INVOLVING TRADITIONAL HEALTH PRACTITIONERS IN HEALTH, HYGIENE AND SANITATION EDUCATION AND PROMOTION

Report to the
WATER RESEARCH COMMISSION

by

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EXECUTIVE SUMMARY

Background and Motivation for Research

Sigodi Marah Martin (SMM) was commissioned by the Water Research Commission (WRC) to research and make recommendations on the potential role of Traditional Health Practitioners (THPs) in health, hygiene and sanitation (HH&S) initiatives. The rationale and significance of this research is located in both international imperatives to reduce mortality rates as well as the legislative provisions for basic services enshrined in the South African Constitution. International experience clearly shows that to effectively impact mortality rates and health at a local level, infrastructure which enables access to clean water and good sanitation are key. This experience has also shown time and again that hardware alone does not necessarily improve health and mortality but that effective education about health and hygiene is also critical.

In South Africa nearly 80% of the population rely on the services of THPs in matters of health and well-being, often prior to engaging the formal health service sector. This means that THPs have access to significant portion of the population, making them potentially a key partner and stakeholder in community health education. Despite this being the case, there seemed little evidence of the potential role that THPs could play in sanitation, health and hygiene being explored or promoted. This research was designed to contribute to addressing this gap and thus making a contribution to the advancement of sanitation, health and hygiene education and promotion.

Based on this starting point, SMM designed a multi-faceted research methodology that included inter alia; a literature review and desktop research, unstructured interviews with stakeholders currently working with THPs and data gathering workshops with THPs themselves (in Gauteng and KwaZulu-Natal). This report summarises the data gathered in each stage of the research and identifies key findings, recommendations and conclusions that have emerged. The report has been structured, as far as possible, to summarise the data so that any given reader may interpret the data and make his/her own conclusions of the findings.

Research Objectives

The specific objectives contained in the original project proposal were threefold:

1. Are there myths or traditional practices that can assist with encouraging positive hand-washing behaviour? If yes, how can these be practically incorporated into hand-washing promotion, hygiene and sanitation education and sanitation promotion initiatives?
2. What is the potential for engaging traditional healers in South Africa to assist with carrying messages related to hand-washing, hygiene education, care of sanitation facilities and sanitation promotion?
3. Can a similar model be used as was utilised for involving them in initiatives to combat HIV/AIDS? If yes, what can be learned from this model?

Early on in the research conceptualisation these objectives were refined into two main focus areas. The first involved broadening the research question into "What is the potential contribution of THPs in HH&S initiatives?" The second involved identifying best practices from engaging THPs in HIV/AIDS initiatives and investigating their application to sanitation, health and hygiene education. These refinements ensured that the original objectives would be met, while recognising and allowing for the maximum utilisation of research data.

As can be seen from the summary of major results and conclusions from the project, the overall objectives of the research were met. However there were two aspects that hold less prominence in the findings. First, the focus on identifying traditional practices concerning hand-washing represents only a small aspect of what was learnt about traditional practices when dealing with HH&S issues. Second, it became clear that the use of myths and stories is a minimal aspect of THPs approach to dealing with clients. Therefore the emphasis in the data gathering was shifted to allow for a wider, more rich range of strategies used when THPs deal with HH&S issues to emerge than stories and storytelling alone.

Major Results and Conclusions

More detail on each of these is contained in the chapter entitled Research Conclusions, but in summary there were four major results:

1. There is definitely potential for THPs to be involved in HH&S promotion. This has been shown specifically in the value add from their involvement in HIV/AIDS work as well as their definitive influence on the daily life of communities in South Africa.

2. In order to maximise this potential role there are a number of challenges that need to be addressed. These include, but are not limited to, the paradigmatic differences between the biomedical and traditional health disciplines as well as the historical relationship of THPs to the legislative context and formal health care infrastructure.

3. This present moment in time when there is legislation being put into place which gives formal recognition to THPs offers a definite opportunity to leverage and engage the expertise of THPs in addressing backlog legacies and in the process bridging the critical gap between hardware installations and changing daily community practices around HH&S issues.

4. In order to effectively engage THPs around HH&S issues there is a definite need for careful consideration around the conceptualisation of materials and processes to support the engagement process. Existing materials are not sufficient given that they tend to approach health from a particular paradigm which is quite different to that of THPs. The arena of health psychology can be of some assistance in this regard.

In terms of specific recommendations the research findings point to the following:

- That there should be active encouragement of the participation of THPs in any HH&S initiative;
- A participatory approach will be most effective when engaging THPs;
- That the development of specific materials about engaging THPs in HH&S issues should build on those utilised in this research project and others in the water services sector; and
- That deliberate strategies are required to create processes that allows for new paradigmatic health services to emerge which integrates the strengths of the disciplines of biomedical and traditional health.

The above results and recommendations are indicators of how well the research objectives were reached. In addition, the research process also uncovered some interesting findings, which contribute new knowledge and perspectives to undertaking this type of research and THPs as a specific sector.

Other significant findings

From the literature review, it became clear that taking into account traditional values and integrating them in efforts geared towards HH&S promotion initiatives is imperative a cultural context. It is therefore important to explore how this integration of traditional and cultural ways of thinking and living can happen at a level, which practically impacts the way that communities live. For instance, like the western systems and perceptions of health, the traditional health system has it own unique characteristics and perceptions around what constitutes an understanding of sanitation and hygiene. Traditional forms of healing may not necessarily qualify as hygienic or appropriate when measured in line the western system of health. This naturally poses a challenge to the adoption of universal health and hygiene practices.

Also, from engaging THPs themselves, it was clear that in order to understand their potential role in the promotion of HH&S requires a deep understanding of traditional healing practices and its cultural context which includes prevailing religious practices and cosmology. Any attempt to understand the role that traditional healers can play in the promotion of health demands an understanding of specific practices and methods involved and the reasoning for these. Without this, prejudices and preconceptions may actually limit the opportunities for synergy.

Future Trends Emerging from this Research

Overall, the most critical question facing government is how to expand their current paradigm of a "developmental state" away from simple service delivery into building healthy communities. In order to do this, a major revision in how healthy communities are conceptualised is required. This research identifies a starting point with the engagement of THPs, but the implications are that in addition to engaging practitioners in redefining the theoretical knowledge base, programme and project practices may also need to be expanded. Specifically this implies that deliberate spaces for the engagement of the biomedical and traditional health approaches must be created and facilitated.

A second important trend emerging from this research is that the legitimisation of the traditional health care sector (as is happening with the Traditional Healers Act) is a complex and challenging process. There needs to be a careful balancing of the individualised nature of training to become a THP with the overall need for consistent standards for the sector. The current biomedical model for the training of doctors cannot be used to accomplish this wholesale. Rather, innovative approaches, which recognise the specific nature of this practice, need to be developed. For example, the oral nature of the tradition, coupled with the diversity of treatment options need to be honoured while still maintaining an overall level of excellence in practice.

Finally, the participative approaches used in this research to engage THPs and benefit from their knowledge can be used to form the foundation of strategies to be employed by water services sector players in terms of engaging with THPs. Outcomes from this could include not only the development of new materials, as recommended in the research, but also a significant training aspect for those who will be implementing the engagement process. To this end, the data generated in the workshops and a careful consideration of the approach taken by facilitators should be expanded into a training manual for stakeholders in the sector.

Capacity Building

Two Masters students from Wits: Modiehi Khuele and Naeema Hoosain were engaged to provide support and assistance with this project. Both were been mentored by the Project Manager: Kate Clement.
They made significant contributions and developed skills in the following areas:

- Research and preparation of literature review
- Organisation and design of traditional and faith healers workshop in Gauteng
- Co-facilitation of traditional and faith healers workshop in Gauteng
- Conceptualisation of the research process
- Capturing results of interviews and transcribing

They also had exposure to and developed skills and competencies in the following areas:

- Applied policy research design
- Workshop design and facilitation
- Sanitation, health and hygiene policy and legislative issues
- Traditional medicine policy and legislative issues
- Report writing and presentation preparation
- Interview skills

Workshops and Presentations

Gauteng Workshop with Traditional and Faith Healers

A focus group workshop was conducted on the 24th of November 2004. A total of 30 were invited and 18 attended. They were all nominated by the Gauteng Provincial Traditional and Faith Medical Practitioners Council, representing the Gauteng Province. The initial plan of the workshop was two fold. The day was divided into two sessions. The first being training on basic hygiene education and sanitation promotion. The second session comprised a focus group discussion geared towards an interrogation of the involvement of traditional healers in health hygiene and sanitation promotion.

KwaZulu-Natal training/advocacy workshops in with traditional healers

On 14/15 November 2005 two workshops were held in KwaZulu-Natal to test and discuss the guideline and a set of workshop tools. These workshops took the following format:

Workshop 1: A full day workshop was held with a set of 8 community development facilitators from the Valley Trust in KZN. The extensive work and learnings of Valley Trust informed significant inputs into both the guideline document and the facilitation tools.

Workshop 2: A full day workshop was held with 12 traditional healers from the Valley of 100 hills area in KwaZulu-Natal. The tools and principles from the guideline were tested with participants.

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ACRONYMS

AICs	African Initiated Churches
CBOs	Community Based Organisations
CDW	Community Development Worker
DoH	Department of Health
DPLG	Department of Local and Provincial Government
DWAF	Department of Water Affairs and Forestry
FH(s)	Faith Healer(s)
H&H	Health and Hygiene
HH&S	Health, Hygiene and Sanitation
NGOs	Non-Governmental Organisations
ORS	Oral Rehydration Solution
PSTTs	Provincial Sanitation Task Teams (PSTTs)
SALGA	South African Local Government Association
TFMPA	Traditional, Faith and Medical Practitioners Association
TH(s)	Traditional healer(s)
THO	Traditional Healers Organisation
WRC	Water Research Commission

GLOSSARY OF TERMS

There are a number of key concepts that form the basis of this research. This glossary of terms outlines them and gives a brief definition for how they should be understood in the context of this particular research project.

Biomedical Scientific Approach

This is defined as an approach characterised by the assumption that disease is due to the malfunctioning and mal-adaptation of bio-psycho-physiological processes of individual persons.

Community Development Workers

Community development workers are defined as community based agents who work in communities to assist community members meet their socio-economic needs. They may or may not be employed and attached to a specific institution.

Community Health Workers

Community health workers are defined as community or clinic-based agents who are concerned with matters of community health, which provide information, education and advice in relation to certain healthy practices and lifestyle choices and health facilities such as clinics and hospitals. They are usually employed by Local Government or the Department of Health.

Traditional Health Practice

The definition used in this document is taken from the Traditional Health Practitioners Act, no. 35 of 2004, which defines traditional health practice as the performance of a function, activity, process or service that includes the utilisation of a traditional medicine or a traditional practice and which has as its object:

- the maintenance or restoration of physical or mental health or function; or
- the diagnosis, treatment or prevention of a physical or mental illness; or
- the rehabilitation of a person so that he or she may resume normal functioning within the family or community; or
- the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death.

Traditional Health Practitioners

For the purposes of this document any person performing the practices defined above is considered a traditional health practitioner. This includes:

a) Traditional healers who consult ancestral spirits in diagnosing the patient and/or client's spiritual, mental and physical ailments and illnesses and utilise herbs to treat those ailments and illnesses. These include *izangoma* (diviners) and *izinyanga* (herbalists).

b) Faith healers who consult a higher being and work with the ‘divine power’ of God to heal the client and/or patient. Generally no scientific diagnosis is made and no herbs or western medicine are provided to the patient and/or client. Water tends to be central to many religious practices and beliefs associated with this modality of healing.

