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‘WE CAN HELP!’ A LITERATURE
REVIEW OF CURRENT PRACTICE
INVOLVING TRADITIONAL AFRICAN
HEALERS IN BIOMEDICAL HIV/AIDS
INTERVENTIONS IN SOUTH AFRICA

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Abstract

This review describes the available research literature involved with efforts at collaboration between Traditional African Healers (TAHs) and biomedical practitioners in HIV/AIDS interventions in Southern Africa. The paper draws on academic texts including published and unpublished research papers, books and reports, and press comments on the subject. The focus is on Southern African literature, but selected texts from elsewhere on the continent are also included. The paper interrogates, in particular, the roles assigned to more spiritually inspired practitioners, such as sangoma, in these interventions. The paper considers the effects on relationships between biomedicine and the traditional health sector and explores some of the obstacles in the way of successful future collaborations. The analysis addresses the following questions: What are the roles assigned to sangoma and other traditional health practitioners in biomedically constructed HIV/AIDS interventions to date? What has been the experience of sangoma and traditional health practitioners of these interventions, and how have biomedical professionals involved in these interventions responded to the traditional health practitioners? What factors contribute to negative responses where these occur, and how might these be addressed? Could the roles of sangoma and traditional health practitioners be enhanced to improve the effectiveness of HIV/AIDS interventions?

Structure of the Review

The paper starts with definitions of essential terms. This is followed in section 1 by an overview of the social and political background to collaborative efforts.

Space does not allow for a comprehensive coverage of the largely anthropological research which has focused on the cultural concepts and practices of traditional African healing across the continent; a brief review of some essential references is included in section 2 in order to contextualise the rest of the paper.

The material in the remaining sections is considered under three subject headings. Section 3 examines studies which are generally but not exclusively motivated by the recommendations for medical collaboration suggested by the World Health Organisation at the Alma Ata conference (WHO 1978). Emphasis is placed on the effects of collaboration on policy-making strategies for African health care, and includes a discussion of the associated WHO policy advocating the professionalisation of African traditional healers. Section 4 explores some early examples of efforts at biomedical/traditional co-operation in Africa and notes the tendency to concentrate on members of the traditional health community such as traditional birth attendants (TBAs) and herbalists who were considered more ‘acceptable’ to biomedicine. Section 5 comprises an examination of examples of co-operation between traditional healers and biomedical professionals in Southern Africa, with specific references to South African models and a focus on interventions in STDs and HIV/AIDS.

In general, the review demonstrates that despite the impetus which HIV/AIDS ostensibly offers to programmes of collaboration, the few examples that actually exist have been ‘seldom evaluated’ (Green *et al* 1995: 503; King 2000: 22). The paper concludes with recommendations and ideas for future research based on the review findings.

Definitions

Traditional African Healing

The term ‘traditional’ is employed throughout this paper to describe the healing practices and medical understandings of Africa. Despite objections to the phrase in anthropological and philosophical discourse (Abu-Lughod 1990; Feierman 1985; Hammond-Tooke 1989), the employment of the term reflects the idiom of the healers themselves. Traditional African Healers (TAHs) interviewed in the field remain convinced and satisfied with the appropriateness of the title, and on

this basis alone, the choice of the phrase is theoretically valid (Wreford in progress). There may indeed be *advantage* in the word ‘traditional’ as an implicit acknowledgement of the very longevity and genealogy (though much of it is unwritten), of the healing knowledge of Africa. These are after all medical systems ‘practised by Africans before the arrival of Europeans and the brutal transformations associated with colonial rule’ (Hours 1986: 43). Far from the fixed definitions of culture and history asserted by some African ‘traditionalists’ (Mndende 2000), they continue, not at all unchanged, but thriving and adaptive.

Sangoma

In South Africa, the Zulu word *isangoma* (in this text the *i*, a noun prefix, is generally omitted), is the title most generally used by patients, traditional practitioners, and biomedical doctors to describe traditional medical healers in South Africa. For the sake of convenience, the noun prefix *i*, (pl: *ama*), and verb prefix *uku* are generally omitted in the text, and I use the word *sangoma* interchangeably as the title ascribed to spiritually inspired traditional healers, as a noun, and occasionally as a verb. Linguists may argue about the semantic purity of *sangoma*, and query its authenticity, but this study adopts the language of practising healers in the contemporary environment of the township of Khayelitsha, outside Cape Town in the Western Cape.

The title of *sangoma* in Southern Africa encompasses healing skills which include those of the diviner, herbalist, psychotherapist and community counsellor, not to mention artist, detective, mediator and sensor (Berglund 1976; Fernandez 1991; Ngubane 1977; Hammond-Tooke 1989; Feerman 1985). They have even been described as ‘African shamans’ (Sodi 1988). The title is employed, with variations, throughout Southern Africa, but always with the emphasis on methods of diagnosis obtained through communication with spiritual others (Arden 1996; Hall 1994; Janzen 1992; Reis 2000; van Binsbergen 1991). In South Africa, *sangoma* are identified as having received a ‘calling’ from their spiritual ancestors, a vocation which must be diagnosed by another qualified *sangoma* before the candidate embarks on a protracted, and often painful and emotional training (*ukuthwasa*). This may last several years, and ends when the candidate achieves a final graduation (*goduswa*) in the presence of her/his peers.

Training and practice are organised within and around a framework of rituals which typically involve the slaughter of an animal, the brewing of a sorghum-based beer (*umqombhoti*) at a gathering of *sangoma*, *thwasa* and others

(*inthlombe*). Drumming, dancing (*xhentsa*) and declamation are powerful features of such events, which may last for several days (Berglund 1976; Buhrmann 1984, 1996; Janzen 1992; Reis 2000) and often include episodes of diagnosis. Trance is often, but not always involved in *sangoma* diagnosis (Beattie 1966; Janzen 1992; Ngubane 1977; Reis 2000; van Binsbergen 1991; Wreford in progress: Ch 5).

Sangoma practice, with its spiritual emphasis, differs from the more practical knowledge of other TAHs such as traditional birth attendants, traditional surgeons and herbalists, although in the latter case the distinction is less clear-cut. Herbalists and many *sangoma* share a wide knowledge of the healing qualities of plant and animal materials, but the herbalists are expected to concentrate on the supply and sale of remedies (*muthi*), while the *sangoma* are also required to investigate the reasons for, and sources of illness. Although there is competition between the two professions there is also a close relationship between *sangoma* and herbalists, and *sangoma*, who often prescribe herbs as part of a diagnosis may refer their clients to a herbalist to obtain the prescription.

Sangoma and Witchcraft

‘to admit to being a *ngaka* [Batswana: traditional healer] without knowing about witchcraft, would be like a modern surgeon saying that he lacked knowledge about anatomy’ (Ingstad 1989: 263).

There is inadequate space in this paper for an analysis of the complex and highly ambiguous relationship which exists between *sangoma* and witchcraft, and which I characterise as ‘umbilical’ (Wreford in progress: Ch. 7). But a few points should be made in context.

Sangoma as a healing system predated the arrival of the first Europeans in South Africa, and has operated as a parallel or complementary health service ever since (Pretorius 1999). Many black South Africans will consult a *sangoma* before, during or after receiving biomedical treatment. This is not out of stubbornness or ignorance, but because biomedicine is unable and unwilling to offer explanations for the onset of illness, the ‘why me? why now?’ rationale which forms a crucial part of *sangoma* understandings of health and healing (Pretorius *et al* 1993:18). Without these explanations any treatment regime, no matter how carefully followed, is unlikely to bestow complete healing, for it has

not been designed to deal with the ‘ultimate cause’ of illness (Green 1994: 55). It should be obvious that this has serious implications for all biomedical regimens, not least those related to HIV/AIDS.

A primary source of sickness - generated by envy, jealousy, anger, revenge, or simply pure malice of relatives, friends and neighbours – is understood to arrive through the offices of the harmers, those who send or inflict witchcraft (Ashforth 2001). *Sangoma* persist in being caricatured with the ‘witchdoctor’ label (Kimani 1981b: 333), a misnomer deliberately applied by missionary doctors in the early years of colonial administration (Green 1986: 120-121). *Sangoma* refuse to be involved in harmful practices, but *are* required to heal the damage inflicted by witchcraft. Yet, no matter how vehemently *sangoma* emphasise that their healing practice differs in intent from the destructive actions of witchcraft (Wreford in progress: Ch. 7), the term has proved tenacious. Thus, *sangoma* and witchcraft are symbiotically connected in an ambiguous relationship which makes it difficult to distinguish the healing of the former from the harming of the latter.

This almost ‘obligatory symbiosis’ (Good 1987: 294) is of particular relevance to this paper to the extent that the witchdoctor label tends to work against rational and engaged debate on *sangoma* practice - especially with biomedical personnel (Kimani 1981b: 339). In the South African context, Swartz suggests that ‘indigenous healing...can function...as an arena in which white [health] practitioners can legitimate their own lack of understanding of many of their fellow-citizens’ (1996: 132). In other words, the ‘witchdoctor’ label makes it easier for allopathic professionals to refuse to acknowledge or pay respect to *sangoma*. The realities of witchcraft - however irrational and unscientific they may appear to be – do constitute a discourse that frames and explains many concepts of illness and well-being in South Africa (Green 1999b; Niehaus 2001; van Binsbergen 2001). Biomedical doctors can ignore the discourse, characterise it as nonsense, and treat their patients exclusively according to the norms of biomedicine. But this attitude of wilful ignorance or derision may expose biomedicine to accusations of enforcing a version of what Fields has labelled an ‘invisible ontology’ (2001). By ridiculing the powerful but unseen discourse of witchcraft, biomedical practitioners may be accepting another, equally invisible, belief system made up of ‘extremely resilient falsities’ (*ibid*: 307). If biomedicine continues to prefer ignorance, it may have to accept that patients will continue to take the unfinished business of their illnesses, the moral concerns which underpin them, to a *sangoma*, for only there will they receive ‘real’ healing.

1. Background to Collaborative Efforts

This section outlines some salient points of the political and social structure against which the concept of co-operation between traditional and biomedical practice must be framed.

