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**Worlds Apart? Religious  
interpretations and witchcraft in  
the negotiation of health strategies  
for HIV/AIDS in South Africa.**

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## Abstract

*Academic research has tended to explain traditional African health practices as part of a belief system, usually understood as religious. Biomedicine meanwhile harnesses this religious definition as validation of the familiar dichotomy between non-factual 'beliefs' and the 'evidence-based' knowledge claims of scientific medicine. This paper rather defines traditional African health practices as a healing system running in parallel to biomedicine as part of the pluralist health service of South Africa. The paper is contextualised on the conference theme of the alignments between religion and health in the harnessing and mobilising social health assets. Focused on fieldwork in the Western Cape Province of South Africa, it presents some assumptions voiced by health workers about the beliefs and practice of amagqirha (Xhosa; pl. igqirha s.: diviner/healers) and considers the various ways in which these are negotiated. The paper first interrogates how health workers' understandings of traditional African healing may be operating to advance or limit the possibilities for cross-cultural health interventions in HIV/AIDS. The second part of the paper considers a particular construction in this equation - the discomfiting question of witchcraft discourse.*

## Introduction

Traditional African health systems have generally been interpreted in academia as part of an essentially religious or spiritual system of 'belief' that involves worship of the ancestors (Hammond-Tooke 1989; van Binsbergen 1991). An acceptance of this interpretation has encouraged scientific medicine in its assertion of an essential opposition between the 'beliefs' of traditional practitioners (Good 1994) and the incontestable quality of the 'knowledge' claimed by scientific method. The consequence of this for contemporary South Africa is reflected in a continuation of the 'disjunctive' relationship between western and traditional medical paradigms (Good 1994), an opposition generally

characterised by mistrust and disengagement. The effects of this oppositional dichotomy have been no less evident in the construction of public health policy in the face of a rampant HIV/AIDS epidemic, where the potential for collaborative efforts between the paradigms has been little explored.<sup>1</sup>

This situation is paradoxical, for, despite scientific medicine's claims of hegemony, in South Africa's diverse therapeutic environment (which 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 and over-stretched (Beresford 2007; Ndlovu 2009; Rawoot 2009). Moreover, public health service clients, even as they access the facilities offered, actually possess a very limited understanding of the science of biomedicine, and are far more likely to be attuned to the more familiar and accessible understandings available through traditional health practitioners. In particular, western medicine is generally bereft of answers to the existential questions that frequently accompany the onset of illness in Africa. For answers to such questions, for an explanation of illness causation, and for an appropriate remedy, clients continue to turn to traditional African health practitioners including the *amagqirha* who are the subject of this paper.<sup>2</sup> 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 may even do so simultaneously (Peltzer 2008).

In any debate that concerns the alignment of public health and religion, a further dichotomy needs consideration however. This exists in the insistence - asserted and maintained by various church organisations in South Africa and by many of the health service staff who belong to them - that there is an essential difference, and even a contradiction, between religious tenets and the theories and ritual practices of traditional health. This binary is confidently asserted even in the face of an accepted reality that public health staff can be simultaneously members of faith-based groups and yet utilise traditional healers, especially in

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<sup>1</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>2</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).

times of stress. It is particularly vehement in the context of the undeniably ambiguous relationship that exists between African health practitioners and witchcraft (Wreford 2008a). The paper introduces some findings on these and related topics taken from fieldwork on the HOPE Cape Town Sangoma Pilot Project (hereafter known as Project HOPE), an HIV/AIDS intervention in which *amagqirha* volunteered to adopt the techniques of HIV/AIDS counselling, and to advocate for HIV/AIDS testing and HAART (Highly Active Antiretroviral Treatment), as part of their conventional divination practice (Xhosa: *ukuvumisa*).

The paper starts with very brief history of Project HOPE. Using testimony from clinic staff and *amagqirha* the first part of the paper then explores some of the complexities presented by local understandings of traditional healers as practitioners of a spiritual system which is understood as at odds with biomedical practice, and often seen as conflicting with religious teachings. This section is particularly interested in discovering the ways in which traditional knowledge and practices are portrayed as potentially oppositional to scientific and religious understandings, and become the subject of contestation within the biomedical territory of a local clinic. The remainder of the paper explores this contestation specifically in the context of HIV/AIDS and witchcraft discourse.<sup>i</sup>

## Methodology

Working as an anthropologist and an *isangoma*,<sup>3</sup> 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.<sup>4</sup> Previous papers have highlighted successes and problems encountered by the *amagqirha*, Community Health Workers (CHWs), and medical staff involved in the project (Wreford 2005; Wreford et al 2006, 2008; Wreford and Esser 2008, 2009), where obstacles encountered were frankly described, and alternative approaches suggested as appropriate. I draw on these and other work to develop the arguments presented here.

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<sup>3</sup> The author graduated as an *isangoma* in Khayelitsha Cape Town, in October 2001. For a comprehensive analysis of this experience see Wreford 2008b.

