slower moving, outward appearance of energy. This leads to an individualised expression of infinite spirit, the nature of which is influenced by an interaction of those energies within which it exists, of which it is comprised, and which it generates.

In his description of the Pedi, Monnig (1969:44) states:

> the words *baropedi and tumelo,* although they may be translated as 'religion', describe an attitude, a way of life which is to be advocated, and are not a definition with a definite content descriptive of a specific range of institutions and modes of behaviour which would be regarded as religious or sacred as opposed to others which are profane. The worlds reflect a belief in certain supernatural powers, and that a correct mode of life in general, and in relation to these forces in particular, is essential to ensure a favourable response.

This fits into the category of a "higher" psychology, as called for by Maslow. It is transpersonal, trans-human and centred in the cosmos.

Looking at the concept of healing, Myers (1988:23) states that within African psychology,

> normalcy assumes health and well being. To be normal is to see oneself and the world as manifestations of infinite spirit. Beginning with one's conception of self as never separate from infinite spirit, one's worth is intrinsic in being. One's purpose in being becomes that of bringing more knowledge of one's nature as infinite into awareness.

In the Afrocentric perspective, it is important to observe how spirit manifests. Human behaviour is spirit made evident and readily perceived by the senses. Through their behaviour, people reveal what is in their consciousness, what their thoughts and emotions are, and how they interact within their conceptual framework (Myers, 1988). African people have developed physical and psychological characteristics consistent with their environments. Central to the traditional African world view is the concept of everything being unified, interdependent and an integrated whole. There is an order inherent in the unity of this holistic orientation that can be seen at all levels of nature, and that provides the basis for defining the impetus for a holistic integrity.

Self-worth and identity within the holistic world of an optimal psychology is based upon being in tune with the whole or the ultimate conception of one. As such, one's worth is inherent in the realisation of one's true essence.

Being aware automatically makes one worthy and gives one a sense of well-being.

Looking at the above arguments, it becomes evident that the belief systems analysis is cognitive therapy in the sense that it is very much concerned with the act or process of knowing, including both awareness and judgement. Being holistic, the orientation does not separate the cognitive from the affective, the behavioural, the optimal, the unconscious, the cultural, the metaphysical or the feminine.

2.4 THE INDIGENOUS HEALING SYSTEM

The term "indigenous healing" is used to refer to ancient and culture-oriented healing practices which were used before the discovery of allopathic medicine (Nzima, Edwards & Makunga, 1992). As stated earlier, this type of healing system is culturally determined and is meaningful only if understood from a socio-cultural point of view.

Technology and modernisation may have influenced the lives of Africans in one way or the other, but the practices of African indigenous healing still employ traditional ways of curing different illnesses (Thorpe, 1993). According to Bannerman, Burton and Wen-Chieh (1983), until the beginning of the nineteenth century, all medical practice was what we now call traditional. It was then that the great philosophical upheaval of the

Renaissance began to introduce Cartesian scientific materialism into all human activities, and notably into the theory and practice of health care. Indigenous healing practices are based on beliefs which were there long before the spread and development of modern medicine. This type of healing is embedded within the African cultural heritage and tradition.

To learn how to release health care resources which are renewable and accessible, we need to turn to indigenous healing systems like that of the !Kung and learn from them about the concept of "healing as transformation" (Peltzer & Ebigbo, (1989). Learning from the practice of indigenous healers, mental health professionals can become servants of the people, sharing their knowledge and expertise rather than hoarding it in order to accumulate personal prestige, power and money.

Indigenous medicine is a rather vague term, loosely used to distinguish ancient and culture-bound health care practices, which existed before the application of science to health matters in modern scientific medicine. Indigenous medicine has been practised to some degree in all cultures, and other terms based on culture include African, Asian or Chinese medicine. Indigenous healing systems emphasise community context and the spiritual dimension. According to Karim et.al (1994), to understand the African indigenous healer and the whole indigenous healing process one needs to understand African religion. This suggests that any healing process that ignores these beliefs is psychologically unsatisfactory and as

such may not be acceptable to the community. This means that indigenous healing is effective because it caters for the individual in their totality. It provides treatment for the physical, psychological and social symptoms. This is in keeping with the World Health Organization's definition of health which states that "health is a state of complete physical, mental and social well-being and not merely the absence of disease" Karim et.al 1994: 4). It should further be stated that African religion does not exclude the dimension of healing and health, thereby making Africans to be in touch with the body, soul and their environment. The dichotimization thinking and application will not fit the African philosophy and life.

According to Bannerman *et al.* (1983: 21), traditional practitioners define life as "the union of body, senses, mind and souls" and describe positive health as "the blending of physical, mental, social, moral and spiritual welfare".

In most South African societies, indigenous healers play a vital role. They hold powerful positions because they act as physicians, councillors and psychiatrists (Hewson, 1998). Their healing "contains some internal logic and consistency" (Helman, 1990:102). In the indigenous healing system, materialistic issues are usually first considered and explored when attempting to explain and treat an illness; however, if solutions cannot be reached, recourse is taken to the metaphysical world. The indigenous

knowledge healing paradigm makes use of both natural and supernatural modes of healing. Natural refers to what would fit a biomedical explanation, and the supernatural refers to a mode that includes traditional belief systems of disease causation. Healing also involves central tasks of psychological development such as defining reality and making its meaning clear; it is not merely confined to treating symptoms. Sometimes patients and healers share a common explanatory model of what could cause their illnesses and sometimes they do not. In some cases, part of the healing process is concerned with the therapist's effort to teach the patient the explanatory model which he holds. From this model, the patient expects healing to occur and also the prevention of future illnesses (Obot in Peltzer & Ebigbo, 1989).

This statement is further explained by Conco (1972:315), who states that traditional healers tend to be vague in their descriptions when they attribute nature as a cause for illness. This leaves open the possibility that the illness can be subsequently reinterpreted in terms of other causative factors such as supernatural causes if it is not resolved through home remedies and other interventions (Conco, 1972:311). This talks directly to the cultural beliefs of the people in terms of disease causation. Edwards *et al.* (1983:215) support this assertion by stating that mystical theories explain disorders in terms of an automatic consequence to some act or experience of the afflicted person.

In his study in one of the Japanese Islands Lebra (1982) postulated three stages which are utilised by the shaman (which is equivalent to a South African indigenous healer) in the treatment of ailments. During the first stage, referred to as negotiating shaman reality, the shaman has to prove that he is able to control seeing, hearing and even possession of spirits. During the second stage, the shaman's therapeutic goal is to establish a relationship and determine the aetiology of the patient's ailment or problems. Instead of the patient revealing his illness, the shaman will divine, though his dealings with the spiritual world, the nature of the problem. During the third stage, the shaman will prescribe a remedial course of action. However, the shaman will indicate that, depending on the ailment, there could be several courses of action:

> There may occur from time to time additional phases or stages which might be termed a new course of action and in other instances respond to the course of action initiated by the patient or by some wholly unexpected turn of events (Lebra, 1982:311).

(Edwards *et al*, 1983:215) give an example of *umnyama* - experiencing illness or adversity because of contact with places or people immediately associated with the major life events such as birth, death and menstruation or a simple ecological health hazard such as lightening.

Basically, the above comment suggests that indigenous medicine must be analysed in its proper context.

These theories form the cornerstone of traditional Zulu cosmological, religious, social and moral world views of good and evil, health and sickness. (Edwards *et al*, 1983:215).

Each group of people construct their own realities through which they interpret the world and construct images for themselves. These materials and symbols are utilised by people in dealing with their environments including rituals, socialization patterns as well as patterning of interactions which at the end constitute their culture and or the indigenous knowledge systems which form these behaviours including what is considered ill health, disease and optimal functioning.

According to Green (1988 a: 492), indigenous healing systems are characterised by causal connections in personalised, purposive terms whereas the explanations of modern medicine tend to be nonpersonalised and nonteleogical. If these two medical models are to be integrated, the belief system, value system and the social structure of the population has to be taken into account. This tradition reflects African culture in terms of belief systems, attitudes, customs, methods and established practices as informed by their cultural world view.

Asuni (1979:176) says that there is a need to use both approaches in the South African health care system because there are more traditional

healers than Western doctors, and that they are more available and accessible to the majority of the population. He further argues that modern doctors, including indigenous healers, are so far removed from the socio-cultural environment of the patients that they cannot always understand them fully.

In support of the above statement, Donald and Hlongwane (1989:248) state that this issue is not only a cross-cultural one in South Africa, but one that interacts fundamentally with both the transitional nature of cultural identification and structural constraints inherent in the socio-political context. In practice, it is this interaction that constitutes the challenge of both effective immediate intervention as well as orientation to the developing needs of the society.

An understanding of traditional beliefs may help to enhance understanding of the indigenous concept of health and disease. They include:

- Beliefs based on the supernatural causation of events, including diseases of witchcraft, magic and extraordinary happenings.
- Beliefs derived from observed natural causation of diseases and natural events. For example, the seasons of the year result in regular changes in climate, rainfall and winds which can affect crop harvests and cause seasonal migration of animals. Sickness may be related to plants classified as non-poisonous, medical or poisonous, or be due

to ordinary causation, like measles and whooping cough. Physiological changes like menstruation, puberty and pregnancy are recognised, as are accidents like fractures requiring the use of *umhlabelo* (a traditional remedy).

- Religious and medicoreligious beliefs. Tribal celebrations held to propitiate the ancestors include *ingeube* (Bacas of the Xhosa) and *umkhosi* (Zulu), and also in the African Separatist Churches, where the Christian faith and traditional beliefs are amalgamated. The adherents of the churches are reluctant to attend clinics or hospitals, and place their children "at risk" of communicable diseases.
- Beliefs in relation to environment. This includes attempts to control the forces of nature such as lightning, hail and rainfall.
- Beliefs in injections. In the indigenous traditional setting, injections (called *gcaba* in Zulu and *umqabulo* in Xhosa) are used for therapeutic and prophylactic purposes as well as for physiological support before difficult undertakings like travelling or meetings (Mankazana, 1979:1005).

No society lacks beliefs and practices having to do with the avoidance of illness. The positive acts and avoidances that constitute preventative medicine in traditional society are often quite different from those of scientific medicine, but they are equally rational (if not always effective) in that they are functions of what is believed about what causes illness (Bannerman *et al.*, 1983:21).

In most traditional settings, the healer relies on a belief system which links all community members to the same set of spiritual forces, and which in turn tie the living and the dead together. By invoking these spirits, the healer provides a powerful system of support linking the distressed patient to a larger community of sympathetic and concerned people and forces. Relying on such a healer redefines the individual's problems in group terms, reintegrates him in the culture and absolves him of guilt for his misdeeds (Peltzer & Ebigbo, 1989).

The indigenous healer's hospital is his home, where the physically and mentally ill live together without any separation or stigmatization of one group by the other. They are part of a therapeutic community where staff, patients and relatives share the facilities. Very rarely, temporary boundaries are created to facilitate healing. This would occur in cases where there is some form of social imbalance and the removal of the patient is the only method of restoring social order in the family or community (Karim et.al, 1994: 4). This non-separation, from their environment makes it easier for the clients to be reintegrated into their society upon recovery.

The indigenous healing system is therefore a valuable cultural heritage. The power of the ancestral spirits has an essential role to play in the making of a healer. This is transmitted from one person to the next for instance, from parents to children or by specialists to apprentices. Sodi (1998), sees the indigenous healing system as; a multiphasic process that

is aimed at the client and the total environment while at the same time providing an opportunity for some access to the spiritual dimension of their experience. In support of the above assertion, Fellhaber & Mayeng (1997) state that, a traditional treatment that is holistic in nature because of its comprehensive approach. It is holistic because it cannot be reduced to a single dimension of treatment or remedy. The purpose of traditional treatment is aimed not only at curing the disease, but also at healing the patient.

2.5 INDIGENOUS HEALING IN TIMES OF ILLNESS

With the difficulties in treating the HIV/AIDS pandemic, one has to look at all possible cures. What is needed is a change in attitude or approach to the treatment of HIV/AIDS.

With the increasing evidence of the importance of culture in society's notion of health and illness, there are many studies that investigate belief systems and practices in relation to illnesses in many different communities.

In Mali, the Bambara base their ideas of health and illness on the notion that they are based on the balances and imbalances between the components of the organism, and between those components and elements of nature such as earth, fire, water and metals and heavenly bodies such as sun, moon and stars (Koumare, 1983). In view of the

above, it can be concluded that from birth, children are exposed to the influence of all these elements; for them to be able to survive; they have to strike some equilibrium in balancing these elements.

According to the *pancha-bhuta* theory (Karkar, 1979), everything in the universe, animate or inanimate, is made of five forms of matter – earth, fire, wind, water and *akasa* (which when translated means ether). Living creatures constantly absorb these elements, which are contained in the nutrition, which in turn are transformed into portions in the body, which ensure growth and development. In short, nutrition is very important. Karkar (1979:230) further argues that "the body like nature is involved with ceaseless transformations of matter which is in a state of perpetual flux, for nothing about the body remains the same. Everything in it is in a state of ceaseless change".

Within the context of a ceaseless flux of body and nature, the ancient Indian physicians believed health to be a state of equilibrium of the aforementioned bodily elements. They believed that illness occurred when any one of the three humours (wind, bile and phlegm) became excessively "agitated" and increased disproportionately in relation to others (Karkar, 1979:231). The imbalance of humours occurs due to excessive use, deficient use or misuse of the objects of the senses, actions and time. This suggests that health rests on the consumption of environmental matter in the right form, proportion and combination and at the right time.

The use of indigenous treatments is common in many parts of the world. It is estimated that in some places in Africa, indigenous healers outnumber biomedical doctors one hundred to one (UNAIDS, 2000). It is further stated that Africans use indigenous medicine for 80% of their health care needs. This can be attributed to cultural interpretations of disease.

While the lack of modern medical technology may have forced primitive peoples to develop their indigenous powers for healing, today it is increasingly recognised that "physical" health and healing sometimes require more than technological treatment (Harner, 1990:135). This is so because of the realisation that physical and mental health are closely connected, especially in community psychology, and that an individual's emotions can play an important role in the onset, progress and cure of any illness. In support of the above, Harner (1990:136) argues that in the shamanic approach to health and healing, there is additional medical evidence that, in an altered state of consciousness, the mind may be able to will the body's immune system into action by stimulating the hypothalamus.

In order to curb the HIV/AIDS pandemic it may seem obvious that the indigenous health care system should be encouraged to complement and in some instances replace the biomedical system, and as such become more renewable and accessible. However, there is evidence that some

health care professionals devalue this form of health care; Kartz and Wexler (1989) state that health care professionals label the traditional health care system as "pre-scientific". As a result of these attitudes, clients and consumers suffer and are denied access to what is a limited resource.

To begin with, Africans should hear about HIV/AIDS in their own language, and the message must address traditional beliefs (Sayagues, 2003:53). However, it would be unfair to expect indigenous healers to convert to ideas and beliefs of Western medicine. In Latin America, for instance, few physicians are puzzled when a patient explains a head cold by saying, "I was struck by *aire* (air)" (Bannerman *et al.*, 1983:11). It is probably important that the communication be standardised to ensure that all parties understand the meaning in context.