1 INTRODUCTION

1.1 Background

This research report is the outcome of a study that Sigodi Marah Martin (SMM) was commissioned to undertake by the Water Research Commission (WRC). The focus of this study has been exploring the potential role of Traditional Health Practitioners (THPs) in assisting the water services and health sectors to address health, hygiene and sanitation (HH&S) challenges in South Africa.

The purpose of this introduction is to create a context for the reader within which to understand the conceptualization, approach and implementation strategy SMM utilized in conducting the research. Specifically this includes a summary of the research significance (which includes the international and local legislative context affecting the issue at hand); purpose and aims of the research; and an outline of the research questions, assumptions and methodological approach. It is intended for the reader as an easy reference guide to understand the sections that follow.

1.2 Research significance

Research by the World Health Organisation (WHO) in 2000 highlights the importance of health and hygiene behaviour change in addressing global mortality rates.

"Nearly 40% (2.4 billion) of the world's population has no access to hygienic means of personal sanitation. Globally, the WHO estimates that 1.8 million people die each year from diarrhoeal disease…and nearly 5 500 children die every day from diseases caused by contaminated food and water. Increasing access to sanitation and improving hygiene behaviours is key to reducing this enormous disease burden." (WHO, 2000)

In addition, international experience has indicated time and again that *local* and *community* support are by far the most important variables for health gains that result from improved sanitation facilities and health and hygiene practices. The real gains come from the day to day practices, behaviours and decisions of people and these are influenced by a variety of factors. One of the very important factors in terms of people's decisions in relation to health in South Africa is the influence of THPs. This is shown in research conducted by Thornton (2002) in South Africa where he estimates that 80% of South Africans consult THPs as a first point of call, making them potentially a key stakeholder in any HHS issue. Therefore a hypothesis in this research is that there are definite gains to be made by exploring the possible contribution that these practitioners can make. For example, many HIV/Aids programmes in different countries, and in particular in Africa have started to include elements which involve working with THPs because of the potential synergies between their work and other health programme interventions.

One of the greatest challenges that South Africa is facing under the new political dispensation is addressing the huge services backlogs created by apartheid policies. This includes thousands of people without access to basic services, in particular without a dignified and safe sanitation facility.

Chapter 2 Section 27 (1b) of the Constitution states that everyone has the right to have access to basic services and a safe, healthy environment. The provision of sanitation and water are primary conditions for these rights to be fulfilled. The Department of Water Affairs and Forestry (DWAF) together with the Department of Provincial and Local Government (DPLG) and the South African Local Government Association (SALGA) set targets for the achievement of this in their 2003 Strategic Framework for Water Services. These targets are as follows:

- ✓ All people in South Africa will have access to a functioning basic water supply facility by 2008;
- ✓ All people in South Africa will have access to a functioning basic sanitation facility by 2010;
- ✓ All schools will have adequate and safe water supply and sanitation services by 2005; and
- ✓ All clinics will have adequate and safe water supply and sanitation services by 2007.

Given these and other socio-economic rights enshrined in the South African Constitution, there has been a significant focus in national and local government on addressing the infrastructural backlog. While it is critical to provide the required hardware in terms of taps and toilets, it is also widely acknowledged that, for sustained benefit, hardware needs to be accompanied by a process which encourages people to understand and implement positive health and hygiene behaviours. This is the finding of a number of international studies, including one done 1991, which is described in the box below.

Excerpt from WHO Sanitation and Hygiene Promotion – Programming Guideline

In 1991 a review of 144 studies linking sanitation and water supply with health, clearly states that the "**role of [water quality] in diarrhoeal disease control [is] less important than that of sanitation and hygiene"**[1]. The study identified six classes of disease where the positive impacts of water supply, sanitation and hygiene have been clearly demonstrated. (WHO, 2000:7)

Given this crucial connection between the provision of hardware and the educative process within communities the Department of Health (DoH); DWAF; non-governmental and community-based organisations; as well as private and public institutions within the health sector, have undertaken various initiatives to promote positive HH&S practices.

From government's side, the prioritization of HH&S issues is indicated by the significant national budget allocations to programmes focused on both the elimination of infrastructure backlogs and the requirement for health and hygiene education to be provided with sanitation projects. As such government has conceptualised this priority from both a community education and an infrastructure development perspective. This commitment is highlighted in the following government department initiatives:

- The DoH Strategic Priorities for the National Health System 2004 – 2009 where one of their key activities is to "…implement activities and interventions to improve key family practices that impact on child health…" and to *"...strengthen community participation (in health) at all levels…"* (DoH, 2004-2007:13)

[1] Esrey. SA, et al 1991:609-621

The implication of these strategic priorities is that the areas of environmental health, including health and hygiene and sanitation are key to these priorities being met.

- The DWAF National Health and Hygiene Education Strategy (2004) was drafted with the intention of facilitating the improvement and promotion of HH&S programmes and emphasises the importance of health and hygiene education as a key and appropriate vehicle for addressing water and sanitation related diseases.
- The recent speech by the Honourable Minister Sonjica (DWAF) launching the 2006 National Sanitation Week by indicating that that *"although water supply is a major issue to communities, water supply and sanitation facilities do not transform health on its own. A major part of good sanitation includes* **appropriate health and hygiene awareness and behaviour***"*[2]. For this reason the theme for Sanitation Week for 2006 was 'Washing of hands for a healthy life'.

These three examples show that there is political and financial support for the sanitation backlog to be eradicated and for HH&S issues and messages to be given prominence. However, despite the national political and financial support and the infrastructure development, an unacceptable number of people continue to fall ill with symptoms, such as diarrhoea, as a result of a lack of sanitation facilities and/or unhygienic practices.

Therefore although DWAF has mandated municipalities to prepare strategies on i) Health Care and ii) Sanitation Education (including maintenance) to accompany the installation of water and sanitation facilities; this alone is not sufficient to ensure the entrenchment of behaviours and practices in communities. Neither will it address the problems in areas where sanitation infrastructure development has not yet taken place. As such there is a need for local actions which address these issues and result in behaviour and attitude changes at community level where it matters most. The activation of community resources is all the more important where there is under-capacity in municipalities to address such challenges.

The outcomes of this research may provide ideas and information which will assist community development and community health workers to involve traditional health practitioners in hygiene education and sanitation promotion initiatives in a positive, effective and meaningful manner.

1.3 Research objectives

The specific objectives contained in the original project proposal were threefold:

1. Are there myths or traditional practices that can assist with encouraging positive hand-washing behaviour? If yes, how can these be practically incorporated into hand-washing promotion, hygiene and sanitation education and sanitation promotion initiatives?
2. What is the potential for engaging traditional healers in South Africa to assist with carrying messages related to hand-washing, hygiene education, care of sanitation facilities and sanitation promotion?

[2] Emphasis by authors.

3. Can a similar model be used as was utilised for involving them in initiatives to combat HIV/AIDS? If yes, what can be learned from this model?

Early on in the research conceptualisation these objectives were refined into two main focus areas. The first, involved broadening the research question into "What is the potential contribution of THPs in HH&S initiatives?" The second involved identifying best practices from engaging THPs in HIV/AIDS initiatives and investigating their application to sanitation, health and hygiene education. These refinements ensured that the original objectives would be met, while recognising and allowing for the maximum utilisation of research data.

As can be seen from the summary of major results and conclusions from the project, the overall objectives of the research were met. However there were two aspects that hold less prominence in the findings. First, the focus on identifying traditional practices concerning hand-washing represents only a small aspect of what was learnt about traditional practices when dealing with HH&S issues. Second, it became clear that the use of myths and stories is a minimal aspect of THPs approach to dealing with clients. Therefore the emphasis in the data gathering was shifted allow for a wider, more rich range of strategies used when THPs deal with HH&S issues to emerge than stories and storytelling alone.

1.4 Research assumptions

Given the specific context and purpose of this research project the following key assumptions formed the basis of the research methodology and approach:

1. The installation of hardware in terms of taps and toilets needs to be accompanied by a learning process on both how these facilities should be used and maintained as well as initiatives promoting good health and hygiene practices.

2. There is a lack of resources, professional skills and human capacity across the HH&S sectors and in local government especially in remote and poverty stricken areas which most require improved sanitation and health practices.

3. Local resources which are already available in communities are not currently effectively engaged. This includes traditional and indigenous knowledge which can help to promote good HH&S behaviours.

4. THPs are extremely valuable resources within communities because of their custodianship of cultural and health-related matters. The positive contribution that they have made in fighting HIV/AIDS indicates that they could also greatly assist with the promotion of safe and effective HH&S practices.

5. In some places community development and community health workers, as the facilitators and promoters of community participation in government initiatives, are under-utilised community resources. Given their

location and proximity to problems experienced they can with the right training and support facilitate effective and appropriate development solutions for their communities.

1.5 Research methodology

The research assumptions and complexity of issues at hand led to the study evolving into a multifaceted research methodology for data gathering.

Literature review and desktop research: The purpose of this stage of the methodology was twofold. Firstly, the researches sought to identify points of engagement with the existing research discourse on THPs and HH&S issues. Through this process it became clear that there is limited current research literature on the role of traditional healers in HH&S matters in the South African context. Therefore, the study looked for an alternative point of engagement within the health sector. This led to the identification of available literature on the involvement of traditional healers in HIV/AIDS programmes. Thus a major focus of the literature scan became to interrogate if there are any substantial lessons to be drawn from the HIV/AIDS experience and whether approaches used in dealing with this issue could form a basis of best practices when involving traditional healers in HH&S initiatives. Secondly, the literature review focused on analysing the legislative and social context regarding the role of THPs within the broader health sector. This included an analysis of research reports, public documents and legislative provisions in engaging matters of HH&S and THPs.

Semi-structured interviews: Given the limited availability of literature regarding the specific connection between THPs and HHS issues, non-governmental actors and THPs involved in these activities were identified for interviewing. These interviews were focused on exploring current practices and points of engagement between issues of HH&S and THPs. As such, the interviewees included Executive Committee Members of the Traditional, Faith and Medical Practitioners Association as well as individuals from a number of non-governmental organisations, government and academia. To account for different educational levels and English language proficiency were the need arose the interviews were conducted in either Zulu or South Sotho. The list of interviews conducted is included in Appendix 2.

Workshops: In order to reach a larger number of THPs the research included four workshops involving a total of 60 participants. These workshops covered both an urban and rural setting. Gauteng was chosen as an urban location given the limitations of the project budget and the diversity of the population in the Province. In terms of identifying a rural setting SMM approached a number of organisations already working with THPs to identify a suitable site and research partner. In the end the choice of KwaZulu-Natal (KwaZulu-Natal) as the rural setting was based on the level of expertise, THP network and general appropriateness of The Valley Trust as an institutional anchor for this element of the project. Both the Gauteng and KwaZulu-Natal workshops tested different participatory methods for engaging with THPs and were extremely useful data gathering exercises. The generally positive and energised response by participants in the workshops indicated that there are effective ways to engage THPs in encouraging them to take a more active role in health matters related to HH&S.