<sup>4</sup> The names of the traditional healers and clinic staff have been changed to protect their identity.

Some obvious methodological issues in this research should be highlighted: although I have an experiential understanding of the significance of *amagqirha* and the working lexicon of that practice, my facility in Xhosa, the first language for most of the participants quoted in the paper, remains most inadequate. To aid me in the interviews of *amagqirha* in particular, I called on the assistance of two Xhosa speakers, Lukholo Ngamlana, a young man from Khayelitsha whose grandfather is an *igqirha*, and Busi Magazi, a female Masters student of anthropology 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 Community Health Workers for interpretation where necessary. In my observations in local clinics, where most staff speak English, but Xhosa was most frequently the language of choice, I decided to rely on what I shall describe as *isangoma* insights for an interpretation of events, asking for translation only where essential.

## **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 PMTCT<sup>5</sup>, 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 nursing staff live outside of Mfuleni, and are Xhosa speakers. The ‘facility manager’ is an Afrikaans speaker, a nursing sister from the ‘coloured’ community. The clinic was completed in late 2007, and caters largely to the newer population of Mfuleni, most of whom were born in the rural areas of the Eastern Cape Province and Xhosa speakers; 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 emphasise that local clinics such as these operate what is essentially a ‘nurse-based service’, in which the majority of nurses are female and Xhosa speakers. Although medical doctors do attend the clinics, their work is restricted in time and focus. In the case HIV/AIDS treatment at Mfuleni for

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<sup>5</sup> Prevention of Mother to Child Transmission programmes are aimed at preventing ‘vertical transmission’ of HIV from mothers to their unborn children.

instance, one doctor is employed by ARK (Absolute Return for Kids) to facilitate the roll-out of highly active antiretroviral treatment (HAART). She shares her time each week between Mfuleni and Delft South clinics (both facilities were accredited for the dispensing of HAART in 2008), and her work is supported by a full-time male nurse, who monitors treatment and assists in the 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 situations and capacity to adhere to treatment), the treatment nurse, the doctor, and the sister in charge of TB treatment.<sup>6</sup> Another doctor, in attendance at Mfuleni clinic for two days each week, specialises in TB treatment. Whilst these medical professionals are available to the nursing staff for advice in the event of an emergency, patients requiring any specialised health treatments are referred to hospital facilities, often at some remove from the clinic.

## **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, but other routes are either semi-tarred or simply dirt roads, too rutted for vehicle access. Roadsides throng with pedestrian traffic, and temporary stalls take advantage of this passing trade to sell cheap clothing, plastic goods, tobacco, sweets and raw and cooked foodstuffs. 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

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<sup>6</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.

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. Not surprisingly, 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 until very recently also occupied a brick house, but 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 far from optimum. 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, and was initiated in 2005 by HOPE (HIV Outreach Program and Education) Cape Town.<sup>7</sup> HOPE believed 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). Project HOPE had 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

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<sup>7</sup> HOPE Cape Town is a not for profit organisation offering outreach and education on HIV and AIDS to peri-urban communities in the Western Cape. The organisation’s outreach work is focused on Community Health Workers who are employed and trained by HOPE.

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. 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,<sup>8</sup> Project HOPE now has 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.<sup>9</sup> 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.

## Part One: Worlds apart?

This section of the paper explores some of the complexities involved in initiating Project HOPE in the clinic at Mfuleni. The emphasis here is on the attitudes of the health staff members involved in the various elements connected

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<sup>8</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>9</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.

with medical HIV/AIDS interventions.<sup>10</sup> Using testimony from clinic health workers and *amagqirha*, among the questions that the paper explores are the challenges faced by health workers in negotiating their personal understandings and experience of traditional healing practice and belief, and cultural interpretations which present traditional practitioners as operating within a spiritual system that is often understood as fundamentally at odds not only with biomedical practice, but with individual religious belief. Amongst other issues, this section explores: how health staff feel about the possibilities for collaboration between traditional and scientific medicine; what role personal religious belief plays in tempering these attitudes and the extent to which a cultural familiarity with traditional practice and belief facilitates or prejudices such attitudes. The discussion is particularly focused on discovering the ways in which traditional knowledges are experienced as potentially oppositional to scientific and religious understandings, and become the subject of contestation within the biomedical territory of a local clinic. The paper presents the evidence in the context of Digby and Sweet's findings which suggest that black nurses play a role as mediators or 'culture brokers' between traditional and biomedical systems (2002).

