

# **Education and Development of Traditional Health Practitioners in isiZulu to Promote their Collaboration with Public Health Care Workers**

**Nceba Gqaleni  
Nompumelelo Mbatha  
Tobias Mkhize  
Soornarian Naidoo**

**Mqansa Makhathini  
Thanile Buthelezi  
Verona David  
Indres Moodley**

## **Abstract**

The African Union has declared 2001-2010 the Decade of African Traditional Medicine (ATM). This declaration has been supported by a call from the World Health Organization, and the African National Congress, for the integration of ATM into the National Health Care System, in the context that communities are allowed to choose whom to consult for their health care needs. In order to facilitate collaboration between traditional health practitioners (THPs) and public health care workers (HCWs), we have developed a cutting edge project focused on establishing a district health-based collaboration between provincial and local authority clinics and THPs. To achieve this, it was necessary to develop training materials in isiZulu to capacitate THPs to document, monitor and evaluate their interaction with patients, and for the referral of patients to these clinics. The training programme is designed to facilitate a meaningful two-way participation between THPs and the clinics. The original materials were developed in South African English by biomedical practitioners in consultation with THPs. These were then translated into isiZulu for purposes of facilitating understanding, promoting ownership, and direction of the process by THPs. The programme has resulted in the empowerment and commitment of THPs

to document their own work in their own language which has a long oral tradition. This has further promoted understanding between THPs and HCWs. Patients can now freely consult THPs and receive health information from them in their own language and, when necessary, be referred to clinics and social workers to access services not rendered by THPs. This process has bridged the gap between the two health systems allayed myths and misconceptions or prejudice each system had about each other that has been a stumbling block to collaboration.

**Keywords:** traditional health practitioners, public health care workers, collaboration, clinics, training

## Introduction

The World Health Organisation (WHO 2000; WHO 2001; WHO 2002; WHO 2003; WHO 2005) and other literature (Pretorius 1999; Morris 2001; Makhathini 2003; Gqaleni *et al.* 2007; Goggin *et al.* 2009; PCH 2009) indicates that 80% of South Africans utilize and rely on traditional medicine for their health care needs. In fact, up to 90% of people living with HIV and AIDS first consult traditional health practitioners before visiting practitioners of allopathic medicine (Morris 2001; Goggin *et al.* 2009). Literature indicates that so many make this decision that most experts now believe that this first health care system of African traditional medicine is actually bearing the brunt of HIV and AIDS care and support (Morris 2001; Goggin *et al.* 2009). How South Africa has developed its second health care system (now known as the national health care systems) is intractably linked to the historical legacy of apartheid and colonialism.

An epidemic such as HIV and AIDS has presented immense challenges to all health care workers, firstly, because it is a new disease to Africa and, secondly, because it has spread rapidly largely through sexual activity, thereby making it a very difficult condition to prevent. The clinical symptoms of AIDS are sometimes similar to the manifestation of *ukuthwasa*; a spiritual calling and training to become *isangoma* (a diviner) in traditional medicine. It thus becomes necessary to develop training programmes to equip traditional health practitioners (THPs) to know how to differentiate between the two conditions and effectively manage the epidemic within their practices

and in their communities. There are currently several training programmes aimed at equipping practitioners of biomedicine with knowledge of HIV and AIDS and its management and prevention, with little or no assistance for THPs.

The South African government, African Union and the World Health Organisation recognize and promote traditional medicine (ANC 1994; WHO 2001; WHO 2005; AU 2007). In a speech by the then Minister of Health, Dr Manto Tshabala-Msimang, at the African Traditional Medicine Day celebration in September 2007, the importance of the inclusion of African Traditional Medicine (ATM) in the national health system was highlighted (NDoH 2007). This marked an important departure from the apartheid and colonial past that marginalized ATM.

The African Union has declared 2001-2010 the Decade of African Traditional Medicine. This declaration has been supported by a call from the World Health Organisation and the African National Congress for the integration of ATM into the National Health Care System in the context that communities are allowed to choose whom to consult for their health care needs (ANC 1994; WHO 2001; WHO 2005; AU 2007). In order to facilitate collaboration between (THPs) and public health care workers (HCWs), we have developed a cutting edge project focused on establishing a district-health-based collaboration between district and local authority clinics and THPs using HIV and AIDS as a focal disease. The objective of this paper is to describe the process we have followed to develop materials in their own language of isiZulu for training to capacitate THPs to document, monitor and evaluate their interaction with patients, their communities, and for the referral of patients to these clinics. We call this project 'saving lives: biomedical and traditional healer collaboration on HIV and AIDS'.

