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Traditional Healing as Indigenous Knowledge: Its Relevance to HIV/AIDS in Southern Africa and the Implications for Counselors

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This article integrates the results of several culture-based studies conducted over the past decade. Specifically, links are made between the continued relevance of the African traditional healer's corpus of knowledge, the efficacy of the healer's cultural authority, and the need for HIV/AIDS-related strategies and interventions that are culturally sensitive, especially counseling. Results of an initial investigation of traditional healing in Lesotho, Swaziland, and Zimbabwe are integrated with more recent research in Botswana and Namibia. Findings from these studies are meshed with preliminary results of an ongoing investigation of the contextual influences and cultural factors associated with the spread of HIV/AIDS in the southern African region. Outcomes of the combined investigations have supported further examination of traditional healing as an indigenous knowledge system, of its relevance to HIV/AIDS, and of its significance to professional counselors in Africa. Related recommendations are offered for consideration by those working within HIV/AIDS systems of intervention.

Key Words. Traditional healing, healing practices, indigenous practices, HIV/AIDS, Southern Africa, counseling
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Social science academicians and practitioners throughout Africa largely have been educated and trained using theories, models, and interventions derived from Euro-American understandings of counseling, education, rehabilitation, psychology, anthropology, and sociology. Euro-American understandings of indigenous knowledge, in general, and indigenous healing practices in particular, have been limited. However, as the philosophy and history of science literatures have indicated a shifting scientific paradigm, our understandings have been moving gradually away from the hegemony of scientific method and Cartesian logic as the only valid dictum of knowledge (e.g., Feyerabend, 1975/1993; Geertz, 1979, 1983; Harding, 1997; Kuhn, 1970; Longino, 1990). If this is the case, if the paradigm truly has been shifting—and thus, awareness of the limitations of scientific method also has been shifting—it behooves academics and practitioners interested in multiple epistemological paradigms to investigate systems of indigenous knowledge and practices that historically have been considered as outside the parameters of the Euro-American scientific paradigm. The framework for African traditional healing offers one such system of indigenous knowledge, and I argue here that it is particularly important for African counselors to engage the cultural relevance of this indigenous knowledge system, especially in the face of the HIV/AIDS pandemic and the reality that many Africans continue to seek health care services from traditional healers.

Semantics

As I introduce the nature and topic of this article, I find it necessary to acknowledge the "slippery slope" that exists in association with the terms indigenous or local knowledge and Euro-American or scientific knowledge. Any discussion of Euro-American versus indigenous knowledge implies philosophical complexities that often are left unexamined; and such differentiation in this instance can serve to oversimplify culturally complex constructs. Agrawal (1995, 1996), for example, qualifies the distinction as an artificial dichotomy with inherent contradictions. Opinions about this vary greatly, as illustrated by the debate in one periodical committed to indigenous knowledge and development (e.g., Adunga, 1996; Benfer & Furbee, 1996; Brookfield, 1996; Brouwar, 1996; Dwyer, 1996; Giarelli, 1996; Incerpi, 1996; Langendijk, 1996; Mwinyimbegu, 1996; Van Crowder, 1996); the debate has become more than a bit contentious, especially as it relates to the application of indigenous knowledge in the development field. However, I respectfully submit that those of us interested in multiple epistemological paradigms have a responsibility at least to problematize associated nuances in meaningful ways through careful analysis.

In this article, I take the position that in the arena of health-related concerns—and by extension, psychosocial and cultural concerns—Euro-American, scientific, biomedical, and modern models of knowledge construction have been imposed upon the cultures under discussion here, particularly in relationship to HIV/AIDS, and mostly without consideration of the cultural contexts in which these models are imposed (for an excellent discussion of this, as it pertains to education, see Chilisa, 2005). This is especially egregious when results are deleterious, and when cultural insensitivity could have been avoided by more

thorough examinations of indigenous knowledge and by attending more conscientiously to local mores. It is this dynamic of systemic "imposition," then, that necessitates a bimodal consideration of knowledge here and that operationally defines local or indigenous knowledge in contrast with Euro-American, scientific, biomedical, or modern knowledge. Following the work of Foucault (1980a, 1980b, 2001), an essential aspect of the arguments elaborated in later sections of this article regards the way in which the knowledge base of Euro-American biomedicine, and related social services arising from the same epistemological assumptions, have brokered and imposed power, in general, within the health arena. I extend this argument to include the particular arena of HIV/AIDS, where it is done, often, at the expense of totally excluding indigenous healing knowledge and practice.

Questions of power and marginalization largely have been ignored in this arena, and essential information has been communicated in ways that are neither culturally sensitive nor culturally appropriate. van Binsbergen (2000, p. 1) observed the following:

> *Since Marx, Mannheim, and Michel Foucault we have been deeply aware that power relations largely determine—often inconspicuously—any production of knowledge. In the context of African studies this observation is of crucial importance. For here a massive volume of knowledge is being produced by outsiders who cannot by any standards identify as Africa[n]. Moreover, this knowledge addresses a part of the world which was subjected to outside domination for long periods, and whose dependence and marginalisation in the contemporary period of globalisation is only increasing. As Africanists we must constantly consider the foundations of our knowledge production, and we must be prepared to thresh out the contradictions in this production in genuine debate with those of our colleagues who (as Africans, as African Americans, as members of Asian, South American, and Oceanian societies) occupy strategically different positions in a world which is at the same time globalising and under North Atlantic hegemony.*

It is neither my intention to vilify the Euro-American biomedical model here nor to romanticize the indigenous medicine model. But as the rates of HIV/AIDS continue to increase throughout the southern region of Africa, as the participation in HIV/AIDS testing is low, and as people have been slow to enroll in ARV treatment, even in a situation where the treatment is free (e.g., Botswana), it is clear that biomedicine alone does not have all the solutions to meet the demands of this complex pandemic. Is it possible, then, that a model bridging the best practices of biomedicine and indigenous knowledge might reap more successful results? Is it possible that a model of counseling that does not rely exclusively upon Euro-American methods, but rather, includes indigenous best practices, might reap more successful results?

