UNTAPPED POTENTIAL: OPPORTUNITIES FOR COLLABORATION WITH TRADITIONAL HEALTH PRACTITIONERS IN HIV/AIDS PREVENTION AND CARE IN SOUTH AFRICA

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ABSTRACT

South Africa continues to have one of the highest prevalence rates of HIV and AIDS in the world. The high rate of infection, coupled with the fact that many South Africans do not have access to adequate healthcare, has led to a crisis that the government has largely been unable to address. After witnessing this health care crisis firsthand while studying and volunteering in Cape Town, I became interested in alternative methods to address this situation. Fortunately, there exists a largely untapped resource in the fight against HIV and AIDS: traditional healers, also known as sangomas. Many South Africans consult sangomas in conjunction with western healthcare providers or as a primary care provider. Though not able to administer medical treatments in a western sense, sangomas could prove to be invaluable resources for educating the population about HIV and AIDS, especially in regards to prevention and adherence to anti-retroviral therapy regimens. Because they are well respected in their communities and share a culture with the population they are serving, sangomas have a unique opportunity to connect with their patients and make a difference in the fight against HIV/AIDS.

This thesis seeks to provide an overview of the complicated role of traditional medicine in modern South Africa, while highlighting programs that have attempted to navigate the divide between traditional and western medicine. Small-scale programs have made great strides toward incorporating traditional healers in HIV prevention and treatment programs in South Africa, but little action has been taken on a national level to increase cooperation. By analyzing the successes and failures of such programs, I hope to contribute to the formation of effective versions of these initiatives that can be replicated on a larger scale.
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Chapter 1: An Overview of HIV/AIDS in South Africa

As soon as I accepted my invitation to study abroad in Cape Town, I began eagerly pouring over guidebooks and reading every bit of information about South Africa that I could get my hands on. From the first glimpse I snuck through the tiny airplane window, I was utterly captivated by the city’s natural beauty. Though I felt thoroughly equipped to handle my semester abroad, no amount of research could have prepared me for what I was about to see on the ride from the airport into town. The contrast between the airport's glistening international terminal and the seemingly endless plain of corrugated aluminum shacks along the highway could not have been more pronounced. Loose electrical wires fell carelessly onto the crumbling roofs of homes, which were often unsteadily stacked two or three on top of each other. The rows of homes were packed impossibly close together, leaving only narrow roads for traffic or outdoor plumbing facilities and expanding outward until a major roadway made further construction impossible. As the airport shuttle cruised past the township, and the colorful cluster of overcrowded homes and their inhabitants faded into the distance, the grand silhouette of Table Mountain grew larger and larger on the horizon. Before I knew it, and I was being given a tour of the University of Cape Town's stately campus, full of ivy-covered and column-lined buildings separated by pristinely manicured gardens, and the sights from the township seemed like a distance memory. But standing on the steps of Upper Campus looking out over the breathtaking panoramic view of the city, I spotted the crowded Khayelitsha Township far off on the horizon, and realized that the two places, though separated by only a few miles, were truly worlds apart. Over the course of my semester in Cape Town, I realized that his dichotomy between rich and poor, which also falls largely along racial lines, pervades nearly every facet of life in Cape Town, from education to employment, and, most interestingly to me, healthcare. I became intensely interested in investigating ways to lesson this divide.
Figure 1: Tapestry depicting HIV/AIDS deaths displayed at the Origins Museum in Johannesburg, South Africa; artist unknown

A National Crisis

According to the World Health Organization, complications from HIV/AIDS kill more South African than any other cause, and more people die from HIV/AIDS in South Africa each year than in any other country in the world. As of 2015, there are more than six million South Africans living with HIV. Though HIV infection rates have generally leveled off since peaking in the mid-2000s, rates are beginning to increase slightly once again. The proportion of South Africans living with HIV increased from 10.6% in 2008 to 12.2% in 2012, according to the Human Sciences Research Council's (HSRC) National HIV Prevalence, Incidence and Behaviour Survey. The pandemic has had the most devastating effects on the black population, who had an
infection rate of 15 percent as of 2012. For comparison, only 0.3 percent of white South Africans and 3.1 percent of colored South Africans are living with HIV.

The HIV/AIDS crisis is compounded by a healthcare system that fails to adequately serve a large portion of its population. Current minister of health Aaron Motsoaledi admits that the 82 percent of people who use public healthcare are receiving second-rate care (The Sunday Times). Not surprisingly, the wealthy spend a significant amount more on healthcare and are therefore able to afford private doctors, who typically offer superior care (Case et al. 2005:18). Individuals of lower socioeconomic status — who generally utilize public health care — are more likely to be HIV-positive, according to the HSRC survey. Under the current system, those most strongly affected by the HIV pandemic, namely poor, black South Africans, are the least likely to receive adequate care.

The inequality of care provided by private versus public hospitals is significant, but a perhaps even larger problem lies in the fact that a portion of South Africans have access to neither form. Even in areas where public healthcare is theoretically accessible, visiting a western doctor is not always feasible. On average, the costs of treatment in a public hospital “amount to nearly twice median per capita monthly income” of the typical patient (Case et al. 2005:18). This estimate does not include travel to and from the clinic or hospital, which to some could be a significant financial burden. In some instances, paying for a medical expenditure can cost more than half a year of schooling for a patient’s child (Case et al. 2005). Clearly, the South African healthcare system is not equipped to handle the basic needs of its citizens, let along the world’s largest AIDS epidemic and the myriad of diseases that its immune-deficient citizens are likely to contract.
A History of HIV/AIDS in South Africa

Despite the fact that the epidemic now disproportionately impacts poor, black women, the initial outbreak of HIV/AIDS in South Africa was largely contained to the male, gay, and white population. In 1981, the country’s first two cases were officially documented (Ras et al. 1983). The two men — both flight attendants — likely contracted the virus while visiting the United States. During the course of the next seven years, the virus spread slowly, leading to only 166 confirmed cases of AIDS in the entire country in that time span. Of these cases, 125 were gay men (Sher 1989).

The first black South African was diagnosed with AIDS in 1987 (Van der Vliet 2004), and by early 1991 the number of cases of heterosexual transmission of the virus surpassed the number attributed to homosexual transmission as the epidemic began to grip the country in earnest (Iliffe 2006). Within the next ten years, South Africa would transition from having one of the lowest rates of infection on the continent with less than one percent of the population infected to being the epicenter of the global AIDS crisis. The growth of HIV prevalence over the course of presidential administrations is represented in Figure 2.
Figure 2: Growth of HIV across presidential administrations

Nelson Mandela was inaugurated as the first democratically elected president of South Africa on May 10, 1994. Despite the widespread adoration of Mandela in South Africa, many have criticized his lack of initiative in addressing the HIV/AIDS epidemic that was gripping the country during his election and subsequent presidential term. "I wanted to win and I didn't talk about AIDS," Mandela himself admitted in a 2003 interview with the BBC (Dimbleby 2003).

When Mandela took office, 7.6 percent of pregnant women were HIV positive and reported cases of the virus were growing exponentially (National HIV & Syphilis Antenatal
Sero-Prevalence Survey in SA 2005). By the time Mandela stepped down from office in 1999, this percentage had grown to 22.4 percent. Mandela cited the multitude of pressing national crises — including keeping a volatile post-apartheid country at peace — in defense of his inaction in the HIV/AIDS fight. Though many sympathize with Mandela’s preoccupation, others have been very critical of the late president’s inaction.

Judge Edwin Cameron, a justice of the South African Constitutional Court and an HIV-positive man, has been an outspoken critic of the president’s complacency regarding the epidemic during his term in office.

"A message from this man of saint-like, in some ways almost god-like stature would have been effective. He didn't do it. In 199 ways he was our country's saviour. In the 200th way he was not," Cameron told the BBC (Dimbleby 2003).

In an interview with PBS titled “Nelson Mandela’s Mixed Legacy on HIV/AIDS,” Cameron claims that while serving as co-chair for the National Convention on AIDS, he persistently requested meetings with Mandela to no avail. As the epidemic continued to escalate, Cameron and his colleagues hoped that Mandela would publicly address the nation regarding the epidemic. “[The] thing he could have done would have been to get out the message of anti-stigma early. Now, still, 25 years after the epidemic started in Africa, stigma is still a central problem,” Cameron said of his hopes for the president. Cameron and many others believe that widespread stigma of HIV and AIDS, partly due to early associations with the homosexual community and conservative sexual values, contributed to the quick spread of the virus. An official statement acknowledging the epidemic could have had significant impacts on the extent of the epidemic over time, Cameron believes.
Reflecting on his time in office, Mandela has said, "It’s no use crying over spilt milk," (Dimbleby 2003). After stepping down from office, Mandela did actively join the fight against HIV and AIDS. In 2001, he spoke publicly against AIDS denialism and addressed Parliament on the importance of stopping mother-to-child transmission of HIV a year later. Soon after, while speaking about his son who had died of AIDS, Mandela wore an “HIV Positive” t-shirt to express solidarity with those infected and to publicly acknowledge the epidemic (Dimbleby 2003).

