



UNIVERSITY OF CAPE TOWN

CENTRE FOR
SOCIAL SCIENCE RESEARCH

**NEGOTIATING RELATIONSHIPS
BETWEEN BIOMEDICINE AND
SANGOMA: FUNDAMENTAL
MISUNDERSTANDINGS,
AVOIDABLE MISTAKES**

Jo Wreford

CSSR Working Paper No. 138



Published by the Centre for Social Science Research
University of Cape Town
2005

Copies of this publication may be obtained from:

The Administrative Officer
Centre for Social Science Research
University of Cape Town
Private Bag
Rondebosch, 7701
Tel: (021) 650 4656
Fax: (021) 650 4657
Email: kforbes@cssr.uct.ac.za

Price in Southern Africa (incl. VAT and postage): R 5.00

or it can be downloaded from our website
<http://www.cssr.uct.ac.za/index.html>

ISBN 1-77011-072-0

© Centre for Social Science Research, UCT, 2005

CENTRE FOR
SOCIAL SCIENCE RESEARCH

Aids and Society Research Unit

NEGOTIATING RELATIONSHIPS
BETWEEN BIOMEDICINE AND
SANGOMA: FUNDAMENTAL
MISUNDERSTANDINGS,
AVOIDABLE MISTAKES

Jo Wreford

CSSR Working Paper No. 138

December 2005

Jo Wreford has a Doctorate in Social Anthropology from the University of Cape Town and is a researcher at the Aids and Society Research Unit (ASRU) within the Centre for Social Science Research (CSSR) at UCT. She graduated as a sangoma, an African traditional healer, in 2001, and continues to practice.

Negotiating Relationships between Biomedicine and Sangoma: Fundamental Misunderstandings, Avoidable Mistakes

Abstract

In South Africa, traditional African and biomedical practitioners operate in parallel, but largely separate, arenas, in which collaboration is largely absent. This paper suggests that any positive benefits of pluralism tend to be undermined by fractious and confrontational relationships between the biomedical and traditional systems, a situation which appears especially the case for traditional practitioners such as sangoma, who call on the spiritual guidance of ancestral agency in their healing work. Motivated in part by the author's personal experience of training and qualification as a sangoma, this paper seeks to stimulate an intellectual debate about sangoma healing as it relates to the scientific understandings of biomedicine, most especially in the context of HIV/AIDS interventions in South Africa. The collaborative medical relationships advocated here do not deny the technical expertise of biomedicine nor question the commitment of allopathic practitioners to health and healing. Rather the paper seeks to address the risks to biomedicine's efficacy in the hubris which drives it to remain disengaged from its traditional counterparts. The paper argues that as biomedicine appears uncomfortable with the spiritual aspects of the traditional paradigm, the absence of spirituality in allopathic practice confuses traditional healers, a situation which prejudices working relationships. I will argue that biomedical professionals, rather than denying or decrying traditional African healing, could emulate the few of their number who have engaged with traditional practice. I will demonstrate how a working knowledge of some of the fundamental ideas of African healing and its spiritual evocations - the question of healing and cure, theories of pollution and cleansing, the functions of ritual, the purposes of witchcraft and the healing of witchcraft, to mention a few - may actually empower biomedical practitioners, and enable them to work with rather than against sangoma.

‘traditional medical culture is routinely analyzed as a set of beliefs, explicitly or implicitly juxtaposed, to medical knowledge, and a central question for research is “how traditional medical beliefs” (which are obviously false) can hold out in the face of biomedicine’s efficacy and claims to rationality’ (Good 1994:40)

Introduction

LeBeau describes the medical system in Namibia, in which traditional African and biomedical practitioners operate in parallel, but largely separate, arenas, as ‘pluralist’ (2003: *passim*). This paper suggests that this pluralist description of healing paradigms has weight in contemporary South Africa. I go further however, to argue that any positive benefits of pluralism to medical practice in the country, are undermined by fractious and confrontational relationships between the traditional and biomedical systems; a situation which is especially true in the case of traditional practitioners such as *sangoma*, who call on the spiritual guidance of ancestral agency. The paper will rather propose the idea of a more collaborative medical pluralism, an approach motivated in part by my own qualification as a *sangoma* (I graduated in October 2001 in Khayelitsha, Cape Town). However, in my other capacity as a social anthropologist engaged in research for the AIDS and Society Research Unit of the University of Cape Town, I use this paper to promote an intellectual debate about *sangoma* healing as it relates to the scientific understandings of biomedicine, and most especially in the context of HIV/AIDS interventions in South Africa. Let me say at the outset that my advocacy of collaborative medical relationships is not intended to deny to biomedicine its technical expertise; nor do I question the commitment of allopathic practitioners to health and healing. Rather the paper seeks to address the risks to biomedicine’s efficacy in the hubris which drives this ‘reified’ system to remain disengaged from its traditional counterparts (Taussig 1980).

I will suggest for example, that just as biomedicine appears uncomfortable with the spiritual aspects of the traditional paradigm (Wreford in progress: Chap 3) the absence of spirituality in allopathic practice confuses traditional healers, a situation which does not make for easy working relationships. I will argue that biomedical professionals, rather than denying or decrying traditional African healing, could emulate the few of their number (Abdool Karim 1993; Farmer 1999; Friedman 1998 for example), who have engaged with traditional practice. Supporting the work of these exemplars I will show that a working knowledge of some of the fundamental ideas of African healing and its spiritual evocations - the question of healing and cure, theories of pollution and cleansing, the functions of ritual, the purposes of witchcraft and the healing of witchcraft, to

mention a few - can empower biomedical practitioners, and enable them to work with rather than against sangoma.

In Part One, I present a short discussion of biomedicine's denial of the spiritual, and the consequent 'disjunctive' relationship between traditional 'belief' and biomedical 'knowledge' (Good 1994: 19-20) which continues to exemplify (and prejudice) bi-sectoral medical relationships in South Africa. Part Two analyses traditional healing in the context of HIV/AIDS policy in the country, and in particular spotlights the tendency for both sides of the medical divide to adopt uncompromising positions in connection with HIV/AIDS interventions. Part Three examines some more prosaic 'surgery-floor' examples of the uneasy relationship between allopathy and traditional practice, and includes a brief overview of some very practical obstacles to collaborative efforts (see also Wreford 2005: 19-20).

Part One: Medical disjuncts or simply missing each other?

The precise date at which medicine was transformed into 'biomedicine' may be mysterious, but from thence to the present it is clear that in its commitment to 'radical materialist thinking' (Scheper-Hughes 1987: 8) biomedicine turned its back on things 'traditional'. The 'variants of Dr. Faust' (M'Bokolo 1995: 124) - herb grannies or sin eaters, charmers, wise women and men, sorcerers, shamans and witch-doctors, healers using herbs, potions, lotions, spells, mantras or magic notions - anyone in fact, who resisted subjection to scientific testability, could thereafter expect to be categorised as practising not medicine, but nonsense (Shweder 1991: 50). The labeling of traditional healing practices as a sum of fallacious beliefs conveniently ignores the parallel beliefs of allopathic doctors and patients - in the power and efficacy of biomedicine. As Anderson puts it, western medicine is 'embedded in culture just as is any health system...shaped by a *belief system*...shot through with symbolic innuendo and learned behaviours' (1996: 406; emphasis added). The adage of 'doctor knows best' may provide comfort to a patient who wants to be well, but the hapless patient is rendered powerless by this belief - in awe of, mystified and frustrated by the 'reification' of science in which medicine is bedded (Taussig 1980)¹.

Whether comparisons of 'popular' medical beliefs (Feierman 1985: 112) are valid or not, African and biomedical ontologies, from common roots, have

¹ That this description of the powerplay at work in the biomedical encounter could be similarly applied to a sangoma session only serves to underline my suggestion of the importance of a pluralistic understanding of health and healing.

become fundamentally unlike, the dissimilarity resting in their constructions of the causation of ill-health (Horton 1993: Chapter 7). Traditional African healing draws upon a cosmology of ancestral connections and spiritual power to explain and verify its efficacy (see Beattie, 1966; Horton, 1993; Hountondji, 1997; Noel, 1997; Winch, 1972). The *sangoma*, for example, considers the human body as part of a cyclical structure, simultaneously social, spiritual, emotional, physical and non-material (Buhrmann, 1984; Feierman, 1992; Iwu, 1986; Janzen, 1992; Ngubane, 1992; Turner, 1992; Willis, 1999). Characterised by a reverence for ancestral authority established through ties of clan and kinship, treatment may involve addressing, and if need be, altering, relationships, both material and spiritual (Gualbert 1997: 236). To treat the sick in isolation from this ‘ontology of invisible beings’ (Appiah 1992: 112) - the spiritual community of the ancestors (or indeed, of the living community) - is almost inconceivable (Iwu 1986; Ngubane 1977; Yoder 1982).

In contrast, spirituality rarely finds a place in the practice of biomedicine.² Western medicine has increasingly inclined towards the separation of mind and spirit from the body. Thus the treatment of illness has become a question of botched biochemistry (Cunningham and Andrews 1997: 5-6) in which the human body is a ‘thing’ to be worked on, altered, adjusted, and, as Margaret Lock’s researches into organ transplants suggests, even rebuilt (2002a: 47). There is little room in this approach for practitioners to consider or acknowledge the legitimate suffering which usually accompanies illness experience (Farmer and Kleinman 1989: 138). While a plethora of behaviourist strictures attempts to shore up the utopian ideal of the ‘inalienable right to health’ (Lock 2002b: 251), biomedical specialisations, paradoxically but self-servingly, tend to expand sickness categories until to be normal or healthy seems more likely to be the exception than the rule (Scheper-Hughes 1987: 26; Harding 1997: 145).

