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FACILITATING RELATIONSHIPS  
BETWEEN AFRICAN TRADITIONAL  
HEALING AND WESTERN MEDICINE IN  
SOUTH AFRICA IN THE TIME OF AIDS: A  
CASE STUDY FROM THE  
WESTERN CAPE

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# Facilitating Relationships between African Traditional Healing and Western Medicine in South Africa in the time of AIDS: A Case Study from the Western Cape

## Abstract

*As the HIV/AIDS epidemic in South Africa matures, the importance of encouraging a more cooperative approach between biomedicine and traditional African healers (TAHs) becomes paramount. This is not solely based on the potential of the additional human resources which might be released by better relationships with traditional healers - biomedical HIV/AIDS interventions themselves could benefit from a better understanding of traditional ideas of health, disease and healing, ideas which could then be appropriately incorporated into the treatment process. This paper offers a portrait of an innovative project based in the Western Cape Province which aims to make a start in improving cross-sectoral relationships. The paper limits its coverage to the initiatory stages of the scheme, and offers unusual insights into both the potential advantages of cooperation, and into some of the, often mundane, pitfalls and obstacles presented by this sort of approach.*

## Introduction

The idea of involving traditional healers in HIV/AIDS interventions in Africa is not new. In many ways, TAHs should make excellent partners for biomedical practitioners involved in HIV/AIDS interventions. They are first and foremost professional healers in their own right. As such, they are accessible, culturally sensitive, affordable, and they speak the language of their clients.<sup>1</sup> The advantages of a serious engagement between the traditional and biomedical paradigms, especially in the time of HIV/AIDS, should by now be self-evident.

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<sup>1</sup> Language here refers not only to the eleven official languages of South Africa, but also to the language of spirit which empowers TAH healing; see Wreford 2005b: Chapter 2.

In South Africa (notably in KwaZulu Natal) several attempts have been made to engage TAHs in cooperation with biomedicine (Abdool Karim 1993; Friedman 1998; Green 1996, 1999; Green *et al* 1995; Leclerc Madlala 2002, Phillips 2006). Yet, as I have rehearsed elsewhere (Wreford 2005a: 15-33), the thrust of these projects, by and large, has been uni-directional, with the focus on medical personnel ‘educating’ the TAHs in the ways of biomedicine. The notion that the instruction might be bi-lateral, that biomedicine has something to learn from traditional African healing - knowledge that could be of benefit in HIV/AIDS (and other) interventions – has rarely, if ever, been seriously addressed (*ibid*). Consequently, TAHs who have been involved with ‘collaborative’ schemes tend to report feelings of disillusionment and disappointment (Green 1994: 180; Leclerc Madlala 2002: 9).

This paper describes an innovatory project, organised and designed by HOPE (HIV Outreach Programme and Education). Run on a relatively small scale, with a budget to match, it constitutes the first of its kind to be attempted in the Western Cape Province of South Africa. The project’s aims are threefold: to encourage bi-sectoral medical collaboration in HIV/AIDS interventions; to avoid potential disruptions to ARV regimens through mistaken prescription by traditional healers; and to persuade more male clients to come forward for HIV testing.<sup>2</sup> The six-week intensive course combined education in biomedical understandings of HIV/AIDS with Voluntary Counselling and Training (VCT). It involved nine *amagqirha* (s. igqirha; Xhosa: traditional healers) (TAHs) and five HOPE-trained Community Health Workers (CHWs). All the participants live and work in five townships around Cape Town.

While the paper limits its coverage to a detailed account of the project, from its initiation, to early stages in the field, the report nonetheless attempts an unusually comprehensive analysis of the scheme. It includes details that may appear at first sight to be peripheral or mundane, but which in fact weigh heavily in the organisation and administration of such projects in Africa, and which, in formal reportage, are too often glossed over or ignored. The paper is structured in six parts with a short conclusion.

## Methodology

The author attended the course for its duration. The methodology combines fieldnote observations and interactions with the participants during the course,

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<sup>2</sup> Men remain reluctant to test for a variety of reasons, including their interpretation of masculinity as being compromised by weak health (e.g. Beck, 2004). A fourth objective, to allow TAHs to carry out sputum-tests for HIV/AIDS awaits a protocol from the Provincial Health Authority.

and afterwards in the field. This documentary evidence is supported by interviews with individuals and small groups, and with anecdotal accounts.

## **Part 1: Background and history**

Estimates of HIV infection across South Africa vary, but the consensus view seems to settle on a figure of 6.2 million people living with the virus. A recent antenatal survey (Thom 2005) revealed other disturbing trends: Not only that the epidemic continues to grow, but also that there is an upward trend of incidence of infection amongst younger women. These depressing statistics underline the fact that prevention messages<sup>3</sup> appear to have had little real impact on behaviour, and that the epidemic is having an especially damaging impact on women in South Africa.

One of the primary difficulties confronting those working in the field lies in the reluctance of people to come forward for testing. A combination of stigma, fear, denial, and a customary unwillingness to talk about sexual relationships or sexual health, together challenge public campaigns intended to encourage testing for HIV/AIDS. This reluctance is particularly noticeable amongst men (Beck 2004).

### **Location**

The Western Cape Province, in which the scheme is set, accounts for 10% of the national population, with over 4.5 million people. Most of the black and coloured population in the province live in townships and informal settlements, especially around Cape Town; already overcrowded and under-resourced, they keep growing.[1] <#\_ftn1> The province has the lowest HIV prevalence in the country, a fact not unconnected to its commitment to provide antiretroviral treatment; for example, the province was the first to implement a HAART programme (in partnership with Medecins Sans Frontieres) in May 2001 (Naimak 2006; Nattrass 2006: 4). Although the highest infection rates continue to be reported from the townships and informal settlements (Naimak 2006: 2-3), anecdotal reports from local clinics suggest that the continuing influx of new residents (most of them from the Eastern Cape), is attributable to the antiretroviral treatment programme and the generally better quality of medical care available in the province.

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<sup>3</sup> Government prevention campaigns, such as they are, favour the ‘ABC’ acronym, ‘Abstain, Be faithful, Condomise’.

## **Government policy, HIV/AIDS and traditional healers<sup>4</sup>**

Despite the gravity of the national situation, the government's policies on HIV/AIDS prevention and treatment have consistently attracted criticism for their deleteriousness and confusion from many quarters (Ashforth 2005: 107-8; Benatar 2001: 364; Natrass 2004: Chap 2; Naidu 2006). Although President Mbeki has more recently preferred to remain silent on his own 'denialist' view of this crucial health issue, the minister of health persists in sending mixed messages. Her advocacy of 'choice' in treatment regimes (Department of Health 2006: 7) is in some sense understandable in a country where TAHs may provide health coverage to more clients than western medicine. Nonetheless while the government pays lip service to the inclusion of traditional healers in its Comprehensive HIV and AIDS Strategy<sup>5</sup>, in reality the TAHs have largely been excluded from local and national HIV/AIDS interventions (Leclerc-Madlala 2002: 1).

The minister's promotion of a variety of alternative remedies (often incorrectly labelled as 'traditional'), must be read alongside her stance on ARVs, which if not actually denialist, certainly tends in that direction, and serves only to further confuse the public. The roll-out of ARVs has been so painfully slow and inadequate, that it would almost appear as though those infected with the HI virus, rather than choosing, are actually being forced to adopt other approaches to treatment (Lederer 2006; Natrass 2005). Such obfuscation leaves the door open for opportunists to make claims of herbal 'cures' for the disease, claims which in turn further aggravate bi-sectoral medical relationships (Beresford 2006; Herman 2006).

### **Alienating allies**

At first sight it might seem that the government's 'holistic' stance on HIV/AIDS treatment is full of promise for traditional healers, but it is also fraught with potential hazards. Obviously the healers appreciate the minister's interest in 'traditional' remedies, but in her enthusiasm she has also embraced some dubious, even dangerous allies. Not least of these (especially in the Western Cape) is the Rath Foundation, which, despite disclaimers by scientific institutions, not only insists that its vitamin prescriptions can 'cure' HIV/AIDS, but encourages patients to abandon adherence to ARVs (Geffen 2005). Perhaps

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<sup>4</sup> For coverage of legislative and other issues related to government strategies on TAH, see Ashforth 2005; Wreford 2005b: Chapter 3.