Although some inhabitants (especially those in urban or suburban areas) have adopted Western customs, many continue to follow or have returned to African traditions and customs (Giarelli & Jacobs, 2003:36).

Indigenous medicine has stubbornly refused to be suppressed or oppressed in the daily lives of the African people, especially in a society where the majority of the people live in rural areas, some of which are far removed from the day-to-day interface with Western medical practices and institutions. This is despite attempts to replace indigenous knowledge

systems with new ideologies. In support of this, Staugaard (1986:54) states that "the missionaries built churches, developed new rituals – which in some cases replaced the old tribal rites – and instituted partially new moral rules and sanctions for their violation". Unfortunately, one of its consequences proved to be the displacement of traditional healers from their central position as advisers to the community. It is therefore imperative that the confidence and wisdom that has been accumulated over many thousands of years be used to improve the health of the population for which society is responsible.

African traditional medicine is thus a distillation of African culture. However, the spirit that moves it is shared by all forms of medicine, since the fear of disease and death and the need for food and health have led people in every age and clime to seek assistance from all that nature can offer.

Staugaard (1986:55) states that traditional healers are generally well integrated into the religious and moral concepts and beliefs prevailing in the society, and thus they assume a stabilising role in social control. In most traditional settings, healers rely on a belief system which links all community members to the same set of spiritual forces, which in turn tie the living and the dead together. By invoking these spirits, healers provide a powerful system of support linking the distressed patient to a larger community of sympathetic and concerned people and forces (Kiev, 1989).

The application of scientific methods to medicine and public health brought dramatic improvements in all those conditions in which material factors such as infection, poisoning, injury, nutrition or personal and environmental hygiene play a major causal role. In degenerative conditions, however, the results have been less striking, and in conditions where behavioural, emotional or spiritual factors play a major role it would be difficult to argue that scientific method has produced noticeable improvements: some would contend that deterioration is evident (Bannerman *et al.,* 1983:11).

2.6 TRADITIONAL IDEAS ABOUT DISEASES, HEALING AND MISFORTUNE IN AFRICA

The therapies found in every society stem largely from prevailing causal beliefs, which underlie treatment. According to most African belief systems, there is a continuous unity and harmony between the Supreme Being, spirits and other living organisms such as plants and animals, including human beings (Crafford, 1996). For instance, the California Indian shaman goes into a trance, identifies the offending spirit, attempts to replace it and sucks out the intruded quartz crystal. The curer identifies the responsible human or supernatural being and, through placation or a

battle of wits, returns the wandering soul to its body (Bannerman *et al.*, 1983:21).

Diseases are common to all human societies, but differ in the way people conceptualise and treat them. According to Christman and Johnson (1996), a disease is a perspective of sickness that refers to some biophysiological abnormality that can be objectively demonstrated by Western scientific means, whereas an illness is a view of sickness that refers to distress as experienced, described and explained by the patient or family. Most African societies regard illness as the result of ancestral spirits, witchcraft or ritual impurity. According to Chavunduka (in Pelzer & Ebigodbo, 1989), the majority of Shona people in Zimbabwe believe that illness may come from ancestor spirits, angry spirits or even alien spirits. These illnesses and diseases can be cured by different specialists like *izangoma* or *dingaka* (African Indigenous healers) that can manipulate powers available to them for the better health of society. Indigenous healers, with their herbal remedies and through divination, treat both natural and supernatural diseases (Monning, 1967).

The Ndembu people of Central Africa believe that illness is caused by supernatural forces, which are triggered by human events such as taboo violations and kinship rule violations. They also believe that the patient will not get better until all the tensions and aggressions in the group's

interrelations have been brought to light and exposed to ritual cleansing or treatment (Kiev, 1989:437).

For the indigenous African, it is extremely important to get to the root cause of the disease rather than just receiving the cure. Whatever the cause, the role of the indigenous healer is to find the deity, ghost or other agent that has caused the illness, and then to determine how to placate or overcome it (Bannerman *et al.,* 1983:20). Until the source of the affliction is discovered, it may render the treatment very insignificant. With that belief in mind, Bannerman *et al.* (1983) argue that this is "the reason why so often traditional peoples happily accept the ministrations of physicians but also insist simultaneously on traditional rituals and ceremonies". The physician is consulted to alleviate the symptoms, but until the ultimate cause is uncovered and dealt with, improvement will be temporary.

According to the indigenous world view of causation, the question of what caused the ailment and why must be addressed. It is an essential part of the healing process that the "who" be ascertained so that cause can be established (Karim et.al, 1994). Failure to answer the question "who" may render the treatment less effective or even unacceptable in some cases. It is therefore not surprising that a patient may go to a biomedical practitioner and later on go to the traditional healer to establish the cause of the illness. The treatment given by the healer may not alleviate the

symptoms, but the reassurance may play an important role in the healing process.

In Latin America, where much illness is attributed to cold air, the affected individual keeps the head and face well covered with *rebozo* especially at night, and does not emerge from a warm room after sleeping until the excess heat from deep sleep has been dissipated by a few minutes of wakefulness (Bannerman *et al.*, 1983:20).

> On the whole, we could generalise and say that indigenous tribal society has had an all-embracing supernatural or metaphysical theory of disease. It is obvious that the traditional African beliefs firstly are caused by a spirit or supernatural agency, and secondly that many illnesses can be alleviated or even cured by the administration of one of many remedies found in nature (Conco, 1972:289).

Expectedly, when an individual shows illnesses from this spiritual origin, an indigenous healer is consulted to ascertain the cause of the ailment.

In the indigenous health system, materialistic issues are usually first considered and explored to explain and treat an illness; however if solutions cannot be reached in this way, recourse is taken to the metaphysical world. According to Conco (1972:315), traditional healers

tend to be vague in their explanation of disease causation. This leaves open the possibility for other interpretations of the disease.

Research shows that indigenous healers were more sensitive not only to local disease aetiologies, but also to family situations, personal lives of patients and local behaviour norms, all of which contributed to a diagnosis (UNAIDS, 2000). The key point here is the ability of the healer to provide a reservoir of ideas when communicating with the client. The indigenous healer blends with the patient's ideologies and sentiments. The therapy is directed at the patient, not only as an individual, but as an integral part of his family and environment. The family together with the patient realise and understand the therapeutic encounter with the traditional healer in the context of shared values (Mumford, 1983:206).

There is a strong cultural component in the treatment techniques of indigenous healers. The critical challenge that they find themselves faced with is to help integrate the individual, who is functioning out of step with the remainder of the people in his immediate environment" (Kiev, 1989:438). Of importance here is the ability of healers to demonstrate that they have special knowledge and abilities to deal in non-commonsense ways with problems presented to them.

Given the long-standing presence of indigenous healers in communities and their respect among the population, perhaps the aim should not be to

ask whether or not to work with indigenous healers, but rather how best to work with them. The point here is not to base whatever relationship or partnership on respect, but to provide a comprehensive service. This will in turn ensure that individuals affected with HIV/AIDS have access to high quality, culturally sensitive health care.

There is a challenge, though, for health professionals and traditional healers to search for similarities and differences within the cultural conceptions of illnesses and diseases in South Africa, it being a multicultural, multiracial society. This search might identify common or universal characteristics of healing and curing different illnesses. Indigenous healers' strategies of probing deeply into the psychological, spiritual and social context of illnesses, and the use of healing ceremonies, seem to be effective in some instances (Hewson, 1998).

Elimination of illnesses is dealt with through a lengthy apprenticeship with an experienced healer. Traditional healers usually work successfully with the illnesses that have high emotional content, HIV/AIDS being a typical example. Indigenous healers usually work with the client's mind and spirit, believing that many afflictions have spiritual causes and those psycho-spiritual imbalances must be fully rectified before a client can recover physically.

2.7 THERAPEUTIC METHODS USED BY INDIGENOUS HEALERS

The indigenous healers, as mentioned earlier, have several roles to play in the community, the role of a community minister of religion, legal adviser, healer, custodian of history and tradition and the community organiser (Gumede, 1991, Ngubane, 1977). They also serve as a local psychologist which helps maintain health in its totality. Over and above these functions they provide medication which will be discussed below.

2.7.1 Types of Medication.

Herbal medication is the most common therapeutic method used by indigenous healers. Other methods include psychosocial counselling, simple surgical procedures, rituals and symbolism (Karim et.al., 1994).
The above authors go on to say that the medications that are used by indigenous healers can be classified into three (3) categories as discussed below:

2.7.1.1 **Preventative and Prophylactic medication;** Among the Zulus, medications for self-fortification are called *amaKhubalo. Izingcunda or iziNtelezi* is sprinkled around and about the kraal to ward off lightning or to cause the *umthakathi* (witch) discomfort in his impious endeavours (Bryant, 1970).

2.7.1.2 **Treatments for Ailments**; According to Gumede (1991), these types of treatments are prepared in different forms such as cold and hot infusions, decoctions, powders and lotions and a variety of earthy ointments that comprise animal fat, clay and sometimes ashes and these are made into different mixtures for the patients. The indigenous healer is usually the only one who knows how these are mixed and they it is kept a secret which can only be passed on to the healer's apprentice. The mixtures can be drunk, smoked, used for washing or steaming or smeared on the body (Karim et.al.1994).

2.7.1.3 Medications used to destroy the power in others; These types of medications are aimed at targeting particular individuals for example the suspected witch. Imperato (1979), states that there is a certain degree of uniformity in the herbs used within regions, as African indigenous healers usually work cooperatively and not competitively with one another and a client may be referred to a colleague by a healer who does not have all the herbs. He also states that these herbs are usually placed on the enemy's path and when the enemy passes by, they will contract a fatal disease and possibly die.

He further states that scarification, blood letting and cupping are the commonest surgical procedures performed by the African indigenous healers and these types of procedures are sometimes performed in areas where other people can see what is happening. In support of this, Gumede, 1991, argues that the letting of the blood is sometimes important

to cast out the illness. The blood is poured into small holes dug in the ground to ensure that the illness is buried in the ground.

Ngubane (1977) states that if the root cause of the illness is that of bewitchment, a number of rituals are performed so as to cast away the spell. Amongst others, these rituals include vomiting, enemas, whistling and animal sacrifices. He further goes on to say that if these rituals are not performed, the ancestors may turn against them and thus these rituals become extremely important. One can then conclude that if these rituals are not performed, the ancestors will not provide the much needed protection thus rendering the individual vulnerable and unprotected from all sorts of illnesses and misfortune. In support of this statement Edwards et al. al. (2006), argue that "In Zulu culture, the intimate relationship between the living and the dead is revealed through the importance attached to the concepts of *umphefumulo* (soul), *umoya* (spirit), the shadow *(isithunzi)* and the ancestral shades' brooding *(ukufukamela)* over the lives of their descendants just as a hen broods over her eggs" (p 2). They further state that the failure to perform the necessary rituals and to take the appropriate steps concerning the brooding can lead to misfortune, illness, madness and vulnerability to various ecological hazards such as lightening as well as sorcery and witchcraft.

The following are treatment methods commonly used by indigenous healers as discussed by Bannerman (1983).

- Inhalation of powdered medication in its dry form the same way people that people inhale snuff - *ukubhema.*
- Sucking of hot medicated liquid from fingertips - *ukuncinda*
- Induction of vomiting via the use of an emetic - *ukuphalaza*
- Rubbing of powdered medicine into incisions - *ukugcaba*
- Steaming or using of a vapour bath – *ukufutha* - (the patient is covered with a large skin or blanket to keep out of cold air and crouches over a boiling pot of medications. This induces perspiration and reduces fever;
- Use of enemas for stomach complaints - *ukuchatha;*
- Use of fomenting treatment for aching feet - *ukuthoba*
- Burning of incense which appeases the ancestors - *ukushuncisa*
- Use of an amulet manufactured from animal skin to ward off evil spirits.

2.8 A HOLISTIC APPROACH TO HEALTH CARE

Thorpe (1993) maintains that, "Generally speaking, it has to be reiterated that the purpose of both divination and medicines given by indigenous healers is the restoration of health and wholeness both for the individual and the community" (Thorpe, 1993:120). As in the systems theory, the community as a whole supersedes its individual members.

Indigenous healing systems emphasise community context and the spiritual dimension. In this context, then, a suitable definition for healing would be "a process of transition towards greater meaning, balance, connectedness and wholeness, both within the individual and their environment (Katz *et al.*, 1989:20).

Although patients may consult indigenous healers as individuals, their families, colleagues, friends, and the environment are in an intensive way integrated into the treatment process (Peltzer 1995:178). As mentioned before, indigenous knowledge systems, especially those related to health care, bring us to our roots and can refresh with their purity and holism. The indigenous healing system suggests a transformational model of the interrelated process of individual and community development, an enhanced state that brings on a sense of connection between a spiritual healing power, the healers and their communities. (Katz *et al.* 1989). Family members are almost always involved and the healing process is facilitated by the broader involvement of members of the community. Within the indigenous healing system of the *isangoma*, individuals are viewed as members of an open system which is characterised by wholeness (Karim et.al, 1994).

The idea that a person is a total being is the essence of holism. This holistic view results in the idea of humans and their universe interacting in

a unified and reciprocal way. In common with most healing systems, traditional healing is linked to a system of beliefs. Because the basic belief of indigenous healing is the link between the science of healing and the prevailing power of ancestors and God, its holistic approach to health involves spiritual, mental and physical health.

Saayman (1992) is of the opinion that illness can be seen as a reflection of a disturbance or imbalance at the psychosocial, physical, material, interpersonal or spiritual levels. The indigenous healer is not only a psychologist, physician and priest, but he or she is also the tribal historian. Healers maintain social stability (Holdstock 1979:119).

Indigenous medicine makes little distinction between body, mind and spirit – the whole person is treated. In fact, the individual is rarely considered apart from the wider societal group, and illness is commonly interpreted as a disturbance in social relationships (Green, 1980:492). Healing efficacy is therefore not a straightforward result, but rather is determined by the subjective evaluation of patients (Green, 1980:493). Healing involves central tasks of psychological development, such as defining reality and making the meaning clear; it is not merely confined to curing the sick.

Practitioners of holistic health care, in this case indigenous healers, differ from orthodox, allopathic practitioners by virtue of their adherence to the concept of health rather than a narrow concern with disease, as well as

their focus on the patient as the subject rather than the object of treatment. The essence of holistic health care is the importance of wellness, which not only entails the absence of clinical disease but also the existence of a positive state of well-being which embraces physical, emotional and spiritual aspects of health (Van Rensburg, Fourie & Pretorius, 1992:313).

Indian shamanic ways of healing are a good example of holistic health care:

> The burgeoning field of holistic medicine shows a tremendous amount of experimentation involving the reinvention of many techniques long practised in shamanism, such as visualisation, altered state of consciousness, aspects of psychoanalysis, hypnotherapy, meditation, positive attitude, stress reduction and emotional and mental expression of personal will for health and healing (Harner, 1990:136).