In 1978, the World Health Organisation 'Alma Ata' conference (WHO 1978) called for official recognition of traditional health practitioners in Africa and advocated their integration into national biomedical health systems, particularly at the level of primary health care. The conference argued that as 'part of the local culture, community and traditions', traditional health practitioners constituted a valuable resource for inexpensive primary health care provision. The notion of traditional healers as 'community health workers', dedicated to the servicing of rural areas, was especially attractive for health structures which were simultaneously cash-strapped and short of trained personnel. Despite these exhortations, a seminar on African medicine in 1986 demonstrated that, apart from some preliminary research into the African *materia medica*, the WHO proposals had largely 'fallen on deaf ears' (Maclean, 1986: 30-36). With the onset of HIV/AIDS, there has been an additional impetus to calls for collaborative interventions, with a special emphasis on the potential role of TAHs as community health educators (King 2000).

Awareness of and involvement in the 'capacity building' potential of Indigenous Knowledge Systems (Crossman and Devisch 2002) has however encouraged considerable interest in other aspects of traditional healing on the continent (Crouch *et al* 1999; Dold and Cocks 1999; Hutchings 1996; Simon and Lamla 1991; van Wyck *et al* 1997). In South Africa, national research institutes and universities are involved in extensive scientific studies of the *materia medica*, often in partnership with pharmaceutical corporates, and advised by practising *sangoma* (Anderson and Kaleeba 2002; Felharber and Mayeng 1999; Gericke 1996; Mayeng 1996; Medical Research Council 2004). But as Maclean (1986) and others have pointed out, this focus on the traditional pharmacopoeia is rarely accompanied by an equivalent preoccupation with the spiritual underpinning of traditional healers (Crossman and Devisch 2002; Green 1986, 1999).

1.1 Traditional Healers, *sangoma* and HIV/AIDS

The ravages of HIV/AIDS have exacerbated demands on public health care systems across the African continent. In South Africa, the health system post apartheid continues to be sharply stratified: An elite multiracial clientele avails itself of biomedical health care at its most mechanised and sophisticated, while at the other end of the spectrum a creaking public health service endeavours to fulfil its ministry to the majority black population. Reports suggest that the pandemic is putting an already overburdened system under immense strain (Abdool Karim 1997; Beresford 2001; Berthiaume 2003; Farren 2002; Kamaldien 2004; Ndaki 2004). Meanwhile, reports suggest that between 60 and 80% of the South African population continues to make the traditional health practitioner its first point of call for diagnosis and treatment (Pretorius 1999: 1). This preference is especially true in the case of STDs and HIV/AIDS (Abdool Karim 1997: 1542; Green 1999; Leclerc-Madlala 2002b: 4). In this context, the possibility of co-operation between traditional practitioners and biomedical doctors obviously needs revisiting.

The response of South Africa's government to the challenge of HIV/AIDS has been described as replete with 'missed opportunities, inadequate analysis, bureaucratic failure and political mismanagement' (Nattrass 2004). Despite the exhortations of grassroots organisations such as the Treatment Action Campaign (TAC) and the Congress of South African Trade Unions (COSATU), the administration is prevaricating on its decision to provide Nevirapine for pregnant HIV positive women (Leclerc-Madlala 2002b: 1), and a promise of access to free antiretroviral treatment (ARVs) throughout the country remains only partially fulfilled (Hassan 2004). The administration rejects an exclusive reliance on conventional biomedical for HIV/AIDS, and advocates the incorporation of traditional medicines in its 'holistic' approach. To this end, the Minister of Health has called for a raising of the profile of traditional healers, and suggested that 'traditional and Western medicine should work hand in hand' (Tshabalala-Msimang 2004).

In contrast to this reluctance to embrace the biomedical therapy of ARVs, the government has enthusiastically sponsored the development of a vaccine for HIV/AIDS. Whilst at first sight this may seem paradoxical, the apparent inconsistency can be better understood when considered in the context of government support for traditional medicine. *Sangoma* practice has long incorporated the notion of the 'traditional injection' in which a medicine is administered to an incision made in the skin with a porcupine quill or more recently, a razor blade. The administration's commitment to the promotion of a

vaccine may be seen simultaneously as evidence of its acknowledgement to traditional medical practice, and, of the advantages of vaccination over the self-administered, and therefore difficult to monitor ARVs.

Alongside this embrace of traditional practice, the government is taking steps to regulate the healers as recommended by the WHO (1977; see also Pillsbury 1982: 1826). Following earlier examples in Ghana, Tanzania, Zambia and Zimbabwe, the South African administration is enacting legislation designed to 'professionalise' traditional healers. The Traditional Health Practitioners Bill (THPB 2003) envisages a regulatory system which includes proposals to register all traditional healers - *sangoma* practitioners, herbalists, traditional midwives and surgeons. The legislation promotes a radical redefinition of the training and practice of traditional practitioners, notably the *sangoma*, in proposing to establish notified 'institutions' for training (*ibid*: 20). This regulatory structure posits a two-tier arrangement for future *sangoma* qualification and challenges the notion of the spiritual gift which has conventionally defined most *sangoma* healers. On the one hand there will be those who have passed and are certified in officially certified premises, and on the other those who have followed their ancestral calling. The effects of this strategy in South Africa have yet to be seen. Zimbabwean practitioners for their part have accepted this distinction, and recognise healers who are spiritually gifted as well as those who achieve their healer status through study (Chavunduka 2004: 2).

The South African regulations also include prohibitions on practitioners making unrealistic claims for 'cures', an important sanction in the context of HIV/AIDS (LeBeau 2003: 43), and one which is considered by the healers themselves a useful tool to limit the activities of 'charlatans' (Wreford in progress: Ch. 2). This prohibitory legislation of course remains to be tested. Recent events in the United Kingdom suggest that a long-standing legal framework for general practitioners has certainly not put a stop to some particularly unpleasant practices by 'rogue doctors' in that country (Andalo 2004). Importantly in the context of this paper, there is also no evidence to suggest that legislation of this sort enacted elsewhere in Africa has made traditional healers any more acceptable to biomedical doctors. It is instructive to note that the South African legislation includes only one reference to 'liaison' between biomedical and traditional practitioners, and offers no practical suggestions for implementation.

Finally, none of these initiatives - scientific studies of traditional herbal remedies, biomedically-defined research into HIV/AIDS vaccines, or professionalising legislation for traditional practitioners - directly addresses the

question of the potential for, and means of establishing, a co-operative relationship between traditional African healers and their counterparts in biomedical practice.

2. An Overview of Traditional African Healing

This section reviews the literature, mostly anthropological, based on participant observation (and occasionally on direct personal experience), which describes the general principles and practices of African traditional healing. It should be noted that although certain premises connect the principles of healing throughout Africa, practices and concepts vary from country to country, and across ethnic or tribal groups. Thus for example in South Africa, the Xhosa and Zulu traditions of healing, while apparently similar in many respects, simultaneously contain considerable differences. Furthermore, traditional healing practice in Africa is flexible and adaptable, and variations appear dependent on social and political factors, the product of a continuously changing praxis.

The texts cited are mainly situated in Southern Africa, but other studies have also been included to offer a broader perspective on African concepts of healing and illness. The review looks first at a group of Southern African healers' life stories. The remaining texts are generally written by anthropologists to portray and interpret some of the fundamental ideas on which traditional African healing is premised - ancestral and other healing spirits, the role of witchcraft and sorcery, natural and 'sent' illness and so on. These texts describe the place of *sangoma*, and other African traditional healers, as interpreters and enactors of these concepts, and explicate the purpose of ritual and the role of TAHs as 'ritual experts' (Kuper 1987: 162).

2.1 Biographies from South Africa

Credo Mutwa's narrative (1996) presents a lyrical blend of African myth and legend interwoven with personal anecdotes. Written from the perspective of a practising Zulu *sangoma* from a genealogy of *sangoma*, Mutwa's tales are both poetic and epic, and designed to convince the English reader of the legitimacy of Africa's claim to a rich and heterogeneous cultural and medical tradition. Three other South African accounts, all autobiographical, offer versions of

disparate experiences of the *sangoma* training of white initiates. Macallum's chronicle (1993) is an honest depiction of the transition of a white Afrikaans woman to healer in the Sotho tradition. The remaining accounts share an exasperating 'new-age' style but are nonetheless original. Arden (1996) provides a blow-by-blow account of her education with a Zulu *sangoma* in Johannesburg. Often humorous, the narrative is also genuine in its respect for the healing traditions of her teacher. Hall (1994) describes *kutfwasa* (initiation and training) in Botswana, a report spoiled by jarring ethnocentric notions. Patrice Malidoma Some offers a history from a very different African healing tradition in his moving and often riveting autobiographical account (1994) of initiation and training as an African 'shaman' in Burkina Faso.

2.2 Versions from the Anthropologist's Tent

Academic anthropological studies provide several 'from the tent' depictions of initiation and training in African traditional healing. Of those specific to Southern Africa, Berglund's study (1976) is a sympathetic and detailed account of Zulu traditions. This is a particularly engaged study, enriched by his eye for detail and comprehensive understanding of the language. By comparison, Ngubane's dispassionate work (1977) does not quite do justice to the potency of the cultural concepts which she so meticulously describes. Janzen's comprehensive survey (1992) remains a source book for anthropologists interested in the traditions of '*ngoma*' in central and Southern Africa, and a useful companion to Hammond-Tooke's extensive Southern-Africa based researches (for example: 1962; 1989; 1994). More recent analyses from Southern Africa have challenged some of Janzen's assumptions, especially his definition of *ngoma* as limited to notions of 'healing and affliction'. Van Dijk, Reis and Spierenburg (2000) describe expanded functions for *ngoma*, still an agency for healing, but within a broader socio-political arena. Reis and Blokland in particular emphasise the intrinsic role of trance in *sangoma* practice which had been vigorously downplayed by Janzen (Blokland 2000; Reis 2000).

2.3 Other Fields

Farther afield, Victor Turner's study (1968) of Ndembu healers in Zambia with its intricate analysis of ritual and healing, is an example of almost iconic anthropological status. Turner's lifetime partner Edith revisits the Ndembu in Zambia to present a very different, experiential version of their dramatic healing rituals (1992). In so doing, she frankly eschews the more conventional tenets of

anthropology which characterised Victor Turner's earlier work (*ibid*: 15). Willis (1999) concentrates on the role of dance in his portrayal of healing events amongst the Lungu of contemporary Zambia. In Niger, Paul Stoller's account of initiation into Songhay sorcery is rich in the notions of the dangerous and unpredictable power of witchcraft (Stoller and Olkes 1987), while de Rosny (1985) depicts his own trepid initiation into Songhay traditions, in a candid account of a dramatic crisis of identity.

