

**HIV/AIDS AND RECONCILING THE IRRECONCILABLE?
ESTABLISHING MIDDLE GROUND BETWEEN THE TRADITIONAL
AND BIOMEDICAL SECTORS IN SOUTH AFRICA**

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HIV/AIDS and Reconciling the Irreconcilable? Establishing Middle Ground between the Traditional and Biomedical Sectors in South Africa

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Abstract:

This paper analyses, from a policymaking perspective, the continued recourse to South Africa's thriving traditional healthcare sector, which operates in tandem with the country's relatively well-developed biomedical healthcare sector. The paper considers the traditional healthcare sector's potential to impact on orthodox approaches to the treatment and management of HIV/AIDS, including the uptake of ARVs. It highlights the urgent necessity of more thorough engagement between the traditional and biomedical sectors, particularly where supernatural elements – an integral part of much traditional diagnosis and treatment of illness and disease – are concerned. The challenge for policymakers is how best to facilitate an effective means of accommodating the potentially conflicting traditional cosmology within the formal healthcare infrastructure; this would represent a vital step towards a more effective overall approach to South Africa's HIV/AIDS pandemic. However, despite the undoubted benefits that such accommodation might engender, the paper queries whether this is indeed feasible.

Keywords: healthcare, HIV/AIDS, policymaking, South Africa, supernatural, traditional medicine

Introduction

In South Africa, recourse to the traditional healthcare sector is part of daily life.¹ It is a sector based on a number of constructions of illness, affliction and wellbeing that are regularly at odds with the biomedical conceptualisation of disease. It is particularly crucial, then, that biomedical practitioners, donor agencies, NGOs and the state bring new urgency to working with, and through, traditional cosmologies, especially where HIV/AIDS is concerned. While there is a general view, expressed in much of the literature, that biomedical accommodation of and collaboration with traditional healthcare within the formal sector is a necessity if HIV/AIDS is to be successfully combated, the ways in which such a relationship might go forward are seldom made entirely clear. South Africa, with its eleven official languages, is by no means culturally homogenous and the term ‘traditional healthcare sector’ represents something of a catchall. However, the real quandary for policymakers is how best to engage with the supernatural aspects that form the basis for so much of the traditional sector’s approach to healthcare. Some branches of the sector, that which encompasses dedicated herbalists for example, can be relatively readily engaged with – and regulated – in biomedical terms, but any approach involving divination and mysticism poses far greater challenges to the bureaucratic mindset. Given the Enlightenment roots in which the biomedical sector is grounded, this is not without reason. In a number of respects, therefore, policymakers focusing on the utilisation of the traditional sector as a means of expanding access to effective healthcare provision may be seeking to reconcile the irreconcilable. At the same time, there is an urgent need for more thorough consideration of the problem, even if only define the parameters of what is and what is not possible.

It goes without saying that much of sub-Saharan Africa, and particularly southern Africa, is in the grips of an AIDS crisis. According to data from the end of 2009 supplied by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2010), on a global level there are an estimated 33.3 million people living with HIV/AIDS, of whom 67 per cent (22.5 million) are African. Over 70 per cent of all deaths from AIDS occur in sub-Saharan Africa. Globally, of the estimated 2.5 million children under the age of 15 infected with HIV/AIDS, 90 per cent (2.3 million) are from countries in sub-Saharan Africa (UNAIDS, 2010). Moreover, estimates suggest that, as of 2008, at least 12 million African children have lost at least one parent to AIDS (UNAIDS, 2008). For the past thirty years, healthcare sectors around the world, both traditional and biomedical, have had to come to terms with the day-to-

¹ Adrian Flint acknowledges gratefully the British Academy’s funding of his fieldwork.

day realities of treating HIV and AIDS. In South Africa, as with many other African countries, a significant proportion of the responsibility has fallen to the traditional healthcare sector. The World Health Organisation (WHO) has accepted that up to 80 per cent of the sub-Saharan population draws on the traditional healthcare sector for its primary healthcare needs (see for example WHO, 2002; WHO, 2008d). Although the WHO statistic is contested (Ashforth, 2005), there is nonetheless clear evidence that many in sub-Saharan Africa at the very least engage in ‘medical pluralism’ (Nagata *et al*, 2011), drawing on both the biomedical and traditional healthcare sectors (Mills, 2005; Nattrass, 2006a). In this regard, South Africa makes a useful case study; here, recourse to the traditional sector continues in spite of what is, particularly in urban areas, a relatively well developed biomedical sector.