## Negotiating medical relationships

The majority of the black nurses working at Mfuleni are culturally attuned to traditional health beliefs, familiar with the practices and rituals that are encompassed by *amagqirha*, and aware that, as one put it to me, 'our people they do go to them'. Indeed, were they ever to doubt the perpetuation of popular allegiance to the authority of traditional healers, patients attending the clinic daily would provide ample evidence to the contrary. In the 'prep room', for example, where mothers (and the very occasional father) present their young children for preliminary checks before they are referred to the appropriate 'curative' nursing sister, I observed the majority of children being weighed, naked but for their traditional medicines; small pouches of cloth or leather carried by necklaces, bracelets and belts of beadwork or animal skin. When I asked their parents about the purpose of these medicines, they cited a variety of roles including protecting the child (*ukuximisa*), helping the child to sleep, and encouraging the child's growth.

The nursing staff running the prep room appeared to be indifferent to these health strategies, and I did not witness any attempts to reprimand or question the

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<sup>10</sup> A companion paper emphasises the *amagqirha*'s responses to the experience (Wreford 2009).

parents for their use of them. I encountered only one instance in which any concern about the use of a parallel health strategy was apparent, and this came from a mother, who, as she joined the queue for the weighing scales, started to remove the *muthi* from her child's neck. Noticing the nonchalance of other mothers, she left the medicine in place. This would appear to suggest that black nurses' familiarity with traditional health practices can serve, as Digby and Sweet suggest (2002), if not a directly mediatory role between traditional and biomedical systems, then at least one which is not immediately conflicted.

Appearances are not always what they seem however, and other evidence suggests that the relationship between traditional beliefs and the medical and religious understandings espoused by black nursing staff is rather more nuanced. Take the testimony of one of the two prep room sisters for example. On one of my first mornings working there, she asked me who had given me my Xhosa name, Thobeka. When I told her that I had received it at my *goduswa*, the graduation ceremony at which I had been recognised and accepted as an *isangoma*,<sup>11</sup> her first response was to look somewhat astonished. She then shrugged her ample shoulders and said: 'How did *that* happen? It's unusual for a white woman', a not uncommon reaction to the appearance of a white *isangoma* as I have described elsewhere (Wreford 2007). I (very briefly) explained the story, thereafter she opined confidently, with a smile that seemed both sympathetic and rather smug: 'you could have avoided all that. If you accept Jesus as your lord and saviour it [the calling to *isangoma*] doesn't affect you.'

Certainly there were times during my experience of *ukuthwasa* when I might have wished that I were able to act on her advice, but for the purposes of this paper I will concentrate on the sister's intriguing suggestion that the power of Christian faith could overwhelm the calling to become a traditional healer. First of all, her use of the phrase 'all that' implies that she is fully aware of precisely what 'all that' entails, a familiarity with the practices associated with traditional medicine, and especially with the 'calling'. This was underlined a few days later when she joined in with a trainee nurse who, having heard about my *isangoma* status, playfully started to drum on a desktop, her fingers tapping out the rhythm associated with the *xhentsa*, or ritual dancing that forms a part of most gatherings of traditional healers (Xhosa: *iinthlombe*). But the question of avoidance of 'the call' is another matter, for traditional practitioners insist that to deny the calling of one's ancestors to *ubungoma* (Zulu: The practice of *izangoma/amagqirha*) is not only difficult, but also dangerous. Failure to respond to the calling may be expected to bring to the reluctant *thwasa* (Xhosa:

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<sup>11</sup> The processual events that accompany the becoming of an *isangoma* or *igqirha* are long and various. The final graduation ceremony is however the essential end of the experience. See Wreford 2008b.

initiate to *ubungoma*) ill-health and/or ‘bad luck’ which will continue until the individual acknowledges their responsibility to ancestral directives.

Despite her apparent confidence, the sister’s comment is suggestive of a conflicted situation: her apparently dismissive attitude towards *amagqirha* is presented in terms of a rather contradictory dichotomy, in which Christian faith is held up as oppositional to traditional belief. Many traditional healers, including those with whom I work, would find this notion particularly irksome, for most are themselves active members of Christian church groups and attend services at weekends. Although the regalia they wear differ for each occasion, the drums that they employ for *izangoma* rituals one weekend are often utilised at a church gathering on another. The nursing sister’s attitude, of course, also provides clear demonstration of the perpetuation of the rebuttal of indigenous beliefs which accompanied the arrival of the first Christian missionaries in South Africa, an insistence that Xhosa Christians renounce their ancestor traditions that persists in the present (Pauw 1975:205).

## **Inside, Outside: Contesting Beliefs in the clinic**

A second example presents a different picture of the contestation between personal religious faith, medical practice and knowledge of the role of traditional healing, as it is experienced by black nursing staff. Describing the involvement of traditional healers in Mfuleni, the nursing sister responsible for the PMTCT clinic there told me:

‘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, as I described above, are given to children from the age of a few weeks. At first reading the comments from nursing sister, who is married to a Christian minister, suggest the same sort of renunciation and separation familiar from the prep room sister quoted earlier. She also implies an intellectual superiority between herself and her fellow nurses, and ‘those coming from the rural areas’ bringing their traditional beliefs, an assertion that echoes the scientific ‘knowledge’ versus traditional ‘beliefs’ divide (Good 1994). The sister implies that the nursing staff, as distinct from their clients, have renounced traditional ways and do not believe in the efficacy of the remedies she describes. Pursuant to this interpretation she is anxious that

those who do accept the beliefs associated with traditional health practice should not ‘impose’ them on the nurses. Yet there is a paradox here, for in emphasising the nurses’ concerns about the possible effects of touching the medicines, the sister unconsciously implies that the same nurses may not be as inured to belief in their agency as she might suggest.

