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Designing an HIV/AIDS Intervention for Traditional Healers in Zimbabwe

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Foreword

HIV needs no passport to cross international borders. It is a health problem with global dimensions. In many countries struggling towards economic development HIV poses additional hardships; straining already meager health resources and threatening economic stability. Around the world, every day, 8000 persons of all ages are infected with HIV. While the rate of new infections is dropping in the developed nations, this same measure is going up dramatically among poorer nations. It is estimated that in the last decade of this century, up to 5.5 million children in Central and Eastern Africa will be orphaned because their parents have succumbed to AIDS.

In the United States and Europe, much research has already been done on the modes of HIV transmission, the culturally relevant risk factors for infection, how HIV interacts and co-occurs with other diseases, and other important research topics. All of this research has contributed in a profound way to our ability to fight and contain the spread of this disease. What is desperately needed now is a better understanding of how this disease moves and interacts within contexts very different from those in the developed world.

It is critical to the world's ability to control the AIDS pandemic to enable developing nations to do their own research, the results of which will be more locally applicable and acceptable. With HIV/AIDS as with many other conditions, the problem goes beyond the mere medical diagnosis; it is critical to study social determinants, values and practices that favor the appearance and spread of the epidemic. It is equally important to analyze the economic burden of this disease, and the most cost effective interventions adaptable to local conditions. Foreign assistance needs to help provide support for local communities to develop their own strategies, taking into account the social and cultural environment.

In the spirit of sponsoring local research, INCLEN is pleased to present this monograph. The authors of this work include Dennis G. Willms, Associate Professor, Department of Clinical Epidemiology and Biostatistics, Faculty of Health Sciences, and the Department of Anthropology, Faculty of Social Science, McMaster University; Alfred Chingono, Lecturer, Department

of Psychiatry, and Health Social Scientist in the Clinical Epidemiology Unit, Faculty of Medicine, University of Zimbabwe; Maureen Wellington, Assistant Director, City Health Department, and Clinical Epidemiologist at the Clinical Epidemiology Unit, Faculty of Medicine, University of Zimbabwe; and Nancy A. Johnson, Research Associate, Department of Clinical Epidemiology and Biostatistics, Faculty of Health Sciences, McMaster University.

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Robert Fletcher, MD
(Chairman of the Board)
Harvard Medical School
Boston, Massachusetts

Claire Bombardier, MD
Faculty of Medicine
University of Toronto
Toronto, Canada

David William Fraser, MD
International Health Consultant
Yardley, Pennsylvania

Julio Frenk, MD, PhD
Fundacion Mexicana de la Frontera para la Salud
Mexico City, Mexico

Ronald Gebert, MD
Universidad
Temuco, Chile

Joyce C. Lashof, MD
Dean Emerita
School of Public Health
Univ. Of Calif. At Berkeley

James McCord
President
OACIS Health Care Systems
Greenbrae, California

Charas Suwanwela, MD
Chulalongkorn University
Bangkok, Thailand

Arturo Morillo, MD
(ex-officio)
Executive Director
INCLEN

Shelly Kessler
(Secretary to the Board) (ex-officio)
Deputy Executive Director
INCLEN

INCLEN, INC. EXECUTIVE OFFICE 3600 MARKET STREET SUITE 380 PHILADELPHIA PA 19104-2644 USA
PHONE: 215.222.7700 FAX: 215.222.7741 EMAIL: INCLEN@MCIMAIL.COM

Designing an HIV/AIDS Educational Intervention for Traditional Healers in Zimbabwe

Dennis G. Willms[1], Alfred Chingono[2], Maureen Wellington[3], and Nancy A. Johnson[4]

Introduction

Designing culturally-compelling HIV/AIDS interventions requires transcending conceptual categories and merging models and reasoning processes. At first glance, this appears to be an impossible task, considering the difference in understanding about HIV/AIDS between Western medical practitioners and Zimbabwean traditional

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[1] Associate Professor, Department of Clinical Epidemiology and Biostatistics, Faculty of Health Sciences, and the Department of Anthropology, Faculty of Social Sciences, McMaster University.