<sup>5</sup> The government rather poetically cites TAH as one of the 'Pillars' of its 'Comprehensive Strategy', although references to TAH in the document are few and far between and lack substance (DOH 2006).

unaware of the risks (and boosted by the administration's support), some groups of TAHs have actually espoused Rath's position under the collective, but misleading banner, of the defence of 'traditional' practice. Rath has been particularly active in the Western Cape's largest black township of Khayelitsha (*ibid*; TAC 2005; Thom 2005). Coincidentally, Rath's most vociferous critics, and long time advocates of ARVs, the Treatment Action Campaign (TAC), are also based in the Province. Rath's activities have caused a storm of protest, and costly legal actions have been set in place by the TAC and biomedical supporters to prohibit Rath's 'experiments'.

Under these circumstances, the support of some traditional healers for Rath is doubly unfortunate. Not only does it alienate potential allies in the fight to curtail the spread of HIV/AIDS, but it also provides ammunition for those in the biomedical fraternity who are content to dismiss the denialists as typical of traditional practitioners whom they characterise as charlatans, rogues or 'witchdoctors'. Thus the biomedical and traditional paradigms, instead of being reciprocally engaged in interventions against the epidemic, operate separately and often acrimoniously, in a condition of mutual alienation rather than cooperation.

## **Part 2: Building trust - HOPE's early initiatives**

It was against this background that the HOPE project was initiated. HOPE recognised that the TAHs could play an important part in the fight against HIV/AIDS, and as part of its general outreach policy made overtures to traditional healers in the Province.<sup>6</sup>

These early contacts led to a series of three meetings, held between December 2003 and March 2004, at Tygerberg Hospital, with the approval of the hospital administration. The purpose of these sessions was gradually to build up trust between western-trained medical professionals and TAHs, in the context of HIV/AIDS. The meetings, attended by TAHs and medical personnel adopted the familiar 'educative' position of most similar interventions. Medical doctors and other staff instructed the healers on their approaches to the disease, to opportunistic infections, possibilities of treatment, and associated material including the importance of hygiene, the prohibition on the re-use of

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<sup>6</sup> Elsewhere in SA, notably in KwaZulu Natal, several attempts have been made to facilitate cooperation between TAHs and biomedicine see Abdool Karim 1993; Friedman 1998; Green 1996, 1999; Green *et al* 1995; Leclerc Madlala 2002; Phillips 2006.

razorblades<sup>7</sup> etc. Unusually however, at the final meeting the TAHs presented their views on HIV/AIDS and treatment (some of which were quite contentious (Wreford 2005b: Chap 5, Part 2)). Despite these difficulties, HOPE was sufficiently encouraged to prepare the ground for an innovatory pilot project. After lengthy negotiations, in July 2005, the Provincial administration finally gave verbal approval to the scheme, which was to become known as 'Bridging Culture - Introducing Partnership'. The project commenced in October 2005.

## The Pilot Project - Aims and Objectives

The scheme set out to achieve three specific aims: First, to encourage collaboration between western medical personnel and TAHs in HIV/AIDS interventions in the Province through 'an official referral system between TAHs and Primary Health Care Facilities' (Hippler *et al* 2006); second, to avoid potential disruptions to patients on ARV regimens through the mistaken prescription by traditional healers of harsh cleansing remedies; third, to persuade more male clients to come forward for HIV testing.<sup>8</sup>

In initiating the project, HOPE commendably eschewed the limitations of the more educative route chosen for similar projects elsewhere (Leclerc-Madlala 2002: 7). HOPE opted instead to encourage the participation of TAHs - still providing education about HIV/AIDS - by offering the new skill of HIV/AIDS counselling. A second important innovation of the project, and one that built on HOPE's community outreach efforts, was the inclusion in the project of five Community Health Workers. Employed and trained by HOPE, these five were to serve as the clinic contacts for the TAHs, to whom the TAHs would refer clients for testing, and from whom clients would be referred back to the TAHs.<sup>9</sup>

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<sup>7</sup> In the traditional practice of *ukukaphula*, medicines are inserted into small incisions made in the skin; customarily these cuts were made with thorns or porcupine quills, but contemporary practitioners generally prefer razor blades. The spread of some fever diseases e.g. Ebola has been traced to the mistaken re-use of syringes by medical personnel (Garret 2001: Chap 2), and it has been alleged that the re-use of razor blades might have been a factor in the spread of HIV (Jolles 2004), although there is no verification of this.

<sup>8</sup> Anecdotal reports from clinic staff and CHWs report that men are particularly reluctant to take an HIV test. Women form the majority coming forward for VCT and testing. See also Beck 2004.

<sup>9</sup> The lack of cross-referral, even after training schemes involving TAHs, has been noted as a continual source of frustration by the TAHs involved (see for example Leclerc-Madlala 2002: 16-17).

## Funding the scheme

All HOPE's initiatives are funded by private donations sourced in Europe and South Africa. Sponsorship for this scheme was provided by Deutsche AIDS Stiftung, MTU PTY LTD, and the Round Table Germany.

## Part 3: Portraits – *amagqirha* and Community Health Workers

The nine *amagqirha* chosen to participate in the project<sup>10</sup> all live in informal settlements or townships in the Western Cape Province, in which HOPE was already operating. The most distant settlement of Mbekweni is sited about 50km to the north east of Cape Town and sits on the outskirts of the town of Paarl in a wealthy wine-producing area. It is home to two healers. Three more live on the outskirts of Kraaifontein, a few kilometres from Paarl, one in Wallacedene and two more in the adjacent Bloekombos. Mfuleni, where two healers have their homes, lies to the south east of Cape Town some 5km from the previously 'coloured' township of Delft South, where the remaining two *amagqirha* live. None of the participating *amagqirha* possesses or has access to private transport. All depend on the public bus and train services, or private taxi routes<sup>11</sup> to get them to and from Tygerberg Hospital, located to the west of the suburb of Bellville in the northwest of Cape Town, where the course was held.

All of the participating *amagqirha* are female. The oldest is 57 years, and the youngest 33. Three are married, living with their husbands, the remainder are now separated or divorced. Most have children, and several have grandchildren. All were born in the Eastern Cape (formally Transkei), and moved to the Western Cape for work. At school, fewer than half of the healers obtained higher than Grade 5. One participant, also the only fluent English speaker, achieved Matric level. IsiXhosa is the first language for all, but the majority also speak Afrikaans, and two speak other South African languages. Of the nine, six *amagqirha* are fully graduated; one graduated a few months after the end of the

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<sup>10</sup> Dr Sobantu Phillip Kubukeli, an active participant in HOPE's work with TAHs for the past two years, was instrumental in the selection of the *amagqirha*. He is a leading member of the Western Cape Traditional and Spiritual Healers' Association, and in this role was known to all of the participants before the scheme commenced.

<sup>11</sup> Combi vans provide an alternative to public transport for most black South Africans. They follow main road routes but will divert to drop passengers at preferred destinations.

course, and two are yet to celebrate their *goduswa* (lit. 'coming home' the graduation ceremony).<sup>12</sup>

## **Amagqirha housing**

The majority of the *amagqirha* live in 'formal' government housing with at least one brick built structure; added rooms provide accommodation for family and friends. Sited in these official housing areas, water, electricity and sewerage are available, and most access roads are tarred.

Three *amagqirha* live in 'shacks', ramshackle self-built structures, consisting of single rooms of a timber frame with various sheeting materials for walls and roof, and a dirt floor often covered with cheap lino or carpet. Swathes of such 'informal' accommodations can be found in all the townships of South Africa. While many shacks are sited in the backyards of 'formal' homes, haphazard developments spread outwards. Few of these informal sites have proper access to services; taps are communal and electricity makeshift. Sanitation is problematic. Roads are unmade and often comprise sandy tracks just a few metres wide.