1.6 Workshop data-gathering approach

It was decided that a participatory approach should be used given best practice in the water services and other development sectors. As identified in the literature review *"Participatory methods have succeeded where other strategies have failed. They are based on principles of adult education and have been field-tested extensively."* (Sawyer, 1998:5)

Because the Participatory Health and Sanitation Transformation [PHAST] system has been tested and adopted not only in South Africa but also in other developing countries, it was identified as a sound reference for the workshop design and facilitation. Specifically the PHAST approach recognises the resources that communities already have, helps people to feel more confident about their ability to act, facilitates the personal development of people as part of the process and creates opportunities for people to share knowledge and engage as equals.

In tailoring this approach for the research purposes useful principles which are appropriate for engaging facilitators and participants on the issues at hand were identified and formed the basis of the workshop approach[3]:

- ✓ *All participants are equal*. This means that interactions between the group and facilitator are open and flow both ways. The facilitator is not the expert and everyone is recognised as equal.
- ✓ *There is no right answer.* The discussions and activities are not about coming to one correct answer. Decisions made by the group are the property of the group - they own them.
- ✓ *Creating the right atmosphere.* People will work better if there is group cohesiveness. This can be created by starting with introductions and some kind of ice-breaker and trying to maintain a relaxed atmosphere during sessions.

[3] Check reference section for further reading on participatory approaches to community development.

2 LITERATURE REVIEW AND DESKTOP RESEARCH

2.1 Introduction

As mentioned earlier the literature review and desktop research was focused on three issues: the role of THPs in HIV/AIDS initiatives; the socio-political context of traditional health practice and legislative and policy provisions on traditional health practice and sanitation, health and hygiene. This chapter is organised around these areas. The overall implications of the findings from the literature review are summarized in the conclusions chapter of this report.

2.2 Learning from the role of traditional health practitioners in HIV/AIDS

As will be shown later in this chapter, the new social and legislative landscape of South Africa has led to a higher recognition of the role THPs play in communities. Although, this recognition has not yet been fully leveraged in the broader health sector, emphasis has been placed on their role in HIV/AIDS programmes. Literature that focussed on this area was therefore identified as a point of discourse engagement for best practices when considering the potential involvement of THPs in HH&S initiatives.

The involvement of THPs in HIV/AIDS programmes has been explained by at least two key factors which are also present when considering HH&S issues:

1. There is a growing recognition that medical doctors alone are unable to curb the escalation of HIV/AIDS. The benefits of utilising THPs in this pandemic is indicated by the statistic that THPs outnumber medical doctors by hundred to one or more, and despite socio-cultural changes, they continue to play an important role in addressing a variety of psycho-social problems (UNAIDS Report, 2000).

2. Due to the holistic nature of the traditional healing practice (that is concerned with the entire person, family, community and with the world of spirits) THPs have often been seen as having a greater potential of offering assistance those infected and affected by HIV/AIDS. This argument is substantiated by two authors identified in the literature review. Steinglass argues that the terminal nature of this disease foregrounds the spiritual side in treatment options (Steinglass, 2003). Nyathi further argues that because western medical practitioners cannot answer questions related to ill health and misfortune within the paradigm of an imbalance between the protection offered by ancestors and ancestral wrath when they are not happy with their descendants, THPs make speak more coherently into the world-view of ordinary people (Nyathi, 2004). Further, this points to the culturally specific and relevant perspectives that THPs offer in assisting people infected and affected by HIV/AIDS.

The literature scan identified the following best practices which can be leveraged when dealing with HH&S issues:

- ✓ Collaboration between the biomedical and traditional health sectors: The collaborative efforts between western medical doctors and traditional healers around HIV/AIDS issues have improved health delivery relevant to HIV/Aids in a number of ways. The UNAIDS report points out that it increased both knowledge and skills amongst THPs as well as confidence in their practice. In addition, by gaining access to the clientele of THPs it also facilitated earlier referrals to hospitals (UNAIDS Report, 2000:10).

- ✓ Establishing formal mechanisms for facilitating participation: In KwaZulu-Natal a Provincial HIV/AIDS Action Unit was established to train THPs as councillors and educators. The Unit managed to train 17 500 practitioners and has been seen as central in educating and mobilizing communities on information and prevention practices within the province (Mokolatsie).

- ✓ Appreciating and understanding the traditional African worldview: Africans experience life in a way that is different from westerners which is where the biomedical paradigm has its origin. When working in any context practices and knowledge has to find synergistic meeting points with that cultural world view. The implication of this within an African context requires the recognition that intervention programmes must respond to specific meanings attributed to sickness, health and sexuality. For example there is a belief that personal illness and health can sometimes be attributed to action on the spiritual dimension (such as witchcraft). While most programmes have concentrated on transmitting the biological facts of HIV/AIDS, working with THPs has made it clearer that there is a critical need to locate information in the context of culture and traditions.

- ✓ Incorporating traditional ideas and practices into health initiatives: THPs are better positioned to give advice to their clientele and in the case of HIV/AIDS they can promote the importance of practicing safe sex whilst upholding traditional values. For example, studies have shown that those that visit THPs for advice on sexual behaviour were encouraged to practice non-penetrative sex such as thigh sex (htt://www.mtholyoka.edu) which is in line with biomedical advice on changing penetrative sex behaviour in reducing infection rates.

- ✓ Leveraging the inherent resources of THPs: By nature of their proximity and availability to communities THPs are able to maintain closer and more consistent links with their patients. This has played an important role in the consistent treatment and care for their patients. For example, in Hlabisa village (KwaZulu-Natal), it was been shown that THPs were able to get 89% compliance to medication versus the 67% success rate of patients supervised by rural clinics. This has been explained by their empathy and ability to follow up through house visits (Sunday Times, 2002).

The outcomes of the literature review suggest that THPs are playing an increasingly important role in HIV/AIDS programmes. Besides the best practices identified it is worth noting that in Africa, THPs are highly trusted and regarded as bearers of spiritual knowledge, problem solving and health care. Most importantly, they are considered as repositories of culture and tradition (Jackson, 2002). The former and the latter are

central in the illumination of the potential influence that traditional healers have and may exert in influencing behaviour change in HH&S related issues.

2.3 The socio-political context of traditional healing in South Africa

In the post 1994 era, South Africa not only witnessed the demise of apartheid, but a shift in paradigm towards the entrenchment of a "true" democracy. This meant an eradication of all forms of inequalities that threatened the coherence of South African society, or ran counter to the democratic principles of political equality. The health sector has not been exempt from this socio-political push to transform government institutions into adherence to the principles of the new Constitution.

This section will look specifically at the background and historical perceptions held around traditional healers in the context of the changing political and socio-economic landscape. This analysis takes into account the existence and role of the traditional health sector in a context characterized by an intensification of modern technology within the health sector. With this in mind any attempt to reassert the role of tradition which has the potential to elicit tensions between what has been dominant, acceptable and legitimated and what represents tradition. Whilst the research focus remains the potential role of THPs it makes sense to do this in relation to its counterpart (i.e. the biomedical health paradigm).

South Africa is characterised by what Helman referred to as medical pluralism. Specifically this refers to the co-existence of diverse therapeutic modes that are often based on entirely different premises and defined by differing cultural paradigmatic world-views (Helman, 1984: 60). In his study of the medical system of Britain, Helman identified three categories that are characteristic of any modern urbanised society (whether western or not). The first is the popular sector which includes all therapeutic options that people utilise without consulting traditional or medical practitioners. The second sector is constituted by traditional healers who are most often not part of the official mainstream medical system, and specialize in sacred or secular forms of healing or a combination. The third is the professional sector that is comprised of organised, legally sanctioned healing professions, such as modern western scientific medicine.

Using this categorisation it is clear that the South African medical framework has been narrowed into a dichotomy of co-existing and often conflicting disciplines as represented by the second and third sector. THPs are characterised by modes of healing that include a more or less shared herbal pharmacopoeia, and distinctive practices of divination and possession by the spirits of ancestors. Indigenous to South Africa in this category are sangomas, inyangas, herbalists, traditional surgeons and faith healers. Non-indigenous practitioners include Buddhist, Chinese, Hindu, Muslim, European herbalists, homeopaths etc. Despite the existence of a variety of traditional healers in South Africa, they have historically been located in the fringes of the broader medical health system. However the literature available has shown that despite a lack of empirical evidence on the extent to which people consult with traditional healers, it is estimated that almost more than 80% of the South African population consult or has consulted with traditional healers (Thornton, 2002).

The legacy of apartheid policies has created large disparities between racial groups, fragmented the health system, created inequitable access to health care (National Health plan for South Africa, 1994), and systematically devalued the traditional health sector. The Health Act of 1974 forbade healers not registered with the South African Medical and Dental Council (and was amended to include those not registered with the South African Associated Health Services Professions Board) from practicing or performing any act pertaining to the medical profession (Freeman, 1992: 79). The marginalisation of THPs was also reflected in the Nationalist Party's government's legislation which disregarded traditional medicine as a health resource. Western medical health practitioners on the other hand were located on a higher social standing with certain rights and obligations that were denied to traditional healers (Helman, 1996).

Tightly linked to the apartheid history of racial segregation as a variable in explaining the marginalisation of traditional healers, is also the legacy of colonialism that Richter (2003) refers to cultural imperialism and the power of the multi-national pharmaceutical industry. Traditional healers have been as a consequence ostracised and their value to communities underplayed.

However, the emergence and the escalation of HIV/AIDS infection rates, has resulted in an increasing presence of THPs in health care programmes and a resurgence of interest in traditional healing. Linked to this, has also been a call for greater investment and support for THPs and traditional medicine, not only by government, but also by civil society and the private sector (Richter, 2003: 26). This renewed interest in the role of THPs has however still failed to recognise the custodial nature of THPs of knowledge on cultural traditional norms and values. The danger of this is that the potential role that tradition and culture can play and has played in shaping attitudinal and behavioural patterns has often been overlooked and remains unexplored in mainstream academia, research and/or media.

Despite this exclusion, there have always been sentiments of certainty that THPs are here to stay. But there has been difficulties in idealising the legislative framework within which the registration, organisation and recognition of traditional healers would be located (Rissik, 1993). The development of the 1990 National Health Plan that sought to conceptualize affordable health, served as a starting point for addressing these difficulties (Freeman, 1992). However, any attempt to integrate THP into mainstream health care has been made difficult by tensions between the traditional health and western health paradigms. Such tensions have served as obstacles that have pessimistically shaped perceptions around the recognition of the traditional health sector.

Sodi (1987) in her study highlights that distrust of traditional healing modalities is rooted in ignorance from western medical practitioners about culture, the western belief that any information not based on scientific evidence is dangerous, as well as a propensity to focus on the failures of traditional healing. Yet Sodi argues that traditional healing as a result of its holistic approach to health and illness can be utilised by the western health practice to promote the good health of communities (Sodi, 1987: 21). These negative perceptions of traditional healing are exacerbated by those biomedical practitioners who view THPs as "…quacks,

charlatans or medicine men who pose danger to their patients health" (Helman, 1996:63). Interestingly, it is not only westerners who hold these opinions. Traditional healing has also been vehemently opposed by some black medical doctors such as Dr Nthato Motlana who in the early 90's argued that:

*"*All of mankind has passed through this stage of being treated by untrained, unschooled people. But as time passed and major scientific discoveries were made, people moved away from the mumbo jumbo and voodoo because they had learned the reality of disease" (Rissik, 1993).