2.4 Ancestors and the Collective Unconscious

Vera Buhrmann, a South African Jungian psychotherapist, investigated Xhosa diviners in the Eastern Cape and wrote extensively on her findings (for example 1981; 1984; 1996). In her analysis, the concept of ancestors is equated with Jung's notion of the 'collective unconscious', an ancestral unconscious which acts as motor, motivator, operator and actor in the here and now world of the living. In *sangoma* practice, this unconscious authority, manifested for example in dream, trance and vision (of *sangoma* and patient), supports and assists the *sangoma* healer (Wreford in progress *passim*), and thus reflects the psychotherapeutic model offered by Buhrmann. A later study of Sotho healers (Sodi 1988) offers a similar analysis, and a psychotherapeutically based interpretation of the !Kung healers of the Kalahari is also presented by Richard Katz (1982).

2.4.1 'Working on their behalf'

How congruent is the relationship suggested by these studies? Obeyesekere has reasonably suggested that it 'simply will not do' to imply that before psychotherapy - we might also add before germ theory, penicillin, antibiotics and vaccinations - 'all of us went our muddled ways in the abysmal dark of ignorance' (1990: 21). For *sangoma*, a breach with ancestral consciousness is seen as life-threatening. The victim, literally cut off from ancestral protection is rendered vulnerable to illness or worse (Buhrmann 1984: 37; Hammond-Tooke 1989: Chapter 4; Kiernan 1982), a fragile situation which closely mirrors the predicament faced by many candidates for psychotherapy. Conversely, there is reciprocity in both systems in their relationships with the ancestors/unconscious. (My teacher referred to this process as 'working on behalf of your ancestors' (Wreford in progress: Chap 3). Thus the power - psychotherapists might call it confidence - and insight of the *thwasa* increases

as ancestral patterns are resolved and unfinished business is settled (Hirst 1990; Janzen 1992; Noel 1997; Reis 2000; Taussig 1987).

Jungian psychotherapy and *sangoma* have essentially similar concerns with the sensitisation of individuals to the metaphysical world. *Thwasa* learn to operate as conduits, as spiritual go-betweens, as surrogate actors for and with ancestral consciousness. *Sangoma* envisage this process as an engagement with a collective of spiritually living, tangible beings. Jungian imagery works with the more ephemeral notion of an unconscious collectivity (Buhrmann 1984: 57). Each is a part of a common reality available to those who are prepared to surrender to a broader sensory perception. And as they continue their education into the ways of the metaphysical world, both candidates, for *sangoma* and psychotherapy, may discover in themselves the confidence and ability to help others to their own healing.

In *sangoma*, and to a lesser extent in psychotherapy, rituals bind the ancestors to the local and larger community (Buhrmann 1984: Chap 6; Sodi 1988: 34-36; Wreford in progress: *passim*). Both systems involve versions of divination, clairvoyance, vision, dream, and trance, enacted within ritualised encounters. The cyclical understanding of time incorporated in *sangoma* cosmology suggests a fluidity in existence which is absent in western understandings (Taussig 1993: 97), and makes for an easier acceptance of nonmaterial realities and the notion that one can literally be in two places at once - the source of trance and ancestral knowledge. Western psychotherapists and their clients, as Buhrmann points out, may be obliged to work harder at listening and observing the intuitive, watching for signs and symbols of the ancestral connections which may help to interpret distress (1984: 95 -101).

To develop this comparison of *sangoma* and psychotherapy, it is possible to speculate that the western existential struggle to acknowledge ancestral influence - through psychotherapeutic method for example - is discomfiting precisely because of the separation of the living from their predecessors. After all, if we accept, as Lock wittily describes it, that 'nothing is watching over us, and we only go round once', there appears little reason to elaborate or celebrate our history, memory or tradition, an unbinding predicament which can lead to despair (2002: 199 - 206). As one means of resolving this dilemma, Jungian psychotherapy has come to signify in the west (and in westernised South Africa) just as *sangoma* (and all traditional African healing) continues to signify to the black African community.

2.4.2 Discrepancies

There are discrepancies in the paradigms of *sangoma* and psychotherapy but these do not substantially lessen the near equivalence proposed by Buhrmann. Rather, they may help scientifically minded analysts to explain the efficacy of *sangoma* (1984: 94-95). The nebulous distancing for example, which Jung's unconscious categories suggest, is quite absent in African understandings, in which ancestral beings are ever present to the living and 'deeply implicated' in everyday life (Bond 2001: 137). The essential spirituality of *sangoma* healing – which I have described as its 'sacred pragmatics' (Wreford in progress Chap 3) - is similarly absent in the 'rational self-reflexivity' of psychotherapy, itself the product of 'a modern universe demystified of the magical and religious worldview' (Obeyesekere 1990: 21). The psychotherapeutic process may serve to open up channels to a deeper, even ecstatic self-consciousness, but this is not its primary purpose, nor can it replace the spiritual.

Another divergence resides in psychotherapy's essentially singular focus, its involvement in the private resolution of individual problems. Systems of family therapy do of course exist in western psychotherapeutics, but the emphasis generally remains on a single figure. In contrast, *sangoma* encompasses a broader spectrum, the individual as part of a cosmological wholeness in which ancestral influence plays an integral part. As Buhrmann describes it, it is this 'relatedness of all participants *in* the ancestors', which contributes to the therapeutic success of *sangoma* (1984: 96).

2.5 Co-operative Collaborations

Edward Green offers an unusual perspective on traditional African healing, especially cogent in the context of this paper. His extensive coverage of the subject (for example, 1986; 1988; 1989; 1996; 1999a) derives from the vision of an anthropologist determined to encourage co-operative collaborations between traditional and biomedical professionals. Green's interest in 'indigenous' theories of disease, whilst by no means unique in anthropological academe, is exceptionally focused on the importance of co-operative efforts to attain an intellectual understanding of these theories. His work has by and large focused on Southern Africa, and various parts of his texts will be covered in more detail in sections 4 and 5 of this review. Several of these projects, together with other examples from Africa, are also mentioned in an overview of collaborative interventions in HIV/AIDS, produced by UNAIDS (King 2000)

2.6 Experiential Researches into *sangoma*

This section ends with references to three academic texts which describe personal experiences of the complexities of initiation and graduation into *sangoma* in South Africa. Hirst's offering (1990) is a dry and remarkably disengaged account of his *thwasa* experience in the townships of Grahamstown. In sharp contrast, van Binsbergen's narrative (1991) embodies much of the peculiarly wrenching process of remaking identity which characterised his experience of becoming a *sangoma* in Botswana. Finally, my thesis provides an ethnography of the psychologically challenging process of becoming a *sangoma* healer in contemporary South Africa (Wreford in progress *passim*).

3. Bridging the Gaps: Health Policy and Strategy for Establishing Collaborative Efforts between Traditional and Biomedical Practitioners

With two exceptions (Wreford in progress; Green 1989; 1997; 1999b), the authors in the previous section made no attempt to apply their understandings to the practicalities of health issues affecting contemporary Africa. In contrast, the literature reviewed in this section emphasises research directed at discovering 'common ground between anthropological theory and the practical exigencies of programs in community health' (Pelto and Pelto 1997: 161). The selected texts are motivated by the Alma Ata proposals and/or are related to health policy concerned with sexually transmitted diseases, including HIV/AIDS. The papers are written by anthropologists and other social scientists with fieldwork experience in Africa. They address the problems and challenges - for health policy makers, biomedical health professionals and administrators, and academic colleagues working in the field - implied in the notion of co-operative working relationships with traditional healers.

The writers have been chosen for the different stances which they adopt on the strategies required to achieve such collaboration, but all the papers start from a common position that some form of co-operation between biomedical and traditional health practice is viable and likely to benefit health care in Africa. Several general points are common to the texts, but will not be developed here. Amongst these are: The lack of progress in collaborative projects since Alma

Ata; the inadequacy of biomedicine to service Africa's populations; the perceived fundamental differences between traditional and biomedical health systems; the emphasis (particularly in early collaborative projects) on practitioners perceived as less threatening to biomedicine (most especially traditional birth attendants and herbalists), or on scientific research into the traditional pharmacopoeia, rather than engaging with spiritually inspired healers such as *sangoma*. Four broad headings separate each piece: Professionalising practice, establishing reciprocity, professional obstacles, and building understanding.

3.1 The Professionalising Route

Neumann and Lauro (1982) promote an 'ideal' primary health care system for Africa which would include traditional and biomedical elements. To achieve this, they advocate legislative changes aimed at 'standardizing, professionalizing, or otherwise mobilizing' traditional practice and training. They call for 'beneficial coexistence' based on:

- i. Government licensing of TAH's
- ii. Establishment of formal schools for candidate TAH's
- iii. Training to 'upgrade' TAH skills and/or
- iv. Incorporation of selected TAH's into Ministry of Health systems
- v. Recruitment of licensed TAH to 'rural health outposts'
- v. Research into the traditional healers' materia medica (*ibid* 1817-1819)

This bureaucratic approach may indeed be an essential step for traditional healing as the WHO has acknowledged (1977). A legal framework for traditional practice is one way of mollifying the professionalised ranks of suspicious biomedicine by regularising the traditional in familiar structures and reining in rogue operators (Green 1988: 256). As Last describes them, such professionalising policies also offer a means to 'defend [the traditional healers'] right to practice against criticism from an expanding medical profession' (1996:11). Pillsbury (1982) is another advocate of the professionalising approach as a necessary prerequisite to successful collaboration. She however stresses the importance of reciprocity in this process, insisting that when programmes are evaluated evidence should be considered of the extent to which the status of traditional healers has been 'legitimize[d]...to facilitate cooperation with other health professionals' (p. 1831).

Strategies which seek to impose hierarchical formats on hitherto loosely associated groups are bound to experience problems. For example, Green (1996:

51), who has been directly associated with schemes involving traditional healers in several countries of Southern Africa, questions the purpose of a 'compendium of precise laws' to define the status of healers whose skills and competence are so diverse and often, cut across categories. On the other hand, a strategy which limits definitions of healing practice to a few idealised groups (as typified in the South African Traditional Health Practitioners Bill 2003) may be a means of avoiding or downplaying the difficulties of negotiating and operating such a formalised system, most especially where this involves healers such as *sangoma*, who work on the premises of spiritual agency.