### **The Biomedical and Traditional Healer Collaboration Project**

The Nelson R Mandela School of Medicine at the University of KwaZulu-Natal has established strong relationships with THPs leading to the signing of a memorandum of understanding with THPs of KwaZulu-Natal (Kahn and Nzama 2003; Ngobese 2009). The relationships are based on sound principles and we believe can become a model for partnerships in this country and perhaps on the continent. The model aims to contribute to the

development of traditional health care knowledge without compromising intellectual property rights of the THPs.

This project on biomedical and traditional healer collaboration on HIV prevention, AIDS care and treatment is funded by the US Presidents Emergency Fund and administered by the Centres for Disease Control and Prevention. The focus of this five-year funded project is on establishing a district and local government level collaboration with clinics and THPs.

Partners in this project include the Nelson R Mandela School of Medicine, the KwaZulu-Natal Traditional Health Practitioners, KwaZulu-Natal Department of Health and the eThekweni Municipality Health Unit. The project centres around a training and implementation programme that has reached 1200 THPs in 3 districts (eThekweni, iLembe and uMgungundlovu). The project starts with a one-week workshop covering:

- Advanced HIV & AIDS Awareness which focuses on the human immunodeficiency viral behaviour, characterisation, transmission, prevention-of-transmission routes, immune system response to viral invasion, and eventual disease progression. The mode of training includes computer-simulated medical animations that are combined with graphics as well as dramatic enactments to ensure precise understanding.
- Prevention Approaches. Throughout the workshops, multiple approaches are taken, including culturally embedded methods, to deepen awareness of the necessity and viability of prevention, and to explore the application of abstinence, faithfulness and other prevention approaches, some specific to traditional healing contexts, in order to reduce the spread of the virus.
- Clinical Guidelines, appropriate to a traditional health practice, for syndromic management of HIV & Aids: These have been developed by the UKZN Department of Family Medicine and the eThekweni Health Unit in collaboration with the leadership of THPs, and are innovative, simplified guidelines for use by traditional health practitioners in their practice, to facilitate recognition of HIV-related symptoms and to facilitate ready referral where necessary. The longstanding relationship between the eThekweni Health Unit and traditional healers, and the involvement of traditional healers in the training of HCWs, have been advantageous in this regard.

- **Monitoring and Evaluation**, including patient record forms, follow-up forms, and referral forms. We have been developing a new patient record system for the THPs to use in their practice, including follow-up forms for repeat visits, and referral forms to facilitate referrals to the nearest provincial or local authority clinics. A monitoring and evaluation team is in place to visit the THPs and collect the relevant data for project reporting and project management.
- **Basic Medical supplies**. A modified version of home-based care kits specifically for THPs, are supplied to those THPs on the programme. These kits contain basic medical supplies such as rubber gloves, bandages, protective aprons, antiseptics, condoms etc. to assist with patient management, reduce the risk of HIV infection to the THPs, and ensure better patient care. Resupply is provided and coordinated by the project.
- **VCT and ARV Awareness Introduction**. The basic principles of voluntary counseling and testing are introduced and discussed, particularly in terms of the relevance to prevention and the need for timely care of those already infected. Basic awareness of antiretroviral drug regimens and potential side effects is combined with discussion of the necessity for caution in combining ARV regimens with traditional medicines.

Within the scope of this project, it was important that language was used in such a way that THPs would be able to fully and intelligently participate in the project without being overwhelmed by biomedical terms used by allopathic practitioners. A true spirit of equality had to be established. Two-way translation took place at two levels; English to isiZulu or isiZulu to English and biomedical scientific language to traditional medicine or *vice versa*. Thus, language as a resource was used in order to find appropriate ways of communicating that would be more conducive to all parties for the complex purpose of the project.

## **Development of Working Instruments**

The project team consisting of THPs and biomedical practitioners had to establish working instruments. These included:

- the patient record and follow up forms as tools for THP record keeping,
- a referral form for the proposed referral system.
- a training manual as a tool for THP capacity building.