During the apartheid struggle there was also a perception that traditional healing promoted superstition which wasted the time and money of the poor. A recent article in the Sunday Times quoted the Deputy National Police Commissioner Timothy Williams, who is also a trained inyanga. Williams indicated that "I used to think that ubunyangi [traditional healing] was just about superstition," he said, adding that many of the city's struggle activists believed traditional medicine to be an "opiate" of the poor and oppressed." (Ngcakani, 2006)

The same article also noted that *"*Even now there is still some stigma attached to traditional medicine*."* The article quotes Dr Mveleli Gqwede, a medical doctor and inyanga practising in Vosloorus saying that *"*Despite the fact that many African people are westernised, they respect the need for inyangas. They go to them at midnight in stilettos and with their [BMW] X5s parked outside*"*. (Ngcakani, 2006). This suggests support for traditional practices but not necessarily social acceptance of them perhaps in particular amongst higher income groups and professionals

The notion of traditional healing as an unprogressive modality has increased the lack of mutual understanding between the two disciplines. Thornton notes that this dynamic serves as one of the obstacles to co-operation in addressing health issues together. In some instances, traditional healers view what is modern, western and white as a threat to African identity, since knowledge of African culture and nature is the root of their power and identity (Thornton, 2002:9). A fear from traditional healers that scientists will steal their knowledge, which could impact on their livelihoods through the loss of intellectual property rights, is also a barrier to closer co-operation between these two fields of medicine.

Notwithstanding the tensions that exist between the two disciplines and negative perceptions from the public, media and communities, there have been calls for closer co-operation internationally and more recently in South Africa. In South Africa and in many other countries, there has been a liberalisation of socio-cultural life which Thornton (2002) argues has resulted in a renaissance of interest in traditional healers. What has been witnessed has also been an overt acceptance and utilization of the traditional health practice. It is therefore a reasonable hypothesis that it is possible for there to be greater synergy between the two fields in addressing common health concerns.

2.4 The legislative context

In the early 1990s, it was estimated that approximately 21 million people did not have access to a basic level of sanitation, which is defined as a ventilated pit-latrine or equivalent (DWAF, 1994). Thus post-1994 a government priority was to address this water supply and sanitation backlog. On 1 July 1994, DWAF was established so as to consolidate government staff into one department. In the absence of a coherent policy for water supply and sanitation, the White Paper on Water Supply and Sanitation Policy (DWAF, 1994) was compiled. The finalization of the White Paper was identified as a key priority, as well as the development of an integrated implementation strategy for addressing the backlog of sanitation provision.

Over the last 12 years (1994 to 2006), considerable progress has been made in addressing the levels of under-servicing in terms of water supply and sanitation. However, the demand for the expansion of municipal infrastructure continues to exceed supply, leading to rising backlogs in some services and limited progress in the elimination of overall backlogs. DWAF together with key sanitation role players, developed and launched a National Sanitation Programme to tackle the sanitation backlog that has begun to show positive results. This programme is focused on the eradication of the sanitation backlog in rural, peri-urban and informal settlement areas by the year 2010. In addition, it targets the eradication of the bucket system (currently estimated at about 428 000 households) by 2007. However, good sanitation is as much about people and their personal dignity as it is about public health, infrastructure provision or environmental management. Government policy states that basic sanitation is a human right, and emphasizes the importance of involving people in choosing, planning and implementing sanitation improvements that meet their needs and aspirations.

It is easy for communities to desire and demand the convenience and comfort which higher levels of sanitation services can provide, however, studies have proved that what is more important is for communities to understand and be aware of their attitudes and behaviour towards water and sanitation. Studies have shown that it is at community levels that work on consciousness raising with regards to hygiene and sanitation education and promotion should be done. For example, the research report 'Hygiene awareness for rural water supply and sanitation projects' highlights the importance of a shift from the communities dependence on the government projects towards sustaining their own projects as well as the development of appropriate hygiene education and awareness programmes.

Incidents such as the 2001 cholera outbreak emphasize further the importance of sanitation and the need for a close link between water supply, sanitation and health necessitates that these issues be addressed jointly and in an integrated manner at national, provincial and local government level.

2.5 Specific legislation and policies with regard to HH&S

The responsibility for government to provide basic services, which includes sanitation, as well as a healthy, safe environment for all its citizens is clearly indicated in the Constitution. As are the key roles for national,

provincial and local government in ensuring that this is achieved. In addition, there are other key pieces of legislation and policy which are discussed below:

The Water Services Act (Act 108 of 1997) was drafted to direct municipalities to meet their role as water services authorities and to look after the interests of the consumer. It also clarifies the role of other water services institutions; especially water services providers and water boards.

The National Water Act (Act 36 of 1998) legislated the way in which the water resource is protected, used, developed, conserved, managed and controlled. It also governs how a municipality may return effluent and other wastewater back to the water resource.

The Municipal Structures Act (Act 33 of 2000), The Municipal Systems Act (Act 32 of 2000), The Municipal Demarcation Act (Act 27 of 1998) and The Division Revenue Act are all pieces of legislation that govern municipal activities which include their functions in terms of the development and management of water supply and sanitation infrastructure and services.

The White Paper on Basic Household Sanitation (DWAF, 2001) emphasizes the provision of a basic level of household sanitation to those areas with the greatest need. It focuses on the safe disposal of human waste in conjunction with appropriate health and hygiene practices. The key to this White Paper is that provision of sanitation services should be demand driven and community-based with a focus on community participation and household choice.

Draft National Health and Hygiene Education Strategy (July, 2004) was drafted with the intention of facilitating the improvement and promotion of health, hygiene and sanitation programmes. The draft paper indicates a commitment geared towards the advancement of community health. In the process it attempts to draw a link between services and health, highlighting the correlation between the two. It does this by emphasizing the importance of health and hygiene education as a key vehicle for addressing water and sanitation related diseases.

Despite the strengths of The National Health and Hygiene education Strategy (July, 2004), it was interesting to note that the draft does not make reference to traditional health practice as a potential role player in the promotion of health and hygiene education in any way. Considering the fact that majority of the people in South Africa live in rural areas and consult with traditional healers on issues of health this could be considered to be a gap.

2.6 Specific legislation relating to traditional health practice

Government has recently passed an Act which recognizes the high number of THPs and legitimises the practice of traditional health modalities. The process to passing this Act began in 2003, and included broad consultation throughout the provinces. Issues related to subjecting traditional healing to a legislative

framework are complex and sensitive hence the need for intensive consultation and lobbying to get this Act passed.

The next part of this section analyses the Act and in doing so indicates how the process for developing this Act demanded an intimate understanding of traditional health practices and raised ethical questions around qualifications and practice. This Act applies to traditional health practice, to people engaged in or learning traditional health practice as well as to matters incidental to traditional health practice in South Africa.

Briefly the aims of the Act as laid out in the first chapter are to provide for:

- ✓ The establishment of the Interim Health Practitioner Council of the Republic of South Africa;
- ✓ A regulatory framework to ensure the efficacy, safety and quality of traditional health care services; and
- ✓ Control over the registration, training and practice of THPs and to provide for matters incidental thereto.

When engaging in an analysis of the Act the following becomes clear:

- The economic setting within which traditional healing is mostly located is critical because the sector predominately acts as a health and medicinal resource for the poor. This is an extremely price sensitive segment of the population. As such the possible impact of regulation on pricing of THP services needs careful consideration. This is not addressed explicitly in the Act.

- As important as it is to acknowledge that the Council is a by-product of the Act, it represents a vehicle for the regulation of the traditional health sector. One of the key challenges of the Council is the question of resources and independence. This raises two key questions such as who funds it, if funded by the government how will it retain and sustain its independence.

- Even though the Council is given responsibility in the promotion of health for the population the Act does not explicitly mention the role of THPs in specific HH&S issues. While it is not necessarily desirable to regulate such involvement, it may be helpful to encourage training standards of THPs in terms of certain areas of community health.

- The Act mandates the Council to promote traditional health practice which complies with universally accepted health care norms and values with a view to improving the quality of life of the general public. However, it does not specify what is meant by universally accepted health care norms and values. The Act generally seems more openly concerned with ensuring compliance, control and regulation.

- Traditional health practice is a very complex and contested terrain, with a diversity of practices and principles. The heterogeneity assumed in this Act can be seen in how it points out distinct categories within traditional healing, but such distinctions are limited to the question of practice. A very central component in traditional healing, i.e. the spiritual (defined by issues such as witchcraft and displeasure by

ancestors in order to find a cure) has not been given much attention. Traditional healing, as opposed to its biomedical counterpart that often relies on tangible and material causation is highly abstract. An attempt to regulate its practice in order to define its influence in the broader health care sector could potentially distort and obscure the traditional health practice.

2.7 Conclusions

The literature review turned up a significant amount of material related to traditional health practice; the legislative context, co-operation with the biomedical health system in terms of HIV/Aids education and treatment and the historical context to traditional health practice in South Africa, which still affects perceptions and practices today.

The information extracted during the literature review laid an important foundation for the other research methodologies, which involved interviews and workshops. In terms of the research process the material in the literature review served to make the case for the potential of THPs to be involved in HH&S and clarified the areas that needed to be interrogated to unearth how to maximise this potential for synergy.

3 DATA GENERATED FROM THE INTERVIEWS

3.1 Introduction

The findings of the literature review and desktop research fed into this data gathering phase of the research. After developing a data base of institutions currently working with THPs and health issues, a list of potential interviewees was developed. This list includes individuals from academic institutions, government departments, NGOs and CBOs. The research team followed this approach in order to identify existing institutions and individuals with knowledge about working with THPs and possibly networks that could provide links to THPs directly. A letter explaining the objectives of the research and requesting assistance was used as the initial contact point. Based on positive responses interviews were then scheduled and conducted (see Appendix 1 for the database listing and Appendix 2 for a list of interviews conducted). A standard request during each interview was a recommendation for referral to other institutions that could add value to the data gathering exercise.

Given the diversity of sectors working with THPs the unstructured interview was chosen as the methodological approach. This allowed for a broad spectrum of data to emerge while maintaining the topic focus. Each interview was recorded and the typed transcripts were then analysed using Dr Boyatzi's Thematic Analysis.

What follows is an overview of the common and significant themes which emerged from the interviews. Congruent with the approach of Thematic Analysis this includes an interpretation by the researchers of the data implications for the research question.

3.2 Common interview themes

The African context requires a new paradigm of health care

Most African people live with a foot in two worlds. The heritage of colonialism is a western infrastructure with all its dominant architecture and culture, poised precariously on a traditional world-view with which even the most westernised African relies on to make meaning of life. These seemingly paradoxical ways of interacting with life are navigated and integrated in the daily practices of ordinary people. When dealing with issues of health and illness this manifests as the utilisation of both modern biomedical and traditional or indigenous expertise.

Most African people, when faced with a health question, will consult both a traditional healer and a western doctor and often take their medication concurrently. Without the benefit of an integrated health care system which recognises this practice, the outcome is a lack of professional oversight or coordination of medication and/or practices prescribed to the client. Each interviewee therefore strongly recommended that government and the health sector recognise that at the very least coordination is required between these two health practice approaches.