## **Making an *amagqirha* living**

All the healers aspire to depend on their *amagqirha* sessions for income, but in contemporary South Africa the work of traditional healing has not proved lucrative for any of them. Several report having to accept temporary periods of work in local factories, or as domestic workers. One is trying to establish a crèche in her home; another supplements her income with a small kiosk in her front yard selling sweets and cigarettes. Those healers who are married report receiving help from their husbands when the latter are working; those caring for children or grandchildren also do their best to access Foster Care or Child Support Grants. None of the participants is yet eligible for a State Pension. Two of the *amagqirha* have *thwasa* (initiates to *amagqirha*) who can be expected to offer household support throughout their training.

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<sup>12</sup> The *goduswa* ritual is the longest of the training, and requires considerable funds to organise. For contemporary *thwasa* the struggle to gather these monies together is more of a constraint to their graduating than any questions relating to their ability to diagnose. For full coverage of this and other rituals see Wreford 2005b Chapters 4-6.

## Knowledge of HIV/AIDS

One of the *amagqirha* had been on one of HOPE's earlier educative sessions held at Tygerberg Hospital, and five had previous experience with HIV/AIDS educative programmes organised by other NGOs. Two *amagqirha* have had arguably more effective direct experience of HIV/AIDS in their personal lives. One has lost two children to the disease, and now brings up two grandchildren one of whom is on ARV treatment. The other has become familiar with the illness through observing her clients, and accompanying them through the difficult terrain of testing and disclosure.<sup>13</sup>

## Partners in health - the HOPE Community Health Workers

All of the five Community Health Workers (CHWs) chosen by HOPE to attend the *izangoma* project course, live in the townships where the *amagqirha* practice, and work in clinics or day hospitals serving these areas. Four are women, and one is male; their ages range from 26 to 46 years. Three are married and live with husbands and children; two (including the man) are single and presently childless. One is married to an *igqirha* who practises from her home. Four were born in the Eastern Cape and have lived in the Western Cape for an average of twelve years; one lives in the 'coloured community' of Delft South. All are competent English speakers. One cites Afrikaans as her first language, the remainder, isiXhosa. Prior to their employment by HOPE most of these workers had experienced unpaid community work through a variety of charitable organisations or NGOs. They now receive monthly salaries from HOPE, as well as uniforms and opportunities for additional training. None of the CHWs has access to their own private transport and with public transport at a premium, questions of funding for 'bread and butter' responsibilities such as home visits tend to be contentious.

## Training CHWs

The CHWs have all reached at least Grade 9. One has a Bachelor's Degree with the University of the Western Cape. On appointment to HOPE they receive training and regular bi-monthly sessions held at Tygerberg Hospital. These meetings also provide an opportunity to share day-to-day problems, frustrations

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<sup>13</sup> In South Africa, access to ARVs, when they are available at all, is not considered until the client has a CD4 count of less than 200, by which time they are considered to be suffering from 'full-blown' AIDS, and are generally very ill indeed.

and concerns. Often these meetings develop individual stories and anecdotes into issues related to the bigger picture of HOPE's community involvement.

## **Being CHWs**

What are the HOPE Community Health Workers' main roles? Their biggest responsibility is to encourage, educate, advise and support members of their community who are, unwittingly or knowingly, at risk of HIV infection. They are expected, somewhat unrealistically, to be on call, at all times. Their support roles include VCT sessions with clients considering testing for HIV/AIDS; advising and supporting clients who present with STIs, TB and other opportunistic infections; referring clients through the system for appropriate treatment, and following up on these and new clients with home visits.

The CHWs should relate and refer to the social workers in the clinics. The depressing reality of health provision in these outlying townships however, is that social work posts (and others such as pharmacists and even doctors), may go unfilled, often for long periods. What is more, most of the clinics in this study lack a designated room for counselling; CHWs tell of sessions held in the less than ideal environments of 'the sluice room' and 'in corridors when no one is passing'.

With regards to HOPE's outreach programmes, the CHWs are also exhorted to educate their communities by helping to set up educative sessions to sensitise people to, for example, the causes of HIV, STIs and other opportunistic infections, their treatment etc. For those living with the disease the CHWs have been instrumental in establishing support groups - for example, for people taking ARVs - both for children and for adults. Several have helped to develop other enterprises; Bloekombos, Wallacedene and Mbekweni for instance, have community gardens with produce grown by the community and used to boost the diets of people living with the HI virus or AIDS.

Nonetheless, Community Health Workers, despite their vital and unique community knowledge<sup>14</sup> still tend to be viewed by western-trained medical personnel as the least important of the clinic staff. It is easy for them to find themselves diverted from their HOPE duties by bureaucratic tasks required by the clinic systems.

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<sup>14</sup> HOPE is confident that many of their CHWs, due to constantly updated training, actually possess more current knowledge about treatments for HIV, and the associated problems of TB and STIs than many of their medical colleagues.

## Working in the clinics

It is rare to visit any one of the clinics under consideration in this study and not to discover lengthy queues, or long lines of people sitting, waiting patiently for attention from a nurse, doctor or CHW. Patients and staff mill around in corridors, clutching folders whose colour indicates the stage or style of treatment. People wander outside to take a forbidden cigarette; new patients arrive in a steady stream. Given the shortage of staff which plagues the entire Public Health Service in South Africa, a visitor may easily feel overwhelmed by the apparent disparity between numbers of people seeking treatment and personnel available to help them. It is not difficult to imagine how demoralising actually working in such an environment may be.

## Part 4: Staying the course - the first six weeks

The HOPE course was held at Tygerberg Hospital and ran over six weeks, for five full days each week. Attendance was compulsory. Given the early starts, and their distance from Tygerberg, participating *amagqirha* were put up at a local hotel during the week. Taxi transportation was provided to and from the hotel to the hospital venue every day. The *amagqirha* returned home for the weekends, and their transport costs for these journeys were covered by HOPE. To further encourage turnout, graduation certificates were offered only to those whose attendance was certified by a register signed daily by all participants.

All the course sessions (with the exception of 'role-plays' during the counselling module) were presented in English. The majority of the sessions were held in a 'classroom' setting; where possible however, these layouts were re-organised to feel less formal.

## The opening day - introducing amagqirha practice

Reflecting participants' feedback from previous sessions with traditional healers, HOPE arranged an *inthlombe* (a gathering of *amagqirha*) on the first day of the official course. This had three functions. First, and most importantly, it paid respect to *amagqirha* practice: The *inthlombe* featured a *xhentsa* (dance) in which the *amagqirha* (and some CHWs and other staff) participated, the burning of *imphepho* (*Helichryssum* - the herb used to cleanse such events and draw in the agency of the ancestors), the stirring of *ubulawu* (a herbal mixture with a heady froth which traditionally accompanies all *amagqirha* ritual occasions), and declamations to the ancestors to invite their support of the course and the participants. Second, it allowed time for the *amagqirha* to gather from their

various townships. Finally, it exposed the western-trained medical staff and visiting dignitaries (some perhaps, for the first time) to the importance of such rituals to *amagqirha* practice.<sup>15</sup>

## Course structure and content

The main body of the course was divided into three sections, with presentations supported by paper documentation, slides and IT techniques. The first section, which occupied the first four days, introduced the *amagqirha* (and served to remind the CHWs) of current biomedical understandings of HIV/AIDS, STIs and other opportunistic infections, and went on to describe the action, prescription and administration of antiretrovirals (ARVs). The presenters emphasised the necessity of treatment adherence for ARV regimens; similarly, they stressed the potential risk of disruption or negation of ARV efficacy in the administration of herbal remedies, especially through enema or emetic.<sup>16</sup> Towards the end of the week associated issues such as compliance and the role of counselling were briefly outlined. The sessions were presented by medical doctors working in the HIV/AIDS field at Tygerberg Hospital, together with associated health professionals from the Western Cape Provincial Health Authority.

## The counselling component

The following four weeks comprised a Voluntary Counselling and Testing module, organised and run by ATTIC (Western Cape AIDS Training Information and Counselling Centre). Three ATTIC facilitators were in attendance, two full-time employees and one consultant. All three were Xhosa speakers, although all the documentation was reproduced in English. The course comprised a mixture of formal 'blackboard' presentations, interactive sessions in which smaller groups were encouraged to discuss particular subjects, individual self-exploration activities such as collage-making, writing and painting, and, increasingly after the second week, role-play. Topics covered familiar VCT ground including orientation, risk assessment, prevention (the emphasis being on the government's behaviour-change message of 'ABC' (Abstain, Be faithful, Condomise)), test-decision and test result counselling, negotiation of a risk reduction plan, partner disclosure, support, referrals, and medical follow-up.

