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**The pragmatics of knowledge
transfer: an HIV/AIDS intervention
with traditional health practitioners
in South Africa**

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Abstract

The persistence of the binary of scientific and indigenous or traditional medicine in contemporary South Africa is particularly unhelpful in the context of HIV/AIDS and encourages biomedical disengagement from a potentially helpful cohort of health professionals recognised within their communities. This article offers and discusses ethnographic evidence from Project HOPE, an HIV/AIDS intervention involving African traditional health practitioners (Xhosa: amagqirha) in the Western Cape province of South Africa. The article suggests several possibilities of advantage to the efficacy of western medical interventions in this sort of collaborative approach. Testimony from participants from both paradigms is offered to support this assertion. The article includes a contextual examination of the debate about HIV/AIDS treatment in South Africa which explores the effects of confused interpretations of 'traditional' and scientific medicine in this regard.

Key words: Traditional health practitioners; indigenous knowledge; biomedicine; HIV/AIDS; medical collaboration

In 1994, Good described the relationship between western and traditional medical paradigms as 'disjunctive', a binary opposition characterised by sectoral mistrust and disengagement. The persistence of this contestation is exhibited in contemporary South Africa where assertions about the credibility and authenticity of various categories of 'indigenous knowledge' are placed in opposition to the hegemony of a universalising science. The dualism has been especially evident in debates about the construction of public health policy in the face of a rampant HIV/AIDS epidemic. The complex colonial and apartheid history that contributed to the longevity of the binary in South African health care has been comprehensively described by historians (for example Crais 2002;

Digby 2006), and will not be reviewed here. This paper considers rather the effects of that history on contemporary medical relationships in South Africa, focused on an HIV/AIDS intervention in the Western Cape Province. The objective of the research and this paper is to encourage constructive dialogue between health paradigms in the face of the HIV/AIDS epidemic.¹

Although scientific medicine makes claims for hegemony in South Africa, the country's diverse therapeutic environment is more accurately described as pluralist (leBeau 2003). Biomedicine actually provides a very partial service: technologically sophisticated and extremely expensive private health care is available to the minority who can afford it, but health services for the general public are relatively weak, and increasingly under-resourced (Beresford 2007; Ndlovu 2009; Thomas 2007). Moreover, in the context of the translation of knowledge, public health service clients, even as they access the facilities it offers, may actually possess only a limited understanding of the scientific of biomedicine. Importantly, western medicine is generally bereft of answers to the existential questions that frequently accompany the onset of illness in Africa. For answers to these questions, for an explanation of illness causation, and for an appropriate remedy, many clients turn to the services provided by traditional African health practitioners including the *amagqirha* who are the subject of this paper.² These practitioners are recognised and utilised as a local and competitive alternative to biomedicine, running in parallel to biomedical operations, but generally at a considerable remove. Clients frequently employ both systems sequentially, and even simultaneously (Peltzer 2008). As Squire notes, there is an absence of qualitative social research around HIV/AIDS, and 'what people say about HIV in their lives' tends to be treated as an 'irrelevant footnote to serious research' (2007: 58). This comment is markedly appropriate in relation to traditional health practitioners, a situation the paper seeks to rectify.

Despite the confidence placed in traditional health practice by clients,³ scientific medicine in general, as well as some traditional health practitioners, have continued to resist proposals for collaborative projects that might begin to destabilise the rigid separation between the two systems. This paper suggests

¹ 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.

² 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).

³ Although the figures are contested, estimates regularly suggest that up to 80 per cent of the South African population consults with traditional health practitioners.

that this myopic attitude is unfortunate on both sides, most especially given the demands placed on biomedical services by the HIV/AIDS epidemic. To support the advantages of the greater cross-sectoral cooperation, the paper introduces preliminary findings from the HOPE Cape Town Sangoma Pilot Project (hereafter known as Project HOPE), which are suggestive of the potential for adaptation, if not yet transformation, in contemporary medical relationships. The evidence presented is based on ethnographic coverage of Project HOPE, an HIV/AIDS intervention in which *amagqirha* volunteered to adopt the techniques of HIV/AIDS counselling, and the advocacy of HIV/AIDS testing and HAART (Highly Active Antiretroviral Treatment), as part of their conventional divination practice (Xhosa: *ukuvumisa*). The paper suggests that mediations such as Project HOPE can advantage the efficacy of western medical interventions, especially those involving HIV/AIDS.

The paper starts with a short history of Project HOPE outlining the project's objectives, and describing some of the main actors (including the author) and their roles; the demographics of the project; and preliminary results. Testimony from *amagqirha* involved in the project explores how they have processed and understood this new knowledge, how it has affected their practice, and the extent (if any) to which it has changed their relationship – real and perceived – with western medicine. The voices of western medical staff and of the other actors in the project are also heard, although the words of the healers themselves are paramount, a shift in focus that is manifestly different from that of most historical records (Digby 2006: 278).

The ethnography is considered in relation to the goal of adapting and changing medical relationships as they are enacted in HIV/AIDS policies in contemporary South Africa. By way of context the discussion concludes with an examination of a contemporary example of the binary opposition of scientific and traditional or indigenous medicine as it has affected HIV/AIDS policy: the social and political controversy over treatment. Activists allied to the Treatment Action Campaign (TAC) have, throughout this sometimes vociferous debate, allied themselves unequivocally with biomedical treatment, and rigorously exposed individuals making opportunistic claims to possess a 'cure' for HIV/AIDS. However justified in respect of such 'quackery', the article argues that the TAC position has the unfortunate result of implicitly or explicitly painting all traditional healers into the opposition's corner, thereby making collaboration between the paradigms problematic.

