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**Adaptations, alterations and shifted  
strategies: the pragmatics of  
knowledge transfer in HIV and AIDS  
interventions in South Africa.**

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# Adaptations, alterations and shifted strategies: the pragmatics of knowledge transfer in HIV and AIDS interventions in South Africa.

## Abstract

*The historical relationship between western and traditional health practitioners in South Africa was always uncomfortable and remote. This paper does not rehearse the complex colonial history of this disjunction, but rather focuses on some of the effects of that history on contemporary medical relationships, especially concerning interventions in the prevention and treatment of HIV and AIDS. The controversy about the rights of HIV positive patients to choose 'traditional' African remedies over biomedical antiretroviral drugs (ARVs) is considered first. The paper argues that by attaching the notion of 'pseudoscience' to traditional medicine in this debate AIDS activists' are reproducing an unhelpful contemporary version of the familiar 'scientific knowledge' versus 'traditional belief' dichotomy, an attitude that alienates traditional health practitioners and discourages useful dialogue and cooperation.*

*The paper then introduces ethnographic coverage of an HIV/AIDS intervention in the Western Cape Province, in which Xhosa traditional health practitioners (THPS)<sup>1</sup> have adopted and adapted the techniques of HIV/AIDS counselling, and advocacy of HIV/AIDS testing and ARVs, into their conventional practice. The testimony of the healers themselves is used to discover the effects of this process of medicalisation and the extent to which it has changed the THPs' relationship – real and perceived – with western medicine. The paper will show that although these THPs are eager to be involved with western medicine, this does not constitute surrender to a superior system, but is simply a pragmatic act of conciliation in the face of the HIV/AIDS epidemic. In their practical approach, the healers can be recognised not as 'ignorant' or naïve, but*

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<sup>1</sup> The use of the term 'traditional' is contested in academia, but less so by the practitioners themselves. Several different categories of healers practice in South Africa; the *amagqirha* who feature in this paper (Xhosa pl.; sing. *igqirha*; Zulu sing. *isangoma*, pl. *izangoma*.) are diviner-healers who achieve their diagnosis and remedies through communication with ancestral spirits (Wreford 2008b).

*realistic. The paper argues that the ‘ignorance’ and ineptitude of which traditional practitioners are often accused is in fact a consequence of the disinterest shown by western medicine towards them.*

## **Introduction**

The relationship between western and African medical paradigms - characterised generally by mistrust and disengagement - has been appropriately described as ‘disjunctive’ (Good 1994). It is a condition that generally holds true in contemporary South Africa. This paper will not rehearse the complex colonial history of the disjunction (it has been comprehensively analysed by historians (see for example Crais 2002; Digby 2006)), but rather focus on some of the *effects* of that history on contemporary medical relationships, especially involving interventions in the prevention and treatment of HIV and AIDS.

The paper considers first the controversy about the rights of HIV positive patients to choose ‘traditional’ African remedies over biomedical antiretroviral drugs (ARVs). This vociferous debate has seen treatment activists unequivocally allying themselves with biomedicine, in opposition to traditional health practice. The paper argues that the activists’ adoption of the duplicitous notion of ‘pseudoscience’ in this confrontation is a contemporary and obstructive version of the familiar ‘scientific knowledge’ versus ‘traditional belief’ dichotomy. The argument is framed by the contrary government stance towards medical treatment of HIV/AIDS that resulted in the hopelessly inadequate response to the provision of antiretroviral treatments for AIDS (ARVs) on the one hand, and the promotion by the then minister of health of remedial treatments (often misrepresented as ‘traditional cures’), on the other.

The paper then introduces a more optimistic scenario, based on ongoing ethnographic coverage of an HIV/AIDS intervention in the Western Cape Province, in which Xhosa traditional health practitioners have taken up the techniques of HIV/AIDS counselling, and advocacy of HIV/AIDS testing and ARVs, as part of their conventional *ukuvumisa* (Xhosa: divination) practice. The results suggest that, given reciprocal attention and respect, there is indeed potential for the transformation of contemporary medical relationships in South Africa. The testimony of the healers themselves is used to discover how they have processed and understood their new medicalised knowledge, how it has affected their practice, and the extent to which it has changed their relationship – real and perceived – with western medicine. Although participants from the public health service and from the organisers of the project are heard, the words

of the healers themselves are paramount, a shift in focus that is manifestly different to that of most historical records (Digby 2006: 278).

The research approach, which uses ethnographic methodology to interact directly with the traditional practitioners' healing knowledge and environment, is characterised as advocatory and mediatory.<sup>3</sup> It reflects on the practitioners' experiences and attempts to develop additional research strategies with the participants. The objective of the research is to encourage constructive dialogue between health paradigms in the face of the HIV/AIDS epidemic.<sup>4</sup> The paper suggests that mediations such as this act as a sort of history-in-the-making, and may advantage the efficacy of western medical interventions, especially those involving HIV/AIDS.