All these instruments were developed in English and then translated into isiZulu in line with the Access to Information Act No 2 of 2000 (South Africa 2000) and recommendations by various scholars (Halliday and Martin 1993; Gazette 2000; Alexander 2005). This translation was done by the University of KwaZulu-Natal's School of isiZulu (language experts) as well as a member of the team who has a good command of both isiZulu, English and the health-related terminology. Some of the team members involved are health workers and scientists deeply rooted in isiZulu culture and biomedicine. The main reason for including an isiZulu language expert and health workers in the translation process was because the language expert could not fully understand traditional or biomedical health issues. The project team met on a regular basis to review the translated information and the newly developed isiZulu language instruments.

## **The Cross Referral System**

A referral system is a mechanism through which the biomedical and traditional healer collaboration could become a reality. It also presents an opportunity to encourage multilingualism so as to improve a formalized patient access across the service platforms. We developed a referral form which was simple and easy to be understood by busy HCWs and THPs but at the same time include as much relevant information as necessary. The purpose of the cross referral system was to implement, for the first time, a referral system between the clinics and THPs that will be conducive for optimized patient care and support. This system is based on the concept that the THPs refer their patients to the health facilities which will then respond accordingly through the acknowledgment note. Ideally this system is designed to improve communication and subsequently bridge the gap between the two systems while improving quality of health care for the patients.

## **Training Manual**

The purpose of the training manual was to sensitize THPs to the clinical guidelines appropriate to their system, HIV and AIDS, referral and the recording keeping system. The training manual provided a conceptual framework, from a biomedical perspective, for understanding illness prevention, treatment and health promotion. In addition, the manual also included a section on African traditional ways of prevention of HIV infection. All the sections of the training manual were translated from English into isiZulu. Those concepts and terms that did not exist in isiZulu were approximated to known contemporary concepts by amaZulu. For example, 'high blood pressure' would be termed '*ihigh high*' or '*i-BP*'. These concepts were given descriptive meanings within their context. This did not only increase knowledge within the traditional healing system, but also contributed in the development of isiZulu language through borrowing of words and concepts from the biomedical terminology.

## **Translation of the Training Manual**

### *The Content of the Translated Training Manual*

The training manual consists of six sections. The first section involves HIV origins, transmission, pathology and prevention. This section introduced traditional healers to the concepts and principles of HIV as a virus, its origin, the way the virus is transmitted from person to person, what happens when the virus gets into the body, how infection leads to AIDS, and how to prevent transmission. It provides THPs with a detailed understanding of HIV, how it behaves, and how to stop it spreading from one person to another.

This section proved to be the most complex to translate and difficult for delivering the desired outcome. Translation was complicated by the fact that some of the terms used openly and generally in English and/or medical sciences were considered to be private or sacred within the traditional healing context. To use some of these terminologies openly in training THPs was considered taboo, an insult or even disrespectful. For example, in isiZulu culture it is considered inappropriate to speak openly about sex, especially talk about genital organs in public. This then meant modification of some of the words and explanations during translation. The word 'penis' is translated

as *umthondo* in isiZulu but it would have been inappropriate to use these words openly in public training, therefore words like *ubuntu besilisa*, the ‘distinct male organ’, or *isitho sangasese sesilisa*, the ‘male private part’ were used instead.

One of the intended outcomes of the training manual was to influence THPs’ attitudes toward causes and origins of HIV and AIDS and therefore reduce the spread of the disease. However, it soon became evident that THPs had their own understanding and knowledge of causes of illness and disease and were unwilling to change to a biomedical approach. There was, however, agreement on prevention approaches used traditionally, which were included. This was an important lesson for the biomedically trained team members.