However this is easier said then done. In reality these two practices are premised on very different paradigms of health and illness. It is therefore not as simple as coordinating medication, although this is a good starting point. The larger challenge is to redefine for the African context how the scientific western notions of germ theory and the holistic systems understanding of traditional healing can coexist in a theoretically sound whole. Besides offering better service provision for clients this would also be beneficial in meeting the common goal of both paradigms which is a healthy population. Leveraging off of the inherent strengths and complementing inherent weaknesses in each approach can pioneer a more viable health care system for the continent as a whole.

The diagram below summarises both the differences in paradigm as well as the potential for common ground between them.

The status of THPs in communities

Across the board, all those interviewed referenced the position of trust and status that THPs hold in communities. For those involved in bringing THPs into government health programmes and initiatives this was a major factor in their decision. Specifically it was noted that this inherent position of trust has two important implications for the health sector. Firstly, it supports the research found by Thornton (2002) that 80% of the South African population have consulted with THPs. Secondly, often THPs are the first point of call when community members experience illness.

When inquiring into why communities give such status to THPs the following emerged:

- ***Cultural beliefs and traditions:*** THPs come from deep-rooted and historically entrenched cultural beliefs and practices, which rely upon natural healing through the use of specific herbal preparations, psychic skills and rituals. These practices are conducted within a worldview which provides for being in constant communication and relationship with the spiritual and material world. Within Africa this is a

fundamental reference point which profoundly defines the reference point for dealing with health, well-being and illness.

- ***Proximity to communities:*** Many THPs occupy a position of trust with their clients because they are members of the communities in which they are located, they are mediums to the spirit world and also because they treat their clients in a holistic manner. People who go to THPs trust them to help with all interconnected aspects of their life. THPs therefore generally take their time in dealing with clients often consulting with family members in the diagnosis, treatment and care of those who are ill. This may even translate into conducting home visits.

- ***Socio-economic availability:*** THPs are generally both more available and more affordable for ordinary people. The fees charged by them in the long run are often not as much as the total costs incurred through seeing a biomedical practitioner. Also, there is generally more flexibility in terms of payment with many THPs agreeing to being paid in instalments or even in-kind. In addition to this, THPs are also generally available closer to where people live and work and operate on a more flexible basis. People also do not have to travel long distances (which may also be costly) and wait in long queues.

The nature of working with THPs

The traditional health sector is by nature informal and lacks a coherent national hierarchy. Access to the sector is therefore gained only through a process of gaining and maintaining trust. Every institution that works with THPs has therefore invested substantial time and resources in building a relationship with individual practitioners. One of the key factors which makes the building of this relationship so time consuming is the inherent secrecy required around the rituals to diagnose and treat clients. This knowledge is carefully guarded as the source of an individual THPs power and efficacy in their practice as well as them playing a wider role in communities as being the keepers of traditional knowledge.

The implication of this dynamic is twofold. Firstly, in the event of engaging THPs there are a series of best practices identified by interviewees and verified in the workshop experience. Secondly, once an institution has managed to gain trust with one practitioner in the sector referral through word of mouth opens up relationships with other THPs.

Challenges of regulation and formalisation of the traditional sector

Although each interviewee confirmed that THPs want recognition from government and legitimisation of their practice through legislation, this is a complex challenge. As noted in the literature review, the passing of the Traditional Health Practitioners Act was the outcome of a protracted negotiation, and still remains challenged by questions of standardising and regulating the training of practitioners. This theme was strongly confirmed across the interviews with the one of the key challenges noted being the oral and informal nature of this

sector. It was further felt that the only viable solution would be leaving the specifics of this to THPs themselves while attempting to mitigate as far as possible empire building or other exclusionary power plays.

The benefits of working with THPs

Across the board all institutions who have engaged THPs in their initiatives state that it has been an extremely valuable exercise. It is also a common experience that overall THPs are very open to learning, engaging the biomedical understanding of health and networking with other practitioners. Given the diversity of approach, training and client base the real benefit of working with THPs happens when a simple and consistent message can be disseminated through their network. This has been possible in HIV/AIDS education and treatment initiatives and everyone in the interviews strongly supported its utilisation in dealing with HH&S related initiatives.

3.3 Conclusions

In summary a number of important themes emerged from the interviews. These included the importance of the cultural and spiritual worldview to health and healing for the majority of the population in South Africa and how this is critical context for healthcare interventions. The interviews also highlighted the status of THPs in communities in South Africa and why people go to them. Useful information also came to light about the nature of working with THPs and the challenges and benefits of doing so.

These gave significant direction to the workshops especially in terms of sensitivities to be aware of, approaches to follow and questions to explore with THPs in workshop settings.

4 DATA GENERATED FROM THE WORKSHOPS

4.1 Workshop Design and Facilitation

Given the key role this data gathering exercise would play in the research findings, substantial thought went into both the conceptualisation of the workshop design as well as locating appropriate facilitators and participants.

In the process of conducting interviews SMM selected two key partners for joint facilitation of workshops with THPs (i.e. the Valley Trust and the Gauteng Association of Traditional and Faith Medical Practitioners). These organisations were selected because of their existing networks with THPs, their willingness to co-operate and their capacity to partner in arranging and in the case of the Valley Trust facilitating workshops. In particular a participatory approach was identified as appropriate for the workshop methodology and specifically tailored for use in the research. The PHAST methodology in particular was an important reference for the KwaZulu-Natal workshops.

One workshop was held in Gauteng and six in KwaZulu-Natal. The methodology for all workshops engaged participants in a combination of group work, group discussions and interactive exercises. The workshop facilitators encouraged the use of mother-tongue because it both allowed for easier expression by participants and established a rapport between facilitators and participants.

Common to all workshops was a basic format. After ice-breakers and introductions, the topics of health, healing and approaches to treating diarrhoeal diseases were used. At an appropriate point the biomedical, disease/germ transmission model was presented for discussion and comparison with the understanding of diarrhoeal disease by participants. This was then followed by the examination of traditional methods of teaching and learning about practices involving the safe disposal of excreta and ensuring health and hygiene in the household and the larger community. The final stage of the workshops invited participants to examine the role that they could play as THPs in promoting HH&S.

The Gauteng workshop was conducted by Modiehi Khuele and Naeema Hussain of SMM in Johannesburg. After the Gauteng workshop a specific set of tools were developed. These were workshopped with the KwaZulu-Natal facilitators in a workshop conducted by Kate Clement of SMM and the workshops with THPs were facilitated by staff from the Valley Trust in rural locations in the Valley of a Thousand Hills in KwaZulu-Natal.

The following table summarises the three tools which formed the backbone of the KwaZulu-Natal workshops (refer to Appendix 3 for the facilitator worksheets designed for each tool):

Name of Tool	Purpose	Target Outcomes	Process
Community Health Check-up	Facilitate participants identifying the relationship between: - water - human waste illness - individual & community health	A better understanding of: - the inter-related nature of health issues - the role and influence of THPs - - root causes behind current community health issues	Step 1: Discussion of water, sanitation and illness Step 2: Discussion of individual health Step 3: Diagnosis of community health
Illness, waste and water	Facilitate participants engaging with the relationship between illness and human waste.	A better understanding of the transmission cycle of harmful bacteria via human waste	Step 1: Role plays Step 2: Poster Step 3: Cards
Where have all the heroes gone?	Facilitate participants sharing stories so as to identify traditional practices as well as them recognising their role in terms of being custodians of tradition and knowledge.	A better understanding of: - the role of traditional practices in community health - the value add of THPs	Step 1: Sharing stories Step 2: Discussion

4.2 Gauteng workshop

The Gauteng workshop (see Appendix 3 for a full report) was designed, organized and run by SMM in collaboration with the Gauteng Association of Traditional and Faith Medical Practitioners. The workshop was held in Johannesburg on 24 November, 2004 with 18 traditional and faith healers who live in Gauteng in urban and peri-urban areas. The specific demographic of participants were as follows:

- 5 males 13 females
- Ages between 30 – 60
- Level of education for all included secondary schooling
- The range for the duration of their practice was between 3 months and 35 years

4.3 KwaZulu-Natal workshops

The workshops with THPs in KwaZulu-Natal (see Appendix 4 for detailed report) were designed by SMM in collaboration with the Valley Trust and organized and facilitated by the Valley Trust in their area of operation in the Valley of a Thousand Hills. A facilitators workshop attended by six Valley Trust facilitators was first held to brief facilitators on the tools developed and to workshop them. This was then followed by a series of six workshops in November and December of 2005.

In total 30 different THPs attended these six workshops. The particular demographics of these participants were:

- 10 males 20 females
- Ages between 24 – 65

4.4 Challenges to the workshop process

A number of challenges were experienced by the facilitators in both the KwaZulu-Natal and Gauteng workshops. The common challenges were as follows;

- Certain subjects were considered to be too embarrassing to address in role plays. For example a role play of some sanitation and hygiene problem scenarios were proposed in the KwaZulu-Natal workshops but participants did not want to carry them out as they were considered to be embarrassing. This highlights the need for facilitators to have a high level of sensitivity around issues which can be embarrassing for participants.

- In both workshop sites there was a tendency for participants to start to discuss a wide range of hygiene issues outside the traditional scope of sanitation and hygiene education programmes. The facilitators in both provinces needed to keep a fairly tight check on this because of time constraints and so as not to lose the focus on traditional sanitation, health and hygiene issues. This of course needs to be done sensitively so as not to discourage participation or implying that what is being discussed is somehow wrong.

- There was a lot of material and ideas to be absorbed in one day and participants tended to get tired. The material could be spread out into more workshops depending on the availability and willingness of participants.

4.4.1 Summary of key success factors in workshops

Some of the key factors which researchers found to make this form of data gathering very effective are outlined below.

✓ ***The approach,*** skills and attitude of facilitators
  - Effective participatory facilitation is a skill. Courses in approaches such as PHAST can equip facilitators with the kinds of competencies that need to be developed to have this skill. It would strongly benefit the process of engaging traditional health practitioners on sanitation, health and hygiene if facilitators had completed the training in PHAST or a similar participatory community development methodology.
  - It is very important that facilitators are sensitive, respectful and open to learning from participants not just “teaching” them. This learning emerged in particular from the KwaZulu-Natal experience where facilitators were often required to apply their skills in terms of asking probing questions, focusing the direction of sessions and adapting tools on the spot to the groups needs.
  - In addition to having the skills to facilitate it was also found to be important for facilitators to take time to reflect on their own attitude, understanding and feelings towards traditional health practices and practitioners. This enables them to become more aware of possible prejudices or preconceptions about traditional health practitioners or practices.

- ✓ *Helping participants to feel comfortable*
  - In the research workshops conducted in KwaZulu-Natal the opening question for the group was "What is the link between traditional healing and water?" This was identified as a question which opened up the workshop well because it allowed the participants to immediately engage with something relevant to them which could also be tied to sanitation, health and hygiene issues later on in the day.

- ✓ *Viewpoints on health and healing*
  - As raised in the Literature Review there are very different perspectives between the biomedical and traditional paradigms of health and healing. One of the interesting exercises early in the workshops in KwaZulu-Natal involved participants discussing the following questions;
    - What is a healthy person? What is this person like? How do they look, sound, behave, feel?
    - Following this the participants were then asked to share how they saw their communities in terms of health and the main health problems that they encountered.

      Participants responded very well to these questions and it opened up into deeper discussions about causes of ill health in communities. With effective facilitation participants were able to identify a wide range of causes of ill-health including those related to diarrhoeal diseases in their communities.