## **History re-made: treatment choices, drug interactions and 'pseudoscience'**

The historiography of medicine is of obvious contextual importance in understanding the bias towards scientific medical care in South Africa that is so evident in the debate about treatment for HIV/AIDS. Remarkably perhaps, the indifference, suspicion, and animosity that were characteristically shown by colonial medical personnel towards traditional practitioners in South Africa persist into the present.<sup>5</sup> It continues to encourage a remote relationship that implicitly discounts any potential advantages to collaboration with the traditional sector. The reciprocal approach, based on 'an open exchange of information and experiences... [with] fellow health-care professionals' (UNAIDS 2006: 6), is exceptional. In South Africa, most collaborative initiatives have been one-sided and uni-directional, so that even those traditional practitioners involved in collaboration become disillusioned (Wreford 2005b). Many are sufficiently alienated by western medical indifference to resist any suggestion of co-operation, even in the face of the HIV/AIDS, a position that prejudices, amongst other things, potential research into the traditional pharmacopoeia in the development of remedies for the disease (Wreford 2008b: 70-75).

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<sup>3</sup> Participative research interventions elsewhere have been described as 'action research' (Grundfest Schoepf 1993), and 'Participatory Action Research' (Squire 2007).

<sup>4</sup> It is accepted that a participative approach such as this is ineffective unless it is linked to supportive policy change (Squire 2007: 60). The HOPE initiative is a small pilot project and the response of the Provincial Health Authorities to its findings is uncertain.

<sup>5</sup> There have been notable exceptions (Conco 1979), and as Digby and Sweet demonstrate, African nurses have often acted as 'culture brokers' between patients and western trained medical doctors (2002).

Any discussion about treatment for HIV/AIDS in South Africa must, of course, take account of the contemporary context of the government's response to the epidemic. Characterised by policy statements that were frequently confusing and always prevaricatory (Fourie 2006: 159-163; Makgoba 2003; Natrass 2006), the rollout of ARVs remains fragmentary and inadequate. 'Denialist' declarations repeatedly threw doubt on the executive's commitment to engage with 'the scope and seriousness of the pandemic' (Whiteside and van Niekerk 2005: 34). The then minister of health's apparent encouragement of entrepreneurial interventions that cynically exploited vulnerable and desperate clients whilst falsely adopting the authority of the 'traditional healer', did particular damage to cross-cultural medical relationships.<sup>6</sup> Persuaded by the minister's (often misapplied) use of the 'traditional' label, some traditional health practitioners supported such claims to 'cure'. This alienated the medical fraternity,<sup>7</sup> and enabled an already sceptical scientific community to deny to *all* traditional practice any substance or reality.

Provoked by government's negligence and apparent indifference to the plight of those living with the disease, the Treatment Action Campaign (TAC) - historically allied with western medicine - insists on the provision of ARVs as the 'only scientifically tested' treatment for AIDS.<sup>8</sup> Naturally, the organisation's advocacy of ARVs - and its exclusively biomedical position - is to a large extent consequent on its dependence on western medicine. However, it is also informed by assumptive notions about traditional practitioners that inhere in the historically dysfunctional relationship between medical doctors and traditional health practitioners. The upshot is that treatment activists tend to project a generally uneasy, often patronising, and sometimes hostile attitude to the role of traditional practitioners in the provision of treatment for the epidemic (Geffen 2007), a 'blinkered' approach that is typical of scientific medicine, but rarely acknowledged (Leach et al 2005: 7-8). This paper does not seek to challenge the TAC's campaign for timeous ARV treatment,<sup>9</sup> but to encourage a more inclusive approach to treatment, especially of HIV.

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<sup>6</sup> The case of the Rath Foundation in Khayelitsha, Cape Town, is notorious (Natrass 2007: 146-155).

<sup>7</sup> Some unscrupulous academics have also been tempted to claims of 'anti-HIV' remedies (Thamm 2006).

<sup>8</sup> The administration's resistance to implement a comprehensive ARV treatment roll-out - promised since 2003 - naturally enraged treatment activists.

<sup>9</sup> Nonetheless, examined in the light of South Africa's parallel health care system, the organisation's rhetoric asserting 'proven' western medicines against 'untested substances' is markedly uncompromising (Hassan and Heywood: 2007). In South Africa biomedical aspirations to equality of treatment have fallen very short (Dubow 2000); but even in the west, where western medicine can more legitimately claim dominance, language that appears to deny freedom of choice over treatment would be questionable. In the context of South Africa

The long-running and acrimonious dispute concerning the treatment of HIV and AIDS in South Africa has been particularly acute in the debate about patient decision-making. Influenced by longstanding but often unverified western medical ‘beliefs’ about traditional healing practice, treatment activists have, in common with activists throughout the world (Biehl 2007; Wynne 2005: 77-78) advocated for an exclusively biomedical treatment solution to the epidemic. In South Africa AIDS activists have gone further, characterising as ‘pseudoscience’ all other approaches (Geffen 2007), and implying a ‘denialist’ position to those who defend or prefer them (Natrass 2007b). This attitude not only appears to deny to patients their right to choose their therapeutic regimen,<sup>10</sup> but, ironically, rarely involves the traditional health practitioners who are key players in the debate.