Nonetheless, the rationalistic, logical, scientific principles underpinning biomedical theory and practice have appropriated an intellectual superiority which is employed to justify biomedicine’s legitimacy as the universal medical model (Ingstad 1989: 269), a situation which certainly applies in the South African medical experience. But are biomedicine’s claims to hegemony tenable? Since the earliest arrival of biomedical health care in Africa, the tendency of colonial authorities was to prioritise the requirements of the white settlers charged with their administration (Neumann and Lauro 1982: 1817). Under the apartheid regime of South Africa this approach was cemented by legislation, so that access to, and quality, of health care was largely determined by race. In the present, while many improvements have been made, health

² With the notable exception of psychotherapy and parapsychology.

provision is additionally conditional, this time upon the patient's capacity to afford the service. An elite clientele (albeit still predominantly white) avails itself of biomedical health care at its most mechanised, sophisticated and expensive (Benatar 2001: 356-357). At the other end of the spectrum, however, a creaking Public Health Service struggles to cope with inadequate facilities and shortages of staff in its ministry to the majority black population (*ibid*; Beresford 2001; Berthiaume 2003; Farren 2002; Kamaldien 2004; Motsuku 2003; Ndaki 2004; Shisana 2003: Chapter 3), a situation now exacerbated by the HIV/AIDS pandemic. Since biomedicine has failed to reach the 'health for all' objectives which might have justified its hegemonic ambitions (WHO 1978), I argue that it is spurious for biomedicine to make claims of universality in South Africa. Meanwhile, the practice of the subjugated - of *sangoma* and other traditional healers - continues alive and well in the country (Leclerc-Madlala 2002b; Pretorius 1999), albeit by and large in isolation from its more dominant biomedical cohort.

What is preventing successful dialogue between these healing paradigms? I have already described how some of the ontological differences, and the divisive history of South Africa can of course, be called to account for much of the schism. But, as medical anthropologists working with traditional healers have testified (see for example Feierman 1985; Good 1994; Hahn 1995; Kleinman 1995; Leclerc-Madlala 2002b; Pool 1994; Wreford in progress), successful dialogue requires mutual respect. Sadly, in South Africa, the diverse interpretations of medical knowledge encompassed in the traditional (Hahn 1995: 39) are at best being only very slowly countenanced (Leclerc-Madlala 2002b: 5-9). Even in the face of HIV/AIDS, a move towards partnership is envisaged as a long-term and *unidirectional* project, in which the traditional healers are expected to learn from, and adapt their practice to, the principles of biomedicine (Bateman 2004). The following excerpt from an educational session organised by a local traditional healers' association in the Western Cape on the subject of HIV/AIDS, serves as an example.

Practising medicine

N reported back to me on the meeting which was organised by DK's Traditional Healers' Association. Doctors from Johannesburg were present she said, "to give the *sangoma* 'advice' about HIV/AIDS." According to N's report the doctors were interested "only in showing us how to work with patients - not to use razor blades more than once - that sort of thing, and to tell us about 'safe sex' and condoms. But I know all that!"

She was disappointed. “They did not seem interested in sharing our remedies. But we can help!” Fieldnote: March 1999

In this incident, although the biomedical personnel were acting with the best of intentions, *sangoma* N returned disgruntled about what she perceived as a lack of respect shown to their traditional counterparts. N concluded that the doctors assumed too much. First, there was the inference that *sangoma* knew nothing about HIV and AIDS (the debate about condoms or the re-use of razorblades in the context of transmission for example). N may have been unusual, but she already knew about the dangers of the use of razorblades in treatment, a subject we had discussed more than once. On the question of condoms she fully appreciated the necessity of behaviour change in sexual practice: She felt patronised, and what may simply have been scientific confidence was interpreted as arrogance, alienating the powerful healing agency of *sangoma* (Leclerc-Madlala 2002b: 13).

In the collaboration described by Green (1999b: Chap 7) the issue of mutual respect between biomedicine and the traditional sector is recognised as long-standing and slow to change: the above overture exemplifies this situation. The western-trained doctors paid lip-service to the authority of the *sangoma*, but their educative, one-sided approach failed to address the professional skill, knowledge, wisdom, insight, which the *sangoma* must earn before graduating or practicing. I have remarked elsewhere (Wreford 2005: 14-34) that biomedical approaches made to *sangoma*, including the one above, are typified by offers of ‘training’, ‘advice’, or ‘education’. It is the *sangoma* who are generally expected to adapt and change, they who should ‘take it upon themselves’ to encourage collaboration (Leclerc-Madlala 2002b: 9). This excerpt illustrates the frailty of successful medical collaborations in biomedicine’s denial of the benefits of a bilateral, mutually educative approach. What is more, to *sangoma* sensitised by an apartheid past, this one-sided attitude tends not just to underline allopathy’s antipathy towards *sangoma*, but to re-open old wounds. In this situation it is small wonder that the traditional healers feel frustrated, even antagonistic to biomedical approaches.

Part Two: HIV/AIDS and the ‘traditional’ in South African medicine

I have already rehearsed the fact that under the pernicious racism of the apartheid regime, the health service in South Africa was characterised by strictly segregated services and the explicit denial of any value to the knowledge of African indigenous healing practice. Post apartheid, ministerial

acknowledgements of traditional medicine and sanction for its practice have attracted publicity, but beyond these public expressions of support, how has the South African government dealt with traditional healing?

Moving the medical goal posts: Professionalising traditional practice

Following previous recommendations of the World Health Organisation (1978; see also Pillsbury 1982: 1826), and, like its neighbours Ghana, Tanzania, Zambia and Zimbabwe, South Africa has taken the 'professionalisation' route (Last and Chavunduka 1986), and recently enacted legislation designed to formalise the structures and organisations representing traditional health practitioners (THPB 2003).³ In the light of my argument for collaborative relationships between health systems in South Africa it is instructive to note that the act includes only passing references to liaison between biomedical and traditional practitioners, and offers no practical suggestions for implementation. The effects the legislation is intended to have on the medical status quo are therefore unclear.⁴

The enactment does however promote a potentially radical reconstitution of training procedures for traditional practitioners - most notably for *sangoma* - by proposing that the Minister of Health, with the constituted Council of Traditional Health Practitioners, may regulate for example, on such fundamentals as the standard of education required for trainee healers, the duration of, and minimum requirements for their training. There are also provisions for ministerial powers to monitor and regulate 'accredited training institutions' and the curricula they offer (THPB 2003: 20). These strictures fly in the face of the spiritual agency that has hitherto identified *sangoma* training in particular, and pose a challenge to these traditional healers. While such legislative measures may address biomedical anxieties about certification and training, there is a risk that thereby much of the subtlety of traditional knowing gathered 'through the intellect, through feelings and intuitions, through bodily automatisms....doing all kinds of things in addition to engaging in intellectual communication', (Hsu 1999: 2) will be quietly displaced.⁵ Possibly South Africa will reflect Zimbabwe's experience, where the establishment of the national association of traditional healers (ZINATHA) enabled the government

³ The Traditional Health Practitioners Act was gazetted in parliament in May 2005.

⁴ In Zimbabwe, despite longstanding experience of similar legislative frameworks, the two systems continue to operate in parallel rather than in partnership (Chavunduka 2004).

⁵ Comparable displacements operate in reverse in the biomedical field. Good and Delvecchio's research at the Harvard Medical School for example, revealed students struggling to remain 'caring' in the face of their allopathic training.

and the healers to recognise spiritually guided healers, and those who qualify through western institutions, as equal (Chavunduka 2004:2).⁶

Nonetheless, in the context of this discussion of medical disjuncts in the time of HIV/AIDS, the official registration of *sangoma* and other traditional health practitioners into recognised organisations does attempt to address another major concern of the allopathic community: the distinction of legitimate from ‘illegal’ or rogue practitioners. The act threatens sanctions – prosecution, fines, and even imprisonment – against those commonly known as ‘charlatans’ who falsely claim to be *sangoma* and offer ineffective ‘cures’ and treatments (THPB 2004: 22-23). It remains to be seen how far such legal niceties will serve to forestall *sangoma* pretenders.⁷ On the other hand, while it contains references to the penalties that may be invoked for ‘unprofessional or disgraceful conduct’ on the part of registered healers, the act fails to define what is constituted by such behaviour. Furthermore, the legislation omits any mention of *registered* practitioners who make claims for cures, an important exclusion with potentially serious consequences for bi-sectoral medical collaborative efforts in the context of HIV/AIDS. The following episode will illustrate some potential consequences of this omission, and demonstrate other loopholes in the ‘professionalisation’ route.