Focus on the healthcare-cosmology interface is by no means new. In 1955, one of the founders of medical anthropology as a discipline, Benjamin Paul, advised policymakers that ‘if you wish to help a community improve its health, you must learn to think like the people of that community’ (cited in Scrimshaw, 2006: 43). Harvard anthropologist Byron Good (1997: 45) outlined how Enlightenment values have worked in the West towards the shaping of a ‘culture-free representation of disease’, in which the biosciences are understood to ‘provid[e] neutral and realistic representations’ while traditional values are depicted as ‘rife with dangerous and ultimately mistaken metaphors’. Good (1997) argued that the biomedical establishment operates along ‘missionary’ lines, seeking to liberate people from ostensibly irrational beliefs. South Africa, in many respects a post-awareness society with respect to HIV/AIDS (interviews, 2010), demonstrates the paucity of this single-minded approach. Policymakers – and biomedical practitioners if they wish to impact positively on the current status quo – must consider ‘local knowledge, cultural influence on the patterns of disease, and structural barriers to good health’ when evaluating and shaping responses to HIV/AIDS (Manderson, 1998: 1025).

Traditional sub-Saharan approaches to illness and healing have been the focus of a range of anthropological studies, including the seminal work of Edward Evans-Pritchard (1937) and Harriet Ngubane (1977), as well as that of Christine Liddell *et al* (2005), Isak Niehaus (2001), Alexander Rödlach (2006) and Felicity Thomas (2008). There has been far less consideration given to the interface between traditional and biomedical approaches and related implications for policymakers and policymaking. However, drawing on ideas about worldview and cosmology to help to explain and engage with reactions to illness and treatment regimes has obvious relevance, particularly when the reactions in question are far removed from the biomedical orthodoxies employed currently in the fight against HIV/AIDS.

The subject is relatively underrepresented in the mainstream HIV/AIDS literature. At the 2010 meeting of the International AIDS Society, attended by over 16,000 academics, activists and policymakers, it was touched on only in passing. That said, there is a growing body of literature specifically dedicated to the subject in a South African context, including notable contributions from Adam Ashforth (2000, 2001, 2002, 2005a, 2005b), Nicoli Nattrass (2005a, 2005b, 2008) and Jo Wreford (2005a, 2005b, 2008a, 2008b, 2008c). In 2005, a special edition of *Social Dynamics*, specifically focused on traditional healthcare, also included ethnographic studies by Annie Devenish (2005), Patricia Henderson (2005), and Elizabeth Mills (2005). The AIDS and Society Research Unit, headed by Nattrass, and part of the Centre for Social Science at the University of Cape Town, continues to provide a platform for related research (<http://www.cssr.uct.ac.za/asru>). There are also pertinent studies examining the effects of ‘modernity’ on traditional healthcare practice in South Africa (see for example Chigona *et al*, 2008).

The interview data for this paper were gathered over July and August 2010 in Johannesburg (Gauteng province), East London and Grahamstown (Eastern Cape province) and Knysna (Western Cape province). The data, based on in-depth, semi-structured, informal interviews, are drawn from both group and individual sessions and include views from a range of traditional healthcare practitioners and their clients. Rather than forming the basis for any single exhaustive claim, the study’s qualitative element was designed to engage the views of a relatively broad cross-section of South African society. The sample therefore reflects rural-urban divides and differences in age, sex, education and financial standing, in the interests of eliciting a sense of the extent of people’s confidence in the efficacy of traditional healthcare, particularly with respect to HIV/AIDS. The identities of all respondents have been anonymised. The traditional practitioners consulted were both South African and from other African states. The practitioner sample includes an established senior healer with a number of apprentices, trainee healers, transient healers, and a number of ‘corporate’ healers with franchises located around the country. The patient-client sample includes individuals variously employed in social work, management, education, domestic service, construction and tourism. Respondents range from settled rural householders outside East London to migrant workers in Johannesburg.

Medical pluralism and the implications for HIV/AIDS

To date, ARVs represent the only proven treatment for AIDS, making their effective distribution and uptake an essential component of any successful management strategy.

Across much of sub-Saharan Africa, coverage has improved significantly under the auspices of major international donor programmes like PEPFAR (the US President's Emergency Plan for AIDS Relief), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the domestic programmes of African states such as Botswana, and literally millions of people's lives have been affected positively as a result. At the same time, even optimal rollout will not guarantee comprehensive uptake; people must have confidence that existing treatment regimes meet their needs, and it is here that the role of traditional healthcare is crucial.

In the North, healthcare tends to be viewed through an Enlightenment lens that understands science to be rational and value-free, a worldview in which representations of disease are seen as 'culture-free' and where disease is perceived as an 'objective reality' (Good, 1997: 45). Data from the United Kingdom, for instance, suggest that nearly 70 per cent of the population has faith in the dependability of science and scientists (Worcester, 2006). As a result, trust in the value and efficacy of biomedical healthcare is very high, although, of course, by no means universal. Approaches to the treatment of HIV/AIDS are no exception. However, the Enlightenment worldview is by no means a global phenomenon – in China, up to nearly half of all medicines consumed are derived from traditional sources (WHO, 2002) – and in much of Africa it is yet to displace widespread and time-honoured traditional approaches to the treatment of illness and disease.