The reliance on the ‘scientific’ position additionally tends to overlook several practical and social realities. First, there is the fact that there exists in South Africa a parallel health environment in which patients experience western medicine as just another treatment agency, to be used pragmatically and appropriately, but not exclusively.<sup>11</sup> Secondly, it is important to be aware of the history of the extreme partiality of colonial health services in the treatment of the black population in South Africa - notably in this context in the treatment of epidemic sexual disease (Jochelson 1999), which to a large extent explains the enduring doubts and suspicions shown by black Africans about the practice and motivation of biomedicine (Fassin 2007). Finally, as Biehl discovers in his study of HIV/AIDS treatment in Brazil, the position typifies scientific medicine’s tendency to concentrate on the pathology of disease: ignoring the contexts of extreme poverty in which ARVs are administered and received, doctors often seem to ‘forget the world’: (2008: 348-352).

The deleterious effects of the alleged dichotomy between scientific ‘knowledge’ and indigenous ‘belief’ on relationships between western medical and traditional

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it simultaneously denies the existence of the parallel but separate traditional service, and refuses patients the democratic right to make their own treatment decisions.

<sup>10</sup> By way of context, it is important here to acknowledge a basic fact: neither western medicine nor the traditional system is presently able to cure HIV/AIDS. While this situation prevails, in an already medically pluralist environment, it is surely valuable to utilise both paradigms. As I have argued elsewhere, independence of treatment choice is likely to be especially worthwhile in the earlier stages of the disease, when many patients already prefer to consult a traditional healer. Arguably, since western medicine has relatively little to offer in these early stages, and there are no documented contraindications between biomedical and traditional therapies, it could well be preferable to employ traditional herbal remedies over antibiotics, for example, with their depletive effect on the immune system.

<sup>11</sup> Although the figures are contested, estimates regularly suggest that up to 80 percent of the South African population consults with traditional health practitioners.

paradigms have been described comprehensively (see especially Good 1994). I suggest that the TAC's blanket denunciation of traditional medicinal preparations and their practitioners as 'pseudoscience' (Geffen 2007) represents (albeit unconsciously) a contemporary perpetuation of this historical contestation of knowledge. The proposition 'pseudoscience' of itself suggests that 'non-orthodox' remedies (Nattrass 2007a: 123), inhere in belief rather than scientific fact, and for lack of scientific verification these treatment options stand condemned. This may be a valid argument, notably in cases like those of Matthias Rath or Zeblon Gwala, whose claims to 'traditional' status are in any event spurious (McGreal 2008). However, in their enthusiasm to expose 'quacks' and 'charlatans' in the debate about treatment, the activists carelessly impute the same 'pseudoscientific' – and therefore inadmissible - impulse to *all* traditional practitioners and their therapies. Thus, they attempt a blanket condemnation of all traditional medicines for the disease, describing them as 'deadly' (Geffen 2007), a tit-for-tat response that seems little more scientific than the then minister of health's description of ARVs as 'poison' is (Garrett 2002). The TAC rightly asserts that Rath (who is *not* a traditional health practitioner) has deterred some patients from maintaining ARV regimens. But, in making indiscriminate statements about the universal danger of traditional remedies, its rhetoric similarly undermines the confidence of patients who may actually prefer the traditional paradigm, and are consulting genuine traditional practitioners for relief.

Curiously, the scientific generalising of the TAC and its dismissal of all traditional practice as inherently dangerous in the context of treatment is itself presented against an apparently confused interpretation of the actual science of HIV and AIDS. HIV/AIDS is a disease of stages: in the three early phases it may be asymptomatic, or characterised by recurrent, but not necessarily life-threatening 'opportunistic' infections, resulting from the progressive depletion of the immune system. During this period, which I have elsewhere called 'the treatment gap' (Wreford 2005a: 66), western medicine has very little by way of therapies to offer patients. Significantly also - in the consideration of the efficacy and safety of traditional remedies - there is as yet no scientific evidence of any contraindications with the range of treatments that are utilised by traditional practitioners to treat opportunistic infections. Contraindication only becomes a possible problem in the fourth stage, when the immune system is so undermined that almost any infection may become lethal, the patient is recognised as having 'full-blown AIDS', and ARVs may be prescribed. In this phase, and only when the patient is taking ARVs, laboratory tests have suggested some potential contraindications between ARVs and some of the herbs used by traditional medicine to boost the immune system (Cohen et al 2002; Mills et al 2005). Thus, the conflation by the TAC of traditional

treatments that appear to be effective for infections associated with early-stage HIV and have no known side-effects on biomedical drugs, with treatments for AIDS and the possible undermining of ARVs, presents a damaging and unwarranted condemnation of traditional practice, which further undermines the potential for constructive engagement in the epidemic.