Methodology

Working as an anthropologist and a graduated *isangoma*,⁴ I have spent the past three years in an advisory and monitoring capacity to HOPE Cape Town, assessing and reviewing the progress of project HOPE. I have worked in the townships where the project is operating, with the *amagqirha*, and at the clinic sites. The ethnography included here comes from fieldnotes, conversations, and semi-structured interviews which I carried out with some of the principal actors.⁵ Previous papers have highlighted successes and problems encountered by the *amagqirha*, Community Health Workers (CHWs), and medical staff involved in the project (Wreford et al 2006; 2008; Wreford and Esser 2008 and 2009). Obstacles encountered have been frankly described, and alternative approaches suggested where appropriate.

There were some obvious practical issues in this research: although I have an experiential understanding of the significance of *amagqirha* practice, my facility in Xhosa, the first language for most of the participants quoted in the paper, remains inadequate. To aid me in the interviews of *amagqirha* I called on the assistance of two Xhosa speakers, Lukholo Ngamlana, a young man from Khayelitsha whose grandfather is himself an *igqirha*, and Busi Magazi, a female Masters student from University of Cape Town. Both are familiar with *amagqirha* conventions, and were able to demonstrate the appropriate respect to the interviewees. I received on-the-spot abbreviated translations, and the taped interviews were later fully translated and transcribed. I also called on the services of some of the HOPE CHWs for interpretation where necessary.

My dual capacity as anthropologist and graduated *isangoma* perhaps uniquely enables me to engage with the underlying meanings attached to *amagqirha* practice. This facilitates an unusually participative approach, which I characterise here as advocatory and mediatory,⁶ and which I hope reflects on the practitioners' experiences and attempts to develop additional research strategies with them.

⁴ The author graduated as an *isangoma* in Khayelitsha Cape Town, in October 2001. For a comprehensive analysis of this experience see Wreford 2008.

⁵ The names of the traditional healers and clinic staff have been changed to protect their identity.

⁶ Participative research interventions elsewhere have been described as 'action research' (Grundfest Schoepf 1993), and 'Participatory Action Research' (Squire 2007).

Research sites: Clinics and surgeries

The medical sites for Project HOPE incorporate three local clinics in Mfuleni, Delft South and Kraaifontein. Coverage in this paper is mainly from Mfuleni, and the testimony of medical staff involved in HAART and other preventive measures such as PMTCT⁷, is primarily from that site, which also provides curative medicine, and includes a Wellness clinic, a tuberculosis (TB) clinic and a dispensing pharmacy. The Mfuleni clinic, like those of Delft South and Kraaifontein deals with upwards of 4,500 clients per month. The majority of the nurses live outside of Mfuleni. The clinic was completed in late 2007, and caters largely to the newer population of Mfuleni, most of whom were born in the Eastern Cape; there is constant movement of clients between the Western and Eastern Cape, a situation that can become problematic for adherence to HAART.

It is important to recognise from the outset that local clinics such as these operate what is best described as a ‘nurse-based service’. For specialised health services, clients are referred to hospital facilities. Although medical doctors do attend the clinics, their work is restricted in time and focus. In the case HIV/AIDS treatment at Mfuleni for instance, one doctor is employed by ARK (Absolute Return for Kids) to facilitate the roll-out of HAART. She shares her time each week between Mfuleni and Delft South clinics (both facilities were accredited for the dispensing of HAART in 2008). The doctor’s work at Mfuleni clinic is supported by a full-time male nurse, who monitors treatment and assists in assessment of client readiness to start HAART. (In the initial stages of HAART joint supervision by the doctor and the nurse is essential to ensure that clients successfully understand and adhere to the treatment regimen. Once the regimen is established a pharmacist dispenses the drugs on a monthly basis). Approximately 400 clients have so far been successfully initiated on HAART in Mfuleni. New clients are started on the treatment each week after consultations between Patient Advocates (local women who visit clients in their homes and assess their social situation and capacity to adhere to treatment), the treatment nurse, the doctor, and the sister in charge of TB treatment.⁸

⁷ Prevention of Mother to Child Transmission programmes are aimed at preventing ‘vertical transmission’ of HIV from mothers to their unborn children.

⁸ 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.

Mfuleni

Mfuleni is situated approximately 30 kilometres from Cape Town, off the busy N2 highway, and roughly opposite the enormous conurbation of Khayelitsha. The original population of the township has expanded greatly in the past few years, not least because incomers (mainly Xhosa-speaking people arriving from the Eastern Cape) recognise that they can access better health services, including HAART, in the Western Cape. Several tarred roads dissect the township, and pavements throng with pedestrian traffic. Other routes are either semi-tarred or simply dirt roads, too rutted for vehicle access. Whilst permanent concrete-block houses are being provided by the provincial government, new residents generally start by occupying shacks, flimsy self-built shelters that are put together with found items such as rough timbers, plastic sheeting and sheet metal, and are either sited in the backyards of government-built houses, or on the sandy open spaces that surround the township. Drainage, fresh water and electricity are 'found' rather than provided, and especially in the cold and wet winter, these shacks provide only precarious and inadequate shelter. The sister in charge of the Mfuleni clinic cited childhood diarrhoea and TB as very common health problems.