The impersonal nature of modern commercialised and institutionalised medicine has several inadequacies, as shown above. It basically looks at the illness and not individuals or their communities.

According to (Buhrman, 1979:24), it seems that certain gifted indigenous healers, in a community with shared constructs, are able to activate the

symbols and to give the unifying and healing potential of the unconscious the necessary power to function in an autonomous way. Shamans, for instance, are frequently members of the same extended family as the patient, with an emotional commitment to the personal well-being of the patient not typical of the "fifteen- minute doctor's visit of contemporary society" (Harner, 1990:136).

> Indigenous healers may work all night, or several nights for the recovery of one patient, involving them and the patient in a dyadic alliance that intertwines the unconscious of both the heroic partnership against disease and death (Harner, 1990:136).

This shows that there is some form of satisfaction that the indigenous healers get from their practice. There is ultimately no distinction between helping others and helping oneself. By helping others indigenously, the healer becomes "more powerful, self fulfilled and joyous" (Harner, 1990:139).

The above assertion is not at all meant to discredit Western doctors. However it intends to point out that although Western scientific and technological medicine has been miraculous in its own right, the indigenous healing system deserves as much respect. As such, both

strategies can help realise the holistic approach to healing and health that so many people are seeking.

2.9 THE ROLE OF INDIGENOUS HEALERS IN THE FIGHT AGAINST HIV/AIDS

Indigenous knowledge that encompasses traditional healing and folklore remedies is actually bearing the brunt of HIV/AIDS care and support in South Africa (Morris, 2001:1190). Indigenous healers and remedies meet a genuine need because they consider the attitudes of the patients as suggested above. As stated by Green (1988:493), "one important difference between modern and indigenous medicine is that the former generally is better at treating disease and the latter is better in treating illness".

Across the ages, a natural response to illness has been to seek healing. The search takes the affected person from his immediate circle of relations to a more distant potential source of help until something that works or someone who knows is found. In this process, the accumulated experience of individuals, assisted by the collective memory of the community, builds a relatively consistent body of health beliefs and practices loosely held together by the community's interpretation of life, birth and death, right and wrong, and other values and beliefs (Quah, 2003:2002).

It has been established that some HIV-infected individuals seek treatments that may be considered "alternative", such as massage and nutritional supplementation (Suarez, Rafaelli & O'Leary, 1996:683). In the absence of a medical cure for AIDS, it is only natural that those affected may use non-medicinal treatments to manage and alleviate symptoms of the disease. In fact, in most societies individuals have access to multiple health care alternatives, including indigenous or folk medicines. Suarez *et al.*, (1996) are of the opinion that folk medicine systems are a well-developed and culturally ingrained way of treating both physical and psychological illnesses. It is therefore imperative that providers of health care be aware of these beliefs and practices among their patients.

What is needed is a change in approach to AIDS prevention. To begin with, Africans should hear about AIDS in their own languages, and the message must be delivered in such a way as to address traditional beliefs (Sayagues, 2003:53). Sayagues (2003:53) gives the example of the Batswana farmers who liken HIV to ticks and condoms to a protective cattle stockade.

Traditional medicine in Africa attributes illness to contamination, witchcraft, natural causes or vengeful spirits. Blood, especially menstrual blood, is regarded as a contaminant. In this view, sex with a menstrual woman brings disease, including AIDS (Sayagues, 2003:53). In a study conducted

by Suarez *et al.* (1996) on a Hispanic population, it was evident that many of the HIV-positive subjects in their study exhibited an active belief in the spirit world and its impact on their physical and emotional well-being, and nearly two-thirds reported engaging in folk healing to manage their illness. Furthermore, it was evident that involvement in folk medicine was greater among those individuals, whose illness had progressed further, suggesting that in the absence of effective biomedical treatment individuals fall back on culturally appropriate alternatives to manage and alleviate disease symptoms.

In support of the above, Buhrman (1979:24) states that the sense of helplessness and hopelessness is diminished by a firm belief in the presence and benevolence of ancestors, as well as the ability of the healer to function as a knowledgeable mediator. It also increases the patient's feelings of acceptance and self-esteem, and anxiety is relieved.

Faced with the controversy over the disease's cause, social and economic barriers to better health care, as well as limited or ineffective educational programmes, South Africans often turn to traditional healers for care and support (Giarelli & Jacobs, 2003:36). Doctors whose clients consult indigenous healers must understand the benefits of traditional healing. Even though there have not been many studies on patients utilising folk medicine to treat their HIV-related conditions, it would seem that folk medicine has a huge coping-mechanism effect, especially with the

assertion that the Hispanics were at an advanced stage of their illness. Being able to cope with anything means that one is in control of the situation and a sense of control is key to dealing with the uncertainties brought about by the disease. Active coping styles do not only help one psychologically, but in some cases there has also been some physical improvement.

Buhrman (1983:15), states that there are conditions and circumstances where the patients, and especially the relatives, turn to traditional healers of their own communities. This is particularly so in life-threatening and chronic diseases and demon-caused conditions. It would appear, then, that indigenous healers get more involved with the whole family, giving them moral and spiritual support, in contrast to the western practitioner who does this only to a limited extent.

In view of all these factors, it would seem that if the co-operation of indigenous practitioners can be enlisted in public health programmes, there can be no more potent impetus for improvement in public health (Green, 1988 a: 125). It would be of benefit for South Africans living in a pluralistic society to try to assess what conditions are best treated by modern medicine and which ones by indigenous methods (Buhrman, 1983:15). This should form the basis of both curative and preventative community health services and effective management of illnesses.

2.10 Gender and HIV

While the government is doing much in the fight against the spread of HIV and AIDS, much more still needs to be done in reaching vulnerable groups. Women in particular are vulnerable to HIV/AIDS, and there is a great need to protect them. The social and economic disadvantages that women face make them especially vulnerable to sexually transmittable diseases, including HIV.

Traditional health-based approaches have been and continue to be inadequate, ignoring the social, cultural, economic and human rights dimensions. A focus on sexual and reproductive rights for women and men is an important corrective measure. Yet an even broader human rights framework is needed to address the range of inequalities that drive HIV/AIDS – including poverty – and that recognises the rights of those that contract HIV through ways other than sex (http://www.bridge.ids.ac.uk/dgb11.html).

Gender inequalities are a major driving force behind the AIDS pandemic. The different attributes and roles societies assign to males and females profoundly affect their ability to protect themselves against HIV/AIDS and cope with its impact (http://www.un.org/ga/aids/ungassfactsheets/html).

Women's sexuality is particularly subject to stigma and control. Indeed, the social construction of sexuality – who should or should not express their sexuality, including men who have sex with men, young people, people with disabilities, and those beyond reproductive age – means they are often denied appropriate sexual health information and services.

When it comes to decision making in relationships, men are expected to dominate and women to be passive. Unequal parties are not in a position to negotiate when and how often they have sex, and how they can protect themselves from sexually transmitted infections. The double standard of condoning multiple sexual partners for men, and the expectation that men should know more about sex, puts them and their partners at risk, and often keeps them from seeking sexual health advice (Sayagues 2003:53). This could emphasise the fact that men still continue to engage in polygamous relationships, which in turn increases the risk of HIV/ AIDS infection.

The relationship between HIV, gender and poverty is complex. Pressing concerns for short-term survival may lead poor women to engage in so-called survival sex, which paradoxically can expose them to the long-term risk of illness and death through HIV infection. Poverty also limits people's access to sexual health information, prevention technologies and treatment. While this is true for both women and men, gender inequality

shapes different experiences of poverty and impacts on women and men's ability to move out of poverty.

Social spending cuts often lead to increased pressure on women and girls to take on the role of social safety net, caring for sick relatives and securing a livelihood as earning family members become sick and die. This is one of the invisible impacts of HIV/AIDS. Furthermore, a variety of factors increase the vulnerability of women and girls to HIV. They include social norms that deny women sexual health knowledge and practices that prevent them from controlling their bodies or deciding the terms on which they have sex. (http://www.un.org/ga/aids/ungassfactsheets/html). These are some of the challenges that communities and families need to confront in order to decrease the chances of infection for girls and boys, as well as men and women.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter will discuss the research design, the research participants, the method of data collection and data analysis chosen for the study.

3.2 QUALITATIVE RESEARCH

According to Banister *et al.* (1994), it is difficult to define, explain or illustrate qualitative research without comparing it to quantitative methods. Although qualitative research is an alternative approach, it does not mean that the qualitative researcher is averse to summarising data numerically or the use of statistical information. A qualitative researcher does, however, focus on the context and the richness of the contributions made by the individuals in the sample and will never build his/her account directly from quantitative data. In comparison with quantitative methods, qualitative research methods provide more accurate and appropriate information about respondents, due to the fact that the aim of the researcher is to understand the respondents' lived experiences (Fonow,

1991). Qualitative research aims to assess how the respondents' experience their social worlds, how they perceive their roles and how they understand and derive meaning from the social and cultural contexts within which they live.

Qualitative research entails a set of methods aimed at uncovering an individual's or group's social, cultural or normative patterns of behaviour and interaction. The qualitative researcher analyses social settings, motives and meanings, actions and reactions, organises their economic activities, the socializations, culture, daily activities and negotiation of roles within the context of everyday life (Fonow, 1991; Rothe, 1993; Banister *et al.*, 1994). Qualitative methodology illuminates the nature and quality of people's experiences in the attempt to gain valid knowledge and understanding. According to this approach, the social context is important in understanding the social world. It is believed that the meaning of a social action or event depends on the context in which it occurs. Thus, similar events or behaviours have different meanings in different settings. Different parts of social life are placed within the larger context so as to gain a more complete understanding of the event or behaviour. Therefore, theory development, description and operationalisation are often outcomes (Morse, 1994).

3.3 WHY A QUALITATIVE RESEARCH DESIGN?

According to Hitchcock and Hughes (1995), the qualitative research design allows the researcher to attempt to understand and view reality as the research participant understands and views it. The researcher is able to learn at first hand about the social world being investigated, by means of involvement and participation in that world through a focus on what the participants say and do. Qualitative research places the individual actors at its centre and it focuses upon context and meanings.

The qualitative research approach focuses on subjective meanings, definitions, metaphors, symbols and descriptions of specific cases. An attempt is made to capture aspects of the social world for which it is difficult to develop precise measures expressed as numbers (Neuman, 1997).

According to Banister *et al.* (1994), research which explores ways in which the subjectivity of the researcher influences the process will provide a more accurate account of the phenomenon in question, compared to research which denies any subjective involvement by the researcher. Research into the experiences and obstacles of indigenous healers with respect to providing health care to HIV-positive individuals therefore provided a more realistic account of the lived experiences of the indigenous healers being studied.

Qualitative research provides more accurate and appropriate information about respondents' experiences, due to the fact that the aim of the researcher is to understand those experiences (Fonow, 1991). The researcher, in seeking to convey the experience of the respondents, forms a non-hierarchical relationship with the participant – a relationship in which the researcher invests more time and energy, along with a commitment to sharing the self. This would, in this case, ensure that the indigenous healers and their patients feel supported, encouraged, understood and valued as worthy contributors to research as well as the community at large.

Qualitative methodology illuminates the nature and quality of people's experiences in their attempt to gain valid knowledge and understanding. Through encouraging participants to speak for themselves, more insight can be gained in the meanings of peoples' experiences and constructions of events and situations. The researcher, therefore, involved the participants in the process of knowledge acquisition and production.

Jones (in Punch, 1995) purports that in order to understand other people's constructions of reality, we would do well to question them in such a way that they can tell us in their terms and in a depth, which addresses the rich context that is the substance of their meanings.

According to (Silverman, 2000), qualitative research has a preference for analysis of words and images rather than numbers, for data obtained by observational and interact ional methods (as opposed to laboratory experiments), from persons studied in real-life settings. The priority of qualitative research is thus to reflect the perspective of participants, in this case the indigenous healers and their patients, revealing their understanding of their worlds and the unique problems they face in working with HIV/AIDS. As a qualitative researcher, I advocate reflexivity of proceedings, where, as a researcher, I will continually reflect on the process and the effect that this process will have on me personally.

Doing research on a sensitive topic such as indigenous healing inevitably had a profound influence on the researcher and challenging the views of individuals was not an easy task.

3.4 RECRUITMENT OF PARTICIPANTS

Initial contact was made with potential participants at a workshop which was held at the DBSA SA (Development Bank of Southern Africa) in February 2005. A trusting relationship was established at that time, which meant that the researcher was not a stranger to the participants when the time came to do the actual research. The researcher was intrigued by the way that the indigenous healers talked about their work. The passion that

they showed for their work made the researcher want to study the area of their service provision even more.

The snowballing technique was the sampling method used to recruit participants. According to Neuman (1997), snowball sampling is a method for identifying and sampling the cases in a network. It is based on an analogy of a snowball, which begins small but becomes larger as it picks up additional snow. In this technique, the sample begins with one or a few people or cases and spreads out on the basis of links to the initial cases. Some respondents were met after consultation with the Indigenous Knowledge Systems (IKS) unit of the National Research Foundation and some names were given to the researcher by Dr Masoga the then director of the IKS The researcher approached a few individuals, and they referred her to other indigenous healers and their patients.

Participants were asked to volunteer. The only criterion was that they had to be indigenous healers working with HIV-positive patients, and the patients had to have utilised the services of indigenous healers. Quotas were not set for the gender, age, race, cultural groups, groups or income levels of respondents. The sample was therefore a purposive sample.

Due to time and budget constraints, the sample design could not include the views or opinions of modern medical doctors to allow correlation of information.

A total of four individual traditional healers were interviewed as well as one focus group for traditional healers comprising of five traditional healers, a total of six HIV-positive patients were interviewed. The latter were interviewed, mainly to validate the information from the traditional healers. It is important to note that the sample is not representative and therefore the results of this study cannot be generalised to the universal pool of HIV-positive people or traditional healers.

3.5 INSTRUMENTS

3.5.1 Introduction

Focus groups and in-depth interviews were used as the methods of data collection. Qualitative interviewing, of which the focus group is an example, is one of the most appropriate techniques for this type of study as it enables the interviewer to take into consideration the personal, racial, gender, ethnic, social, political and cultural contexts of the interviewees (Fontana & Frey, 1994).

3.5.2 Focus group

The focus group interview was originally intended as a market research technique, originating as a counter-response to large samples and polling techniques, which provided lots of numbers but little insight into the meaning of these numbers. The focus group interview aims at eliciting the subjective experiences of a relatively homogeneous group of participants.

Kruger (1988) and Shamdasani (1990) define a focus group as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. The success of this method is based on the supposition that in a group setting individuals will be more willing to share their feelings and thoughts with others that have similar experiences.

A list of open-ended questions was asked in order to encourage the participants to relate their experiences. This allowed the researcher to identify useful information that would have been omitted had a questionnaire with close-ended questions been used.