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<sup>15</sup> For detailed coverage of these and other ceremonies and practices see Wreford 2005b Chapters 4-6.

<sup>16</sup> The question of contraindication between ARVs and traditional herbal remedies remains controversial (Mills *et al* 2005). However, medical doctors and TAHs alike increasingly seem to accept that for those with AIDS it is better to adhere to one treatment route.

During role-play, the participants were divided into three groups, each supported by one ATTIC member, working in separate rooms. In addition to the protocols outlined above, the role-play practice focused on other counselling roles involved with PMTCT (Prevention of Mother To Child Transmission), grief and bereavement, depression and suicide, and counselling for adolescents and children. Role-plays typically involved one participant acting as 'patient', the other as 'counsellor', while the remainder of the group observed and gave feedback. At the end of the four weeks, individual assessments, based on ATTIC protocols, were produced for each participant. Time was allowed in the groups for self-reflection and self-expression.<sup>17</sup>

In the final week the course had been planned to revert to more formal presentations by HOPE staff and additional Tygerberg medical personnel to cover associated subjects including ethics, referral forms and procedures, clinic structure and organisation, and HIV/AIDS policy in the Western Cape Province. The *amagqirha* were trained to use referral forms which were to be completed for each client who had been counselled and volunteered for testing.<sup>18</sup> Unforeseen problems however, necessitated some changes, and opportunities appeared for some *impromptu* sessions such as organising support groups (for VCT counsellors *and* for patients), a 'play' session to test the TAHs understanding of their new knowledge, witchcraft and HIV/AIDS,<sup>19</sup> and a feedback session to which all the participants were encouraged to contribute.

## Participants' feedback

From observation of the traditional healers and CHWs during the programme and from interviews carried out afterwards, it is clear that in general all the participants enjoyed and valued the course. Their perceptions were shrewd and prosaic by turn, but were often insightful and even poignant.

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<sup>17</sup> Nonetheless, the personal nature of the counselling often created stress. Early in the process I was amused to find several *amagqirha* sequestered in the tiny WC. They were sharing snuff, and announced that it was their way of relieving the tension. As the course went on the healers became more public about their consumption of the narcotic.

<sup>18</sup> The forms were to be received by the CHWs at the clinics as evidence of a referral from a TAH. When appropriate, they were to be re-used to refer the client back to the TAH for further counselling or treatment.

<sup>19</sup> In Africa, and elsewhere, witchcraft has been associated in the popular mind with HIV/AIDS causation. See Ashforth 2002; Farmer 1990; Wreford 2005b and 2005c.

## **`We want to get the knowledge!'**

One of the most obvious (and easily overlooked) benefits perceived by the *amagqirha* was simply, the choice of venue. As they saw it, their daily appearance at Tygerberg Hospital served to demonstrate to western-trained medical staff their dedication to extending their healing skills, in this case by engaging with biomedical understandings of HIV/AIDS. One healer for example, acknowledged her limitations faced with `this new disease of HIV/AIDS' when she spoke of `not knowing how to help our people. The only thing we knew was our own traditions.' In another instance, when asked to state her personal goal for the course, one practitioner noted simply that she required `more knowledge'. This objective was shared by all the *amagqirha* as shown by an incident in the very first week. A presentation of the symptoms of STIs included some particularly graphic slides, for which the presenter apologised, apparently appreciating that she might have offended her audience. The response of the *amagqirha*, however stoic, was also reassuring:

`We want to get the knowledge so there's nothing to worry about!'

Similar responses were reported to sessions on the use of condoms. The *amagqirha*, though individually squeamish, were nonetheless anxious to understand the correct use the sheath, known as `a raincoat for the grandfather! (penis)'. This said, in conversations afterwards, few of the healers thought that male condoms were the answer. The likelihood of women negotiating for safer sex seemed highly improbable: `a wife who suggested using condoms will attract suspicion that *she* is being unfaithful', said one *igqirha*.

## **Bridging the communication gap**

Once the counselling section of the course commenced, the healers' aspirations to demonstrate the benefits of collaboration to their biomedical counterparts appeared.<sup>20</sup> Previous experience in this regard had not been hopeful. Without exception, asked about their historical relationships with medical doctors, the *amagqirha* responded that there was very little, if any, connection. One put it quite bluntly: `there's still a lack of relationship. No communication.' Traditional practitioners throughout Africa have long sought to change this static situation (see for example Anderson and Kaleeba 2002) although largely without success (Leclerc-Madlala 2002: 4). Nonetheless one *igqirha*'s goal for the course was `to be able to explain to medical doctors and staff about traditional healing practice'.

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<sup>20</sup> One effect of the *amagqirha*'s presence in the hospital (which did not escape their amused notice) was that the demeanour of this vibrant and unusually voluble group, attracted the curiosity of medical staff and patients alike.

The participating *amagqirha* appeared to appreciate the group's role as pioneers in this struggle in the Western Cape. A remark taken from the final week illustrates an understanding of this, and an acknowledgement of the long-term benefit of their involvement: 'All in all, I am sure you will repeat this with other *amagqirha*. People must see from our example.' The HOPE staff took pains to emphasise this developmental role, one reminding the *amagqirha* how far they had come: 'A few years back *sangoma* (Zulu: equivalent of *amagqirha*) weren't even allowed in this hospital - you've opened the gate!'

By the end of the programme the healers could wholeheartedly appreciate the importance of what they had learned and the fact that the doctors were at last beginning to talk to them:<sup>21</sup>

'We hear about HIV but they didn't try to show us how it enters the body. It was very dark for us.'

But this learning had not come easily, and further observations from the final week's feedback session demonstrate the sometimes emotional consequences of the course experience, especially in the confrontation with old fears.

In part, this was just a question of grappling with new language. Describing the first week's submersion in biomedical understandings of HIV/AIDS for example, one healer talked of being made 'dizzy' by new medical words and ideas, while for another it felt 'like being in a black room'. Even from my position as participant and academic observer, the course content of this first week was especially dense, the unfamiliar medical language difficult to assimilate, and the presentation sometimes dry. This was perhaps an inevitable consequence of the need to compress so much information into five days, but it also meant that there was rarely adequate time for questions.<sup>22</sup> My observations of the *amagqirha* suggest that by the end of each session they were simply too tired to extend the debate.

Especially at the beginning, the CHWs meanwhile, clearly relished opportunities to demonstrate their superior knowledge of English and HIV/AIDS to the *amagqirha*. Thus each CHW took turns to translate from English into isiXhosa (and occasionally in reverse). Nonetheless, although the traditional healers struggled with the need for a rapid intake of language and ideas, 'the language

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<sup>21</sup> It should be emphasised however, that even in provinces of SA where similar projects have been carried out, the pattern of communication between medical personnel and TAHs continues to be one-way, with the TAHs expected to change according to biomedicine's diktat (see for example Leclerc-Madlala 2002).

<sup>22</sup> Furthermore, throughout these sessions the *amagqirha* industriously wrote out the contents of the slides presented to them; this concentration on their notes made it difficult for them to formulate questions.

of medicine' also presented a challenge to the CHWs. As one put it, 'it was difficult *even for us* because the doctors talk as though they talk to other doctors.'

In some instances the entire process was deeply personal. Asked for her insight, a traditional practitioner described with humour and poesy her feelings. When she had first arrived she was, as she put it, 'in an island, I didn't know where I was, I just came. I was so afraid.' Invited to sign the 'blue paper' (a statement of intent signed on Day One by all the participants) she joked: 'I said to myself I'm going straight to jail!' Yet by the second week she found the language of the doctors are 'like singing, because I know nothing'. But there were also doubts redolent of South Africa's apartheid history, and historic differentiations based on colour, race, culture and class. One *igqirha* for example said simply 'I didn't know what the course would do to me and how the facilitators would take me,' and a CHW reflected this when she remarked 'we are so lucky! Despite this time of apartheid we find people who treat us like we are all the same.' Nonetheless it was apparent that the customary boundaries were often still in operation. Thus for example, especially early on, the CHWs and traditional healers asserted their difference by sitting in separate groups.