[2] Lecturer, Department of Psychiatry, and Health Social Scientist in the Clinical Epidemiology Unit, Faculty of Medicine, University of Zimbabwe.

[3] Assistant Director, City Health Department, and Clinical Epidemiologist in the Clinical Epidemiology Unit, Faculty of Medicine, University of Zimbabwe.

[4] Research Associate, Department of Clinical Epidemiology and Biostatistics, Faculty of Health Sciences, McMaster University.

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healers and their patients. Biomedical explanations of HIV and how it is transmitted are based on a scientific understanding of physiological and immunological processes and the natural history of disease and illness. Indigenous or lay explanations of the disease may derive from spiritual, interpersonal, natural, and social beliefs, empirically grounded, but based also on moral principles.

In this paper, we describe the process used to develop a model that combines Western and indigenous explanations to create a culturally-compelling HIV/AIDS intervention. In addition, we demonstrate the importance of ethnographic research in uncovering the complex web of understandings about HIV/AIDS and, thus making such an endeavor possible.

Traditional Healers, Therapeutic Practices, and Risk for HIV/AIDS

Traditional healers were legally recognized by the Government of Zimbabwe in 1981 (Traditional Medical Practitioners Act, No. 38). At present, the Zimbabwe National Traditional Healers Association (ZINATHA) reports that there are approximately 35,000 - 50,000 licensed traditional healers in the country, comprising a variety of traditional healing subspecialties: herbalists, midwives, spirit mediums, and diviners (Chavunduka, 1986). Traditional healers remain an important source of primary health care for many Zimbabweans, particularly those in the rural districts (Arkovitz and Manley, 1990). In the more urban areas, they are often consulted prior to, or in conjunction with, biomedical practitioners. As Neumann and Lauro (1982) note, "many of the practices of traditional medicine practitioners are designed to preserve cultural institutions and to help the patient live at peace with family, clan, village, tribe and inner self." Care is directed at the social, psychological, spiritual, and physical aspects of the person. Traditional healers, therefore, also act as marriage counselors, moral advisors, social workers, and legal and political consultants (Chavunduka, 1986) and are involved with the *prevention* of illness and misfortune.

As diagnosed and suspected AIDS patients are increasingly coming to traditional healers for therapeutic and psycho-social support, healers are in a position to have a significant impact in terms of secondary prevention by educating and counselling patients. The invasive nature of many of their healing practices, however, place traditional healers and their patients at risk of HIV infection.

For example, traditional healers use razor blades or other cutting instruments to scarify patients. Tiny incisions or *nyora* are made on the body, usually the joints, and medicine is applied to the wounds. Risk for HIV transmission may occur when a single razor blade or cutting instrument is used to scarify a number of patients, when medicines are rubbed into the *nyora* with the bare hands, or care is not taken to avoid contaminating the contents of the *calabash,* or container, in which the medicine is stored, with the patient's blood. Traditional healers are also called upon to "clean" women's uteruses or to "bite out". In the case of "biting out", an "object" which has been induced into the patient's body by witchcraft is removed. The traditional healer "traps" the object at some location on the body by making a series of *nyora*. Using her[5] teeth, she then bites the cuts where the object has been "caught", and sucks out the object taking the patient's blood into her mouth. Cleaning a woman's uterus requires the traditional healer to insert her fingers into the woman's vagina, bringing her into contact with the vaginal fluids, and in many cases, a bloody or STD-related

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[5] Chavanduka estimates that the majority (54.8%) of traditional healers in Zimbabwe are women (1994:43). Traditional birth attendants are, of course, normally women. In this paper, we switch between the male and female case when referring to traditional healers, except in instances where the text obviously refers to one sex over the other.

discharge. Those traditional healers who practice midwifery unavoidably come into contact with blood and bodily fluids during the course of delivery and pre- and post-natal care. Circumcision and ear piercing are sometimes performed on several individuals at one occasion with a family knife, in the former case, or needle, in the latter. The instrument may not be sterilized between individuals. At issue is not the appropriateness of the traditional healing practices, nor their invasiveness as many Western medical practices are equally, if not more, invasive, but how to modify existing practices to make them safer for patients and healers alike.