Of the three *amagqirha* in Project HOPE, only one, in Delft, lives in a brick-built house and her surgery is a self-built addition in the back yard. The healer from Mfuleni who, until very recently also occupied a brick house, was unfortunately removed from it by family members and now lives in a shack, as does the healer in Kraaifontein. Both have rooms designated as a surgery, but conditions are clearly not optimal. None of the *amagqirha* has more than a Grade 6 education, and all are women and Xhosa speakers.

Project HOPE

Although the provincial health authority in the Western Cape has pioneered biomedical HIV/AIDS treatment (Naimak 2006), Project HOPE is the first intervention in the province to involve traditional health practitioners. HOPE (HIV Outreach Program and Education) Cape Town, which promoted the scheme, is a not-for-profit organisation offering outreach and education on HIV and AIDS to peri-urban communities in the Western Cape. HOPE Cape Town is based at Tygerberg Academic Hospital where, from the *Ithemba* Ward, which it established, it provides HAART to a limited number of children. HOPE Cape Town's activities are supported by medical staff from the hospital, and two currently sit on its Management Board. The work of the organisation is allied

with HIV/AIDS research at Tygerberg hospital including that of the 'Kid CRU' Research Unit, which pioneers HAART treatment in children, and with researchers at Stellenbosch University. The organisation's outreach work is focused on Community Health Workers (CHWs) who are employed and trained by HOPE. As their name implies these men and women operate within the communities in which they themselves live, where they are based in local clinics and Day Hospitals. Funding for HOPE Cape Town is sourced from a number of European and local organisations, and by individual contribution.

Project HOPE was conceived in 2005 out of the belief that traditional health practitioners could 'play an important part' if they were included 'in the process of testing and treatment of HIV/AIDS' (Hippler 2006:3). The project was preceded by a series of workshops at which medical personnel from Tygerberg and traditional practitioners met at the hospital to share their understandings and experience of the disease. Following these preliminary gatherings HOPE Cape Town decided to establish a formal collaborative project, which was again based at Tygerberg Academic Hospital. Project HOPE commenced 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 HAART regimens through prescriptions by traditional healers, and to persuade more male clients to test. Nine *amagqirha* living and working in five peri-urban settlements were chosen by the chairman of the Western Cape Traditional and Spiritual Healers' Association. Five HOPE Community Health Workers, one from each community, were also selected to join the project. I entered the project at this stage at the invitation of HOPE Cape Town, acting in my capacity as anthropological observer and as a participating *igqirha*.

The scheme was initiated with a six-week course held at Tygerberg Hospital. This commenced with a week-long education in biomedical understandings of HIV/AIDS and its treatment. The course material was in English, and the CHWs provided Xhosa translations for the *amagqirha* participants. Seminar sessions were presented by medical staff from the hospital, from the Provincial Health Authority and from HOPE. Emphasis was placed on the possible contraindications between some traditional remedies and HAART (Cohen et al 2002; Mills et al 2005), the *amagqirha* being specifically advised to avoid invasive treatments where they suspected a depleted immune system. Then followed four weeks of training in Voluntary Counselling and Testing (VCT), a module which was managed and run by the AIDS Training Information Counselling and Testing Centre of Cape Town (ATIC), and accredited all participants as HIV/AIDS counsellors. In the final week the *amagqirha* were further prepared for their new role as counsellors and HAART advocates, with

sessions on bereavement, the ethics of HIV/AIDS prevention and treatment and so on. One of the major objectives of the project being to encourage HIV/AIDS testing at clinics, the healers were tutored in the completion of Referral Forms, which clients were to present to the HOPE CHWs at the clinics, and in the maintenance of a client register designed to ensure client confidentiality. Together this paper trail was also expected to assist in monitoring of the number of referrals achieved by *amagqirha* in Project HOPE. After the course, the participating *amagqirha* and HOPE CHWs returned to work in their communities.

Following some preliminary hiccoughs, and notwithstanding a steep learning curve,⁹ Project HOPE has now established three *amagqirha* who are successfully liaising with local clinics in Mfuleni, Kraaifontein and Delft South. Results already demonstrate success for HOPE's main objectives: since the project's official inauguration in March 2006, over 120 clients have been referred for testing.¹⁰ Nearly fifty percent of these referrals are male, a figure that is considerably higher than obtained by the clinics, and which suggests that the *amagqirha* are providing a valuable connection between male clients and the clinics. Finally, the *amagqirha* have begun to establish confident bonds with the clinics, and as testimonies included later in the paper suggest, some medical staff approve their involvement and would support the enrolment of more healers in similar initiatives (Wreford et al 2006; 2008).

The Findings: Changing practices or practising changes?

Has Project HOPE experience altered or changed *amagqirha* practice, and if so, in what ways and what impact has the intervention had on medical staff involved? The fieldwork examples included below describe some of the responses of some of the *amagqirha* participants and medical staff. These excerpts demonstrate that the *amagqirha* are prepared to adopt an eclectic and conspicuously generous inclusiveness in their interpretation of the knowledge of healing. They also suggest an approach that is often pragmatic but surprisingly

⁹ 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.