But despite his delayed efforts to support the fight against HIV after leaving office, Mandela set the tone for his predecessor. As he left office, Mandela passed the burden to his former Deputy President Thabo Mbeki, under whose administration the epidemic would reach catastrophic proportions.

**Mbeki: “Fiddling while Rome burns”**

Thabo Mbeki was elected president on June 14, 1999. In October of the same year, he gave a speech to the National Council of Provinces in which he cautioned against the purported dangers of antiretroviral therapy. The following April, Mbeki famously penned a letter to United States President Bill Clinton in which he described South Africa’s plan for addressing the HIV/AIDS epidemic. Though he cites the formation of a task force, National AIDS Council, and research teams, his letter drips with denialism of the of the AIDS epidemic at large. Mbeki writes that AIDS is a “uniquely African catastrophe” and argues that applying knowledge from the Western AIDS outbreak would be “absurd and illogical.” Without explicitly stating in the letter that he believes HIV does not cause AIDS, Mbeki refers to the “intellectual intimidation and terrorism” that he and others who hold dissenting opinions about the link between HIV and
AIDS face. He alludes to witch-hunting and writes that his freedom of speech is being violated by being pressure into accepting scientific research on the epidemic.

The letter was leaked to the Washington Post and prompted a barrage of backlash from the international community, as depicted in Figure 3. But Mbeki was relentless in his questioning of the link between HIV and AIDS, and over the next six years would continue to raise doubts about the effectiveness of ARV use while promoting alternative medicines and natural cures. (This would have dire consequences on public perception of traditional medicine, which will be discussed in detail in Chapter 4 of this thesis.) Nicoli Nattrass, director of the AIDS and Society Research Unit and professor at the University of Cape Town, summarized Mbeki’s time in office, writing that he “championed a small group of AIDS denialists who believed that HIV is harmless and that AIDS symptoms are caused by malnutrition, drug abuse and even ARVs themselves,” (2008). Cape Town Archbishop Desmond Tutu compared Mbeki’s inactions while HIV prevalence rose to “fiddling while Rome burns” (Gumede 2005).

Figure 3: Zapiro cartoon depicting Mbeki originally published in The Sowetan on February 11, 2004
Though the government officially announced that it had changed its policy on October 26, 2006, and would begin distributing ARVs in public hospitals nationally, messages from the President’s cabinet were mixed and often confusing. Minister of Health Manto Tshabalala-Msimang infamously advocated for use of garlic, lemon, and beetroot to treat HIV/AIDS, while publicly expressing doubts about the use of ARVs, even after the official government rollout of the drugs (Chigwedere et al. 2008). Multiple studies have suggested that the policies implemented by Mbeki and Tshabalala-Msimang contributed to the deaths of more than 300,000 South Africans before 2006, particularly due to their administration's stalling of a program to prevent mother-to-child transmission of HIV (Nattrass 2008, Chigwedere 2008).

Many view the election of Jacob Zuma to the presidency in 2009 as the formal end of AIDS denialism in South Africa. Though Zuma set a poor example by publicly admitting to showering after having unprotected sex with an HIV-positive woman to reduce his risk of contracting the virus, as depicted in Figure 4, policies enacted during his administration have led to a significant decrease in new cases of HIV and a large increase in the number of ARV users.

*Figure 4: Zapiro cartoon depicting Zuma originally published in the Mail & Guardian on May 11, 2006*
Looking to the Future

There are currently more South Africans on ARVs than ever before, and rates of mother-to-child have decreased more than 90 percent since the pandemic peaked (McNeil 2014). Despite these positive steps, rates of infection have increased slightly since 2008, as shown in Figure 2. In the same time frame, condom usage has decreased from 85 to 68 percent for 15-24 year olds and from 44 to 36 percent in men aged 25-49, according to national surveys by the Human Sciences Research Council.

Compounding increasing rates of infection, the South African government also faces a sharp decrease in international funding to support the fight against HIV. Though roughly 80 percent of South Africa’s HIV/AIDS budget comes from internal sources, the country continues to rely on foreign aid to fund relief programs. The United States government, via the President’s Emergency Plan for AIDS Relief (Pepfar), is the largest foreign contributor to the HIV/AIDS effort in South Africa, but will be decreasing funding by nearly one-third in 2016 (McNeil 2014). In a study following up after the closure of a Pepfar-funded HIV clinic due to budget cuts, it was discovered that nearly 20 percent of patients did not renew their ARV prescriptions at alternative clinics after closure (Cloete et al. 2014). If this trend continues when funding is decreased nationally, thousands of patients could suffer disruption of care. Though the South African treasury promises to scale-up funding to accommodate the loss of international aid, only time will tell if the country’s healthcare system is able to withstand with this change and the persisting HIV/AIDS crisis at large.
Fortunately, there exists a largely untapped resource in the fight against HIV/AIDS in South Africa. Traditional healers, or sangomas, remain an important component of life for many South Africans. Cooperation between the traditional and western medical sectors could be instrumental in improving HIV education, prevention, and adherence to treatment regimens, particularly in populations currently underserved by the public healthcare system. In the remainder of this thesis, I will detail the role that traditional healers play in modern South Africa using demographic information and anthropological evaluations of their cultural relevance and status. This information will be contextualized with an overview of the controversy surrounding the incorporation of traditional healers into the national health care system, with particular attention being paid to public opinion regarding legislation. Case studies detailing programs that have provided HIV/AIDS education to sangomas, or otherwise included sangomas in prevention programs, will be summarized and evaluated for strengths and weaknesses. Finally, recommendations will be proposed for national policy formation and to guide future research.
Chapter 2 : The Role of Traditional Healers in South Africa

Soon after starting classes at the University of Cape Town, I became involved with SHAWCO Health, a student-run organization that provides free healthcare from a mobile clinic to residents of townships. We treated hundreds of patients a week from a rickety trailer made up of four tiny exam rooms, one very crowded hallway, and a perpetually under-stocked medicine cabinet. My first role in the clinic was to assist the medical students with examining and interviewing patients, but before long I was doing intakes and HIV testing myself. I vividly remember first positive result I ever had to deliver to a patient. The statistics about the astronomical HIV prevalence in South Africa had always astounded me, but now they had a face and a name.

One night when the clinic was postponed due to poor weather, I realized that many of our regular patients would likely have to go without healthcare for that week. The local public hospital closed early in the evening, and, for many of our patients, missing work to visit the doctor was simply not an option. It became clear to me that the healthcare system was not adequately serving the country's poor. Over the course of the semester, I became increasingly interested in exploring alternatives to the current system.

I can't remember who first introduced me to the traditional healthcare system in South Africa, but I was immediately intrigued. After studying sangoma, or traditiona healers, for hours in the UCT library, I was eager to see one in action and arranged an observation.. I anxiously set out with my translator, and though I struggled to keep up with the conversations in isiXhosa, I watched in awe as the sangoma diagnosed and treated her patient. Between chatting about the patient's concerns, literally "throwing bones" to diagnose the illness, and mixing up medicine for the patient to take home, more than two hours had passed before the session ended. Unlike the rushed and crowded clinics, the interaction between the sangoma and her client was intimate and personal. The sangoma spoke kindly and confidently, and her patient listened intently to her every word.
The World Health Organization defines a traditional health practitioner as “a person recognized by the community in which he or she lives as competent to carry out diagnoses with local sociocultural methods, and contributes to the physical, mental, social, and spiritual well-being of the members of their communities” (Kasilo and Trapsida 2010). Traditional healers, often referred to as *sangomas* in South Africa, are a “fully part of South African life and consciousness” (Thornton 2009:17). Sangomas offer services ranging from treating physical illnesses, to giving relationship advice, to protecting clients from car wrecks (Thornton 2009). The system of traditional healing in South Africa is complicated, but can be briefly summarized as follows:

“In general, three forms of healing are practised by African traditional healers and their clients: (1) that practised by those who have ‘graduated’ from the period of tuition and self healing, called *sangomas*; (2) the practice of those who use or sell herbal remedies
The term sangoma is often used colloquially to refer to all three types of traditional healers, and will be used as such in this paper.