Designing a Culturally-Compelling HIV/AIDS Educational Intervention for Traditional Healers

Concern for the risk of HIV transmission in the *matare* or "surgery" of the traditional healer, coupled with a recognition of the healers' influential role in the community motivated the development of an AIDS educational workshop for traditional healers with the following goals:

> (1) to develop with the traditional healers, a model of HIV/AIDS which helps them to assess risk of HIV transmission, including aspects of their practices that are risky to themselves and to their patients;
>
> (2) to increase the traditional healers' awareness of the significant impact they can have on the HIV/AIDS problem in terms of primary and secondary prevention, both in the *matare* and the community, by educating and counselling their patients, providing psycho-social support, and moving toward greater collaboration with Western-trained medical practitioners; and
>
> (3) to develop new practice procedures that reduce the risk of HIV transmission in the *matare* as well as guidelines for patient education and counselling.

Our primary goal was to identify and change risky healing practices. Change of any kind, however, is inherently threatening to people who are dependent on and protectors of tradition, as are the traditional healers. There are many reasons for important HIV/AIDS risk reduction messages to be either rejected or subtly ignored, as they have been in previous AIDS education programs for traditional healers. Not the least of these is the underlying suggestion to the healers that their healing practices are potentially dangerous. Such messages are disempowering rather than enabling.

By explicitly concentrating on the second intervention goal, it was felt that the other two would be more easily accomplished. To focus on the positive contribution traditional healers can make in terms of providing compelling information and advice is inherently empowering. It was posited that in the context of learning how to

educate their patients, the traditional healers would more readily accept the idea of changing the risky aspects of their practice.

The principal challenges of the workshop were to engage the traditional healers in a participatory learning process and to negotiate a merged model of AIDS that was satisfactory from both the indigenous and biomedical perspectives, that is, one which was acceptable and understandable to the traditional healers and which resulted in an appreciation of risk events and how they could be eliminated. From our prior ethnographic study, we gained insight into indigenous understandings of AIDS, from which a preliminary version of a merged model was developed. Using the workshops, the preliminary version of the model was refined and elaborated. In addition to cultural appropriateness of the content, the following principles also guided the design of the 3-1/2 day event:

1) Traditional healers should be respected as autonomous professionals.

Traditional healers were not regarded as "extra bodies" to be recruited as trusted, accessible, and inexpensive community health workers who would hand out condoms or, to paraphrase Nzimande (1988), "make their clients available to Western interventions", by recognizing symptoms and referring to Western medical practitioners.[6]

The traditional healers' unequal relationship with Western medical practitioners, and their political struggle for power in relationship to this group, was carefully considered. It would have been futile, and possibly damaging to the purpose of the workshop, to suggest that traditional healers refer all suspected AIDS patients to the hospital or clinic for testing, or to have had Western medical practitioners alone facilitate the workshop.

2) The importance of the spirits in the healing process must be recognized and respected.

Most traditional healers claim to be possessed by a spirit which is called upon when diagnosing and treating patients. As it is the healing spirit that makes decisions and conducts healing events in the opinion of both healers and patients, the spirits must be accorded a proper place in the process of the workshop. It would be inappropriate, therefore, to deny that traditional healers are protected from getting AIDS because

[6] See Hoff 1992 for an overview of projects in various countries, many of which have developed training strategies for traditional healers based on an "incorporation" rather than "collaboration" model of linkages between traditional healers and Western medical practitioners.

there are no *mudzimu* (ancestral spirits) protecting them. Instead, facilitators needed to help traditional healers convince each other that the spirits may not be able to protect them because this is a new disease which the spirits have not yet mastered, and that it may be possible to negotiate change in practices with the spirits in the same manner that healers have, in the past, negotiated such things as wearing modern clothes and using modern transportation.

In order to make the traditional healers feel comfortable with the workshop process and demonstrate acceptance of their belief system and the reality of their spirits, the healers' own process of initiating an event ceremonially was adopted. Each morning, the local spiritual leaders lead the group in a private prayer asking the spirits to open the way for them to learn.