Organization of the Article

This article integrates the results of several culture-based investigations that I have conducted and focuses on the links amongst the importance of African traditional healing's corpus of knowledge, the efficacy of the healer's cultural authority, and the need for HIV/AIDS-related strategies and interventions that are informed by this system of indigenous knowledge and are thereby more culturally sensitive and culturally relevant. This article, then, is organized around a background discussion of the contextual and cultural factors associated with traditional healing practices in the southern region of Africa. The information presented here represents the first-hand knowledge that I have gleaned from ethnographic research with traditional healers over the past decade in the following southern African countries: Botswana, Lesotho, Namibia, Swaziland, and Zimbabwe. This participatory research has been informed primarily by rich dialogue with many healers—healers who have been selected purposefully for their authenticity and credibility and who have given their time graciously and generously; secondary sources also have informed these studies, by way of extensive reviews of the relevant epistemological and ethnomedical literatures. An important caveat for the reader is that traditional healing practices in sub-Saharan Africa may be viewed as having special characteristics (Janzen, 1992; Turner, 1968); these practices differ somewhat throughout the regions of sub-Saharan Africa, and indeed, from country to country within the southern African region. Therefore, the discussion presented in this article is intended as an overview of traditional healing as an indigenous knowledge system with its related practices, as these are specific to Botswana, Lesotho, Namibia, Swaziland, and Zimbabwe; the interested reader is directed to the many references cited here for more generalized discussions. The article concludes with critical considerations and salient suggestions for practical applications, especially for counselors working in the Euro-American-donor-sponsored HIV/AIDS arena in Africa.

Methodological Perspectives

I have decided to depart from the standard academic convention of providing a section on research design and methodology after an introduction and review of the literature. Since I am integrating the results of multiple studies (Levers, 1997, 1999, 2001, 2002; Levers & Maki, 1994, 1995) with the preliminary results of my current research agenda (an examination of the contextual influences and cultural factors associated with HIV/AIDS in southern Africa), and because the focus of this article is not on reporting research results per se, but rather, on explicating African traditional healing as a system of indigenous knowledge, I believe that a brief introductory overview of the basic methodological approaches taken in my various investigations, at this juncture, is both adequate and appropriate.

The examinations reported here are ethnographic and phenomenological in orientation, aimed at generating new knowledge about contextual influences and cultural factors associat-

ed with traditional healing practices, with the spread of HIV/AIDS, and with prevention-based services, counseling, and educational interventions in the southern region of Africa. The strategies for the investigations have been based on participatory action research and multiple-case-study, using phenomenological and cross-case-analysis models of data collection and interpretation. As is characteristic of much qualitative methodology, a blend of knowledge-generating research strategies has been used (Tesch, 1990).

The methodologies largely have employed tenets of Rapid Appraisal Methods (RAM) (Beebe, 2001; Dale, Shipman, Lacock, & Davies, 1996; Kumar, 1993; Levers, 2003, 2006; Sweetser, 1996) to discover and extrapolate contextual influences and cultural factors. RAMs have been used in all parts of the world and describe a family of methodologies, commonly including the following: key informant interviews, focus groups, community interviews, consultative workshops, direct observation, and mini-surveys. According to a USAID (1996, p. 2) publication, some of the strengths of rapid appraisal methods are their rapidity, low cost, and flexibility, as well as their effectiveness at ". . . providing indepth understanding of complex socioeconomic systems or processes." This last point makes RAMs a highly suitable choice for examining the cultural factors and contextual influences associated with the topic of this article.

Key informants who have been interviewed and focus group members who have participated include village elders, village chiefs, traditional healers, spiritual leaders, members of African independent churches, those working with orphans and other vulnerable children, teachers, counselors, wildlife/tourism workers, miners, journalists, academics, university administrators, Ministry administrators and employees, and various others. The methodologies have relied heavily upon principles of participatory action research (Guba & Lincoln, 1989; Rosas, 1997) and case study (Merriam, 1988; Yin, 1989). Methodological triangulation has been, and continues to be, accomplished by the simultaneous use of these and a variety of RAMs (Freudenberger, 1998; Kumar, 1993). The studies have applied anthropological constructs, as I have entered new cultures as an outsider (etic) and have attempted to understand from the perspective and experience of the insider (emic) (Daniel, 1996; Denzin, 1994; Geertz, 1979, 1983; Guba & Lincoln, 1994 same as above comment; Levers, 1997; Lincoln & Guba, 1985; Patton, 2002).

As is characteristic of the iterative and recursive aspects of many qualitative research methods, the data analyses began immediately and have been highly interactive with the research process throughout the various investigations (Denzin, 1989; Huberman & Miles, 1994). Analytical triangulation has been achieved through my knowledge about the phenomena and through regular processing of findings with experts from the culture who have been willing to participate as members of a "research team" formed for the purpose of processing and interpreting findings. Freudenberger (1998) has emphasized the importance of triangulating the perceptions of multiple members of the research team with the various perspectives of the participants, using multiple methodological strategies, so that data collection, management, analysis, and interpretation can be as trustworthy as possible.