‘Uyaxoka!’ – ‘He was a liar!’: Charlatans and dissidents in sangoma

This episode took place at a meeting co-ordinated by the Hope Association at the Tygerberg Hospital in Cape Town. HOPE runs outreach programmes in the HIV/AIDS field throughout Western Cape Province, including a number of township clinics and the ITHEMBA childrens’ ward at Tygerberg Hospital. The meeting was the third in a series. Convened in May 2004, it allowed a group of *sangoma* - largely organised by *sangoma* K who accepts biomedical understandings of HIV/AIDS and is determined to improve working relationships with allopathy in the face of the disease - to address a group of biomedical doctors, students and paramedics from the hospital on the principles of *sangoma* practice in the context of AIDS. Previous meetings had comprised

⁶ Additionally, it is unclear how these differences will be viewed by practitioners or their clients. It may be that the stratifications come to reflect existing distinctions and reinforce competition, between herbalists (*isinyanga*), for example, who tend to choose their profession and garner their knowledge from parents, grandparents or other professionals, and *sangoma*, who are chosen by their ancestors and in their training submit to spiritual others.

⁷ The existence of legislation for biomedicine in the United States has neither prevented ‘sanctioned physicians’ from practising, nor halted the prescription of untested drugs (Hahn 1995: 147), and, in the United Kingdom, ‘rogue doctors’ still appear despite longstanding regulatory frameworks (Andalo 2004).

reciprocal educative information for the *sangoma* in the biomedical history, pathology, symptomology and treatment of HIV/AIDS.

The meeting was scheduled to run from early morning to mid-afternoon. The previous evening the *sangoma* had chosen one of their number (not one of K's group), to act as convenor of the meeting. This man was a fluent English speaker, confident and assured at the microphone. Shortly before the morning teabreak he suddenly announced:

If someone comes to me who is taking ARVs [Antiretroviral therapy] I tell him to stop taking them. If he refuses I would not treat him.⁸
Why? Because I can cure AIDS, and within four weeks! Fieldnote:
21.05.2004

The *sangoma* refused to discuss the matter further and left the platform without offering any evidence for his claims. This statement was greeted with a palpable 'sharp intake of breath' from the biomedical staff present in the hall. Coming as it did in the context of a meeting to describe *sangoma* understandings of healing in general, and HIV/AIDS in particular, it spectacularly achieved two things. First, by fulfilling all biomedicine's worst nightmares about the *sangoma* as peddlers of 'extraordinary beliefs' (Swift and Strang 1993), it alienated all the allopathic representatives there. Secondly, it put *sangoma* K and his entourage on the back foot with their biomedical counterparts, and undermined his supporters from the Hope Foundation. Visibly discomfited, K sought to reassure the hospital staff by repeating his own conviction that "AIDS is a modern disease, and we have no cure for it." Other persons from his group affirmed that they would always refer a patient with HIV "direct to the clinic." But the damage was done, and these assurances fell on deaf ears. The number of hospital staff who returned to the meeting after the tea break which followed was severely depleted.

LeBeau has pointed to a similar situation in Namibia, remarking that,

it is the traditional healers themselves who must overcome problems to which they may also contribute. Too many traditional healers, wishing to promote themselves, make claims for treatments they do not possess (2003: 43).

⁸ In this assertion, ironically, the *sangoma* reflects biomedical research which purports to show that the action of ARVs may be undermined by the simultaneous use of some traditional herbs (Mills *at al* 2005). It unfortunately goes without saying that the researchers in question gave no credit to *sangoma* for their insight.

But when I questioned K later about this incident, he, in the context of his acceptance of biomedical interpretations of HIV/AIDS as without cure, dismissed the *sangoma* as a ‘charlatan’, and expressed his confidence that government legislation on *sangoma* professionalisation would expose such fraud. Na, another *sangoma* practising in Khayelitsha, was less charitable. She immediately branded the man *ixoki* (liar) and dismissed his claims with disdain. Nonetheless, like K, Na had no intention of reprimanding the errant practitioner, adopting instead the disarmingly *laissez faire* attitude to rogue practitioners which is familiar amongst *sangoma* and unfortunate in the context of collaborative efforts.

Healing, curing and other ambiguities

Another question integral to *sangoma* healing also arises from this excerpt, that of the understanding of ‘healing’ and curing which in traditional terms differs dramatically from that of biomedicine (Chavunduka 2004: 11). *Sangoma* and their clients assert that ‘absence of symptoms’ equates with a cure. *Sangoma* Na, for example, shortly after branding the dissident *sangoma* a liar, asserted, in the context of a discussion on sickness, that “If there are no symptoms, the patient is cured.” This opinion was echoed by K, and is underlined in Leclerc-Madlala’s researches in KwaZulu-Natal (2002b: 13). It is an interpretation of healing and curing which has obvious and serious ramifications for the treatment of HIV and AIDS, for while *sangoma* do recognise and successfully treat symptoms of the opportunistic infections commonly accompanying HIV/AIDS, there is as yet no evidence that they can affect the virus. The episode might then be explained in biomedical terms as simple misdiagnosis. Since AIDS displays symptoms which are similar to other recognised sexually connected diseases the *sangoma* may have misread the case and believed it cured once the symptoms had subsided (LeBeau 2003: 133). In this scheme of things the dissident, or ‘charlatan’ may have claimed (and believed) that he had produced a cure whilst in fact only dealing with associated symptoms.

Official support, dubious partnerships

LeBeau’s researches in Namibia, however, together with comments from other South African *sangoma*, point up another urgent matter raised by this incident. The ‘hardline’ attitude adopted by the Tygerberg *sangoma* towards the use of antiretroviral therapy (ARVs) in conjunction with traditional remedies is by no means an isolated position amongst traditional healers (LeBeau 2003: 180;

Salva 2005),⁹ and their determination to defend traditional medical efficacy has led some sections of *sangoma* to take up with dubious allies. These alliances are made more controversial and confusing by the government's equivocation about HIV/AIDS treatment policy.

The policies of the South African administration towards the devastating pandemic of HIV/AIDS have drawn criticism as being fraught with 'missed opportunities, inadequate analysis, bureaucratic failure and political mismanagement' (Nattrass 2004: 41). President Thabo Mbeki's controversial stance, however it may be cloaked in justifiable concern about the role of poverty in the disease, is unhelpful (Craddock 2004: 5), and messages from the government about the benefits of antiretroviral therapy are characterised as confusing if not actually in opposition to the treatment (Makgoba 2003; Medecins Sans Frontieres 2003; Tabane 2005). To counter criticism of this prevarication, the administration has presented an alternative 'holistic' policy with an 'indigenous' slant. It is said to include nutrition, together with herbal or 'traditional' medicine (Green 2004; Tshabalala-Msimang 2004), but the regimen is vaguely defined and even less obviously implemented (Hooper-Box 2005). Nonetheless, statements by the health minister advocating traditional remedies (and, tacitly the practitioners who administer them), have drawn some *sangoma* into alliances with the government and other allies. Naturally, traditional healers are anxious to boost public confidence in their remedies, and can be expected to welcome the ministerial support. But the minister's ambivalent approach to ARVs has also encompassed support of AIDS denialists. One in particular, the Rath Foundation, has ruthlessly exploited this support and allied itself to those traditional healers who insist that traditional medicines can cure AIDS (Merten and Deane 2005; Ndenze 2005).

The extent to which the *sangoma* are cognisant of their position in this 'alternative' HIV/AIDS campaign is questionable, and there are potential and significant liabilities for traditional healers in this ambiguity. For example, the Treatment Action Campaign (TAC), ardent supporters of ARVs, are engaged in vociferous legal disputes with the Rath Foundation and traditional healers allied to it, about the relative merits of antiretroviral therapy versus traditional or alternative remedies (TAC 2005 *passim*). The Rath Foundation accuses the TAC of collusion with international pharmaceutical companies, while the TAC on its side counters with questions about the economic and political connections of Rath's supporters amongst the traditional healers (Ndenze 2005).

There are other liabilities. *Sangoma* are anxious to remind the public that they can successfully treat some of the opportunistic infections which accompany

⁹ The *sangoma* in this incident has already established a school for traditional medicine, and it must be assumed that he will promote his views to his students.

HIV/AIDS. ¹⁰ Just as surely the *sangoma* will pursue their attempts to stem HIV/AIDS, especially as the vast majority of patients, frustrated by the inadequacy of public health facilities - themselves overwhelmed by demand - continue to rely on *sangoma* services (Leclerc-Madlala 2002b: 4; Green 1999b: 136). Some traditional practitioners, as the Tygerberg excerpt also demonstrated, may continue to claim (despite legislative strictures) that they have a cure for the disease. In the event that any such traditional treatment is contraindicated, scientific medicine - whose responsibility for the outbreak of the disease remains unclear (Harrison-Chirimuuta 1997; Hooper 2000) - may be tempted into an 'I told you so' position, or take the opportunity to camouflage its shortcomings by blaming its failures on the 'traditional' paradigm (Hountondji 1997: 14). The next excerpt presents a contemporary version of the latter scenario.

A Khayelitsha story

one medical system may be knowledgeable, but unable to put its knowledge into effect, whereas another's techniques work, despite relative ignorance (Hahn, 1995: 34)

The following story exemplifies Hahn's argument about the intrinsic complications of attempting to assert biomedical knowledge while refusing to take cognisance of a pre-existing medical system. The episode described will be used to defend my case for an inclusive, collaborative approach to South African medicine, and demonstrate some potential consequences for biomedical interventions should *sangoma* remain exiled at the margins of the country's health care structure. The narrative illustrates some elemental issues: First, the difference in approach to diagnosis and treatment between the two systems; Second, the absence of biomedical understanding of those differences, and finally, the consequences. To end the commentary I refer to an alternative scenario that assumes an enhanced co-operation between allopathic and traditional practitioners.