The same sister then went on to describe what she clearly felt was a better scenario, one that came from her experience working at a clinic in the older Cape Town township of Gugulethu:

‘In Gugs they [the patients] take off the traditional medicines before the examination, and after examination they put it back because they know this is a medical centre. But we know that many of them they do believe in traditional healers.’

Fieldnote: 17.03.09

Here, the sister approves a much clearer separation of powers, in which the authority of biomedicine and the clinic in which it operates, are evoked as necessarily separate from other healing approaches. Use of biomedicine it seems, requires that clients renounce, however temporarily, any other health understandings: for instance, in response to a question about whether she believes that patients tell the clinic staff when they are seeing traditional practitioners, a young nurse trainee at Mfuleni told me, ‘No they don’t, because they know they’ll be told not to go there!’ Outside of the clinic then, clients may hold to their traditional ways (and wear their *muthis*) but once inside it they are expected to ‘stick with us’, as a nurse from the clinic in Delft South once bluntly put it to me.

How does the experience of medical doctors working in the clinics compare to the testimonies from nursing staff? Before my fieldwork experience, I confess that, given the conflicted history of medicine in South Africa, I had expected that a proscriptive attitude would prevail. However, work in the field suggests that medical practitioners, notably those from a different cultural background, are not so much intolerant as simply ignorant of the signs and significations of traditional medicines.<sup>12</sup> Asked about personal experience of clients visiting traditional practitioners, for example, a doctor at Mfuleni replied that ‘people don’t volunteer information, and we [medical doctors] are quite arrogant, we don’t ask the clients.’ An English and Afrikaans speaker, this doctor used a Xhosa-speaking community based carer to translate for patients. During sessions it became apparent that, perhaps operating her own version of the scenario of ‘private acceptance and public denial’ described by Digby and Sweet (2002: 125), the translator did not point out evidences of the use of traditional medicine

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<sup>12</sup> This finding is borne out by my teaching work with medical students at the University of Cape Town’s medical school at Groote Schuur Hospital.

which I was able to pick up.<sup>13</sup> The doctor thus missed some important clues that could have assisted her in the negotiation of treatment strategies for her clients.

## Porous Boundaries

As I have already rehearsed, the negotiation of health strategies is complicated. Evidence suggests that not all nursing staff are as determined as the PMTCT sister for example, to keep the boundaries between the biomedical and traditional worldview separate. Indeed, according to the testimony of the traditional healers, some black nurses appear quite sanguine about the role played by the *amagqirha* in Project HOPE. *Igqirha* 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, another *igqirha* attached to Project HOPE, 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 tensions that exist discovered by Digby and Sweet (2002) within the ranks of the black African nursing profession on the issue of relationships with traditional healers:

‘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

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<sup>13</sup> The doctor later acknowledged that she would not herself have recognised these signs, and was sympathetic to the idea that traditional healers might be utilised in this advisory capacity.

The efforts of some nursing staff notwithstanding, the boundaries between traditional and western medical paradigms are porous, as this excerpt from Nomonde clearly demonstrates. The extract suggests that some nursing staff do indeed operate as ‘culture brokers’.

But there is also evidence in these testimonies of the marking of boundaries – the healers protecting their professional turf, as it were. My research with the *amagqirha* involved in Project HOPE has unambiguously shown that they do not view their induction into western medical understandings of HIV/AIDS as a capitulation to biomedicine, but as a genuine, and hopefully reciprocal learning process (Wreford 2009). They are nonetheless aware that clients utilise their services and those of the clinics pragmatically, and that there may be risks to their own professional status in this ‘treatment itinerary’ (Janzen 1992). Accepting this premise Nomonde here stresses that clients whose arrival at the clinic was in the first place dependent on her advice and counsel, should return, or better still, be referred back to her, because, as she puts it, ‘[they] came to me first for help.’

## **Culture brokers?**

The ethnography presented thus far confirms that black nurses working within the biomedical environment of the local clinic have at times to negotiate some complex questions in connection with traditional healing practice. Is the notion of black nurses as ‘culture brokers’ still plausible? The findings presented here do seem to suggest that black nurses can indeed act as bridge builders between traditional and western medical systems. However, as Digby and Sweet discovered, it is a role that is by no means comfortable or straightforward and although some nurses may be more willing to accept traditional healers as providers of a parallel health system, others are less sanguine. Even as they straddle this uncomfortable ‘either/or’ situation, nurses may be conscious of the (frequently quite hostile) attitudes towards traditional practice promoted by the church organisations to which they belong. Their unease then, is not simply concerned with the science of biomedicine, but also relates to the alleged associations with evil, or wrongdoing that are attached to traditional practice and practitioners.