## **Counselling one, counselling all**

This situation changed with the counselling section of the programme,<sup>23</sup> as the facilitators sensibly insisted on more representative groups. The four-week counselling practice was for all an intensely private, and at the same time very public experience, and was immensely challenging for the whole group. One CHW seemed to speak for all when he remarked that 'the first week was very difficult for all of us. We were all crying. But we became strong as we understood ourselves.' A second CHW recognised that 'now I've got a skill I didn't know about' while another appreciated the 'repeated sessions to help us get it right,' a sentiment echoed by a simple statement from her colleague: 'I know what I'm doing - I'm not afraid now.' The TAHs' appreciation was equally sincere, perhaps best expressed by this heartfelt insight:

'Everything was clearer in my eyes. This is what I've been looking for. You must know what you want to do for the people.'

But the counselling training served another purpose, again acknowledged by everyone. It was a significant factor in the constructing of new relationships between the CHWs and TAHs. For instance, by the end of the course both *amagqirha* and CHWs had come to recognise the very positive benefit of the

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<sup>23</sup> For a description of the counselling module see Part 4 of this paper.

counselling work (notably the role-play) in overcoming their mutual suspicions. One *igqirha* appreciated the new collectivity shared by the whole group as a result of their counselling training: 'it was strange. It was as though we all came from one home. If one has a problem we recognise it and try to help.' Similarly, a CHW highlighted the importance of the counselling in 'understanding [the] differences between us,' and noted that despite this 'we managed to work together.' Notions of family often served as a symbol of this new togetherness. One CHW for example, compared the *amagqirha* to 'our mothers', while in contrast, a healer said of the CHWs: 'All five, they showed us love and they try to help us when we don't understand something. They treated us like their children even though we are older than them!' Continuing this family theme, a healer noted that 'the CHWs are like our brothers and sisters in the same boat', while another merely suggested that 'we [*amagqirha* and CHWs] have no problems. We are like one group'. Still another made a lyrical assessment of the value of these new connections:

'I would like to praise the HOPE CHWs to help us to understand everything. Without them we'd have been in a deep, dark forest.'

This was by no means a straightforward process, however, and the CHWs in particular brought with them their own prejudices about TAHs, some of them extremely personal. For their part, the healers were well aware of the difficulties of maintaining these enhanced relationships in the 'real' world. One cautioned against complacency, and pointedly offered this advice to the CHW working in her township:

'We are going to the same community. She must try by all means to work with us - we just put our trust in her. We will go to her for advice with things we don't know.'

Another exhorted all the CHWs to 'continue supporting and respecting [the *amagqirha*] so that we can work together in the community'.

### **'They know exactly now....'**

Some benefits were particular to each group of participants. For the CHWs, not least of the perceived benefits of the course was a renewed confidence in the work of the *amagqirha*. By the end of the course the CHWs seemed to have shed their doubts and fears about the healers' practice, and could more easily embrace their new colleagues. One conversation taken from an interview with all the CHWs, serves as an example of the whole:

CHW: For myself, I think that it was a good idea for us to work together [murmurs of agreement from others] with the traditional healers, because you

know, before, when we were not working with them, we were just wondering OK we know we are giving this client this medication, and we know on the other side she's going to go to the *sangoma*, and the way the western medication for the doctors are working compared to the traditional healers - it's totally different - but now we know that the traditional healers, where they see that they can change their - what can I call it? Actions - like instead of cleansing what they can put instead you know. They know exactly now if I'm cleansing somebody who may I cleanse...

T: Or *how*?

C: Or how may I cleanse. And which time, you know they know exactly now, OK I can't cleanse somebody who's on ARVs - I can't give this now...And we are also happy about that.

## Dealing with professional jealousies

The healers (who, unlike the CHWs, rely on their clients for income) planned for some very practical, work-related benefits from the course. Most of the healers mentioned that they hoped that their client base would increase after the course. They reasoned that the graduation certificates that would certify their new skills would enhance their status within their communities, and encourage client visits.<sup>24</sup> This workaday objective was however, often accompanied with apprehension: The TAHs' ambitions for more business were often announced in parenthesis to references to the 'jealousy' of other healers who had *not* been chosen for the project, and exposed an acute awareness of the reality of envy in cash-strapped communities.<sup>25</sup>

Whilst this did not blunt the healers' zeal, it did give them cause for concern. One *igqirha*, for example, using a mixture of Christian and traditional imagery exclaimed 'I'm afraid that the light can be blown out by evil spirits. But we have oil in our lamps - keep them alight!' The same healer later returned to her interrogation by colleagues not on the course. She described their scoffing remarks - 'you can't be social workers! Where did you get this training? How did you afford this?' - and she rather gloomily predicted that rival healers would 'speak bad things about me.' This anxiety was echoed by another healer who was 'expecting difficulty.' Interestingly, the issue of professional jealousy was appreciated by the CHWs. One contributed 'We know there is jealousy and envy

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<sup>24</sup> As discussion in the latter part of this paper makes clear, this remained their aspiration even after any immediate financial benefit was curtailed by their agreement to a fixed (and very low) charge for the VCT.

<sup>25</sup> Witchcraft as a symptom of social envy is a popular point of reference in South Africa. It also comes into play in the explanation of HIV/AIDS. See Ashcroft 2005; Wreford 2005b Chapter 8; 2005c.

about why we are chosen and the same with the traditional healers,' a remark which suggests that future courses should eventually take in all HOPE CHWs.

## **Important details, Simple delights**

Yet some benefits simply brought delight to the traditional healers as they enjoyed (often for the first time) comforts generally taken for granted by worldly westerners. For an example, none of the healers had ever before experienced a stay in hotel accommodation (however basic), and the joy of spending their nights alone, untroubled by family or children was astonishingly powerful. One participant, having referred to this novelty, volunteered another. To gales of laughter and appreciation she said 'I am worried I'm leaving the hotel now because I've never been so fat!' Though there were occasional complaints, the regular supply of food (sandwiches, a cooked lunch and take-away supper were daily provided by HOPE) was sufficiently novel as to be mentioned by several healers, and the CHWs. One healer poignantly emphasised the connection she had evinced between this 'food for our stomachs' and the esteem in which HOPE held the *amagqirha*:

We are very grateful we have a lunch box. We can open it and we are very important people and we didn't know that.

The reactions to these 'luxuries', by all the participants, of course, also reflects the perpetuation of social difference, and the reality of poverty in contemporary peri-urban South Africa.

## **Giving knowledge, stimulating curiosity**

Overall, the TAHs seemed satisfied that their major ambition for the course - new knowledge about HIV/AIDS and treatment - had been achieved. One healer interviewed after the course showed that the new information had wet her appetite for more:

I always ask myself about how an unborn child gets infected while she's inside the womb, but now I have much more knowledge and it was very interesting and very exciting. I've become more and more curious!

She cited 'her book' (participants were given a ring binder in which to keep the course material) as a resource, something she could 'read more and more. I've got better knowledge now.' Another accepted some difficulties - 'it was of course a bit difficult' - but emphasised that 'it also added to the little knowledge that I had and gave me another field, and more experience - which was also

good for my English!' A third traditional healer succinctly stated the benefits for her:

For me, the main part that I liked is to learn more about the diseases - HIV and AIDS, TB, STIs and so on - but it was when we got deeper information about those illnesses. We knew about them, but we didn't know much. So the additional information was very good.