In exploratory research such as this, focus groups enable the researcher to identify important variables in the particular area being studied.
In semi- structured focus groups, the interviewer simply suggests the general theme of discussion and poses further questions as they come up in a spontaneous development of interaction between the participants and researcher (Welman & Kruger, 1999). This is particularly true with respect

to indigenous healers and their patients, most of whom may feel unsupported and alienated. The fact that other people may have the same concerns or share a similar experience provides the necessary security to elicit in-depth, meaningful perceptions and attitudes. In addition to the sense of security, the group dynamics provide spontaneous responses by participants as well as the production of emotional involvement, necessary for in-depth, meaningful responses. Some individuals are stimulated by the expressions of others, which elicits their viewpoints, experiences and attitudes, giving worthwhile data.

Focus groups are part of a participatory and action research process, in which the participants and the researcher are equal partners in the planning and implementation of the research process and where the research topic is a mutual concern. (Vaughn, Schumm & Sinagub, 1996).

3.6 GENERAL PROCEDURES

The participants were given letters describing the research and consent forms (see Appendix One) to sign before commencing with data collection.

Participants were given the option of which language would be used during the interviews, since the researcher could understand all the languages spoken by the participants. They chose English because they

felt that it would be comfortable and it would be much easier for them to express their feelings in that language. They also felt that English was the common language among them. Therefore, interviews were conducted in English, which all of the indigenous healers and their patients could understand. This simplified the interview process, because there was no need to translate to the other participants.

The focus groups were tape-recorded and field notes were made both during and after the interviews. Initial impressions were written down as soon as the interviews were finished.

Due to the sensitive nature of the subject under investigation, the researcher had to take down notes and ask questions at the same time, which made it difficult at times to probe further. An interview guide composed of open-ended questions was utilised (see Appendix Two).

The participants were assured of confidentiality and anonymity. They were promised that no names would be attached to the documentation.

The interviews were conducted at the workplace of the participants since it seemed convenient for all parties concerned. For those who were not comfortable with that, the interviews were held in the researcher's office. Participants were assured of the confidentiality of the whole process and

they were asked to be free to say anything, as there would be no names attached to the final document.

As a black woman (understanding the black culture) and a former nursing sister (understanding the politics of the biomedical sector), the researcher could empathise with the indigenous healers on the issues they were discussing. This brought the temptation to ask leading questions. However, the researcher had guiding questions, which she utilised throughout the interview process. During the interviews, participation was encouraged from everybody in the group to ensure that all views were represented.

All the data tape recordings were transcribed verbatim onto the computer. There were a few problems with the recorded data because some portions of the interviews were not clearly audible. In this case, the field notes were used to enhance data capture from the tape recordings.

3.7 DATA ANALYSIS

3.7.1 The theory

The interview data was recorded and transcribed verbatim. The initial impressions were written down as soon as the interview was finished. This

was to make sure that even if something went wrong with the tapes, there was still data to work with. After that had been done, themes and common trends were pulled out.

The data was analysed utilising the grounded theory approach. According to Punch (1995), the essential idea in discovering a grounded theory is to find a core category at a high level of abstraction but which is also grounded in the data, and which accounts for what is central in the data. The grounded theory approach is useful when addressing sensitive issues such as abortion. Packer and Addison (1988) believe that this method assists one to understand the significance of complex human interactions in the context of their settings, relationships between behaviours, practices, historical events and the economic background against which they take place.

Grounded theory systematically and intensively analyses data, often sentence by sentence or phrase by phrase of the field notes, interview or other document. The data is extensively collected and coded. Thus the researcher is constantly coding, comparing and analysing (Strauss, 1987).

3.7.2 The process of analysis

3.7.2.1 Introduction

The audio-taped data was transcribed verbatim. The data was then analysed thematically. The challenge was to make sense of massive amounts of data, reduce the volume of information, identify significant patterns and construct a framework for communicating the essence of what the data revealed (Patton, 1990).

3.7.2.2 Organising the data

During the organising process, the data was read repeatedly to familiarise the researcher with the contents of the interviews. The process of listening to the data while transcribing it, made it much easier for the researcher to familiarise herself with the data.

3.7.2.3 Generating categories, themes and patterns

The interview protocols were read through several times over a period of a week in order for the researcher to further familiarise herself with the information. This allowed the researcher to become aware of her own ideas. Protocols should be read with this in mind, while trying to pick up

new or unexpected ideas (Fiedeldey, 1991). The protocols were put aside for another week and then read again.

Having completed the orientation with the protocols, responses were analysed by emphasising the meaning of the sentences. Categories were generated by grouping units of meanings that seemed to belong together. The thematic content was distinctive enough to warrant the establishment of separate experiential categories. From the categories generated, themes that fitted the same pattern were highlighted using different colour codes. Marshall and Rossman (1995) call this process identifying salient themes, recruiting ideas or language and patterns of beliefs that link people and settings together.

According to Neumann (1997), despite underlying differences across various interviews, important relationships can be found. Despite differing personal, social and economic contexts and the idea that each provider is unique, shared meanings can still be found.

Through this process, categories were found and developed. Themes that emerged from the data were discussed in a way that addressed the research questions. Once the themes were identified, passages and sentences were quoted verbatim to support the emergent themes.

3.8 TESTING THE EMERGENT HYPOTHESIS AGAINST THE DATA

As categories and patterns between them became apparent, the researcher began the process of evaluating the plausibility of these developing hypotheses and testing them by using the data (Marshall & Rossman, 1995). The researcher then evaluated the plausibility of the categories, considering the different emotions that the two groups showed, as this could have influenced their responses. However, lack of plausibility was not enough to reject the data at this stage. The data was still useful as it answered the questions that had been asked.

3.9 WRITING THE REPORT

In report writing, the researcher is engaging in the interpretive act and formulating meaning for the massive amounts of data.

Having gone through all the steps outlined above, the research findings were drawn. They will be discussed in the following chapter. The findings will be presented according to the themes identified from the questions asked during the interview.

3.10 RELIABILITY AND VALIDITY

3.10.1 Introduction

Validity and reliability are essential components in any research process. Although the construction thereof is different from the expectations regarding quantitative research, it is still necessary in order to reflect a meaningful understanding of the research topic.

3.10.2 Validity

The epistemological foundation, upon which qualitative research is based, assumes that there is no pre-existing set of absolute truths upon which all knowledge is founded. Truth is therefore not something that is objective and agreed upon by all, something that exists "out there" waiting to be discovered. Rather, truth is reactive, something that is constructed rather than discovered. Truth reflects a perspective, and as such there is no universal truth but multiple truths or "multiverses". In the case of the indigenous healers and their patients' attitudes, the researcher's interpretation can only be accurately conveyed if the feelings and frustrations that these indigenous healers and their patients experience in accessing the indigenous health system are adequately reflected and realistically represented. In order to do this, the researcher had to be personally involved.

Tindall (in Banister *et al.*, 1994) argues that validity in qualitative research is about an adequate representation of the meanings of participants. In research it becomes a quality of the knowers due to their interaction with the data and participants. A valid research project is thus one in which the researcher is able to represent the subjective experiences of those researched in a way that does justice and gives credibility to the participants. According to Boje (2000), validity from a qualitative perspective has to do with the rigour of the description and the credibility of the explanation.

Altheide and Johnson (in Boje, 2000: 994) argue for the use of interpretative validity in qualitative research, where interpretative refers to "definitions of the situation through deep immersion where the life world of the participant is explored so as to learn the inhabitants' point of view". In this way, knowledge claims come from a grounded and experienced understanding of what it is like to be in the setting being researched (Boje, 2000).

3.10.3 Reliability

Reliability from a quantitative, positivist perspective has to do with the replicability of results, a state that is obtained when measuring instruments are reliable and the conditions under which they are administered are

identical. When focusing on social behaviour in social contexts, attempts at replicating results appear futile, as social reality is always in a fluctuating state, and therefore instruments will never replicate the same measurements. From a post-modernist, qualitative perspective, replications are no longer essential for quality research (Merrian, 1998), as no situation can ever be replicated.

A qualitative researcher, therefore, never claims that research is perfectly replicable, due to the fact that every research project is different – different because of different researchers and participants, and different because of an ever-changing social reality. Each researcher has unique epistemological assumptions which influence the perceptions formed by the individual; therefore, given an identical set of circumstances, no two researchers will interpret them in exactly the same way. No interpretation will be an exact replication of reality, for the map (explanation of territory), can never be the territory itself (Bateson, 1972). All meaning is indexical (dependent on context) and will therefore change as the situation changes. Qualitative research thus aims for specificity rather than replicability.

Research results also have to be seen as relational, personal and time-bound. From a qualitative perspective, there will always be a difference between the interpretation of a particular research setting by a researcher and the meanings assigned to the same situation by the participant. These

in turn will also be different from the final interpretation assigned to the report by the reader. These differences, however, do not mean that the research project is not reliable. In the case of the indigenous healers and their patients, reliability will not be measured by replicability, as no two indigenous healers and their patients will have the same experience. Reliability is reflected in the ability of the researcher to accurately represent the feelings and attitudes of the indigenous healers and their patients and the unique challenges and difficulties they face "within" themselves and from "without" (by their colleagues and community members).

To increase the validity and reliability of the research process, the analytical methods involved should be made transparent. Thus it is important for readers to follow and evaluate the research process (Stanley, 1997).

3.11 Issues of reflexivity

Tindall (in Banister *et al.*, 1994) proposes that reflexivity is possibly the most distinctive feature found in qualitative research, and can be understood as an attempt to make explicit the processes involved in the

whole research project. The subjectivities of the researcher and of those being studied form part of the research process, and as such need to be made explicit and not denied. Making explicit, therefore, involves revealing rather than concealing the level of personal involvement of the researcher in the process.

Reflexivity implies that researchers reflect on their own experiences as well as the influence that their presence has had on the research process. Personal reflexivity, therefore, is about acknowledging who one is, one's individuality as a researcher and how one's personal interest and values influence the process of research from initial idea to outcome. Reflexivity also refers to the researcher's awareness of the effect that the research has on developing or challenging him/her as individual, since the experience of exploring personally relevant topics, and being actively engaged with participants, feed back into life experiences and often triggers personal change.

As a black woman and a former nurse, this researcher had a personal interest in the topic under investigation. The biomedical system was extremely unaccepting of indigenous healing practices, and those who sought help from indigenous healers were frequently turned away. As a researcher, I felt that those individuals who provide this kind of service need to be supported. From the onset, the researcher experienced fear of the unknown, in terms of the research process being unfamiliar for the

researcher. The failure to find a cure for HIV/AIDS and the continuous complaints from patients about the side effects of antiretrovirals as well as the death of a close family relative gave the researcher the necessary strength to continue with the study. Furthermore, this topic directly and indirectly talks to issues of emancipation for women in particular and blacks in general. The socialising process enforced the subordination of women, including failure to make decisions that would affect their own lives. The issue of seeking help from indigenous healers is one where many blacks feel free in terms of making a decision as to whom to seek help from and exercising their individual right to seek help from someone who understands not only their beliefs but also their person in totality.

As the researcher was interacting with the participants through the interview process, feelings and emotions were evoked in her that could have influenced the data analysis process. Being a former nurse and a black woman, the researcher identified with the participants in many ways. This worked to the researcher's advantage, as participants were more willing to open up to her and to express their emotions freely. This openness nearly interfered with the researcher's objectivity, as she was at times tempted to deviate from the guiding interview questions.

Nevertheless, it was difficult for some of the respondents to be forthcoming to the researcher. As she is a former nurse, psychologist and a black woman, in their eyes she was a person coming from the "other"

school of thought concerning illness and health issues. For others it was the direct opposite. They hoped that they would be given a platform to vent their feelings and frustrations with the biomedical health system. They were hopeful that the Minister of Health would assist them and their practice.

Some of the participants' responses were totally against the researcher's belief system, which at times tempted her to express her opinion. However, ethical issues and scientific practices guided the whole process, and were always in the background of the researcher's mind. In the end, the courage of the patients and indigenous healers, who wanted to continue with traditional healing despite the negative attitudes of Western doctors and other parties cited by them, convinced the researcher that the service would be sustained. The researcher also felt that with such determination she could continue with the research process.

3.12 CONCLUSION

Due to the abstract nature of indigenous healing and its belief systems, a flexible research approach was essential. This approach was sensitive to the constructions of the indigenous healers and the patients seeking assistance from them. The qualitative approach ensured that the researcher was aware of her construction of indigenous healing as well as the diverse constructions of the participants. The researcher acknowledges the importance of indigenous voices in formulating a position for this dissertation. The researcher and the participants therefore became co-participants in the process of collective knowledge publication. It was felt that understanding the role of indigenous healers and their patients would create an awareness of the impact of their beliefs and behaviour on the patients seeking traditional interventions.

CHAPTER 4

RESULTS AND DISCUSSION

Introduction

In this chapter, the results of the study are discussed by interpreting the themes, which emerged from the interviews. As mentioned previously, the themes which were extracted were guided by the research questions.

The results should be interpreted with the idea of cultural relativism in mind. The concepts of healing should be interpreted within the particular world view of the traditional healer as well as their patients. For instance, in traditional African healer's world view healing rests on the assumption that if the mind is healed, the body takes care of itself. In western medicine, the converse is often considered true.

4.1 Contribution of indigenous African healers

Traditional healers have been slowly but surely emerging as a part of the treatment of HIV/AIDS. The Minister of Health has been working on incorporating traditional healers with modern medicine in order to have a bigger impact in treatment of this pandemic. The Minister believes strongly that traditional medicine and nutritional supplements should be an integral part of treatment. Counselling is also very important in the management of HIV/AIDS. Traditional healers claimed that they offer counselling services to their clients, which helps them to understand their patients and to gain their trust. This assertion is supported by (Hewson, 1998) who believes

that indigenous healers hold a powerful position as they act as physicians, councillors and psychiatrists.

4.2 EXPERIENCE IN WORKING WITH HIV/AIDS

Some traditional healers interviewed agreed that HIV/AIDS was a new concept to them. They said that they were still not sure what HIV was, but they could recognise the symptoms that affected HIV-positive patients. On the other hand, some healers maintained that they knew HIV and they had enough experience to treat it. One of the traditional healers claimed that he himself was once HIV-positive and that he had healed himself of the disease.

The healers declared that they did not carry out any tests to confirm the patient's status, as they did not have proper technology to do that. However, they reported that they could see when a person was HIV positive by casting the bones.

4.3 METHODS OF PROMOTING HEALTH

4.3.1 Holistic approach

The traditional healers reported that they used a holistic approach to the treatment of HIV/AIDS. This included spiritual, medicinal and nutritional techniques. Most of the respondents reported that they incorporated

traditional medicine with nutrition as it is an important element of the treatment. They used traditional herbs to treat their patients. Some of them claimed to feed their patients if they were hungry when they came seeking treatment. They said that some of the patients went days without any food, and they sometimes even cooked for their patients.

Some said they concurred with the President when he said it was not only the injections and antiretrovirals that could cure a person who was HIV-positive. Nutrition was an important factor. They also reported that they had conducted some pilot studies, during which they worked with nutrition, and it has been very effective. One healer said that he did not encourage people to rely only on antiretrovirals, but to also use traditional medicines

4.3.2 Detox method

Dr. H. believed that ARVs were good only for a period of time; once they saturated the body they stopped working. It was important that patients detoxify periodically; once the toxins are out, they could again use ARVs. One of the detoxification methods included inducing vomiting and cleansing the bowel.