Some nurses are willing to adopt a ‘liberal’ attitude to traditional healers and their remedies, and may even quietly engage with different healing strategies. In so doing, they tacitly acknowledge and even encourage 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 this is

considered as a personal matter for their clients and not one that is part of the service provided within the 'medical centre.' Moreover, any acknowledgement of their clients' use of traditional health practices must be negotiated within the scientific environment in which such strategies are more often than not considered alien or antagonistic to the aims and objectives of the clinic.

Questions of status, intellectual superiority and personal security also come into play. As Digby and Sweet point out, it is not known how many black nurses in South Africa 'either believe in, or actively consult, traditional medicine' as a result of tensions related to medical or religious allegiances (2002:124 -125). As some of the testimony presented here suggests, nurses at Mfuleni are very conscious of the value of their western education, of their nursing training and skills, and of the social status that these privilege. The practices associated with traditional healing on the other hand are envisaged as 'primitive', the product of poverty or the inadequate education associated with life in the 'rural areas' of South Africa. It is entirely possible that some of these black nurses, conscious of their social position both within the profession and in the wider community, chose to withhold sharing their own private views about traditional medicine while they were on biomedical territory. Although I did not see anything suggestive of the 'schizophrenic' situation which Digby and Sweet describe, I appreciate that conflicts are probably unavoidable.

It is noticeable however, that community health workers employed by HOPE, and VCT counsellors, were in general less reticent about admitting to their own and their clients' use of traditional healers on occasion. This is not altogether surprising. Although their work is based within the clinic environment, their success depends on the maintenance of close links with the communities they serve. Even those community health workers who were committed members of church organisations, and who at times expressed quite negative opinions about the practices of traditional healers, nonetheless shared this 'healthworld' with their clients and were usually prepared to acknowledge its influence and efficacy. Finally, their comparatively lowly position in the clinic hierarchy makes them less vulnerable than the nursing staff to criticism or censure for accepting alternative healing strategies. As representatives of western medicine, the nurses may feel that they have far more to lose.

## Part Two: Witchcraft, Medicine, Belief and HIV/AIDS

In the first section of this paper I examined the contested territory of the medical clinic to explore the ways in which strongly held religious viewpoints might affect health interventions designed around medical collaborations between different healing paradigms. The ethnography presented so far does not however, altogether explain the suspicion and concern expressed by church-going health workers, black and white, about *ubungoma*. Arguably one issue stands out in this regard: the subject of witchcraft, and this provides the focus for the remainder of the paper.

### Healing, not harming

Interactions between traditional and western medicine in Africa were historically very limited, not least because European doctors were from the start determined to assert scientific medicine as ‘the dominant paradigm’ (Digby 2006: 94-95). The misnomer of ‘witchdoctor’ which was, from first contacts, applied by colonial missionaries and medical practitioners to their African counterparts, was possibly spurred by the discomfiting realities and undeniable ambiguities surrounding witchcraft (Wreford 2008: Chap 8). But this erroneous identification of healers such as *igqirha* and *isangoma* as one and the same with their opposite, the *igqwirha* or witch harmers certainly presented a particularly formidable barrier to communications. In the present, this connection continues to be promoted by some religious institutions, and, especially for those medical personnel who espouse these homiletics, this presents an obvious challenge to the idea of collaboration.

The misleading characterisation of traditional healers as harmers probably reflects an awareness of another historical reality: after all, early European beliefs, religious and medical, consisted of confusion with, as Porter graphically describes it ‘the word *pharmakos* [meaning] both remedy and poison – ‘kill’ and ‘cure’ were apparently indistinguishable...death and the doctors riding together’ (1997: 4). Indeed, since Europeans understood health and illness in these conflicting terms until the ‘age of reason’, it is not inconceivable that the rebuttal by religious organisations and contemporary biomedicine to suggestions of collaboration with traditional health systems actually rests on a collective memory, even fear of this ‘residual shadow presence’ (9).

Whatever the reality of this proposition, the witchcraft worldview, often portrayed as a consequence of ignorance or naïveté, presents a reliable target – albeit a thoroughly intangible one – for accusations from church organisations and medical opinion that traditional health practitioners are, if only by association, evil in intent.<sup>14</sup> In this interpretation the subtleties of the essential separation between evil and good, between the witch (*igqwirha*)<sup>15</sup> as the harmer, and the *igqirha* who acts to heal the harm that witches do, is easily obscured, substituted by a simplistic characterisation of the healers – the *amagqirha* and *izangoma* - as themselves harmers.