A final recommendation came from a different, but influential source. Two weeks after the end of the course, in a community hall in Khayelitsha township, *amagqirha* from around the Western Cape, as well as a substantial number of members of the public, gathered *en masse* to offer an exhilarating welcome to the course graduates. HOPE funded this event. The healers who attended were by and large co-ordinated by Dr Kubukeli, and could thus be said to be mainly supportive of his efforts to bring biomedical and traditional practitioners together. As is always the case with such gatherings, the knowledge that free food would be available acted as a secondary inducement, but the very genuine enthusiasm expressed by the crowds for the graduating healers boosted the confidence of all those who had been involved. The enthusiastic participation of so many healers suggests that there is definite potential in an extension of the project.<sup>26</sup>

On this optimistic note Part 5 will now develop some of the advantages of collaborative medical efforts as recognised by the course participants, in particular the counselling component.

## **Part 5: Breaking the mould - Discussion of the HOPE approach**

How does the HOPE project differ from other similar schemes, and what can it tell us about the potential advantages of a committed and two-way collaboration between traditional healers and biomedicine in HIV/AIDS interventions?

Two factors distinguish the HOPE project from more usual approaches. First, is the emphasis on the counselling component, and second, the involvement, through the entire process, of the Community Health Workers. Whilst it might be argued that the CHWs occupy the 'lowest rank' in terms of strict biomedical hierarchies, their work in the clinics and day hospitals entails important day-to-day interaction with medical personnel and locates them as links to the community: These relationships make a solid foundation for the HOPE

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<sup>26</sup> The involvement of TAHs in biomedical collaborations is not uncontentious in *amagqirha* networks see Wreford 2005c.

traditional healer project.<sup>27</sup> The extra connection established between the traditional healers and the CHWs - a direct result of the emphasis of counselling on the HOPE course - has the potential to create an even more secure base within the community, from, and towards which, the clinic staff in general can operate.

Statements from the CHWs described in section three of this paper testify to the fact that both the CHWs and the TAHs appreciated the 'shared learning' experience of the course, most especially that which was focused on counselling. All the participants acknowledged that their collective engagement on the course tended to create 'group solidarity' and a commitment to work together; but the experience of learning from others' very personal expressions made the value of the counselling process itself abundantly clear. One healer put this quite simply: 'I was counselled myself on the course so it has really strengthened me'.

The following anecdotes illustrate some of the changes which came about as a consequence of these intense interactions, and the fragility of the new relationships. The first comes from a joint interview with the CHWs after the course, in which they expressed a new confidence in the TAHs' abilities and their skill in counselling. One CHW amusingly compared her own practice, frantic and cursory, with that of the TAHs:

A: For an example I remember [N, a TAH] was talking about her client, when the client was coming in her house. She said 'I can take the client, and I open the door, and give them the chair and ask them 'What can I help you with?' You see?

T: It's a more welcoming and caring way? So how often, in the real live world out there in the clinics, as CHWs, how often d'you get the opportunity, the time, to open the door, greet the person...?

A: That's why I said to you I thought 'if they are doing it like this - this is the really good way' because to us you just call the name [A mimics this process perfectly], and the person must open the door herself ! You see? And when you've finished you don't even say 'goodbye' you just call out 'Next!' [loud agreement from the others].

Fieldnote: 25.04.06<sup>28</sup>

The same CHW went on to describe even more graphically the differences which she perceived between the biomedical approach and that of the traditional practitioners:

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<sup>27</sup> This subject is discussed in more detail in the final section of this paper.

<sup>28</sup> The pressure of time and workload has been recognised in other reports on the problems associated with VCT counselling in Africa see Marum *et al* 2002.

A: But to them they've got a chance to stay with the client. If the client is there, they listen. They listen to them. Even after the *ukuvumisa* [the *amagqirha* process of divination to arrive at a diagnosis] I can see that they are asking questions: 'Have you got any questions to ask?' You see? Some of the doctors don't even ask you that - they just write, you know, medication and give you, you must go to the pharmacy - but the traditional healers ask 'Have you got any questions? How do you feel about this?' You see? And after that - giving you that medication, she will give you the medication and say to you 'After this bottle is finished you must come back'. And when the client comes back she will ask the client 'How was this? [the medicine]' But the doctor, when the medicine is finished, you've got to take another money and go there. The doctor won't say 'If this bottle is finished you must come here.' You will think for yourself! That this bottle is finished, but I need more... You see? Everything in the western side you've got to think for yourself, because they don't worry even if you've five tablets - if you've finished those five tablets if you want another one you must come with another R120...

T: So the question of *you* having the time - that's a very important one, if you are truly to be counsellors then somehow we have to find time for you to do that...

A: Ummm

T: But the other thing is in the interim you obviously value the assistance of the *izangoma*, the way they do things? So from your point of view you can really feel comfortable now about encouraging people to go for counselling to the *izangoma*?

All: Yes...

These bonds of communality are still delicate however, and, once returned to the frenetic environment of the township, clinic or day-hospital, the foundations of mutual assistance and cross-referrals laid on the course appear to need constant reinforcement. Take for example, the next episode which took place at a Training Session for HOPE CHWs. Three of the five project CHWs were in attendance, and the difficulties which the CHWs experience in providing 'proper' counselling was again in focus. They instanced lack of space (and therefore lack of privacy), the responsibilities of their other duties, and most importantly, the shortage of time for counselling.

This meeting took place in May 2006, barely one month after the interview which produced the supportive comments quoted above. It was surprising then, that even when they were prompted, not one of the CHWs from the course recalled that interview. They seemed already to have forgotten the confidence in the TAHs which they had expressed there, and no longer recognised the traditional healers as an additional resource on which they could call for assistance. If the HOPE CHWs struggle to maintain these connections, how

likely is it that other medical staff - many of whom are likely to be less amenable to the ideas of collaboration which underscore the HOPE project - will be persuaded?

## **As the healers see it**

In contrast, the TAHs themselves seem to be quite clear about the advantages of committed two-way cooperation between themselves and biomedicine in HIV/AIDS interventions. First, they emphasise the importance of language, communication and mutual understanding. By far the largest proportion of the South African population avails itself, at one time or another, of the services of TAHs. They do so not out of stubbornness, or ignorance, but because the traditional health practitioner speaks their language: a language at once mundane, and cast in the notions of spiritual agency in which the healers, and those who seek to be healed, understand health and illness. Thus the healers are trusted to make sense of illness, to fill the gaps often left void by biomedicine - in short, to answer the 'Why me? Why now?' questions which generally accompany sickness in Africa. That this situation operates in the context of HIV/AIDS as it does for other diseases, has been recognised (Green 1999; Leclerc-Madlala 2002: 4).

Testimony from the HOPE project healers illustrates the point. One practitioner, when asked whether she thought patients might listen to her more than to a western-trained doctor replied: 'Yes. They will come because of our communication and the language, and...because we stay together.' The *igqirha* here identifies 'communication', a factor easily overlooked in discussions about traditional healing. By drawing attention to this, the healer brings into the debate an essential element in *amagqirha* diagnosis; the communication will take place not just between the client and practitioner, but also through the medium of the ancestral spirits who provide agency to the work. Of course, as borne out by the testimony of another *igqirha*, the success of this communication also depends on the client: 'I can't say that.... It depends on the individual person's belief and faith, whether they believe in traditional healing or in western medicine.' On a more mundane level, the first *igqirha* did mention language, and the fact that the *amagqirha* live within the community, as factors in her ability to communicate with her clients. It is relevant here to note that the issue of language in medical conversations is often very basic indeed. Several of the CHWs for example, pointed out in interviews that they are regularly called in by medical staff in the clinics to act as translators for their patients.

On the other hand, contextualised within the HIV/AIDS epidemic in South Africa, the questions of the accessibility and communality of the TAHs may not

be quite so straightforwardly beneficial, especially for TAHs such as those in the HOPE project group. I rehearsed in section three of this paper the fact that the TAHs expect their client base to increase as a result of their new VCT training. I also noted that one of the harsh realities connected with the spread of HIV/AIDS in the country is the continuing stigma associated with the disease which in turn tends to discourage disclosure. Thus, clients will often avoid visiting their local clinics 'because people will be curious'. One TAH pointed out the implications for the HOPE project traditional healers in this pattern of avoidance: 'Perhaps they will not come to us now, they will see that we are connected with the clinic and HIV/AIDS.'