Is it unsurprising then, that some traditional practitioners (and their patients) interpret this medical fundamentalism from the TAC and its allies as hostile, and indeed, as a scientific version of AIDS denialism?<sup>12</sup> The scientific position after all implicitly denies that the traditional practitioners possess any empirical knowledge based in their surgery experience of HIV and AIDS. In all the discussions about ‘choice’, moreover, there is a disconcerting tendency to patronise patients, and deny their right to choose their therapeutic regimen. It may be the case that some people are alienated from science and technology ‘because they cannot understand it, probably due to inadequate science education’ (Geffen 2007: 34). However, the TAC should also recognise that other patients – mindful perhaps of the distinctly partial history of the provision of western medicine in South Africa mentioned earlier - might in reality prefer to put their trust in traditional practice over scientific medical solutions.<sup>13</sup>

Blanket accusations that traditional remedies ‘[do] harm to others’ (Geffen 2007:18-19) furthermore repudiate the reality that it is the patients who, in the event of any illness, pilot their own treatment response and often use traditional and biomedical solutions interchangeably. Self-medication has long been recognised as a component of health seeking behaviour in South Africa (Cocks and Dold 2000); the pressures of urban and rural poverty have only encouraged the practice (Digby 2006). As Squire discovers, in the case of HIV/AIDS, the self-care approach by patients constitutes less a repudiation of biomedicine *per se* than a ‘pragmatic negotiation of the possibilities within the epidemic’ (2007: 89-90). Finally, whilst western medicine and activists are quick to place the blame for ‘harming’ on the ignorance of the traditional practitioners, biomedical disengagement from this cohort of healers recognised as health professionals within their communities denies the potential of a respectful and useful debate about differences in medical interpretations and practice as they relate to HIV and AIDS. Can this uncomfortable contestation of medical knowledges arrive at a different outcome? The remainder of this paper examines one instance of

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<sup>12</sup> One of the most damaging factors in the encouragement of a broader and more democratic debate on the subject of treatment is the reality that to be seen or heard defending traditional practice in the context of HIV and AIDS is so readily equated with AIDS denialism (Fassin 2007: Chap3)

<sup>13</sup> A recent survey in rural Kwa-Zulu Natal suggests that the preference for traditional treatment for HIV/AIDS against biomedical drugs is remarkably pervasive (HSRC 2008).

cross-cultural medical relationships in South Africa and presents evidence that suggests that this is indeed possible.

## **Raising the bar: experiences of collaboration in the Western Cape Province**

Although the provincial health authority in the Western Cape has pioneered HIV/AIDS treatment (Naimak 2006), the HOPE project is the first intervention in the province to include traditional health practitioners. Run on a limited budget, this small pilot scheme was established in October 2005 with three main aims: to encourage medical collaboration and cross referrals between *amagqirha* and western medicine in HIV/AIDS interventions; to avoid potential disruptions to ARV regimens through prescriptions by traditional healers, and to persuade more male clients to test. Nine *amagqirha* were recruited to the project to work with five HOPE Community Health Workers (CHWs) in five peri-urban settlements on the outskirts of Cape Town.

The scheme was initiated at Tygerberg Academic Hospital with a six-week course that included education in biomedical understandings of HIV/AIDS and its treatment. Emphasis was placed on the possible contraindications between some traditional remedies and ARVs and the *amagqirha* were advised to avoid invasive treatments where they suspected a depleted immune system. Then followed four weeks of Voluntary Counselling and Testing training (VCT). In the final week the *amagqirha* were prepared for their new role as counsellors. To monitor the success of referrals, they learned how to complete Referral Forms, which clients were to present to CHWs at the clinics, and how to maintain a client register whilst ensuring client confidentiality. After the course, the participating *amagqirha* and CHWs returned to work in their communities.

Three THPs are now liaising with local clinics in Mfuleni, Wallacedene and Delft South, and results already demonstrate success for HOPE's main objectives.<sup>14</sup> Since the project's official inauguration in March 2006, a total of 186 clients have been referred for testing.<sup>15</sup> Nearly fifty percent of the referrals

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<sup>14</sup> As might be expected, the project was not without difficulties. For coverage of the development of the scheme and obstacles encountered, see Wreford et al 2006; 2008.

<sup>15</sup> These numbers are certainly understated: the *amagqirha* registers show that more patients have been referred than have arrived for testing. In some instances, this may be explained by patients' deciding after all not to test. However, a positive diagnosis of HIV/AIDS still attaches enormous stigma in South Africa, and to avoid this patients often opt to visit clinics remote from their homes where the project is not recognised.

are male, a figure that is considerably higher than obtained by the health centres, and suggests that the *amagqirha* are providing a valuable connection between male clients and the clinics. Finally, the *amagqirha* have established bonds with the clinics, and as the testimonies that follow suggest, some staff approve their involvement and would support the enrolment of more healers in similar initiatives. The fieldwork examples included below describe the response of the *amagqirha* to the acquisition of this biomedical knowledge. The excerpts demonstrate the remarkable capacity of traditional practitioners to adopt an eclectic and conspicuously generous inclusiveness in their interpretation of the knowledge of healing. They suggest an approach that is often pragmatic but surprisingly unproblematic, and which always prioritises the well-being of the patient.