Several versions of the following story exist¹¹ a reality that I suggest serves not to undermine the veracity of the tale, but to reinforce the influence of an 'invisible ontology' (Fields 2001), in this case, within biomedical thinking in South Africa. In other words, whatever its roots in actual fact, this piece of oral history is symptomatic of the attitude of biomedical suspicion and ignorance of

¹⁰ There are scientific studies to support these claims (see for example King *et al* 1994; King 2000; McMillen *et al* 2000; Nshakira *et al* 1995; Scheinman *et al* 1992).

¹¹ I am grateful to Dr Stephan Hippler of the Hope Association in Cape Town for this rendering.

sangoma. My purpose in narrating this anecdote is not to use it as an indicator of the inadequacy and dangers of traditional healing knowledge and methods. Rather I employ it as an illustration of the risks of *prolonging the ignorance of biomedicine* about the knowledge systems and methods which inform traditional African healing. I fully recognise the pressures on dedicated biomedical professionals, and their desperate efforts to help their patients. I acknowledge too their frustration at the effects of a *sangoma* diagnosis which may appear to them to deliberately undermine their efforts. But I contest the position that responsibility for the outcome of this episode rests solely with the traditional healer.

Urban myths and alternative realities

The story concerns a patient who was received at a Medecins Sans Frontieres (MSF) clinic in Khayelitsha, Cape Town.¹² He was seriously ill with full-blown AIDS. After tests, it was decided that this patient was a candidate for ARV therapy, and his regimen commenced. The patient began to make a good recovery. Then, “something appeared to go wrong,” and the patient visited a *sangoma*. As a result of the consultation it was alleged that the *sangoma* prescribed a cleansing substance which produced profuse purging in the patient. In the course of this, so the story goes, the ARVs were expelled from his body, and the patient relapsed. He died some time later.

Some of the facts of this Khayelitsha story have assumed almost mythical status, but a review of what is alleged of the case may be useful. The patient, suspecting perhaps that he has AIDS, visits the MSF clinic, and on receiving the diagnosis, assents to ARV treatment. It is presumed that he was carefully counselled, and understood the importance of continuing the treatment, every day, at the same time, no matter how much better he appeared to be (Medecins Sans Frontieres 2003: 3-6). Somewhere along the line however, “something went wrong.” What this was remains mysterious, but it was serious enough for the patient to visit a traditional healer. The blame for the situation which followed was placed wholly upon the *sangoma*. I hold that there are alternative scenarios to this one-sided interpretation.

For example, might the patient, before his visit to the *sangoma*, have experienced side-effects from the ARVs, and stopped taking the treatment? Might other family members, not previously consulted about the regimen, have persuaded him to halt the therapy? It is often assumed that unless there is

¹² The MSF clinic is one of three sites established in community health centres in the township since May 2001 where highly active antiretroviral therapy (ARV) is available (Medecins Sans Frontieres 2003).

harmony within family or community relationships applied medicines will be ineffective: Was there some underlying and unspoken dispute that required ‘confession’ and resolution through a *sangoma*’s diagnosis (Berglund 1989: 112), or did the client fear that witchcraft was involved? In other words, is it reasonable to allocate responsibility for this event solely with the traditional healer? What I am suggesting here is that had the doctors engaged in a meaningful dialogue with *sangoma* practitioners, treating their knowledge and understandings as different but complementary to biomedical insights, they might better have comprehended, and *taken account of*, the context within which the *sangoma* offered the cleansing medicine. The remainder of this section will seek to obtain a more nuanced exploration of the events.

Funny Questions

My examination starts with the mysterious “something” which occurred to upset the patient’s equilibrium. The nature of this “something” must remain vague and ill defined. Its import however, was sufficient to require a visit to the *sangoma*, and it is safe to assume that it fell within the “Why me? Why now? Who has sent this?” system of causation indispensable to traditional African healing, for clients and practitioners alike (see for example Ashforth 2002; Green 1992; Kruger 1974). Several questions now arise, the answers to which are critical to *sangoma* understanding of illness and health, and biomedicine’s misconceptions of the same.

First, did the patient inform the healer that he was taking the ARVs? A significant difference between biomedical and *sangoma* practice rests in the fact that the *sangoma* patient rarely proffers information about a condition before receiving a diagnosis. N often referred to occasions at which the patient was not even identified in a family group, and the first task for the healer was to discover “Which one is ill.” There were no ‘funny questions’ at the start of a consultation (West 1975: 17). The idea that a doctor should ask a patient “What is wrong with you?” is thus seen as risible in *sangoma* practice, evidence of a practitioner’s incompetence, or inadequate communication with ancestral messages (see Berglund 1976; Buhrmann 1984; Hirst 1990; Ngubane 1977; Peek 1991). Successful diagnosis (that is, one that satisfies the patient) may be followed by discreet and indirect questions about relationships amongst the living, and importantly, between the living and the deceased. Broader societal relationships may well be investigated later in an effort to ascertain the source of the problem. Only after a thorough search, and after the family has expressed themselves satisfied that such an examination is now exhausted, will the *sangoma* attempt to offer remedial action and prescribe the treatment which will effect a cure.

Pollution and cleansing

The next question highlighted by this episode is why the *sangoma* considered a cleansing remedy essential in the first place, and this brings into play the twin notions of ‘pollution’ or contamination (LeBeau 2003: 98-100) and purification. These are fundamental concepts on which much *sangoma* healing practice is premised (*ibid*: 77; Hammond-Tooke 1989: Chap 6; Leclerc-Madlala 2002b: 89), but which have often been ignored or have eluded many anthropologists (Green 1999b: 83-85), let alone medical practitioners. Significantly for this case, the notion of being ‘dirty’ or polluted is especially powerful in relation to diseases connected to sexual and moral behaviour, and to blood, all axiomatic in HIV/AIDS (Green et al 1995; Green 1999b; Grundfest Schoepf 1992; Haram 1991; Ingstad 1990; Jordan-Smith 2003; LeBeau 2003:133; Niehaus 2001a: 28; Pool 1994). Such pollution is thought to be dangerous, even contagious (Green 1999b; Leclerc-Madlala 2001b: 42), and may also diminish resistance to disease and increase the victim’s susceptibility to illness (Ngubane 1977: 77), another symptom typical of AIDS. Adultery is a particular cause for concern (Werbner 2001: 203), for patients and healers imply a potent link between adulterous relationships and the idea that pollution may be ‘sent’ through witchcraft as a punishment for adultery (Bawa Yamba 1997; Farmer 1992; Grundfest Schoepf 1991; Leclerc-Madlala 2001b; Niehaus 2001a). Whatever the source of the pollution, the remedy necessitates some form of cleansing (Green 1997: 94-96; Hammond-Tooke 1989: 91-93).

In the Khayelitsha scenario it would seem that the *sangoma* diagnosed pollution, and adjudged the need for cleansing. Once diagnosed (and pollution is implicated in the majority of illnesses (Hammond-Tooke 1989; Green 1999b)), action to rid the body and spirit of the corrupting influence is the first step to recovery. Herbs for this purpose abound, varying in their strength and effects (Gelfand *et al* 1985: 85-86; van Wyck et al 1997). Application can take the form of an enema or drinking a herbal mixture, but methods such as steaming, smoking, ointments, and bathing in herbal mixtures are also available.

‘Fidelity medicines’ and other connections

It is unlikely that, following his visits to the MSF clinic, the Khayelitsha patient failed to understand the likelihood of a sexual causation of his illness, but paradoxically this knowledge may have further contributed to his anxiety as to its ‘real’, or underlying cause (Green 1999b: 82). Here, another question pertinent to *sangoma* understandings of illness arises: The connections between HIV/AIDS, sexual behaviour and witchcraft (LeBeau 2003: 128-129).

Enforced changes in social and family networking, first, as a consequence of apartheid and, progressively, through the economic privations of contemporary urban living (Marks and Anderson 1990: 36-47), have produced shifts and challenges to sexual mores in South Africa, and increased the incidence of the potential for sexual misconduct (Hammond-Tooke 1989: 100). The historic use of medicines to ensure fidelity (especially of husbands seeking to control their wives) has often been reported (Hammond-Tooke 1989: 100; Green 1992:122). Leclerc-Madlala offers evidence for a modern reversal of the practice in which 'out-of-control' women are accused of employing 'love potions' to attract men 'unfairly' (2001a: 543). There is no space here for a discussion of the gendered position that Leclerc-Madlala's article argues. Rather I will introduce a profound ambiguity in *sangoma* healing, a confusion which results from the ubiquitous interchangeability in popular discourse between the titles *sangoma* and 'witchdoctor' (Louw and Pretorius 1995: 42).¹³

For the purposes of my discussion here, the difference between *sangoma* and witchdoctor is defined by intent, or as my teacher categorically put it, "The *sangoma* works for the good, the "witchdoctor" is evil." In this understanding, the *sangoma* should be recognised as the *healer of*, not the practitioner, of witchcraft; like the diviners of Yombe belief in Zambia, they work for the public good rather than for selfish or hurtful ends (Bond 2001: 148). Nonetheless *sangoma* and witchcraft continue in the popular (and biomedical) mind to be jointly understood and implicated in the distribution of medicines, not least those intended to secure fidelity.