In order to become a sangoma, an individual must undergo formal training, or *mpandze*. Teachers, or *emagobela*, engage formally with students, or *bathwasana* and share their knowledge of divination, herbal remedies, and more (Thornton 2005). The selection and training of sangomas is a complex process. Though many choose to pursue the discipline after suffering “fits of mania or depression,” which is perceived to be a vocational calling from ancestor spirits, all sangomas must be “reasonably healthy and motivated” (Thornton 2005: 29). The training is not only demanding and time consuming, but also very expensive. Thornton estimates that training can cost anywhere from R5,323 to R9,000, which is the equivalent of six months’ salary for a typical worker. Not only is training to become a sangoma a prized honor, but it is also a significant investment of time and money.

**A Culturally Sensitive Solution**

In the South African context, traditional healers represent a legitimate alternative to western medicine in variety situations. Although there is no denying that certain ailments require western medicine (such as antiretroviral therapies), sangomas provide services that western doctors cannot. Sangomas are “accessible, culturally sensitive, affordable, and they speak the language of the clients” (Wreford 2006: 1). While the typical South African doctor in a public hospital has more patients than he or she can handle, it is estimated that an average sangoma sees
just 14 patients per week (Green et al. 1995). This is not due to disinterest in the practice of sangomas, but rather due to the sheer volume of traditional healers that are available for consultation. There are an estimated 200,000 traditional healers in South Africa compared to just 37,000 medical doctors. This favorable patient to client ratio means that sangomas have more time to spend with each client, and are therefore able to provide more personal and interactive care. While a doctor might simply treat a patient and prescribe medicine, the sangoma has the time to converse with a patient to ensure total understanding of the diagnosis and best course of treatment.

Though it is clear that more sangomas are more readily available than western practitioners, and that sangomas typically have more time to dedicate to each patient, it is unclear whether they are a more affordable option. While some argue that sangomas are “not a poor man’s doctor” (Thornton 2009: 17), others maintain that sangomas are the “affordable” option (Wreford 2006: 1). A national household survey found that the median price for a visit to a traditional healer is R150 (Nxumalo et al.). Of the individuals who reported consulting traditional healers in this survey, 64 percent spent more than 10 percent of their monthly income on traditional medical services, with those in the lowest income brackets being more likely to spend a larger portion of their income (Nxumalo et al. 2011: 132). In comparison, only 13.6 percent of respondents spent more than ten percent of their income on health care services from public hospitals, and 32.2 percent spent more than ten percent at private hospitals. The same study also found that though traditional medical services are roughly the same as private medical services, traditional healers are often more flexible in regards to payment. Some use a “no-cure-no-pay” system while others accept livestock or other non-monetary forms of payment.
While it may be true that certain services offered by the sangoma cost the same as their western counterparts, factors like transportation and missed work must be factored into the affordability equation. Often, sangomas are more conveniently located, and therefore less expensive to access. More importantly, cost is not always a simply monetary issue. As mentioned previously, there are certain aspects of traditional medicine that western practitioners cannot replicate, not the least of which is the notion of shared culture.

**Who Consults Sangomas?**

There is a range of conflicting statistics regarding the use of traditional healers in South Africa. One widely cited statistic claims that 80 percent of South Africans consult traditional healers to address their primary medical needs (Peltzer 2008). Many others put forth vague claims about the prevalence of traditional medicine, with statements like: “traditional healers are the first to be called for help when illness strikes the majority of South Africans,” (van Niekerk 2012). Despite the fact that these papers are published in peer-reviewed national and international journals, their claims of widespread traditional medicine use are unsubstantiated.

The trail of misleading citations appears to trace back to a report published by the World Health Organization in 2008. The report claimed — without a citation — that “in Africa up to 80 percent of the population uses TM [traditional medicine] to help meet their health care needs” (WHO Traditional Medicine Fact Sheet). The statistic is repeated later in the report, this time citing the book *Traditional Medicine and Healthcare Coverage* written by Robert Bannerman, a former WHO regional director. Bannerman writes,
“In many of these developing countries primary health care devolves on the healer, herbalist, traditional midwife, and other traditional practitioners. These are the health workers that offer services to the disadvantaged groups that total about 80 percent of the world’s population and have no easy access to any permanent form of health care,” (Bannerman 1983: 320).

Bannerman cites no empirical data that he used to reach this conclusion. Though his statement seems innocuous in isolation, the manner in which this “statistic” has been warped since 1983 is troubling. After stating in 2008 that 80 percent of Africans use traditional medicine to meet their primary care needs, WHO published a progress report in 2011, this time reporting that traditional medicine is the “first source” of healthcare for 80 percent of Africans. Even more problematic is the manner in which this statistic is applied to South Africa. Not only is the statistic unsubstantiated, but it is also was never directly used by the WHO to describe South Africans.

It is apparent that there is little to no validity to the claim that 80 percent of South Africans consult sangomas regularly. But even after eliminating this outlying value, there is still a large range of values for the prevalence of traditional healer use in South Africa. The South African Department of Health 2003 Demographic and Health Survey found that 7.9 percent of men and 6.3 percent of women had consulted a traditional or faith healer in a 12 month period. Of those individuals who had sought treatment for a sexually transmitted infection, 9.6 percent of men and 1.2 percent of women reported visiting a traditional healer. Another home survey conducted by the University of the Witwatersrand found that only 1.2 percent of South Africans had visited a traditional health practitioner in the last 30 days (Nxumalo et al. 2011). The authors noted that individuals who visited traditional healers “were more likely to be poor, unemployed,
living in rural areas, aged between 25 and 49 years and to have reported low health status” (Nuxumalo et al. 2011: 132).

A study conducted on health-seeking practices in rural areas of KwaZulu Natal found that almost every adult seeks the help of conventional, allopathic medicine (Case 2005: 18). The same study that found that most people in rural KwaZulu Natal visit a western doctor when sick also found that more than 50 percent of people visited a traditional healer as well (Case 2005: 18). A similar analysis of health-seeking behavior conducted in Khayelitsha, an urban township outside of Cape Town, found that only about 6 percent of respondents visited a sangoma the last time they were “seriously sick” (Nattrass 2005). The results of the quantitative analysis led Nattrass to conclude that primary factor that leads people to seek traditional medicine is socio-economic status, and not living in a rural or urban setting, as was previously thought. It was concluded that the determining factor as to whether or not a citizen of Khayelitsha would consult a sangoma was actually whether or not that individual was receiving a disability grant. Those who receive disability grants are not only more likely to visits a sangoma because they are disabled, but also because they have the means to do so. This points to the fact that traditional healers might not be any less expensive than western medicine, but they are still sought after and respected by the community (Nattrass 2005).

Overall, it is difficult to say how many South Africans regularly consult traditional healers, though credible values range from one to fifty percent of the population. In many instances, individuals who consult sangomas do so while concurrently seeking conventional medical treatment. Whatever the actual rate may be, traditional medicine is a booming industry in South Africa. Including both visits to a traditional health practitioner and purchasing
traditional remedies from other sources, the traditional medicine trade contributes 2.9 billion rand to the nation’s economy annually (Mander et al. 2007).

**Benefits of Incorporation**

In addition to the fact that traditional medicine contributes significantly to the economy, there are many arguments to be made as to why traditional healers should be an integral part of the healthcare system in South Africa. Freeman and Mostei (1992) summarize the benefits by listing the following reasons for continued use of traditional healers: (1) the healthcare provided in the conventional manner is inadequate for large portions of the population; (2) sangomas provide cultural continuity; (3) there is an emphasis on human care and interaction; and (4) *muti*, or herbal remedies, prescribed by sangomas can be very effective at treating certain ailments. Wreford (2006) adds that sangomas are easier for community members to trust than western medical professionals, as many patients feel that sangomas are better at keeping information confidential, because they understand the cultural stigmas associated with certain diagnoses. Wreford recounts several instances in which western practitioners acted carelessly and revealed information that the patient did not want to be revealed. As a member of the community him- or herself, the sangoma would understand what ailments are considered taboo, and which ailments people would want to keep hidden.