## **A thirst for knowledge and recognition**

What prompted the *amagqirha* to participate in this intervention? Several explanations are offered, but three common themes emerge. The first concerns the healers' enthusiasm for new knowledge - a point that has often been mentioned in the literature on collaborative projects, but that is generally underestimated, especially by western medicine (Green 1994; Leclerc-Madlala 2002). *Igqirha* Nomonde for example, portrays herself in this regard as being 'thirsty for knowledge', a response that is largely driven by her desperation in the face of the epidemic. Lyrically, she describes the doctors on the course as 'like singing - because I know nothing'. *Igqirha* Nomvuyo expresses her determination to understand even more frankly: 'I wanted to know', she says. All of the healers refer, obliquely or overtly, to the importance of understanding how western medicine understands the virus, means of infection and prevention, and how antiretroviral medicines work, information that, as Nomonde expresses it, 'was very dark for us' before the HOPE experience.

A second, associated theme concerns the traditional practitioners' enthusiasm for the idea of 'working together' with their western-trained counterparts. Although this is by no means a universal position, several of the *amagqirha* on the HOPE course emphasise the point. 'Traditional doctors and western doctors need to work together so that we can learn from one another' remarks Nomvuyo. Putting her point in the context of HIV/AIDS Nomonde emphasises that 'it would be a good idea if western doctors worked closely with *amagqirha* because we all want to fight the disease.' The fact that this expectation is often envisioned in quite unrealistic terms in respect of western medicine (see for example Summerton 2006: 309) does not make it any the less potent for the healers. For instance, Nomonde expresses her professional standing vis a vis

western trained doctors as being: ‘almost on the same level as a medical doctor’, an equivalence that makes sense to her given the length of her training and her ancestrally gifted knowledge of healing,<sup>16</sup> but which many medical professionals – citing the science and belief dichotomy discussed earlier - would find absurd.

These and similar aspirations are commonly heard from traditional practitioners and have been recognised by medical anthropologists (Good 1987): that they fall on deaf ears in the biomedical environment is a source of frustration and disappointment. Conceivably, western medicine misinterprets this thirst for knowledge as capitulation: recognition by the healers of the superior science of modern medicine. Reverting to the notion of a welfare driven science operating universally as an ‘instrument of salvation’ (Melzack-Jasanoff 2005: 190-191), western-trained doctors perhaps read the traditional practitioners’ enthusiasm for co-operation as a form of conversion to ‘the gospel of Western medicine’ (Ranger 1981: 271). As a professor of medicine at Tygerberg Academic Hospital commenting on the effects of the HOPE project put it to me: ‘They have given up their old ideas’. However, this is not at all how the traditional practitioners read the situation.

The healers’ enthusiasm for working together with western medicine does not imply subservience, or submission to a dominant paradigm, nor does their desire to learn about what western medicine has to offer challenge their confidence in the provenance of their healing skill, or the ‘seeing’ gifts bestowed by their ancestors. Rather, especially in the context of HIV/AIDS, the traditional practitioners’ desire to learn is focused on their acute awareness of the devastation being wrought by the epidemic. The determination to work with western medicine is another pragmatic negotiation in the face of the disease, driven by a powerful healing vocation. As Nomonde puts it: ‘All I want is for people to be cured and to be helped.’ Taken in this light, the healers’ co-operation is entirely practical: it constitutes a means to an end. Simply put, the *amagqirha* are prepared to accept that the knowledge that western medicine possesses about the virus can assist them in their practice. This does not constitute surrender. On the contrary, it is a position that is reminiscent of the earliest aspirations of colonial medicine, and suggestive of its unrealised ideal of the achievement of ‘better and more diffuse well-being’ for all (Denoon 1988:121).

‘Working together’ is a notion that insists on co-operation: unsurprisingly therefore, the question of cross-referrals is an important objective for the healer participants in the HOPE initiative. Nomonde puts this succinctly: ‘We want to

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<sup>16</sup> The ‘calling’ to become an *igqirha* is processual and may last several years. See Wreford 2008b: Chap 4.

come up with a proper referral system between traditional healers and the clinics.’ ‘Proper’ in her view means a system that - quite unlike the ‘one-way street’ approach that typifies most current practice - goes in both directions and operates from a core of mutual respect. Traditional practitioners are generally not averse to referring their clients to medical facilities.<sup>17</sup> In contrast, and much to their chagrin, biomedical personnel rarely cross-refer. The next comment, from a Xhosa nurse, suggests that collaboration is too often seen as operating in one direction only:

‘I think it is a good idea because our people do go to traditional healers and some of them [healers] they don’t believe in HIV so if there are traditional healers who are working to encourage people to come to the clinic to test, that is very good.’