MacCormack highlights other hazards of the professionalising route. Healers' associations she suggests, run the risk of being subordinated to 'junior partner' status by the medical professions. Legal status may offer technical legitimacy and the semblance of parity with allopathy. It may also encourage legal actions against rogue *sangoma*, which could potentially undermine the credibility of the profession, especially in the eyes of biomedical agencies (MacCormack 1986:153). There may however be an important advantage in the professional association approach for HIV/AIDS interventions in South Africa. *Sangoma* and other traditional healers, organised within recognised structures, may become more accessible to the promoters of co-operative health programmes, enabling the large-scale replication of successful projects which has thus far tended to be elusive (Pillsbury 1982: 1828).

The traditional healers in Zimbabwe have followed the model of professionalisation for over twenty years, apparently without significant alteration to their reputation or status. The Zimbabwe National Traditional Healers Association (ZINATHA) was established after independence in 1980 to replace a number of ad hoc associations (Chavunduka 1986). Recognised by the government, ZINATHA's register now includes up to 55,000 practitioners (Chavunduka 2004: 2). Similar institutions are operating in Ghana, Nigeria, Swaziland, Zambia, Uganda and Kenya (Green 1988). The South African Traditional Health Practitioners' Bill (THPB) sees the country firmly on the same professionalising path.

3.2 Promoting Professional Reciprocity

'those who will work together should develop their professional relationship (and interdependence) from the start' (University Centre for Health Sciences, Yaounde, Cameroon; quoted in Good *et al* 1979: 150).

The South African Traditional Health Practitioners' Bill (THPB 2003) incorporates many of the points included in a paper by Neumann and Lauro (1982). Two proposals specifically address the question of reciprocity in collaborative projects. The first, a call for 'cross-cultural training' in the medical understandings of traditional healing, advocates reciprocal retraining and education for biomedical staff, health administrators and biomedical students (*ibid*: 1819, pt. 6). Pillsbury (1982) reinforces this notion of reciprocity suggesting that any appraisals of traditional health practices should be accompanied by equivalent evaluations of their biomedical counterparts (1982: 1831). Good *et al* also attempt to encourage a more respectful relationship by criticising biomedical scientists for their assumption that traditional healers are alone in occasionally operating in dangerous or inappropriate ways. Biomedicine as they point out, has had its fair share of 'fads' and some spectacular failures (1979: 144).

Neumann and Lauro's second suggestion is for the inclusion of some traditional medicine understandings into the curricula of biomedical students (1982: 1819 pt. 8). The stated aim is twofold: first to 'personalize' the practice of biomedicine, which appears to recognise the value of the patient-centred approach of TAHs, and secondly, to promote 'appreciation' of traditional ideas of health and illness. Significantly, application of this two-way process in South Africa however, seems problematic; both propositions are conspicuous by their absence in the draft legislation (THPB 2003).

Good *et al* (1979) recognise the 'dualism which characterizes health care in Africa', but notably reject registration and professionalisation as means of promoting co-operation between the traditional and biomedical sectors. Describing legal frameworks as 'alien to the fabric' of traditional healing (*ibid*: 151) they direct attention to the surgery floor as it were, and emphasise instead the 'education' of TAHs. Good *et al* stress the discomfort which biomedicine appears to experience in its attempts to co-operate with healers who work from spiritual inspiration. But this apparently supportive stance towards 'called' healers - such as *sangoma* in South Africa - is contradicted when Good *et al* advocate that TAH's be trained as 'aides' to their biomedical colleagues (1979:150). This title might be applicable to traditional birth attendants (TBAs), who are not 'particularly alien' to biomedicine (Pillsbury 1982: 1826-1827), and conventionally support biomedical objectives. But the appellation is scarcely respectful of the skills and knowledge of other traditional healers, professionals whom Good *et al* accept are already recognised as competent within their own communities (*ibid*: 141-143).

The ‘culture gap’ epitomised by this ‘health aide’ nomenclature may adversely affect collaborative efforts. Pillsbury notes that traditional healers are for the most part ‘mature adults’ (1982: 1830). TAHs are generally older, and, as practicing professionals, quite unlike the ‘village health worker’ concept, generally envisaged as young and, until being suitably trained, without health qualifications of any sort (Maclean 1986). TAHs, Pillsbury suggests, are thus far less likely to accept at face value biomedical training material and instructions. Green (1989) draws attention to another version of cultural distancing, in which he remarks ‘medically educated Africans and their expatriate advisers’ trying to foist western health ideas upon traditional healers (*ibid*: 251). The main lesson for co-operative efforts in both these examples lies in the assertion of the hegemony of biomedicine as the universally valid knowledge system upon which all collaborative exercises should be founded. No matter that traditional healers are anxious to enhance their knowledge of biomedicine (King 2000: 22), the process of ‘retraining’ or ‘re-education’ is essentially perceived as one-way (*ibid*: 15). The assumption of allopathic superiority makes respect for the traditional problematic, and constitutes ‘a poor starting point for co-operation’ (Ingstad 1989: 269).

Thus, despite citing evidence which demonstrates that TAHs are keen to engage in dialogue with biomedicine, these researchers tend to concentrate solely on incentives which might persuade the TAHs to co-operate. The financial inducement of being able to charge higher fees, for example, is most often cited (Green 1992: 126-7; Neumann and Lauro 1982: 1822). Another suggested incentive is the increased status attached to TAHs who have been involved in biomedical ‘upgrading’. However, given the levels of poverty and unemployment characteristic of rural and urban clientele in South Africa, the chance of increasing fees may be counterproductive and represent a dubious advantage. Again, since the primary means of translating the new ‘status’ is likely to be financial, the previous argument will apply. Furthermore, the low cost of these ‘training and education’ schemes which is often emphasised as advantageous for impoverished public health care systems (see for example, Green 1988: 254; Neumann and Lauro 1982: 1820), may simply reinforce the suspicion that the *sangoma* are envisaged as a cheap second-tier in relation to their biomedical counterparts. Meanwhile the incentive of garnering greater respect for traditional healing knowledge from biomedical colleagues, and thereby enabling a professional relationship which recognises the importance of both, remains a stumbling block which few of the contributors considered here identify, and for which none appear to have an answer.

3.3 Practical Obstacles to Policy Change

Pillsbury (1982: 1828) concentrates on some of the obstacles experienced in a selection of 'small pilot or other localized' collaborative efforts; problems, she suggests, which are too often overlooked by the anthropologists who are in the vanguard of their promotion. These are hazards which have relevance for contemporary health policy in South Africa especially in respect of HIV/AIDS. For example, changes in personnel - whether in government departments, local health administration programmes or NGO's - may jeopardise the smooth enactment of promising experiments in collaboration. (In South Africa, one would need to include the shortfalls in staff, training and equipment which have epitomised the government's response to the epidemic (for example Deane 2004; Hassan 2004; Kamaldien 2004)). An opposite, but just as difficult question pertinent to South Africa, lies in the longevity in her post of a health minister whose course of action often appears to be subject more to personal or presidential whim than to considered policy (Dinat 2004; Makgoba 2003).

Pillsbury (1982: 1828-1829) goes on to highlight the lack of evaluation of those few schemes which have been initiated. Other commentators (for example Good *et al* 1979: 148; Green 1988) mention this important oversight, which they agree helps to explain why so few pilot projects are adopted at national policy level (Pillsbury 1982: 1828). This haphazard approach to research projects appears to be reflected in contemporary South Africa. Pillsbury comments that 'supportive international policy' such as the Alma Ata declaration (WHO 1978) may facilitate the adoption of health strategy but by no means guarantees its successful implementation (*ibid*: 1826), an insight which it seems is depressingly applicable at domestic level. For example, only one of the several pilot schemes in Southern Africa reported by Green (1995) appears to have been replicated and independently evaluated (Leclerc-Madlala 2002b).

On the other hand, the lack of evaluation, and the haphazard quality of these schemes may simply be a reflection of the idiosyncrasy of much traditional healing, especially that practised by spiritually gifted practitioners (Wreford in progress: Chap 2). *Sangoma* do not constitute a homogeneous whole. Thus, while it may be obvious that what works in the west is by no means guaranteed of success elsewhere, it is also important to remember that what works for one area of Africa may be quite inappropriate for another. Obviously, the success of co-operative schemes will be advanced by the incorporation of local knowledge and health concepts. However, this is a complex question and the importance of language and expression should not be understated.

This is not simply a question of semantics, but of the ‘language of healing’ (Wreford in progress: Chap 2). Take for example a meeting held in May 2004 at the Tygerberg Hospital, Cape Town. Co-ordinated by the Hope Foundation, a group of *sangoma* had been asked to explain their ideas about health, illness and HIV/AIDS to a group of doctors, health administrators and paramedics. The healers addressed the meeting in ‘*sangoma* speak’, using basic terms like ‘ancestors’ and ‘being called’ with which they were familiar, but which left the audience bemused, tending to reinforce their doubts about the provenance of the TAHs (*ibid.*). Furthermore, the interpreter supplied for the meeting was unable to offer translations for several *sangoma* terms. Anthropologists, social scientists and translators alike need then to be able not only to comprehend the subtle nuances of the healers’ understandings (Treichler 1992), but also able to interpret these often complex notions to sceptical biomedical colleagues (Coreil 1990: 17-20).

Pillsbury notes two other factors applicable to South Africa which may hinder collaborative experiments. First, that the success or failure of TAHs in collaborative schemes should not be assessed in a vacuum. Biomedical performance may also be involved, and evaluation should thus include the scheme, and the performance of allopathic professionals (1982: 1831). In South Africa, the public health service faces staff changes, shortages of qualified staff, inadequate supplies of medication and other essentials, to say nothing of poor facilities and infrastructure (for example Beresford 2001; Motsuku 2003; Ndaki 2004). Under these circumstances, the performance of biomedical professionals is often perceived as inadequate. Secondly, Pillsbury argues that the costs of biomedicine may override and outreach possible expenditure on traditional health initiatives; the additional costs associated with HIV/AIDS in the South African pandemic are taxing health budgets and personnel to an even more alarming extent (Leclerc-Madlala 2002b).

