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MYTHS, MASKS AND STARK
REALITIES: TRADITIONAL AFRICAN
HEALERS, HIV/AIDS NARRATIVES AND
PATTERNS OF HIV/AIDS AVOIDANCE

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Myths, masks and stark realities: traditional African healers, HIV/AIDS narratives and patterns of HIV/AIDS avoidance

Abstract

Based on field evidence from anthropological research with Traditional Health Practitioners in the Western Cape Province, this paper presents narratives that demonstrate the use of myth and camouflage in popular responses to HIV/AIDS, as experienced by Traditional Health Practitioners. The narratives are analysed from the perspective of the traditional healers in order to interrogate biomedical assumptions that traditional health practitioners are largely to blame for encouraging denial and non-disclosure, or wilfully undermining western medical efforts to deal with the epidemic. The paper explains the effects of popular explanations of HIV/AIDS on traditional health practitioners, and suggests that they do not simply endorse these accounts, but are prepared to be sceptical and to challenge them when they arise.

Introduction

This paper presents field narratives selected as illustrations of mythologising and masking in popular responses to HIV/AIDS in South Africa. The stories appear in the context of traditional health practitioners (THPs)¹ and the testimony of the healers is used to demonstrate the ways in which they interpret these narratives, and seek to challenge them.² The examination then re-assesses these accounts, and the healers' responses to them, in relation to the antipathy that exists between western medicine and traditional healing in the context of HIV/AIDS.

¹ The THPs in this study are diviner/healers known as *izangoma* pl. *isangoma* s. (Zulu); *amagqirha* pl. *igqirha* s. (Xhosa).

² The narratives presented in this paper form part of research with Traditional Health Practitioners who have been involved over the past two years in the HOPE (HIV Outreach and Education Program) Cape Town pilot sangoma project, an HIV/AIDS educational and counselling initiative in the Western Cape Province. See Wreford et al 2006; 2007.

The narratives demonstrate two themes: the first discovers bewitchment utilised as a disguise for HIV/AIDS. The discussion analyses the logic behind this apparently denialist tactic, and explores the subtler influences at play. The paper goes on to propose that the rituals essential to the healing of witchcraft have enormous potential for a transformation of the emotional effects of the stigma attached to HIV/AIDS. The second group of stories appears under the title of ‘pretending *ukuthwasa*’, in which individuals are regarded by traditional healers as faking the ‘calling’³ to become a traditional healer. This serves as another form of disguise: to avoid disclosure, HIV-positive people can portray their illness as a calling rather than as symptoms of HIV. As will be shown in the paper, this is particularly problematic for the practice of traditional healing in the time of HIV/AIDS.

In previous papers I have emphasised the importance of building reciprocal associations between the traditional and western medical paradigms in HIV/AIDS interventions (Wreford 2005a, 2005b, 2007; Wreford *et al* 2006). To maintain this theme, the initial analysis and discussion of the narratives is presented from the traditional healers’ perspective, to ascertain their effects on traditional practice and healers’ attitudes to HIV/AIDS. The paper then unpacks the stories, this time with reference to the implications for developing mutually respectful relationships between western medicine and traditional practice.

The picture generally presented by scientific and western medical opinion about traditional healers’ responsibilities for the HIV/AIDS epidemic in South Africa tends to be negative, even provocative.⁴ The paper argues that THPs cannot simply be blamed for spreading stories or encouraging denial and non-disclosure: the stories presented here neither illustrate the gullibility of THPs, nor do they seek to show the THPs as wilfully undermining western medical efforts to deal with the HIV/AIDS epidemic. Rather, these personal stories illustrate the evasive lengths that people in South Africa will go to rather than admit that they have HIV/AIDS. The paper explains the effects of these popular explanations of HIV/AIDS on traditional health practitioners, and suggests that traditional healers do not simply endorse these accounts, but are prepared to be sceptical and to challenge them when they arise.

³ For details of the process known as ‘the sickness of calling’ see Wreford 2008: Chap 4.

⁴ Wreford 2005b: 13-18 presents an example of this sort of medical mythologizing.

Background

Confronting the possibility of a positive HIV/AIDS diagnosis is always an immensely challenging individual experience even when a strong support structure is in place (Cameron 2005; Levin 2005). For the majority population of South Africa, the significance of this personal ordeal is compounded negatively by dread of the expected responses to the condition – stigmatisation, isolation, abandonment, violence, blaming and gossip - which are generally understood to accompany discovery of the disease. For some, these fears have been very real and with especially brutal consequences (Kortjaas and Msomi 1998). For others, even the ‘perception’ of stigma is a powerful deterrent to disclosure (Maughan-Brown 2007). Under these circumstances it is scarcely surprising to find that people opt for evasion rather than disclosure, avoidance rather than candour; that they choose to run away from the problem rather than facing it. The myths and masking stories narrated here each illustrate at least one of these reactions.