Ceremony, including prayer, songs, beating of drums, and dancing, was an important part of the structure of the entire workshop. The first half of the morning sessions consisted of ceremonial activities and discussions of the previous day's events. The traditional healers were encouraged to consult their spirits in the evening on the day's activities, through prayer and dreams, so that on the following morning the spirits' opinions could be presented and discussed in a public forum. In this way, information was shared by all three types of participants. On the evening of the third day, the traditional healers and facilitators jointly planned and participated in a *bira,* a traditional ceremony to honor the spirits.

3) The facilitators and traditional healers should be equal partners in the learning process.

Everyone had something to learn from or teach each other. Establishing a successful working relationship between the facilitators and the participants was a key factor in the success of the workshop.

Seven workshops were conducted, one workshop per randomly selected district in seven of the eight provinces in Zimbabwe, over a 4-month period from December 1994 to April 1995. On average, each of the workshops was attended by 30 healers. The majority of the traditional healers who attended were those who had been randomly selected from the district to participate and who had completed a pre-intervention program survey in the intervention districts. Usually, two or three traditional healers who had not completed the survey would arrive at a workshop wishing to attend and would be asked to complete the survey prior to participating. Generally, two District and two Provincial Health Personnel attended each workshop and shared their perspective on the AIDS problem. The participation of chiefs and *kraal* heads was also encouraged.

The same team of facilitators led each of the workshops. Initially, there were five facilitators. One was a traditional healer and a research assistant on the project, T.

Mark Musara. An additional one or two research assistants, Thoko Fuyane and Gertrude Khumalo-Sakutukwa[7], guided by one or both of the research investigators from the University of Zimbabwe, Alfred Chingono and Maureen Wellington, also acted as facilitators. The traditional healer facilitator provided an intimate knowledge of the language, culture, and practice of traditional healing. He was able to identify with the needs and aspirations of the participants. The other facilitators provided an objective, "outside" perspective. Their team facilitation actively demonstrated the possibilities of cooperation and sharing across health disciplines, e.g., clinical epidemiology, clinical and health psychology, social work, and medical anthropology, and between different systems of thought.

The facilitators were required to conduct themselves in a respectful and friendly manner and be good, responsive listeners. At the outset of the workshop, roles, working procedure, and expected outcomes were discussed to allay participants' fears of hidden motives and exploitation and to convince them that the facilitators had something of benefit to offer. Every attempt was made to address the healers' concerns. In some instances, the workshop program was modified slightly to suit their expectations.

4) The form as well as the content of the workshop should be sensitive to social, cultural, political, and economic barriers to acceptance of information.

In order that the workshop would seem relevant and authentic to the participants, oral and performed messages were favoured over the written word, ancestral spirits were systematically included, by making references to them during the day and asking that they be consulted at night, and the entire learning process was explicitly structured after a traditional healing in a *matare*.

Materials and items used in the practice of traditional healing such as *gona,* medicine container, *hakata*, bones thrown for diagnosing patients, and scarification instruments, were brought to the workshops to help make the traditional healers feel more at home and the demonstrations and role plays more authentic.

5) People need to "own" a problem, that is, they must be "disturbed" by the problem and feel compelled and capable of doing something about it -- in order to actively participate in its solution.

We suspected that many traditional healers had direct, disturbing experiences with AIDS, including death of their own family members. However, comments made by

[7] Gertrude Khumalo-Sakutukwa is a social worker in the Faculty of Medicine, University of Zimbabwe, and currently an INCLEN Fellow (Health Social Scientist) at the University of Newcastle.

traditional healers to the effect that the AIDS epidemic is decreasing, that fewer and fewer AIDS patients are showing up every year for treatment, and that the AIDS epidemic is over-blown for some political end, necessitated an initial stage in the workshop whereby the traditional healers were "disturbed" about the magnitude of the problem and the need to take action. It was only after this, that the traditional healers could make a decision to do something about the problem and actively participate in the workshop.

Active participation by the traditional healers was crucial. People must own not only the problem but the solution as well. They need to participate fully in defining the problem, searching for solutions, and applying them.

An initial objective, then, was to develop a feeling of need for the traditional healers to ask themselves what could be done about the AIDS problem. It was the facilitators' task to help them realize that they are the ones who can do something. This was the focus of day one of the workshop.