Fidelity medicines are expected to pollute any man who engages in sexual relations with a woman so treated. In a discussion on the subject, *sangoma* Na insisted that such treatments "are only available from a witchdoctor," but the fact that *sangoma* too, have historically been characterised as 'morality custodians' (Ngubane 1992: 366) inevitably creates tension.¹⁴ Indeed, as Green's studies in Southern Africa demonstrate, traditional healers are increasingly unwilling to make 'fidelity medicines' because they are so often identified with 'a type of witchcraft', and thus expose the healers to false accusations of wrongdoing (Green 1994: 67). At the same time, both the old scourge of tuberculosis (Farmer 1990: 23), and the new HIV/AIDS pandemic have been attributed to witchcraft (Ashforth 2002; Bond 2001: 155; Grundfest Schoepf 1992: 272; LeBeau 2003: 132-133; Susser and Stein 2004: 136).

I have rehearsed that the Khayelitsha patient had made the connection between HIV/AIDS and sexual behaviour. It is this association which may have led him

¹³ For a more comprehensive examination of this confusion see Wreford in progress Chap 8.

¹⁴ Bodibe's contemporary rendering of the *sangoma* as 'sex therapist[s]' (1992: 164) threatens to confuse the situation still further.

to fear and suspect not only pollution, but also witchcraft (Green 1999b: 82), and hence to his consultation with the *healer of witchery* - the *sangoma*. At the consultation, he would also have predicted a diagnosis which would involve purging (*ibid*: Chapter 5), a radical cleansing of the “dirty blood” which had infected him. Whether the cleansing medicine prescribed in this case was particularly fierce, or whether the patient’s damaged system simply could not cope remains imponderable, but the story has now come full circle.

Obtaining a better outcome

My purpose in dissecting this incident so painstakingly has been to emphasise notions implicit in, and essential, to *sangoma* healing, ideas that western doctors have apparently failed (or not even attempted) to comprehend. I argue that a more considered engagement with these principles could have contributed to a better outcome for this case, and for the rollout of HIV/ARV in the future. Having grasped something of the complexity of the reasons why their patient, with his mysterious problem, had consulted a traditional healer, something of the ‘local knowledge’ (Yoder 1997: 139), biomedical doctors may have been enabled to design an ARV treatment regimen *in tandem with*, rather than in opposition to traditional practice. Thus, in this instance, an emetic, enema or other internal cleansing substance could have been arranged *before* the ARV treatment commenced. In the event that the patient was too infirm, alternative external cleansings such as steaming, bathing or smoking could conceivably have been arranged.

I have elsewhere outlined a practical scenario in which this approach might be implemented and tested in a hospital or clinic environment (Wreford 2005: 39-40). The engaged involvement I envisage would be designed not only to avoid the disastrous outcome alleged in the case of the man from Khayelitsha, but to effect positive results for all parties concerned. The patient would be reassured that the traditional, ancestral, metaphysical and moral attributes of his illness - its ‘underlying cause’ (Green 1992: 126) - had been addressed in the *sangoma*’s remedy. The biomedical professionals equally could be satisfied that the ARV treatment, once commenced, would remain in place, and their client would continue healthy. Finally, the traditional African healer would be content in the knowledge that she or he was being respected and included, and that traditional explanations for healing had been accounted for.

Considered together, the Tygerberg incident and the Khayelitsha story tell a tale of two halves, opposite sides of the same medical experience. In both examples medical personnel adopt an uncompromising position which insists that ‘their’ treatment – traditional or biomedical – is the *only* approach, an intractable

situation which not only excludes the idea of alternatives but leads to mutual alienation. The events help to explain the persistence of the disjunctive relationships in which traditional and biomedical practitioners in South Africa continue to miss each other. The final section of this paper explores other more practical obstacles in the way of collaboration.

Part Three: Further Contestations and uncomfortable predicaments

First let us look at the training of medical professionals. The existing condition of separate development, the divergence of attitude and approach to healing between medical sectors, has practical consequences for black African doctors training in contemporary South Africa. This may not always be as extreme as the ‘schizophrenic position’ which Neumann and Lauro allege (1982: 1823), but healers who choose the biomedical path to practice may certainly find themselves caught in uncomfortable predicaments. Versed in the idiom of *sangoma*, these medical professionals are obliged, as Chavunduka confirms (2004: 6), to repudiate ‘unscientific’ traditional principles in the face of superior ‘knowledge’.

This dilemma is illustrated by the following excerpt concerning N’s grandson (Nd), who was at the time in his second year of Medical School at the University of Cape Town:

Nd tells N and myself of his experiences at medical school. He has been working in the wards and one evening this week was called to the bedside of a very young female patient who was clearly distressed. He sat with her and spent a long time talking with her until she had calmed down.

N approved of his method, seeing in it evidence that Nd was also a *sangoma* candidate.

But as Nd told us ruefully, “I was so late getting home, and so tired, and no one really appreciates me for doing this. It’s not the way they do it.”

He tells us that the training techniques of dissection which start very early on inure the students to pain and suffering. “You learn to forget that the body is a body with feelings.”

But later Nd is apparently confused and a little embarrassed at his grandmother's *sangoma* antics, as she scatters snuff around the *umqombhoti* barrel and then sips greedily from the plastic pot, and bursts into a spontaneous song with the words "It is my grandfather who made me what I am." She says later, "He thinks I will get very drunk!" she smiles, laughing about it, but it's clear that she is as upset as he at the schism between them. Fieldnote: 10.04.1999

Nd's obvious discomfort with the dissection process reflects Good's researches in medical education in the United States (1994), where students are subjected to the break up and invasion of cadavers in the aptly named 'gross anatomy lab'. So shocking is this experience that one of his student informants describes it as akin to 'changing my brain every day' (*ibid*: 65). It is hard to resist the connection between this patient-body attitude and the gruesome science-as-fiction references to 'living cadavers' discovered by Lock in her researches into the industry of human organ transplants (2002a: 192).

I was struck by Nd's empathy, and his multiple evocations of the pain of illness, qualities that may well turn out to be the defining factor in his medical practice. N, the practicing *sangoma*, was justifiably proud of her grandson's achievements in the biomedical world. Nonetheless, just as she hoped that his compassion and empathy would protect him against the alienation of his chosen profession, she also anticipated that he would eventually recognise the value of *sangoma* and even undergo *ukuthwasa* himself. "He is a natural!" she said. For N, the traits I recognised singled him out as a future *sangoma* candidate.

The patient knows best

Another characteristic of *sangoma*, generally either ignored or deplored by biomedicine, is the fact that for traditional medical practitioners and patients alike the question of its efficacy is already answered. The anthropological notion of the 'therapeutic itinerary'- in which the patient makes use of whichever medical system is deemed most likely to achieve results, either serially or in tandem - (see for example Auge 1998:115; Hours 1986: 48) is valid.¹⁵ In a remarkable demonstration of consumer power and eclectic reach, the African clientele (traditional practitioners themselves being no exception) unabashedly sample traditional, allopathic or other treatments in their search for the appropriate remedy (Haram 1991: 173; Good *et al* 1979: 141). In this

¹⁵ Even if this results in a tendency to assume a patient entirely 'free' to make multiple health choices, it is self-evident that in South Africa as elsewhere, the idea of voluntarism in health choices is a chimera, prejudiced and confined by practicalities social, economic and political (Good 1994: 43).

pluralistic scheme of things biomedicine simply becomes one amongst several medical systems on offer, and traditional healing is certainly *not* a matter of last resort.

A consultation with a *sangoma* will often incorporate a referral to a biomedical institution (Le Beau 2003: 85), the *sangoma* very likely suggesting that the patient return for further non-allopathic remedial action in order to get to the root of the trouble (West 1975: Chap. 6). Rituals and treatments are designed to correct whatever is identified in the ancestral or relationship pantheon to be the 'real' source of the problem. The decision about whether to follow up such ritual acts is left with the family and the patient. Doubtless people will continue to assay the biomedical route in South Africa, as elsewhere on the continent, availing themselves where they can of the services offered by clinics and hospitals (Good *et al* 1979; Neumann and Lauro 1982; West 1975). But they will also continue to visit *sangoma*.

The traditional doctor is unlikely to censure the patient who has tried the allopathic system - or any other - nor rule out the possibility that he may do so again. Biomedical doctors are less charitable. In an interview, *sangoma* K lamented:

Yes...that is what we are fighting against sometimes. Why can't we people have our 'specialists'? When they always say refer the person to the medical practitioner. When are they going to say "Refer the person to the traditional healers?"

Here he laughs ruefully. "So that is always the question sometimes...
Interview: 13.12.2001

K's complaint about 'one-way' referrals is well taken, and often repeated (Bateman 2004: 74; Haram 1991: 174; Ingstad 1989: 269; Leclerc-Madlala 2002b: 16-17). In contrast, K proudly displays certificates attesting to his attendance at a variety of workshops and seminars, HIV/AIDS training courses and so on, as evidence of his repeated attempts to get on terms with the interests of biomedicine.

Negotiating the medical market

Other practical and material odds are stacked against the *sangoma* when dealing with the medical market. For example, there is the question of qualifications. The biomedical professional, black or white, is equipped with an extensive western education and training. The *sangoma* is equivalently qualified in her paradigm and has been examined by her peers both living and transcendent, but

lacks qualifications considered credible by biomedical standards.¹⁶ Charles Good notes the potential problems associated with ‘low levels of literacy and formal education’ of the traditional healers in their relationship with biomedical staff in Kenya (1987: 301). On this very practical level such disparities in education present *sangoma* with considerable hurdles, especially where officialdom or bureaucracy is involved. In the South African context, handicapped by historic, and continuing, educational inequalities, the traditional healer in South Africa still has a mountain to climb. N and K are examples of a relatively advantaged minority in the *sangoma* community. Both have received a basic western education and have a good command of English and Afrikaans. K is possessed of telephone, fax, a computer; he is confident and assured of his skills and social position, and would certainly consider himself one of Feerman’s ‘traditional intellectuals’ (1985: 113), but other *sangoma* cannot even write (Salva 2005).