¹⁰ 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.

unproblematic, and which always prioritises the well-being of the patient. For the medical staff perhaps the primary effect of Project HOPE is to remind them of the existence of traditional practitioners, and to encourage a more cooperative relationship with those they begin to trust.

Hopes and aspirations: a thirst for knowledge and recognition

What prompted the *amagqirha* to participate in this intervention? I heard several explanations, but three common themes seem to 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 undervalued, especially by western medicine (Green 1994; Leclerc-Madlala 2002). *Igqirha* Nomonde for instance, portrayed herself in this regard as being 'thirsty for knowledge', a response that was largely driven by her personal desperation in the face of the epidemic. Lyrically, she described the medical information offered on the course at Tygerberg Hospital as 'like singing – because I know nothing'. Nomvuyo put this determination to understand even more frankly: 'I wanted to know', she declared. All of the healers referred, obliquely or more directly, to the importance they attributed to understanding how western medicine sees the virus, means of infection and prevention, and how antiretroviral medicines work, information that, as Nomonde expressed it, 'was very dark for us' before the HOPE experience.

A second theme, connected with the first, concerns the traditional practitioners' enthusiasm for the idea of 'working together' with their western-trained counterparts. This is by no means a universal position, and the Project HOPE healers had obviously made the decision to cooperate, but they nonetheless emphasised the point. 'Traditional doctors and western doctors need to work together so that we can learn from one another' remarked Nomvuyo. Putting her point in the context of HIV/AIDS Nomonde emphasised 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 objective may be pictured in quite unrealistic terms in respect of western medicine (Summerton 2006: 309) does not make it any the less potent for the healers. For instance, Nomonde envisioned her professional standing vis a vis western trained doctors as being 'almost on the same level as a medical doctor', an equivalence that made sense to her given the

length of her training and her ancestrally gifted knowledge of healing, although it would be challenged by the strictures of scientific medicine.¹¹

‘Working together’ is a notion that is dependent on cooperation: unsurprisingly therefore, the question of cross-referrals is an important objective for the healer participants in Project HOPE. Nomonde puts this succinctly: ‘We want to come up with a proper referral system between traditional healers and the clinics.’ Traditional practitioners are generally not averse to referring their clients to medical facilities,¹² a position that is rarely reciprocated. An *iqgirha* not associated with Project HOPE, who would like to see more co-operation, recently described to me her disappointment at this lack of reciprocity: ‘I don’t have a problem with the doctor I’m working with, but others they’ve got a stigma ... I refer a patient to Groote Schuur [hospital] I would never even have a feedback!’ ‘Proper’ in this instance then, means a system that, unlike the ‘one-way street’ approach that typifies most current practice, goes in both directions and operates from a core of mutual respect. The next comment, from a Xhosa speaking nursing sister, shows how collaboration is usually understood in this uni-directional way:

‘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.’

Fieldwork note: 18.06.07

This response came as part of a group meeting of staff at the clinic, however, a biomedical environment in which the nurse in question may well have felt it injudicious to show too much enthusiasm for interactions with traditional practitioners (Digby and Sweet 2002: 124). In the early days of Project HOPE one of the *amagqirha* discovered more overt prejudice in the case of clinic staff who were found to have advised a client attending for HIV testing – a client who had been referred by the *igqirha* and would have been unlikely to attend without her intervention – not to return to the traditional practitioner. This distinction may be appropriate for clients who are put onto HAART after testing, where use of some traditional herbal remedies may undermine the efficacy of ARVs. In this case however, the client did not meet the protocol for HAART, and the question of contraindications did not arise. Obviously, this closed-door approach

¹¹ The ‘calling’ to become an *igqirha* is processual and may last several years. See Wreford 2008b: Chapter 4.

¹² 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).

threatened the livelihood of the healer, and is a considerable disincentive to successful collaboration. A VCT counsellor at the clinic made a clear proscription on traditional medicines in conjunction with HAART:

‘I tell them to send their patients first to the clinic, then after their test they can go back to the *sangoma*. But some of them [Traditional Health Practitioners] they can’t be trusted, because they are not fully trained and they are not fully knowing about the herbs. But I tell the patients not to use the two systems at the same time. If they choose to use traditional medicine they should stick with that.’

Fieldnote: 17.03.09

When I pointed out that the fact that many clients simply do not admit to visiting traditional healers, for whatever purpose she agreed, emphasising at the same time the typical response to such an admission, ‘No, they don’t, because they know they’ll be told not to go there.’ The doctor in charge of HAART at Mfuleni acknowledged this exclusive emphasis. Asked about her personal experience of clients visiting traditional practitioners, she replied that ‘people don’t volunteer information, and we [medical doctors] are quite arrogant, we don’t ask the clients.’ She had however, come across clients preferring to use the vitamin ‘cures’ peddled by Matthias Rath.

There may be other, more subtle reasons behind the nurses’ objections to traditional healing practice. A Xhosa-speaking nursing sister, hearing that I was an *isangoma*, gave her prescription for relief from the distress of the experience of the ‘calling’ to *ubungoma*. ‘If you accept Jesus as your lord and saviour, you’ll have no problems with this’. This sort of message, whether explicitly Christian or not, often carries an implicit rejection of traditional beliefs, and is a familiar one in the clinics. Take the testimony of a nursing sister responsible for the PMTCT clinic:

‘It’s a few people and it’s taboo to try and make everybody believe in it [traditional medicine]. Here in Mfuleni people are coming from the rural areas. They shouldn’t impose their beliefs – they’re supposed to take off the traditional medicines because some of our nurses they worry about touching it [the medicine].’