The next step was to diagnose the problem. Through a morning of discussion which attempted to merge indigenous and biomedical understandings of what AIDS is, how it works on the body, and how it is passed from one individual to another, the facilitators helped the traditional healers to define the problem and move toward the idea that the solution is two-pronged and involves changing their own practices and providing information to patients and influential people in the community. This was the focus of the first half of day two of the workshop.

The second half of day two, all of day three, and the early part of day four were devoted to discussion, negotiation, and practice of changes in traditional healers' practices and guidelines for educating and counselling patients. The remainder of day four focused on consolidation of what had been learned and consideration of what steps the traditional healers needed to take to further their own knowledge, share their knowledge with other traditional healers, and take AIDS prevention into their communities.

There is a remarkable similarity of structure between the stages of a traditional *matare* healing and the stages suggested by the innovation acceptance model. This might be expected considering the generality of the model and the healers' goal of themselves creating change (healing). However, it also demonstrates the appropriateness of adopting the *matare* healing structure as an explicit model for the workshop.

6) People learn best when they actively "work" with new information in problem-solving or role-playing exercises.

Each segment of the workshop began with discussion that laid a foundation of

existing indigenous knowledge. These traditional constructs and "ways of knowing" were fused with biomedical understandings through further discussion in which analogies, metaphors, and parables from traditional therapeutic practice were used. The healers were then given the opportunity to apply the results of the discussion to a concrete and practical problem. They were divided into small groups, often on the basis of their type of practice, and asked to role-play different risk scenarios and patient-healer interactions or to problem-solve how they might deal with certain moral and professional dilemmas. The focus was on traditional healers teaching and learning from each other.

A facilitators' manual was produced in order to standardize the educational intervention. It contains a schedule of activities and a theoretical and background section which describes much of the thought behind the crafting of the workshop (Willms, Chingono, Wellington, et al. 1996). The schedule is laid out so as to provide the facilitators, at a glance, with a description of the goals, rationale, and activities for each segment. Also included in the schedule of activities are summaries of the kinds of things that traditional healers are saying with respect to the topic at hand.[8]

Workshop Content: Using Ethnographic Findings to Create Culturally-Compelling Interventions

An ethnographic study involving participant observation, in-depth interviews, and focus groups with 30 traditional healers in both urban (Harare) and rural (Gutu) districts was conducted over the period of two years. Analysis and interpretation of the ethnographic data generated case studies of traditional healers, illness narratives documenting the health-seeking behaviors of AIDS patients, texts describing risk scenarios in the "surgeries" of the healers, and interpretive summaries of emergent issues and themes with respect to indigenous understandings of HIV/AIDS.

The following sections describe traditional healers' understandings of AIDS as they emerged in the texts generated from the ethnographic research, and demonstrate both the richness of the data that can be obtained through such an approach and how such information was used to develop a preliminary version of a merged model of AIDS.

Traditional Healers' Explanatory Models of AIDS

There is a great deal of variation in what traditional healers say, publicly and privately, about AIDS. There are, however, areas of consensus from which two

[8] Supported by funds from UNICEF, a resource manual for traditional healers is currently being written in Ndbele and Shona to complement the training strategy. It will be disseminated to workshop participants in the future.

indigenous base models of AIDS can be discerned.

A great deal of debate exists among healers around whether AIDS is a new disease or a new name for the traditional diseases known as *runyoka* and *rukombe*. *Runyoka* and *rukombe* are diseases that an individual acquires as punishment for engaging in culturally-inappropriate sexual behavior -- that is, sexual behavior that violates cultural taboos (taboos around extra-marital sex in the case of *runyoka* and around pre-marital sex with *rukombe*). Publicly at least, most traditional healers, while acknowledging that the symptoms of AIDS closely resemble those of *runyoka* and *rukombe*, state that AIDS is a new disease. There is good cause to suspect, however, that many are privately of the opinion that AIDS is, in fact, *runyoka/rukombe*, or at minimum, feel that there is some kind of relationship between AIDS and these traditional diseases, but are uncertain what it is.