Research suggests that sangomas are increasingly supportive of the use of biomedicine in the fight against HIV and AIDS. In a qualitative study of the behavior of 25 sangomas in the Eastern Cape in 2006, it was concluded that traditional healers are willing to promote the use of ARVs for many reasons. While some reasons are purely practical and self-serving, such as avoiding punishment under the Traditional Health Practitioners Act (which will be discussed
further in Chapter 3), which prohibits traditional healers from treating chronic illnesses like HIV, other reasons are more complicated (Shuster 2009: 18). Many of the sangomas who approved of ARVs had intimate connections with the drugs, either by using them personally or having witnessed a family member take them. All sangomas interviewed for the study had previously engaged in HIV/AIDS prevention and caring training provided by the Africare organization. In this particular instance, it would appear that exposure to information about ARVs is crucial for fostering a meaningful partnership in the fight against HIV.

**Obstacles to Incorporation**

Although there are many benefits to incorporating sangomas into the healthcare system, there are certainly problems that need to be addressed. One major issue is that it is difficult to regulate the large and ever expanding network of traditional healers. Though in theory regulation and recognition is a very positive step forward, it could have negative consequences. By recognizing certain sangomas, the government essentially validates the entire practice in the eyes of the public. This can be harmful when patients trust healers who are not formally registered, and perhaps are using unsafe practices. Though it is necessary that sangomas be regulated to ensure no poisonous herbal remedies are being used, it is difficult to determine the extent to which they are regulated, and even more difficult to devise a feasible plan for regulating on a national scale. As of 2009, only about 30 percent of sangomas are registered formally with any organization (Thornton 2009). Most sangomas do not see any benefit to registering. In addition, as Fassin posits, “the stronger the traditional legitimacy, the less need to rational-legal legitimation” (1988: 30). Due to the longstanding division between traditional and conventional medicine, veterans in both sectors tend to be unwilling to collaborate with the other.
An additional obstacle to overcome is the fact that some sangomas are reluctant to take part in western health practices (Bye & Dutton 1991). Mainly, sangomas are hesitant to refer patients to clinics or hospitals because it means loss of income for them. Referrals in the reverse direction, from doctor to sangoma, are essentially non-existent, and sangomas cannot afford to lose their already insufficient income (Wreford 2006). Additionally, sangomas face losing their special status in the community, due to the fact that they might be perceived as weak or incapable of performing their duty when they refer patients elsewhere (Bye & Dutton 1991).

Moreover, sangomas are reluctant to join national organization, which are typically led by English-speaking men, because they have difficulty reading and writing in English (Green et al. 1995). While these issues are not insignificant and must be considered in the formation of legislation regarding cooperation between the two sectors, they are far from deal breakers in the relationship between sangomas and conventional medicine.

**Building Relationships**

Moving forward, Freeman and Motsei see three logical options for linking traditional healers and Western medicine: (1) incorporation, (2) cooperation, and (3) total integration. In the first option, traditional healers are incorporated into the Western healthcare system as a first point of contact. Sangomas would treat patients using only practices that have been approved by the medical community, which, as Freeman and Motsei note, could result in certain traditional practices being “strongly discouraged or even banned” (Freeman & Motsei 1992: 1184). This notion of incorporation is problematic, for reasons similar to Thornton’s protest of the Traditional Practitioners Act. By neglecting to consider the wealth of knowledge sangomas have
in non-Western practices, this method of incorporation reduces them to watered-down versions of healthcare practitioners.

Freeman and Mostei’s second option involving cooperation and collaboration points toward a much more productive traditional/ Western relationship. This option, which seems to most closely resemble the current state of affairs, involves both sides remaining autonomous, but would rely on a system of “mutual referral” (Freeman & Mostei 1992: 1184). Sangomas, under the Traditional Practitioners Act, must refer patients to Western-style doctors for diagnosis and treatment of chronic illness such as HIV. There is little to no research to suggest that physicians are making an effort to refer patients to sangomas. As has been argued in this paper, sangomas can provide many aspects of care that conventional medicine cannot, including shared culture with patients, greater accessibility, and more time to spend discussing concerns with patients one-on-one. In order for the cooperation and collaboration method to be effective, both sides need to acknowledge the potential of collaboration with the other side. To reach this goal, communication must be kept open between the two sides, and education should be emphasized. Not only should sangomas be trained in recognizing which illnesses are outside their ability to treat, but Western health care workers should also be knowledgeable about what illnesses sangomas can effectively treat. By referring patients to sangomas for certain maladies, or for counseling or preventive care, the strain of overcrowding in hospitals could potentially be reduced. The doctor would then be encouraged to refer the patient back to the sangoma for spiritual counseling and healing (Bolognesi 2006: 627). The patient benefits twofold: first in the sense that sangomas know when a problem is serious enough to warrant conventional medical intervention, and second that patients would receive more personalized counseling, which could
be the difference between fully understanding a diagnosis and not following an ARV treatment plan.

The third method proposed by Freeman and Mostei is total integration. In this scenario, sangomas and conventional practitioners would work together in one comprehensive system. This could mean sangomas would explain the cause or “why” by calling on ancestors, while a doctor might treat the illness with either a conventional drug or traditional muti. Though it seems unlikely that sangomas and medical doctors will ever operate under the same roof for logistic and practical concerns, steps are already been taken in this direction. Medical students at the University of Cape Town, for example, are being trained in cultural awareness and traditional healing, specifically regarding HIV/AIDS (Bateman 2010: 80).

In summary, sangomas are a highly respected alternative to many South Africans, including those most affected by the HIV epidemic, for a variety of healthcare concerns. Sangomas hold a unique position of power and respect in the community, and can bring many elements to the healthcare system that conventional medicine cannot. Though the potential for collaboration is great, to date the two systems operate entirely independently, and, as will be discussed in the next chapter, are often at odds with one another.
Chapter 3 : Legislation and Public Perception

While I impatiently waited for a friend of mine to arrange the sangoma observation I described in Chapter 2, I decided to pursue a sangoma visit on my own. After I quick internet search, I discovered Dr. Ibrahim, a sangoma advertising a vast array of services ranging from relationship counseling to protection from enemies and good luck potions. After sending a couple of emails to him with no response, I ventured out to Long Street with a particularly adventurous friend in tow to see if the doctor would accept walk-ins. Nestled between a bar and a tattoo parlor, Dr. Ibrahim’s office was cramped and poorly lit. The small waiting room, which was completely empty at 2 pm, looked exactly how someone might envision a “mad scientist’s” lab, if you ignore the numerous plastic bottles labeled “male sperm enhancement” that littered the shelves.

On one of the dusty shelves stocked with nondescript liquids of varying hues, we spotted and hesitantly rang a service bell. Moments later, Dr. Ibrahim himself emerged from the back room. He enthusiastically asked what services we were in need of, and I explained to him that I was interested in learning more about traditional medicine, and wondered if he might let me observe him in action. As I expected, he said that such an honor would cost me, and asked for 1000 rand, or 100 USD, to continue our conversation. A bit taken aback by the sticker shock, but by this point accustomed to haggling with vendors in town, I attempted to negotiate a lower price. Unfortunately, the doctor was unwilling to budge, and instead tried to sell me on his abilities, promising that after our consultation I would finally find the man of my dreams. Disappointed, but slightly amused, my friend and I left the shop with no consultation.
As discussed in Chapter 2, the potential for cooperation with traditional healers is great. Unfortunately, as the history outlined in Chapter 1 shows, the current relationships between the two are complicated at best. From the earliest stages of post-apartheid South Africa, traditional medicine was intended to be an integral component of the public healthcare system. During the first democratic election in 1994, the African National Congress releases a statement saying that “traditional healing will become an integral and recognized part of healthcare in South Africa” and that “legislation will be changed to facilitate controlled use of traditional practitioners.” Despite this statement and others like it, policies to support this stance were slow to follow. It was not until 2004 that the Traditional Health Practitioners Act, which mandated the formation of a council to oversee the regulation and training of traditional healers, was signed into law by a nearly unanimous vote in parliament. Shortly after its passage, the Act was ruled unconstitutional on the basis that proper public forums were not held while the Act was being drafted. The
campaign to repeal the Act, led by the faith-based organization Doctors for Life International, succeeded in delaying the passage of the Act for three years. The Traditional Health Practitioners Act of 2007 was passed without modifications to the wording of the 2004 bill.

As stated in the legislation’s introduction, the primary objectives of the Traditional Health Practitioners Act are:

“To establish the Interim Traditional Health Practitioners Council of South Africa; to provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for the management and control over the registration, training and conduct of practitioners, students and specific categories in the traditional health practitioners profession; and to provide for matters connected therewith.”