Fieldnote: 17.03.09

The medicines the sister is referring to here are given to children at the age of a few weeks; primarily intended to protect the child (*ukuximisa*), others encourage growth, and help children to sleep. They usually comprise a fabric or leather purse in which the medicine is secreted, and these are strung on to beads, hide or cloth strings and tied at the neck, around the waist, or across the shoulders. In

my observation the majority of children passing through the clinic's 'prep room', where babies are weighed, and have their temperatures taken, and where any problems are noted before they are passed on to the appropriate sister, wore these. Interestingly, as she notes the nurses' concern about the possible effects of touching the medicines, the sister appears to imply that the same nurses may not be as inured to belief in their agency as she might suggest.

On the other hand, according to the testimony of the traditional healers, some black nurses are more sanguine about the role played by the *amagqirha* in Project HOPE. Nomboniso here describes how individual nurses at her local clinic directly refer clients 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 cooperative picture is reflected by Nomonde, who told me, 'the nurses from the clinic know that I helped many patients, so I don't see any problems with medical staff.' She later underlined 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 has regained energy and feels better I will give them traditional medicines.'

Interview 25.02.06

Since this remark seemed to suggest that clients were taking traditional medicines and western medicines conjointly, I asked whether the clinic staff were aware of this situation. Nomonde's answer was 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 relationships with 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 Nomonde confirms the porosity of the boundaries between traditional and western medical paradigms. The excerpt also demonstrates that nursing staff are sometimes willing to adopt a 'liberal' attitude to traditional healers and their remedies, acknowledging and even encouraging the so-called 'healing itinerary'

that can infuriate western-trained doctors but makes pragmatic sense to patients in the context of the HIV/AIDS (Squire 2007: 87-90). But there is also evidence here of the marking of boundaries – the healer protecting her professional turf, as it were. As indicated in the discussion earlier in the paper concerning the healers’ reasons for collaboration with biomedicine, the *amagqirha* do not view their induction into western medical understandings as capitulation, but as a genuine, and hopefully reciprocal learning process. Accepting this premise it seems only logical to Nomboniso that clients whose arrival at the clinic was 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.’

The aspirations and hopes recorded here are commonly heard from traditional practitioners and have been recognised by medical anthropologists (Good 1987; Leclerc-Madlala 2002: 25): that they generally fall on deaf ears in the biomedical environment is a source of frustration and disappointment. Most attempts at collaboration in the field of HIV/AIDS could be compared to a one-way revolving door, which remains stubbornly turning only in the direction of biomedicine. Conceivably, as healers themselves have recognised, this is a question of western medicine simply misinterpreting the healers’ thirst for knowledge as a capitulation to the superior science of modern medicine (Leclerc-Madlala 2002: 25). Read in the contemporary context of HIV/AIDS and HAART the ‘salvation ethos’ intrinsic to biomedicine has certainly tried to create ‘a popular culture that is enamored with the biology of hope’ (DelVecchio-Good 2007: 376-377), and, reverting to this historical salvationist stance, western-trained doctors might thus be reading the traditional practitioners’ enthusiasm for co-operation as a form of conversion to ‘the gospel of Western medicine’ (Ranger 1981: 271). A professor of HIV/AIDS medicine at Tygerberg Academic Hospital, for example, described the HOPE *amagqirha* as having ‘given up their old ideas’: But this is not at all how the traditional practitioners read the situation.

The exhortations of the *amagqirha* involved with Project HOPE to western medicine to ‘work together’ are not meant to 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 skills, 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 an acute awareness of the devastation being wrought by the epidemic. ‘Our people are dying’ said Nomboniso. The determination to work with western medicine is driven by a powerful healing vocation. As Nomonde put it: ‘All I want is for people to be cured and to be helped.’ Taken in this light, their cooperation with and the translation of new knowledge is pragmatic: it

constitutes a means to an end. The *amagqirha* are prepared to accept that the knowledge that western medicine possesses about the virus can assist them in their healing role. 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).]

The pragmatics of knowledge transfer

It is apparent that there exists considerable potential for adaptation, alteration, and even hybridisation in the sort of collaboration that Project HOPE represents, and significant issues arise. How do *amagqirha* comprehend the biomedical aetiology of HIV/AIDS? Has this changed the way they previously understood causation, and how do they communicate their new understanding to their clients? A second topic relates to the direct effects of the *amagqirha* involvement in Project HOPE on their *ukuvumisa* practice, and the changes, if any, that they perceive in their practice as a consequence. Space does not allow for a detailed consideration of these questions so one or two examples will have to suffice.¹³

The *amagqirha* participants in the HOPE initiative generally seem to 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,¹⁴ but simultaneously employ ‘local’ understandings to make sense of the situation. Discussing a case of HIV associated TB¹⁵ for example, Nomonde, having accurately described the biomedical symptomology of the infection in a client, then remarked that in this instance it had been caused by ‘this man drinking too much cold beer’. The linkage she was making between excessive alcohol consumption and HIV/AIDS is borne out in research – but for Nomonde it was the fact that the beer was cold that created the problem. Whilst she had understood the environmental factors that contribute to the spread of TB, her theory of causation was straightforward

¹³ The topic will be considered in future papers.