In South Africa, antiretrovirals (when they are available) are not the only form of support available to those living with HIV/AIDS. Although the figures are contested,⁵ many people in the townships in which this study is set continue to consult traditional health practitioners, especially for the symptoms of sexual diseases including HIV/AIDS. Space does not allow for a detailed discussion in this paper of the reasons for this,⁶ of the differences between western and traditional healing paradigms, or of the benefits of involving THPs in interventions aimed at increasing testing and disclosure.⁷ What is important to understand here is that while this is sometimes a question of different perceptions of illness, whatever the condition, but especially when (as with HIV/AIDS) it persists, the client will start ‘searching for answers’ as one healer put it. Unlike western medicine, which treats illness through reading the physical body, traditional healing is trusted to respond to the ‘why me? Why now?’ questions, to uncover and treat the underlying causes of illness.

As has been accepted by a small minority of biomedical practitioners in South Africa (Ellis 2004: 69; SAMJ 2006: 29-30), in a pluralist health environment, a socio-cultural understanding of illness is essential to achieve a mutually

⁵ One study from Khayelitsha asserts that people use THPs for very specific reasons, and that the figures for attendance at THPs surgeries are overstated (Nattrass 2005). Anne Digby provides a useful overview of the contested figures that characterise this much debated but poorly understood subject (2006: 300-301).

⁶ The relationship between biomedicine and apartheid has however contributed, especially in the context of sexual disease. Enduring suspicions persist about the motivation and efficacy of western medical practitioners (Jochelson 1999; Vaughan 1991: 24).

⁷ For background on these topics see Wreford 2005a, 2005b, 2007; 2008; Wreford *et al* 2006.

beneficial diagnosis. The discussion of the narratives in this paper is intended to inform and assist western trained doctors amongst others, to better appreciate the context of popular explanations of HIV and AIDS causation that motivate visits to THPs. It is hoped that it will also encourage collaborative efforts between THPs and western medicine to ensure a safer and more efficacious environment for HIV/AIDS interventions.

Context

The social stigmatisation that attaches to HIV/AIDS is arguably the overarching question that attends discussion of disclosure throughout South Africa, as suggested by the numerous research studies on the topic.⁸ In South Africa, despite the scattered existence of ARVs, the often severely limited health service resources and treatment capacities continue to render HIV/AIDS life-threatening for the majority of its victims (Shisana *et al* 2005). The stark reality of HIV/AIDS, and the social constructions put upon the disease (Soskolne 2003: 22) - progressive disability, debilitation and pain leading to death - goes some way to explicate the patterns of denial, avoidance and prevarication in the face of HIV/AIDS. But the results of disclosure are also frequently perceived only to add to the burden of the disease (*ibid*: 23): the decision to disclose is therefore taken strategically, measured against the need to protect self, household and income, and children for example (Brandt 2005: 21-24).

As many studies have shown, HIV/AIDS in Africa demonstrates a depressingly familiar gendered face in this regard (for examples in South Africa see Brandt 2005; Kistner *et al* 2003; Rohleder and Gibson 2005; Soskolne 2003). The consequences of disclosure for women are legion and specific, an ‘arsenal of threat’ (Soskolne *et al* 2003: 21) that includes abandonment, violence or other forms of abuse, ostracism and destitution. The second set of narratives discussed in this paper provide unusual evidence of a scenario within which young women, in particular, can be seen trying to find respite, and seek solace from the fears and distress of disclosing a positive status to their families.

But although the prevalence of HIV/AIDS in South Africa is disproportionately found in the female population, the disease affects everyone. In a very recent report Ndinda *et al* discover a startling display of the insidious and diverse effects of stigma in rural KwaZulu-Natal (2007); despite this rural setting their findings are entirely relevant for this study set in the peri-urban communities of

⁸ For studies in the Western Cape Province see Almeleh 2004, 2006; Khan 2004; Maughan-Brown 2007.

the Western Cape. Membership of any community involves the incorporation of shared values, beliefs and attitudes. In the context of HIV/AIDS men and women who find themselves harbouring the virus automatically internalise familiar and customary stigmatising messages (Rohleder and Gibson 2005: 19-20; Soskolne *et al* 2003). Thus Ndinda *et al* portray stigmatisation as a self-fulfilling process in which the mere expectation of being ostracised as HIV positive is sufficient to refuse disclosure (2007: 95-98). Thus in a stigmatising environment the secrecy and denial of themselves generate ‘perceived’ stigmas, based now on gossip and rumour (Maughan-Brown 2007): in the absence of facts, everyone, it seems, is talking about everyone else behind their backs. The collective denial is cumulative, and even as it presents a defiant face to stigma, it permits a dangerous defiance of the reality of the disease.⁹ Ndinda *et al* conclude that more openness, education and understanding of the disease are essential prerequisites to the reduction of stigma; on the other hand they admit that the question of the significance of who benefits from disclosure remains unanswered (2007: 96), and their study does not address the question of ARV treatment and its effects on disclosure.