The act gives the Council — made up of traditional healers, policy makers, and conventional medical practitioners — the power to create national registries, set standards for safe practices, and develop national training standards. In addition, the Council has the power to set guidelines for pricing of services and to impose penalties on healers who do not meet these standards.

Though members of parliament supported the act almost unanimously, several groups in addition to Doctors for Life actively opposed the law. The general public held mixed views regarding the role of traditional medicine in the national healthcare system. The newspaper headlines included in Figure 6 represent a small sample of the media coverage surrounding the controversial topic of healer recognition. For the South Africans who seek traditional medicine a variety of health concerns, sangomas are an integral part of their well-being and hold a position of respect in the community. But for South Africans who do not personally interact with sangomas, perceptions of traditional medicine are often vastly different. Advertisements like
those put forth by Dr. Ibrahim, as shown in Figure 7, in which sangomas promise success at work and male sexual enhancement abound in urban centers such as Cape Town and Johannesburg. In addition, memories of government officials singing the praised of traditional medicine while casting doubts on ARVs and allowing thousands of citizens to die are still fresh in the minds of many South Africans. To make matter worse, tabloid-style newspapers such as the Daily Sun frequently run sensationalized stories of sangomas “using [herbs] to make rats get him cash” and stealing large sums of money from patients. Even reputable sources such as the Mail & Guardian tend to portray traditional healers in a negative light, focusing on stories about and “muti murders” rather than positive aspects of traditional medicine. Faced with stories and images of dangerous “witch doctors” and swindling frauds, it is not surprising that many South Africans did not share the government’s enthusiasm for incorporating traditional medicine into the healthcare system, and continue to express doubts about the merit of such a system. In order for the two systems to work together, both must become more familiar and comfortable with the other.
In theory, the Act has components aimed to assuage misgivings from both the dissenters and the individuals who utilize traditional medicine. On one hand, it mandates the formation of a council tasked with establishing a national registry of traditional health practitioners, setting guidelines for safe practices, and levying penalties. For South Africans concerned with potentially dangerous herbal and traditional treatments (including many allopathic medical professionals), the Act provides a framework for long overdue regulation. On the other hand, for South Africans who consult traditional healers regularly, the Act ensures that they are receiving safe and appropriate care and legitimizes their choice of healthcare in the view of the government. Optimistically, the Act will help to clearly distinguish between properly trained traditional practitioners and charlatans who put the health of their patients in danger more clear.
By reducing the number of fraudulent sangomas through harsh fines and penalties, the Act could help make strides to improving perceptions of traditional practices.

But in reality, the benefits of the Act have yet to be seen. In addition to the substantial delays in the process of passing the law, the formation of the Traditional Health Practitioners Council has been incredibly slow moving. It was not until late 2014 — nearly seven years after the passing of the Act — that members of the council were appointed. As of early 2015, the Council had yet to release any reports on progress or implement any projects or programs. Whether they will succeed in regulating the traditional healthcare field remains to be seen, but even if the council were to function efficiently and to the fullest extent intended by the Act, it would most likely not appropriately address the HIV/AIDS crisis in the country. Additionally, thought the act might indirectly lead to shifts in public opinion of traditional medicine, the language in the Act itself does not specifically call for outreach or education programs to inform non-traditional medicine users and medical professionals about traditional medicine, which is essential for improving relations between the two groups.

In spite of the fact that its implementation has been slow and the effectiveness of its council has yet to be proven, the concept of a nationally organized group of traditional practitioners represents forward progress. But the language of the Act focuses on mitigation of negative effects of current practices, but does not encourage proactive measures to integrate traditional medicine into larger public health initiatives. Though the act states that the Interim Traditional Health Practitioners Council must “make decisions regarding matters relating to the educational framework, fees, funding, registration procedure, code for professional conduct and ethics,” it cites the creation of “a nationally standardized education program” as an optional rather than compulsory function of the council. In order to integrate traditional healers into the
healthcare system to their fullest potential, the council should take action to incorporate traditional healers into national HIV prevention and education programs. In the next section, I will present and analyze case studies of programs that could provide a framework for the Traditional Health Practitioners Council.
Chapter 4 : Case Studies

This chapter will discuss a series of case studies that have sought to improve the relationships between the conventional and traditional healthcare systems in regards to HIV and AIDS mitigation. Though the amount of research on the topic is limited to date, these case studies provide insight into which strategies have most effectively incorporated sangomas into public health programs, and which have failed to do so. Information on programs such as these would serve as a valuable resource for members of the Traditional Health Practitioners Council with the power to develop national educational standards for traditional healers. The following table summarizes the case studies in the context of important dates in the HIV crisis in South Africa.

<table>
<thead>
<tr>
<th>Year of Publication</th>
<th>Authors</th>
<th>Sponsor</th>
<th>Location</th>
<th>Sample Size</th>
<th>Type of Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>Green et al</td>
<td>AIDS Control and Prevention</td>
<td>National (rural and urban)</td>
<td>660 trained 70 interviewed</td>
<td>HIV education program; peer education</td>
</tr>
<tr>
<td>2004</td>
<td>Large-scale rollout of antiretroviral drugs from the government; version one of Traditional Health Practitioners Act signed into law then repealed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Wreford</td>
<td>Project Hope</td>
<td>Western Cape (urban)</td>
<td>9</td>
<td>HIV education; cooperation with CHW</td>
</tr>
<tr>
<td></td>
<td>Peltzer</td>
<td>—</td>
<td>KwaZulu-Natal</td>
<td>233</td>
<td>HIV/STI/TB Education</td>
</tr>
<tr>
<td>2007</td>
<td>Traditional Health Practitioners Act of 2007 signed into law</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>Peltzer</td>
<td>—</td>
<td>KwaZulu-Natal</td>
<td>222 patients</td>
<td>Surveyed patietns to confirm success of Peltzer 2006</td>
</tr>
<tr>
<td>2009</td>
<td>Matsabisa</td>
<td>Indigenous Knowledge Systems; S.A. National Tuberculosis Association</td>
<td>Cape Town, Western Cape</td>
<td>20 traditional healers</td>
<td>HIV/TB education</td>
</tr>
<tr>
<td>2014</td>
<td>Traditional Health Practitioners Council Formed</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Table 1: Chronological list of case studies and important dates
AIDSCAP Assessment

The AIDS Control and Prevention (AIDSCAP) program was assessed for its effectiveness at using traditional healers as a means to spread knowledge of HIV/AIDS prevention and treatment (Green et al. 1995). The goal of the program, funded by several US organizations, was to train 30 traditional healers in HIV prevention. Each participating healer would then train 30 additional healers, who would in turn train 30 additional healers. Though the second and third group of healers would primarily be peer-trained, they would also be encouraged to attend formal workshops to expand on their knowledge. At the time this research was conducted, the first group of healers had trained a total of 630 additional healers. To assess the effectiveness of this peer training, Green interviewed 70 second-generation healers regarding information on HIV prevention. The 70 healers were selected from diverse location; 33 were from urban areas and 37 were from rural areas. There was diversity in ethnicity, as Zulu, Tsonga, Sotho, Swazi, Xhosa, and Pedi “tribes” were all represented. The sample interviewed was 82 percent female, which is characteristic of national sangomas demographics.

The healers were interviewed using both formal and informal interviews and both open- and close-ended questions. Of the 70 healers, 51 were able to correctly define HIV while the remaining 19 gave answers that were either ambiguous or incorrect. A similarly high number of healers were able to list symptoms of HIV as well as identify modes of transmission and methods for prevention. Only 26 percent of healers said they treated HIV or AIDS. Some healers answered that they were unsure of their patients’ HIV status. One healer answered, “I have sent some patients for HIV testing but I don’t know if they went” (Green et al. 1995: 506).

When questioned about techniques used to treat HIV and AIDS, most answered that they used herbal remedies as well as counseling services. Only one referred a client to a hospital.
Thirty-seven healers answered that they believed HIV could be cured using herbal remedies or by contacting the ancestors. The answers provided by the second generation of healers showed that the information passed down was largely correct and corresponded with what western medical professionals would be teaching. Most participants interviewed felt that the training they received was “very useful” (Green et al. 1995: 508). One particular aspect of the training that many healers found particularly useful was the information on correct condom usage, as well as a model for demonstrating correct usage to clients. All but one healer said that they have advocated condom usage since undergoing training. Ninety-three percent of healers said they had demonstrated proper usage to at least one client.