Data have been analyzed and coded continuously, in terms of "units of meaning" (Kruger, 1981) and "lived experience" (van Manen, 1990). Methods for data management and analysis have continued to be refined as the project has evolved (Huberman & Miles, 1994). Earlier data have provided, and current data are expected to provide, "thick descriptions" regarding the phenomena under investigation (Denzin, 1989; Geertz, 1979, 1983); and the analytic strategy has relied upon the theoretical propositions embedded in the philosophical contexts of the studies (Yin, 1989). Theoretical triangulation has been attained by bringing theories from multiple disciplines to bear on knowledge production related to understanding the cultural factors and contextual influences associated with traditional healing practices, HIV/AIDS, prevention-based counseling, and educational interventions in the southern region of Africa.

African Traditional Healing as a System of Indigenous Knowledge

African traditional medical practices are embedded in African cosmology. Unlike the Cartesian premise of modern Euro-American science, but like other indigenous worldviews, mind and body are not separated; therefore, there can be no separation of that which is scientific from that which is spiritual or existential. Contextual influences relating to the worldview of a particular culture are embedded in that culture and remain important to how members of the culture make meaning of their lives. While this is a premise open for interpretation, it may well be the most salient part of the explanation for most Euro-American misunderstandings of indigenous healing models in general. It even may offer an important key for analyzing and understanding the failure of so many programs aimed at mitigating the spread of HIV/AIDS in southern Africa, as well as for designing more culturally sensitive interventions. This is not intended to impute blame; rather, it is intended to emphasize how essential it is for counselors and other social scientists to understand the embeddedness of indigenous worldview.

Traditional Healers and Health Care Delivery

Indigenous healers–or traditional doctors–play a significant and recognized role in health care provision in Africa (e.g., Freeman & Motsei, 1992; LeBeau, 1999; Leonard, 2001; Mpofu, 2003; Oppong, 1989). They engage in a broad array of practices (e.g., Dingaka Tsa Setso Association, 2000; Zimbabwe Parliament, 1981; ZINATHA, 1991); some identify themselves primarily as herbalists, others as spiritualists or diviners, and many as a combination of both. Levers and Maki (1994, 1995) found that the healers placed a high value on talking to their patients in ways that are very similar to how counselors speak with their clients. We further realized a strong overlap between the way the healers counseled their patients and what we understand as the tenets of existential counseling practices (the interested reader can find the details of this in

Levers & Maki, 1994, 1995; the discussion is beyond the scope of this article).

Various terms are used for traditional doctors, and the variations mostly are associated with linguistic, tribal, and regional differences. Some of the terms that are indigenous to the southern region include Dingaka, Lituela, Ngoma, Nyanga, Ondudu, and Sangoma. Many of the local language terms contain some variation of the root word "ngoma," which translates literally as "drum," but has metaphoric meanings and implications far beyond the literal translation of the word (Janzen, 1992). While there have been extensive discussions and some controversy relative to terminology, the terms "indigenous healer," "traditional healer," "healer," and "traditional doctor" are used interchangeably throughout this article; this is in conformity with the manner in which most of the healers refer to themselves in English. However, as the professionalization of traditional doctors has increased dramatically over the past two decades (Chavunduka, 1984, 1986; Last, 1990; Levers & Maki, 1994, 1995), some healers also refer to themselves as Traditional Healer Practitioners (THPs) in relationship to their particular traditional healers' organizations or associations.

Many of the healers are members of the African Traditional Healers' Organization (THO), which represents healers from the entire African continent. Indeed, THPs are credentialed in Zimbabwe, they recently have been recognized by the postapartheid government of the Republic of South Africa, an amendment to an Act of Parliament is in process in Botswana to credential THPs, and in Namibia the THPs have mobilized and are being considered for inclusion in that country's medical and allied health practitioner Act. Such credentialing efforts are significant, because "anti-witchcraft" laws still exist throughout sub-Saharan Africa (e.g., Statutes of Swaziland, 1889); these laws generally can be expunged only when legislative efforts to credential the healers successfully replace the old laws, such as in the countries just mentioned. The "anti-witchcraft" laws were originally enacted and enforced by Christian colonizers, who erroneously interpreted all traditional practices as "witchcraft." This in effect established an "official" prohibition against traditional healing practices of all types, misconstrued as satanic; this unfortunately included medical and spiritual practices as well. Even so, as a testimonial to the resilient spirit of the African people, traditional healing practices have remained an important aspect of the cultures throughout the southern region.

Clearly I am referencing legitimate healing practices here. In juxtaposition to the ability of the African peoples to retain this important aspect of their traditional cultures, a newly emerging and contrasting phenomenon involving "newer era" traditional healing practices (that are not traditional at all) has been identified by sociologists as a kind of social anomie associated with rapid societal changes and disintegration of traditional cultural norms. This trend appears particularly prominent in the Republic of South Africa, where frequent and recent vicious murders, especially by burning, reportedly have been manipulated by the "new healers" in response to suspected "witchery." The media also have reported a variety of serious sexual assaults against children, ostensibly promulgated by certain practitioners, as a way of "purifying" the body against HIV/AIDS. It is difficult to discern to what extent these reports are a reflection of reality or of urban legend or of a combination of both, and a discussion of this complex sociological phenomenon is beyond the scope of this article. The discussion here clearly relates only to authentic traditional practices as indigenous knowledge and is not intended to account for this emerging new trend, which is something of a different socio-cultural nature. It is important to note, however, that laws formalizing the credentialing process can assist the legitimate practitioner associations to better govern qualified practices.