To date, there has been no actual evidence of this, but a different and associated scenario has indeed arisen, necessitating a change of plan. Within the first couple of months of the operation of the project it became apparent that in general the clients still preferred to avoid visiting their local clinics for testing. The original arrangement of the HOPE project had seen the *amagqirha* referring counselled clients direct to their local clinic, sending the person with a referral form including the name of the CHW to whom they should report. The clients' resistance to local clinics made this impracticable. To circumvent this, the *amagqirha* have since been given a list of all the clinics and day-hospitals in which HOPE operates, and contacts for all the HOPE CHWs. Referrals can now be made to the client's clinic of choice.<sup>29</sup>

## Keeping secrets

A second factor in the traditional healers' list of the benefits of utilising traditional healers is the popular assumption that once they have diagnosed a person, *amagqirha* are bound to keep their diagnosis and all information they have received confidential (whether from their ancestral spirits or from the client). As the previous paragraphs make clear, the continuing stigmatisation of HIV/AIDS in South Africa makes the issue of confidentiality a fraught one. For some clients, this is quite simply a question of visibility, of being 'seen' visiting the local clinic, which is often enough to generate unkind gossip. But another factor in this regard is the popular perception that nurses and other clinic staff may be being less than discreet about their knowledge of the status of HIV/AIDS patients. Unfortunately, feedback from the CHWs appears to support this presumption: 'Some of them are too easy about disclosing status,' reported

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<sup>29</sup> An administrative detail for HOPE associated with this operational change, concerns the ten CHWs not on the course. It has become apparent that they have been inadequately briefed about the project, have little or no understanding of its intentions, and, most importantly, no details of the *amagqirha* involved. HOPE has since undertaken to correct this situation.

one CHW. But an episode which occurred in a clinic staffed by a HOPE project CHW (after the course had ended), demonstrates that the awareness of confidentiality is by no means limited to the medical staff.

On a visit to the clinic we [two HOPE project *amagqirha* and myself] were shown around by the CHW to introduce us to the staff. At one point, with only a peremptory knock at the door, we were taken into a room in which, as became clear immediately, a counselling session was going on. The nurse/counsellor pronounced that there was 'no problem' as the session was just finishing, but by then the damage for the client had been done. She then had to sit there while these intruders exchanged pleasantries.

I apologised to the client as we left, but no-one else seemed to even be aware of this breach of privacy. After this intrusion, the client would have had every reason to feel disillusioned with any promises of confidentiality, the counselling process, and the clinic.

Fieldnote: 31.01.06

In contrast, the *amagqirha*, in their own surgery settings, are fully aware of the importance of keeping confidences. One practitioner described her understanding of this responsibility:

If you diagnose someone [as an *igqirha*] then whatever they should discover from that person you have to keep it to yourself because it's a secret. That person can then say 'OK, I am able to come back to this person because this person can really keep confidential information.

Fieldnote: 08.04.06

Here, the *igqirha* clearly recognises that no-one will return to a healer whom they suspect of divulging confidential information. Indeed, as the example of the clinic cited above suggests, her failure to keep secrets will actually lose her business. Nonetheless, whilst still acknowledging the fundamentals of discretion, this practitioner was also able to identify the advantages of the more probing effects of counselling on her practice, which, 'because there are private things that are coming across, makes it easier to look at their problems.'

## **Part 6: Lessons and recommendations**

As stated in the Introduction, the HOPE project is a pilot. The previous section investigated the potential advantages of the collaboration envisaged in the scheme. The final part will examine the lessons that need to be learned from the HOPE project as presently conceived, and how they might be resolved. It looks

at problems encountered on the course, and makes some recommendations for the present and for the future.

## Paying for the service

Part 5 of the paper identified the advantages, perceived by the TAHs, by the CHWs, by some medical staff and by the clients, in the quality of counselling offered by the traditional healers: They are accessible, and available 'out-of-hours', they are prepared to spend time, and they guarantee the privacy and confidentiality of their clients. All of the above serve to introduce the vexed question of payment for these services.<sup>30</sup>

Over a decade into majority rule, the black African population of South Africa is continually confronted with the legacies of neglect of their needs which characterised not only the previous apartheid regime, but also colonial rule in general. Although there has been significant income redistribution during the post-apartheid period, there remains a significant, unemployed and marginalised population (Seekings and Natrass, 2005). For those, like the community health workers and traditional healers who form the subject of this study, who live in the townships and informal settlements which continue to grow on the outskirts of all South Africa's major conurbations, life is a perpetual struggle to make ends meet. There is nothing in the way of social security or welfare payments for working age adults, although the disabled<sup>31</sup> (including, for a limited period only, those on ARVs), and those fostering and caring for children can claim limited monthly allowances (if they pass the means test). Work is in short supply, and even those who are lucky enough to have regular employment may find themselves succumbing to sickness. HIV/AIDS has only exacerbated this situation. It is within and against this scenario that traditional healers and biomedical personnel alike attempt to minister to their communities.

There is a tendency to assume that the work of traditional healers who agree to provide healing services alongside biomedical medicine comes *gratis*. A doctor at one of the HOPE clinics, for instance, hearing that the TAHs were to be more involved in their work, immediately concluded that 'they can come in and help us to explain the ARVs to patients!': The implication appeared to be that this service would be offered free of charge. Of course, the volunteerism implied in this picture of the *amagqirha* is one possibility, but the reality is that traditional

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<sup>30</sup> It is interesting to note that in the literature on the subject there is little if any reference to this vital question. Since it seems highly unlikely that it never arose, it is fascinating to speculate on why this is. Certainly it would be helpful to know how it was resolved elsewhere.

<sup>31</sup> For detailed coverage of the relationship between the Disability Grant and HIV/AIDS see Natrass 2004b.

healers, unlike the clinic staff (notably in this context the CHWs), do not receive a regular salary. They are self-employed professionals, and depend on their client base to make a living.<sup>32</sup>

Recognising this, HOPE has always accepted that the *amagqirha* involved in the project would be able to charge for their counselling services. In the final week of the course, therefore, a special session was held to decide the fee which the *amagqirha* could charge their clients for VCT. Hope's [director] Rev. Fr. Stefan Hippler, made clear that in his opinion the charge should be kept 'very low'. The logic of his argument was in many ways impeccable: the TAHs had received free training from HOPE, their clients are impoverished, and they can go to the clinics and receive free VCT. An added incentive, he reminded the TAHs, was that provincial officials were expecting them to 'rip people off'; the lower figure would 'prove them wrong'. The participants were divided into two groups. One decided that R50 was reasonable, the other (which intriguingly contained more CHWs) suggested R10. Agreement on the lower figure hinged on the assumption that charging less would encourage clients to come forward.

How has this aspiration translated in practice? According to the TAHs, clients are presenting a whole raft of excuses for not paying the R10. Amongst the most common is that they do not have money for the session; if challenged, they retort that 'we can get this for free at the clinic'. Others suggest that 'we are not going to pay just for talking' that they would only pay if they receive *amayeza* (medicines).

TAHs are customarily guarded about revealing their charges, but they acknowledge that the cost of a session might range from R25 to 'a lot more' and is always case-dependent. But whatever the cost, the *amagqirha* agree that clients coming to a traditional healer would be *expecting* to pay for the service, sometimes at considerable cost. Furthermore, the cost of treatment is often taken as an indicator of quality. Most especially in the context of HIV/AIDS some TAHs (though many would describe them as 'charlatans') are shamelessly peddling 'cures' for the disease, for which they are charging considerable sums of money. Two HOPE CHWs for example, reported cases of 'traditional healers' in their areas asking up to R3000 for 'the medication for HIV'.<sup>33</sup> It is entirely possible that the collapsing of the healer's fee (including VCT) into a

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<sup>32</sup> As the portraits of the participants in Part 2 of this paper illustrate, some healers are forced to find other employment to supplement their income. The implications of this are discussed in the final part of the paper.

<sup>33</sup> The HOPE TAHs amongst others assert that healers who charge very high fees are 'charlatans' who will soon lose their healing gift through the disapproval of the ancestral spirits who gifted it (see Tangwa 2005). For further discussion on attempts to curb 'charlatans' see Ashforth 2005; Wreford 2005b: Chapter 3.

flat R10 might actually be giving the clients the impression that since the charge was so low, the treatment (and counseling) was likely to be inadequate.