The sangomas were also questioned about their feelings toward a national registry of sangomas. As noted previously, many of the healers had serious concerns regarding national organizations. Rather than considering the possibility of an AIDSCAP-driven organization, the authors considered the prospect of tapping into pre-existing social structures. An impande is made up of a group of healers as well as their medicines and the rituals they use. Impande are fluid organizational groups that disband and reform as necessary. The majority of healers interviewed were in favor of utilizing impande as a form of formal organization. These groups meet regularly, and could be used as a forum for teaching and problem solving. Another factor that the authors note makes impande a favorable option is the fact that donors would be more willing to donate to a program that is culturally appropriate than they would be willing to donate to a national registration program that could potential be harmful to traditional value systems.

The program was seen to be largely successful in accomplishing the goals it set to attain, despite minor setbacks (including a shortage of condoms for demonstrations as well as distribution). The second generation was seen to be as competent as the first generation of
healers who were trained by medical professionals. Not only is peer-teaching a more effective method than using an outside instructor, but it is a more sustainable model, as sangmas are better suited to select other individuals for the next round of training. The sangomas were largely left to their own devices when training the next generation, which led to the formation of more culturally appropriate and effective teaching techniques. The largest question left unanswered in the minds of the authors is whether impande are appropriate organizational units, and whether individual impande can band together to form productive units. Though there has been evidence to show that successful organizations have formed in townships outside of Cape Town, more research still needs to be conducted on the subject to draw any kind of formal conclusion.

Project Hope

A second case study assesses the effectiveness of an HIV intervention project called HOPE (HIV Outreach and Programme and Education) (Wreford 2006). The program consisted of a six-week course designed to give biomedical information about HIV and AIDS to traditional healers in the Western Cape. The research, published in 2006, seeks to evaluate the effectiveness of the HOPE initiative in terms of meeting three major goals: (1) encouraging interaction between traditional healers and western medical personnel through an official referral system, (2) ensuring that traditional healers were not interfering with ARV regimens, and (3) persuading more male clients to get tested for HIV.

The nine traditional healers chosen for the project lived in urban areas in the Western Cape. An innovative feature of the HOPE project is that Community Health Workers (CHWs) were an integral part of the training. The CHWs live in the townships where the sangomas practice, and serve as liaisons between members of the community and the western healthcare
system. The primary responsibility of the CHW is to “encourage, educate, advise, and support members of the community who are, unwittingly or unknowingly, at risk of HIV infection” (Wreford 2006: 10). The CHWs were trained specifically to handle the challenges associated with traditional healers being trained in HIV and AIDS prevention. Even though they may be considered by western practitioners to be “the least important of the clinical staff” (Wreford 2006: 10), the CHWs still function as an important intermediary in this program.

The program training ran five days a week for six weeks. The course consisted of an introduction to biomedical understandings of HIV and was followed by a module on counseling and testing. The information was presented in a variety of formal, non-formal, and interactive ways. Participant feedback showed overwhelmingly that the program was very useful for the sangomas, who wanted to be better informed on HIV prevention and treatment. The sangomas also appreciated the fact that they were being taught by medical doctors, who they expressed having difficulty communicating with in the past. Though many healers experienced difficulty understanding “the language of medicine” (Wreford 2006, 15), they found their new knowledge to be incredibly useful. The counseling portion of the training was said to be particularly useful. As opposed to the information dense education module, the counseling module was comprised of informal role play and group discussion. One sangoma, when asked about the module on counseling, responded,

“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,” (Wreford 2006: 16).

The healers also reacted favorably to their newfound relationship with CHWs. One commented on this new dynamic saying,
“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” (Wreford 2006: 17).

At the same time, many CHWs expressed renewed confidence in the healers. In particular, one CHW noted that she would no longer worry about a sangoma prescribing an herbal remedy that would interfere with ARV therapy.

Though response was overwhelmingly positive, the sangomas did raise some concerns about the program. One common misgiving was that other healers (who had not taken part in the program) would be jealous of the program graduates. Some healers worried this would have negative impacts on business, as the jealous healers would be likely to speak poorly about the program and its participants. Additionally, the authors of this study pointed out that after the program ended, healers retained little support from the organization. But when discussing the overall effectiveness of the program, the authors commend the HOPE project for taking a new approach to education. Most importantly, the inclusion of CHWs provides a crucial link between western and traditional medicine. The sangomas benefited greatly from the medical knowledge shared by the CHWs, and the CHWs became more familiar with traditional medical practices, and therefore more confident in the abilities of the sangomas. In addition to learning about traditional healing techniques, many CHWs expressed that they learned more personal practitioner-patient interaction after observing the sangomas at work.

**KwaZulu-Natal: A Controlled Study of an HIV/AIDS/STI/TB Intervention**

A third case study involves study of 233 traditional healers from a mix of both rural and urban areas (Peltzer et al. 2006). One hundred sixty healers were chosen to attend a 3.5-day educational session, while the remaining 73 served as a control group. Participants from both
groups were surveyed about their knowledge of the HIV/AIDS, sexually transmitted infections, and tuberculosis, as well as about their personal healing practices. The survey was completed once before the training and once 7-9 months after training (the control group was surveyed at the same time).

The training sessions for the intervention group were modeled after initiatives such as the HOPE project. The introduction to the course consisted of an overview of HIV/AIDS, managing STIs, and recognizing the symptoms of common illnesses. Similar to Wreford’s role playing module, the second half of the course consisted of discussions of counseling techniques, social stigmas, and collaboration and referral.

The results of the follow up survey conducted 2-3 months after training indicated that the intervention group showed higher rates of correct answers than the control group in most categories. Though the follow up only had an retention rate of 60 percent, the sangomas who did return showed an improved understanding of HIV transmission and treatment. The intervention group was also significantly more likely to have conducted HIV prevention counseling and to have distributed condoms.

**KwaZulu Natal Follow Up**

In a continuation of the above study, Peltzer surveyed 222 patients when exiting an appointment with a traditional healer in KwaZulu Natal (Peltzer 2008). Sites eligible for the studies were limited to traditional healers who had attended the formal training outlined by Peltzer (2006), were registered nationally, and were actively practicing in the community. The patients surveyed had visited the sangoma for a wide range of reasons, including HIV concerns, headache, stomach pain and reversal of bad luck. Of the eighteen HIV positive patients surveyed,
twelve were using ARVs and traditional remedies concurrently. The remaining six reported that they were relying on traditional medicine alone to treat their illnesses. Despite the few patients who decided to refuse ARVs in favor of a traditional “cure,” most of the patients received appropriate HIV counseling from the sangomas. The twelve patients using the two systems simultaneously understand that the ARVs treat the illness while the traditional medicine can help manage symptoms of HIV or the ARVs themselves. By referring patients to medical doctors when appropriate, educating the community about HIV prevention, and distributing condoms, the sangomas demonstrated that many of the goals of the Peltzer’s training were successful.

**Khayelitsha: TB and HIV/AIDS Awareness Program**

In this study, 20 traditional healers were randomly selected from the Khayelitsha Township outside of Cape Town to complete a traditional health practitioners’ awareness training program (Matsabisa et al. 2009). A 30-question survey was completed before and after a training program, but no control group was used. The training program, a collaborative effort between the Indigenous Knowledge Systems [Health] Lead Program, South African National Tuberculosis Association, and People Management Organization, was held one day per week over a two-month period, for a total of eight sessions. The course contained information on the prevention and treatment of TB and HIV, as well as training on how sangomas can support TB patients as they undergo treatment.

The sangomas reported that they felt more knowledgeable about TB and HIV/AIDS at the end of training, and also expressed excitement about the notion of collaborating with biomedical professionals. Visits to TB and HIV research centers were particularly effective at
engaging the sangomas in the training, according to the authors. Seventy to ninety percent of the sangomas felt that the training was useful and needed to be continued.

**Comparisons**

Considered together, these case studies can provide significant insight into the effectiveness of sangoma education programs and a framework for the development of future programs. It is important to note that the Green case study is limited by the fact that it was conducted before the rollout of ARVs, and before traditional healers were recognized by the Traditional Practitioners Act, and before the treatment of HIV by sangomas was declared illegal. Due to this constraint, the Green (1995) study was lacking in that it did not provide for any sort of training in referring patients to western doctors for HIV treatment, as the sangomas would have treated the patients themselves. The Wreford program (2006), on the other hand, focused on encouraging healers to refer patients to western practitioners when necessary. However, because the Wreford study did not quantify any results, it is difficult to determine whether the training was effective. The results of the study focused primarily on the attitudes of the sangomas and CHWs, which are critically important but not the only indicator of the success of such a program. The Peltzer (2006) study, on the other hand, not only used a control group and quantifiable measures of effectiveness, but also followed up on the participants after 7-9 months, and in another subsequent study (Peltzer 2008).