¹⁴ It is important to note at the outset that all the biomedical information on the course was 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.

¹⁵ On average each of the participating clinics sees 4,500 patients each month. Of those who test positive for TB, approximately 50 per cent are also HIV positive.

and sympathetic. ‘If they drink the beer warm it would be better’, she said. To Nomonde, the temperature of the beer was a crucial factor – drinking cold beer on a cold day (the interview was held in the winter) in a cold shack made no sense to her, and was a logical explanation for the severity of the lung infection.

Nomonde is also prepared to recognise that, even as her *ukuvumisa* practice and the divinatory ‘seeing’ she employs is quite different from the scientific gaze of biomedicine with its sophisticated technology, *ukuvumisa* 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. Her approach implicitly acknowledges the limits of ancestral guidance in HIV diagnosis but does not undermine the authority of *ukuvumisa*. Rather, she accepts the superior seeing available to biomedicine and incorporates it into her remedial strategy. Here is her description of the approach:

‘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 this excerpt the *igqirha* tacitly acknowledges the limits of ancestral agency in the context of HIV and AIDS. However, by using the terminology of ‘hiding and finding’ familiar to an *ukuvumisa* session¹⁶ - ‘there are diseases that are hidden’ - she simultaneously accepts the advantage of biomedical technology in this process and binds it to the notions that structure the conventions of *ukuvumisa* practice.¹⁷ Once the scientific gaze has revealed whether or not there is a problem in the client’s blood, Nomonde is confident that the *abaphantsi* will be willing to assist in developing a remedial strategy.

¹⁶ 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.

¹⁷ Wreford 2008b: Chapter 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*).

Adaptations, alterations and other strategies

The training in voluntary counselling for HIV/AIDS (VCT), which the traditional practitioners received through project HOPE, is arguably the most potentially alternative intervention in relation to *amagqirha* practice. There are distinct differences between the techniques employed in counselling and those familiar to the divination process of *ukuvumisa*. 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 her connection with ancestral agency, to divine the problem, and the therapy. Remedies are usually prescriptive and if the client wishes to be well the remedy should be followed to the letter. Although means exist for the practitioner to sound out the client's reaction to a diagnosis,¹⁸ in counselling terms the *igqirha* approach is notably dogmatic: the healer leads the way to a diagnosis, and decides on the solution. The HOPE *amagqirha* seem to read these distinctions between *ukuvumisa* and counselling methodology as remarkably unproblematic. By dint 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.¹⁹

In a recent conversation Nomonde presented 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 young woman in this case was pregnant, and had tested positive for HIV; her partner had not yet tested, but both attended the session. The *igqirha* saw it as a priority to convince the couple that, as she put it: 'They can live with HIV, and they will die in their own time [naturally].' Her message was simple: 'They must use condoms to protect themselves. They must look after themselves because

¹⁸ If the healer is 'on the right track' the client will respond with a loud '*Siyavuma!* (We agree!).

¹⁹ 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).

nobody else will care for them, and they *will* live.’ In this situation, Nomonde used the authority vested in her *igqirha* status to persuade the pair that a combination of safer sex, PMTCT and HAART would 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 appeared to reinforce it, and their response to her advice and support is remarkable in its linkage with the lexicon of *amagqirha* understandings. ‘We will come back to you,’ they said, ‘because you have given us spirit.’

The collaborative approach of Project HOPE

It might appear that Project HOPE follows the conventions of the few other collaborative HIV/AIDS interventions in Southern Africa (Wreford 2005b). Two major innovations do distinguish the project however: the VCT component, and the inclusion of the HOPE CHWs together with the *amagqirha* on the course.

As anyone familiar with the process will understand, counselling practice often leads to the exposure of intensely personal and emotionally cathartic experiences. The fact that CHWs and *amagqirha* were able to share such experiences on the course led, at least initially, to an occasionally quite profound fellowship and to a reconsideration by the participants about themselves, and their roles in the prevention and treatment of HIV/ AIDS. *Amagqirha* are recognised within their communities as professional healers, and as the CHWs knew from personal experience, clients coming to the clinics were often recently arrived from the rural areas of the Eastern Cape where *amagqirha* are regularly consulted. One explained this to me as part of her own history: ‘And you must know Thobs, eh? We are coming from the rural areas and in the rural areas, we use those medicines – we were not using western medicines – we were using those things.’ The healers’ insight and guidance is sought after especially when health problems are long-standing and cannot be satisfactorily explained by the medical terminology and treatments familiar to the clinic environment. Other HOPE CHWs were frank about their own recourse to traditional practitioners, especially in the context of emotional distress. One described it thus:

‘For instance, if I’ve got those bad dreams what’s in those bad dreams? Then maybe the family will say “OK I’m going to the *sangoma* to ask.” Then the *sangoma* will tell you that “No you want for this culture for this to be done for this, and this,” you know? I’m talking about things like that, but not that much about the physical stuff.’