Does the availability of ARVs change attitudes to disclosure? Within the African diaspora in the United Kingdom (where ARVs are universally available), it would seem that availability of treatment has not led to increased openness about the disease (Calin *et al* 2007). Research from the Western Cape Province (which enjoys one of longest-running ARV rollout programmes in South Africa) provides valuable local insights on this topic. At one end of the spectrum, Almeleh draws on interviews with a group of female AIDS activists from the township of Khayelitsha (2004). Almeleh emphasises that, even for these activists, - some of whom are taking ARVs and who can call on a variety of community structures for encouragement - the notion of all-inclusiveness implied in going ‘public’ with an HIV diagnosis actually has very different meanings and contexts in reality. Looked at from their position as treatment advocates and counsellors, for example, the women embrace the notion of a very ‘public’ disclosure; assessing disclosure in the context of their personal lives – and especially the effects on their relationships with family and partners - they are far more ambivalent (17-19). Although Almeleh’s more recent work on the topic highlights the psychological benefits (2006), Maughan-Brown demonstrates the role of stigma in reinforcing a persistent and powerful resistance to disclosure (2007).

⁹ As one man in the study puts it, ‘according to the community and to my family nobody I meet is suffering from AIDS’ (ibid: 97), a rebuff that bears a remarkable and uncomfortable similarity to a notorious statement issued by President Thabo Mbeki of South Africa.

The vociferous campaigns by the Treatment Action Campaign and other activists in South Africa demonstrate that ARVs can serve to lessen stigmatisation by presenting healthier images of people living with the disease. As borne out by Almeleh's work (2004; 2006), such imagery, supported by advocacy projects such as *Longlife*, serve to counter the linkage between HIV/AIDS and the inevitability of sickness and death. Nonetheless, as Rohleder and Gibson point out (2005), other popular notions associated with HIV/AIDS - deviancy, dirtiness, the idea of HIV/AIDS as a punishment, and above all gossip about all of these - continue to operate as triggers for stigmatising behaviour. In contrast to the activists, the women in Rohleder and Gibson's study - who live in the same township and are on treatment, express comparatively little feeling of support. Although they try to resist the negative effects of the unwelcome social discourse about the disease, their efforts to cope with what they characterise as their 'spoiled identity' are often unsuccessful.

As the evidence from the research quoted above shows, many narratives about HIV/AIDS are well-rehearsed in the public domain (albeit behind backs and closed doors). In contrast, the accounts included in this paper may be less familiar, or perhaps less often vocalised, if only because they are presented from and within the more hidden environs of traditional health practice in South Africa.

Methodology

The paper is the result of an ongoing anthropological study based on direct participation and observation of traditional healers working in collaboration with western medicine in the Western Cape Province. Data is taken from fieldnotes, supported by in-depth recorded interviews with graduate traditional health practitioners (isiXhosa: *amagqirha*; isiZulu: *izangoma* - diviner/healers) and initiate healers (known in both languages as *thwasa*). The content is concentrated in three peri-urban areas, Mfuleni, Delft South, and Wallacedene, and includes additional anecdotal evidence and excerpts from interviews with health service personnel and community health workers (CHWs). Ethics clearance for this research has been received from the relevant academic authorities.

The Stories

Healers' stories one: 'Uthakathiwe (she has been bewitched)

Q: And here's another thing. How many people do you think in your community look at HIV and think 'witchcraft'?

A: Chuckles...Oh so many! A lot of them!

What is to be understood from the idea of the power of witchcraft in the context of HIV/AIDS?¹⁰ It may appear hopelessly anachronistic to those who have embraced the scientific principles of western medicine. Nonetheless, the possibility of malevolent intent as a source of contagion and sickness continues to resonate in the lives of many South Africans. Indeed, in the frenetic environment of the townships in which this study is set, despite (or perhaps because of) an impoverished experience of modernity, they may be seen to have acquired new and sinister authority (Ashforth 2001; 2005).

In these densely occupied communities, where customary bonds of kin and clan membership have been severed, a disquieting anonymity encourages suspicion and uncertainty. This is especially the case in the so-called 'informal settlements' where newly arrived migrants from even poorer rural communities tend to congregate, and habitation is often transitory and quite literally fragile. In these circumstances it is difficult to know whom to trust. With poverty and unemployment the norm, any success, or even the capacity to rise above the mean level of one's neighbours can be enough, for those who decide to perceive it in this way, to invite suspicions of wrongdoing, of an unholy and unhealthy link with witchery (Ashforth 2005: 89; Geschiere 1997: 135; 2001 45-46).