Fieldnote: 18.06.07

This response came as part of a group meeting of clinic staff in the clinic building, a biomedical environment in which the nurse may well have felt it injudicious to show too much enthusiasm for interactions with traditional practitioners (Digby and Sweet 2002: 124). On occasion this can go further: in the early days of the HOPE project the *amagqirha* discovered clinic staff advising patients attending for HIV testing – patients who have been referred by the *amagqirha* and would have been unlikely to attend without their intervention – not to return to the traditional practitioner. Obviously, this threatens the livelihood of the healers, and is a considerable disincentive for them to continue their collaboration.

Some nursing staff are now more ready to acknowledge the important role played by the *amagqirha* in the HOPE scheme. Nomonde here describes how the nursing staff at the local clinic directly refer patients to her surgery:

‘There are people who are referred [to me] by the nurses to come for counselling, more especially the Xhosa-speaking nurses...I’ve got a very good relationship with the people working there [at the clinic]’.

Interview: 23.03.2006.

This picture is reflected by Nomboniso, who reports that ‘the nurses from the clinic know that I helped many patients, so I don’t see any problems with medical staff.’ She later underlines a growing confidence in her role:

‘because of my close contact with the nurses if I realised that the patient is very weak I will send them to the clinic. When the patient

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<sup>17</sup> Indeed, as I have described elsewhere, medical accusations that traditional practitioners deliberately delay the appearance of AIDS patients at health centres may be grossly exaggerated (Wreford 2008a).

has regained energy and feels better I will give them traditional medicines.’

Interview 25.02.06

Since this remark seems to suggest that clients were taking traditional medicines and western medicines conjointly, I then asked whether the clinic staff were aware of this situation. Her answer is opaque, and gives a flavour of the sorts of tensions that exist, especially within the ranks of the black African nursing profession, on the issue of traditional healers (Digby 2006: Chap 6; Digby and Sweet 2002):

‘I am not sure but I suspect that they know because I am the one who refers the patient to the clinic, then they send the patient back to me. I think they know I will give a patient traditional medicines because the client came to me first for help.’

Interview: 26.03.06

Here is confirmation of the porosity of the boundaries between traditional and western medical paradigms and a demonstration that nursing staff are willing to adopt a ‘liberal’ attitude to traditional healers and their remedies, acknowledging and even encouraging the so-called ‘healing itinerary’ that infuriates activists and western-trained doctors but makes pragmatic sense to HIV/AIDS patients (see for example Squire 2007).

However, in this testimony Nomboniso is also seen to be marking her own territory. As indicated in the earlier discussion about the healers’ reasons for collaboration with biomedicine, the *amagqirha* do not accept their induction into western medical understandings as a capitulation, but rather as a genuine, and hopefully reciprocal, cross-cultural process aimed at the well-being of their clientele. Accepting this premise it seems quite logical to Nomboniso that patients whose attendance at the clinic was, after all, dependent on her advice and counsel, should return, or better still be referred back to her, because as she put it ‘[they] came to me first for help.’

## **Adaptations, alterations and strategies: the pragmatics of knowledge transfer**

It is apparent that considerable potential for adaptation, alteration, and even hybridisation exists in the sort of collaboration that the HOPE project represents.

Significant issues arise here for the traditional practitioners,<sup>18</sup> for instance: how do the *amagqirha* comprehend the biomedical aetiology of HIV/AIDS? How do they communicate their new understanding to their clients? Has this medicalising changed the way they previously understood causation? A second topic relates to the effects of the *amagqirha* involvement in the HOPE project on their *ukuvumisa* practice, and the changes, if any, that they perceive in consequence. Space does not allow for a detailed consideration of these questions but one or two examples will serve to illustrate.<sup>19</sup>

The *amagqirha* participants in the HOPE initiative generally adopt a pragmatic, and distinctly malleable, approach to the aetiology of HIV and AIDS, and opportunistic infections, in which they broadly acknowledge biomedical interpretations of the disease,<sup>20</sup> but simultaneously employ ‘local’ understandings to make sense of the situation. In a discussion of a case of HIV associated tuberculosis (TB)<sup>21</sup> for example, Nomonde, starts with an accurate description of the biomedical symptomology of the infection in her client; she then remarks that in this instance it had been caused by ‘this man drinking too much cold beer’. The linkage she makes here between excessive alcohol consumption and HIV/AIDS is uncontested (see Kiene et al 2008 for example) – but for Nomonde it is the fact that the beer was cold that creates the problem. Whilst she had understands the environmental factors that contribute to the spread of TB,<sup>22</sup> her theory of causation accepts notions that are more sympathetic. Thus ‘if they drink the beer warm it would be better’, she says. To Nomonde, the temperature of the beer is a crucial factor – drinking cold beer on a cold day (the interview was held in the winter) in a cold and damp shack provides a logical explanation for the onset of the lung infection.