3.4 Promoting Collaboration through better Understanding

‘If you wish to help a community improve its health, you must learn to think like the people of that community’ (Paul 1955: 1, quoted in Good 1994: 26)

Green (1992) is unusual in directing much of his consideration of existing examples of biomedical/traditional collaboration towards the ‘misunderstanding’ of traditional healing practices. Utilising data on traditional

interpretations of STDs and AIDS gathered in Swaziland for example, he calls for anthropological studies of traditional healing practice and of client and healer understandings of STDs and HIV/AIDS, as well as the efficacy of traditional remedies. His thesis on the usefulness of such data to public health, argues that the application of this information to the design of future HIV/AIDS interventions will ensure improved performance. Five years later, both Yoder (1997) and Pelto and Pelto (1997) repeated the call, unfortunate evidence of the lack of progress in initiating this sort of cross-system dialogue.

Pelto and Pelto (1997: 152) emphasise Green's call for an applied anthropology in order to influence health policy and promote intellectual engagement with traditional healing practice. They note that there have been few successful demonstrations of even 'moderate communication' - let alone integration - between TAHs and biomedicine. They call for research methodologies which will 'sharpen the practical use' of ethnography for policy designers. To this end they advocate and outline 'focused ethnographic studies' as a research technique better suited to the acquisition of key information and insights than the more conventional knowledge, attitudes, and practice (KAP) health surveys, or quantitative survey methods (*ibid*: 154-155).

Yoder (1997) parallels the Peltos' interest in establishing the relationship between knowledge and practice related to different concepts of health, disease and illness. Given the dominance of input from biomedical professionals into discussions about traditional health which has already been noted, Yoder concedes that:

'anthropologists working in such contexts face the challenge of negotiating with public health colleagues what information is considered as relevant to the health problems being studied' (*ibid*: 131).

Drawing on his experience of USAID funded projects in Africa, Yoder (1997: 139) is dismayed at the continued resistance of doctors and nurses to recognising the relevance of local knowledge. He suggests that anthropologists have tended to present an uncritical picture of local health understandings, a situation which contributes to the often uncomfortable situation of anthropologists involved in primary health care projects (Mull and Mull 1990). Underlining Byron Good's warning against the anthropological convention of posing traditional 'belief' against scientific 'knowledge' (Good 1994: 20), Yoder urges anthropologists to expand the envelope within which local

knowledge is defined, and demonstrate the relevance of that knowledge to planning and project implementation (1997: 139).

3.5 Discussion: Ways forward to enhanced Co-operation

In the texts cited above, the question of professional reciprocity is occasionally recognised as a barrier to communication across medical boundaries, but there is not much research that suggests a solution, an omission which may continue to jeopardise future HIV/AIDS interventions. An improved understanding of the allopathic definitions and treatment of disease is of course helpful, as the *sangoma* themselves admit (Green 1988: 256). But there exists a parallel and vital incentivisation, one which will persuade suspicious and sceptical biomedical professionals to be similarly enthusiastic about the potentials of collaboration.

A unidirectional and educative approach continues to epitomise exchanges between biomedical and traditional practitioners (Leclerc-Madlala 2002b: 16-17; World Health Organisation 1990). The unwillingness of most biomedical professionals - though there are certainly welcome exceptions (see Friedman 1998; Abdool Karim 1993) - to attempt to understand and incorporate the medical premises of the traditional healers into biomedical interventions is problematic. For anthropologists anxious to encourage co-operation, the question of what constitutes relevance (Yoder 1997) may not be the end of the matter, as doctors may even reject research that is considered too complex (Coreil 1990). All the selections reviewed here tacitly acknowledge that allopathic professionals have something to gain by treating traditional ideas of health and illness seriously; as different to biomedical principles, but in the context, parallel. The author of this paper is herself trained and graduated as a *sangoma* (Wreford in progress). Abdool Karim (1993, 1997), Green (1992) and Friedman (1998) have engaged with the intellectual principles of traditional African healing - the question of ancestors, the primacy of ritual, the notions of pollution and cleansing, for example. This sort of engagement, although challenging to scientific principles can, and should, be advocated as an incentive, a means of improving the design of health programmes that, being better 'linked to reality' (Pillsbury 1982:1831), are more likely to ensure successful outcomes.

4. Early Examples of Biomedical/Traditional Co-operation

Attempts at collaboration between biomedicine and traditional healing had been operating, albeit in a piecemeal and ad hoc fashion, for several years prior to the WHO endorsement at the 1978 Alma Ata Conference. Good *et al* (1979: 149) refer to the experimental use of traditional healers in psychiatry in Nigeria and the inclusion of traditional birth attendants in educative projects in several other African countries. As they point out, it was the ‘localized and limited’ nature of these experiments which Alma Ata sought to change, by moving the question of co-operation onto national health agendas (*ibid*: 148). The aspirations to larger scale and longer term collaborative projects present in the Alma Ata declarations however, did not materialise. The schemes which were initiated - often funded and promoted by outside organisations and NGOs - continued to be identified as ‘individual adjustments to present reality’, rather than efforts to co-ordinate national policies of engagement (*ibid*).

Kimani, for example, describes attempts to coordinate the work of TAH’s and ‘modern’ doctors in Nairobi (1981a). In a related paper (1981b: 335), she describes an experiment directed at the ‘coordination and cooperation of *some selected areas* of the modern and traditional health systems’ (emphasis added), a curtailment which flies in the face of the healers’ (*waganga*) aspirations (however ambitious) for an understanding of subjects ranging from first aid to heart conditions and cancer (*ibid*: 421). In the end, this experiment entailed merely a series of meetings of traditional healers, at which they were to be ‘trained’ in some familiar basics of biomedicine. Kimani is clearly supportive of a more inclusive role for traditional healers, and accepts that mutual learning between health systems would be of benefit. But the lack of mutual respect from biomedical doctors, and their suspicions of TAH practice (especially in relation to the perpetuation of the confusion between *waganga* practice and witchcraft) presented an ongoing handicap to supportive relationships. Kimani concludes pessimistically under these circumstances it is ‘difficult to form any channels of communication’ (*ibid*: 339).

More positive examples of collaborative strategies are included in the reports from a seminar on ‘African Medicine in the Modern World’ held in 1986 (Maclean). I will limit coverage to the more appropriate references. In Warren’s text, several projects invited traditional birth attendants in Ghana to ‘improve their skills’ (1986: 73-86). A preliminary series of schemes led to the establishment in 1983 in Techiman District of the broader-based Primary Health

Training for Indigenous Healers Project (PRHETIH). Funded through the Ministry of Health with support from the American Peace Corps, this example involved a programme of training for 120 traditional healers in simple biomedical principles. Once again the emphasis was on educating the TAHs, and although Warren suggests that relationships with allopathic health workers improved as a result, he offers no evidence for this. The intrinsically related question of mutual respect is nowhere recognised or addressed.

Green contributes a paper describing two pilot projects involving first, traditional birth attendants in Swaziland, and secondly TBAs and herbalists in Nigeria (1986: 115-144). The projects were funded by USAID and the Pathfinder Fund respectively. The former refers to yet another 'training programme...in primary health care' for TBAs, run along similar lines to Warren's example from Ghana. In the second project, Green describes a family planning intervention in Nigeria. Here, TBAs and herbalists (Green notes that male herbalists in Nigeria specialise in midwifery and contraceptive methods) were involved in a family planning intervention. Teaching was provided by biomedically trained nurses and educators. Green remarks that 'the presence of modern-sector professionals helps ensure a certain amount of respectability and pre-empts criticism of the program', a perhaps unintentionally candid assessment of the uncertain state of relations between traditional and biomedical practitioners, indicative of all the examples cited thus far (*ibid*: 138-139).

Finally, Chavunduka (1986: 59-72) extols the development of 'African medicine' in Zimbabwe via the professionalising route described in the previous section (cf. Neumann and Lauro 1982). The advantages for the traditional health sector which Chavunduka perceives in this approach include the recognition of all traditional practitioners as 'doctors', and a development of an independent traditional health sector, financed through the Ministry of Health but 'without much government control' (1986: 63). This is a policy strategy which Chavunduka has developed, becoming a proponent of 'separate development' for the two sectors. He likens the tension between the sectors - a direct consequence of the assumption of biomedical superiority - to a war for the 'total recognition of traditional medicine in Zimbabwe'. While he continues to advocate mutual respect between health sectors, he aims for parallel but distinct operations, including a call for 'two kinds of hospitals, two kinds of clinics and so on' (2004: 6-7). These aspirations seem unlikely to reach fruition in the context of contemporary Zimbabwe, where the public health service is reported as close to collapse.

4.1 Discussion: Lessons for the Future as the Culture Gap continues

The examples included in this section offer evidence of early efforts at collaboration between health sectors, prompted and encouraged by the WHO Alma Ata conference. They provide data which illustrates the limitations of co-operative interventions to date, and so offers guidance towards a different approach in future interventions in HIV/AIDS. First, the preference for collaborations with traditional birth attendants and herbalists, to the exclusion of spiritually inspired healers such as the *sangoma* of South Africa. These associations may be considered 'acceptable' to biomedical personnel because they deal with more familiar practices and are thus deemed less threatening, but this limited approach undermines the plurality of roles and skills exemplified in the idiosyncrasies of traditional healers in Africa. A second characteristic of these projects is their disposition to be small-scale and short-term, with a lack of evaluation which leads to a continual reinvention of the wheel. Thirdly, in the absence of a national policy structure, they are subject to the dispensation of outside funding, and/or changes in supervisory personnel.

Finally, these research samples are exemplary of the one-sided and unidirectional approach outlined in the previous section of this paper. The 'educative' stance typifies the projects, as the traditional healers are called upon to be taught in the ways of biomedicine. In his early contribution to the debate, even Green is unusually disinterested in the health concepts of the traditional practitioners he is working with, while Warren's work unashamedly looks only at 'improving' the traditional. The assumption of the superiority of biomedical science, its 'corrosive authority' (Good 1994: 28) goes without saying, and the idea of co-operative engagement based on complementary theories of health and illness is starkly absent. The 'culture gap' highlighted in section 2 is, it seems, still firmly in place.