While it is difficult to pinpoint exactly how dependent people living in Africa are on the traditional sector for their healthcare needs (Ashforth, 2005; Nattrass 2005a), the figure of 80 per cent is routinely referred to in the literature (WHO, 2002, 2008). There is also little doubt that, particularly in rural areas and in countries where there is a low biomedical practitioner-to-patient ratio, traditional practitioners are frequently the only available healthcare providers. Uganda is a good case in point: here, the traditional practitioner-to-population ratio ranges between 1:200 and 1:400, compared to the biomedical practitioner-to-population ratio of 1:20,000 (WHO, 2002). South Africa's population of just over 50 million is home to an estimated 300,000-plus traditional practitioners (Liddell *et al*, 2005), in stark contrast to its approximately 33,000 biomedical practitioners (South African Department of Labour, 2008 - data from 2006). However, it is not only the availability of biomedical practitioners that determines people's engagement with biomedicine. Despite South Africa's relatively developed biomedical infrastructure and high levels of urbanisation, recourse to traditional healthcare remains extremely high throughout the country.

For those engaged in developing and tailoring healthcare policy, an understanding of traditional healthcare and its accompanying worldviews is vital if further inroads are to be

made into the spread of HIV/AIDS. The need for engagement has been recognised, if tacitly, by international aid and donor organisations (particularly the WHO but recently also less overtly health-orientated agencies such as the World Bank), which have since the mid-1970s made a point of interacting, on some level at least, with the traditional healthcare sector. At the same time, the relevant studies suffer from a relative dearth of insight into the worldviews upon which much traditional healthcare rests – a crucial oversight, given the potentially contentious nature of some elements of the cosmologies underpinning African traditional healthcare. Significantly, the idea of HIV/AIDS as a communicable disease, and its treatment as such, sits awkwardly within this general outlook, becoming a major obstacle to the potential success of the many prevention programs focussing on the twin tenets of behavioural change and risk aversion. Adam Ashforth (2002: 122) notes the lack of analytical engagement with this aspect of the debate, highlighting how the omission tends only to be recognised in passing and often then only alongside the point that it ‘complicates education programmes’. A ready explanation is that, for many engaged in the provision and practice of biomedicine, cosmology and worldview belong more to the realms of psychology and social anthropology.

A number of African governments, including that of South Africa, have worked towards the integration of their biomedical and traditional sectors in the interests of expanding access to healthcare. These efforts to regulate and professionalise traditional healthcare have met with varying degrees of success. However, integration initiatives have for the most part tended to focus on the ‘re-education’ of traditional healthcare practitioners rather than make meaningful attempts to understand and harness the potentially important contribution of the latter to HIV/AIDS management: medical missionary work, if you will, as opposed to any real endeavour to reconcile conflicting perspectives. One result of this is that traditional practitioners who do take steps to engage with their biomedical counterparts can experience what they see as disrespectful and patronising attitudes towards the perspectives they put forward (Chigona *et al*, 2008; Wreford 2005a, 2005b, 2008c).

Grafting the traditional to the biomedical

However, that is not necessarily to argue against the relevance of medical ‘missionary work’. It may be that the basic premises on which the two sectors are based are simply too disparate for there to be any real middle ground between them. While the socio-cultural advantages of a more truly collaborative approach to bridging the divide are palpable, the risks to health posed by equitable integration may, for many biomedical practitioners, be too high. The fear

is that drawing traditional practitioners into the mainstream may serve to legitimate unproven treatments and impede transfer to biomedical treatment regimes (UNAIDS, 2000). Moreover, where HIV/AIDS is concerned, some important advances have been made in instances where traditional healers have come 'on side' and have engaged with biomedical programmes. Looking back on a range of less-than-successful biomedical HIV/AIDS strategies, Edward Green (World Bank, 2004) stressed traditional practitioners' potentially significant capacity to encourage client-patients to engage with biomedical prevention and treatment options. Green pointed to the progress made by Senegal and Uganda in creating bridges between the two sectors and, in particular, drew attention to Uganda's THETA (Traditional and Modern Health Practitioners Together against AIDS) programme. In the early 1990s, THETA brought together the Ministry of Health, the National AIDS Commission and a group of NGOs in an undertaking directed at convincing traditional practitioners of the importance of raising the subject of HIV/AIDS with their client-patients and encouraging the latter to practise safer sex and have themselves tested (UNAIDS, 2000). Between 1997 and 1998, THETA provided biomedical training for traditional practitioners in the interests of improving diagnosis rates. This 15-month training programme was linked to a significant increase in the number of patients subsequently referred to biomedical facilities for HIV testing (UNAIDS, 2000). A similar project in Tanzania, the Tanga AIDS Working Group (TAWG), was associated with a dramatic increase in referrals and a notable increase in condom sales (Prakash, 2005; UNAIDS, 2000). Other African countries, including Botswana, the Central African Republic, Malawi, Mozambique and Zambia, have seen the initiation of comparable projects, some successful, others less so (UNAIDS, 2000; WHO, 2003). All of these programmes have had at their core the basic premise that the optimum approach to engagement with the traditional sector involves cooption rather than synthesis. In South Africa, the professional association of traditional practitioners, the Traditional Healers Organisation (THO), incorporates training for members in biomedical AIDS prevention and care. The THO's mission statement is unambiguous in its assertion that while 'modern medicine is needed for the accurate diagnosis of AIDS, it is the traditional health practitioners who would probably be the primary care providers and in the front line in the prevention and control of the spread of this disease' (THO, undated).