Salva’s testimony reports on the difficulties of her illiteracy, for example, in making a visit with a client to a local hospital to receive their diagnosis (Salva 2005), and my experience of visiting clinics in Khayelitsha suggests that other quotidian realities of township life would also impinge on her experience. There would first be a long and frequently awkward journey, very early in the morning, on foot and by taxi. This could be followed by an hour or more of queueing, outside, until the facility opened its doors. Finally the *sangoma* and her client might well have to wait a whole day for treatment.

Spiritual languages

Finally, in all their dealings with the medical market there is the question of the language of *sangoma*. To explain this I refer again to the Tygerberg Hospital meeting cited in Part Two of this paper, where the *sangoma* addressed their western trained audience in ‘*sangoma* speak’ as I have called it elsewhere (Wreford in progress: Chap 3), language which to them is quotidian and normal. But references to ‘being called’ and ‘ancestors’, to take just two very basic examples, perplexed the listeners, and, when even the translator provided for the meeting declared himself unable to find appropriate equivalents, the audience was left bemused, and the subtleties of *sangoma* understandings and practice were obscured.

The Tygerberg meeting illustrates one other aspect of *sangoma* language – that of ritual. The event was opened with a *xhentsa*, a ritual dance involving all the

¹⁶ As I have already rehearsed, attempts to constrain *sangoma* training and certification within a legislative framework (THPB 2004 discussed earlier) may result in a further distancing from its spiritually inspired base.

sangoma present, accompanied by vigorous drumming, clapping, singing, and the sharp aroma of burning *imphepho*. The audience was again puzzled, possibly a little derisive. What had this to do with healing? Yet all *sangoma* gatherings (*inthlombe*), and especially those connected with healing intent, involve a supplication to the ancestors, whether in the form of quiet contemplation or the more aggressive dancing of Tygerberg. Thus the ancestors are persuaded into the arena, their presence brought to bear on proceedings. The *xhentsa* served this purpose at the Tygerberg meeting. Here again, the importance of translation, to render the concepts of *sangoma* intelligible to sceptical biomedical personnel, looms large.

Conclusion

The situation of traditional healers in postcolonial Africa has been described as one of ‘autonomy without authority’ (Feierman 1985: 114). I would argue from observation of the *sangoma* and from personal experience, that within their community, and based in a ‘common stock of experience’ (Osei-Hwedie 1996: 2), *sangoma* are certainly not short on authority. The difficulty is that, contemporary government policies notwithstanding, the cultural authority of the traditional paradigm continues to go unrecognised by the biomedical establishment (Good et al 1979: 141). That doctors and traditional practitioners could work collaboratively ought to go without saying (Green 1989a; Good 1987). I have suggested that such engagement demands a mutual and sophisticated degree of intellectual interest in the knowledge, skills and spiritual aetiology of medical systems: a mutuality of respect. Better understanding would enable more efficacious interventions, precisely because they had acknowledged and included important elements of traditional African healing. It is to be hoped that the particular demands of HIV/AIDS will provide the anvil upon which reciprocal medical respect and involvement can be forged in South Africa.

Some time ago Feierman asked of the relationship between African traditional healing and biomedicine,

‘How are biomedical practitioners to use the services of popular healers if they do not accept the basic premises of popular practice?’ (1985: 126).

Feierman also pointed out that the therapist has the potential to act as a ‘conduit transmitting general social values....capable of reshaping and reinterpreting those values in the healing process’ (Feierman 1985: 75). This applies to therapists traditional or allopathic, and, in the context of this paper, and the

battle to acknowledge and control the AIDS/HIV pandemic in South Africa, it seems almost axiomatic to suggest that utilising this 'reshaping and reinterpreting' role of the *sangoma* could be crucial. In this paper I have argued that the issue of mutual respect is fundamental to successful dialogue between medical paradigms. I have shown that the appreciation of biomedical principles and practice which allopathic medicine demands of traditional doctors is often given willingly, and with humility. With rare exceptions (Abdool Karim 1993; Farmer 1999; Friedman 1998; Green 1999a and 1999b for example), it has not been reciprocated. I have illustrated that medical matters, especially as they affect HIV/AIDS interventions, may go very awry unless biomedical personnel become willing to offer an equivalent appreciation to traditional practice, if, despite the formal structures envisaged in professionalising legislation, the traditional is allowed to continue to operate at best, tangentially, and at worst in outright opposition, to its scientific counterpart.

Bibliography

- Abdool Karim, S.S. (1993), Traditional Healers and AIDS Prevention, *SAMJ* 83(6): 423-425
- Andalo, D. (2004), 'Shipman report condemns doctors' watchdog', *Guardian Unlimited*, <http://www.guardian.co.uk/>
- Anderson, R. (1996), *Magic, Science and Health: The Aims and Achievements of Medical Anthropology*, New York: Harcourt Brace College Pubs.
- Appiah, K. A. (1992), *In My Father's House: Africa in the Philosophy of Culture*, London: Methuen.
- Ashforth, A. (2002), 'An Epidemic of Witchcraft? The Implications of AIDS for the Post-Apartheid State', *African Studies* 61 (1).
- Auge, M. (1998), *A Sense for the Other*, Stanford, California: Stanford University Press.
- Bateman, C. (2004), 'Healers 'get real' about tackling AIDS', *SAMJ* 94 (2) 74-75.
- Bawa Yamba, C. (1997), 'Cosmologies in Turmoil: Witchfinding and AIDS in Chiawa, Zambia', *Africa* 67(2) 201-222.
- Beattie, J. (1966), *Other Cultures: Aims, Methods and Achievements in Social Anthropology*, London: Routledge and Kegan Paul.
- Benatar, Dr S. (2001), South Africa's transition in a globalizing world: HIV/AIDS as a window and a mirror, *International Affairs* 77 (2) 347-375.
- Beresford, B. (2001a), 'Big hospital of horrors', *Mail and Guardian* Nov 9 -15, Johannesburg: M&G Media Ltd.
- Berglund, A-I. (1976), *Zulu Thought Patterns and Symbolism*, London: Hurst and Co.
- Berglund, A-I. (1989), 'Confessions of Guilt and Restoration to Health. Some Illustrative Zulu Examples', in A. Jacobson-Widding and D. Westerlund (eds), *Culture, Experience and Pluralism: Essays on African Ideas of Illness and Healing*, Uppsala Studies in Cultural Anthropology 13, Uppsala, Sweden: University of Uppsala.
- Berthiaume, L. (2003), 'A System in Crisis', *Mail and Guardian*, June 27 to July 3, Johannesburg: M&G Media Ltd.
- Bodibe, R. (1992), 'Traditional Healing: An Indigenous Approach to Mental Health Problems', in J. Uys (ed), *Psychological Counselling in a South African Context*, Cape Town: Maskew Miller Longman.
- Bond, G.C. (2001), 'Ancestors and Witches: Explanations and the Ideology of Individual Power in Northern Zambia', in G.C.Bond and D. Ciekawy (eds), *Witchcraft dialogues: Anthropological and philosophical exchanges*, Ohio: Center for International Studies.

- Buhrmann, V. (1984), *Living in Two Worlds*, Cape Town: Human and Rousseau.
- Chavunduka, G. L. (2004), 'Jimmy and Busi's interview with Prof. Chavunduka, Chairman of Zimbabwe National Traditional Healers Association, ZINATHA', [fag>>religion>>til mode i healerforeningen>>engelsk udskrift af interview med Prof. Chavunduka](#)
- Craddock, S. (2004), 'Beyond Epidemiology: Locating AIDS in Africa', Introduction in Kalipeni, E.; Craddock, S.; Oponng, J. and Ghosh, J. (eds), *HIV and AIDS in Africa: Beyond Epidemiology*, Oxford: Blackwell Publishing.
- Cunningham, A. and Andrews, B. (1997), 'Introduction', in A. Cunningham and B. Andrews (eds), *Western medicine as contested knowledge*, Manchester: Manchester University Press.
- Farmer, P. (1990), 'Sending Sickness: Sorcery, Politics, and Changing Concepts of AIDS in Rural Haiti. *Medical Anthropology Quarterly* 4(1) 6-27.
- Farmer, P. (1999), *Infections and Inequalities - The Modern Plagues*, Berkeley: University of California Press.
- Farmer, P. and Kleinman, A. (1989), 'AIDS as Human Suffering', *Daedalus* 118(2) 136 -160.
- Farren, T. (2002), 'Health-care funds run dry', *Mail and Guardian* Oct 4 -10, Johannesburg: M&G Media Ltd.
- Feierman, S. (1985), 'Struggles in Control: The Social Roots of Health and Healing in Modern Africa', *African Studies Review*, June/Sept. 2/3: 73-149.
- Feierman, S. (1992), 'Introduction' in S. Feierman and J.M. Janzen (eds), *The Social basis of Health and Healing in Africa*, Berkeley: University of California Press.
- Fields, K. (2001), 'Witchcraft and Racecraft: Invisible Ontology and Its Sensible Manifestations', in G.C. Bond and D. Ciekawy (eds) *Witchcraft dialogues: Anthropological and philosophical exchanges*, Ohio: Ohio University Press.
- Friedman, Dr. I. (1998), 'Achieving Partnerships with Traditional Healers/Sangomas', South Africa: Health Systems Trust, <http://www.hst.org.za/update37/policy4.htm>
- Gelfand, M., Mavi, S., Drummond, R. and Ndemera, B. (1985), *The Traditional Medical Practitioner in Zimbabwe*, Harare, Zimbabwe: Mambo Press.
- Good, B.S. (1994), *Medicine, Rationality, and Experience: An Anthropological Perspective*, Cambridge: Cambridge University Press.
- Good, C. (1987), *Ethnomedical Systems in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya*, London/New York: Guilford Press.
- Good, C., Hunter, J., Katz, S. and Katz, S.S. (1979), 'The Interface of Dual Systems of Health Care in the Developing World: Toward Health Policy Initiatives in Africa', *Social Science and Medicine* 13D: 141-154.