5. Collaboration in HIV/AIDS Interventions in Southern Africa

Maria de Bruyn describes the potential of working collaboratively with traditional healers in HIV/AIDS interventions as able to:

‘(1) expand the number of people actively involved in disseminating information and participating in counseling; (2) provide avenues for altering healing practices which might form a possible transmission route for HIV; and (3) make the number of people available for providing care to AIDS patients larger since the healers can help treat opportunistic infections and by their example help eliminate others’ fears that contacts with AIDS patients are dangerous.’ (1992: 258).

The quote is used here to illustrate the educative and behavioural-change emphasis which, as the last section demonstrated, characterised early collaborations between traditional and biomedical practitioners and continues in more current interventions in HIV/AIDS (King *et al* 1994; Leclerc-Madlala 2002b; Mberesero and Mngao 1999; McMillen *et al* 2000; Nshakira *et al* 1995). This section reviews examples of literature assessing efforts at medical co-operation in HIV/AIDS interventions dating from the early 1990s to the present. Most examples are from Southern Africa, but given the small number of texts, others from East Africa have also been included.

5.1 Engagement in Practice? Manica Province, Mozambique 1991-1992

I start with another ‘pilot project’ (Green 1999). In contrast to the early examples cited above, whilst there is still a focus on the role of TAHs in education and behavioural change, a novel approach is apparent in this study. This collaborative venture is unusual in its emphasis on understanding and *utilising* ‘indigenous health systems’. Working from his experience of previous interventions in Southern Africa and elsewhere (for example Green 1986; 1988; 1989), Green confidently promotes the notion of culture-appropriate interventions. For example, in explaining the need for behavioural change in sexual relationships, the traditional healers, who ‘already share - and strongly influence - the health beliefs of those who consult them’ (*ibid*: 74) are paramount. He goes on to argue that their familiarity with customary healing practice and understandings of illness renders the TAHs preferable to the majority of trained biomedical staff even when their input is limited to an educative role.

Green offers practical examples of the potential advantages. From interviews with his healer informants, he gathers useful definitions of traditional categories of sexually related illnesses in Manica province, as well as the interrelated concepts of ‘dirt’ and ‘pollution’ (1999: 68-71). The category *isiki* for example

is ascribed to a group of STDs commonly appearing as ‘cofactors of HIV infection’. These are further classified as ‘naturalistic’ or impersonal illnesses, ‘fundamentally compatible with the medical model’ (*ibid*: 72) - healers for example recognise the possibility of cross-infection from women to unborn children with *isiki* illness. In what Green points out are methods quite comparable to biomedical interventions, treatment of these ‘naturalistic’ illnesses comprises herbal remedies taken internally or applied locally. What is more the medicine is often prescribed along with advice to refrain from sexual intercourse and the consumption of alcohol until better. While Green does not comment on the efficacy of these treatments, other studies of herbal medicines have shown positive results (Homsy *et al* 1999; Homsy and King 1996; Scheinman *et al* 1992).

5.1.1 Pollution and Cleansing, Myths and Realities

The Manica province healers additionally claim that these illnesses may be transferred through ‘contamination’, another biomedically sensible conclusion. The concept of ‘pollution’ is a notion familiar in most Southern African healing systems (see for example Berglund 1976; Jewkes and Wood 1999; Leclerc-Madlala 2002a; Ngubane 1977), and, as Green finds it, ‘not so mystical’ (1999: 70). Pollution illnesses are considered highly contagious, and pollution can be passed on through physical contamination with a person or substance considered unclean or ‘dirty’. The affected individual should be kept apart until a ritual cleansing - usually incorporating the administration of herbal remedies - has been carried out by the healer. Leclerc-Madlala supplies a comprehensive list of the methods of cleansing used by *sangoma* in KwaZulu-Natal as their ‘first-line defence’ against the pollution of illness (Leclerc-Madlala 2002b: 89). From the perspective of scientific medicine, such spiritual cleansing is ineffective and will not challenge infectious illness. But for the traditional practitioner, and the patient, the cleansing is seen as an essential prerequisite, an act of decontamination which will ensure the successful healing effects of any subsequent treatment.

The notion of cleansing is not unproblematic. It has been implicated in a particularly dangerous behavioural myth with direct implications for HIV/AIDS in Africa (Abdool Karim 1997). Leclerc-Madlala describes the effects and gendered nature of the ‘virgin-cleansing myth’ in the context of Zulu tradition in contemporary South Africa (Leclerc-Madlala 2001; 2002a). Leclerc-Madlala points out that the belief in the idea of sex with a virgin as a prophylactic and preventative measure is accompanied by the idea that the virgin-healer will

remain uninfected, the act of unprotected intercourse presumably acting as a form of inoculation against the disease. The notion that a man may protect or cure himself of HIV/AIDS through intercourse with a virgin has often been attributed to traditional healers (see for example Allwood *et al* 1992: 100), but the reality may be different and more nuanced. The story certainly exists in other African countries (the author for example often heard of this practice in Zimbabwe between 1992 and 1997, and while all of Leclerc-Madlala's informants for example attest to knowing others who circulate the story, none of them admit to spreading it themselves (*ibid*: 92). Conceivably, like tales of witchcraft (remarkable for their similarity across the continent), the source of these modern tales may be better placed in rumour and gossip (White 2000) than at the door of a perhaps mythical traditional healer.

5.1.2 Striking Similarities

Green is not alone in identifying Southern African illness categories, and others have also noted some obvious connections to the characteristics of HIV/AIDS: for example the links with blood and bodily fluids, and with sexual relationships (especially with suspicions of infidelity, or with the breaking of sexual mores). In the context of this paper, Ingstad's findings (1990) on this subject are especially pertinent. She points to the similarities in cause (the sexual linkage), in symptoms (wasting, coughing, diarrhoea), and above all in the route of pollution (blood and semen), to the biomedical understandings of the sexual connections, symptomology and means of transmission of HIV/AIDSs. Her research in Botswana furthermore demonstrates that these 'striking similarities' gathered in the years 1984-1985 (before AIDS became an issue in that country) were purely coincidental and not a consequence of familiarity with biomedical health information.

5.1.3 Defensive Forces

In his paper however, Green (1999) introduces an additional concept, that of *nyoka*, an internal force in the body powerfully reminiscent of the immune system. *Nyoka*'s function is to keep the body (and itself) clean and free of pollution, and the methods by which *nyoka* achieves this are through discharges such as diarrhoea, vomiting and menstruation. Green's findings suggest that the *nyoka*-related illnesses understood by healers in Manica province best fit genitourinary infections and conditions usually considered biomedically as not sexually transmitted but having an effect on the genitals and lower abdomen.

Some of these fall into the category of opportunistic infections for HIV/AIDS, and treatments again comprise herbal mixtures taken internally or applied externally (*ibid*: 70 -71).

5.1.4 Different Interpretations and the Sending of Sickness

The question of witchcraft, of illness ‘sent’ by a person who is jealous or angry, or who for some other reason wishes the victim ill (cf. Ashforth 2001; Farmer 1990; Geschiere 1997; Wreford in progress: Ch 6), comprises a further category briefly considered by Green. This class differs from naturalistic, pollution related and *nyoka* classifications. It is targeted or directed at one person, and is not thought contagious. Only one sexually related illness is identified by the Manica province healers as attributable to witchcraft, and is caused by a ‘dangerous medicine used by men to ‘protect’ their wives and lovers from sexual contact with other men’. While Green suggests ‘adultery or infidelity’ (1999: 71) as the underlying cause of this illness, marital jealousy better explains its links with witchcraft.

Ingstad’s earlier work in Botswana (1990) alerts us to the possibility that HIV/AIDS may be interpreted in different ways by different healers in different places. Thus the Botswana healers may choose to classify the disease either as a ‘Tswana’, or, as a ‘modern’ illness, representing a division of ‘the familiar from the unknown’ (*ibid*: 33-38). Their choice may have other implications, and here Farmer’s research into HIV/AIDS in Haiti (1999) should be considered. In Haiti, the sources of illness, like the Manica province classifications, are divided according to ‘natural’ and ‘supernatural’ (the latter includes witchcraft): AIDS or ‘SIDA’ is attributed to both. Haitians believe that preventive measures can be applied against both forms of the disease, but that condoms will only protect against the natural or ‘infectious’ SIDA: they are considered quite useless against the ‘sent’ version (*ibid*: 175-177). The implications of this dual status for HIV/AIDS for behavioural intervention are uncomfortable; if a patient believes that his/her illness has been ‘sent’, it is unlikely that they will easily be convinced of the importance or relevance of the use of condoms. Similar constructions of the disease should be investigated in Southern African contexts. Similarly, Green’s findings of illness categorisation of HIV/AIDS in the Manica province may not be applicable elsewhere in Southern Africa, but certainly suggest an area for fruitful additional research.

5.1.5 Applying the Knowledge

Along with the familiar emphasis on encouraging condom use, referring suspected patients to the clinic, and never re-using razor blades or other tools of traditional injection, Green utilises the new understandings of traditional healing concepts in innovative applications. He develops a strategy for an intervention in which HIV/AIDS is envisaged as a new illness in the existing *isiki* category. As he points out, the fact that the healers recognise *isiki* illness in terms which reflect germ theory (1999a: 72), and already advocate practices which are allopathically sound in relation to existing *isiki* categories – sexual abstinence and no alcohol until better, for example (*ibid*: 69) - seems likely to make this approach a good fit. The *nyoka* concept is also incorporated - characterised as a sort of personified immune system - into explanations of the causes of HIV/AIDS. At the same time, traditional beliefs of the dangers of sex outside of marriage (however defined), with strangers, multiple partners, or people with *isiki* symptoms are reinforced as a means of combating infection (*ibid*: 72-73). This pioneering example of applied ethnography has been noted and advocated by Leclerc-Madlala working on HIV/AIDS issues in KwaZulu-Natal (2002a: 93).

Future interventions in South Africa could learn from the database of sickness categories, and add to it. But it is in their functional application to the design of collaborative programmes with traditional healers that these classifications are distinguished from the theoretical data of more conventional anthropological studies covered in section 1 of this paper. The healers of the Manica province offered notions of health and sickness, notably the concepts of *isiki* and *nyoka* which, applied to HIV/AIDS and STDs, could be re-employed and integrated to provide new, culturally appropriate explanations of familiar illnesses as well as to the HIV/AIDS pandemic. Thus, the TAHs were given information, which helped them to explain HIV/AIDS to self and to others because it was framed within the context of their own understandings and against a background of contemporary social issues.