Ethnomedicine: Paradigms of Illness, Health, and Healing

The ethnomedical literature amplifies the importance of understanding the various paradigms of illness and health that are bound to culture, social construction, and, at least in part, to worldview. Phillips and Verhasselt state that ". . . there is evidently neither a single, universally applicable health system nor an agreed view of health as a concept" (1994, p. 316). Feierman provides a thoughtful discourse regarding the social and cultural determinants of health and illness and states that the ". . . evolution of health cannot be separated from the broader story of social change. The political and economic forces which shaped the [African] continent's history also established the framework within which patterns of diagnosis and treatment, health and disease, emerged" (1985, p.73). Others point to the relationship between culture and disease (Brown & Inhorn, 1990; Dressler, 1990; Kleinman, 1977a, 1977b, 1986) and a view of illness as a construct differentiated from disease (Caplan, Engelhardt, & McCartney, 1981; Lyon, 1993; Moch, 1989; Vaux, 1978).

Comaroff (1978, 1980, 1982) has analyzed the symbolic representations of medicine and healing in non-Euro-American cultures, while indicating how parallel analysis within Euro-American culture has been limited. She addresses the importance of how the person experiences and perceives illness in any given culture (1978) and notes that affliction is a disruption in social and environmental processes (1980). The term "affliction" is used frequently in the anthropological and ethnomedical literatures to imply that such disruptions may be not only of a physical nature, but can extend to the psychological, social, and cultural; it is a useful construct in this discussion and is not intended as derogatory.

Comaroff describes healing as ". . . fundamentally concerned with the reconstitution of physical, social, and spiritual order . . . [and that] . . . it cannot be meaningfully examined if isolated from the wider sociocultural system" (1980, p. 639). She views healing as a universal symbolic process (1982). Comaroff further explicates healing as a dialectical relationship, suggesting that "…if we are to understand fully the logic of plural health systems in Third World contexts… [we must examine change in those contexts as]….a dialectic between cultural order and subjective experience" (1980, p. 655). According to Comaroff, in order to understand this dialectic—

and thus health, illness, and healing—we first must realize and examine the symbolism of the cultural order, the experience of afflictions, categories of affliction, and metaphors used to attribute causality (1980). She states that:

> *[Affliction] is the dislocation of self and context; healing is the objectification and restructuring of such dislocation. Central to this process is the rendering of disorder in terms of metaphors of opposition between the impaired subject and an intrusive, external agent (Comaroff, 1980, p. 644).*

While it is beyond the scope of this article to fully examine the powerful metaphors in varying cultural constructions of illness, medicine, and health, it is necessary to at least signify their tacit presence, especially while looking at the cosmological considerations implicit in the various cultural conceptions of medicine and healing (Comaroff, 1982; Green, 1989). Janzen (1992, p. 4) points out that, "Current scholarship tends to break down into a distinction between religion and healing, but this distinction is not so useful in the present [African] setting." My findings echo this perspective, and the contextual ramifications of HIV/AIDS particularly emphasize the importance of not oversimplifying this matter. It has been my experience, having visited many types of healers and numerous churches of the African Independent Movement, that the boundaries between religion and healing are relatively blurred.

Comaroff explains that the challenge to ". . . the adequacy of tacitly assumed material individualism . . . [brings us] . . . face-to-face with universal conundrums of human existence as they are refracted through the forms of our socio-cultural system, and projected in such contexts as that of biomedical practice" (1982, pp. 57-58). It is in the face of such universal conundrums that Lakoff and Johnson (1980) suggest that the "metaphors we live by" are implicit in the everyday contexts of our respective cultures. Such metaphors include those many cultural practices we take for granted without even thinking about them; at the risk of overgeneralization, in modern Euro-American culture a person might not think about the consequences of an assertive and individualistic action, for example, whereas in traditional African culture a person might not think about the consequences of a communally or collectively oriented action. How do we perform as actors in our everyday scenarios? What language do we use to talk about such everyday activity? This is significant precisely because metaphor is situated in the language that links healing processes with wider social, cultural, epistemological, ontological, and cosmological considerations. If we are ignoring these relevant linguistic and cultural linkages in reference to HIV/AIDS, then we also are ignoring parallel pathways toward efficacious prevention and treatment strategies. It becomes important, within the context of African cultures, to consider the following carefully: (1) How have health-related concerns of African cultures been refracted and then projected through the context of biomedical practices, and what onerous effects has this had? (2) How have naturalistically occurring metaphors become absorbed and even commodified by imposed social constructions? (3) What meaning do these concerns hold for members of the societies in which biomedicine has imposed rigid epistemological presumptions about the etiology and treatment of disease?

By developing an initial understanding of how these links interrelate, it may be possible to extend this understanding universally to all paradigms of healing. Janzen (1992) offers a beginning point for this universality in his treatise on "ngoma," a term with multiple levels of meaning—expounded upon in detail by Janzen—and ultimately bridging the literal translation, drum or drumming, to all its associations with the institution of healing in southern Africa. According to Janzen, ngoma implies the doing of ngoma, the process of healing and all levels of ritual associated with it. Janzen elaborates on ngoma as the case study for a broader framework of inquiry with potential universal applicability; however, I believe that an important point here, worthy of further examination, regards the dynamic and culturally powerful process of traditional healing and its potential for connecting with some relevant aspects of HIV/AIDS prevention and treatment. This indigenous knowledge system obviously has been under-utilized—or virtually unused—for purposes related to HIV/AIDS interventions.