- Green, E.C. (1992), Sexually Transmitted Disease, Ethnomedicine and Health Policy in Africa, *Social Science and Medicine* 35(2) 121-130.
- Green, E.C. (1994), *AIDS and STDs in Africa*, Boulder, Colorado: Westview Press.
- Green, E.C. (1997), 'Purity, Pollution and the Invisible Snake in Southern Africa', *Medical Anthropology* 17: 83-100.
- Green, E.C. (1999b), *Indigenous Theories of Contagious Disease*, London/California: SAGE/Altamira Press
- Green J. (2004), 'Traditional medicines against HIV/AIDS to be tested on people soon', *Cape Times*, Cape Town.
- Green, E.C., Zokwe, B. and Dupree, J. (1995), 'The experience of an AIDS Prevention Program Focused on South African Traditional Healers', *Social Science and Medicine* 40(4) 503-515.
- Grundfest Schoepf, B.G. (1992), 'Women at Risk: Case Studies from Zaire', in G. Herdt and S. Lindenbaum (eds), *The Time of AIDS: Social Analysis, Theory, and Method*, London: SAGE.
- Grundfest Schoepf, B.G. (1991), 'Ethical, Methodological and Political Issues in AIDS Research', *Social Science and Medicine* 33(7) 749-763.
- Gualbert, R.A. (1997), 'Traditional Models of mental Health and Illness in Benin', in P.J. Hountondji (ed), *Endogenous Knowledge: Research Trails*, Dakar: Codesria Book Series.
- Hahn, R.A. (1995), *Sickness and Healing: An Anthropological Perspective*, New Haven & London: Yale University Press.
- Hammond-Tooke, D. (1989), *Rituals and Medicines: Indigenous Healing in South Africa*, Johannesburg: A.D. Donker.
- Haram, L. (1991), 'Tswana Medicine in Interaction with Biomedicine', *Social Science and Medicine* 33(2) 167-175.
- Harding, J. (1997), Bodies at risk: 'Sex, surveillance and Hormone Replacement Therapy', in A. Petersen and R. Bunton (eds), *Foucault, Health and Medicine*, London: Routledge.
- Harrison-Chirimuuta, R. (1997), 'AIDS from Africa: Western science or racist mythology?', in Cunningham, A. and B. Andrews, *Western medicine as contested knowledge*, Manchester: Manchester University Press.
- Hirst, M. (1990), *The Healer's Art: Cape Nguni Diviners in the Townships of Grahamstown, Eastern Cape, South Africa*, East London: Rhodes University PhD Thesis.
- Hooper, E. (2000), *The River: A journey back to the source of HIV and AIDS*, London: Penguin Books.
- Hooper-Box, C. (2005), 'Aids drugs and food parcels not keeping up with demand', *Sunday Independent*, 3 July : Cape Town.
- Horton, R. (1993), *Patterns of Thought in Africa and the West*, Cambridge: Cambridge University Press.

- Hours, B. (1986), 'African Medicine as an Alibi and as a Reality', in *African Medicine in the Modern World: Proceeds of a Seminar*, Edinburgh: Centre of African Studies.
- Hountondji, P.J. (1997), *Endogenous Knowledge: Research Trails*, Dakar: Codesria Book Series.
- Hsu, E. (1999), *The Transmission of Chinese Medicine*, Cambridge: Cambridge University Press.
- Ingstad, B. (1989), 'Healer, Witch, Prophet, or Modern Health Worker?: The Changing Role of *Ngaka Ya Setswana* (Botswana)', in A. Jacobson-Widding and D.Westerlund (eds), *Culture, experience, and Pluralism: Essays on African ideas of Illness and Healing*, Uppsala, Sweden: University of Uppsala Press.
- Ingstad, B. (1990), 'The Cultural Construction of AIDS and Its Consequences for Prevention in Botswana', *Medical Anthropology Quarterly* 4: 28-40.
- Iwu, M. (1986), *African Ethnomedicine*, Nigeria: UPS.
- Janzen, J.M. (1992), *Ngoma: Discourses of Healing in Central and Southern Africa*, Berkeley: University of California Press.
- Jordan-Smith, D. (2003), 'Imagining HIV/AIDS: Morality and Perceptions of Risk in Nigeria', *Medical Anthropology* 22: 343-372.
- Kamaldien, Y. (2004), 'Patients pay high price for free hospitals', *Thisday* March 3, Johannesburg.
- King, R et al (1994), 'Traditional Healers as AIDS educators and counsellors in Kampala, Uganda', X International Conference on AIDS: Yokohama (abs. PD0247).
- Kleinman, A. (1995), *Writing at the Margin: Discourse between anthropology and medicine*, Berkeley/London: University of California Press.
- Kruger, D., (1974), 'Xhosa Divining and Psychotherapy: A reciprocal Perspective', Fort Hare Papers.
- Last, M. and G. Chavunduka (1986), *The Professionalisation of African Medicine*, Manchester: Manchester University Press (International African Institute).
- LeBeau, D. (2003), *Dealing with disorder: Traditional and Western medicine in Katutura (Namibia)*, Cologne: Rudiger Koppe.
- Leclerc-Madlala, S. (2001b), 'Demonising Women in the era of AIDS: on the relationship between cultural constructions of both HIV/AIDS and femininity', *Society in Transition* 32(1) 38-46.
- Leclerc-Madlala, S. (2002b), *Traditional Medical Practitioners AIDS Training and Support Programme: Final Evaluation Report*, AIDS Foundation of South Africa.
- Lock, M. (2002a), *Twice Dead: Organ Transplants and the Reinvention of Death*, Berkeley: University of California Press.

- Lock, M. (2002b), 'Utopias of health eugenics, and germline engineering', in N. Nichter and M. Lock (eds), *New Horizons in Medical Anthropology*, London/New York: Routledge.
- Louw, D. and Pretorius, E. (1995), 'The Traditional Healer in a Multicultural Society', in L. Adler and B. Mukherji (eds), *Spirit Versus Scalpel: Traditional Healing and Modern Psychotherapy*, Connecticut: Bergin and Garvey.
- Makgoba, M. (2003), 'Mixed signals on Aids eroding confidence', Sunday Independent May 25, Johannesburg: Independent Newspapers.
- Marks, S. and Anderson, N. (1990), 'The Epidemiology and Culture of Violence', in N. Manganyi and A. du Toit (eds), *Political Violence and the Struggle in South Africa*, South Africa: Southern Book Publishers.
- Medecins Sans Frontieres, The Department of Public Health at the University of Cape Town and the Provincial Administration of the Western Cape (2003), 'Antiretroviral therapy in primary health care: Experience of the Khayelitsha Programme in South Africa', Geneva: World Health Organisation
- M'Bokolo, E. (1995), 'History of Disease, History and Disease', in M. Auge and C. Herzlich (eds) (1995), *The Meaning of Illness*, New York: Harwood Academy Press.
- McMillen, H. *et al* (2000), 'Tanga AIDS Working Group Evaluation', unpublished report quoted in S. Anderson, S. and Kaleeba, N. (2002), 'Ancient Remedies, New Disease: Involving traditional healers in increasing access to AIDS care and prevention in East Africa', UNAIDS, <http://www.unaids.org>
- Merten, M. & N. Deane (2005), 'Vitriolic Dr Rath attacks TAC', *Mail and Guardian* Mar 18-23, Johannesburg: M&G Media Ltd.
- Mills J et al (2005), *AIDS* Jan 3-19 (1) 95-97.
- Motsuku, T. (2003), 'Rural hospitals in dire need of doctors', *Mail and Guardian* Nov 7 -13, Johannesburg: M&G Media Ltd.
- Nattrass, N. (2004), *The Moral Economy of AIDS in South Africa*, Cambridge: Cambridge University Press.
- Ndaki, K. (2004), 'Gauteng takes strain', *Mail and Guardian* May 7 -13, Johannesburg: M&G Media Ltd.
- Ndenze, B. (2005), 'Traditional healers stick to guns over TAC's 'funders'', *Cape Times* 28 Feb, Cape Town: Cape Times.
- Neumann, A.K. and Lauro, P. (1982), 'Ethnomedicine and Biomedicine', *Social Science and Medicine* 16: 1817-1824.
- Ngubane, H. (1992), 'Clinical practice of Indigenous Healers in South Africa', in S. Feierman and J.M. Janzen (eds), *The Social basis of Health and Healing in Africa*, Berkeley: University of California Press.