To try to resolve this HOPE produced posters for each TAH, written in isiXhosa, advertising their VCT skills and explaining the minimum fee. But client excuses, and refusals to pay, continued. Other approaches are under discussion. First, HOPE could subsidise the TAHs and pay them R10 for each client counseled and referred to a clinic. Alternatively, the *amagqirha* should practice in their accustomed way, diagnosing and providing *amayeza* as required. If, during this process, they recognised that there was a need for VCT counselling, they should bring this element into the session. The healers could thus charge the fee that they would normally expect to ask for their services, including their counselling skills, and perhaps disregarding the R10 limit altogether. At the time of writing there is no resolution of this difficult problem.

## Involvement and connection

As has been noted in earlier sections of this paper, while the course was in operation at Tygerberg Hospital enthusiasm for the project was continually being generated. The TAHs' presence in the hospital was emphasised as a first, and their role as pioneers frequently reinforced. The presenters of the course, in the first and final weeks (by and large sourced from the hospital) also helped to forge relationships. So far, so good. It soon became apparent however, that after the TAHs returned to their communities, these connections became more fragile and had to be both regularly reinforced, and spread. For the project to prosper, a support network was vital: to boost morale, to underline the commitment of everyone involved, and most importantly, to start to build links between the biomedical staff in the clinics and the *amagqirha*.

In reality, such liaison was lacking in several areas. Meetings involving medical personnel and HOPE staff and CHWs did take place at the clinics, to introduce the traditional healers and the scheme's intentions. However, most of these meetings were *ad hoc*, and appeared to be arranged almost as an afterthought to coincide with normal HOPE visits.<sup>34</sup> The *amagqirha*, and their addresses and contact numbers, were rarely formally introduced, which simply appeared disrespectful, perpetuating the feeling that the TAHs were not really valued.<sup>35</sup> Explanations of the project were somewhat desultory: important procedures,

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<sup>34</sup> The workload in the clinics is enormous. On one visit, the sister-in-charge was on the verge of refusing to meet with HOPE until they had made a formal appointment, citing pressure of time.

<sup>35</sup> On the other hand the reception given to the *amagqirha* by some individual members of staff was very enthusiastic.

such as those connected with the referral forms - an essential element in verifying the success of the scheme - were vague. All of this tended to create the impression, for TAHs (and arguably for the clinic staff) of a lack of commitment from HOPE. This is not to suggest that these visits were entirely wasted, but it was clear that it was only in those environments employing HOPE doctors or staff members who been directly involved in the course, that there was any real understanding of the importance of the undertaking.

Other shortcomings in promotion and liaison became more real as the project developed. The example of the problems associated with clients' refusal to visit local clinics, and the minor administrative task of supplying alternative clinic contacts has already been mentioned. But this change of plan also exposed voids in awareness and understanding amongst other HOPE staff (in particular, the CHWs not on the course), not only of the project's aims and objectives but of the basic principles of traditional healing. For example, the HOPE staff at this meeting had not yet been briefed about the purpose of the project, nor on the details of its implementation, notably on the use of the referral forms. It is recommended that HOPE proceed to fill these gaps immediately. The importance of these liaison activities is not limited to HOPE staff, and HOPE's CHWs cannot always be expected to be available to receive referral forms, or explain systems. For this, and future projects to succeed, it is recommended that HOPE ensure that as many medical staff as possible are fully advised of the procedures and aims of the interventions *before* they are implemented.<sup>36</sup>

## **Bureaucratic tasks, essential liaisons**

Liaison and communication with the TAHs is also essential. It is apparent that to a large extent the traditional healers have been left to their own devices since the course ended. Observation of the process suggests that HOPE administrator(s) are depending largely on the monthly SGMs (Support Group Meetings). These were established as soon as the course at Tygerberg ended, and were intended to allow the participating *amagqirha* and CHWs a safe space for sharing experiences of the VCT process. Instead, the SGMs have become 'report back' sessions and a secondary means of ascertaining the numbers of clients referred for testing by the TAHs.<sup>37</sup> To date, for reasons described earlier in this section, these figures may appear a little disappointing. Nonetheless, the TAHs, verified

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<sup>36</sup> This is by no means a simple process: the division of clinic responsibilities between municipal and provincial health authorities further complicates the situation.

<sup>37</sup> Clearly, this is a useful forum for the gathering of these statistics, but the SGMs were originally intended as an essential 'sharing' element in the onerous responsibilities of VCT, an opportunity for the continuation and reinforcement of the relationships between TAHs and CHWs forged during the course.

by the CHWs, are reporting a slow but steady increase in referrals, and a small increase in male candidates to testing.

Formal procedures need to be in place to organise verifiable evidence of the success of the scheme. At a minimum these should include: Regular monthly collection of the referral forms; regular monthly cross-checking between the *amagqirha* register of clients referred and the referral forms; weekly liaison between CHWs and TAHs to regularise these processes.

## **Maintaining enthusiasm**

Returning now to the administration of the project and the issue of the SGMs. Transport is certainly one deterrent to attendance, but others should be considered. For example, given their current 'report back' format, it is quite possible that, with progress on referrals so disappointing, the TAHs are actually embarrassed by the numbers. Again, the SGMs are not conducive to the sharing of problems, or the discussion of related matters (such as stigmatisation in HIV/AIDS and how to intervene to prevent it).

This paper considers it essential to encourage and stimulate the participants. One solution might be to suspend the SGMs, and in their place, invite the TAHs to one of the bi-monthly training sessions held for the CHWs. The content of such meetings could then be tailored with the *amagqirha* in mind; interpreters should be provided as a matter of course. The agenda might cover a variety of related subjects, for instance, home based care, home remedies, first aid treatment, infant feeding etc. This would have the advantage of refining and expanding the healers' knowledge base, and providing a further 'official' forum for communication with the CHWs and HOPE.

## **Selection and assessment of participants**

Two related questions now require consideration: The selection criteria for participating *amagqirha*, and the matter of assessment of their knowledge of HIV/AIDS before, and after the course. The HOPE course studied here sensibly relied on previous contacts in the TAH community for selection.<sup>38</sup> However, with the project in operation now for just over four months, some obvious difficulties have arisen. It has already been pointed out that the TAHs are self-employed. What was not appreciated was the extent to which the chosen TAHs rely for additional income on periods of temporary employment outside of their

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<sup>38</sup> See footnote 10.

healing work.<sup>39</sup> It is recommended that selection for future courses be dependent on the participants being full-time healers.

Another factor related to selection involves previous experience of HIV/AIDS, and VCT counselling. Again, the lack of selection criteria meant that several of the chosen TAHs for this course had already been exposed to other educative sessions in HIV/AIDS. Completion of a questionnaire prior to commencement of the course would have established the extent of the candidates HIV/AIDS awareness: Candidates with least or no exposure might then have been preferred.<sup>40</sup> This constitutes the final recommendation of this paper.

## Conclusion

Although the imperative of improved cooperation between the traditional and biomedical paradigms in the time of AIDS in South Africa has long been recognised, schemes directly engaged in this process have been few and far between. The advantage of working with traditional African healers in HIV/AIDS interventions consists not only in educating the TAHs into the ways and means of biomedicine. Such an approach also affords biomedical personnel an opportunity to begin to understand, and where appropriate, actively incorporate the meanings attached to health, disease and healing in the traditional context in South Africa.

This paper has provided a portrait of the very earliest stages of one such project. The analysis has not only pointed to some of the positive effects of improving relationships between medical systems. It has also highlighted some of the pitfalls and obstacles which almost inevitably accompany this objective in contemporary South Africa.

It is hoped that the paper will thus support the initiation of further cooperative projects, and, with that in mind, provides useful guidance and insights for those considering the establishment of cross-sectoral efforts in HIV/AIDS work,

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<sup>39</sup> Three of the nine are presently engaged in other full-time employment.. This affects the time and energy they can commit to the VCT work and may distort the statistical success rate of the project as a whole.

<sup>40</sup> The same questionnaire could of course have been employed to re-assess the TAHs' knowledge after the course, thus providing one test of its effect.

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