The second section involves clinical guidelines for optimisation of the management of HIV and AIDS by THPs appropriate to their health care practices. This was the most exciting to engage in and involved translations of HIV and AIDS related diseases, symptoms, diagnosis and management, including, where applicable, referral to other THPs or public health care clinics. This session established much of the commonalities in approach between biomedical practitioners and THPs. For example, we realized that in both systems the Stott-Davis model during consultation is followed (Stott and Davis 1979). In this model, practitioners first learn about the management of patient’s presenting symptoms, then underlying symptoms are established followed by behaviour modification, the management of the patients continuing problem (where appropriate), and lastly, to look for opportunities for health promotion. Conditions such as Herpes zoster (*ibhande*), TB (*isifo sofuba*), AIDS (*isifo sengculazi*), sexually transmitted diseases (*izifo ezithathelanayo zocansi*), oral rehydration fluid (*umbhubhudlo onosawoti*), were translated to a language THPs are familiar with in their everyday work.

The third section deals with monitoring and evaluation tools. Its aim is to introduce THPs to concepts and principles of the monitoring and evaluation process and to provide them with a thorough understanding of the instruments developed for the project. For the first time THPs are able to have documented records of their patient interactions for themselves in addition to their oral way which has been well established and perfected over centuries.

The fourth section deals with issues of palliative and/or home-based care. It was introduced at the request of THPs who required assistance for their patients who either presented late or required to be cared in the home environment. The section introduces THPs to the concepts and principles of practice and home-based care and to develop further understanding of how to apply principles of universal protection, prevention of the spread of infectious diseases and promotion of health among patients.

Section five includes antiretroviral (ARV) literacy. This section is intended to equip THPs with the understanding of ARV treatment (*ukwelapha ngemishanguzo yegciwane iHIV*) and its effect on people living with HIV. It is also aimed at helping THPs understand the importance of their roles in helping the patients adhere to the treatment, if applicable. It was another complex section to translate because of medical and scientific terminology not related to traditional approaches to treatment. For example, in order to facilitate understanding of the concepts for the THPs, we were obliged to use names associated with the shape of the viral structure e.g. *inkomishi* ‘cup’ was used to describe the receptors of the CD4 cell and *isagila* ‘club or knobkierie’ was used to describe GP 120 of the human immuno deficiency virus. Section six deals with voluntary counseling and testing (VCT) (*ukweluleka ngokuhlolela igciwane lengculazi ngokuzikhethela*), its meaning and purpose. Basic counseling in a trusting and private environment is where THPs are strong when compared to public health centres.

## **Interpreting during the Training Workshop**

A key principle of this project is the involvement of both THPs and biomedical practitioners as co-facilitators in the simultaneous interpreting from English to isiZulu including biomedical terminology to the language of traditional medicine. The co-ordinator of the workshop is a THP, assisted by 3 additional THPs, 2 nurses, 3 biomedical practitioners and 3 scientists. All these collaborated in interpreting during the workshop.

Interpreting during training took place on three different levels. Firstly, a workshop interpreter carefully articulates what is being narrated by the English speaking facilitator. Secondly, THPs interact with the training manual written in isiZulu during the workshop and ask for more clarity on

biomedical concepts they do not understand. This is where interpreting of science to the traditional (cultural) approaches includes the THPs facilitators in addition to biomedically trained practitioners. Thirdly, the practical level involves role play using the Objective Structured Clinical Examination method where THPs get a chance to relate the content of the training to their practices.

The workshop is participatory and open in that participants are encouraged to share their experiences. In this way we have been able to identify some of the similarities between African traditional and Western medical practices which we would otherwise have not been able to identify within the normal learning environment. For example we have been able to see common practices in terms of patient care, protocols and ethics of health care.

## **Language Conceptualization**

It should be noted that, when it comes to the origins of HIV, there were differences on how the THPs and Western practitioners conceptualized the disease. This is due to the fact that, historically, traditional healers are not familiar with the germ theory. The conceptualization of the origins of HIV for THPs is determined by their cultural values and beliefs. Because of their holistic approach, THPs believe that HIV may originate from a number of factors which may be interrelated. Such factors would include environmental, social, biological, psychological as well as spiritual factors.

This is in contrast with the biomedical practitioners who conceptualize causes of illness as being exclusively due to biological factors. However, there were points of congruence when it comes to prevention of HIV. For example, it is an African cultural value that, before people start eating, they need to wash their hands. This facilitated consensus between traditional healers and biomedical practitioners when it comes to the biomedical concept of hygiene as a way of illness prevention. The African concept of *ubuntu* (a human is a human being because of other humans) embraces a number of African norms (expected ways of behaviour). All people are expected to behave appropriately so as to maintain high moral standards.