He went on to say that "if there was support from the media and doctors we would give our herbs to the clients to detoxify then they take the ARV's again, unfortunately there isn't much cooperation".

4.3.3 Talking to spirits

They also reported talking to their spirits to get guidance regarding healing and helping their patients. "I have one that was diagnosed HIV-positive in 1997 July, and he is still very strong. We are still using the very same methods. And when we say they must go and check their CD4 count, it is still higher that 300 or 400", said one doctor. "We as healers must talk to the inner person because once the inner person is strong we can cure them by word of mouth, not necessarily food", said the healer.

4.3.4 Traditional medicines

Traditional healers use herbs which they harvest from the bush. They reported that these work very well. They also use pure methylated spirits to mix with many herbs, because it helps drain the water and dry the chest. One respondent used herbs for children, to prevent illness. "Herbs clean your blood so that it is not easy to be infected with any diseases." This same healer also stressed the importance of food to promote health. He and others reported that they prayed or talked to their ancestors before they attended to patient.

4.3.5 Referrals

Some healers reported that they referred clients to the modern medical doctors if they were unable to deal with the patients' problem. They never kept patients if they were aware that they could not help them. They also said that they sent patients to modern doctors to get HIV testing, since they themselves did not have the testing equipment, and since the law forbids them to assume that the patient is positive without proper tests.

4.4 PREVENTION OF ILLNESS

4.4.1 Culture and customs

Traditional healers still believe in the power of customs, cultures and tradition to prevent illnesses, including HIV and AIDS. The participants claimed that these customs, including initiation, are guided by our beliefs. There are customs which prevents many illnesses. Some customs discourage sexual intercourse before marriage. This obviously prevents HIV.

4.4.2 Education

Traditional healers try to train their patients. Dr T reported that he had about 52 training sessions. He calls people from hospitals and from the South African National Tuberculosis Association (SANTA) to come to

teach his patients about tuberculosis, and people from various NGOs and hospitals to teach them about HIV/AIDS and counselling.

4.5 PROBLEMS AND HINDRANCES

4.5.1 LACK OF SUPPORT

The main problem that the healers are facing is the lack of support from policy, from the general public and from the modern medical system. They are being discarded as unimportant and ineffective. The interviewees believed that modern medical doctors disregard the importance of working together with traditional healers, and do not believe these healers can contribute toward the treatment of HIV and AIDS.

4.5.2 Lack of knowledge

Another difficulty that healers encounter is the lack of knowledge that patients have about their status and about HIV/AIDS in general. Patients go to traditional healers thinking that they will be cured. That is the most difficult part – to know that they don't understand the depth of their disease. Some patients expect too much from the healers because of this lack of understanding.

> You know, it was like a joke. Somebody came here with a broken leg. And instead of getting POP (plaster of Paris) he

never wanted to go there, until such time that I told that person that you have a broken leg, you need to go get a POP. He then went there and everything was okay, but if maybe I didn't say, he would not have gone the hospital (Interview, Dr T, 28/06/2005).

This shows the extent to which many people trust traditional healers.

4.5.3 Poverty

Another problem faced by traditional healers is the poverty in which most of their clients find themselves. They believe that medicine cannot be isolated or divorced from nutrition, and the main problem is that most of their patients cannot afford good food. Furthermore, some patients do not even have money to pay for the treatment that they receive. At times they have to treat these patients without receiving any payment from them.

4.5.4 Social resistance

Healers expressed their frustration with some churches that advise or prohibit people from going to traditional healers. These churches treat the healers as if they are witches, even though they have been there since the beginning of time.

4.5.5 Finance

One healer reported his main challenge as being the doctors that appear on radio to advertise that they can heal or treat HIV. He says that they only do that because they can afford to buy airtime, and lie on air about their medicine.

> They would show you one bottle of medicine and they say it cures everything. That is nonsense because they have nothing to even help pull up somebody who is bedridden. Sometimes people come and they have no money, but they still need help and there is no way you can turn them away; you have to assist them. Patients also stay far away from us and it is difficult for us to get there (Interview, Dr S, 08/05/2005).

4.6 SUPPORT NEEDED BY TRADITIONAL HEALERS

4.6.1 Formal structures

Traditional healers reported that they needed formal structures and formal support from the government in the form of policies and legislation. They also wanted support from the public and the modern medical fraternity.

Furthermore, the healers said that they would like to have a regulatory body, which would handle administration and have a database for all the

doctors, which people could access. They also suggested the development of a booklet which would have information on traditional healing methods and indigenous systems and cultures.

> People must know how to be cleansed when there has been death in the family, and about a lot of things (Interview, Dr T, 28/06/2005).

4.6.2 FUNDING

The traditional healers felt that they needed funding to set up their organisations, as well as a website that people could access when they needed their services.

> We need to have our own hospitals like the Chinese do (Interview, Dr S, 08/05/2005).

4.6.3 Support

Traditional healers felt that they needed to be supported and not undermined by medical doctors.

> The doctors must realise that we have a very important job just like them so they do not have to look at us and think that we are useless or we are taking their jobs from them. We know what we are doing. They just need to be educated on who we are and what role we play in all this. Therefore, we

> will be able to reach an understanding (Interview, Dr. S 08/05/2005).

They wanted the support and co-operation of the medical doctors, and they needed them to understand that they were not in competition with them. The healers acknowledged that medical doctors were much better than traditional healers with regards to some medical aspects, and they (the medical doctors) should acknowledge that traditional healers were better than them in other aspects. If all doctors and healers were patient-inclined, they believed, they would succeed.

4.6.4 Education

Healers have attended workshops in order to learn about the HIV virus.

> In our collaboration and talking, attending workshops with medical doctors, we found that this is something that we could not say we could cure. And we needed medical doctors and traditional healers to take part in this. ... We started to formulate our bones in such a way that they could show us who is positive.

The traditional healers said that they needed to learn more and be educated about this disease so that they could advance in fighting the

disease. They started some programmes where they used the African potato.

4.7 EXPERIENCE IN WORKING WITH HIV/AIDS

4.7.1 ABILITY TO CURE THE DISEASE

Dr H. maintained that he himself was once HIV-positive and now he is healed. He said that he contracted the disease while he was a truck driver. He reported that there are some people who had the same symptoms as he did and they have since passed away. He reported that he had helped people who were bedridden, and said that most of his patients could get up and walk after a few month of treatment. This shows some inconsistency with the other healers who were very clear that they were only able to cure the symptoms, but not the disease itself. Perhaps, a much more comprehensive study needs to be undertaken with those healers that believe they can cure the disease.

4.7.1 COMMON SYMPTOMS IDENTIFIED BY HEALERS AS HIV

Among other things, Dr H. reported the following symptoms:

- fluid draining between the thighs: used to use diapers;
- painful kidneys;
- inability to lift arms;
- coughing (showing flu-like symptoms) ;

- dizziness; and
- headache.

As a result of this, Dr H, believed that not only was he HIV-positive, but he had full-blown AIDS.

4.7.2 HIV TESTS

Traditional healers reported that they did not test for HIV as they had no means of doing that. They were legally required to send their patients for testing through modern medical procedures. Most healers said that they preferred the modern medical doctors to check the patients using Western ways, and then to allow the traditional healers to treat them accordingly, as they relied only on their ancestors showing them when the patient was positive. What is important to note is that these healers said that the disease was not presented to their bones as HIV/AIDS, but that they were only shown the known symptoms of HIV and then deduced that the person is positive.

In the same token, Dr H reported that although he believed he had full-blown AIDS, he never went for any testing; he based his conclusion on the fact that he knew the symptoms.

No, I know I was positive because of the signs and symptoms I was showing, but amazingly after I took my herbs to treat myself I went for the test in 2004 and I tested negative.

4.8 PERCEPTION OF OWN CONTRIBUTION

Traditional healers believed that they had a very important role to play in the treatment of HIV and AIDS. They said that they offered support to their patients on a personal basis. They reported that their methods differed from that of modern doctors because they formed personal relationships with their patients. They offered a complete package including counselling and spiritual support. As one healer said, traditional healers know their patients, their families, where they come from, what they eat and everything about their families and their background. All healers interviewed reported that they had seen an improvement in their patients' status, health and physical being.

Most traditional healers believed that healers could make a great contribution to dealing with HIV. They believed that their herbs healed and promoted health.

I am a living example. If I have used the same herbs to cure myself then I will be able to help the next person. This gives one the opportunity to teach people. People do not need to

be certificate educated, but they need to be mentally educated.

Traditional healers also understand the limits to their contribution, and they refer patients to doctors when needed.

> If somebody whom the people trust who is using traditional healing is telling them about HIV and modern disease they do come together. So they feel I am saying something which is right, in referring them to hospitals, gynaecologist. You know, I am not everything, then they understand. In the past a healer would be almost everything.

They reported that they were able to cure symptoms of HIV by using nutrition; some patients are very healthy but they are HIV-positive. Their clients were fit and they could work.

> You can deceive other people into thinking we are curing AIDS, but no, they just boost the immune system not heal HIV

4.9 PATIENTS

For the purpose of this study, patients are the respondents that used the services of traditional healers. They did not have to use exclusively traditional methods. A total of three patients were interviewed. All of them

maintained that traditional healing was a very important part of treating HIV.

Two found out over a year ago from the hospital that they were HIV-positive. One patient said that he found out 11 months ago that he was positive, having been tested with a group of his friends. He reported that he did not use any modern medicine, and did not take any form or ARVs. Most importantly, he believed that he was healed. He reported that he was bedridden before he started consulting a traditional healer.

The other two patients said that they were using ARVs together with traditional medicine. They said that the herbs were very helpful and that they worked better than ARVs. They believed that ARVs made them weaker but that the traditional medicine gave them energy and made them feel much better.

One patient believed that traditional healers and modern doctors should work together to fight the pandemic. He said that the major difference between the two types of practices was that traditional medicines are herbs and modern medicines are drugs.

A 48-year-old male was interviewed, and believed that Doctor M healed people with HIV. He said that he has known about his status for ten years. He reported that this traditional healer helped him and others that work at

his company. He alleged that Dr M healed a patient that was released from a hospital. This patient also believed that modern medicine and traditional healing should find a common ground and be able to work together. He said that people could benefit tremendously from both.

4.10 CASE STUDY

4.10.1 BACKGROUND

Creselda Kananda is a host on the show called *Positive Talk* on Kaya FM. Her radio show is geared at speaking to the public and educating people about HIV/AIDS. For the purpose of this study, an interview between her and the traditional healer's organisation was analysed.

Creselda stresses the importance of nutrition and traditional medicine in the treatment of HIV/AIDS. She advocates better relationships and communication between all stakeholders, professionals and concerned parties. She believes that education and working together are key to prevention and treatment of HIV/AIDS. In her teachings, she stresses the daily consumption of herbs to help ease the symptoms of HIV.

The traditional healers' organisation and the nutrition association are in negotiations so that they can work together to promote nutrition and

traditional medicine, as they believe nutrition is a vital ingredient for living healthy and treating HIV/AIDS.

4.10.2 HEALTH PROBLEMS

This section was aimed at identifying the kinds of health problems that the respondents had, in order to be able to assess whether the use of traditional healers could alleviate constant health problems.

4.11 CRITICAL EVALUATION

From the argument above, the researcher is of the opinion that the indigenous healing system can provide healing in that, the client and the healer share the same world view and therefore share a common understanding. This is to say that whatever process that takes place sheds the same results because the healing technique takes place between them. This system cannot be reduced to psychosocial or social forms only, but it is a legitimate form of conceptualization of their experiences. This gives symbolic unity for the healer and the client as well as the community at large. If there is a change in the belief system of the community, there could be serious consequences as this will affect how individuals will act and access health care. The sense of community symbolism which comes with indigenous healing provides will power for the African people in times of crisis such as being struck with the HIV/AIDS pandemic. With the above in mind one can conclude that, healing in the indigenous sense is

determined by the subjective evaluation of the patients and more often than note, the evaluations are based on the patients' belief system and values.

It seems that with the healer and the client sharing the same belief system, the healer spends time reassuring the client and treating other relevant psychosocial problems and or provides meaningful and acceptable explanations of the patient's illnesses.

The indigenous healer seems to have a major role in the fight against HIV/AIDS. If all healthcare professionals were to unite in their approach to combat this pandemic, Africa would be able to at least prevent the continual spread of the disease in the absence of a cure or a vaccine. The utilization of indigenous healers is crucial because great numbers of people believe in the power of indigenous healers and their remedies. These healers may be used to disseminate knowledge to members of the community to enlist their co-operation in modifying attitudes and in motivating people to carry out health promoting practices.

Because of the high illiteracy rate, especially amongst rural South Africans, indigenous healers could be used as a powerful medium to transmit preventative messages. With healers being viewed by their communities as a link to convey messages from the cosmos and as possessing the skill to penetrate and impart the secrets of the universe, they can be used as mediators between the spiritual world and the human being. They can thus be used to promote appropriate health care

measures, including the use of condoms. Although the use of condoms has been viewed as a thing of Western medicine, the high credibility of the healers could be an influence in modifying current attitudes towards condoms.

Since the indigenous healers involves the whole person and uses the social, psychological and spiritual as well as the physical domain, they could utilize rituals that will be of assistance to clients. They could assist clients to accept and integrate what may seem like a threatening part of themselves as this gives them an opportunity to ventilate their anxieties and make them become less threatening and meaningful.

The indigenous healer also treats clients in their natural setting which ensures that AIDS patients are incorporated in the life and activities of the healer's household and are treated like a family member not like a bed or a cubicle which unfortunately is the case in most hospitals nowadays. The clients are also lonely at the hospitals and isolated as opposed to being with the healer, who ensures that the patient is not alienated from family or community. AIDS patients need a humane environment in which to live because this is conducive to health and health promotion.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 CONCLUSION

Traditional healers have demonstrated that they can make a very important contribution to the treatment of HIV/AIDS. They are not receiving a fair opportunity to demonstrate their knowledge and expertise in treating HIV and AIDS. They also lack support from the public, from government policy, and from the modern medical fraternity.

There have been efforts by the Minister of Health to incorporate traditional healing and traditional medicine as part of a holistic approach to treatment and containment of HIV.

Traditional healers need support and recognition from the public, the government and the modern medical fraternity.

Healers could use the special place that has been given to them by African society to effect preventative AIDS measures as well as use their status as a therapeutic and healing property in HIV/AIDS prevention and management.

Currently, there are insufficient conventional health care resources to meet the existing needs to fight the disease and it could be very expensive and time consuming to train more doctors. The use of resources already in

existence in communities such as indigenous healers, appears to be one viable route in the fight against AIDS. Such healing practices would allow African people to go back to their roots in health care, whilst still having the choice of Western approaches to medicine if available to them. The other advantage would be the prevention of illness and misfortune as well, as it does not only provide a curative intervention. Since the community views indigenous healer as psychologists, physicians, priests and prophets, they have an established credibility and as such they possess pervasive influence in the lives of the majority of blacks in African society.