But this cloak and dagger stuff is not only about explaining unusual events, be they positive or negative; bewitchment also has particular historical connections with the sudden onset of serious and debilitating illness, not least when the 'cause' can be located in suspicions of sexual misbehaviour (Green 1996: 93-94; LeBeau 2003: 128-129; Lwanda 2004: 35; Stewart and Strathern 2004: 79). It is this link that helps to explain the mask-like function of bewitchment as a counter-narrative to the acceptance of HIV/AIDS: that, and an uncanny

¹⁰ For in depth discussion of the umbilical relationship between THPs and witchcraft see Wreford 2005a: Chaps 3 and 8. For the implications for HIV/AIDS see Wreford 2005b: 68-77.

commonality of symptoms and means of transmission (Cocks and Moller 2002: 394) supplies ample ammunition to explanations that cite witchcraft as the source, and cause of HIV/AIDS.

'Injalo. It's just like that. These days you shouldn't say a person is positive, you should say she is witched for you to be a right person. [Sheepish laugh]. Because if you say a person is positive then 'you don't know what you are talking about' [you are spreading rumours].'

Ashforth's research in Soweto suggests that bewitchment offers a convenient escape from the embarrassment and distress of an unacceptable reality (2005: 135). The excerpt quoted above reveals this motivation, with witchcraft forming part of the pattern of social constraint on the open discussion of HIV and AIDS.

Witchcraft then, is being used as a disguise behind which to hide the reality of the rapid onset, the wasting symptoms, the loss of energy and vitality of HIV/AIDS. Indeed, to avoid the gossip that attends HIV/AIDS it may be better by far to pretend to the sort of internecine feuds, the family 'dirty laundry' that also accompany stories of bewitchment (Ashforth 2005: 67-71). And if this means sticking to the story until death, so be it (Sethosa and Peltzer 2005). A traditional healer provides an example of this situation:

When the one has already passed away, they won't say 'it's HIV'. You know at the funeral, in the programme, you must say the reason why she's lying there. They will lie and say 'OK she's bewitched and this and this...'

The story is told here in the context of a familiar township funeral, complete with printed programme, photographs of the deceased, and an edited biography. The proceedings usually include a queue of friends and family offering emotional eulogies, interspersed with powerful hymn singing. As this excerpt suggests, a detailed telling of what caused the death of the deceased is also compulsory. In this story, serving like a grotesque death mask, bewitchment acts to conceal the embarrassment and loss of dignity that disclosure of HIV/AIDS might have produced. Under other circumstances, where witchcraft was suspected, the healer telling the story would have been called upon first to diagnose, and then to perform a ritual of cleansing to eliminate the witchery and start the healing process. But she is powerless to intervene here. Asked what she would have done if this case had been presented to her, the *igqirha* declared with evident irritation 'I was called to tell the truth as a healer. I don't suffer fools gladly.'

Although this appears to be a categorical statement there is ambivalence in this response.¹¹ The healer's declaration that she is 'called to tell the truth' is perhaps intended to demonstrate her new skill: She may be suggesting that, as a consequence of her HIV/AIDS training, she can now recognise the symptoms of the disease and is less inclined to be patient with those who falsely adopt the woolly mask of bewitchment. On the other hand, as an *igqirha*, the healer of witchery, she acknowledges the role of witchcraft in illness causation. Each case presented to an *igqirha* is individual and has to be put to the ancestral spirits to divine;¹² thus, in this instance, while HIV/AIDS may indeed be the proximate cause of the symptoms, witchcraft may still be signalled as the ultimate cause.

I have pointed out that as a tactic for evasion witchery certainly coheres neatly with customary understandings of ill health, especially as these relate to sicknesses connected with sexual (mis)behaviour. As such, it has become part of the lexicon of popular explanations for HIV/AIDS, an alternative to disclosure of positive HIV status. Yet if, as the testimonies so far examined suggest, witchcraft has now become an accepted counter-narrative for HIV/AIDS, surely the factor of disguise disappears? This begs the question as to why it continues to resonate, and what else might be at play to explain its continuing potency. In other words, is disguise the sole motive for using the witchcraft explanation? I suggest not, and the THPs seem to agree. Asked a question about why she felt that people use this excuse rather than admitting to the reality of HIV/AIDS one *thwasa* responded:

My understanding is that people with HIV/AIDS, once they know, they think that they are going to die soon. What happens is that when people become aware of their HIV positive status they tend to think about a lot of things so people also lose hope and think about death only. They also start thinking about the people they had seen before who have had HIV/AIDS, they just cast themselves in that image, and people think it is the end of life.

But when they believe that they have been bewitched they know they can do something about it, they can be treated and heal.

The last sentence of this initiate's description encompasses the essential difference between the witch *igqwirha*, and the healer of witchery *igqirha*.¹³ The testimony also begins to explain the agency provided by the intimation of

¹¹ Ambivalence and ambiguity inform any discussion or exploration of witchcraft (see Ashforth 2005; Geschiere 1997; Wreford 2008: Chap 8).

¹² For discussion of the role of ancestors in *izangoma* healing see Wreford 2008: Chap 2.