Efficacy of the Healer's Wisdom

The World Health Organization (WHO, 1978), along with others (Green & Makhubu, 1984; Letsie, 1992, 1994; Ngubane, 1992), has promoted collaborative efforts for some time between the biomedical and indigenous healing communities in developing countries. The WHO has defined Traditional Healers as:

> *…a group of persons recognized by the community in which they live as being competent to provide health care by using vegetable, animal and mineral substances and other methods based on the social, cultural and religious backgrounds as well as the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well being and the causation of disease and disability (WHO, 1978, p. 41).*

The WHO has defined traditional medicine in the following way:

> *The totality of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social disequilibrium and relying exclusively on practical experience and observation handed down from generation to generation, verbally or in writing (WHO, 1976, p. 3).*

The services of indigenous healers have been sought routinely throughout Africa (Dillon-Malone, 1988). It has been estimated that 80% of the indigenous African people seek treatment from traditional doctors throughout most of Africa (UNAIDS, 2000). A study sponsored by the WHO and the

Ministry of Health in Lesotho revealed that the people there seek treatment from both indigenous healers and Euro-American-trained medical professionals; the type of practitioner chosen has depended upon the nature of the problem (Gay & Gill, 1993). Many Africans, including some Whites, have sought only the services of indigenous healers, while others only have sought the services of Euro-American-trained medical practitioners if traditional healing practices have failed to improve their conditions (Feierman, 1985; Gay, 1993; Gay & Gill, 1993; Janzen, 1992). Research has suggested that indigenous healers have a higher success rate with certain physical disorders than with others, having more positive outcomes with such disorders as asthma, infertility, alcoholism, and certain sexually transmitted diseases (STDs) (Gay, 1993; Gay & Gill, 1993; Gelfand, Mavi, Drummond, & Ndamara, 1985; Green, 1992; Janzen, 1992; Torrey, 1986); research further has suggested that indigenous healers have a particularly high success rate with some psychiatric disorders (Edgerton, 1980; Phillips & Verhasselt, 1994; Torrey, 1986). Rudnick (2000) has pointed out that patients and their families often consult traditional healers even after hospitalization.

The perception of efficacy, then, combined with the actual health seeking practices of many (if not most) Africans, would seem to indicate a high level of local confidence surrounding the practices of traditional doctors. Simply put, as major players in health-care provision for most Africans, traditional healers have been major opinion leaders in Africa and possess significant social capital.

The WHO has been promoting collaborative efforts between the biomedical and indigenous healing communities for over two decades (WHO, 1978); it also has advocated the inclusion of traditional healers in HIV/AIDS programs since the early 1990s (UNAIDS, 2000). According to the UNAIDS (p. 10) publication, "In 1994, the WHO offered further observations and direction regarding traditional healers, suggesting that upgrading their skills made more sense than training new groups of health workers, such as village health workers." Yet there remains a tendency among many (if not most) non-indigenous practitioners of Euro-American biomedicine–and by extension, some African practitioners trained in or affiliated with Euro-American models of medical and allied health service delivery–to disregard traditional medicine practices, oftentimes along with other indigenous aspects of local culture. Many, if not most, of those who come from Euro-American countries to engage in HIV/AIDS-related endeavors seem strongly biased against indigenous healing practices. They do not seem open to the consideration that these practices are exactly the sources of cultural authority with which they should begin the examination of the new culture in which they have started to work. Indeed, for many, the question of the importance of first understanding systems of indigenous knowledge does not even occur to them; so partnership is therefore also not considered. And African Ministries of Health largely collude with this marginalization of traditional healers by not accepting them as useful practitioners and by not supporting indigenous knowledge as a legitimate knowledge system having cultural currency.

Euro-American Bias against Traditional Healing and the Traditional Healer as "Other"

Historic assumptions that have been made about African traditional healing in association with "witchcraft" continue to fuel the contemporary discourse on traditional healing. The issue of "witchcraft" remains an interesting one, and the connotation has contributed greatly to the stigmatization of African traditional healing. Mudimbe (1988, 1994) has defined how Africans have been cast as the "other," in general. In his critique of colonial perceptions about magic and religion, Moodley (2005, p. 4) points to "…the exotic, erotic, or neurotic projections by the West toward supernatural and shamanic healing of cultures of the diaspora." Questions emerge from such critique regarding the way in which African traditional healers have been "othered," especially in juxtaposition with Euro-American biomedicine practitioners.

Following the work of Sander Gilman (1982, 1985), the art historian who identified an iconography of madness in Western still art from the middle ages through the early 20th century, I conducted an ethnographic content analysis of images of psychiatric disability in 50 years of Hollywood films (Levers, 2001); I identified virtually the same iconography of madness in film as that identified by Gilman in still art, with some latter 20th century additions. Gilman (1985) also explicated "Blackness" as the most deep-rooted stereotype associated with Western perceptions about madness. Although one dimension of my study was to identify stereotypic portrayals of psychiatric disability in films, Black actors did not appear in the Hollywood films that I analyzed, and I was not able to use Gilman's work on the stereotypes of "Blackness." As a result, I could only assume that Hollywood racism was even more deeply rooted than the stereotype of "Blackness" as it has been associated with madness in centuries of still art. Aside from my social justice sensibilities, this had little research relevance for me until a number of years later, after I had conducted the funded study with traditional healers in Lesotho, Swaziland, and Zimbabwe (Levers & Maki, 1994, 1995). As I was preparing materials for a lecture about this cultural research, I extrapolated from my field notes a list of icons associated with the traditional healers. It was at this time that I realized a strong connection between the icons associated with madness in Euro-American art and film and those associated with African traditional healing (e.g., wearing a feathered headdress, holding a spear or spear-like object). This was an incredible insight for me into the deep cultural stigma held by Euro-Americans—and by extension, Africans who have introjected strong Euro-American influences—toward African traditional healing. Iconographic images often have the power to convey an entire history about a given topic, a perspective that may or may not be prejudicial; the "messages" inherent in these images may be received subconsciously, and therefore, not unpacked intellectually or processed critically. I believe that this relates greatly to the seeming utter disregard for systems of indigenous knowledge, especially traditional healing, by the Euro-American donor-funded organizations working in the HIV/AIDS arena. For those interested, Bloom (1995) offers a valuable perceptual tool for examining such

good/evil dichotomies in his seminal work about the human condition as it relates to the forces of history.