On the one hand, it is argued that AIDS is not *runyoka/rukombe* because: (1) *runyoka* attacks only men, both sexes can get AIDS; (2) *runyoka* and *rukombe* are curable, whereas AIDS is not; (3) infants and young children can get AIDS but not *runyoka* or *rukombe*; (4) AIDS is found all over the world, *runyoka* and *rukombe* are illnesses that can only be found in some African countries; and (5) people die from *runyoka* and *rukombe* much more quickly than they do of AIDS. In essence what is being argued is that *guilty* people (people who have violated a cultural taboo) get *runyoka* and *rukombe*. This does not fit with the observational reality that *less guilty* (spouses) and *innocent* (children) persons also get AIDS.

It became apparent during the ethnographic research that traditional healers are struggling with the notion of *transmission*. They use *runyoka/rukombe* as the base model for understanding AIDS, but have modified it to accommodate the observational evidence about who does or does not get AIDS (eg., the fact that innocent children can get this new disease). How is this disease “passed”? What is being “passed”? Does the “something” that is passed start the disease, or is the disease created because of a wrongful act?

For those traditional healers who understand or suspect AIDS to be a new name for *runyoka/rukombe* or a new type of *runyoka/rukombe*, the disease has always existed. It was not as prevalent in the past because people used to be “decent”, that is, they used to respect their culture and did not engage in “promiscuous” behavior. *Runyoka* and *rukombe* have become more prevalent, as well as difficult to treat, because now, “men sleep with so many women [that] when they get *runyoka* they do not know which woman they got it from”, and therefore cannot make the appropriate restitution and affect their cure.

Those traditional healers who understand AIDS to be a new disease often state that it came from outside Zimbabwe and was brought by Europeans. That AIDS was “brought by Europeans” appears to be understood in several different ways.

Traditional healers observe that many people fled the country during the Independence War and later returned, guerillas went overseas for military training, and after Independence there was an influx of tourists and business travellers from Europe and elsewhere. They argue that Zimbabweans who left the country and returned, and visiting "outsiders" brought AIDS to Zimbabwe. Alternatively, some traditional healers state that AIDS was brought to Zimbabwe by Italian soldiers during WWII. "Brought" may mean AIDS existed among Europeans and was introduced to Zimbabwe, or it may mean that AIDS arose out of the "mixing" of the races, in the sense that this mixing "breeds something evil", or the adoption of European/Western ways and the loss of traditional culture.

Whether AIDS is understood to be a new disease or a new name for an old disease, traditional healers agree that an increase in prostitution and promiscuity has led to the spread of AIDS. The term "promiscuity", as it is used by the healers, connotes sexual behaviour which violates a cultural taboo. Being promiscuous does not simply mean, as it generally does in Western use, "having many partners". Traditionally, culturally-inappropriate sexual behaviour includes pre-marital sex, extra-marital sex, extra-racial/tribal sex, sex with someone outside one's own age set, and sex with a woman who has recently aborted or given birth or who is menstruating. Those who engage in such behaviour are understood to be *guilty* or *unclean*.

That the loss of traditional culture and the adoption of Western ways is at the root of the increase in promiscuity/prostitution is universally accepted by traditional healers. It is for this reason that they advocate a return to traditional culture as the primary means of controlling the spread of AIDS. It is here, at the level of ultimate causation, that biomedical and indigenous explanatory models of AIDS converge. Both knowledge systems hold that:

- AIDS is spread primarily through sexual intercourse (non-sexual spread of the disease is de-emphasized in indigenous understandings).

- It is people's sexual behavior that puts them at risk of getting AIDS.

- The way to stop the spread of AIDS is for people to change their sexual behavior.

The two understandings diverge in the knowledge of *how* various sexual behaviors put people in danger of getting AIDS -- that is, in how AIDS "gets started" in the body and how it "gets passed" from one person to another.