¹³ In much coverage of the topic, these opposing roles are more usually conflated, as the persistent use of the pejorative 'witchdoctor' demonstrates.

witchcraft to HIV/AIDS causation. As the *thwasa* points out, a belief in witchcraft (even if it is premised in a refusal to acknowledge an uncomfortable truth), offers something that, certainly in the early stages of the disease, the biomedical diagnosis of HIV/AIDS cannot: the possibility that something can be done, 'that they can be treated and heal.'¹⁴

It is this possibility of salvaging a situation that seems hopeless – actually 'the end of life' – that helps to explain the potency of witchcraft in relation to HIV/AIDS. In itself, this is not a new idea (Iliffe 2006: 92; Reynolds-Whyte 1997), but, taken in context, it suggests an innovative and potent role for the healers of witchcraft, the *amagqirha*. In my conversations with traditional healers in the Western Cape, they acknowledge their responsibility to carefully and sensitively explain to their clients the reality of HIV/AIDS.¹⁵ This said, as the healers of witchcraft, they also recognise that, for someone who is convinced (or prefers to appear convinced) of that paradigm, there exists enormous potential for a powerful and transformative use of cleansing rituals and practices in HIV/AIDS interventions (Kayombo *et al* 2007: 6). Employed as an accompaniment to western medical interventions, such rituals could significantly affect the distress of HIV/AIDS, by offering a cleansing of the emotional body, most particularly of the stigma attached to it. One spoke of her vision about this idea:

I think it's a very positive thing it can be very positive because it will give hope and it will be like kind of thanking the ancestors and God for keeping that person. Because in most cases when a person is being attacked by HIV/AIDS then it doesn't last long. It's very quick. So it's for thanking the ancestors for keeping that person. That will give hope to a particular person. Even if it's something like a celebration, like a ritual.

Cleansing rituals as envisaged here would not cure, but for a client who prefers to be convinced of a witchcraft diagnosis, they could be expected to operate rather like a medical placebo. Working with the client's beliefs, and with the familiar accompaniments of witchcraft – 'dirt', 'dirty blood', *idliso* (poison) and

¹⁴ See Wreford 2005a: 72-74 for evidence of this agency at work. The trust in ritual and magic as restorative may seem delusory, but nevertheless offers a means of regaining control over apparent chaos and catastrophe. It was very apparent in Renaissance Europe, where, as Ball describes, belief in magic and witchcraft were used to explain a fragmented and dangerous world (2007: 80-81).

¹⁵ The majority of the healers quoted in this paper have taken part in HIV/AIDS training (Wreford *et al* 2006), and are content to accept the biomedical explanation for the disease, and the use of ARVs for the treatment of AIDS.

so on - they could operate at a deeply emotional level to break down the stigma of witchcraft, or of HIV/AIDS.¹⁶

Some independent church movements in South Africa have experimented with this sort of ceremony for rape victims (Dube 2006: 149-152; Phiri 2006:123-124) as well as for HIV/AIDS (Scorgie 2006). It remains to be seen whether rituals can be designed and enacted within the framework of traditional healing. For those participating it would require the courage to challenge stigma and acknowledge and publicly declare their status. A safe environment would be essential to maintain and contain the ritual in a meaningful way. But perhaps the biggest stumbling block lies in the contentious history of relationships between the traditional and western medical paradigms in South Africa (Wreford 2005a: Chap 3), a relationship that has been particularly sensitive in the context of HIV/AIDS. Biomedical practitioners are understandably furious about false claims being made of 'traditional cures' for HIV/AIDS. Given the Minister of Health's support for such remedies, ceremonies such as are visualised here would likewise be vulnerable to accusations of 'traditional' quackery. Some very sensitive management (and careful explanations of the context) would be required to minimise the risk of this reaction.

Healers' stories two: Pretending ukuthwasa

The reason they go to the healers first is they believe that they have been bewitched. But what I am most concerned about is when a person is newly diagnosed with HIV, she goes through all sorts of emotions and mental instability. I personally don't support the idea of newly diagnosed people going to a healer because people don't want to think they may be HIV positive, they would then say they are being called.

This excerpt, offered by a *thwasa*, starts with the familiar assertion of the power of witchcraft in HIV/AIDS discourse. But the narrator then goes on to explain another disguising technique, one that is particularly significant for traditional health practitioners. This is the notion of what I call 'pretending *thwasa*' – when a person, knowing or suspecting that he or she may be HIV positive and fearing

¹⁶ Since some studies recognise that stress acts as a depressor to the immune system (for example Catalan 1999; Olley 2003; Whitesman and Booth 2004), it can be assumed that cleansing rituals might relieve (if only temporarily) a compromised immunity, and thus act to produce a physical, as well as an emotional recovery.

the consequences of disclosure, rather pretends to have received the ‘calling’ to *ukuthwasa*, to become a traditional healer.¹⁷

Just as there are ‘charlatans’¹⁸ in the ranks of traditional practitioners, it is not impossible that there are those who will try to dissemble a calling.¹⁹ But according to testimony of healers and community health workers, the issue of pretending *ukuthwasa* has recently become a very real cover for an HIV/AIDS exposé. A graduate healer offers this very personal anecdote:

[There is this relative] she is already on [ARV] treatment. She went to the clinic through me you know? She was tested through me. She works in the taxi rank, she’s selling there. She came to me and say ‘hey auntie, I’m having those dreams! I was dreaming I was in the water, the big water doing like this with the traditional healers, you know - slaughtering and whatever.’ So I have got a relative that has been called while she’s already on treatment!