## **Outcomes**

We developed pre- and post-assessment questionnaires in isiZulu for the purpose of quality assurance, monitoring and evaluation. The aim of these questionnaires were, firstly, to identify the level of shift in knowledge and attitudes particularly on understanding of HIV and AIDS, its causes, modes of transmission, signs and symptoms, and prevention. Secondly, their aim was to determine whether the training workshop had achieved its objectives or that learning did take place. Table 1 indicates that, on average, there was a significant, positive change noted on the level of understanding during post-training assessment compared to pre -training assessment.

**Table 1: Outcomes of pre- and post-assessment of the traditional health practitioners' workshop**

| SECTION                                                               | PRE -ASSESEMENT | POST- ASSESEMENT | CHANGE |
|-----------------------------------------------------------------------|-----------------|------------------|--------|
| Understanding origins of HIV and AIDS                                 | 39%             | 98%              | 59%    |
| Understanding methods of HIV transmission                             | 43%             | 82%              | 39%    |
| Understanding of methods of prevention                                | 53%             | 72%              | 19%    |
| Understanding of signs and symptoms of HIV and AIDS related illnesses | 35%             | 95%              | 60%    |

With regard to participants' level of understanding of HIV and AIDS and signs and symptoms of AIDS, there was a significant difference in terms of pre- and post-assessments (59% & 60% respectively) and modes of transmission (39%). We may attribute this to the African cultural influence over THPs' attitudes as they still believe that traditional methods of prevention and moral regeneration is the best approach towards prevention of HIV transmission. This was evident in the post assessment on methods of

cultural prevention where 95% of THPs chose cultural methods as most effective methods of prevention.

According to the THPs at the training workshop, young people are expected to delay sexual activities until marriage. This facilitated consensus between THPs and the public health approach of abstinence with respect to the transmission of HIV infection. However, THPs go beyond this and discuss traditional ways of prevention that have been recently recognised by scientists. These include male circumcision (not just a surgical procedure but a cultural method of passage from boyhood to manhood), *ukuhlolwa kwezintombi* (virginity testing); a cultural training of maidens to maintain virginity and be proud of their femininity, *ukusoma* (sexual intercourse without vaginal penetration), and use of the traditional condom (*umnwedo*- a genital sheath) introduced by King Shaka for his warriors (Knight and McBride 1989; Harris 1998). Thus, condomisation is not a completely new concept to amaZulu.

This project has been successful thus far in terms of capacity building and creating a better awareness for THPs on the biomedical approach to HIV and AIDS. Moreover, the training has opened a new opportunity for information sharing and knowledge. From the training aspect, particularly role plays, frequently asked questions and comments it has become apparent that there is still a need for cross-cultural information sharing and learning.

The translation of documents which were part of the project will assist the Nelson R Mandela School of Medicine to begin to identify modules that could be developed in isiZulu in terms of concepts and terminology which, in the long run, could be offered in English and isiZulu.

## **General Discussion, Observations and Conclusions**

According to Mapi (2009), when an indigenous language is used as a medium of instruction at an institution of higher learning, such language becomes intellectualized. It is important to note that training was conducted in collaboration with Nelson Mandela School of Medicine, University of KwaZulu-Natal in Durban and the various associations of THPs from eThekweni, iLembe, and uMgungundlovu districts. The training workshops were conducted in an indigenous language (isiZulu) and this is part of the process which may subsequently contribute to the isiZulu language acquiring its intellectual status (Stott & Davis 1979).

The translation of the training manual into isiZulu has served to demystify science and promote a public understanding of science using a local language and concepts (Makgoba 2000). Further the project has contributed to the development of the isiZulu language to include biomedical and scientific concepts and terminology.

The disempowerment of African indigenous languages by the previous South African colonial and apartheid governments who considered them as non official languages and their marginalization by the current democratic South African government during the first ten years of democracy seem to have contributed to the underdevelopment of African traditional healers and subsequent poor health care service delivery in South Africa. This is reflected when Beukes (2004) argues that:

a thorough analysis of developments over the last decade, against the background of 300 years of colonialism, segregation, and apartheid, suggest that language is one of the pivotal factors that will determine the direction in which our society will develop.