Traditional healthcare and the supernatural

Since South Africa incorporates a multiplicity of ethnic and language groups, presentation of a 'South African' perspective on illness and healing would be, without doubt, a vast

oversimplification. At the same time, a number of commonalities in outlook across the country arguably make it possible, and useful, to engage with the concept, albeit extremely broad-based, of a 'traditional' understanding of disease and treatment. Here, in what Ashforth (2000, 2002, 2005a) has described as a 'witchcraft paradigm', the role of the supernatural is significant, if not paramount. In much of South Africa, understandings of illness and healing extend beyond the confines of medical practice as it is understood in the North to incorporate an almost religious dimension that is difficult to articulate in English. Traditional healthcare practitioners are more than simply medical doctors. As part of their broader role in maintaining wellbeing, they also act as advisors, counsellors and detectives within the community and, importantly, as conduits between community members and the ancestral realm (Ashforth, 2000; Ntloedibe-Kuswani, 1999).

This multi-dimensional understanding of health and healthcare is deep-rooted and widespread, traversing borders, urban/rural divides, gulfs in education and income, and age cohorts. Similarities in outlook have been noted in seminal studies of societies as far apart as the Azande of Central Africa (Evans-Pritchard, 1937) and South Africa's Zulu community (Ngubane, 1977). Commonalities have also been identified in Tanzania (Beidelman, 1963), Uganda (Beattie, 1963) and the southern Sudan (Buxton, 1963). Studies conducted since the outbreak of the HIV/AIDS pandemic by, for instance, Felicity Thomas (2008), Christine Liddell *et al* (2005), Ashforth (2001, 2002, 2004), Isak Niehaus (2001), Anne Meyer-Weitz *et al* (1998) and Benedicte Ingstad (1990) have also served to highlight the widespread nature of the paradigm.

In South African cities and towns like East London and Grahamstown in the Eastern Cape, traditional health practitioners from Kenya, Uganda, Tanzania and Zimbabwe have established themselves within local communities, reflecting how the degree of interchangeability within the continent's belief systems can transcend national borders (interviews, 2010). Perhaps most significant, however, is that which points to sustained urban support for traditional belief systems, including their supernatural aspects (interviews 2010). Soweto, the sprawling apartheid-era 'township' subsequently incorporated within adjacent Johannesburg, is a case in point (Ashforth, 2000, 2005a). The extent to which recourse to traditional healthcare continues here reflects the current prevalence of traditional beliefs in twenty-first century urban South Africa.

The traditional healthcare sector has moved with the times. It has embraced contemporary marketing strategies, with services now being advertised widely in mainstream South African lifestyle magazines such as *You* (English-medium) and *Huisgenoot* (Afrikaans-

medium). Today's South African high streets testify to the burgeoning of traditional pharmacies, which dispense ingredients common to traditional remedies. Practitioners routinely make use of mobile phone technology to stay in contact with patients and many keep computerised records (Chigona, *et al* 2008). Despite the commercialisation of the sector, however, the supernatural aspects of traditional healthcare have by no means receded. Traditional practitioners interviewed in the Eastern Cape were perplexed by the tendency of biomedical practitioners to consider medicine and religious/spiritual belief as separate (interviews, 2010). To these practitioners, good fortune, of which good health is part, is achievable through intercession with the ancestral realm by means of specific observances. Misfortune itself is similarly understood to result from the action of supernatural forces, instigated either by slighted ancestors or individuals within the community motivated, most often, by envy and resentment of the success of others.