Here the THP gently chastises her relative for what we might simply interpret as an ill-judged (and under the circumstances, disrespectful) attempt to disguise her own embarrassment at her status. After all, the relative obviously knew that she had been actively assisted by the healer, and to some extent at least, owed her ARV treatment to her intervention. Rather than face her AIDS diagnosis,²⁰ the woman’s public dissembling - pretending *ukuthwasa* to explain her symptoms - was more acceptable (and safer) than admitting to the reality of the disease. Of course it is quite possible for a *thwasa* (or an *igqirha*) to be HIV positive and taking ARVs, but in this instance the healer is describing a clear example of the use of dissembling a calling in order to disguise AIDS.

The notion of pretending *ukuthwasa* not only acts as a means of avoiding disclosure to family and friends. For the traditional healers it radically challenges some of the processes customarily associated with the calling and

¹⁷ For descriptions of this processual experience see Wreford 2008.

¹⁸ THPs accept that ‘charlatans’ or rogue practitioners are working within their ranks. The issue is particularly sensitive in relation to HIV/AIDS because fraudsters are actively promoting expensive bogus ‘cures’ for the disease. The Traditional Health Practitioners Bill 2003 is in part aimed at limiting the activities of these pretenders but is currently delayed due to a legal challenge apparently by an anti-abortion lobby ‘Doctors for Life’ who are unhappy with the public consultation process carried out before its enactment. Wreford 2008: Chapter 3 provides further discussion of the Act.

¹⁹ The privations and emotional turmoil that characterise *ukuthwasa* generally have the opposite effect however. People often do all they can to avoid accepting their ‘call’ until the sickness that accompanies it forces them to submit to their vocation (Wreford 2005a: Chap 4).

²⁰ Research suggests that for those who have progressed to AIDS, the stigma and isolation that is expected to accompany HIV is even more exaggerated see Ndinda *et al* 2007.

training. For example, the call should be manifested in a dream, in which the *thwasa*'s teacher should be made known. This dream is ideally repeated at least once, and the candidate and her family then seek the teacher out. In interviews that follow the teacher will seek to confirm the calling (often but by no means including evidence of dreams or visions of their own), and often ask for additional proofs, before accepting the initiate. If the candidate is accepted she remains with the teacher, to return home only when agreed with the tutor (Berglund 1976; Janzen 1992: 41; Ngubane 1992, 1977).

Contemporary realities already preclude some of this ideal scenario; HIV/AIDS threatens it further (Flint 2001: 173). First, there is the matter of charlatans.²¹ Especially in the peri-urban settlements that characterise this study, life is a struggle, with poverty and unemployment making daily existence precarious. Survival is difficult, not least as a self-employed professional healer. It is expected that graduated healers 'the big ones' will train *thwasa* of their own, and each trainee is expected to contribute financially to his or her training. This offers a mighty temptation: to charlatans – the pretenders who at the best of times operate without scruple – and are likely to have few qualms about adopting those with a fraudulent 'calling', whether for pure financial gain, or because they simply lack the professional expertise to judge the reality of a true calling.²²

Furthermore, the similarity between some of the symptoms of HIV/AIDS and the calling of itself acts as a sort of mask, as this healer noted:

Let me say, I am not sure when people are diagnosed HIV, get disturbed mentally. Because some would say they have a vision that they should become *thwasa*. But you will see that a person keeps on losing weight though she had accepted *ukuthwasa*.

Both HIV/AIDS and the calling are characterised by emotional disturbance and a range of physical symptoms: wasting, lack of appetite, upsets to the digestive system and so on. As has already been noted it is possible to have a calling (with all *its* symptoms) and to be HIV positive and exhibit the same or similar symptoms. Under these circumstances a longstanding and important marker of

²¹ See footnote 16.

²² According to the testimony of the THPs in the HOPE Cape Town project the pandemic, and the desire to make a living, has led to an increase in fraudulent 'traditional practitioners'. Rueing this phenomenon one THP remarked: 'Healers were respected in the old days. Nowadays there's no respect because they [frauds] don't respect themselves. Each and everyone is a healer now.'

the status of the teacher – his or her ability to distinguish the real from the fake calling – becomes ever more problematic. One healer described the difficulty:

Sometimes [you] can diagnose HIV but a client would say s/he is ill because of a calling. So as a healer you will advise a client to get tested at the clinic and the client will ask you to test for what s/he thinks is a calling. I mean I have seen many people who have undergone traditional training but continue to lose weight and eventually die. And they tell themselves that it's all about the calling.