Despite positive qualities, the Peltzer studies were limited in that they utilized relatively small sample sizes and concentrated on one geographic area. In the 2006 study, attendance dropped significantly between the training and follow up session. In addition, the initial training was considerably shorter than other programs. In comparison, the Matsabisa program was
conducted over the course of two months, but unlike Peltzer used neither a control group nor quantitative analysis.

As mentioned previously, a major innovation of the HOPE project was to include community health workers. In doing so, the program opens the door for communication between traditional and western health practitioners. Not only are sangomas learning from CHWs, but community health workers are also learning from the sangomas, and misconceptions are being resolved. A major flaw in the AIDSCAP model is that there is a limited relationship being promoted between traditional and modern. The education, while useful, is unidirectional. Sangomas might be more likely to refer patients to conventional doctors if they are able to see how the doctors function firsthand. Both the Wreford and Matsabisa program began to address this issue by conducting training sessions in hospitals and research labs, which was well-recvied by the participants. Participants in the HOPE study particularly appreciated the location of training, because it gave them an opportunity to “demonstrate to western-trained medical staff their dedication to extending their skills,” (Wreford 14) which is a significant step in building a working relationship between the two groups.

One final issue that the Green study addressed but the others did not is sustainability. The AIDSCAP program discussed the possibility of using impande as a means to regulate sangomas, but the HOPE project suggested no such plans for the future. Similarly, neither the Peltzer nor the Matsabisa program suggested options for long-term continuation of the programs.

Used together, the strengths and weaknesses of the two programs can be incredibly useful moving forward. For example, the Wreford case study is the only one that discusses the importance of educating western practitioners about traditional techniques. Without this insight into the importance of a two-way relationship, others might have continued to neglect this
important aspect of the program. Because of the limited amount of research on the subject, it has yet to be determined whether newer programs have implemented such changes.
Chapter 5: Conclusions and Recommendations

It is clear that the HIV/AIDS pandemic continues to grip South Africa. As antiretroviral therapies become more readily available, attention should be paid to increasing HIV education, testing, and adherence to treatment regimens. Because the current healthcare model does not adequately meet the needs of the population, particularly those living in informal settlements and townships, creative solutions aimed at improving healthcare delivery as it relates to HIV/AIDS should be pursued. As it currently stands, the conventional and traditional healthcare models are at odds. Allopathic practitioners express skepticism over the legitimacy of traditional healthcare practices and potentially dangerous pharmacological interactions. Sangomas tend to distrust of conventional practitioners and express concerns of being overregulated by the government. By opening the dialogue between traditional health practitioners and biomedical professionals and the general public, important strides can be made toward improving the overall health of South Africans.

The Future of Medical Pluralism in South Africa

Though many misgivings about traditional medicine are often due to lack of information as discussed in Chapter 3, there are some legitimate issues with ARV therapy adherence and the use of traditional medicine. Though the intervention studies discussed above have produces favorable results, several studies have shown a strong negative relationship between ARV adherence and utilization of traditional medicine (Pantelic et al. 2014 and Peltzer et al. 2011). The findings of these studies primarily focused on the use of traditional herbal remedies as opposed to spiritual or faith healing. However, a 2014 study of traditional medicine usage in Durban found that patients possessed a nuanced understanding of the roles of traditional and
allopathic medicine (Belisle et al. 2014). The patients surveyed, who were utilizing both ARV therapy and spiritual healing from a sangoma, disagreed with the assertions from allopathic providers that individuals only seek treatment for HIV from sangomas out of desperation. They understood that ARV and traditional medicine, in the form of spiritual counseling or ancestor communication, served completely different purposes. Though the patients were HIV-positive, their visits to traditional healers were typically for reasons other than HIV management or for managing psychological rather than physiological symptoms. The results of this study suggest that medical pluralism does not necessarily equate to decreased ARV adherence, and used appropriately can improve overall care and well-being.

It is unclear whether the state of medical pluralism in regards to traditional medicine in particular is harmful to HIV-positive patients. What is clear, however, is that improved relationships between allopathic and traditional healers are necessary, whether they serve to limit harmful interactions between herbal remedies and ARVs or to provide more well-rounded care to individuals for whom traditional medicine is an important component of healthcare. The case studies discussed in Chapter 4, although limited in scope, have demonstrated that it is possible to increase knowledge about HIV/AIDS among traditional health practitioners. Expansion of these programs to a national scale could not only help to mitigate negative relationships between adherence to ARV therapy and traditional medicine use, but could also serve as a proactive measure to increase knowledge of HIV and encourage preventive measures.
Summary of Recommendations

Looking forward, there are several key elements that should be included in any successful plans to incorporate sangomas into the national healthcare system. Namely,

(1) Programs should focus on delivering comprehensive, yet understandable information about HIV prevention, transmission, and treatment;

(2) Sagnomas should be trained to pay particular attention to symptoms of HIV, and must be instructed on how to refer patients to medical clinics for testing and treatment;

(3) Referrals should be documented to track which sanogmas are using the referral system;

(4) Medical professionals should be trained to discuss traditional medicine openly and without bias, and should be trained to refer patients to sangomas for pain management, counseling, and other service;

(5) As patients are referred back to sangomas after diagnosis and onset of treatment, sangomas should be trained to emphasize the importance of ARV adherence;

(6) Training programs must be sustainable and should use pre-existing organizational structures when possible;

(7) The effectiveness of programs should be quantified to aid further research on the topic; and finally

(8) Meeting between biomedical professions (including doctors, nurses, or community health workers) must be arranged to encourage open dialogue and improved understanding between the two groups.
Great Potential

The Traditional Health Practitioners Act is a step in the right direction toward full incorporation. By legitimizing traditional medicine legislatively, and punishing those practicing unsafe methods or practicing without qualifications, the Act will go a long way to improve the image of traditional medicine by minimizing fraudulent practitioners. Moreover, the Act provides for official venues for communication between the two medical systems, which will be critically important for future collaborations. As the case studies outlined in this thesis have shown, there is tremendous potential for collaboration between the two sectors in regards to HIV/AIDS programs. Traditional healers are largely receptive to learning new information about HIV prevention, transmission, and treatment, while allopathic medical providers often reevaluate their preconceived notions about traditional medicine.

The Traditional Health Practitioners Council has an unprecedented opportunity to improve relations between traditional and conventional medicine, while helping to addressing one of the nation’s largest public health concerns. However, if the sluggish inception of the Council is any indicator of future progress, the outlook is not the most promising. In reality, the formation of the council was decades overdue. As Mbeki’s administration preached the value of traditional medicine over biomedical interventions, the prevalence of HIV skyrocketed while popular opinion of traditional medicine, both internationally and domestically, plummeted. After the end of AIDS denialism and the introduction of ARVs, the pendulum swung heavily in favor of an entirely biomedical approach, and traditional medicine fell to the wayside. In the years that followed, the two systems appeared to become increasingly at odds with each other. The Traditional Health Practitioners Council has the opportunity not only to undo these misgivings by regulating traditional medicine, but also to open pathways of communication and make
progress toward harmonious cooperation between the two sectors. From the examples presented in this thesis, it is clear that the potential for collaboration is great.

South Africa is just one of many sub-Saharan African nations struggling to define the role of traditional medicine in an increasingly modern society. At the close of the World Health Organization’s Decade of African Traditional Medicine in 2010 more than half of the Member States of the African Regional Office had adopted national policies to regulate traditional medicine. As one of the most developed counties in southern Africa, South Africa is in a unique position to act as a leader for other countries in the region. By working not only to fix past mistakes, but also to proactively promote cooperation in prevention and education programs, South Africa can demonstrate that a pluralistic healthcare system — one that serves the public’s health concerns in a culturally respectful and appropriate way — can function harmoniously.
Though South Africa faces a seemingly unsurmountable task in the HIV/AIDS crisis, I do not doubt the country’s ability to come together to overcome hardship. Despite the bureaucracy that is currently stifling the progress of traditional medicine (as is has stifled many other initiatives) the outlook of many South Africans remains positive. During my time in the country, I learned that “Ubuntu” a Zulu term meaning “human kindness” or “togetherness” truly embodies the spirit of South Africa. Whether it came in the form of doctors volunteering their time in an overcrowded clinic, university students tutoring children in townships with poor educational systems, or people who truly mean it when they ask “How are you?” when passing you on the street, the unity and friendliness of the country, despite its crippling inequality, left me optimistic for the future of the country.