Critically, illness and lack of wellbeing is viewed less by traditional practitioners and their clients as the outcome of random assaults on the body by viruses, bacteria and other organisms than as manifestations of supernatural forces at work. In a considerable number of African societies, illness can be divided into that which is 'natural' and that which has been engendered by witchcraft and malevolent intent. Death from old age is understood to be 'natural', but as a result of any other reason can be seen as 'unnatural' (Orubuloye and Oguntimehin, 1999). Distinguishing between 'natural' and 'unnatural' disease is key. Harriet Ngubane's (1977) ground-breaking study of illness within Zulu culture attested to the extent to which 'natural' disease was understood to come about by chance. Examples of diseases considered 'natural' include the 'childhood' illnesses – measles, mumps – and common afflictions like colds and influenza. Some forms of mental illness also fall into this category. These illnesses are not viewed as being in any way remarkable, and are treated accordingly, with little recourse to ceremony and ritual. 'Unnatural' diseases, on the other hand, often necessitate a different type of intervention. It is these that are understood to have been prompted by malevolent supernatural forces that demand neutralization. Within this worldview, sudden death, wasting, long-term incapacity – all afflicting previously healthy people in the prime of life, and especially young adults – are difficult to comprehend without recourse to Ashforth's (2000, 2005a) witchcraft paradigm. Significantly, within the paradigm it becomes necessary to locate the malevolent origin of a victim's affliction, usually with the assistance of a traditional practitioner, both in order to understand the nature of the illness and the reason for the individual being singled out in this way (Liddell *et al*, 2005).

Cosmology, society and HIV/AIDS

People living with HIV/AIDS are involved in a sustained psychological as well as physical battle, something that is not always easily dealt with by resource-strained biomedical practitioners. For policymakers, incorporating traditional healthcare within the formal healthcare infrastructure offers the opportunity for ‘different and overlapping forms of care’ (Mills, 2005: 155). Traditional healthcare can potentially fulfil needs that extend beyond diagnosis and treatment. In the early days of the pandemic, many people whose HIV-status became public were heavily stigmatised. In some instances, the backlash had severe consequences. The cases of Gugu Dlamini in 1998 (Iliffe, 2004) and Lorna Mlosana in 2003 (Bhana *et al*, 2004) were two high-profile instances in which women were murdered as a result of their status becoming public. That levels of stigmatisation have decreased somewhat is at least partly attributable to public figures like Mangasothu Buthelezi, who lost two children to AIDS in 2004, and Nelson Mandela, whose eldest son Makgatho died in 2005, acknowledging HIV/AIDS within their own families. However, it has by no means become a socially acceptable condition (Simbayi *et al*, 2007). It is still often perceived to be self-inflicted, which is why many South Africans never seek confirmation of their status. Witchcraft narratives provide socially-acceptable explanations for symptoms that might otherwise be associated with HIV/AIDS. In addition, ‘blame’ for symptoms is shifted from the patient (now a victim of witchcraft, rather than HIV/AIDS) to the ‘perpetrator’, enabling the former to continue to receive the sympathy and support of the community at large (Mills, 2005; Thomas, 2008).

However, if the goal for policymakers is to take advantage of the paradigm’s ability to render HIV/AIDS a socially acceptable condition, the blame-shift from ‘victim’ to alleged perpetrator results in an associated shift, rather than decrease, in social cost. Identification of the perpetrator of witchcraft is often an important aspect of diagnosis and treatment (interviews 2010). As is the case in much of sub-Saharan Africa (Federici, 2008; Miguel, 2004; Rödlach, 2006; UN, 2006), a high proportion of elderly people, especially women, are frequently targeted as malicious agents (interviews, 2010)². A 1995 Commission of Inquiry into Witchcraft Violence and Ritual Murders in Northern Province investigated the nearly 150 deaths during the preceding year known to have been associated with witchcraft

² In the fictional *Welcome to our Hillbrow*, Phaswane Mpe (2001) who died in 2004 from what is believed to have been an AIDS-related illness, depicts AIDS and witchcraft in rural Limpopo province, reflecting eloquently the extent to which witch hunts continue to be commonplace in many parts of South Africa, sometimes with fatal consequences.

accusations. The South African Commission for Gender Equality subsequently called on the government to take witchcraft-related violence more seriously and to legislate more stringently against it (CGE, 1998). In 2007, Mpumalanga province attempted to address the issue of identifying or ‘sniffing out’ witches in its Witchcraft Suppression Bill, which made it an offence to employ or solicit ‘any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard’. However, little real progress has been made where the problem of witch-hunts is concerned (Petrus, 2011). While engagement with the supernatural aspects of traditional healthcare may have advantages for individuals living with HIV/AIDS, policymakers continue to wrestle with the potentially socially divisive spillover.

Regulating the traditional healthcare sector

If traditional healthcare practice is to be drawn more fully into the formal healthcare sector, more exacting regulation and legislation is critical. However, an innate suspicion of traditional practice on the part of the formal healthcare establishment, together with the former’s informal and frequently esoteric nature, exacerbates the challenges of bringing bureaucratic order and structure to the traditional sector. The supernatural basis for a significant proportion of traditional practitioners’ knowledge and understanding of the causes of and remedies for illness and disease remains a primary obstacle for outsiders to the cosmology. So, too, do aspects of traditional approaches to training and apprenticeship. A number of African countries have legislated in the interests of regulating the often informal nature of traditional healthcare (WHO, 2002), including Burkina Faso, Ghana, Mali, Nigeria, Senegal, Uganda, Tanzania and Zambia. The Kwame Nkrumah University of Science and Technology in Ghana offers an undergraduate degree in herbal medicine. In Zambia, it is possible to qualify as a Doctor of Naturopathic Medicine (WHO, 2009).