Here the healer closes with an important additional observation: whether or not the teacher has recognised the HIV status of a *thwasa* under her/his tutelage, acceptance and disclosure of this diagnosis is ultimately always in the hands of the *thwasa*. Some will opt to 'die rather than disclose' (Sethosa and Peltzer 2005: 36). Despite these hurdles, healers remain quite confident that they can distinguish between a true and a pretend experience of *ukuthwasa*:

it's something they cannot tell the doctors they have this call [to *ukuthwasa*]. Then sometimes it's true when the person goes through the rituals she gets better, because it was a call. But on the other side you do get people who are really HIV positive and they will say it's a call, really they're just pretending and want an excuse for HIV.

Discussion

The remainder of the paper re-examines these stories and considers their implications for developing mutually respectful relationships between western medicine and traditional practice.

As some medical doctors themselves acknowledge, much of the responsibility for the mistrust between western and traditional medical practitioners lies with their profession, and its refusal to engage seriously with the traditional sector (SAMJ 2006). Ironically, this diffidence (often combined with a degree of hostility) perpetuates the very ignorance and inadequacy of scientific understanding that traditional practitioners are charged with. It is after all somewhat disingenuous for doctors to persist in alleging that THPs' practices are undermining western medicine's objectives – in the prescription of harsh traditional cleansing remedies for patients on ARVs for example – whilst simultaneously refusing to acknowledge the THPs, or to make any attempt to

relate biomedical concerns to them. On the other hand, if the communication that does take place insists on scientific supremacy and refuses reciprocity, the effort is likely to disappoint (UNAIDS 2006: 6).²³ It is vital (particularly so in the context of HIV/AIDS) that western trained medical personnel start to make serious, and respectful efforts to connect intellectually with the ideas that underline traditional practice. Without this, the implication for the THPs is likely to continue to be destructive of better cooperation in the face of the disease.

In the context of bewitchment and HIV/AIDS, for example, whilst acknowledging that some THPs (and their clients) may connive in this masking notion²⁴ what attempts have western trained doctors made to understand why this is, or to reach out to practitioners in their areas of work? If biomedical complaints about THP practice are to be taken seriously, medical professionals must demonstrate their willingness to engage with the traditional practitioners to explain their concerns. Many healers have often (and rigorously) expressed their enthusiasm for learning more about western medicine's understanding and treatment of HIV/AIDS, STIs, TB, MTCT, ARVs and so on (for example Kayombo *et al* 2007: 8). A healer involved in the HOPE Cape Town project stated this categorically:

I am thirsty for knowledge and I am also keen on meeting with western doctors so that we can share ideas and knowledge about tackling this disease [HIV/AIDS] and save our people.

Such interactions, organised sensitively, can pay dividends, as demonstrated by the practical results of the project that backgrounds this study.²⁵ In the HOPE Cape Town case, over time, the participating healers have forged strong working relationships with their local clinics and the staff who work there. The issue of cross-referrals however - from clinics back to THPs - remains contentious, an expression of biomedical suspicion and reluctance to reciprocate that has typified other collaborative interventions (for example Leclerc-Madlala 2002: 16).

How different it would be if a doctor or other health professional (through careful and sensitive questioning of the patient (Ellis 2004)) was able to

²³ See Wreford 2008: Chap 3 for examples.

²⁴ Wreford 2005a: 73-77 provides an instance of this scenario from the Eastern Cape.

²⁵ For coverage of the initiatory stages see Wreford *et al* 2006. Over a two year period three traditional practitioners have successfully referred 80 clients to local clinics for HIV/AIDS testing. A forthcoming paper, to be published as a Working Paper by ASRU, describes the results of this initiative in detail (Wreford *et al* 2007b).

appreciate that, according to their understanding, witchcraft offers a credible explanation for the symptoms. Experience of interaction with THPs would alert the doctor to possible complications, of unwanted drug interactions that might arise if the patient was taking herbal medication for instance.²⁶ Secondly, in the context of the positive uses of witchcraft discourse discussed earlier in the paper, even if the physician were unable to dissuade the patient from his or her belief, there would still be another option. Having established confident liaisons with local THPs,²⁷ the patient could be safely referred by the doctor to a healer. The traditional practitioner could then use traditional and VCT counselling skills, and where appropriate, cleansing rituals could be enacted to exploit the same belief beneficently, psychologically ridding the person of their contamination and the emotional trauma of HIV/AIDS.

The advantages to this approach are threefold: the medical practitioner could be satisfied that the liaison with THPs would ensure the minimum of unwanted drug interactions or other unhelpful situations; the THP would be satisfied that traditional approaches to treatment and diagnosis had been respected and acted on; finally, the patient, having involved both paradigms, could be assured that nothing had been left out in the search for a solution.