Need for HIV/AIDS-Related Interventions Informed by Indigenous Knowledge

While much recent progress has been reported in the fight against HIV/AIDS (UNAIDS, 2006), a Southern African Development Community (2001) publication revealed the total number of people living with AIDS in sub Saharan Africa in 2000 as 25.3 million. Epidemiologic statistics (UNAIDS, 2004) have indicated that of the highest global prevalence rates of HIV/AIDS over 20%, the top six countries are in southern Africa. With an estimated adult infection rate of 38.8%, Swaziland ranked first, followed, in order, by Botswana (37.3%), Lesotho (28.9%), Zimbabwe (24.6%), the Republic of South Africa (21.5%), and Namibia (21.3%) (US Central Intelligence Agency, 2006). It was estimated that at least one adult in five in these six countries is living with HIV. The numbers have continued to cause alarm, especially since such statistics account only for adults and only for those adults who willingly seek or agree to HIV testing; these statistics do not speak to the 17 million Africans who have died, to the many who refuse testing, nor to the over 12 million children who have been orphaned. According to a recent Congressional Research Service Issue Brief (Copson, 2001, p. 2) ". . . mortality is rising–2.4 million Africans died of AIDS in 2000, compared with 2.2 million in 1999. AIDS has surpassed malaria as the leading cause of death in sub-Saharan Africa, and it kills many times more people than Africa's armed conflicts." A UNAIDS (2000) publication suggested that these deaths account for an estimated 5,500 funerals each day.

At the opening of the 2001 United Nations conference on AIDS, the President of the Republic of Botswana, the honorable President Mogae, spoke of the HIV/AIDS pandemic as the most pressing global challenge right now, addressing the importance of Western countries' continued assistance to developing countries, especially regarding the AIDS crisis and especially in southern Africa. President Mogae also emphasized the importance of HIV/AIDS education and counseling several times during his brief speech. It would seem that a strategy of culturally appropriate counseling interventions aimed at slowing the spread of HIV/AIDS is exactly right not only for Botswana, but also for other countries throughout Africa. However, since large amounts of donor funding have been aimed at HIV/AIDS abatement strategies that seemingly have not worked, the obvious questions that emerge are: Why are funded programs not working? and, How is it that these well-intended interventions are not working as planned?

Much of the anti-AIDS activity on the continent has been based on Euro-American medical and social service models and has not included the cultural wisdom of the elders, village chiefs, local educators, traditional healers, or spiritual leaders of indigenous religious groups. Even in the 21st Century, business continues to be conducted as if medical and social service systems can be extracted surgically from an industrial context and transplanted into a developing context. For example, four of the most common theories of behavioral change cited in the HIV prevention literature (AIDSCAP, 1999) focus on the individual and rely on personal intentionality as the key predictor of desired change, failing to take environmental and social factors into account. While efficacious in a Euro-American context, the individualist and intentional dimensions of these theoretical frameworks can pose numerous problems when transplanted into a developing context that fosters a more collectivist cultural ethos, with a more fatalistic worldview. This is not to suggest a rigid "either/or" proposition in the other direction, which constitutes its own "slippery slope;" rather, it is to raise the possibility of an "and/both" approach, and simply, to emphasize the essential importance of cultural awareness and sensitivity. While well intentioned, Euro-American donor organizations, for the most part, have failed to perceive, understand, appreciate, and engage the cosmological, ontological, and epistemological differences that separate Euro-American and African medical and cultural understandings of the AIDS pandemic. These are paradigmatic differences of great significance, and successful solutions to the current crisis can be attained only through a careful examination of these differences.

The UNAIDS (2000) reports that there has been a dearth of research that actually examines the impact of indigenous healers' involvement in HIV/AIDS prevention and care activities in sub-Saharan Africa. However, in an extensive review of the literature regarding traditional healers' involvement, UNAIDS identified and compared eight projects determined as meeting the joint organizations' Best Practice criteria of ". . . effectiveness, efficiency, relevance, ethical soundness and sustainability" (UNAID, 2000, p. 7). Of the collaborative ventures identified, six countries in the southern region were represented; these included Botswana, Malawi, Mozambique, the Republic of South Africa, Tanzania, and Zambia. The remaining two examples of collaboration, according to UNAIDS Best Practice criteria, were the Central African Republic and Uganda. The major efficacious threads of most of the projects involved training of trainers, increasing traditional healers' knowledge, and expanding the role of the traditional healer to include HIV/AIDS-related community health promotion. However, the efforts of these projects were realized well over a decade ago, before the current effects of the pandemic were known; much has changed since the onset of these projects. In addition, in a pilot study that I conducted in 2001 in Botswana, when I inquired about the UNAIDS study, neither administrators at the Ministry of Health nor leaders of the Botswana Dingaka Association knew anything about these past efforts.

Conversely, I have had conversations with numerous traditional healers who express the desire for cooperation and collaboration between them and biomedical practitioners. When the president of the Botswana Dingaka Association showed me a number of the certificates that he has been awarded for attendance at and participation in biomedical-oriented workshops, conferences, and other training events, he rhetorically stated, "I wonder why they never ask us for training or even for our opinions." This same healer has posters in his office urging

that patients seek HIV testing.

Contextual Influences

There is an urgent need for HIV/AIDS-related strategies and interventions that are informed by indigenous knowledge systems of healing. Grenier (1998) zeros in on how indigenous knowledge can contribute to a sustainable development strategy that accounts for the experience and wisdom of the indigenous population. Along with an indigenous world view that is not necessarily synchronous with Euro-American biomedical and social science models, other contextual factors in the southern region of Africa hamper AIDS abatement efforts. Interventions to slow the spread of HIV/AIDS vary widely, and prevention is complex (UNAIDS, 2000). Barriers include, but are not limited to poverty, psychosocial stressors, gender, other risk factors, and economic impact. The limited information that we have about these barriers (Cohen & Trussell, 1996; Loewenson & Whiteside, 1997; Ministry of Health, Botswana, 1997; United Nations Development Programme, 2001; Whelan, 1999) is discussed briefly below; suggestions relative to the region's capacity for addressing these barriers are offered in the "Recommendations" section.