How AIDS "Gets Started": A Traditional Healing Perspective

Much of what traditional healers understand about how AIDS "works" on the body is bound up in how they understand AIDS "gets started". Those traditional healers who

argue that AIDS is a new disease offer a variety of explanations for how AIDS starts. AIDS starts when:

- young (hot) blood mixes with old (cold) blood.
- white (European) blood mixes with black (Zimbabwean) blood.
- the blood of one tribe mixes with the blood of another tribe.
- "dirty" blood mixes with "clean" blood (where "dirty" blood is that of a woman who is "dirty", that is, one who is menstruating or has recently given birth or aborted).
- many kinds of blood mix.
- local diseases mix with foreign diseases.
- various STDs mix together to start AIDS.

These explanations may be thought of as attempts to link a particular manifestation of the loss of traditional culture and inappropriate sexual behavior with one of two notions about how AIDS starts -- the "mixing of blood" or the "mixing of diseases".

According to the "mixing of blood" explanations, the blood of the partners "mixes" or "meets" during sexual intercourse. Presumably, the mixing would be two-way and the disease would start in both partners. Instead, the focus is on the "guilty" partner with his or her blood becoming "diluted", "weakened", or "spoilt" during the mixing. The "diluted" or "spoilt" blood "weakens" the body so that it becomes vulnerable to the many illnesses that together constitute AIDS (weight loss, diarrhea, vomiting, etc.).

The base model for understanding AIDS appears to be that of *runyoka/rukombe*:

- the disease starts when a man and woman engage in immoral sex.
- it is the guilty person in whom the disease starts.
- one act of immoral sex is sufficient to start the disease in someone.

According to the "mixing of diseases" explanations, AIDS starts as a result of the accumulation of disease, foreign and local or various STDs, which, when some unspecified threshold is reached, one of two things may happen:

- the body becomes so weak that many illnesses begin to attack it.

- a new disease (AIDS) arises from the combination of diseases.

The base model here may be that of syphilis and gonorrhea -- other diseases *caused by sex,* although not necessarily immoral sex.[9]

STDs are said to be caused by an accumulation of "dirt" (*tsvina*) in the stomach, the bladder, or the sex organs. The "dirt" forms an "egg" which "hatches", sprouting worms that invade the whole body via the blood. These worms kill the body and make the person vulnerable to all sorts of diseases. "Dirt" is not well defined. Sometimes it is described as dead sperm, menstrual blood, or "leftovers" of STDs. What is pertinent is that this "dirt" is "passed" or transmitted during sexual intercourse and that it accumulates to produce an illness state. The "mixing of diseases" explanations entail:

- something (diseases) being passed during sexual intercourse (moral and immoral).
- something (diseases) accumulating to produce a new illness state -- AIDS.

Toward a Merged Model of AIDS

Given that traditional healers are unlikely to dispense entirely with their base explanatory models, a merged model must incorporate indigenous understandings, highlighting where they converge with biomedical ones. Where understandings diverge, the gaps must be bridged in a language or idiom that is familiar, acceptable, and understandable to traditional healers.

A merged model of how AIDS starts in the body would need to predict that:

- people may be dangerous without having symptoms of AIDS (i.e., while HIV+).
- one exposure may be enough to contract the disease.
- AIDS can be passed by non-immoral sex (sex with a spouse or spouses).
- AIDS can be passed by non-sexual blood contact.

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[9] Something else may also be going on. Some of the things that traditional healers say may be novel integrations of what they have heard about AIDS with their own way of thinking. The "mixing of diseases" explanations may not be indigenous. Western biomedical discourse such as "AIDS is a complex of diseases" -- meaning "HIV can result in a complex of diseases" -- may have been understood by traditional healers as "AIDS is caused by mixing a complex of diseases." Some traditional healers' understandings that AIDS is caused by a mixing of diseases may be about the different manifestations AIDS can have.

- only a very small amount of contact is necessary.
- having an active STD increases the risk of getting AIDS.

- healers are not protected by their *mudzimus*.

