

Traditional healers and AIDS prevention

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Abstract A qualitative case study of the views and experiences of an isangoma was undertaken to explore potential preventive health roles that traditional healers could play with regard to the AIDS epidemic. The isangoma's knowledge of the transmission mechanisms, risk groups and prevention strategies for AIDS was accurate. Her questionable beliefs included a Nazi conspiracy as the source of AIDS, a string ritual to prevent promiscuity and a conviction that she could treat AIDS. Notwithstanding the latter beliefs, her generally factual knowledge of AIDS indicated that she could be an important source of AIDS information in the community; she was, in fact, already providing some AIDS counselling. Considering their large clientele, established preventive health ethic, extensive distribution in rural areas and potential ability to influence the contextual factors that affect risk-reducing behaviours (e.g. condom use), it is recommended that traditional healers be incorporated into AIDS prevention programmes where they can play a role in community-based AIDS education and condom promotion.

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Control of the AIDS epidemic poses a major challenge to all involved in health care. The potential scale of the epidemic,¹ coupled with the general lack of success of prevention programmes in many countries,^{2,3} necessitates innovative approaches to AIDS prevention programmes in South Africa. Within this context everyone, including parents, religious leaders and traditional healers, could play (and in some countries^{4,5} have been playing) a role in the control of AIDS.

In South Africa AIDS prevention programmes, particularly condom promotion, by government agencies and services are viewed with suspicion by some sectors of the population.^{6,7} The success of AIDS prevention programmes is therefore to some extent dependent on contributions to these programmes by individuals and organisations not associated with the Government.

A recent case study by Simon⁸ demonstrated the extensive utilisation and adaptability of traditional healers. The subsequent responses to that report highlighted the controversial nature of the issue of traditional healers,⁹⁻¹² particularly with regard to their curative role. This qualitative case study focuses rather on the preventive role of traditional healers and explores potential roles they could play in preventing the spread of AIDS.

Methods

During a study on scarification and hepatitis B, the author had extensive interactions with 9 isangomas in two black townships north of Durban. These interactions provided several opportunities to discuss

AIDS. This case study is of one particular isangoma, a highly respected trainer of isangomas, who shared her views on and experience of AIDS in the course of three discussions which lasted a total of about 7 hours.

The discussions were conducted in a congenial atmosphere, usually over tea. Throughout, the author's approach was non-judgemental and open-ended. Information obtained in earlier discussions was corroborated in subsequent discussions as a means of confirming its accuracy. In the last discussion, the isangoma consented to her views being published.

Since she found it difficult to express herself clearly in English, she chose to speak in Zulu. Translation from English to Zulu and vice versa was undertaken by a fellow isangoma who was fluent in both languages. Since the isangoma being interviewed knew sufficient English to understand most of what was being said in English, she corrected the translator on the few occasions when she felt that he had not translated accurately.

Results

The isangoma practised in her 4-room township house. A huge woman, she is revered by the other isangomas who respectfully refer to her as 'Mother'. Dressed colourfully with a cloth of black and yellow across her shoulder covering half her chest and abdomen, she appeared suitably matriarchal. Adorned with a hat somewhat like a fez made of colourful beads, a pink skirt with the word 'amakosi' embroidered in beads and holding a wand made of horse's hair, she called on the spirits to assist her in treating her 'patients'.

In discussing the cause of AIDS, the isangoma expounded her theory that soldiers were the main conduit for the spread of AIDS. She said that soldiers from Hitler's war were given a 'vaccine' (via injection) which contained AIDS. When they went to fight in foreign countries they were told not to have sex with foreign women. However, some engaged in this forbidden act, mainly with prostitutes, thereby initiating the spread of AIDS. The prostitutes, in turn, spread AIDS within their communities. When the soldiers returned after the war, they were given an antidote 'vaccine' so that they would not spread AIDS in their own country.