Poverty. Poverty is a contextual factor associated with all health issues in sub-Saharan Africa and cannot be ignored in relationship to the HIV/AIDS epidemic. Recent theories of microeconomics take into account the interrelationships among poverty, health, and education issues in developing countries and their labor markets (Ray, 1998). Poverty interacts with and complicates the risk factors associated with health care in general, including HIV/AIDS and other STDs. Any consideration of poverty as a contextual factor related to HIV/AIDS must include issues associated with disease prevention, disease transmission, co-morbidity with other diseases, access to health care systems, barriers to accessing adequate health care, treatment of the disease, management of the disease, and quality of living with the disease (Cohen & Trussell, 1996; Copson, 2001; Loewenson & Whiteside, 1997; Ministry of Health, Botswana, 1997; United Nations Development Programme, 2001). A consideration of poverty as a contextual factor related to other dimensions of living includes access to educational, employment, and quality-of-life opportunities. The impact of poverty on HIV/AIDS is considered most catastrophic at the household level (AIDS Foundation South Africa, 2005); in addition, the common worries held by caretakers of persons with AIDS often are associated with poverty (Brouwer, Lok, Wolffers, & Sebagalls, 2000).

Psychosocial Stressors. Psychosocial stressors that may have an impact on HIV/AIDS in southern Africa include, but are not limited to, civil unrest and wars, refugee and military movements, migration, alcoholism (primarily overuse of home-brewed traditional beer), domestic violence, and sexual assault (Cohen & Trussell, 1996; Levers, 2002; Loewenson & Whiteside, 1997; Ministry of Health, Botswana, 1997; United Nations Development Programme, 2001). Interpersonal violence, especially domestic violence and sexual assault, increases women's and young girls' vulnerability to HIV infection. It becomes more difficult for women to refuse unsafe sex when the fear or threat of violence is present. A United Nations Population Fund (2000) publication reported that "Researchers in South Africa . . . concluded that male violence has 'enormous consequences' for the nation's struggle to stop the spread of HIV/AIDS. Their comprehensive study surveyed more than 37,000 young men. One in four admitted having had forced sex without a woman's consent before the age of 18." The elimination of violence against women and girls must be a priority issue embedded in HIV/AIDS abatement programs (African Development Forum, 2000b); however, Euro-American feminism and related models of assertiveness training are not the entire answer and are not necessarily the "best fits" with local cultures.

Gender. To a large extent, and as already implied above, the issue of gender is inextricably interwoven with other risk factors having an impact on HIV/AIDS in southern Africa (Whelan, 1999). In fact, some psychosocial and socioeconomic influences are only meaningful in relationship to the imbalance of power between men and women in Africa. The pandemic is not solely a health crisis, and given the typical means of HIV transmission in Africa, it represents a highly gendered context. According to a UNAIDS' (n.d., ¶1) website report, women and girls in sub-Saharan Africa "…already make up almost 60% of adults living with HIV." Women are more likely to be infected with HIV, and women are also more likely to serve as primary care givers for those who are ill. Women are more vulnerable physiologically to HIV infection, and women are more vulnerable to sexual assault and to forced and unprotected sex within marriage. At the same time that traditional culture may support some of the negative consequences of an unequal distribution of power, there are other traditional cultural practices, which historically have promoted respect for and dignity of women, that have broken down or been lost.

Other Risk Factors. Other risk factors that may have an impact on HIV/AIDS in southern Africa include, but are not limited to, sexual behaviors (both partner selection and particular practices), presence of STDs, presence of tuberculosis, male circumcision, age vulnerability, family structure (polygamous versus monogamous), living space, geographical mobility, poor health habits, extent of alcohol consumption, lack of adequate nutrition, poor communication with partner(s), lack of knowledge and information regarding HIV/AIDS, lack of access to basic sanitation, and poor living conditions (Cohen & Trussell, 1996; Loewenson & Whiteside, 1997; Ministry of Health, Botswana, 1997; United Nations Development Programme, 2001). Sex workers, truckers, miners, and other workers with high levels of geographical mobility are considered to have high-risk occupations. An additional risk factor that some Africans are beginning to articulate is one that I have associated with Western-influenced materialism and consumerism. There is growing speculation among Africans that many young women are willing to engage in transactional sexual relations with older men in order to acquire materials seemingly made attractive by a borrowed sense of Western consumerism. Epidemiological evidence on HIV infection and seroprevalence

among young women in the 15-25 age cohort supports this premise (Whalen, 1999). In such situations, the bargaining power of the young women may be limited, and therefore, safe sex practices often are compromised.

Economic Impact. Beyond considerations of materialism and consumerism, the AIDS pandemic is having an enormous economic impact throughout the region (African Development Forum, 2000; International Labour Office, 2000; Loewenson & Whiteside, 1997), and much of the economic development of the last several decades stands to be lost. According to Copson (2001, p. 8), ". . . in acting on the FY 1998 foreign operations appropriations legislation, [the U.S.] Congress earmarked funds for fighting AIDS worldwide, and House appropriators noted that in Africa, AIDS had the potential for 'undermining all development efforts' to date (H Rept. 100-283)." Associated problems over the next twenty years are forecasted, such as further impoverishment of the poor, impoverishment of the emerging middle class, and creation of an impoverished and highly vulnerable orphan cohort (Copson, 2001). The loss of human capital is predicted to have a devastating effect on gains made in health and education, not to mention the effects associated with decreased national productivities and earnings. Copson cites Karen Stanecki, of the U.S. Census Bureau, in her presentation at AIDS2000, the July 2000 AIDS conference held in Durban, South Africa, as offering the highly sobering report that ". . . AIDS [has] cut life expectancy in Botswana from 71 years to 39 and in Zimbabwe from 70 years to 38 . . . . [She] predicted that South Africa, Zimbabwe, and Botswana will begin to experience negative population growth … and that by 2010, life expectancy at birth will have fallen to about 30 years throughout southern Africa due to AIDS" (Copson, p. 4).