5.2 RECOMMENDATIONS

From the findings of the study, it is recommended that:

A standardised training programme in aspects of biomedical model relevant to the provision of primary health care is needed. This is to empower indigenous healers to work in collaboration with biomedical staff in the fight against HIV/AIDS. This will also enable the biomedical staff and indigenous healers to understand how each one of them work.

There should be courses in tertiary institutions that explain the nature of indigenous healing as well as indigenous knowledge systems at large. These courses should include community based education where students are exposed to the practice of indigenous healing. This will help dispel misconceptions and suspicions.

Society should create networks to build partnerships between indigenous healers and biomedical doctors and these networks should be comprised of both indigenous healers and biomedical doctors.

It is further recommended that a nationwide study be conducted with more emphasis on the patients that have consulted indigenous healers. This needs to take into account a wider range of community members.

REFERENCE LIST

Asuni, T. (1979). Modern Medicine and Traditional Healers. In Ademuwagun, Z.A., Ayoade, J.A.A, Harrison, I.E. & Warren, D.M. *African Therapeutic Systems.* USA: African Studies Association.

Baleta, A. (1998) . South African to bring traditional healers into mainstream medicine. *Lancet.* (352) Issue 9127 554-557.

Banister, P. Burman, E. Parker, I. Taylor, M. & Tindall, C. (1994). *Qualitative methods in psychology:* A research guide. Buckingham: Open University Press.

Bannerman, R. H., Burton, J. and Wen-Chieh (Eds) (1983). *Traditional Medicine and Health Care Coverage:* A reader for health Administrators and practitioners. Geneva: World Health Organization.

Bateson, G. (1972). *Steps to an Ecology of Mind.* New York: Valentine Books.

Boje, D. M. (2000). *Narrative Methods for Organizational and Communication Research.* London: Sage.

Bryant, A. T. (1970). *Zulu Medicine and Medicine Men.* Cape Town: Struik.

Buhrmann, V.M. (1983) Community health and traditional healers. *Psychotherapeia.* (Nov 1983) 16-29.

Buhrmann V. M. (1979) Why are certain procedures of indigenous healers effective? *Psychotherapeia* 5(3) 20-25.

Cheetham, R. W, & Griffiths, J. A. (1982). The traditional healer/diviner as psychotherapist. *South African Medical Journal* (62) 957-958.

Conco, W. Z. (1972) The African Bantu traditional practice of medicine: Some preliminary observations. *Social Science and Medicine* (6) 283-322.

Crafford, D. (1996) The African Traditional religions. In Meiring, P. (Ed) *A World of Religions-A South African Perspective.* Pretoria: Kagiso Publishers.

Davis, J. (1996). An integral approach to the scientific study of the human spirit. In Driver, B. L. Dustin, D., Baltic, T., Elsner, G. & Petersen, G. (eds) *Nature of the human spirit.* Radnor, PA: Venture Publishing.

Dockecki, P. R. (1992) On knowing the Community of Caring Persons: A methodological Basis for the Reflective-Generative Practice of Community Psychology. *Journal of Community Psychology* (20) Jan 1992. 26-35.

Donald, D. R. & Hlongwane, M.M. (1989) Issues in the Integration of Traditional African Healing and Western Counselling in School Psychological Practice. *School Psychology International.* (10). 243-249.

Easthope, G. (1986) *Healers and Alternative Medicine*: A Sociological Examination. Dorset. Blackmore Press.

Edwards, S. (1986) Traditional and modern medicine in South Africa: A research Study. *Social Science and Medicine,* 22 (11) 1273-1276.

Edwards, S. D., Grobbelaar P.W., Makunga, N. V. Sibaya, P.T. Nene, L. M. Kunene, S.T. and Magwaza, A.S. (1983). Some Indigenous South African Views On Illness and Healing. *Publication Series of University of Zululand. Series B* No. 49 pp 35-49.

Edwards, S. Makunga, N, Thwala, J. & Mbele, B (2006). The role of ancestors in healing. *Indilinga article in press.*

Egbertin, R. B. (1979). A traditional African Psychiatrist. In Z. A. Ademuwagun, J. A.A. Ayoade, I. E. Harrison & D. M. Warren (Eds). *African therapeutic systems* (pp. 87-94) Massachusetts: African Studies Association.

Felhaber, T. & Mayeng, I. (1997). *South African Traditional Healer's Primary Health Care Handbook.* Cape Town: Kagiso.

Fiedeldey, A.C. (1991). *Experiencing nature on hiking trails*: A psychological study. Unpublished Doctoral Thesis. University of Pretoria.

Fonow, M & Cook, J. (1991). *Beyond Methodology*: Feminist Scholarship as lived Research. Bloomington: Indiana University Press.

Fontana, M. & Frey, J.H. (1994). Interviewing: The art of Science. In Denzin, N. K & Lincoln, Y. S. *Handbook of Qualitative Research.* Thousand Oaks: SAGE Publications.

Freeman, M & Motsei, M. (1992). Planning Health Care in South Africa-Is there a Role for Traditional Healers? *Social Science and Medicine* 34 (11). 1183-1190.

Giarelli, E. & Jacobs, A. (2003). Traditional Healing and HIV/AIDS in Kwazulu Natal, South Africa. *AJN.* 103 (10) 36-47.

Goud, N.H. (2001).The Symbolic Identity Technique. *Journal of Humanistic Counselling, Education and Development,* 440, 114-121.

Green, E. C. (1988a) Can Collaborative Programs between Biomedical and African Indigenous Health Practitioners Succeed? *Social Science and Medicine* 27 (11) 1125-1130.

Green, E. C. (1988b) Roles for African traditional healers. *Medical Anthropology.* (4) 489-522.

Gumede, M. V. (1991). *Traditional Healers.* Johannesburg: Skotaville Publishers.

Hamer, M. (1990). *The way of the Shaman.* New York; Bantam.

Helman, C. G. (1990). *Culture, health and illness.* London: Butterworth.

Hewson, M. G. (1998). Traditional Healers in Southern Africa. *Annals of Internal Medicine,* 128 (12), 1029-1034.

Hitchcock, G. & Hughes, D. (1995). *Research and the teacher:* A Qualitative Introduction to School-based Research. London: Routledge.

Holdstock, T. L. (1979). Indigenous Healing in South Africa: A neglected potential. *South African Journal of Psychology* (9).118-124.

Imperato, P. J. (1979). Traditional medical practitioners among the Bambara of Mali and their role in the modern health care delivery system In: Ademuwagun, Z. A., Ayaode, J.A.A., Harrison, I. E. *African Therapeutic Systems.* Waltham, Mass: Crossroads Press.

Jung, C. G. (1953). *Two Essays on Analytical Psychology.* Meridian Books: New York.

Karim, S.S.A., Ziqubu-Page, T.T. & Arendse, R. (1996).Bridging the gap. Potential for a health care partnership between African traditional healers and biomedical personal in South Africa. *South African Medical Journal.* Dec 1994, pp 1-16.

Karkar, S. (1979). *Shamans, mystics and doctors:* A psychological inquiry into India and its healing traditions. Boston: Beacon Press.

Katz, R. & Wexler, A. (1989). Healing and transformation: Lessons from indigenous people. In Pelzer, K. & Ebigo, P.O. (eds). *Clinical Psychology in Africa:* South of the Sahara, the Caribbean and Afro-Latin American. Chuka Printing Company: Nigeria.

Kiev, A. (1989). Some psycho-therapeutic factors in traditional forms of healing. In Peltzer, & P. O. Ebigo (Eds). *Clinical Psychology in Africa:* A textbook for universities and paramedical schools (pp.437-444). Enugu: Chuka Printing Company Limited.

Kleinman, A. & Sung L. H. (1979) Why Do Indigenous Practitioners Successfully Heal? *Social Science and Medicine.* (138) 7-26.

Koumare, M. (1983). Traditional medicine and psychiatry in Africa. In R. H. Bannerman, J. Burton & S. Wen-Chieh (Eds), *Traditional Medicine and health care coverage:* A reader for health administrators and practitioners. Geneva: World Health Organization.

Kruger, D. (1988). *An Introduction to phenomenological psychology* (2nd ed.) Cape Town: Juta & Company.

Lebra, T. S. (1982). Self-reconstruction in Japanese religious psychotherapy. In A.J. Marsella & G.M. White (Eds), *Cultural conceptions of mental health and therapy* (pp. 269-283). Dordrecht: D. Reidel Publishing Company.

Mankazana, E.M. (1979) A Case of the Traditional Healer in South Africa. *South African Medical Journal.* 1003-1007.

Marshall, C. and Rossman, G.B. (1995). *Designing Qualitative research.* London: SAGE Publications.

Maslow, A. H. (1962). *Towards a psychology of being.* New York: Van Nostrand Reinhold.

Maslow, A. H. (1968) *Towards a psychology of being.* (2nd Ed). New York: Van Nostrand Reinhold.

Mbiti, J. S. (1969), *African religions and philosophy.* New York: Anchor.

Merrian, S. B. (1998). *Qualitative Research and Case study Applications in Education.* San Fransisco: Jossey-Bass Publishers.

Meyer, W. F. Moore, C. & Viljoen, H. G. (1997). *Personality Theories*: From Freud to Frankl. Heinemann: Johannesburg.

Monnig, H.O. (1967). *The Pedi.* J. L. van Schaik; Pretoria.

Morris, K. (2001) Treating HIV in South Africa—A tale of Two Systems. *Lancet* (357) Issue 9263.1190-1192.

Morse, J. M. (1994). *Critical Issues in Qualitative Research Methods.* London: Sage Publications.

Myers, L. M. (1988). *Understanding an Afrocentric World View:* Introduction to an optimal Psychology. Kendall/Hunt Publishing Company, Iowa.

Neuman, W.L. (1997) *Social Research Methods.* Qualitative and Quantitative approaches. Allyn and Bacon; Boston.

Ngubane, H. (1977). *Body and Mind in Zulu Medicine.* New York: Academic Press.

Nzima, D. R, Edwards, S. D. & Makunga N. V. (1992) *Professionalization of Traditional Healers in South Africa:* A Case Study.

Packer, I. (1989). The crisis of modern social psychology damages Africa. *The Psychologist,* October, pp462-465.

Paton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd Ed). Newbury Park: Sage.

Pearson, E. (1994). *A new look at Maslow's humanism through radical and postmodern criticism.* Ann Arbor: University of Michigan Dissertation Services.

Pelzer, K. (1993) *Psychology and Health in African Cultures:* Examples of Ethnopsychotherapeutic Practice.Frankfurt. IKO-Verlag fur Interkulturelle Kommunikation.

Peltzer, K. and Ebigodbo, P.O. (1989). *Clinical Psychology in Africa:* South of the Sahara, the Caribbean and Afro-Latin American. Chuka Printing Company: Nigeria.

Podeschi, R. (1983). Maslow's dance with Philosophy. *Journal of Thought,* 18 (4), 94-100.

Podeschi, R. (1986). Maslow's dance with philosophy. *Journal of Thought,* 18 (4), 94-100.

Punch, N. K. (1995). *Introduction to Social Research:* Quantitative and Qualitative Research Approaches. Collecting Qualitative Data. London. Sage Publications.

Quah, S. R. (2003)Traditional healing systems and the ethos of science. *Social Science and medicine.* (27)1997-2012.

Rothe, J. P. (1993). *Qualitative Research.* Ontario: RCI Publications.

Saayman, W. S. (1992) Concepts of sickness and health in South Africa: A semiotic approach. *Journal for the study of Religion* (5) 31-46.

Sayagues, M. (2003) Withcraft, Vengeful spirits and the Plague. The AIDS Battle needs a new approach. *Newsweek* (Atlantic edition) (142) 24. 53-54

Scotton, B. W. (1996). The contribution of C. G. Jung to transpersonal Psychiatry. In Scotton, B.W., Chinnen, A. B. & Battista, J. R. (Eds). *Textbook of transpersonal Psychiatry and Psychology.* New York: Basic Books.

Scotton, B.W., Chinnen, A. B. & Battista, J. R. (Eds). (1997). *Textbook of transpersonal Psychiatry and Psychology.* New York: Basic Books.

Silverman, D. (2000). *Interpreting Qualitative Data.* Methods for Analysing Talk, Text and Interaction. Sage Publications: London.

Sodi, T. (1998). A phenomenological study of healing in a North Sotho community. Unpublished doctoral thesis.

Stanley, M., (1997). *Introducing Women's Studies.* Mcmillan Press.

Staugaard, F. (1986) Traditional healers. In Last, M. & Chavunduka, G. L. *The professionalization of African Medicine.* Manchester: Manchester University Press.

Strauss, A.J. (1987). *Qualitative Analysis for Social Scientists.* Cambridge: Cambridge University Press.

Suarez, M., Raffaeli, M. & O'Leary, A. (1996) Use of folk healing practices by HIV-infected Hispanics living in the United States. *AIDS Care.* (8) 683-691.

Suzuki, D. T. (1968). *The essence of Buddhism.* Kyoto, Japan: Hozokan.

Thorpe, S. (1993) *Shamans, Medicine men and traditional healers.* University of South Africa, Pretoria.

UNAIDS. (2000). Collaboration with Traditional Healers in HIV / AIDS Prevention and Care in sub-Saharan Africa.

Van Rensburg, H.C. J, Fourie, A. & Pretorius, E. (1992). *Health Care in South Africa.* Structure and dynamics. Pretoria. Academia.

Walker, J. R. el-Guebaly, Ros, A. & Curie, R. F. (1992) Where Do You Turn for Help? A Community Survey of the Use of Professionals, Reading Materials, and Group Programs for Three Problems in Living. *Journal of Community Psychology.* (20) 84-89.

Welman, J. C. and Kruger, S. J (1999). *Research Methodology for the business and Administrative Sciences.* New York: Oxford University Press.

APPENDIX 1

LETTERS AND CONSENT FORMS

Dear Indigenous Healer,

I intend doing research on Indigenous Healers in South Africa who have been involved in the treatment of patients who are infected with HIV. I am currently completing my Doctoral degree in Community Psychology at the University of Zululand and the research will contribute towards my degree.

My research will explore your experiences in this field. It will mainly investigate the indigenous African methods of health promotion and HIV/AIDS prevention. You may be requested to talk about factors which make it easy or difficult for your work to be conducted.

If you agree to be interviewed, please sign the consent form.

I thank you.

Busisiwe Precious Dlamini

CONSENT FORM

You are hereby requested to participate in a research project. The information gathered and received from you as an indigenous healer will form part of and will be used in a research project on Indigenous African Methods of Health promotion and HIV/AIDS prevention.

Your consent will enable me Busisiwe Precious Dlamini, to complete my Doctoral thesis.

Your assistance in this regard is highly appreciated.

I .....realise that the information I will provide will form part of Busisiwe Precious Dlamini's research project and I hereby consent to the information being utilised for research purposes.