"In time, we shall be in a position to bestow on South Africa the greatest possible gift - a more human face." — Steven Biko
Appendix A

Figure 8: Map of the provinces of South Africa (via Wikipedia Commons User Htonl)

Table 2: HIV prevalence by province according to the 2012 South African National HIV Prevalence, Incidence and Behaviour Survey

[Bar graph showing HIV prevalence by province with data points for KZN, MP, FS, NW, GP, EC, LP, NC, and WC]
Table 3: HIV prevalence by sex and age according to the South African National HIV Prevalence, Incidence and Behaviour Survey

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>2.32%</td>
<td>0.7%</td>
</tr>
<tr>
<td>15-19</td>
<td>5.6%</td>
<td>5.1%</td>
</tr>
<tr>
<td>20-24</td>
<td>17.4%</td>
<td>17.3%</td>
</tr>
<tr>
<td>25-29</td>
<td>28.4%</td>
<td>28.6%</td>
</tr>
<tr>
<td>30-34</td>
<td>36.0%</td>
<td>31.6%</td>
</tr>
<tr>
<td>35-39</td>
<td>28.0%</td>
<td>15.8%</td>
</tr>
<tr>
<td>40-44</td>
<td>15.6%</td>
<td>13.4%</td>
</tr>
<tr>
<td>45-49</td>
<td>14.8%</td>
<td>15.5%</td>
</tr>
<tr>
<td>50-54</td>
<td>5.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>55-59</td>
<td>9.7%</td>
<td>4.6%</td>
</tr>
<tr>
<td>60+</td>
<td>4.6%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Table 4: HIV prevalence by sex, age, race, and location according to the 2012 South African National HIV Prevalence, Incidence and Behaviour Survey

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11,464</td>
<td>26.2%</td>
<td>24.6-27.8</td>
</tr>
<tr>
<td>Female</td>
<td>15,080</td>
<td>27.3%</td>
<td>25.8-28.9</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>7,154</td>
<td>28.6%</td>
<td>26.8-30.4</td>
</tr>
<tr>
<td>25-39</td>
<td>11,634</td>
<td>27.7%</td>
<td>26.0-29.4</td>
</tr>
<tr>
<td>50+</td>
<td>7,756</td>
<td>22.4%</td>
<td>20.5-24.4</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black African</td>
<td>15,231</td>
<td>25.6%</td>
<td>22.1-25.2</td>
</tr>
<tr>
<td>White</td>
<td>2,860</td>
<td>33.3%</td>
<td>39.1-37.6</td>
</tr>
<tr>
<td>Coloured</td>
<td>4,942</td>
<td>33.3%</td>
<td>27.4-33.5</td>
</tr>
<tr>
<td>Indian/Asian</td>
<td>3,438</td>
<td>41.4%</td>
<td>37.4-45.5</td>
</tr>
<tr>
<td>Locality type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban formal</td>
<td>15,686</td>
<td>31.7%</td>
<td>29.6-33.8</td>
</tr>
<tr>
<td>Urban informal</td>
<td>2,701</td>
<td>21.9%</td>
<td>19.1-25.0</td>
</tr>
<tr>
<td>Rural informal</td>
<td>5,597</td>
<td>20.8%</td>
<td>19.0-21.7</td>
</tr>
<tr>
<td>Rural formal</td>
<td>2,560</td>
<td>24.8%</td>
<td>21.2-28.8</td>
</tr>
<tr>
<td>Province</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Cape</td>
<td>3,263</td>
<td>29.5%</td>
<td>26.5-32.5</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>3,332</td>
<td>25.6%</td>
<td>22.4-28.0</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>2,049</td>
<td>28.0%</td>
<td>22.7-33.9</td>
</tr>
<tr>
<td>Free State</td>
<td>1,980</td>
<td>31.7%</td>
<td>30.3-33.5</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>6,216</td>
<td>24.4%</td>
<td>22.1-26.9</td>
</tr>
<tr>
<td>North West</td>
<td>1,826</td>
<td>20.8%</td>
<td>18.1-23.9</td>
</tr>
<tr>
<td>Gauteng</td>
<td>3,659</td>
<td>31.7%</td>
<td>28.4-35.3</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>1,905</td>
<td>21.9%</td>
<td>18.1-24.6</td>
</tr>
<tr>
<td>Limpopo</td>
<td>2,514</td>
<td>19.3%</td>
<td>16.0-22.2</td>
</tr>
<tr>
<td>Total</td>
<td>26,544</td>
<td>26.8%</td>
<td>25.5-28.1</td>
</tr>
</tbody>
</table>
Appendix B: South Africa Profile

According the CIA World Fact Book

**Population:** 48,375,645

**Ethnic Groups:** black African 79.2%, white 8.9%, colored 8.9%, Indian/Asian 2.5%, other 0.5%

**Languages:** IsiZulu (official) 22.7%, IsiXhosa (official) 16%, Afrikaans (official) 13.5%, English (official) 9.6%, Sepedi (official) 9.1%, Setswana (official) 8%, Sesotho (official) 7.6%, Xitsonga (official) 4.5%, siSwati (official) 2.5%, Tshivenda (official) 2.4%, isiNdebele (official) 2.1%, sign language 0.5%, other 1.6%

**Religions:** Protestant 36.6% (Zionist Christian 11.1%, Pentecostal/Charismatic 8.2%, Methodist 6.8%, Dutch Reformed 6.7%, Anglican 3.8%), Catholic 7.1%, Muslim 1.5%, other Christian 36%, other 2.3%, unspecified 1.4%, none 15.1%

**Birth Rate:** 18.94 births/1,000 population

**Death Rate:** 17.49 deaths/1,000 population

**Urban Population:** 62% of total population

**Major Urban Centers-Population:** Johannesburg 3.844 million; Cape Town (legislative capital) 3.562 million; Ekurhuleni (East Rand) 3.357 million; Durban 3.012 million; PRETORIA (capital) 1.501 million; Vereeniging 1.2 million; Bloemfontein (judicial capital) 468,000

**Mother’s Mean Age at First Birth:** 22.5

**Maternal Mortality Rate:** 300 deaths /100,000 live births

**Infant Mortality Rate:** 41.61 deaths/1,000 live births

**Life Expectancy at Birth:** 49.56 years

**Health Expenditures:** 8.5% of GDP

**Physician Density:** 0.76 physicians/1,000 population

**Hospital Bed Density:** 2.8 beds/1,000 population

**HIV/ AIDS -**

- Adult Prevalence Rate: 17.9%
- People Living with: 6,070,800
- Deaths: 235,100
Appendix C: Citations for Figures

Note: All photographs not cited are property of the author

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ACADEMIC VITA

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Education
The Pennsylvania State University, Schreyer Honors College University Park, PA        May 2015
  • Bachelor of Arts in Anthropology with Minors in biology, Spanish, and International Studies
University of Cape Town Cape Town, South Africa                        Fall 2013

Experience
Clinic Intern, Penn State University Health Services                                      August 2014- present
  • Measure vital signs and interview patients about reason for visit
SHAWCO Health Intern Cape Town, South Africa                                   July 2013-October 2013
  • Assisted with HIV testing, counseling, and preventive education during patient visits at a mobile clinic that provided healthcare to medically-underserved townships
Museum Intern Historic Bethlehem Museums and Sites, Bethlehem, PA           May-August 2012
  • Assisted the curator by researching acquisitions, installing exhibitions, cataloging collections using PastPerfect software, and completing office tasks

Activities and Leadership
Pre-Health Professional Honor Society (Alpha Epsilon Delta)                  September 2011-present
Schreyer Honors College Tour Guide                        September 2011-present
Treasurer of Global Ambassadors                            January 2014- present
THON Dancer Relations Committee Member                 September 2011- May 2013
The Daily Collegian Metro Reporter                         September 2012-June 2013

Volunteer Experience
Adult Literacy Volunteer Tutor, Pennsylvania Literacy Corps January 2015- present
Health Education Volunteer Outreach360, Monte Cristi, Dominican Republic March 2013
Hospital Volunteer Lehigh Valley Health Network, Bethlehem, PA May 2013-August 2014
SHAWCO Education Volunteer Khayelitsha, Cape Town, South Africa July-October 2013

Awards and Recognition
Academic Excellence Scholarship, Alpha Epsilon Delta member, Paterno Fellowship, Liberal Arts College Enrichment Fund Recipient, Schreyer Honors College Travel Grant Recipient