Language development, upon which multilingualism for language access and language intellectualization depends, is the responsibility of the South African government which must show political commitment by creating an enabling environment conducive for the promotion of linguistic diversity and respect for the different African indigenous languages (Halliday & Martin 1993). It should, however, be noted that the South African government has shown political commitment by developing a National Policy Framework which forms the basis for the development of previously neglected South African indigenous language (Webb 1992). It is through this National Policy Framework that much effort should be made to ensure that multilingualism for language access and language intellectualization becomes a reality in South Africa. Because of the fact that language is considered the basic instrument for learning, traditional healers were encouraged to use their home language as a language of learning during the training workshop. While traditional healers were able to access information through the language of their own choice, the isiZulu language itself also developed.

Marginalisation of African indigenous languages which are a vehicle of cultural heritage has also denied the HCWs an opportunity to become sensitized to indigenous cultures in a culturally diverse society thus, rendering them culturally incompetent and less effective in their health care practice (Schweitzer 1983; Beukes 2004). Using language policy development which is in line with the objectives of the South African constitution, the biomedical and traditional healer collaboration partners will be able to overcome some of the challenges associated with the African traditional healing system created during the colonial and apartheid era in South Africa, and which also contributed to inappropriate and less effective health care services (Webb 1992). Some of these challenges would include, for example, lack of equality between traditional healing and the biomedical systems in terms of their legal status, lack of development of traditional healers and lack of collaboration and development of mutual tolerance and respect between traditional healers and biomedical health practitioners in terms of their cultural and linguistic diversity (Webb 1992). With the practical intervention of the state, the biomedical traditional healer collaboration partners may be able to help elevate the status and reinforce the use of indigenous languages which is necessary for effective therapeutic interventions.

### **Acknowledgements**

The authors wish to dedicate this paper to the late Makhosi Queen Ntuli and late Baba Mpungushe Pius Shange, Baba Mkhuluwe Protus Cele and Baba Mzomunye Arthur Thabethe. These are THP leaders we have worked with successfully in the development and implementation of this project. This work is supported by the Inter-Agency PEPFAR Annual Programme Statement: US Program Missions to South Africa - under PA 04281. This publication is supported by the CDC U62/CCU024561. The contents are solely the responsibility of the authors and do not necessarily represent the official views of PEPFAR or CDC. Professor Gqaleni is funded by the Department of Science and Technology (DST) and the National Research Foundation (NRF). The views expressed by him do not reflect the official position of DST/NRF.

## References

- Alexander, N 2005. *Multilingualism, Cultural Diversity and Cyberspace. An African Perspective*. Cape Town: PRAESA, University of Cape Town.
- ANC 1994. A National Health Plan for South Africa. URL: <http://www.anc.org.za/ancdocs/policy/health.htm>.
- AU 2007. *The Status of Traditional Medicine in Africa and Review of Progress made on the Implementation of the Plan of Action on the African Union Decade of Traditional Medicine (2001- 2010)*. Proceedings of the Third Session of the African Union Conference, April 9-13 2007; Johannesburg, South Africa. URL: <http://www.africa-union.org/root/UA/Conferences/2007/>
- Beukes, AM 2004. *The First Ten Years of Democracy: Language Policy in South Africa*. X<sup>th</sup> Lingapax Congress on Linguistic Diversity, Sustainability and Peace, May 20-23 2004, Barcelona.
- Goggin, K, M Pinkston, N Gqaleni, T Puoane, D Wilson, J Berkley-Patton & DA Martinez 2009. *The Role of South African Traditional Health Practitioners in HIV/AIDS Prevention and Treatment*. In Pope C, R White, R Malow (eds): *HIV/AIDS Global Frontiers in Prevention/ Intervention*. New York: Routledge Taylor and Francis.
- Gqaleni, N, I Moodley, H Kruger, A Ntuli & H McLeod 2007. *Traditional and Complementary Medicine*. In: Harrison S, R Bhana & A Ntuli (eds): *South African Health Review 2007*. Durban: Health Systems Trust.
- Halliday, MAK & JR Martin 1993. *Writing Science. Literacy and Discursive Power*. London & Washington, DC: The Falmer Press.
- Harris, D 1998. *The Washing of the Spears: A History of the Rise of the Zulu Nation under Shaka and its Fall in the Zulu War of 1879*. Cambridge, Massachusetts: Da Capo Press.
- Kahn, F & W Nzama 2003. Doctors and Healers Sign Memorandum. *The Mercury* October 24 2003.
- Knight, I & A McBride 1989. *The Zulus*. Oxford: Osprey Publishing.
- Makgoba, MWM 2000. *The Makgoba Affair: A Reflection on Transformation*. Florida, US: Vuvlia Publishers & Booksellers.
- Makhathini, ME 2003. *An Investigation into Preventive and Promotive Health Care in the Practice of Indigenous Healers*. Unpublished Masters Dissertation, University of Natal, Durban.
- Mapi, T 2009. Intellectualism of Indigenous Languages. From <http://www>.