Signed on.....2005

.....

Signature

APPENDIX 2

OPEN-ENDED INTERVIEW GUIDE FOR FOCUS GROUP

Guiding Questions for Traditional Healers

1. What is your experience in working with HIV/AIDS?
2. What methods do you use to promote health?
3. What methods do you use to prevent illness?
4. How do you perceive your contribution to the fight against HIV/AIDS?
5. Which support is key in ensuring that indigenous health care becomes a mainstream form of health care, as is the current biomedical approach?
6. What problems do you encounter in your work and what could be the solution to your problems?
7. Would you be prepared to share your success stories relating to the treatment of infected people?

QUESTIONNAIRE FOR THE END USER

Conventional/ modern medicine

1. *How long have you know about your positive status?*
2. *When did you begin treatment?*
3. *What type of treatment are you on?*
4. *Would you say the treatment is helpful to you?*
5. *Has being on treatment changed your health status?*

Traditional medicine

6. *Have you ever used traditional methods?*
7. *What types of medicines were you given?*
8. *Are you still using the traditional medicines?*
9. *Would you say the traditional medicines have helped you?*
10. *Why do you say so?*
11. *What would you say are the major differences between the traditional and the modern medicines?*
12. *What do you think are the major difficulties faced by traditional healers?*
13. *What are the major difficulties faced by modern medical doctors?*
14. *Do you think that people can fully depend only on traditional medicine?*
15. *Why do you say that?*

16. *Can people depend entirely on modern medicine?*
17. *Please explain why you say that?*
18. *Between traditional and modern doctors, who do you believe is more effective in treating HIV? Please support your response.*

Nutrition

19. *How important do you think nutrition is in fighting HIV/AIDS?*
20. *What nutritional supplements are you on?*
21. *Would you say they make a difference? Explain.*
22. *Where did you hear about nutrition as an important factor in the treatment of HIV?*
23. *What are the hindrances in using nutrition as part of the treatment?*
24. *In your view, should traditional healing be incorporated with modern healing to treat HIV?*
25. *Why do you say that?*

APPENDIX 3

TRANSCRIPTIONS OF INTERVIEWS WITH TRADITIONAL HEALERS

INTERVIEW 1

Busi: This is an interview with Doctor H and today's date is 15 August 2005. It's in the evening. The time now is 20h00 I am at my practice office at Louis Pasteur Hospital in Pretoria. My name is Busi Dlamini. Good evening Dr H.. I am here to discuss a very important topic with you and get more information from you because I am of an understanding that you have immense knowledge on what I would like to find out.

Dr H.: Yebo, sisi.

B: Yes, thank you. The purpose of this interview here is to establish the level of contribution that you as an indigenous African healer will make or are making in the treatment of HIV and AIDS. What is your experience in working with HIV/ AIDS?

Dr. H: In fact, I am a former long-distance truck driver myself. In fact that is where it all started. The lady I had a relationship with died in 1997. The whole relationship ended in 1995. That was the last time I saw her. Before it all happened, her scalp was dry and her hair was very fluffy. The question I ask myself now is that, is it all the reason why truck drivers used to die? Then we were so ignorant as truck drivers. It is only now that we

are becoming sensitised, especially talks around condoms. All the people whom she had relationships with would show signs and symptoms of being pale before dying.

B. So now what do you associate that with?

Dr H: I think we were all giving each other the illness. You could find that one woman was involved with three of us at the same time. We were all infecting one another. We were actually thinking that somebody was bewitching us in the whole firm, especially us the long-distance truck drivers. They were showing signs and symptoms of abdominal pains and vomiting. They later on died and one could see that they needed water in their bodies. Because I am an indigenous healer, when I started being ill, I started using my herbs. I saw some fluid draining in between my thighs. I used to use diapers. I had painful kidneys and I could not lift my arms. When I continued taking the herbal treatment, I started coughing (showing flu-like symptoms). I had dizziness and headache. However, I felt better afterwards. When people realised I was healed, they started coming for consultation. I was then fired from work in 1999.

B. Was it because you were treating people?

Dr H: No. There was a strike and we pushed the manager out, and then we were all fired as we were accused of being responsible for the riot. Since then I have been assisting the community who have the same symptoms. I used to see at least 20 people per day. Now I have since opened branches as far as Qwaqwa, Kimberly, even Lesotho.

B. Do you think you were HIV + yourself when you fell ill?

Dr. H: No, I was not positive. I was fully blown AIDS.

B. Were you tested and told you were positive?

Dr. H: No, I know I was positive because of the signs and symptoms I was showing, but amazingly after I took my herbs to treat myself I went for the test in 2004 and I tested negative. From 2005 January I give blood to the Blood Bank quarterly and I am blood group O.

B. Do you think they would have told you if you were HIV +?

Dr. H: Yes, I am sure I would have been told, but it does not bother me now because I am negative.

B. What methods do you use to promote health?

Dr. H: The Westernised doctor uses things like injections. I am against that because it makes the children to be wet in the chest and cold on the limbs, and once they are sick it is difficult to help them. I use pure methylated spirits to mix with my herbs because it helps drain the water and dry the chest. However, I use my herbs and give children to drink, to prevent illness. Herbs clean your blood so that it is not easy to be infected with any diseases. Food is also important to promote health. I really do not advocate tablets because they only know the inlet, but they don't know the outlet. With herbs, it is very different because there is both the inlet and the outlet. It is a pity that universities do not listen to us; instead, whatever we say falls on deaf ears.

B. How do you think universities should assist you?

Dr. H: They should join hands with us in doing research so that they can talk about something that they know and not what they think.

B. How do you prevent illness?

Dr. H: I encourage people to drink herbs because I use them myself. As such, I do not even use gloves when I care for the HIV-positive people.

B. Do you think HIV is caused by bad luck, bewitchment or ancestors turning their back on you?

Dr. H: HIV is a pure disease which people need to be taught about and how to behave. There is nothing like bewitchment. This is a country issue. It is unfortunate the media is concerned about celebrities because what we are doing will still help people in hundred years to come.

B. What do you perceive your contribution to be in the fight against HIV/AIDS?

Dr H: .I believe doctors and the media are not supportive to us. They do not come and sit with us to ask questions. It is only one businessman in Lesotho who is very happy with my contribution to his bus company. He says that since I have had my practice in Lesotho he has not buried any of his employees the way he used to.

B. What do you mean?

Dr. H: The thing is that ARVs are good only once; they get saturated in the body, they stop working. They need one to detoxify periodically; once the toxins are out, they can start again using them. If there was support from the media and doctors we would give our herbs to the clients to detoxify, then they take the ARVs again. Unfortunately there isn't much co-operation.

B. Suppose you as an indigenous healer were to join the mainstream health care. How do you think that would be put in place to make sure we fight the pandemic together?

Dr. H: I would like the doctors to check the patients using their Western ways and allow me to check them and treat them accordingly.

B. Tell me, how do you check to see that one is HIV +?

Dr. H: Apart from throwing the bones, I use body heat, and then I am able to tell if the person is HIV or not.

B. Now that you are treating people who are HIV+, do you encounter any problems?

Dr. H: The main problem is these radio doctors who buy airtime and lie on air about medicine that they have. They would show you one bottle of medicine and they say it cures everything. That is nonsense because they have nothing to even help pull somebody who is bedridden up. Doctors turn people away instead of rehydrating them. Sometimes people come and they have no money, but they still need help and there is no way you can turn them away. You have to assist them.
Patients also stay far away from us and it is difficult for us to get there.

B. So would you be happy if there was an office for indigenous healers in hospitals?

Dr. H: Yes, but all we need is not to be discriminated against. We should be treated equally.

B. What do you mean treated equally?

Dr. H: The doctors must realise that we have a very important job just like them, so they do not have to look at us and think that we are useless or we are taking their jobs from them. We know what we are doing. They just need to be educated on who we are and what role we play in all this. Therefore we will be able to reach an understanding.

B. Tell me about your success stories in dealing with HIV and AIDS.

Dr. H: The general of health in the Free State has called me to see one of the clients that I have assisted from last year who was HIV positive. He was weak and coughing. I have assisted that person and now the client tested HIV negative. I am actually not trying to report this to the Department of Health, but what I am saying is that it is very important for Manto to allow us to work with you, the doctors. I really respect her for giving us this opportunity to educate people in what they believe in.

Actually, the client I will be seeing on 25. August 2005. Another thing is that if you tell the clients that they are HIV+ they run away, but if you speak the same language as them they would listen – for instance, to say that they have been bewitched, they give you their undivided attention.

B. Would that not cause friction then?

Dr. H: Not at all, because we have a way of making them think they are on top of things. In fact, they would listen to us. We have a good relationship with our clients; they respect us and we respect back. I am a living example. If I have used the same herbs to cure myself then I will be able to help the next person. This gives one the opportunity to teach people. You see, doctor, people do not need to be certificate educated, but they need to be mentally educated.

,You know I also believe we can cure Ebola if given the necessary support. I am sure we can fight it and win. You see, even with HIV and AIDS we were only worried when it was on the increase, which is why we must fight Ebola now. I need about three doctors to go to Angola with me so that we can fight the Ebola whilst it is still manageable; otherwise it will get out of hand like HIV now.

My last contribution in all this is to ask you to convey this message to the Minister, because it is difficult to find the person who is in high positions, especially in the Department of Health, to be trained in the same

field like doctors and nurses, but they just have clerks who really would not understand what is happening or what is needed for things to succeed..

If you need any information from me, dear, please call me because I think we need more researchers in this topic. My address is PO Box 21569, Poelong, Witsieshoek 9874. My phone number is 083 504 8675.

B. Thank you very much for all your contribution and time, Dr H.

Dr H: Thanks. I hope you get more people who want to do research.

INTERVIEW 2

Busi: This is an interview with Doctor T. of Kloppper. Today's date is 28June 2005. It's in the afternoon. I am at his practice at home, and my name is Busi Dlamini.

Doctor T, good afternoon.

Dr T: Yes, good afternoon.

Busi: Yes, I am here to collect a set of data from you because I am of an understanding that you have immense knowledge on what I would like to find out.

Dr T: Correct.

B: Yes, thank you. The purpose of my study and my visit here is to establish the level of contribution that you as an indigenous African healer will make in or is making in the treatment of HIV and AIDS. And to determine and understand, now that the Minister has said that the traditional healers and our western doctors should work together in the fight against HIV/AIDS, and so as to find out from you what it is that you think should be put in place to make sure that this collaboration or relationship is in such a way that there is smooth running and understanding.

Dr T: Thank you very much. Let me start by saying that AIDS is a newly found disease. It was rather difficult for traditional healers to learn exactly what the AIDS was entailing, until in 1992 I attended a conference in Zimbabwe. Eh, not Zimbabwe but in Zambia, where we spoke about AIDS. And during those days in 1992 it was really not easy to identify people who had AIDS. We tried long time to know much, and we attended workshops as healers to understand what this HIV pandemic really means. And then it was or it is a reality that the disease is there. In our collaboration and talking, attending workshops with medical doctors, we found that this is something that we could not say we could cure. And we needed medical doctors and traditional healers to take part in this. And after seeing patients, at about 1993/94, people were many. We started to know much

about those people; we started to know people who are HIV-positive who have been diagnosed by conventional medicine, people who have been tested. We started to formulate our bones in such a way that they could show us who is positive. And then I started some programmes whereby I used the very same African potato; I used the very same medicine that we used for rush, for fluffy hair, for nutrition. We were not at that stage knowing exactly what is the problem. But we couldn't even say we have cured somebody even though we saw somebody with fluffy hair, coughing and other stuff. These were such time that we had people who are positive.

B: So now you are saying that what you have described that .....

Dr T: We know when the person is positive. I can throw the bones and tell you exactly when someone is positive. And then even the symptoms of people who are HIV/AIDS, we know them very, very well, and then we can cure that, not the HIV itself.

B: Ok.

Dr T: I concur with the President, when he says it is not only the injections, retrovirals and other stuff that can cure a person who is HIV-positive. There are a lot of things like nutrition, because we use lots of garlic, African potato, we use olive oil; we use vegetable and fruits, more

especially vegetables. They are helping us a lot, because we have made some pilot studies where we worked with those things, where we give people these things to eat, and then we need food with starch, garlic and other stuff. So we agree, and I concur with the President and Manto Tshabalala-Msimang that it is not only retrovirals that can cure AIDS. And I don't even encourage people that to rely only on retrovirals. We have a lot of people who were positive, who came to us; we gave them medication and they lived to plus-minus seven years. I have one that was diagnosed HIV-positive in 1997 July and he is still very strong. We are still using the very same methods. And when we say they must go and check their cd4 count, it is still higher that 300 or 400.

B: Ok, so what you are saying now is that you cannot cure HIV but you can cure the symptoms?

Dr T: You can definitely cure the symptoms. There are a lot of people who came to me looking for services, who could not support themselves, who couldn't walk. We gave them a lot of garlic and olive oil, we gave them our medicine, and they are just like yourself. They are still very healthy but they are positive. But they are fit, they can work and you can deceive other people into thinking we are curing AIDS, but no, we have just boosted the immune system.

B: So what would you say your experience is in terms of working with HIV/Aids?

Dr T: Part of it is to see someone who is dying and you know them very, very well. And then the most difficult part of it is that they have this mentality of saying healers can cure them. They came to us 100% sure that they are going to be cured. That is the most difficult part, to know that they don't have the depth of their disease. They mostly don't understand. And when we tell them that death is everywhere and that God is the only one who knows and that they must live their lives to the fullest, they tend to accept.

B: So your relationship with the client/patient is very important.

Dr T: My relationship is very important because they can go out without telling anybody, even their parents. But once I have spoken to them they are able to go home and tell that they are positive. I talk to them and tell them how it is important to know their status. I tell them that I cannot do anything without knowing their status. Another thing is that I tell them that as a healer, I am not allowed to tell someone that he or she is positive. It is only conventional doctors through proper machineries or proper way of detecting that disease to tell one that he is positive. Even though through my bones I can tell that someone is positive, I encourage them to go and test.

B: Someone in background: Are you able to detect that?

Dr T: Yes, simple. Very, very simple. More than that, I saw more that 100. Because every day I see more than ten people. They will start by denying, but when I speak to them very nicely, at the end they will admit.

B: So counselling is important?

Dr T: Very important. Counselling is number one because without counselling you will never achieve anything because that person will die. The other thing that makes us important is that they have our full trust and they want to tell us more than anybody else. Last week somebody came from this village. She just told them that she wants to touch my place and she will get better. Then I went outside; she was in that house. I went to greet that lady; I found that she is normal. By greeting her she told me that, "Today I can tell them that I am dying, but I will die peacefully because I told you; you are the first person to know that they told me that I am positive". I told her that there is still life after death. She laughed and she died the very next Monday. She lived only Sunday and she died on Monday. She was buried on Saturday. And many more. I am the last to be told about these things.

Somebody was saying to me, you must have somebody to counsel you as well. Because every day I see more than ten. Even though they can never tell, I will detect from my bones.

B: You live with that knowledge?

