



## HIV/AIDS: Traditional Healers, Community Self-assessment, and Empowerment

**M**ost African countries have ratified the *African Charter on Human and People's Rights*, which states the rights to health, education, and "promoting, safeguarding, and reinforcing mutual respect and tolerance." In Sub-Saharan Africa alone, some 17.2 million have died of HIV/AIDS which includes some 3.7 million children under the age of 15. Fighting the disease has so far concentrated on prevention, and only limited attention has been directed towards treatment and the social and human rights aspects related to the pandemic. This seems to put the Charter to the test. Although several western pharmaceutical companies have lowered expenses for HIV/AIDS retroviral treatment, these medicines are still beyond the reach of most Africans. And even if medicine was provided free of charge, countries in Sub-Saharan Africa lack the medical infrastructure to distribute the medicine, and it is doubtful if health systems can be expanded at the speed and quality required. Finally there is a high risk that the resources allocated to fight the disease will not be fully accessed by the beneficiaries for whom it was intended. The focus here is, therefore,

on how traditional healers and indigenous knowledge can empower communities to deal with the social consequences of the pandemic, and, at the same time, be able to ensure that government resources are actually being used to their benefit.

U.N. Secretary General Kofi Annan asked recently for an addition of \$7 billion to \$10 billion per year as a minimum transfer from rich countries to Africa to fight HIV/AIDS. But some experts in the region says that even such sums will have little impact until African nations build up their health systems to administer the drugs and monitor the health of those receiving them. The formal health care system only

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reaches 10 to 20 percent of the people, and those mainly in urban centers at hospitals and clinics. Traditional healers provide primary health care for 80 percent of the population and live in the communities where help is needed; they are the ones who today treat many patients for HIV/AIDS-related diseases. Some healers have already been successful in extending the lives of patients with HIV/AIDS using medicines they from locally grown medicinal plants. A good example is the work being done near Tanga in Tanzania.

Should Western medicine finally become available at affordable rates to poor communities, traditional healers could be the ones to distribute the medicine and ensure that patients take the right doses. While traditional healers will need to be educated to do this, it will be less expensive to upgrade their knowledge than to expand the formal health system. Building on existing systems seems to have a higher chance of sustainability.

HIV/AIDS does not respect boundaries of class, culture or race, but lack of knowledge and misconception on how the

disease is transmitted from one person to another often result in human rights violations by exclusion or isolation of individuals and families with HIV/AIDS. And the social effects affect the poor the most. Many communities have become aware that HIV/AIDS is transmitted via blood and sexual intercourse, but there is also a widespread misconception that transmission occurs by shaking hands, eating or bathing together, wearing the same clothes, using the same tools, or for children sleeping in the same bed. Education and information on how HIV/AIDS is being transmitted has so far been the core initiative in fighting the disease. Little attention has been directed towards lifting the social stigma related to the pandemic in spite of the fact that “what we cannot speak about we can do nothing about.” Individual and social empowerment is essential for communities to handle the challenge, which is mainly left to them in the HIV/AIDS crisis. Moreover, when resources for the World Bank-assisted Multisector Aids Program (MAP) initiatives begin to flow, communities should be empowered to access and monitor resources intended for them. A very useful tool of empowerment was applied in the transitional period from apartheid up to the election in South Africa where NGOs and civil rights organizations managed to mobilize communities all over the country. The campaign was the largest ever undertaken anywhere at the time. The method was rooted in the facilitation of communities to create their own human rights charter based on democracy and respect for individuals of all races (Dorsey 1997). The idea was based on Paulo Freire’s democratic proposals of problem-solving education where “men and women develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as a static reality but as a reality in the process of transformation” (Freire 2000).

To apply the successful experience of social mobilization in the fight against HIV/AIDS, a mini epidemiological study has to be undertaken *by community members and for the community*. Traditional healers (especially women healers) could be key facilitators in this process. What is important in community-managed research is the process its members go through, which differs fundamentally from a social assessment in which data collection is the most important. The

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process of community-managed research could be facilitated, apart from the traditional healers, by a local NGO/CBO to balance any attempt by local elites to dominate the process. Among the issues to be dealt with are the following:

- Where does the community think HIV/AIDS comes from?
- How does a person get the disease?
- Are there particular places where the risk for getting the disease is high?
- Are there many community members who often go to these places?
- Are there particular groups at high risk?
- Who in the community are seriously ill?
- What occupation did the ill persons have at the time they became ill?
- Has there been change in the person(s)' occupation since they became ill?
- How have the symptoms developed over time?
- Who did they contact when they first fell ill?
- Did they get some medical help and where did they get it?
- Has their social conditions changed after they became ill and how has it changed?
- What happens to a family (socially and economically) that has a member with HIV/AIDS?
- What initiatives have been taken by the community, by the government, or by the municipality/district in relation to the HIV/AIDS pandemic?
- Is anybody aware of resources for which the community can apply in order to fight HIV/AIDS?

The aim of such community research is: (i) to begin a process within the community to focus on HIV/AIDS, so as to enable people to talk about the disease; (ii) to increase awareness that the disease is not an abstract phenomenon talked about on the radio but something concerning members of their own community; (iii) to get personal stories which may help others in the same situation; (iv) to raise awareness among risk groups; (v) to make the disease become a concern for the community—e.g., on how the disease can be prevented and how the patients and their families including orphans can be helped; and, finally and very important, (vi) *facilitate the community to formulate their own Bill of Rights*. Each Community Bill of Rights will have unique features depending on the particular local conditions. But what the communities have agreed upon they will also be eager to enforce and to install social sanctions against those who violate what is in the best interest of the community as a whole.

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“Charter Making and Participatory Research” by Ellen Dorsey in *Human Rights Education for the Twenty-First Century* edited by George J. Andreopolos and Richard Pierre Claude, University of Pennsylvania Press, Philadelphia 1997.  
*Pedagogy of the Oppressed* by Paulo Freire., 30<sup>th</sup> Anniversary Edition, Continuum, New York 2000.

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