      As well as being a useful exercise for the participants this is an informative exercise for facilitators for it brings to light how the participants view health, which may be different to the view of the facilitator. Being exposed to these different viewpoints on health can enable the facilitator to increase their level of awareness about how to effectively influence positive health-related behaviour changes in communities.

- ✓ *Recognizing and remembering existing knowledge and resources*
  - In the research workshops many participants raised the important point that much of what is covered in terms of health and hygiene and sanitation training or education is already known by most people. Further to this, there are many practices which were historically carried out in communities to address most of these issues. Intuitively this makes sense as the problems of sanitation and hygiene are fundamentally no different today as to what they have been for thousands of years namely how is human waste disposed of safely and how are living environments made safe.

An important insight came to light in one of the workshops held in KwaZulu-Natal as reflected by the following quote from the Valley Trust workshop report:

"There was a realisation amongst traditional health practitioners that diseases don't only come from flies but also from losing our own culture and trying to adopt other people's cultures, (in the process) we leave behind customs that can at a very practical level contribute to wellness and minimise the spread of disease."

4.5 Sample of Workshop Data

Through these workshops a substantial amount of data was generated. The key elements form part of the conclusions and recommendations chapter, but for the reader here is a sample of some traditional practices related to HH&S that were shared:

- Rubbing one's hands with ash as well as washing hands with bile from animals to ensure clean and sterile hands. These practices were identified as particularly important in areas were water was not readily available.

- The group discussions concluded that societal developments have impacted on approaches to health and hygiene related matters. In the past, people have always had their own ways of ensuring and maintaining hygienic and healthy ways of living. This was despite the fact that water was not as easily accessible.

- According to participants at this workshop, people relied on river water for bathing and laundry. Ground water was used for consumption. Rivers were respected; there was no dumping in the rivers. Rubbish was dumped in a special place where it would be burnt for hygienic reasons namely, for people not to be exposed to it so as to pick up germs from it.

- Not defecating in water that is used for consumption by communities.

- Awareness that germs can be passed on from handshaking, therefore encourage handwashing habits especially when hands are to be used in preparing food or eating.

- In the case of protecting newborn babies against illnesses such as diarrhoea, breastfeeding mothers must be discouraged from breastfeeding when they are ill. Mothers must also be encouraged to wash their hands before coming into contact with the baby especially when they are about to breastfeed.

- Some interesting stories also emerged which are told to children to encourage them to adopt hygienic toileting practices. For example some traditional health practitioners would tell children fairy tales to scare them - if they defecate and do not cover the waste with soil then the angels will not give you blessings or if a crab drinks your urine because you urinated in the water or in the open then you will change sex.

4.6 Key Workshop Findings

- Many traditional health practitioners are custodians of culture and knowledge in communities. Participatory processes need to engage with participants in such a way that this is highlighted.

- It is indeed possible for traditional health practitioners to become allies in sanitation, health and hygiene promotion given the right approach and facilitation.

- All groups felt that their clients include individuals and families and they need to engage them on issues of cleanliness and sanitation with a force similar to the way that everyone is engaging issues related to HIV/Aids. Participants also felt that they could pass on some of the discussions and information that had been generated with other THPs who were not present. Two groups said that this could be done informally at various ceremonies when people are preparing food together as leaders of ceremonies and their clients. They also stated that they could be more proactive when they see meat lying around and beer pots uncovered and ensure that both are covered so that flies do not pass on diseases.

- It is possible to generate interest in issues related to HH&S amongst THPs and for them to become motivated to influence positive hygiene and sanitation behavior amongst their clients and in the larger community. Most participants were appreciative of the learning opportunities afforded by the workshops and the recognition of their role in communities.

4.7 Key Principles for Engaging THPs

Community health and development workers may encounter resistance from traditional health practitioners in the initial phases of processes of engagement. They may even be treated with suspicion of coming to steal something in terms of information about herbs or treatments. Traditional health practitioners have been insulted, exploited for their knowledge, not been adequately consulted in processes that involve them and have often not been acknowledged or given incentives for their involvement, commitment and hard work. Many have good reason to be suspicious or resentful. It will be up to the community development or health worker to find ways to engage with traditional health practitioners to build an alliance for the benefit of the health of the community.

The lessons from these workshops have been distilled into the following set of principles for engaging with traditional health practitioners on HH&S issues.

Awareness

When engaging with THPs health and development workers need to be conscious of the fact that people come from different backgrounds and are influenced by diverse cultures, beliefs, values and perceptions. There may be clashes in beliefs and ways of practice in terms of biomedically based education materials and how THPs practice and view health and disease. The challenge for community development and health

workers is to remain aware of their own possible prejudices and worldview and stay open to the different worldviews of THPs. They will then have the opportunity to explore synergies together with participants.

Respect

Respect is one of our most fundamental needs as a human being. It is critical that in engagements with THPs people appreciate the fact that they are dealing with respectable members of the community and therefore a certain appropriate level of respect and politeness is required. It should also be appreciated that THPs are experts in their area of work and that many of them are well deserving of their credibility.

In addition some traditional health practitioners are conservative in their practices, especially in the way they operate and deal with people. Community development workers must learn to understand and respect protocols guiding their ways.

Respect is only one of the elements from which openness, willingness, participation and cooperation emanates. If no respect is shown and if force is used in engaging THPs, this may immediately be interpreted as an imposition and invasion of space. In addition it is important to remember that traditional healing knowledge is based on secret knowledge, and therefore is usually guarded especially since THPs have fallen victim to exploitation and certain levels of criticism in the past. There are also very tangible ways that respect needs to be expressed. For example many THPs rely on their clients to generate income. To take a day out to attend training represents potential loss of income. It is therefore important that their time is respected, that activities are conducted in an efficient manner and that the best use is made of their time.

Buy-In

In order to get buy-in on any process the consultation of THPs should happen from the beginning of the engagement process. This is also crucial given that for THPs to be involved in promoting good HH&S practices in a sustainable manner requires strong ownership of these issues and a clear understanding of their role.

Commitment to a two way learning process

The approach of the facilitator is important. If the approach is one of coming to teach people certain aspects about hygiene education the impact will be limited. However, if the approach is to come and explore common concerns and find common solutions in terms of health issues that are related to hygiene and sanitation then there will be more room for learning to occur in both directions.

Transparency / Information flow

This involves updates and feedback to stakeholders. Without this, trust will not be developed and the process may not go very far. This will also be enhanced with clear communication upfront from the facilitator as to expectations and objectives and an opportunity for traditional health practitioners to state their objectives and expectations.

Sensitivity

There needs to be a high level of sensitivity in terms of how THPs are perceived in the community and how the relationship between them and any members of the community is established. Many people in communities place THPs in a high position of trust with regard to their personal lives and it is important that community members do not get the impression that this is somehow being compromised by the work being done with "outsiders". Encouraging THPs to be open with the community about workshops or training that they are attending is one way that this can be avoided.

Enthusiasm and Confidence

Enthusiasm, confidence, optimism, hard work and commitment are some of the most important ingredients for attracting active and potentially sustained participation. It is absolutely critical to display these characteristics in engaging any person. These characteristics are generally appreciated and often draw interest. A lack of confidence, optimism, commitment and enthusiasm will generally result in the people with whom you are trying to engage with being disinterested and unenthusiastic.

4.8 Conclusions

The workshops were extremely valuable exercises in a number of respects. Not only did they provide crucial information about how to maximise the potential for engaging THPs on HH&S issues but the workshop design process resulted in the development of a number of useful workshop facilitation tools. They also made clear the principles that need to be engaged in doing so and these were drawn out of direct experience of engaging with THPs.

It is beyond the scope of this research project in its current form however to take this further into a training document or guideline but an important foundation has already been laid in the development work that has been done to date.

Throughout the workshops it also became clear that there is a high level of willingness of the part of THPs to participate in training and workshops and to co-operate with other parties. This is in spite of prejudicial treatment by institutions in the past. In all cases the participants willingly engaged with the workshop processes, shared information and were enthusiastic to learn.

5 RESEARCH CONCLUSIONS

5.1 Introduction

This chapter is organised around two different aspects of the research: firstly, an exploration of key research findings and secondly specific recommendations flowing from this. The report has deliberately been structured so that the proceeding chapters summarise the data sources in order that this section may be read as one specific set of interpretations and conclusions reached by the researchers through their analysis process. This does not exclude the possibility of additional interpretations of the data gathered, but is intended to be a fairly comprehensive starting point.

1. Regarding the overall research question the unequivocal answer is there is definitely the potential for THPs to be involved in HH&S promotion initiatives.

The data gathered supports this conclusion in the following ways:

- The experience of both government and non-government organisations in HIV/AIDS work has shown that this model of involvement is possible, desirable and adds value.

- Many THPs in communities are respected and trusted which lends legitimacy to any intervention within which they choose to participate or which they choose to support.

- The potential engagement of THPs is strengthened by the willingness they have to be engaged, to participate and to promote initiatives that will benefit communities. This was very clear both through the HIV/AIDS experience as well as during the engagement of THPs in the workshop process of this research.

- There are already successful experiences of organisations engaging THPs from which lessons can be learned. A few identified by this research (e.g. Valley Trust, eThekwini Municipality) can become a starting point for a larger benchmarking and learning exercise.

- The policy and legislative environment is encouraging and creates the starting point of a facilitative process to engage THPs. This is seen through the introduction of the Traditional Health Practitioner Act and the emerging programme from the DoH to engage and capacitate THPs to assist in the delivery of public health programmes.

2. However, there are definite challenges associated with engaging with THPs on HH&S issues that programmes will need to factor into their design and implementation.

Overall the three most important challenges are:

- A very clear paradigmatic difference in the biomedical and traditional conceptualisations of health, where the biomedical has clear formal dominance. This has an impact not just on how the sector is currently organised but also what materials on health education are available. A reconceptualisation, which allows for the integration points of these two paradigms, is needed.

- Given the particular South African context, there is historical baggage as well as inherent infrastructural legacies to overcome. From the side of THPs there is a deep experience of their knowledge being denigrated and unrecognised by legislation, coupled with a fear of their practice and expertise being stolen or misused. From the side of biomedical practitioners there is an experience of having to manage the effects of poorly practiced traditional medicine, and a traditional dominance in legitimacy that can be manifested in personal prejudices or lack of understanding.

- Structurally the challenge is that few spaces currently exist for the interaction between practitioners from the two disciplines. Those spaces that do exist often do not encourage equal exchange, sharing and mutual learning.

3. Aside from the above challenges a further conclusion is that there exists a definite opportunity for engaging THPs in HH&S issues. This opportunity is closely linked to the current historical moment in the following ways:

- Government has begun the process of creating an enabling legislative environment and beginning to practice engagement with THPs. This can be seen in the current Traditional Health Practitioner Act as well as initiatives by the DoH in establishing a unit for working with THPs on health issues. In addition to this direct engagement, an important implication is that government is providing a legitimisation of traditional ways and practices which can impact larger social discourses.

- As an outcome of the above there are models of engagement from which to learn. These models are both in the private and governmental sector, and are related directly to the field of health and hygiene and sanitation as well as other health issues. Building off of this current experience, leveraging international experience and working with the socio-political imperatives of service delivery offer a crucial entry point and momentum for such initiatives.