- Ngubane, H. (1977), *Body and Mind in Zulu Medicine: An Ethnography of Health and Disease in Nyswa-Zulu Thought and Practice*, London/New York: Academic Press.
- Niehaus, I. (2001a), *Witchcraft, power, and Politics: Exploring the Occult in the South African Lowveld*, Cape Town: David Philip; London: Pluto Press.
- Noel, D.C. (1997), *The Soul of Shamanism: Western Fantasies, Imaginal Realities*, New York: Continuum Publishing Co.
- Nshakira, N. L. Kwamya, A. Ssali *et al* (1995), 'Traditional healers as community healers on HIV/AIDS: an evaluation of a THETA initiative in Kampala, Uganda', IX International Conference on AIDS/STD in Africa, Kampala (Abs.TuD686).
- Osei-Hwedie, K. (1996), 'Rationale for Using Indigenous Knowledge in Human Service Provision', in H. Normann, I.Snyman and M. Cohen (eds), *Indigenous Knowledge and its uses in South Africa*, Pretoria: Human Sciences research Council.
- Peek, P.M. (1991), 'African Divination Systems: Non-normal Modes of Cognition', in P.M. Peek (ed), *African Divination Systems: Ways of Knowing*, Bloomington: Indiana University Press.
- Pillsbury, B. (1982), Policy and Evaluation Perspectives on Traditional Health Practitioners in National Health Care Systems, *Social Science and Medicine* Vol. 16: 1825-1834.
- Pool, R. (1994), *Dialogue and the Interpretation of Illness*, Oxford: Berg Publishers.
- Portelli, A. (1991), *The Death of Luigi Trastelli and Other Stories: Form and Meaning in Oral History*, Albany: State University of New York Press.
- Pretorius, E. (1999), 'Traditional Healers' in The South African Health Review 1999, <http://www.hst.org.za/99/chap18.htm>
- Salva, M.M. (2005), 'An Equal Treatment interview with a traditional healer', *Equal Treatment*, Newsletter of the Treatment Action Campaign, Cape Town.
- Scheinman, D., R. Nerje *et al* (1992), 'Treating HIV with Traditional Medicine', *AIDS and Society* 3(3):5.
- Scheper-Hughes, N. (1987), 'The Mindful Body: a Prolegomenon to future work in Medical Anthropology', *Medical Anthropology Quarterly* 1(1): 6-31.
- Shweder, R. (1991), *Thinking through Cultures: Expeditions in Cultural Psychology*, Cambridge /London: Harvard University Press.
- Shisana, O. (2003), The Impact of HIV/AIDS on the Health Sector, Report prepared for the South African Department of Health with the HSRC, Pretoria: HSRC.
- Susser, I. and Stein, Z. (2004), 'Culture, Sexuality, and Women's Agency in the Prevention of HIV/AIDS in Southern Africa', in E. Kalipeni, S.

- Craddock, J. R. Oppong and J. Ghosh (eds), *HIV and AIDS in Africa*, Oxford: Blackwell Publishing.
- Swift, P. and Strang, J. (1993), Letter, *SAMJ* 83(9) 690-691.
- Tabane, R. (2005), 'Manto loves Rath', *Mail and Guardian*, May 6 to 12, Johannesburg, South Africa: M&G Media Ltd.
- Taussig, M. (1980), 'Reification and the Consciousness of the Patient', *Social Science and Medicine* 14B: 3-13.
- The Traditional Health Practitioners Bill (2003), B66, Government Gazette no 24751,14 April, Cape Town: South Africa.
- Tshabalala-Msimang, M. (2004), 'Tackling the Treatment Action Campaign', *Mail and Guardian*, July 9 to 15, Johannesburg, South Africa: M&G Media Ltd.
- Turner, E. (1992), with Blodgett, W., Kahona, S., Benwa, F., *Experiencing Ritual: A new Interpretation of African Healing*, Philadelphia: University of Pennsylvania Press.
- van Wyck, B-E, van Oudtshoorn, B. and Gericke, N. (1997), *Medicinal Plants of South Africa*, Pretoria: Briza Publications.
- Werbner, R. (2001), 'Truth-on-Balance: Knowing the Opaque Other in Tswapong Wisdom Divination, in G. C. Bond and D. Ciekawy (eds), *Witchcraft dialogues: Anthropological and philosophical exchanges*, Ohio: Center for International Studies.
- West, Martin. (1975), *Bishops and Prophets in a Black City: African Independent Churches in Soweto*, Johannesburg/Cape Town: David Philip.
- Willis, R. (1999), *Some Spirits Heal, Others Only Dance*, Oxford: Berg.
- Winch, P. (1972), *Ethics and Action*, London: Routledge and Kegan Paul.
- World Health Organisation (1978), Primary Health Care, Report of the International Conference on Primary Health Care, Alma Ata, Geneva, Geneva: World Health Organisation.
- Wreford, J. (2005), 'We Can Help! A literature review of current practice involving traditional African healers in biomedical HIV/AIDS interventions in South Africa, *CSSR Working Paper* 108, Centre for Social Science Research, Cape Town: University of Cape Town.
- Wreford, J. in progress, *Ukusebenza n'ethongo: working with spirit: The role of sangoma in contemporary South Africa*, Oxford: Berghan Press.
- Yoder, P. (1982), 'Commentary on African Systems of Medicine' in *African Health and Healing Systems: Proceedings of a Symposium*, UCLA: African Studies Center, African Studies Assoc., Office of International Health.
- Yoder, P. (1997), 'Negotiating Relevance: Belief, Knowledge, and Practice in International Health Projects', *Medical Anthropology Quarterly* 11(2) 131-146.

The Centre for Social Science Research

Working Paper Series

RECENT TITLES

Collins, D. 2005. *Financial instruments of the poor: Initial findings from the financial diaries study*. CSSR Working Paper no. 130.

Cichello, P. 2005. *Hindrances to Self-employment Activity: Evidence from the 2000 Khayelitsha/Mitchell's Plain Survey*. CSSR Working Paper no. 131.

Wittenberg, M. 2005. *Testing for a common latent variable in a linear regression: Or how to "fix" a bad variable by adding multiple proxies for it*. CSSR Working Paper no. 132.

Burger, R. and Woolard, I. 2005. *The State of the Labour Market in South Africa after the First Decade of Democracy*. CSSR Working Paper no. 133.

Barkan, J. 2005. *Emerging legislature or rubber stamp? The South African national assembly after ten years of democracy*. CSSR Working Paper no. 134.

Brandt, R. 2005. *Maternal well-being, childcare and child adjustment in the context of HIV/AIDS: What does the psychological literature say?* CSSR Working Paper no. 135.

Moses, S. 2005. *Does space and place matter? Perspectives from girls growing up in a Cape Town neighbourhood created under Apartheid*. CSSR Working Paper no. 136

de Lannoy, A. 2005. *"There is no other way out". Educational decision-making in an era of AIDS: How do HIV-positive mothers value education?* CSSR Working Paper no 137.

The Centre for Social Science Research

The CSSR is an umbrella organisation comprising five units:

The **AIDS and Society Research Unit** (ASRU) supports innovative research into the social dimensions of AIDS in South Africa. Special emphasis is placed on exploring the interface between qualitative and quantitative research. By forging creative links between academic research and outreach activities, we hope to improve our understanding of the relationship between AIDS and society and to make a difference to those living with AIDS. Focus areas include: AIDS-stigma, sexual relationships in the age of AIDS, the social and economic factors influencing disclosure (of HIV-status to others), the interface between traditional medicine and biomedicine, and the impact of providing antiretroviral treatment on individuals and households.

The **Data First Resource Unit** ('Data First') provides training and resources for research. Its main functions are: 1) to provide access to digital data resources and specialised published material; 2) to facilitate the collection, exchange and use of data sets on a collaborative basis; 3) to provide basic and advanced training in data analysis; 4) the ongoing development of a web site to disseminate data and research output.

The **Democracy in Africa Research Unit** (DARU) supports students and scholars who conduct systematic research in the following three areas: 1) public opinion and political culture in Africa and its role in democratisation and consolidation; 2) elections and voting in Africa; and 3) the impact of the HIV/AIDS pandemic on democratisation in Southern Africa. DARU has developed close working relationships with projects such as the Afrobarometer (a cross national survey of public opinion in fifteen African countries), the Comparative National Elections Project, and the Health Economics and AIDS Research Unit at the University of Natal.

The **Social Surveys Unit** (SSU) promotes critical analysis of the methodology, ethics and results of South African social science research. Our core activities include the overlapping Cape Area Study and Cape Area Panel Study. The Cape Area Study comprises a series of surveys of social, economic and political aspects of life in Cape Town. The Cape Area Panel Study is an ongoing study of 4800 young adults in Cape Town as they move from school into the worlds of work, unemployment, adulthood and parenthood.

The **Southern Africa Labour and Development Research Unit** (SALDRU) was established in 1975 as part of the School of Economics and joined the CSSR in 2002. In line with its historical contribution, SALDRU's researchers continue to conduct research detailing changing patterns of well-being in South Africa and assessing the impact of government policy on the poor. Current research work falls into the following research themes: post-apartheid poverty; employment and migration dynamics; family support structures in an era of rapid social change; the financial strategies of the poor; public works and public infrastructure programmes; common property resources and the poor.