Fieldnote: 18.11.05

Yet until they participated in Project HOPE, the CHWs had not considered *amagqirha* as potential colleagues or allies in the fight against HIV/AIDS. Rather, they were more likely to be viewed, through a biomedical lens, as it were, as a potential problem. A CHW explains:

‘For myself, I think that it was a good idea for us to work together [murmurs of agreement from others] with the traditional healers, because you know, before, when we were not working with them, we were just wondering OK we know we are giving this client this medication, and we know on the other side she’s going to go to the *sangoma*, and the way the western medication for the doctors are working compared to the traditional healers – it’s totally different’

Group Interview with HOPE CHWs: 25.04.06

After the course, the same CHW recognised that the healers’ awareness had changed, and that this had also produced a change in her attitude towards the healers: ‘Now we know that the traditional healers, where they see that they can change their - what can I call it? - actions – like instead of cleansing what they can put instead you know. They know exactly now if I’m cleansing somebody who may I cleanse ...’ The CHW is here referring to the common practice of cleansing that follows diagnosis. This may be achieved through invasive methods such as emetics and enemas, but less severe measures, such as steaming, washing or smoking are also available.²⁰ The *amagqirha* working on Project HOPE are discouraged from using the former where they suspect a depleted immune system or if the client is on HAART.

A second advantage to the counselling process recognised by Project HOPE participants concerns the vexed question of confidentiality and HIV/AIDS stigma. *Amagqirha* surgeries are understood to be a safe and secure environment in which the *igqirha* will take the necessary time to ‘find’ what is wrong, a process in which the client may have confidences and secrets safely brought to light without fear of public exposure. As Nomboniso put it: ‘If you diagnose someone [as an *igqirha*] then whatever they should discover from that person you have to keep it to yourself because it’s a secret.’ Clearly, as the CHWs recognised, this guarantee of confidentiality has considerable leverage in the management of HIV/AIDS as reflected in the following testimony:

‘And each and one of them is just confidentiality, is also what I like. You know with HIV you must be somebody who is confidential. They

²⁰ This strategy is not without problems however, for clients themselves may be expecting the radical treatment and may feel that lesser remedies are inadequate or ineffective (Wreford et al 2006).

have got confidentiality, that is also what I like. And, no, I'm trying to say things are better now, things are much better now.'

Group Interview with HOPE CHWs: 25.04.06

The stigma attached to HIV/AIDS, and the fear of public disclosure of seropositivity together operate in South Africa as powerful disincentives against testing and knowing one's HIV status (Almeleh 2006; Maughan-Brown 2007). Clinics are notorious for their porosity, and my experience suggests that this reputation is entirely plausible (Wreford et al 2006: 25). Sitting in on counselling sessions at Mfuleni clinic for instance (my presence was first agreed with each client) I was shocked to note how regularly the 'confidentiality' of this environment was ruptured, as other clients, and members of staff frequently entered the room uninvited, and were rarely admonished. (To be even-handed, I should also point out that the noise coming from the clinic corridors made it difficult for the counsellor to hear whether anyone had indeed knocked.) In contrast, the *igqirha* surgery provides a familiar, and a safer environment in which the implications of seropositivity may be discussed and addressed, not only at the practical and material level but also in relationship to ancestral issues.

Treatment choices, drug interactions and 'pseudoscience'

The paper thus far has concentrated on the presentation and discussion of ethnographic evidence from one example of an HIV/AIDS intervention, with the intention of demonstrating some of the possibilities as well as the problems inherent in obtaining a closer working relationship between western medicine and traditional healers in the field in South Africa. I stated at the outset that conditions are hardly ideal for this sort of collaborative effort. Western medicine by and large presents a one-way revolving door policy towards the traditional practitioners, in a contemporary version of the binary contestation between the scientific and traditional paradigms, and this has certainly not helped to encourage cross-sectoral involvement. But the idea of collaboration has been made particularly sensitive as a result of a political climate in which the scientific aetiology of HIV/AIDS and its treatment have been publicly challenged and questioned by leading members of the government administration. The remainder of this article looks at one instance of the consequence of this situation in which the scientific/indigenous (or traditional) dichotomy has been particularly acute: the debate about patient decision-making and choice of treatment.

Until the change of leadership in the ruling African National Congress (ANC) in November 2008,²¹ the government response to the HIV/AIDS epidemic in South Africa was characterised by confusion and prevarication (Fourie 2006: 159-163; Makgoba 2003; Natrass 2006; Thornton 2008). ‘Denialist’ declarations from then President Thabo Mbeki repeatedly threw doubt on the state’s commitment to engage with ‘the scope and seriousness of the pandemic’ (Whiteside and van Niekerk 2005: 34). But Manto Tshabalala-Msimang, then minister of health, did particular damage to cross-cultural medical relationships with her encouragement of several entrepreneurs who claimed to possess ‘cures’ for HIV/AIDS, cynically exploiting vulnerable and desperate clients (the activities of Matthias Rath in Khayelitsha, Cape Town, and Zebon Gwala in KwaZulu-Natal are especially notorious (Natrass 2007a: 146-155)).²² By falsely adopting the authority of the ‘traditional healer’ these operators persuaded some traditional healers to support their ‘curing’ claims, an outcome that simultaneously implicated by association all *amagqirha*.