In South Africa, former President Thabo Mbeki’s administration (1999-2008), in an attempt to retake the initiative in the wake of reams of adverse publicity generated by AIDS-denialism, looked to the traditional healthcare sector for potential ‘African solutions to an African problem’.³ Fronted by the then Minister of Health, Dr Manto Tshabalala-Msimang, the Mbeki government became vocal in its support of traditional healthcare as an alternative

³ The phrase ‘African solutions to African problems’ is tied to Mbeki’s 1997 articulation of an African Renaissance. In the interests of attracting foreign investment, Mbeki (1997) argued that ‘Africa’s time has come...[t]he new century must be an African century’. Despite its initial focus on aid and investment, the sentiment came to dominate the AIDS debate (McNeill, 2009). However, the prioritisation of locally-developed ‘cures’ like Virodene (Nattrass, 2008) and, subsequently, traditional healthcare put the administration at odds with the global biomedical community. See discussions of the Virodene scandal in Van der Vliet (2001) and Nattrass (2006).

to antiretroviral therapy and as a means of empowering communities (Mills, 2005). However, even with this impetus behind it, exacting legislation has proved difficult. In 2003, the Traditional Health Practitioners Bill, for example, sought to outline the qualifications necessary for recognition as a practitioner, but failed to engage with the importance regularly accorded to the supernatural within the sector.⁴ The Traditional Healers Organisation (THO), which currently claims a membership of 29,000 traditional practitioners in South Africa and beyond, has established its own certification, code of ethics, complaints procedures, training guidelines and referral service (<http://www.traditionalhealth.org.za>). However the criteria it employs to define the attributes of a traditional practitioner are extremely vague⁵ and skirt around the issue of the supernatural.

Practitioners who rely on divination for their powers and ability are believed to have been chosen for their calling by their ancestors. While novices would be expected to submit to periods of training with established practitioners, a significant proportion of knowledge is acquired through dreams or visions (Ashforth, 2005a; Ngubane, 1977; Wreford, 2008c). A number of traditional practitioner-respondants in the Eastern Cape, both local and from neighbouring countries, described similar entries into the profession. Without exception, they spoke of having had dreams, usually from a young age, for some as young as six, in which they communed with their ancestors (interviews, 2010). Their ability to communicate with the ancestors, they argued, formed the basis of their power as practitioners and legitimised their abilities before their communities. Quite often a practitioner literally has to ‘sleep on it’ in order to fully assess a client’s needs.

None of the traditional practitioners consulted in the course of this study demonstrated any interest in certification, professional associations or regulation. Similarly, Annie Devenish (2005), working in KwaZulu-Natal province, found resistance on the part of many practitioners to standardisation, based on what is by their own recognition the intensely personal and esoteric aspects of their practice. Client-respondents (interviews, 2010) also evinced a lack of interest in the formalisation of the sector. Clients are attracted less by state-

⁴ The Bill was declared invalid by the Constitutional Court in 2006 after Doctors for Life challenged it on the basis of insufficient consultation. Following minor revisions, it was assented to in January 2007.

⁵ See sections ‘Qualities of a Competent Traditional Health Practitioner’, which lists being a good learner, sincerity, decisiveness, honesty, passion, courage, good hygiene and loyalty as key attributes <http://www.traditionalhealth.org.za/t/documents/competen_practitioner.html>. See also section headed ‘Guidelines for formulating policies on training of healers’, which is extremely vague with respect to specifics <<http://www.traditionalhealth.org.za/t/documents.html>>.

sanctioned qualifications than by word-of-mouth, frequently engaging several healers in searches for successful remedies.

From a regulatory perspective, a complicating factor is that failure to find a cure is often viewed as an indication not of fraudulence or misdiagnosis on the part of the traditional practitioner, but rather of the strength of supernatural forces aligned against the patient. In such cases, it is then a matter of seeking out a more powerful practitioner. When pressed, client-respondents were vague about what separates genuine practitioners from charlatans, other than to repeat the generally-expressed view that practitioners who demand full payment up front are to be considered suspect (interviews, 2010). Legitimate practitioners, it is argued, will request full payment only once clients are satisfied.