Recommendations

One critical reason for examining indigenous knowledge is to address links between existing cultural practices and potential HIV/AIDS abatement interventions in Africa. Recommendations here are based upon the following needs: (1) identifying and understanding positive aspects of indigenous knowledge systems; (2) identifying and removing or diminishing barriers that impede a cooperative multi-dimensional, multisystemic, multi-disciplinary, and multi-phasic response to HIV/AIDS; (3) developing, motivating, and rewarding local leadership in these efforts; and, thereby, (4) improving access to culturally relevant and gender sensitive interventions related to HIV/AIDS. Embedded in these efforts are strategies aimed at prevention, as well as stigma reduction for people living with HIV/AIDS, especially women and youth; and these efforts are predicated upon the design of culturally relevant health-related (counseling, prevention, and education) programs.

A major strategy for developing culturally specific interventions requires indigenous grass-roots mobilization and advocacy through the engagement of indigenous health, governmental, academic, religious, and other cultural leaders in public education efforts. Such empowerment and related behavioral change activities must be developed with keen sensitivity to local cultures. The recommendations posed here rely on including natural Afrocentric or indigenous knowledge systems of intervention and support to mitigate the spread of HIV/AIDS and to inform initiatives, rather than to rely exclusively on Euro-American models of health and social service delivery. An underlying assumption here is that HIV/AIDS abatement endeavors can succeed only if relevant contextual influences are taken into consideration. Success depends first upon attention to the embeddedness of the African medical paradigm in African cosmology, ontology, and epistemology; it depends second upon an ability to operationalize this into functional systemic service delivery, which in turn is reinforced by relevant research and training efforts and the adequate preparation of professionals.

Functional Systemic Service Delivery

The ability to render adequate counseling, prevention, and educational interventions, which have the potential to abate the spread of HIV/AIDS in southern Africa, is dependent upon developing a more functional systemic service delivery. Functional systemic service delivery is defined here as the delivery of coordinated multi-sectoral services that are informed by contextual factors, taking local cultures and an ecological view of human development into account. An example of such service delivery, from a functional and systemic perspective, is one that integrates HIV/AIDS interventions with other existing services within the Primary Health Care (PHC) system. It is one that honors local participatory health mechanisms and allows the voice of community members to be heard at the District level, as well as ensuring representation at the national level.

Health care reform in many African countries has included efforts aimed at decentralization, with the intended result of a service delivery system that is more "horizontal," and therefore more dependent upon community participation (Görgen & Schmidt-Ehry, 2004). This assumes leadership that is sensitive to the challenges associated with such a shift in power from central health authorities to district authorities. This also assumes deliverers of services whose training has been based on culturally relevant rather than exclusively Euro-American models of social services and has aspired to develop capacity while making use of the underlying indigenous infrastructure.

Research and Training

Consideration of the relevance of indigenous knowledge systems in Africa, along with associated contextual factors, illuminates the need for continued research and for training indigenous professionals and paraprofessionals who understand their own cultures. The design of such participatory action research and ensuing training–especially training of trainers–aimed at capacity building, must be informed by the context of local cultures; it must be signified by legitimate voices of cultural authority; its implementation must be developed and conducted by indigenous practitioners who are trusted by the populace; it must hold cultural competencies as essential;

and, it must make use of indigenous knowledge systems. This echoes UNAIDS' (2000) best practices with traditional healers: training-of-trainers training, increasing knowledge about HIV/AIDS, and facilitating the expansion of roles in health promotion activities. Such training results in strong multiplier effects, due to the nature of the grass-roots mobilization strategy of training of trainers and tapping and developing local leadership.

Counselor Preparation

Academic preparation of counselors, psychologists, and other helping professionals at African institutions of higher education also must be examined critically. If Euro-American models of counseling interventions are taught, to the exclusion of indigenous models of helping, then the problems outlined in this article are exacerbated. Culturally relevant models of counseling and related educational and program-design interventions need to be included in the pre-service training of African counselors. Preparatory training needs to include an emphasis on contemporary problems in Africa, and problem analysis needs to be linked to Afro-centric models of problem solving. Students need to understand the psychology of indigenous ways of knowing and encouraged to construct intervention models that address the needs of most Africans in culturally meaningful ways. Such preparation could lead the way to systemic social service that alters the course of how African health care is delivered.

Conclusion

The intelligent use and promulgation of indigenous knowledge systems has the potential for making a profound impact upon slowing the spread of HIV/AIDS in sub-Saharan Africa by including traditional healers and other indigenous opinion leaders in designing and implementing culturally relevant prevention and treatment strategies. I am optimistic that such endeavors could have a positive impact, if intelligently conceptualized. I remain concerned that the unintended-but-misguided Euro-American HIV/AIDS interventions in Africa have been serving, de facto, as the latest wave of colonialism; some members of the African intelligentsia even point to the existence of an "industry of HIV/AIDS" (e.g., Nicanor, 2002). I have faith that participatory and collaborative action can induce the former and serve as an object lesson against the latter. I also have faith that African counselors can emerge as important leaders in this transformational action.

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