- Building off of these imperatives has a clear advantage because of how much of the general population is exposed to THPs. This impacts not only the credibility of messages sent through them, as noted previously, but also increases exponentially the scale of people reached.

4. A critical conclusion that allows for the proper leveraging of THPs in HH&S issues is that new materials and approaches will need to be conceptualised in order to account for their paradigm of health. The research show this in the following manner:

- Through the literature review and preparation work for the workshops it became apparent that current materials on HH&S are all premised on the biomedical view of health. This happens in two ways. Firstly, germ transmission theory forms the basis on any understanding of HH&S issues. Secondly, as an implication of this, only the physiological aspects of illness are represented. Therefore, without a re-conceptualisation of tools the full richness of traditional approaches will not be leveraged.

Specific Recommendations

In light of the above research findings there are four key interrelated recommendations for action in leveraging the potential of THPs in HH&S issues. These are that:

1. There should be active and deliberate encouragement of THPs in HH&S education and promotion. This recommendation is for both government as well as the private health sector. The models and approaches uncovered in this research can be referenced for developing specific approaches.

2. In order to fully benefit from working with THPs, a participatory approach should be utilized when engaging them in any initiative. In particular the approach developed through this research project and others can be a starting point, but there are also key principles of participation that can form the basis of diverse approaches.

3. So as to implement a participatory approach the development of specific materials and processes will be required. This can be done in at least three ways:

- build off of existing materials from participatory programmes such as PHAST;
- revise existing materials to make provision for the re-activation and encouragement of indigenous knowledge to not only inform HH&S issues but also leverage cultural practices such as storytelling; and
- ensure that facilitators have a format to increase awareness of their personal attitudes and possible prejudices towards traditional health and health practices with the aim of reducing the influence of any such prejudices.

4. All stakeholders in the health sector (including community health workers, health practitioners and development workers) should be encouraged to engage THPs. This requires the deliberate creation and sustaining of social spaces to build relationships, realize common ground and enrich the work of health practitioners. Government can take the lead in this by leveraging off existing legislative frameworks and creating incentives for others to participate.

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National Water Act of 1988

Municipal Structures Act of 2000

Water Services Act of 1997

Internet documents.

Mokolatsie, Chris: KwaZulu-Natal Department of Health: Healers play an important role in KwaZulu-Natal’s AIDS Response. http://kznhealth.gov.za

Traditional Healers: htt://www.mtholyoka.edu.

APPENDIX 1

DATABASE OF POTENTIAL INTERVIEWEES

GAUTENG

ORGANISATION	CONTACT	TEL	FAX	E-MAIL / WEBSITE	ADDRESS	FOCUS
Alexandra Health Centre And University Clinic	Ms Catherine Mvelase	011440-1231	011 440-1665	cmoyasi@alexclinic.org.za	P O Box 175 Bergvlei 2012	Health
CSIR	Ms Berenice Lue Marais	012 841-2200	012 841-3789	blue@csir.co.za	P O Box 395 Pretoria 0001	Health; Water
Development Resource Centre [DRC]	Mr Zane Dangor	011 838-7504	011 838-6310	drc@sn.apc.org	P O Box 6079 Johannesburg 2000	Research
HIV/AID Link Education and Development Organization	Mr Solomon Sekhaolelo				P O Box 132 Residentia 1980	AIDS
Human Sciences Research Council [HSRC]		012 302-2013/23	012 302-2002	http://www.hsrc.ac.za	Private Bag X41 Pretoria	Research
Wits Foundation	Prof I P Steadman	011 717-9712	011 339-7235		P O Box 107 Wits 1621	Research
Institute of Urban Primary Health Care [IUPHC]	Mr Joel Perry	011 440-1231	011 440-1243	iuphc@pixie.co.za	P O Box 67 Bergvlei	Health
National Progressive Primary Health Care Network [NPPHCN]	Hazzy Sibanyoni	011 403-4647	011 403-2517	pphcnjhb@sn.apc.org	P O Box 32095 Braamfontein 2017	Health
National Research Foundation [NRF]	Mr William Blankley	012 481-4055	012 349-1179	info@nrf.ac.za http://www.nrf.acza	B O Box 2600 Pretoria 0001	Research
Rand Water Education Services	Mr B Kris	011 682-0495	011 682-067		P O Box 1127 Johannesburg 2000	Water
Reproductive Health Research Unit	Ms Linda van Blerk	011 933-1228	011 933-1227		P O Box 2013 Bertsham 2013	Health
Rural Development Services Network [RDSN]	Mr Edward Cottle	011 403-7324	011403-7109	info@rdsn.org.za	Private Bag X67 Braamfontein 2017	Health; Water
Thusano School of Public Health [TSPH]	Ms Kathy Dennill	012 325-1218	012 328-6040	tsphsect@iafrica.com	Private Bag X385 Pretoria 2128	Health
Township AIDS Project [TAP]	Mrs Enea Motaung	011 982-1016/27	011 982-5621	tap@icon.co.za	P O Box 4168 Johannesburg 2050	AIDS

Mvula Trust	Ms Kate Skinner	011403-3425	011 403-1260	kates@mvula.co.za	P O Box 32351 Braamfontein 2017	Water
Women's Health Project	Ms Barbara Klugman	011 489-9917	011489-9922	womenhp@sn.apc. org	P O Box 1038 Johannesburg 1685	Health
Zanendaba Storytellers	Ms Khosi Mazibuko	011 339-6906	011 339-6906		P O Box 31929 Braamfontein 1800	Storytelling

KWAZULU-NATAL

ORGANISATION	CONTACT	TEL	FAX	E-MAIL / WEBSITE	ADDRESS	FOCUS
AIDS Training Information and Counseling Centre [ATICC]		031 300- 3104	031 306-9294	mared@durban.gov.co.za	P O Box 2443 Durban 4000	Health; AIDS
Amatikulu Primary Health Training Centre [APHTC]	Mr N A Khanyile	032 453-0039	032 453-0058	admin@aahc.pmb. healthlink.org.za	Private Bag X2113 Nyoni 3802	Health
Centre for Health and Social Studies [CHESS]	Mr Sibongiseni Ngema	031 260-1569/71	031260-1585	chess@shep.und.ac.za	Private Bag X10 Dalbridge 4014	Health
Community Organisation for Research and Documentation [CORD]	Mr Peter Deman	031 303-5510	031 303-5513	pderman@iafrica.com	P O Box 47400 Greyville 4023	Research
Drama in AIDS Education [DRAMAIDE]	Mr Mkhonzeni Gumede	031260-1564	031 260-1568	sunitha@nu.ac.za	University of Natal Durban 4041	Health
Health Systems Trust	Mr David Mametja	031 307-2954	031 304-0775	davidm@hst.org.za http://www.hst.org.za	P O Box 808 Durban 4000	Health
Inanda Health Information Centre [IHIC]	Ms Zanele Gwala	031 519-0903	031 519-0903	-	P O Box 17173 Congella 4013	Health
National Development and Restoration of Traditional Customs Forum	Mr M C Ngebe	031 252-0007	031252-9067	-	P O Box 840 Kokstad 4700	AIDS
National Progressive Primary Health Care Network [NPPHCN]	Ms Khosi Nyawo	031 301-2902 / 306-2463	031301-2906	pphckzn@wn.apc.org	P O Box 3840 Durban 4000	AIDS
Phoenix Community Health Centre [PCHC]	Ms R Moodley	031507-6774	031 500-4290	-	Private Bag X007 Mount Edgecombe 4300	Health
School of Family and Public Health Medicine [SFPHM]	Prof C Jinabhai	031260-4387	031 260-4211	pillaym@med.und.ac.za	University of Natal, Private Bag X7 Congella 4013	Health

Siyabona Rural Development	Mr Gordan Bailey	039 971-1632	039 971-1661	siyabona@xinet.co.za	P O Box 65 Scottburgh 4180	Health
The Valley Trust	Mr Richard Haigh	031777-1955	031 777-1114	tvt@vtrust.org.za http://www.healthlink.org.za/valley	P O Box 33 Botha's Hill 3660	Health
Thornwood Health Project [THP]	Ms R Ngubane	031 718-2630	031 718-2641	-	C/o Thornwood Library P O Box 49, Pinetown	Health
Umgeni Water	Ms C Janneker	033 341-1111	033 341-1084	Info@umgeni.co.za http://www.umgeni.co.za	P O Box 9 Pietermaritzburg 3200	Water
Ziphakamise	Rev L J Bhodla	039 682-1834	039 682-1795	zipha@venturenet.co.za	P O Box 511 Port Shepstone 4240	AIDS
Nelson Mandela [Medical School, University of KwaZulu-Natal]	Dr Jerry Coovadia					AIDS; Health

LIMPOPO

ORGANISATION	CONTACT	TEL	FAX	E-MAIL / WEBSITE	ADDRESS	FOCUS
AIDS Training Counseling and Information Centre [ATICC]	Mr H Smith	015 290 2363	015 290 2364		P O Box 111 Pietersburg 1700	AIDS; Health
Association for Water and Rural Development [AWARD]	Laurenzo Bertolo	013 797 0555	013 797 0767	julian@award.org.za http://www.award.org.za	Private Bag X483 Acornhoek 1360	Water
Choice Comprehensive Health Care	Ms Fiona MacDonald	015 307 6329	015 307 6329	choicetz@mweb. co.za	P O Box 2181 Tzaneen 850	AIDS; Health
Health Systems Development Unit [HSDU]	Doreen Nkuna	013 797 0076	013 797 0082	hsdu@soft.co.za	P O Box 2 Cornhusk 1360	AIDS; Health
Hlathlolanang Health and Nutritional Education Centre Project [HHNEC]	Mr Jacob M Mseteka	013 2651189/ 380	013 2651348	hhnec@sn.apc.org	P O Box 718 Jane Furse	Health
Mokhale Malesa Educare Centre	Mr Peter Mokwena	Cell 083 746-0870			P O Box 3432 Tzaneen 850	Health
Northern Province Rural Development Forum [NPRDF]	Mr Moshabi Malatsi	015 291 1036 / 53	015 295 2107	rdfnporg@sn.apc.org	P O Box 4538 Pietersburg 700	Water; Sanitation
Thinkawu Theatre laboratory	Ms Mavhungu Lerule	015 556 3120 X 212	015 5563180	akanani@icon.co.za	P O Box 43 Elim Hospital	Health
Tshehlwaneng Development Centre [TDC]	Mr Abram Mashegoane	Cell 083 311 7529			P O Box 568 Sekhukhune 1124	AIDS; Health
Tsogang Water and Sanitation	Mr John Kings	015 307 2673	015 307 5299	tsogang@pixie.co.za	P O Box 1111 Tzaneen 850	Water
United Community Health Development and Welfare Department	Mr M R Rivimbi	Cell 082] 533 2096			P O Box 632 Duiwelskloof 835	AIDS
Wits Rural Facility [WRF]	Mr George Varkey	015 793 3991	015 793 3992	vgeorge@global. co.za	Private Bag 420 Acornhoek 1360	Health