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<sup>18</sup> As Biehl, Squire, Leach and others have pointed out, the same is true for western medical practitioners. This apparent truism however is rarely acknowledged (2008; 2007; 2005).

<sup>19</sup> The topic is the subject of ongoing research.

<sup>20</sup> It is important to note at the outset that the biomedical information on the course was all produced and conveyed in English, an immediate handicap for a group of traditional practitioners none of whom had the benefit of advanced level education, and whose grasp of the English language (let alone that of biomedicine) was at best, sketchy. The project organisers tried to make up for this by using the CHWs to translate, but it was clear that much of the detail was ‘lost in translation’. See Wreford et al 2006: 14-16.

<sup>21</sup> On average, each of the participating clinics see 4,500 patients each month. Of those who test positive for TB, approximately 50 percent are also HIV positive.

<sup>22</sup> As an airborne infection, especially in winter, the township shack, where one family of several people commonly shares a tiny space, creates an ideal environment for the spread of the disease. Windows are often missing, or do not open if they exist, and in the cold Western province winters people attempt to keep the chill out by using paraffin heaters and closing all openings, including doors.

Nomonde also recognises that, whilst her *ukuvumisa* practice and the divinatory ‘seeing’ she employs is quite different from the scientific gaze of biomedicine with its sophisticated technology, she can, on occasion, be assisted by science. With this in mind, she has developed a strategy to persuade her male clients to attend the clinic for an HIV test, a plan that implicitly acknowledges the limits of ancestral guidance in HIV diagnosis but does not undermine the authority of *ukuvumisa*. Here is her description of the method:

‘It depends on the kind of approach that you use with that particular person approaching them, mens. Because you can’t just tell a man anyhow, and they are not all the same, so you have to be careful...I say “you know, sometimes there are diseases that are hidden, and by going and testing your blood then you can manage to know what’s going on in your body and then when you come back we can ask the ancestors (*abaphantsi*) what they want you to do about it.”’

Interview: 29.04.07

Although there are exceptions, many *amagqirha*, like Nomonde, describe HIV and AIDS as a ‘new’ disease, an explanation that accounts for the failure of ancestral mentors to recognise it. In the above excerpt, Nomonde tacitly acknowledges the limits of ancestral agency in the context of HIV and AIDS. By using terminology familiar to an *ukuvumisa* session - ‘there are diseases that are hidden’ - she simultaneously accepts the advantage of biomedical technology in this ‘hiding and finding’ process and reinforces the notions that structure the conventions of *ukuvumisa* practice.<sup>23</sup>

Nomonde’s approach thus frankly acknowledges the superiority of medical wizardry in discovering ‘what’s going on’ in the patient’s body. However, far from ceding authority to the scientific gaze, she then incorporates this technical in-seeing and weaves it pragmatically into her remedial strategy. Immersed as it is in the authority of the ancestors this will provide the patient with answers to the existential ‘Why me? Why now?’ questions that accompany the onset of an unexplained illness in Africa. In asking ‘what they want you to do about it’ she and her clients can be confident that a solution will be found.

The training in voluntary counselling for HIV and AIDS that the traditional practitioners received through HOPE, is arguably the most potentially alterative intervention in relation to *amagqirha* practice, for there are distinct differences between the techniques employed in counselling and those familiar to the

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<sup>23</sup> Wreford 2008b: Chap 4 describes some of the methods employed to hone these seeing skills during *ukuthwasa*, the period of initiation and training to become an *igqirha/isangoma* including descriptions of the Zulu practice of ‘hiding and finding’ (*umhlahlo*).

divination process of *ukuvumisa*.<sup>24</sup> To take the most obvious example, the intention in a counselling session is to draw out the client, to persuade them from the outset to engage as much as possible with the process, and thus to expand the understanding of their problem through a recapitulation of their experience of it. This involves careful and respectful listening to the client, observation of body language and words, with the aim of enabling them to reach a solution. In contrast, in the conventions of an *ukuvumisa* session, the client is generally silent: it is the healer's business, through connection with ancestral agents to divine the problem, and the therapy. Although means exist for the practitioner to sound out the client's reaction to a diagnosis,<sup>25</sup> in counselling terms this approach is notably dogmatic: the healer leads the way to a diagnosis, and decides on the solution. Remedies are generally prescriptive: if the client wishes to be well the treatment should be followed to the letter.

Interviews with the *amagqirha* suggest that they interpret these distinctions between *ukuvumisa* and counselling methodology as remarkably unproblematic. By virtue of the careful observation and astute listening skills that are part and parcel of their training for example, the *amagqirha* suggest that they are able to seamlessly move from the conventions of *ukuvumisa* to the questioning and probing required of a counsellor, almost unbeknownst to their clients.<sup>26</sup> In a recent conversation, Nomonde presents a particularly moving example of this. Involving a young man and woman, this case is suggestive of the ways in which Nomonde's 'scientific' counselling techniques can literally and figuratively reinforce the spirit empowerment of *ukuvumisa*.