- renaissance-mtl.com/133-intellectualism-of-indigenous-languages.
- Morris, K 2001. *Treating HIV in South Africa – A Tale of Two Systems*. *Lancet* 357,9263: 1190.
- NDoH 2007. Speech by Health Minister Manto Tshabalala-Msimang at African Traditional Medicine Day. From: <http://www.doh.gov.za/docs/sp/sp0906-f.html>.
- Ngobese, N 2009. Traditional Healers Team up with Doctors. *ECHO: The Supplement to the Natal Witness* May 7 2009.
- PCH 2009. People's Health Movement. People's Charter for Health. URL: <http://www.phmovement.org/charter/pch-english.html>
- Pretorius, E 1999. *Traditional Healers*. In Crisp N, A Ntuli (eds): *South African Health Review 1999*. Durban: Health Systems Trust.
- Schweitzer, RD 1983. *A Phenomenological Explication of Dream Interpretation among Rural and Urban Nguni People*. Unpublished Doctoral Thesis, Rhodes University. Grahamstown.
- South Africa 2000. Government Gazette. *The Promotion of Access to Information Act No 2 of 2000*. Pretoria: Government Printer.
- Stott, NCH, & RH Davis 1979. The Exceptional Potential in each Primary Care Consultation. *Journal of the Royal College of General Practitioners* 29: 201-205.
- Webb, VN 1992. *Language Policy Development in South Africa*. Pretoria. The Centre for Research in Politics of Language: University of Pretoria.
- WHO. 2000. *Promoting the Role of Traditional Medicine in Health Systems: A Strategy for the African Region 2001-2010*. From <http://apps.who.int/medicinedocs/en/d/Js2297e/11.html>.
- WHO. 2001. *World Health Organization Welcomes OAU Declaration on Traditional Medicine*. From <http://www.afro.who.int/press/2001/pr20010820.html>.
- WHO. 2002. *Traditional Medicine Strategy 2002-2005*. From [http://whqlibdoc.who.int/hq/2002/WHO\\_EDM\\_TRM\\_2002.1.pdf](http://whqlibdoc.who.int/hq/2002/WHO_EDM_TRM_2002.1.pdf).
- WHO. 2003. *Traditional Medicine*. From <http://www.who.int/mediacentre/factsheets/2003/fs134/en/>.
- WHO. 2005a. *National Policy on Traditional Medicine and Regulation of Herbal Medicines: Report of a WHO Global Survey*. From [http://www.correofarmaceutico.com/documentos/190905\\_plantas.pdf](http://www.correofarmaceutico.com/documentos/190905_plantas.pdf).

WHO. 2005b. *Programmes and Projects: African Traditional Medicine*.  
From [http://www.who.int/medicines\\_technologies/trm\\_day/en/](http://www.who.int/medicines_technologies/trm_day/en/).

Nceba Gqaleni, Nelson R Mandela School of Medicine,  
University of KwaZulu-Natal

Mqansa Makhathini, Edendale Hospital, Pietermaritzburg

Nompumelelo Mbatha, KwaZulu-Natal Traditional Health Practitioner

Thanile Buthelezi, KwaZulu-Natal Traditional Health Practitioner

Tobias Mkhize, Health Unit, eThekweni Municipality

Verona David, Nelson R Mandela School of Medicine, University of  
KwaZulu-Natal

Soornarian Naidoo, Nelson R. Mandela School of Medicine, University of  
KwaZulu- Natal

Indres Moodley, Nelson R. Mandela School of Medicine, University of  
KwaZulu- Natal