In addition to the matters already discussed, Green's (1999a) paper raises some methodological questions for researchers in the field of collaborative efforts in HIV/AIDS. Early in the piece, he reveals something of the professional pressures already noted by other anthropologists engaged in this sort of study (Neumann and Lauro 1982: 1823). Green feels compelled to defend his methodology of Rapid Research and Focused Ethnographic Studies, against the anticipated criticism of those who prefer more 'traditional' field techniques (1999a: 66). But his attempts to apply his anthropological understandings

demonstrate an exemplary start in the task of ‘negotiating with public health colleagues what [ethnographic] information is..... relevant’ in specific health interventions (Yoder 1997: 131).

5.2 Educating the Trainers: South Africa 1992-1993

Green *et al* (1995) pursued this involvement and commitment to collaborative strategies with an ‘HIV/STD prevention program focused on traditional healers’ in South Africa. This project, started in late 1992, was initiated by the AIDS Control and Prevention (AIDSCAP) project, funded by USAID with administration by Family Health International and The AIDS Communication project (AIDSCOM), both of the United States. Green cites as references five other seed projects in Southern Africa, including the one just reviewed. The methodology introduced the concept of ‘peer education’ in which a small group of healers were selected for initial training in HIV/AIDS and STD prevention, and then committed themselves to educating 30 additional healers each. The paper reviews the outcome of the project. Green spends much of this paper debating the pros and cons of working with ‘official’ traditional healers’ organisations (relatively new to South Africa at that time), rather than the more traditional groupings he labels ‘*impandes*’ or ‘*ingcambu*’ (isiXhosa). This is a useful debate which may however soon be overtaken by events as the regulatory framework of the Traditional Health Practitioners Bill (THPB 2003) comes into force.

Green’s insights into some of the practical problems stemming from this sort of educative strategy appear prophetic of South Africa’s response to the HIV/AIDS pandemic, and are demonstrably still operating to block the successful implementation of all AIDS interventions, whether collaborative or not. The shortfall of condoms (exacerbated now by short supplies of ARVs, counsellors and trained personnel) continues to be problematic (Deane 2004; Hassan, 2004; Kalmadien, 2004; Siegfried 2004). As Green points out, it is all very well educating TAHs and their clients about the practice of safer sex, and the importance of knowing one’s HIV status, but without an adequate supply of condoms and access to clinics able and equipped to provide ARVs, the lesson will be harder to teach. Another obstacle, an administrative and political one, concerns the difficulties associated with changes of personnel. Finally the confusion and obfuscation which characterises the South African administration’s HIV/AIDS policy is a hindrance which has been noted as especially problematic in South Africa’s response (Dinat 2004; Makgoba 2003; Nattrass 2004).

5.2.1 Confining Roles

Yet, despite its collaborative aspirations to working with South Africa's 'traditional intellectuals' (Feierman 1985: 113), this scheme is content to confine the role of the selected TAHs to that of community educators. Their task is to absorb biomedical information (albeit couched in 'local terms' (Green *et al*: 505)), and spread the word. References already cited show that TAHs are anxious to be involved with biomedicine in educative projects, keen to receive scientific information about the derivations of illness, and disappointed at the lack of respect shown by biomedicine towards their own expertise. Given Green's avowed allegiance to traditional concepts of health, it is curious that this project shows no evidence of extending the boundaries of collaboration, the sort of genuine interest which the TAHs, as respected healers in their own communities, could be expected to demand.

The key to this anomaly may lie with the funding agencies. This project was initiated in the period leading up to the first post apartheid elections, a time characterised by fierce ethnic and political factionalism, and a burgeoning pride in black South Africans' ability to organise their own affairs. Green refers to criticisms of AIDSCAP for working with large NGOs perceived as 'administered by whites' rather than more community-based organisations. The recommendation of involving the *impande* groupings was not supported by AIDSCOM/AIDSCAP who were wary of working with groups perceived as ad hoc and lacking formal structure. One can imagine how much more difficult it might have been to persuade these organisations to take on a more engaged form of co-operation with South Africa's traditional healers.

5.3 South African Experiences: AIDS Foundation in KwaZulu-Natal 1995-2001

Between 1995 and 2001, the AIDS Foundation of South Africa, at the behest of local traditional practitioners, instituted the Traditional Medical Practitioners AIDS Training and Support Programme in KwaZulu-Natal and selected other areas. Prior to the scheme being transferred from the AIDS Foundation to the Provincial Council of Traditional Healers, the scheme was analysed by anthropologist Suzanne Leclerc-Madlala (2002b). The project to date had trained over 6000 healers drawn from rural, urban and peri-urban sites. Philosophically, the project seems to reflect Green's approach described in the previous paragraphs (Green *et al* 1995). Leclerc-Madlala emphasises the

‘deeply empathetic and genuinely concerned...engagement’ of AIDS Foundation personnel to the scheme (*ibid*: 4). The report accepts that the vast majority of clients with STD symptoms approach a traditional healer before a biomedical practitioner, and under these circumstances the role of the TAHs is ‘pivotal’. Practically, the scheme also echoes the 1995 experiment, with an initial group of healers trained and then going on to become trainers of others (Leclerc-Madlala 2002b: 3-5).

Despite the emphasis on empathy and liaison, the limited involvement which characterised the earlier version (Green *et al* 1995) seems to be perpetuated here. The stress is placed on educating the traditional healers, and suggests that this education is designed to educate the TAHs out of practices considered unacceptable, as much as into biomedical praxis. Leclerc-Madlala points to limited evidence of ‘a growing respect’ between the two sectors, but goes on to argue that an improvement in the relationship is ‘an ongoing long-term project’ (2002b : 5): The unidirectional limits of the scheme are soon identified when she suggests that:

‘healers must take it upon themselves to persevere in developing workable relations with local health authorities....Healers should explore ways to turn this good intention into the services they desire, and the healers themselves should seek to define the parameters and tone of their engagement.....It is recommended that the healers take the initiative to ensure that the collaboration between the two sectors is not a one-way promotion of biomedicine amongst the healers’ (p.9. emphasis added).

It is difficult to correlate the AIDS Foundation’s ambitions for two-way communication with the single-handed responsibilities described by Leclerc-Madlala.

5.4 The Way to go? Examples of Collaboration from Uganda, Kenya and Tanzania, early 1990s to Present

Three sample projects reviewed under the ‘best practice’ ordinances of UNAIDS suggest a more proactive strategy for collaborative projects (Anderson and Kaleeba 2002).

Women Fighting AIDS in Kenya (WOFAK) (p. 10-17) is a local organisation providing the now familiar training for traditional healers in counselling, basic education and home-based care. But its innovative policies include a 'drop-in centre' where biomedical and traditional health services are provided 'side by side'; two-way cross-referrals are therefore common and encouraged. In support of this practice of dual treatment regimes, the Kenyan Medical Research Institute (KEMRI) and the Kenyan Forestry Research Institute (KEFRI) are involved in growing, processing and conducting safety assessments and analysis on several medicinal plants utilised by the healers. It is true that this cross-sectoral collaboration is as yet limited to an emphasis on the *materia medica*. Nonetheless, the cross-referral to the research bodies, together with the presence of the TAHs in the clinic and client feedback on successful treatments, renders the biomedical staff in WOFAK less able to ignore their traditional colleagues, and more willing to exchange knowledge.

The Tanga AIDS Working Group (TAWG) (Anderson and Kaleeba 2002: 18-30) in the Tanga District of Tanzania, operates in the context of a more integrated policy at national level, reflecting the Zimbabwean experience (cf. Chavunduka 1986, 2004). A Department of Traditional Medicine already exists in the Tanzanian Ministry of Health, and in Dar es Salaam, the Institute of Traditional Medicine has established guidelines for collaborative projects and is now engaged in formulating a legal framework. TAWG provides services which are broadly similar to those of WOFAK (Mberesero and Mngao 1999; McMillen *et al* 2000) and works out of premises in the Regional Hospital of Tanga District. Biomedical practitioners working with TAWG are 'truly interested in partnering for the benefit of their patients' (Anderson and Kaleeba 2002: 19). Once again the emphasis at present is on the traditional pharmacopoeia and the application of herbal remedies for the successful treatment of opportunistic infections. In this instance, TAWG carries out its own research (Homsy *et al* 1996, 1999; Scheinman *et al* 1992).

The third scheme considered by Anderson and Kaleeba is the Traditional and Modern Health Practitioners Together Against AIDS (THETA) in Uganda (p. 31-46). Here, in addition to characteristics broadly in line with the previous two, THETA reflects Green's confidence in the 'unique ways' in which the skills of the TAHs can be counted on to make these traditional health professionals effective educators and counsellors. An important additional complement to their services, not so evident in the others, is THETA's emphasis on integration of biomedical health workers into the training programme (which lasts up to four years). This, the authors suggest, leads to the creation of 'a relationship of trust, and....[the cultivation of] a genuine interest in each other' (*ibid*: 46). Papers produced by biomedical personnel on the efficacy of the TAHs *materia*

medica suggest that this interest is genuine (Homsy *et al* 1995; Homsy and King 1996).

5.5 Discussion

Although still relatively small scale, and with the emphasis on research into the traditional pharmacopoeia, these three schemes nonetheless demonstrate an innovative direction for collaborative projects. Anderson and Kaleeba attribute their success to:

‘a mutual willingness on the part of traditional healers and conventional practitioners to collaborate, and....a genuine interest in the beliefs and values of traditional healers’ (2002: 8).

In essence, this message may sound very similar to Green’s, but it is in the practical execution of this aspiration to a healthy respect between medical sectors that the approach described here differs. Thus, although the educative and behavioural emphasis of Green’s examples is not neglected, an actively co-operative strategy is pursued, such that the knowledge of the TAHs is used in tandem with that of biomedicine. Importantly, this is not only in meetings or seminars, but also in the treatment room. Of course, as Green noted (1986: 138-139), the involvement of government research institutions in the experiment can only reinforce the confidence of biomedical personnel in this partnership direction.