Dr T: No, I try. I try. You know, we are having trainings here. I have had plus-minus 52 trainings. I call people from hospitals, from SANTA, to come and teach them about tuberculosis. We call people from NGOs, hospitals to come and teach them about HIV/AIDS and counselling. Every group has been taught.

B: So now in your practice, what methods do you use to...

Dr T: A lot. You know, I am very much proud because some religions were looking down on us. Some religions were not helping clients. They teach something that is out of this world. The first thing I do is to tell people that I respect every religion. But now we must talk about this disease. Talk about a dying person, somebody who is sick. In doing that, we are not in competition with other people who are medical doctors and other people in the profession, the nurses and the doctors. But nurses and doctors... in the beginning when I wrote a letter and said to the doctor, I

have tried to help this person, I am failing, please use your methodology to ensure that this person is healed, they were saying, Tyale spent the money, the person is dying, now he is giving them to us. Some nurses were saying all sorts of words to the patients, saying that they are wasting time with the traditional healers and other stuff, but now, after the democracy, they even refer people to us and say, in conventional medicine we see this problem this way but do you not see something funny about this person? So now we have a relationship with some of these nurses.

B: So now that mentality of mistrust is lowering with the nurses?

Dr T: It is slowly lowering down, and it is helping quite a lot of people.

B: So if I were to bring a group of ... (inaudible)

Dr T: Firstly they must respect each other. Secondly they must know about *icanzi* (how to take care of themselves sexually), and then drugs, and then drunkenness, toxicants, all toxicants. If they were to refrain from that, they would become a much better community.

B: How do you perceive in general your contribution against the fight against HIV/AIDS?

Dr T: My contribution is quite a lot, because if somebody whom the people trust who is using traditional healing is telling them about HIV and modern disease, they do come together. So they feel I am saying something which is right in referring them to hospitals, gynaecologist. You know, I am not everything, then they understand. In the past a healer would be almost everything. We are fighting that. Let a healer take his own part of work, and where one sees that a person needs conventional medicine, let the person be referred to the doctor where they can be assisted.

B: So in using your .... (Inaudible)

Dr T: Definitely. You know, it was like a joke. Somebody came here with a broken leg. And instead of getting POP [plaster of Paris], he never wanted to go there, until such time that I told that person that you have a broken leg, you need to go and get POP. He then went there and everything was ok, but if maybe I didn't say, he would not have gone there.

B: OK. Now that the Minister says you and the ..... (Inaudible)

Dr T: The relationship is still very much the ... I say thanks to Manto Tshabalala-Msimang. She is a real African. We had our own doctors, our own brothers, who had done this and they were not even agreeing to see

us. But I should think they are a big potion that we can play as healers, and I should say. We are not in competition with the conventional doctors. They are far much better than us in other aspects and we are far better than them in other aspects.

B: So having said that, what form of a relationship do you think you should have with those doctors?

Dr T: We are all patient-inclined, so we should meet at the patient, and then we are not going to dilute our practice. We are not having any clashes with conventional doctors. So let us all be patient-inclined and then we shall succeed.

B: (Inaudible)

Dr T: There are a lot of problems. The first thing is pay. They don't have money because they don't work. We make them pay because we are taking medicine from far away. The powders and other stuff they don't have to pay, but attendance is quite well because I for one see more that 40 clients per day. We are now trying to have a common voice because the Minister has passed a bill; it is waiting for the President to sign it as a law, whereby traditional healers in Nquthu will be the same as the one in Polokwane. We must have the same code of ethics and a code of conduct and then we must be one. Then we must have a database for the all the

healers, so that if someone makes a mistake, they should be called to book.

B: So you need a regulatory body as well?

Dr T: We need a regulatory body. We would like to have that if there is budget, whereby people can get our booklet about healing methods and indigenous system, about what to do when somebody has passed away, they must know how to be cleansed after death, they must know about this thing of... a lot of things, I would say. So that if somebody needs to come to Tyane for cleansing... they must know how to cleanse themselves. They must know that you take sea water, plus this plus this...and get cleansed, because people are having lots of things nowadays. So I think of having those booklets to tell people, and then it will help the community at large who want to know how to be cleansed, how to pray the traditional way at funerals so that even a healer can come to have a short prayer at a funeral. So that when we are burying our loved ones we don't follow the old system that you don't know like *umlendelo*. What we are waiting for, we don't know. So if we do not do that ritual we know exactly what to say to our deceased.

B: Apart from the ones that you have ... (inaudible)

Dr T: A lot of them. Quite a lot. Seemingly you saw a lot of children coming in this morning. We have a crocodile skin. When winter is approaching we cook that and they drink out of that. We have had a thousand drink this month. They come and drink the water boiled in crocodile skin. It prevents coughing and colds. Even now, when you look there, there is a very big pot, and other people come with taxis. They came on Sunday and said: we understand you have a skin of a crocodile. Make us a ritual too for us. From Saturday up to now, we have had more that a thousand people who have come to drink out of that pot. It has been done in the olden days. They are doing it now. You put *serokolo* in the crocodile skin. They will come until the pot is empty.

We are having a programme here we have a class, ladies and gentlemen. We are having those people here and in the morning we start our programme as from four in the morning. They clean the rooms that they are using, they wash and at six o'clock, they are finished cleaning and washing and then they are going to dance. But before that, five o'clock in the morning, they must take their ritual. We call it *lehulo*. After taking that, they can dance for the morning session. They communicate with their ancestors, to get a fresh mind for the day. Then after singing and dancing for about two hours, at about eight o'clock, I am coming now to work, and others who are long here will help me with giving people the medicine. The day has started. Then on Wednesday, they go to dig. There

is a very big lorry; they go to the bushes; they are going to be taught, but they must bring them here so that they can know the medicine in winter and in summer. Thursday they will sit down, and also Friday. Saturday they will see their visitors and other people. Sunday we go and pray for other people. We have a programme here that you can look at. End of the year, we have a celebration ceremony. That is the programme for a year. It means on that day, the leader will be taken home. They are many. I know in March next year where will I be. You see, it is from January 2005 to 2006. It is planned so it makes our work easier. Five o'clock, they are going to take the rituals again. Five in the morning and five in the evening. After five, they will relax; I have got a TV there. See the TV helps to be away from what they are doing, and after seven o'clock, they start with their classes. If it is winter then they start at 6:30. They have their classes for one and a half hour. Then at nine o'clock they are free to sit and watch TV, to discuss people, and then they will start again in the morning at four.

B: Do you ever...

Dr T: We don't allow any sexual intercourse. We don't. If somebody is in love with someone, it is punishable. They are even expelled. Someone in background: so if ... (inaudible). If it is just an affair, they are making.. . (inaudible). Because, if we can know that, instead of building a family, we would be breaking the law. But somebody can marry someone they got trained with. We don't allow them to have sex, but they can have a

relationship; then afterwards, they can go and then get married. It is just for the sake of having law and order, because if we allow that, they will never finish, and then others are marrying. ... (inaudible)... but the danger part of it is that you lose your money.

[The tape has a lot of breaks and disruptions..... as if a tape is being changed.]

INTERVIEW 3

This next part is the focus group interview with a group of traditional healers who were teachers by profession before they received the calling to be traditional healers.

Busi: I would like to ask questions. If you feel like you can add something to what someone is saying, please just go ahead and say anything or add on it. The first question is, I would like to know your experience, in working with HIV/AIDS.

M: ... (Inaudible)

B: You are training but you still work with the people that are HIV. In your organisation what have you seen to date?

M: ... All I know is that there is a lot of people who are affected by the HIV and there is a need for these people to be helped.

F: ..... Yes, and we have seen a lot of them coming here to get treatment from Dr T.. We assist him with these cases. The truth is we see the symptoms go away; once they start taking treatment they improve.

B: So basically what you are saying is you cannot heal the virus but you can heal the symptoms of HIV. What methods do you use to heal these symptoms as traditional healers? We know that there is nutrition, but as indigenous healers what can you use to promote health?

[People speaking in the background.... Inaudible.]

M: We also get basic training on HIV. We know what needs to be done once somebody is diagnosed as being positive. We are told that if we eat fruits and vegetables we will definitely become better.

F: We eat morogo.

B: How do you think traditionally we can deal with HIV/AIDS? Traditionally we have to oblige when the man says no condom, we have to oblige. So what is your role as traditional women in the fight against HIV?

M: If it is my husband and me, and he doesn't want a condom? No, I just have to teach him about HIV and to tell him that if he does not want to use a condom then I cannot have sex with him..... (inaudible).

M: (man – inaudible). A young boy and a young man need to be taught about these things because it is now about preserving our health and not power as it may seem. They also need to stick to one partner, but it is not easy as ..... (inaudible.)

B: But then our fathers and our grandfathers, before them, there were no condoms. So what were they using? Do you know? I mean, they still had sex, but the number of children...

M: Maybe after the child he went and had another woman, I don't know what...(inaudible.)

B: The Minister says that the traditional healers and the medical doctors should work together. In a way, what structures would you like put in place, for this relationship to be smooth sailing?

M: We have to be given offices and we do our thing and they do their thing, as long as there is communication about what is going on I am sure that would be fine. ....

B: Does this mean, there should be no one who should be above the other....? So you are saying there should be that kind of a relationship? Mm. In your work so far, what kind of problems have you encountered?

M: We take them down to the hospitals. That's where the hospitals come in.

B: . (inaudible). You have not been exposed. You haven't dealt with your own patients, so it takes away the last part.

F: I have got problems of people that work and are brainwashed by the government.....and the churches. They make people believe that we do something wrong. Some are telling their people not to come to traditional healers.

B: If I am hearing correctly, you are saying people should be educated about the traditional, indigenous healers, because it does not necessarily mean that if you are a traditional healer you are a witch?

Fe: Yes.

M: Yes.

M: Yes, it is our churches and government who does not teach people the correct things. It is very unfortunate because ... and I believe they should come and ask us what we do. They lack insight and that thing..... (inaudible) if only we can communicate amongst one another. They do not know what we are doing. They just think that we are doing the wrong thing.

B: . ... the same thing. Open lines of communication. And you don't necessarily need to be above the other; you just need in parallel where the other one can easily communicate with you.

M: Yes. What we are saying. Again is .. the bones will never mislead us .... (Interrupted)

B: Oh, coming to that, are you able to see when you throw your bones that this person is HIV-positive? Are they designed in such a way that you can be able to see? And what is it that you can pick up to say that this person is positive?

F: You can see that the person has a disease in the blood but you cannot really say it is HIV or see what their problem is. But you can see that they have something in the blood.

M: ... (inaudible)....

B: So what you are saying to me is that you can see that the person has a disease in the blood. So it can be cancer, it can be AIDS, it can be anything

M: Yes, disease that affects the blood.

B: Oh. And then do you find people confiding in you? That say, "Eh, I have been diagnosed with this" or what is the normal?

M: Actually we have not had patients yet. But some people would tell us because we have a good relation ship with them.... (Inaudible). (*the bell rings in the background).* Now it is time for our activities.

B: Thanks ... thanks a lot.

INTERVIEW 4

Dr S.) (8/5/5)

B: What is your experience in working with HIV/AIDS?

Dr S: As I said to you, HIV is not the disease. There were diseases before which were incurable and deadlier than HIV/AIDS. According to my experience HIV/AIDS is still a disease that is unknown to us. What we see about it are the signs and symptoms which we as natural healers cure; therefore we can't claim that we can cure AIDS. We can heal those symptoms that for sure "we beat them". If somebody could bring HIV/AIDS and put it in front of me, I would be satisfied and say, now I have seen it and I can cure it. We traditional healers cure what we can see. How can I cure something that I don't know, something I don't see?

B: What methods do you use to promote health?

Dr S: There are various ways used to promote health like the modern medicine does, and what we also do as the indigenous health practitioners. Nutrition is the key to health promotion which ensure immune boosters. There are several food types that people take and now are taken for granted, like your peppers, *inkakha* and the rest. We encourage such people to eat correct diet. We only advise our infected people to use as far as possible organic fruits and vegetables. HIV-positive people need to have a special diet, or balance both spiritual and food-wise. During my own research treating these people is not easy, but the diet is very important for them. Personally I will recommend the following:

Garlic, parsley, honey (original), apple cider vinegar.

Hi-vite capsules.

DON'Ts:

If you smoke, cut down.

If you drink, cut down.

Use preventative measures when having sexual intercourse.

B: What methods do you use to prevent illness?

Dr S: Customs, cultures and tradition – i.e. which are guided by our beliefs. Things such as initiation is one of them. There are customs which prevent lots and lots of illnesses. With regards to HIV/AIDS, our people are no more killed by AIDS per se; they are killed by fear. We as healers must talk to the inner person because once the inner person is strong we can cure them by word of mouth, not necessarily food. That is why before you attend to your patient or give him/her medicine you must pray. This is to show the spirit of *ubuntu*. *Ubuntu* philosophy goes a long way, and is a concept of us as a nation. No one can claim to own *ubuntu; ubuntu* belongs to us Africans. In this regard I mean that counselling is also very key in the treatment of HIV/AIDS, or its management for that matter. A person must eat afterwards. How can you cure a person on an empty stomach? `

B: How do you perceive your contribution in the fight against HIV/AIDS?

Dr S: Our diagnosis is holistic. Why? Because we look at the person as a whole and at the same time we counsel that person, meaning spiritually and physically. Our diagnosis also brings together our different spirits, i.e. the spirit of your patient's forefathers and mothers, including God (Qamata) together with (phahla) prayer.

B: Which support is key in ensuring that indigenous health becomes a mainstream form of health care, as is the current biomedical approach?

Dr S: Collaboration - working together. Modern medicine must understand our God-given gift. We need to have our own hospitals like the Chinese do. Our own platform, such as clinics or hospitals where our clients can go to consult us. There is nothing as painful as seeing clients today and not being able to see them tomorrow because we have moved to another area or location.

B: What problems do you encounter in your ,work and what could be the solution to your problem?

Dr S: Lack of empowerment. Government should help in the empowerment of indigenous healers – for instance, the development of the indigenous knowledge systems.

B: Could you share your success stories so far, relating to the treatment of infected people?

Dr S: I have so many ,clients; I can never finish telling you my success stories.

APPENDIX 4

DEFINITION OF TERMS

INDIGENOUS HEALING: This term is used in this context to refer to a healing system that is often regarded as primitive, pre-literature or non-western.

PREVENTION: Interventions used to reduce the incidence of illness to persons with potential risk.

HERBAL TREATMENT: appropriate herbal medicine prepared by indigenous healers which are used to cleanse the individual's body and to strengthen their immune system. These are treatments prepared from plants, roots and or leaves.

PURGATIVES/EMETICS: these are practices of using enemas and herbal teas for purging and vomiting.

SCARIFICATION: This includes scaring, where a healer makes ritual cuts or punctures in patient's skin, and rubs an herbal mixture into the cuts.

INDIGENOUS KNOWLEDGE: the systemic body of knowledge acquired by local people through the accumulation of experiences,

information experiments and intimate understanding of the environment in a given culture.