The woman in this case was pregnant, and had tested positive for HIV; her partner had not yet tested. Nomonde sees it as a priority to convince the couple that, as she puts it: 'They can live with HIV, and they will die in their own time [naturally].' Her message is simple: 'They must use condoms to protect themselves. They must look after themselves because nobody else will care for them, and they *will* live.' In this situation, Nomonde uses the authority vested in her *igqirha* status to persuade the pair that a combination of safer sex, PMTCT<sup>27</sup>

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<sup>24</sup> Although the methods used in *amagqirha* divination practice vary a great deal, the basic process is dependent on the healer's communication with the empowering ancestral spirits, and generally follows a recognised pattern aimed at finding that which is 'hidden' or as yet unknown.

<sup>25</sup> If the healer is 'on the right track' the client will respond with a loud 'Siyavuma! (We agree!).

<sup>26</sup> The position is not unchallenged however. Some clients for example, appear to be reluctant to pay the *amagqirha* for 'just talking', as counselling is popularly known (Wreford et al 2006: 27).

<sup>27</sup> Prevention of Mother to Child Transmission programmes are aimed at preventing 'vertical transmission' of HIV from mothers to their unborn children.

and ARVs will prolong their lives, and that of their unborn child. Far from undermining their confidence in her *igqirha* healing skills, this inclusive and pragmatic approach rather appears to reinforce it. Their response to her advice and support is remarkable in its almost literal reinterpretation of the lexicon of *amagqirha* understandings: ‘We will come back to you,’ they said, ‘because you have given us spirit.’

## **Conclusion: Transforming the past, acting in the present**

In her excellent volume describing the diverse and divisory history of medical relationships in South Africa, Anne Digby succinctly portrays the historic split between medical paradigms thus:

Western and indigenous medicine existed side by side spatially but intersected intellectually hardly at all (2006: 333).

It is unfortunate that this condition of separate existence continues to this day. Supported by collective memories, by myth, and by conjecture rooted deeply in the past, it persists, paradoxically, even in the face of the devastation wrought by the HIV and AIDS epidemic.

This paper features testimony from traditional healers who are ready to be involved with western medicine, specifically in the context of HIV and AIDS. Their interest in working with the knowledge presented by western medicine does not represent simple capitulation to a superior medical system, but constitutes a pragmatic step in the interests of their beleaguered clientele, towards a more complete health understanding and practice. It is undeniable that many traditional healers lack the scientific expertise required to comprehend the complexities in western medical interventions for HIV/AIDS, or for other diseases. This does not render them ‘ignorant’ or naïve. Indeed, the paper has suggested that the diffident attitude generally adopted by western medical personnel towards traditional healers, of itself perpetuates and, by default, actually promotes the very ‘ignorance’ and ineptitude of which traditional practitioners are often accused. To this end, in the discussion about AIDS activism and ‘pseudoscience’, this paper has explored the effects of biomedical reluctance to show a reciprocal respect for the knowledge of medical others in contemporary South Africa.

The HOPE project in the Western Cape Province was then presented as one example of the possibilities of change in this unequal relationship.<sup>28</sup> The initiative is still at an early stage, and a totally reciprocal interaction still remote. Naturally, the achievement of reciprocity presupposes something that has hitherto been almost invisible in professional medical relationships in South Africa, including the HOPE scheme – a willingness to engage and establish rapprochement through mutually respectful dialogue. To acquiesce in *amagqirha* understandings of HIV and AIDS is not to endorse them, but rather to acknowledge and respect their agency for patients and practitioners alike.

The paper sought to demonstrate that, in acknowledging these different interpretations of health and illness, and where appropriate incorporating them into its practice,<sup>29</sup> the efficacy of biomedical HIV/AIDS interventions could be significantly enhanced. The mediatory approach to the research that informs this paper seeks to encourage this development. By providing a space for the voices of the traditional health practitioners as they engage in a sort of history in the re-making, it has attempted to present a positive example of the potential that exists for constructing a dynamic and transformative relationship with western medicine. Similarly, it has shown that partnerships between different health paradigms, though they may start at a comparatively modest level, can nonetheless be powerful in their potential for change.

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<sup>28</sup> It may be that this process will also be organic: as more medical doctors from black African communities are trained in South Africa, the dichotomy may become more a question of the acknowledgement of difference. Thus, effective and sympathetic communication with patients in terms and language that are respectful of their cultural understanding of health and illness, whilst still engaging with the western medical paradigm, is not inconceivable. Forthcoming papers describing the author's research with medical students at UCT's Medical School at Groote Schuur Hospital will offer some evidence in this respect.

<sup>29</sup> For example, Wreford 2005a describes the potential for cleansing ritual practices in the healing of the emotional wounding of an HIV and AIDS diagnosis.

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