The Treatment Action Campaign (TAC) has always insisted on the provision of ARVs as the ‘only scientifically tested’ treatment for AIDS and it is not my intention here to challenge that campaign for timely ARV treatment.²³ Rather I seek to encourage a more inclusive approach to treatment, especially in the early stages of HIV.²⁴ Ironically, the scientific position of the TAC is presented against a somewhat misleading interpretation of the scientific understanding of

²¹ Although the new minister of health has taken a proactive stance with regard to the roll-out of HAART, her approach to the question of treatment choice and traditional practitioners is as yet unclear.

²² It should be noted that at least one unscrupulous academic has also been tempted to claims of ‘anti-HIV’ remedies (Thamm 2006).

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

²⁴ 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.

the HI virus on which HAART rests. The science of HIV/AIDS describes it as 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 (as borne out by my observations at Mfuleni clinic for example) can offer only a limited therapy of vitamins and antibiotics. There is as yet no scientific evidence of any contraindications between these treatments and the herbal remedies for opportunistic infections that are utilised by traditional practitioners.²⁵

In the fourth stage of HIV, when the immune system is so undermined that almost any infection may become lethal, the client is recognised as being ‘AIDS sick’, and only then may HAART be prescribed. It is only in this phase, and *only* if the patient is on HAART, that possible contraindications have been identified between the ARVs and some of the herbs used by traditional medicine to boost the immune system (Cohen et al 2002; Mills et al 2005). The TAC’s position conflates traditional treatments that are effective for opportunistic infections in early-stage HIV and have no known side-effects, with contraindications that may occur in a patient suffering from AIDS and on HAART. It is unfortunate that this confusion tends to promote a damaging and unwarranted condemnation of traditional practice *in toto*.

The problem, I suggest, with the TAC’s advocacy of an exclusively biomedical treatment solution to the epidemic, is that it dismisses *all* other approaches, whether real or charlatan, especially in relation to the ‘treatment gap’. Characterised as ‘pseudoscience’ (Geffen 2007) this critique also subtly imputes a ‘denialist’ position to anything other than the biomedical option (Natrass 2007b). It implies that clients are simply wrong to choose a non-biomedical ‘untested’ therapeutic regimen (Hassan and Heywood 2007), a position that is unlikely to persuade sceptical traditional practitioners to cooperate with scientific research into the traditional pharmacopoeia which might result in the availability of ‘tested’ therapies for the disease (Wreford 2008b: 70-75). Another version of the one-way revolving door policy, this approach lacks the sort of reciprocity encouraged by some medical professionals in the field, based on ‘an open exchange of information and experiences ... [with] fellow health-care professionals’ (UNAIDS 2006: 6).

²⁵ Blanket accusations that traditional remedies ‘[do] harm to others’ (Geffen 2007:18-19), moreover repudiate the reality that it is the clients who, in the event of any illness, often pilot their own treatment response, even using traditional and biomedical solutions interchangeably.

I suggest that the TAC's presentation of all alternative medicinal preparations as 'pseudoscience' (Geffen 2007) represents a contemporary perpetuation of the historical contestation between universalising science and indigenous knowledge. The proposition is that 'non-orthodox' remedies (Nattrass 2007a: 123) inhere in belief rather than scientific fact. For lack of scientific verification, the argument goes, these treatment options should be discouraged (a position that conveniently ignores the paucity of scientific interest in such research). A justifiable determination to expose 'quacks' and 'charlatans' in the treatment debate surely does not justify the imputation of a blanket 'pseudoscientific' impulse to *all* traditional practitioners and their therapies. The TAC rightly asserts that Matthias Rath has deterred patients from maintaining HAART regimens, but in making universalising statements about the danger of traditional remedies, its rhetoric similarly undermines the confidence of those who may actually prefer the traditional paradigm (Peltzer 2008). It may be the case, as Geffen avers, that some people are alienated from science and technology 'because they cannot understand it, probably due to inadequate science education' (2007: 34). But it would be more helpful if the TAC were to recognise that others may in reality prefer to put their trust in traditional practice over scientific medical solutions. In so doing, it is possible that the overtures made by the TAC to traditional healers (Equal Treatment, 2005) would ultimately prove to be more constructive and useful in the prevention and treatment of HIV/AIDS in South Africa.

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: 'Western and indigenous medicine existed side by side spatially but intersected intellectually hardly at all' (2006: 333). The continuation of this binary is seen as particularly unhelpful in the context of HIV/AIDS, encouraging as it does biomedical disengagement from a potentially helpful cohort of health professionals recognised within their communities. This article has provided and discussed ethnographic evidence from Project HOPE, an HIV/AIDS intervention involving African traditional health practitioners, *amagqirha*, in the Western Cape province of South Africa. The article suggests that there are several possibilities for considerable advantage to the efficacy of western medical interventions in this sort of collaborative approach, and offers testimony from participants from both paradigms to support this assertion.

The paper utilises testimony from traditional healers who are prepared to take a pragmatic stance in relation to western medicine, specifically in the context of HIV/AIDS. The article has shown that this enthusiasm to work with the knowledge presented by western medicine does not represent capitulation to a superior system, but a pragmatic step, in the interests of their beleaguered clients, towards a more inclusive health understanding and practice. Project HOPE serves as one example of the possibilities of change in this binary relationship.²⁶ The initiative is at an early stage, and a totally reciprocal interaction is still remote, yet it demonstrates that partnerships between different health paradigms, even at a comparatively modest level can be powerful in their potential for change.

²⁶ 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.

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