What is undeniable is that the understandings of health and illness on which traditional African health practice is premised, and in terms of which it is recognised by the communities that it serves, necessarily encompass the discourse of witchcraft. In reaching their diagnoses traditional healers must negotiate within a complex worldview that relies on the generally beneficent agency of ancestral spirits, but also acknowledges the malevolent power of witchcraft - acts motivated by individual greed, envy, rage, jealousy and sometimes pure malice - with the deliberate intention of bringing harm to others. Contemporary church members and local clinic staff may, as Preston-Whyte finds, deny the existence of witchcraft, but ‘rumor and gossip continually suggest that other people take it seriously, and many are convinced that they or their neighbors have evidence to substantiate their belief’ (2008: 266). Mavhungu takes this proposition even further, describing African societies as existing in ‘social worlds that are engulfed in constant fear resulting from people’s experience and knowledge of witchcraft’ (2002: 75). Building on this societal anxiety about the association of healers with harming and evil enables church organisations to promote a further connection – that of healers with the ‘devil’ – an idea that has steadily gained purchase in popular opinion. Thus, as Rödlach’s Zimbabwean research shows, traditional healers ‘are frequently thought to be involved in benevolent as well as malevolent activities; thus diviners and healers are seen as ambiguous persons with the potential for being sorcerers’ (2006: 24-25).

It has to be said that the healers are often apparently complicit in this uncertain territory, albeit to protect themselves from accusations of guilt by association. As part of the Project HOPE training, for instance, I requested a discussion of

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<sup>14</sup> Exceptions do exist. The Jesuit priest and anthropologist Peter Knox for example (2008) and de Rosny (1985) provide sympathetic and thoughtful commentary on traditional African healers; but the same prejudicial stance is also reflected in biomedical opinion.

<sup>15</sup> The potential for in this conflation of roles is however clearly present in local terminology, as the disconcerting similarity of the Xhosa word for witch *igqwirha* and the word *igqirha* (diviner/healer), shows.

witchcraft in the context of HIV/AIDS. The *amagqirha* greeted the idea with some obvious disquiet. Although they acceded to my request, it was evident from their reticence during the session, and the uncomfortable looks shared by participants, that they were extremely reluctant to admit to possessing any actual experience or knowledge of witchcraft, no matter the context.<sup>16</sup> Rödlach discovered the same in his attempts to uncover healers' attitudes to the links between 'sorcery' and HIV/AIDS causation. He found his efforts thwarted by the healers' defensiveness, as, 'perhaps aware that they would be the prime suspects of sorcery practices, they adamantly denied them' (2006: 24).

The moral ambiguity accompanying witchcraft is reinforced by the fact that some remedies, regularly requested by clients, and supplied by traditional healers, are popularly understood as 'witchcraft'. 'Love potions' serve as a useful example of this phenomenon, and one that is particularly relevant to the discussion of witchcraft in the context of HIV/AIDS. Such substances are designed to persuade wandering partners, husbands or wives to return home and never to stray again: an apparently benign intent which has aptly been described as putting 'a fence around the home' (Rödlach 2006: 88 - 90). At face value any attempt to enforce more responsible sexual behaviour seems commendable, not least in the context of the pattern of multiple relationships which ethnographic studies have suggested as a primary driver of HIV/AIDS in Southern Africa (Epstein 2007; Thornton 2008). Yet when I asked a colleague, an *igqirha* who has been practising for many years about her use of similar substances, she denied any knowledge of them and insisted that they were only supplied by 'witchdoctors'; the same response was given by the *amagqirha* involved in project HOPE and was discovered by LeBeau's research with healers in Namibia (2002: 99).

What might prompt this denial? One answer lies in the confusion rehearsed above of the colonial concept of the 'witchdoctor': If, as this namer suggests, the witch and the doctor are one and the same, then in order to avoid being labelled as witches, healers naturally deny connection with any practice, including the use of love potions, which might fall into that category. Another explanation lies in the effects of colonial legislation still in operation, which simultaneously declares witchcraft 'a false belief' and yet makes the practice of witchcraft accusation illegal. This, some suggest, has created a situation that increasingly undermines community respect for traditional healers and has led to an increase in witchcraft accusations against them (Mavhungu 2002: 75 -76).

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<sup>16</sup> The personal consequences of this session were extremely uncomfortable for the author, as described in Wreford 2008b: 222.

## Witchcraft or HIV/AIDS?

The connection between HIV/AIDS causation and witchcraft has been especially evident in responses to the disease in Africa, explained by anthropologists and others as an attempt to ‘make sense’ of the arrival of an unexplained illness, by linking it to the recognised phenomenon of witchcraft, with its uncanny similarities, in symptomology and aetiology (Ashforth 2005; LeBeau 2003; Knox 2008; Rödlach 2006; Wreford 2008b: Chap 8). More insidiously, as I have described elsewhere, the attribution of blame to witchcraft can serve as a mask or shield against the greater shame of admitting to a diagnosis of a highly stigmatised disease (Wreford 2008c).