ECAPE						
ORGANISATION	CONTACT	TEL	FAX	E-MAIL	ADDRESS	FOCUS
African Culture Community Development Association	Mr Ryan Mapisa	043 743 7410	043 743 7410	accda@sn.apc.org	P O Box 7282 East London 5200	Storytelling
African Medical Mission [AMM]	Prof C McConnachie	047 531 2652	047 532 2426	ammsa@wildcoast.co.za	Umtata General Hospital	Health
AIDS Training, Information and Counseling Centre [ATICC]	Ms Victoria Ndyamara	045 838 3244	045 838 3244	-	Private Bag X7111 Queenstown 5320	AIDS; Health
Community Health and Welfare Initiative [CHWI]	Ms L Mahonga	041 454 4002	041 454 3911/ 484 3811	-	22 Mfuku Street New Brighton 6200	AIDS; Health
Eastern Cape Appropriate Technology Unit [ECATU]	Mr D Lefutso	047 1682 3/4	047 532 4601	-	P O Box 225 Umtata 5100	Water
Elliot Health Centre	Ms Nancy Myburgh	045] 931 1371	045 931 1224	nancymyburgh@hotmail.com	P O Box 136 Elliot 5460	Health
Environmental Development Agency Trust [EDA]	Mr Moses Jumo	051 603 0026	051 603 0189	maryanne@edahersc hel.org.za	P O Box 157 Lady Grey	Water
Health Care Trust [HCT]	Ms Beatrice Ndima	047 877 0262	047 877 0947		P O Box 374 Elliot 5460	Health
Healthy People, Happy Communities	Ms Y Miles	Cell 083 548 0212 041484 7475			164 Caxton Street Quigney	Health
Imbizo Arts Of South Africa IASA]	Mxolisi Nyezwa	041454 6614	041 454 6611		P O Box 63 New Brighton 6200	Storytelling
Itekeng-Zama Rural Development	Ms Mahlonono Kungu	039 737 4461	039 737 4461		P O Box 1805 Matatiele 4730	AIDS
Rural Support Services [RSS]	Ms Lesley Steele	043 743 0051	043 743 2503	rss@rss.co.za	P O Box 11067 Southernwood 5201	AIDS; Health; Water
Small Projects Foundation [SPF]	Mr P B Cromhout	043 743 9592	043 743 4721	spfinfo@intekom.co.za	5 St James Road, Southernwood East London 5201	Water
Southern Africa Development, Research and Training Institute	Ms Sepi Rouhani & Mr. Gerhard Luck	041 582-4155	041] 582-4155	sadrat@intekom.co.za	P O Box 19352 Linton Grange Port Elizabeth 6015	AIDS
Talking Hands Educational Trust	Ms Elyse van Houten	046 622 7594	046 622 2962	puppets@imaginet.co.za	P O Box 625 Grahamstown 6140	AIDS; Health

Umthathi Training Project Trust	Ms Irene Walker	046 622 4550	046 622 6350	umthathi@eastcape.net	Spoornet Station Building Lower High Street Grahamstown 6139	AIDS
Zimele Rural Development	Mr S M Magxiva	045 838 5832	045 838 5832		P O Box 556 Queenstown	Water

APPENDIX 2

LISTING OF PEOPLE INTERVIEWED

GAUTENG / NATIONAL

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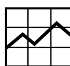
APPENDIX 3

DESCRIPTIONS AND FACILITATOR WORKSHEETS FOR WORKSHOP TOOLS

Community health check up



Purpose of the tool

The purpose of the tool is to assist development workers to facilitate a session where traditional and faith healers identify the relationship that they see between;

- water
- human waste illness
- individual and
- community health.

Target outcomes

The tool will assist participants to;

- have a better understanding of the inter-related nature of health issues in the community especially in terms of sanitation, health and hygiene.
- have a clearer picture of the state of health of the community that can act as a reference to see if there are any changes in the health of the community.
- have a more positive perception of themselves as people who can influence health related to sanitation and hygiene practices.
- have an increased understanding of the root causes behind the current state of community health in the community/ies of participants and in particular those related to poor sanitation and hygiene practices.

Time needed: 45 minutes – one hour

Process

The process is intended to be used in a participatory way in a workshop with several participants. It is specifically designed for use in opening a workshop on health, hygiene and sanitation issues with traditional health practitioners.

The process involves 4 parts;

Part 1: Discussion of water, sanitation and illnesses

Part 2: Discussion of individual health

Part 3: Diagnosis of community health

Note: It is important the facilitator tries to elicit discussion from participants based on their experience and view not the view about what the facilitator thinks is "right".

Part 1: Discussion on illnesses, water and human waste

The facilitator will encourage discussion around the following three areas for +/- 10 minutes each.

As a THP what is the relationship between water and illness for you?

As a THP how do you view the problem of runny tummies? What are the causes of this?

As a THP what is the relationship between human waste and illness for you?

Part 2: Discussion on individual and community health

What is a healthy person for you? What is this person like?

How do they look, sound, act, behave, feel?

Use this discussion to bring out the different types of health, for example emotional, physical, spiritual, mental etc.

How are the communities that you work in, in terms of these different types of health?

What are the main health problems of your community that people come to see you about?

Part 3: Discussion about why this is the current situation of health in communities

Note: The facilitator is encouraged to use a way of questioning that deepens the understanding of the problems by participants to help them to get to the root causes of the health problems in their communities. Facilitators can keep asking the question " But why?" to each response of the participants.

The facilitator could present the idea of the onion and how it can be seen to represent our understanding of the reason for things. Each time we ask the question why? We peel off another layer of the onion. It takes time to get through to the centre of the onion, there may be many layers of it (and yes some may even make use want to cry!) but it is important to keep peeling until we are sure we are at the centre.

Part 4: Discussion about why this is the current situation of health in communities

An understanding of the biological causes of health problems related to sanitation, health and hygiene practices.

Why is the state of community health like it is today?

But Why?

But Why?

Resources needed:

- A comfortable, quiet space for the people to meet.
- A facilitator
- Large pieces of paper – flipchart size
- Different coloured koki pens
- Prestik or tape

Illness, waste and water

Purpose of the tool

The purpose of the tool is to assist development workers to facilitate a session where traditional health practitioners can engage with the relationship between illnesses and human waste.

Target outcomes

Participants have an understanding of the transmission cycle of harmful bacteria via human waste.

Time needed: 30 minutes

Process

The process is intended to be used in a participatory way in a workshop with several participants.

The process involves 3 parts

Part 1: Role-playing

The facilitator will invite participants to role play the following in little groups;

- How they think diseases are transmitted
- What happens when people come to them with sicknesses, especially runny tummies and
- What practices people do in terms of human waste

Part 2: Poster

The facilitator will draw or use a poster which shows the cycle of how germs are carried through human waste and the health problems that result from this. The facilitator will explain the steps of the cycle and then facilitate a discussion about the steps of the cycle and the earlier discussions of the group about root causes. *Note: It is very important that the facilitator presents this information in a way that respects the views and ideas expressed earlier. It is important that the facilitator indicates that this is one way of explaining these things.*

Part 3: Cards

The facilitator will use the story cards to facilitate discussion about the stories in little groups. The groups will be given separate cards and they will have to discuss putting them in order.

Resources needed:

- A comfortable, quiet space for the people to meet.

- A facilitator
- A poster
- Story cards
- A poster of the cycle of germs being carried through human waste
- Large pieces of paper – flipchart size
- Different coloured koki pen
- Prestik or tape

Where have all the heroes gone?

Purpose of the tool

The purpose of the tool is to assist development workers to facilitate a session where traditional and faith healers examine the role of traditional stories, elders, storytelling, traditional healers and faith healers in community health now and in the past and to identify any stories or practices that were used to ensure the safe disposal of human waste and to avoid sicknesses associated with this.

Target outcomes

The following outcomes are intended from the use of this tool

- Participants to identify the role of THPs and traditional practices in communities in relation to sanitation, health and hygiene.
- Participants to recognise the value of these different people and practices in communities in relation to community health hygiene.

Time needed: 45 minutes

Process

The process is intended to be used in a participatory way in a workshop with several participants. It is specifically designed for use after the tool *" Illness, Waste and Water?"* in a workshop on health, hygiene and sanitation issues with traditional health practitioners.

The process involves 2 parts.

Part 1: Sharing stories about health heroes and stories

The facilitator will invite participants to sit quietly for 10 minutes of their own and to think about the following;

- Who taught them about going to the toilet and what to do after going to the toilet and about cleaning and handling food. Was it someone in the family, someone in school or no-body and how did they teach them? With a story, by showing them, by scaring them?
- Were they taught about getting rid of the faeces of babies? Is it considered to be any different to that of adults?

The facilitator then invites participants to sit in groups of 2-3 and share what they remember about this.

The facilitator will invite a person from each small group to share the findings of the group.

Part 2: Discussion

The facilitator will then open up a discussion on the heroes of community health that came out of the discussions of the groups. Who were the teachers and custodians of learning and information about health in relation to going to the toilet and household food hygiene and what stories and methods that they used to teach.

The facilitator will then lead discussion towards the current situation in the community. The following guiding questions can be used;

- Is it still the same as when the participants were growing up in terms of learning about these things?
- Do people know these things?
- Do they act according to this knowledge? Do they use this knowledge everyday?
- Does everyone clean their hands after the toilet – how do they clean them?
- Does everyone clean their hands before touching food?
- Are stories used to teach about toilet usage and handling food?
- Are there modern heroes of health in the community? Who are they?
- Are there enough of these heroes? Is their work working? *Facilitator* n*ote: refer to the results of "Taking the Pulse"*

Note: The facilitator should have in mind that they are trying to get participants to move towards seeing who in the current context has the role of community health heroes when it comes to sanitation, health and hygiene. It is important that the group answers honestly. It may be that no-one has this role anymore and if this is the case its important it comes out.

Resources needed:

- A comfortable, quiet space for the people to meet.
- A facilitator

Celebrating Community Treasures

Purpose of the tool

The purpose of the tool is to assist development workers to facilitate a session where traditional and faith healers identify the wealth of resources that they have to offer the community that can help to improve community health especially in terms of sanitation, health and hygiene practices.

Target outcomes

The following outcomes are intended from the use of this tool

- Participants to examine their role in terms of information, education, advocacy and treatment in matters related to the disposal of human waste and cleanliness practices after the disposal of human waste.
- Participants to recognise the value of this role.

Time needed: 45 minutes

Process

The process is intended to be used in a participatory way in a workshop with several participants. It is specifically designed for use after the tool *" Where have all the heroes gone?"* in a workshop on health, hygiene and sanitation issues with traditional health practitioners.

The process involves 3 parts.

Part 1: Group discussion about their role as traditional and faith healers in community health

The facilitator will facilitate a discussion in which participants identify the roles that they can play in sanitation, health and hygiene in terms of ;

- Information
- Education
- Treatment
- Advocacy

Note: The facilitator may want to draw this up in a series of mind-maps.

Part 2: Discussion about the value of this to the community

The facilitator will facilitate a discussion in which participants discuss what impact their actions in each of these areas could have.

The facilitator should invite them to think BIG. The facilitator should refer back to the outputs of the first *session “Taking the Pulse – Community Health Check Up”* and get participants to point out where their actions can have an impact.

Part 3: Group reflection

The facilitator will facilitate a discussion in which participants share what they have learned during the day with questions such as the following;

- What did you learn today?
- Did you gain anything from today?
- Do you think you will do things differently after today?

Resources needed:

- A comfortable, quiet space for the people to meet.
- A facilitator
- Koki pens
- Flipchart or large pieces of paper
- Prestik or tape