The biomedical understanding which predicts or explains these things is that of "infection", which is not currently an important part of traditional healers' understanding of disease or illness. *The challenge of creating a culturally-compelling intervention requires, in this instance, that we take pieces of each of the indigenous base models, which fit with the biomedical notion of infection or disease causation by means of a transmissible agent, and put them together in a new way, phrased in a suitable idiom.* The problem with Base Model A, the *runyoka* model, is that it predicts that only those who engage in immoral sex will get AIDS. The difficulty with the STD model, Base Model B, is that an accumulation of dirt, resulting from many sexual encounters, rather than a very small amount of the transmissible agent from just one sexual encounter, starts the disease. Thus, we borrowed the notion that one sexual act, moral or immoral, is enough to start the disease from the *runyoka* model, taking also from the STD model the idea that there is something, "dirt" or *tsvina*, that resides in the body and is passed from one individual to another during sexual intercourse. The strength, in biomedical terms, of one indigenous base model is at the heart of the problem with the other one. Our challenge was to combine the strengths of each model to create a new model which avoids the pitfalls of the others. According to this new merged model, disease formation is the result of the *moral and immoral acquisition of "dirt"* (tsvina) *or virus in any amount rather than its accumulation*.

Moving from Sexual Transmission to Non-Sexual Transmission: Learning to Assess Risk in the Matare

Only with this new model in place can we begin to consider, along with traditional healers, non-sexual transmission in the context of the *matare* and their various healing practices. Our ethnographic research revealed that AIDS is categorized along with other diseases *caused by sex* such as gonorrhea, syphilis, and "drop". The danger of getting AIDS is in the act of sexual intercourse, and as such, non-sexual means of HIV transmission through healing practices such as scarification are, by definition, not recognized or experienced as risky.

Rather than supply the traditional healers with ready made solutions to perceived problems in their practice, we helped them identify risky practices and develop their own solutions. In the course of the workshops, facilitators asked traditional healers their sense of when and how particular therapeutic situations become risky, as well as specific aspects of their practices in which they or their patients come in contact with blood or other bodily fluids. Facilitators also asked the traditional healers to think

about their practice setting, the types of patients they have and their expectations, and identify problems and solutions.

The final step in the workshop develops the traditional healers' abilities to communicate new understandings to a wider audience. It is felt generally, that patients probably need to go through a learning process similar to the traditional healers. That is, they need to be disturbed by the seriousness of the disease and convinced that prevention is the answer so that they will have an interest in understanding, in a new way, how AIDS works.

The workshops provide a context in which the traditional healers develop ideas about the kinds of things that are important to say to particular types of patients and methods for saying them. Traditional healers also need to reason through the moral dilemmas with which they are faced. Many of these dilemmas have to do with their patient's welfare versus the welfare of the patient's contacts. These dilemmas are discussed as a first step in moving from concern for the patient to a concern for the larger community.

Conclusion

The development of culturally compelling HIV/AIDS interventions can be a formidable process, involving the navigation of diverse cultural worlds. At the start, these worlds may appear more competitive than complementary, with stakeholders holding claim to truths, principles, or even cures that they vigorously defend. Yet, if a common ground is established early on in the journey, through trust, respect, mutual support, and agreements to remain morally accountable to each other, an opportunity is afforded for an excursion in which illness and disease are exposed to new avenues of conceptualization, healing, and support.

There is a tendency to thrive and find solace in fixed, culturally-constructed explanations. Thus, in the context of HIV/AIDS and for those of us who are Western-trained, there is the propensity to advance primary prevention strategies in languages and idioms often ill-suited to the life-world of those most affected by the disease. As a consequence, there is the danger that scientific assumptions are not compatible with indigenous ways of understanding or perceiving reality.

What is required, therefore, is a more dynamic, transcultural approach to addressing the problems and solutions to HIV/AIDS. This paper describes a process in which many parties have come together to map out a strategic, culturally-compelling intervention. At present, quantitative and qualitative surveys are being conducted with experimental and control groups to ascertain the efficacy of such an intervention.[10] Our preliminary results indicate the worthwhileness and clinical

[12] See Chingono et al. (forthcoming), Survey Results of the HIV/AIDS Educational Intervention for Traditional Healers in Zimbabwe. Harare: Department of Psychiatry, University of Zimbabwe.

efficacy of this participatory approach: traditional healers are talking to chiefs, *kraal* heads, and other healers. Traditional healers are urging their ancestral spirits to renegotiate with them the meaning of this disease and how to treat it. They are seeking a new way to understand the relationship between human behavior and AIDS.

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