Biomedicine often accuses traditional healers of encouraging such ideas (Wreford 2008a) but it is important to note that medical staff on occasion also rationalise their own status by this means. As research into prevention messages has shown, knowledge of the medical aetiology of HIV/AIDS does not guarantee acceptance, and health workers can be discovered insisting on witchcraft causation, especially when they confront the personal crisis of a positive diagnosis. Take for example this story, told by a HOPE Community Health Worker. Her friend, herself a nurse, had tested for HIV and been found positive, a diagnosis she disclosed to the community health worker. Her response was to travel to her home in the Eastern Cape, where she sought out a traditional healer. On her return to Paarl she reported that the healer had diagnosed that “Someone has poured this on me.<sup>17</sup> Now, I am better!” The nurse’s willingness to consult the healer suggests that she was in denial about her HIV status, and already constructing a causation that fitted a witchcraft scenario: This would explain her visit to the healer as a logical step in the process of discovering the perpetrator. But what could account for her denial?

The nurse was, after all, a trained health professional. Why did she then reject the HIV diagnosis and prefer instead the advice of a traditional healer? One very probable reason for her resistance is the stigmatization that continues to accompany disclosure of HIV status in South Africa (Almeleh 2006). Ashforth suggests that the acknowledgement of HIV/AIDS, like witchcraft, is a strictly hidden business, arrived at in secret and behind closed doors (Ashforth 2002: 135). But my research suggests that there is more at work in this conflation of witchcraft and HIV/AIDS than mere denial. What is at stake here is the question of personal agency in the face of a death-bringing illness. In other words, the capacity of a person made ill to take action to become better.

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<sup>17</sup> The notion of something being ‘poured’ into the victim is symbolic of the use of witchcraft.

Let us unpack the nurse's story with this in mind. With her biomedical education and training one can safely assume that she understood the implications of the positive HIV result. No matter that HAART might later be available to her, the disease might still present itself more in terms of a death sentence than of a controllable condition, for crucially, she would have understood that there is, as yet, no cure for HIV/AIDS. She would thus be rendered powerless to change her situation. An explanation of witchcraft, on the other hand, offers agency, for it gives the possibility of an intervention, by means of an *isangoma* or *igqirha*, aimed at healing. The nurse appears to have adopted this strategy, and her optimistic (albeit foolhardy) denial of her status on her return from the Eastern Cape suggests that, for her, the approach had "worked."<sup>18</sup>

## Demonising Symptoms: Interpreting HIV/AIDS

The following excerpt, which comes from a counselling session at the Mfuleni clinic, provides another example of the conflation of witchcraft and HIV/AIDS, and the assumed authority of traditional healers to intervene. The counselling had been initiated as a result of the suspicion of TB, and was intended to encourage the client to test for HIV/AIDS.<sup>19</sup> The counsellor, a Xhosa-speaker in her early forties, has been working at Mfuleni for some months, and is employed by the Philippi Trust, one of the NGOs providing HIV/AIDS prevention and treatment services in the Western Cape. Accompanied by his daughter, the client, a man of perhaps 50 years, had only recently arrived from the Eastern Cape. He looked exhausted. After introductions, the counsellor proceeded to explain the connections between TB and HIV/AIDS and the importance of testing for the latter. During this explanation I noticed that the man remained quite detached, but frequently looked across at me. I was therefore not entirely surprised when the counsellor explained that he had inquired whether I was a *sangoma*. When this was confirmed, his daughter immediately described her father's other symptoms – including sleeplessness, emotional disturbance at night and bad dreams. This, she said, had been upsetting the whole family and

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<sup>18</sup> I should stress that I do not endorse the nurse's denial – I was as surprised as the health worker by her story. I merely use this narrative to accentuate the authority of witchcraft discourse as a means of empowering those made helpless in the face of a biomedical diagnosis of HIV/AIDS. I also wish to emphasize that while biomedicine may continue to insist on agnosticism regarding witchcraft, it must also accept that patients will continue to take the unfinished business of their illnesses - the social, moral, and psychological concerns which underpin them - to a traditional health practitioner.

<sup>19</sup> The symbiotic links between HIV/AIDS and TB are well known. Patients, especially males, are often very reluctant to test for HIV/AIDS but willingly present themselves at the TB clinics. Should the suspicion of TB be confirmed, they are then encouraged to take an HIV/AIDS test. Many refuse.

her inference was that these symptoms were far more significant than the physical problems possibly associated with TB or HIV/AIDS which were the sole priority for biomedicine. She told us that the family had consulted two traditional healers, with no effect. Could I do something to help?<sup>20</sup>

It was very evident that the clients in this excerpt, father and daughter, both suspected that witchcraft was involved. The father's emotional condition was it seemed, at least as important and significant as his difficulty in breathing, weight loss and harsh cough: certainly the two were co-dependent. Thus for these clients, the medication for TB (or AIDS), whilst it might alleviate the physical symptoms, seemed unlikely to provide an answer to the disturbed sleep and nightmares which represented to them a malign influence requiring an entirely different approach. Accepting this premise, they had already consulted two traditional healers to remedy the situation; that the healers had been unable to solve the problem did not so much evidence the inefficacy of traditional practice, as confirm the power of the bewitchment. Of particular interest in this case is the fact that, during this discussion, the counsellor appeared to find no contradictions with the clients' clear attribution of witchcraft to the father's situation, and her own biomedical role and objective of persuading the man to test for HIV/AIDS.