Further guidelines governing traditional practitioners' qualifications are to be welcomed. However, the briefest engagement with the Traditional Health Practitioners Bill, the wording of which is in places vague to the point of meaninglessness, highlights the difficulties for regulators. The 2007 Mpumalanga Witchcraft Suppression Bill is similarly vague in its prescriptions regarding the comportment and policing of traditional practitioners. Moreover, empirical evidence suggests that efforts at top-down formalisation and regulation ignores may be misdirected. In this regard, the *uBhejane* (rhino) herbal 'cure' for HIV/AIDS provides a pertinent example. The *uBhejane* treatment, which became hugely controversial in South Africa, was claimed by Zeblon Gwala, a former haulier, to have been revealed to him in a dream by his late grandfather, a traditional practitioner (TAC, 2008). The widespread promotion of *uBhejane* in KwaZulu Natal, the province with the highest HIV-prevalence in South Africa, included Gwala's claim that the treatment 'increases your CD4 count and reduces the viral load until it disappears' (ASA, 2008: 1). Gwala also advised patients to discontinue ARV treatment when taking *uBhejane*. When tested in 2005, the Medical University of South Africa found *uBhejane* to have no effect on the treatment of HIV/AIDS (Doctors for Life, 2006). Despite the best efforts of activist groups like the Treatment Action Campaign (TAC) to shut down Gwala's operation, including a 2010 attempt to have him prosecuted for false claims surrounding the registering of *uBhejane* with the South African Medicines Control Council, and no evidence of efficacy, it continues to be sold (TAC, 2010).

UBhejane has operated on a bigger commercial scale than most traditional alternatives to mainstream HIV/AIDS therapies, but it is by no means anomalous or even particularly unusual. The fact that Gwala's power as a traditional practitioner was based on dreams rather than any formal qualification in no way disqualified his claims in the eyes of relevant communities. *UBhejane* is therefore a stark reminder that the certification of

traditional practitioners does not guard against the prescription and utilisation of untested, unproven remedies. The Traditional Health Practitioners Act (2007) acknowledges a ‘traditional philosophy’ that incorporates ‘traditional medicines communicated from ancestors to descendants’. This regulatory approach merely makes it illegal for unregistered practitioners to make competing claims (South African Government, 2007). In essence, the overriding challenge for policymakers lies in how to formalise and regulate through biomedically-acceptable avenues a worldview that conceptualises illness and disease within the context of the supernatural.

One of the most intriguing (and telling) aspects of the commercial success of *uBhejane*, and traditional healthcare more generally, is the high cost associated with such treatments. Traditional practitioners in the Eastern Cape currently charge between R150-R300 (\$22.30-\$44.60) per treatment, depending on the nature of the problem, with rates rising to as much as R2000 (\$297) if animal sacrifices are included. A domestic worker in Gauteng province (interviews, 2010) spoke of having paid for three animal sacrifices in the interests of addressing her marital difficulties, costing in excess of R5000 (\$742.87). The cost of traditional healthcare becomes particularly pertinent in an HIV/AIDS context; in South Africa, ARV therapy is increasingly either free of charge or subsidised heavily. Although its price has now fallen, *uBhejane* cost R2000 (\$262) per month in 2006 (*Financial Mail*, 05/05/2006), a significant investment when the average salary of a domestic worker, on a minimum wage of between R6-R8 per hour (\$0.89-\$1.18) is frequently less than that (South African Government, 2010). *UBhejane* also highlights the extent to which the traditional sector, although obviously small-scale when compared to profits generated by the western pharmaceutical giants, is becoming corporate. ‘AIDS entrepreneurship’ is one of a number of aspects that has seen the traditional healthcare sector in South Africa increase in value to an estimated R2.9 billion (\$420 million) per year (Mander *et al*, 2007).

Where HIV/AIDS is concerned, the *uBhejane* case, albeit particularly high-profile, is still only one amongst many; claims for HIV/AIDS treatment and even outright cures abound (Nattrass, 2008; Orubuloyen and Oguntimehin, 1999). None of the practitioners interviewed for this study claimed to be able to cure HIV/AIDS (see also Henderson, 2005), but they all argued that they were capable of significantly bolstering immune systems and prolonging life (interviews, 2010). A number of both practitioners and clients also argued that some illnesses presenting as AIDS or AIDS-related conditions were in fact symptoms engendered by supernatural forces.

It is entirely possible for traditional practitioners to be most sincere in any claims regarding effective HIV/AIDS treatment or even cures. Clients themselves are likely to think in terms of good practitioners and ineffective ones (interviews, 2010). A further complicating factor, over and above engagement with the supernatural, is the view that an absence of symptoms equates with a cure (Wreford, 2008c). Healers may therefore be justified in claiming as ‘cures’ their effective (if short term) treatment of AIDS-related opportunistic infections and declining bodyweight.