I appreciate that western trained practitioners may find the notions of witchcraft entirely implausible and without relevance to their practice. I am not suggesting that they should accept such interpretations as 'true'. What I do suggest is important is that they become aware that for many of their patients such explanations do carry weight and authority, and have enormous influence in the process of healing. To acquiesce in the patients' understandings of the disease is not to endorse them, but rather to acknowledge and respect their agency. I am confident that by paying attention to different interpretations of health and illness, and where appropriate, incorporating them in practice, the efficacy of biomedical HIV/AIDS interventions could be significantly enhanced. I would like to hope that some doctors and western trained medical professionals will at least be willing to leave behind their suspicions and frustrations and consider a constructive engagement with a cohort of professionals who possess different knowledges and employ different practices to enact their healing.²⁸

²⁶ Through discussions with their THP counterparts it would also have been recognised that many THPs argue that traditional and western medicines should not be used simultaneously, and criticise western medicine for giving 'harsh' medicine like ARVs to someone with a depleted immune system.

²⁷ Through projects such as the HOPE Cape Town initiative for example.

²⁸ With this aim in mind, the author is currently involved with other THPs in introducing students at the University of Cape Town's Medical School at Groote Schuur Hospital to the concepts of traditional practice.

Pretending and pretenders as barriers to collaboration

The story I have called ‘pretending *ukuthwasa*’ may at first sight appear to be of concern only to traditional healers. It is certainly true, as discussed earlier, that the tale presents graduate healers, notably those involved in the training of initiates or *thwasa*, with an unusual challenge. But here I would like to point to some of the implications for collaborative efforts between biomedicine and THPs in this new twist in the customary practice of traditional healers.

First of all, and most damaging in the context of the controversy around charlatan practitioners, pretend *thwasas* – those offering a bogus or convenience calling to mask HIV/AIDS - might be accepted by unscrupulous practitioners simply for the financial gain of the fees to be garnered from their ‘training’. This might offer doctors more ammunition in their characterisation of all THPs as frauds: a further discouragement to collaborative efforts. Secondly, in the pretending *ukuthwasa* scenario, it is essential to remember that the masquerading *thwasa* will obviously not have informed the teacher of their real status. It is therefore possible (although given the haphazard distribution of the drugs, perhaps unlikely) that, if the *thwasa* is already on ARVs, there could arise an unwanted interaction between traditional and biomedical medications.

A third comment has more practical implications for those intending to establish collaborative initiatives with the traditional healing sector. The accomplished charlatan will often be able to boast of a large and flourishing practice, especially when the remedies offer hope of a ‘cure’ for the desperate. As already emphasised, THPs tend to be disarmingly sanguine about the existence of charlatan healers. But there are some assumptions made in identifying such frauds. For instance, in the context of HIV/AIDS, the healers involved in the HOPE Cape Town project tend to suspect anyone offering a ‘cure’ for the disease. As one healer put it: ‘I think they are lying, from my personal experience, they are not telling the truth’, a censure that condemns the behaviour of the fraudulent ‘curer’ as an affront to genuine healers. But, as another healer remarked, charlatans ‘are greedy for money’. Bogus ‘cures’ for HIV/AIDS are generally offered only in return for large sums.²⁹ The healer’s critique implicitly acknowledges that being ‘greedy for money’ is of itself a contradiction of traditional practice (in which payment was renounced until a cure was successfully achieved (Tangwa 2005)), and therefore an admission of fraud.

²⁹ See Wreford *et al* 2006: 26 for anecdotal evidence of a fraud at work from community health workers associated with the HOPE Cape Town project.

Western trained medical personnel looking to find THPs for collaborative initiatives will need to be alert to the possibility of ‘pretenders’. To avoid disillusionment, it is important to get to know and seek to work with, those healers who have the trust of their communities, have an established practice, and a good reputation. The use of local knowledge, such as that of Community Health Workers, community organisations and clinic staff should help to avoid bogus associations. With this information as a foundation, more accessible and applicable trainings for THPs in HIV/AIDS interventions could well be devised (Mazaza 2006). The establishment of relationships of trust will not be easy, but I am confident that the incorporation of South Africa’s existing cohort of traditional healers into HIV/AIDS prevention and treatment can only improve outcomes of those interventions.

Conclusion

This paper has examined two narratives that arise in the context of avoidance of disclosure of HIV/AIDS in South Africa. These accounts, narrated by the traditional health practitioners, show the discourse of bewitchment, and the customary processes involved in becoming a traditional healer (*ukuthwasa*), being subverted as tactics of avoidance of a positive HIV/AIDS diagnosis. The paper suggests that traditional healers (especially those who are familiar with western concepts of HIV/AIDS) do not simply endorse these accounts, but are prepared to be sceptical and to challenge them when they arise. The paper argues that THPs can by no means always be legitimately blamed for encouraging denial and non-disclosure, or for wilfully undermining western medical efforts to deal with the epidemic. Throughout, the paper calls on medical personnel in particular to engage seriously with traditional practitioners in order to improve and enhance the prevention and treatment of HIV/AIDS in South Africa.

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