The policy of researching herbal remedies demonstrated in the WOFAK and THETA projects is similar to the South African Medical Research Council’s Indigenous Knowledge Systems Initiative (IKS) (MRC 2004). First overtures for this initiative were made to TAHs in Khayelitsha 2001 (Wreford in progress: Ch 2). The IKS at MRC is now actively involved with the South African Traditional Medicines Database (TRAMEDIII) based at the University of Cape Town’s Department of Pharmacology and works in conjunction with pharmaceutical investors. How does the MRC envisage the *sangoma* community fitting into this scientific scenario? Publicity for the initiative suggests that ‘traditional health practices’ will be advanced by making the TRAMED database accessible to ‘indigenous people’ (MRC 2004). Beyond giving *sangoma* ‘scientific’ confirmation of the efficacy of substances which originate in their own botanical and spiritually inspired empiricism, and with which they are already quite familiar, it is singularly unclear how this vaunted

‘advance’ is to be achieved. Meanwhile, it appears that the thorny question of intellectual property rights, and presumably, the issue of how to allocate the expected profits from successful production of pharmacological drugs connected with these researches, is presently under discussion (XINHUA News Agency 2004).

Meanwhile, the MRC’s ambitions for the IKS unit as a locus for the ‘integration of traditional and contemporary scientific knowledge’ (*ibid*), suggests that the organisation is going wholeheartedly at the project of incorporative rather than collaborative efforts in the practice of health. At the same time, the questions of intellectual property rights, and the ‘equitable sharing’ of the expected rewards of this research, although they rate a mention in the initiative’s statement of aims and objectives, remain singularly opaque (*ibid*). And it remains to be seen whether the MRC has any intentions of inviting the *sangoma* into the sort of co-operative engagement illustrated in the WOFAK example.

6. Conclusion

Researchers, scheme designers and biomedical practitioners need to recognise that poverty and cultural sensitivity play a huge part in clients’ choice of health care in South Africa. Patients will continue to visit traditional practitioners regardless of the judgements of allopathy. Biomedical interventions should acknowledge this reality and seek to work within this context rather than maintaining an indifferent and suspicious distance from their traditional counterparts. Some recommendations and pointers for a different practice based on the shortfalls in existing collaborative practice suggested by this literature review are briefly considered below.

6.1 Learning from Experience

Taking methodological praxis first, the review demonstrates that the collaborative projects to date have been few. They tend to be characterised as small-scale and localised, relatively short-term, and subject to the financial and administrative anxieties associated with NGO funding. Government support for such schemes may help to alleviate the financial and administrative insecurity as the TAWG scheme in Tanzania demonstrates (Anderson and Kaleeba 2002). It may well be that the small-scale approach, being easier to monitor and

control, is the preferred method of operation, for it has the advantage of reflecting the idiosyncratic practice of the healers themselves. On the other hand, the professionalising framework envisaged for *sangoma* practice in South Africa (THPB 2003) may offer a means by which a more co-ordinated method can be implemented. The second characteristic of collaborative schemes is that they are often inadequately reported and evaluated; valuable experience and lessons are lost (King 2000: 23). Research should focus on the sort of comparative study exemplified by the Kaleeba and Anderson report (2002) with evaluative insights which may be applicable to other projects.

6.2 Encouraging Reciprocity

In her introduction to the AIDS Foundation collaborative project in Kwazulu-Natal, Leclerc-Madlala suggests that:

‘the AIDS epidemic itself has provided a context for government and a historically arrogant and dismissive modern health care sector to reach out to healers and seek collaboration...The future will tell whether biomedical practitioners become health delivery *partners* who are open and sympathetic to healers’ (2002b:2). (Emphasis added).

Real partnership is based on mutual respect, acceptance of different viewpoints, and shared dialogue. To date, the respect which allopathic medicine demands of traditional practitioners has in general been given willingly, and with enthusiasm (King 2000: 22). Biomedicine for its part is largely characterised by ‘entrenched attitudes’ regarding traditional health practitioners, much of it directed at healers demonised as ‘witchdoctors’ (Green 1999: 76).

The lack of reciprocity identified in these studies emerges twofold. The first concerns the financial benefits perceived in co-operative strategies, in which low cost is often cited as advantageous for impoverished public health care systems. This emphasis on financial benefit may simultaneously reinforce the suspicion that the *sangoma* are envisaged as a cheap second-class option in relation to their biomedical counterparts: not a desirable platform from which to advocate co-operation. Moreover, the second-rate label is very unlikely to lead to sustainable long-term co-operation between the sectors. Finally, although *sangoma* view their training as enhancing their status and so bringing financial

benefit, an impoverished client base may undermine their ambitions on this score.

The second aspect of reciprocity and arguably far more important for being so intractable, concerns the lack of intellectual appreciation and respect from biomedical professionals for traditional healers (King 2000: 23), especially those, like *sangoma*, who operate from a spiritual base. This review of the literature has underlined the emphasis on the ‘health education’ approach of the majority of co-operative efforts to date (King 2000; World Health Organisation 1990). *Sangoma* and, by association, their potential clientele, are perceived and treated as in need of education in scientific fact, portrayed in terms of biomedical ideas and techniques. *Sangoma* recognise that an improved understanding of the allopathic definition and treatment of HIV/AIDS is helpful. But an educative approach in which *sangoma* are characterised as the *only* ones in need of instruction tends, even in the most enlightened programmes, to limit the *sangoma* role and may even appear to demean or diminish their existing status in the community. Certainly, the *sangoma* in several of the programmes reviewed in this paper emphasise their disappointment at the apparent disinterest of the biomedical doctors in a reciprocal appreciation of the spiritual underpinnings of traditional healing (Leclerc-Madlala 2002b; Wreford: in progress).

6.3 Limited or Liberated Collaborations?

This section considers the final recommendation of this paper, which I will here only sketch out. Further papers will test these ideas in the context of a study of an intended collaboration between TAHs and biomedical professionals in the Western Cape (Wreford in progress).

Green describes his approach as one which builds on ‘existing local beliefs and practices, rather than to ignore or challenge them’. He hypothesises that existing traditional health concepts can be ‘promotive of health, damaging to health, or of no direct health consequence’ (1999a: 75). In his researches, Green has gone a long way (and further than most) towards the acceptance of African traditional health practice, but he falls short of a genuine rapprochement with the traditional healers. He will admit to being ‘willing to accept existing beliefs and practices....without compromising public health principles’ (*ibid*: 75), and he imaginatively creates ways of using those beliefs to help the healers explain HIV/AIDS to themselves and to their clients. However, he resists actual engagement with the catalogue of ideas which he has gathered, and in so doing,

his ‘acceptance’ crucially ignores the effects of the healing practices: the therapeutic value of the rituals through which so much of African traditional healing is enacted (cf. section 2 above), and the ‘social and psychological’ benefits of traditional practice (Green 1999: 75).

To illustrate the consequences of this limited engagement, I want to sketch an idealised example set in South Africa. We start with the sort of small-scale, side-by-side model of WOFAK from Kenya (Anderson and Kaleeba 2002), comprising a treatment and counselling centre for HIV/AIDS and STDs which operates a two-way biomedical and traditional diagnosis and prescription policy. A closer, and more trusting relationship between health sector professionals can be projected from the mutuality of this sort of working set-up, as the WOFAK experiment suggests. Had Green been working in the side-by-side way thus envisaged, he might have felt able to take his acceptance of the TAHs’ principles and practice one step further, actually demonstrating his acknowledgement by *incorporating some of their practices* into biomedical treatment interventions.

To develop this point, I envisage adding to the side-by-side clinic scenario the idea of an enhanced application of *sangoma* healing: specifically (to put it into context of the review thus far), a purifying ritual treatment for a person attending the clinic who has been diagnosed with HIV and is traditionally considered polluted. The purification principle, as we have seen, is an essential part of traditional health understanding and practice for healers and their clients. Accepting Green’s analysis, the effect of virtually any health practice (including a biomedical one and especially the application of ARVs) may be different depending on the patient’s health status. Thus, a traditional purging in the face of pollution may be health promoting or of ‘no consequence’ to someone whose immune system is sound, while it may be dangerous to one whose system is compromised. Taking our side-by-side scenario, we can assume that the clinic staff already includes biomedically educated and AIDS-aware traditional healers. In the course of collaboration - as co-operative partners rather than passive students - the *sangoma* will also have shared their purification methods and have considered the appropriate application of them in the context of HIV/AIDS. Given this awareness, less invasive purifying treatments like bathing, smoking and steaming, could be applied without physical damage to the patient. I suggest that the psychological consequence of this incorporative approach would, for the reasons outlined below, result in an enhanced effect for any biomedical practice which followed.

Such an active incorporation of the healers' practice would enable the health promotive and social and psychological benefits cited by Green to perform to their full potential. Without this, being practically, if not intellectually ignored, they would continue to go unfulfilled. The clients and the healers would thus remain insecure and uncertain of the long-term viability of the biomedical treatment. This presents the possibility that at some later stage, traditional purging (which do include invasive enemas and emetics) would be sought and administered (although not by a healer attached to our exemplary clinic) to cleanse the body still thought polluted. Far more deleterious effects can be expected from this scenario than would have been the case had a purification been appropriately incorporated before the biomedical treatment regimen commenced (cf. Wreford in progress: Ch 2).

6.4 Recognising Parallel Health Systems

This paper concludes by suggesting that allopathic professionals have much to gain from treating traditional ideas of health and illness as different but of parallel importance to biomedical science in South Africa. Researchers could assist in this process by applying their research findings towards health policy design, with a view to enhancing the scope of interaction between the traditional and biomedical sectors. In an effort to ensure that biomedicine works co-operatively with, rather than competitively against *sangoma*, anthropological research could be designed with the intention of providing data which may assist in devising HIV/AIDS interventions, accommodating and incorporating substantially more of the practice related to traditional concepts of disease and illness. In particular, I would argue that although the importance of ritual in *sangoma* has been widely recognised (cf. Section 2 above and Wreford in progress: *passim*), it has not been adequately utilised or imaginatively incorporated into HIV/AIDS interventions. Research into this aspect of the practice and its potential for collaborative efforts merits attention.

Anthropological and practitioner insights into the construction of illness and the causes of disease in traditional medicine should be incorporated into teaching modules for the education of biomedical professionals, administrators and policy advisers, as recommended by Neumann and Lauro (1982). This early acculturation at educational level could lead to a more co-operative environment within which to implement health programmes. Once traditional healing concepts have been understood, respected and actively included in HIV/AIDS interventions, it should be possible to enhance the prospect of successful outcomes and avoid potentially harmful mistakes.

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