## Rituals of redemption

The ethnographic excerpts presented in the second part of this paper demonstrate the reality of the plural health worlds of South Africa. In negotiating this complex environment the territory of local clinics, the minds of the staff working there and of their clients, become contested spaces, the location of a variety of contacts that necessitate the simultaneous consideration of scientific, religious and traditional illness explanations, especially in connection with HIV/AIDS. The impact of witchcraft and its various roles on health decision-making and health providers is necessarily much in evidence, in exchanges that are occasionally overt, but are more often likely to be subtle, or hidden entirely.

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<sup>20</sup> This request presented obvious professional and personal dilemmas, and my response was necessarily guarded. Some black African clients, attribute white *izangoma* with particular authority (Wreford 2007a), and the clients' interest in consulting my services as a healer may have derived from this position. On the other hand, I was anxious not to appear to be taking work from the local *igqirha*. My practice is also at a considerable distance from Mfuleni. Eventually I suggested rather that I refer them to the HOPE *igqirha* working in Mfuleni. The daughter replied that 'the family will talk about it first' and then decide.

In the first narrative concerning the HIV positive nurse, evidence is offered of a potentially self-empowering role for witchcraft. In this example, using the attribution of bewitchment to account for her diagnosis, the nurse attempts to reclaim some agency over the life threatening disease. Unlike the medical identification of the disease, a diagnosis of witchcraft for HIV/AIDS causation is seen here as allowing for its opposite, and the possibility of some redemption: the bewitched can also be un-witched. Having received a confirmation of witchcraft for her condition, the nurse conceivably requests a cleansing of the contamination from the traditional healer. Thus enacted, within the familiar context of reverence and acceptance of ancestral authority as represented by the *isangoma* or *igqirha*, the ritual appears to have empowered her emotional body even though it remains powerless to affect the virus itself.

The second case exhibits the same tension between health worlds. The anxiety of the TB client and his family about his situation (and the need to attribute a reason for it) renders inadequate the purely biomedical interpretation of the symptoms offered by the clinic staff. Whilst father and daughter (and the counsellor) do not wholly dismiss the biomedical explanation for his symptoms, they are fully convinced that there is something else involved; something so fundamentally wrong that no regimen of pills offered by the clinic staff will solve the situation. For an explanation of this ill, and for remedy, they must consult a traditional healer: their search for resolution will continue until they are satisfied of a positive outcome. Whether or not the family in this example follow the strictures of western medicine with regard to the medical treatment of TB (or HIV/AIDS) it is very unlikely that they will not keep trying to resolve the deeper, 'behind the scenes' issue that, in the context of the power of witchcraft, makes so much more sense to them.

These ethnographic examples evidence the discomfiting reality that witchcraft causation has become a familiar strategy for the explanation of HIV/AIDS in South Africa: for those who cannot acknowledge their illness, for those who wish that their circumstances could be otherwise, and for those who genuinely believe that witchcraft is responsible for the disease. I would like to suggest that these constructions, together with the practices that accompany the treatment of witchcraft, could be utilised to secure some redemption for the afflicted. Building on the authority of the *amagqirha/izangoma* as healers of pollution and witchcraft, I propose that the aetiological construct of witchcraft as an agent of HIV/AIDS causation, particularly the cleansing rituals utilised as agents of its transformation, could be powerfully employed in the context of *amagqirha/izangoma* practice. How might this transformation be achieved?

For traditional healers and their clients, the first, *essential*, step to recovery from pollution involves the ritualised application of a remedy to cleanse and purify the body (and spirit) of the corrupting influence. I suggest that this strategy - the application of specially designed cleansing rituals – has the potential for beneficial outcome, especially for people living with HIV and not yet taking HAART. I am persuaded of three potential effects of the voluntary participation of those living with the HI virus in appropriately designed cleansing ceremonies: First, individuals and families living with the virus could thus be provoked, not to bogus physical recovery, but towards a powerful healing of the emotional distress of the disease. Moreover, since research has demonstrated that stress of any sort acts negatively on the immune system (Whitesman and Booth 2004) it is reasonable to suppose then that the relief of emotional distress obtained from a cleansing ritual would act beneficially to boost the immune system. Secondly, such rituals, carefully executed, might do much to undermine the personal and collective negativity of the stigma that attaches to HIV/AIDS. Finally, taken together, these outcomes would I believe, enhance the possibilities of a more proactive engagement with the disease, and its treatment.

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