She said that AIDS had become a serious problem in South Africa because soldiers from neighbouring countries have been coming here. These soldiers had been given an inactive form of AIDS 'vaccine', which became activated when drugs such as Mandrax were taken. She felt strongly that these soldiers were responsible for bringing AIDS to South Africa because they abused drugs and had sex with prostitutes.

Besides prostitutes, she thought that it was mainly 'stayaways' who were at greatest risk of contracting AIDS. She explained that 'stayaways' are teenagers who do not listen to their parents and often stay away from home. She said that these 'stayaways' often travelled to other parts of the country before they came home and this degree of mobility added to their risk of contracting AIDS, as they had sex with many people during these travels.

In her opinion, to control the spread of AIDS one had to concentrate on the very young. She said that when babies are a few weeks old, they must undergo a ritual known as 'ukuguda', whereby a string around the abdomen is pushed into the baby's anus and pulled out

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At the other end of the health-care delivery scale, technology could play a fundamental role in supporting the provision of adequate care in the primary areas of prevention and rehabilitation. There have been complaints about the shortage of doctors in rural areas everywhere. Russia and India have responded to the problem by introducing the *feldscher* and 'barefoot doctor', respectively. In South Africa this option has been resisted for a long time because of fears that the high standard of medicine will be threatened by 'third-rate' doctors. It is certain that we will not be able to persuade doctors to move to the rural areas. The allure of city life is just too great, even for those who originally came from the countryside. Technology provides a means to extend capabilities and make medical services more equitable by overcoming challenges of geographic distribution. The health problems of the Third World can be solved in part by technologies specially created to address them and developed in that context.

As an example, let us look at the concept of a computerised mobile health-care clinic for rural areas. Beyond obvious diagnostic-therapeutic benefits, such a unit would have the parallel purpose of gathering up-to-date health-care information for planning, together with efficient patient records and follow-up systems. In addition, it could offer a computer-aided diagnosis system to assist the community nurse. This would have obvious positive educational spin-offs. The most important part of mobile clinic's technology would clearly be the special-purpose computer hardware and software, which would need to be resilient, reliable and portable. With the aid of such equipment, a trained nurse could supervise accurate collection and analysis of clinical information. An 'expert system' included in the computer could help the nurse to screen for unusual or complex diseases. Certain on-line inputs, such as temperature, ECG, blood pressure and lung function data could be recorded directly by the system. At the local community hospital batch-recorded data and automated diagnostic 'suggestions' could be verified by a medical doctor or modified accordingly. Patients so identified who require special treatment could be brought in and channelled to secondary hospitals. There could be a computer network with more distant specialised hospitals and this would provide access to still higher-level professional expertise. Updated health review information could also be transmitted regularly to facilitate optimal planning and resource allocation.

The computer and networking technology necessary to perform the above functions is at present available in this country and is becoming ever cheaper and more accessible. The expertise to develop the equipment needed for direct data collection and to write the necessary software for analysis exists, and communication networks (SAPONET and DIGINET) are suitable for transmitting information between local centres and large hospitals.

These ideas and others that make the benefits of new technology more equitable should be given serious consideration. Grand plans are difficult to put into practice and cannot be achieved overnight, but if such a system is to be implemented within the next 10 years, feasibility studies should be undertaken without delay.

Conclusions

Health-care technology is becoming of increasing concern to all of us. This concern exists not because of the technology itself, but arises from the haphazard and sporadic way it has been applied in health care. Through proper planning and consideration of non-monetary factors, technology could be better deployed and perceived as a useful ally by the medical profession. Local solutions to local problems must be sought, especially with regard to the application of newer micro-electronic and digital telecommunication technologies, which are rapidly advancing and becoming cheaper. Planners must be encouraged by both medical and non-medical disciplines to work towards optimal health care for the whole country, using technological tools where and when appropriate.

The new VITALINK programme of the South African Research Council, which is a collaborative programme for the advancement of health care through technology, is certainly a step in the right direction. It aims to bring together all the role players in South African health-care technology in order to launch a concerted attack on the rising costs and inappropriateness we are witnessing today.

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