Regulating traditional pharmaceuticals

Even if policymakers were to focus as exclusively as possible on pharmaceutical efficacy, the incorporation of traditional healthcare into the formal sector remains beset with difficulties. Periodically, both the popular and alternative health media have publicised the pharmaceutical potential of various key ingredients in traditional African remedies, for example *hypoxis*, the African potato. In a limited number of cases some traditional African ingredients have shown some success in treating diseases like malaria and sickle cell-disease (WHO, 2003). However, to date, there is no clinical evidence for the efficacy of any traditional African ingredients in treating HIV/AIDS. HIV/AIDS is not, after all, a ‘traditional’ African disease, a point acknowledged by many traditional practitioners (interviews, 2010; Henderson, 2005; Wreford, 2008c). Given its twentieth-century origins, it is hardly surprising that its treatment lacks historical antecedents. Furthermore, efforts to elicit a traditional cure capable of withstanding the rigours of clinical trials disregards the nature of traditional pharmacology. For the most part, traditional remedies are based on directives outlined in practitioners’ dream-conversations with ancestors rather than the pharmaceutical properties of the ingredients concerned. Furthermore, the majority of treatments for serious illnesses are tailored to the patient; in these instances, across-the-board medications have little place within the cosmology.

For those who, like the late Tshabalala-Msimang, have stressed the importance of traditional responses to HIV/AIDS, the clinical evidence elicited from a number of trials has been unforgiving; ARVs remain the only proven treatment for HIV/AIDS (Pekala, 2007). Moreover, the latest clinical evidence circulated at the 2011 International AIDS Society Conference in Rome confirms anecdotal evidence on the value of ARVs in preventing the further spread of HIV/AIDS (Cohen *et al*, 2011).

As with many medicines, traditional or otherwise, ingredients utilised by traditional practitioners can be toxic; at times, fatally so. Tagwireyi *et al* (2002) have shown that

poisoning as a result of ingesting traditional medicine is a major cause of hospitalisation across sub-Saharan Africa. Some estimates have put the annual number of traditional medicine-related fatalities in the thousands (Popat *et al*, 2001). In part, this is because some traditional medicines have been known to contain toxic plants such as *euphorbia* (wartweed), *solanum* (nightshade), *datura* (Jamestown weed), *ricinis communis* (castorbean) and cantharides (Spanish fly) (Tagwireyi *et al*, 2002). *Callilepis laureola* (*impila* in Zulu, also known as the southern African ox-eye daisy) is a case in point. It is an ingredient common to Zulu remedies, used to treat complaints ranging from menstrual cramps and tapeworm infestations to impotence. It is also believed to ward off evil forces (Popat *et al*, 2001). However, *callilepis laureola* is poisonous and ingestion can cause renal failure (Steenkamp *et al*, 1999). It is possible that in South Africa as many as 1,500 people die every year from *callilepis laureola* poisoning (Popat *et al*, 2001), but, as with so many aspects of traditional medicine, the situation is unclear. Since *callilepis laureola* is fast-acting, and can result in death within 24 hours, many cases may go unreported (Steenkamp *et al*, 1999). Even when patients do gain access to biomedical treatment in time, they may be unaware of either the toxic nature of *callilepis laureola* and the quantities they have consumed, or even that they have consumed it at all, all of which makes screening extremely difficult (Stewart *et al*, 1999).

The perception of traditional ingredients as less harmful because they are ‘natural’ is problematic. Moreover, many remedies are frequently neither ‘natural’ nor based on time-tested application. In urban areas in particular, traditional practitioners have made use of substances to hand. A range of industrial products, including potassium permanganate, thinners and turpentine are now in relatively common use. Chloroxynol (the active ingredient in Dettol), soap and caustics have been found in enemas, a common treatment in traditional healthcare (Dunn *et al*, 1991; Steenkamp *et al*, 2002; Steenkamp, 2002).

As with alternative therapies in many parts of the world, the absence of official guidelines has resulted in a lack of regulation governing dosage. Children, of course, are particularly vulnerable to incorrect dosing, even if the treatment might in other respects be either beneficial or innocuous. Conscious of a regulatory minefield, the European Union has, in its Food Supplements Directive, responded with controversial plans to prohibit manufacturers from making therapeutic claims for their non-clinically-proven products. The high-profile South African AIDS advocacy group the Treatment Action Campaign (TAC) has taken the ‘name and shame’ route, devoting a section of its website to reviewing alternative therapies and treatments (<http://www.quackdown.info>). The post-apartheid South African

government, on the other hand, has sought to engage directly with the process of clinically verifying the ‘efficacy, safety and quality [of traditional ingredients] ... with a view to incorporating their use in the healthcare system’ (South African Government, 1996: 26). Through the auspices of the state-sponsored South African Medical Research Council, funded by the Ministry of Health, a number of bodies were created to investigate the clinical efficacy of various traditional African ingredients. The Traditional Medicines Research Unit was established in 1999, the African Traditional Medicine and Drug Discovery National Collaborative Research Programme in 2007, and the African Drug Discovery and Development Research Unit in 2009. In the past decade, *sutherlandia* (cancer bush) came under particular focus alongside *hypoxis*, not least due to the attention generated by both in international alternative health circles. In South Africa, both are employed widely as cure-alls, *hypoxis* to treat urinary infections, heart weakness, tumours, nervous disorders and immune-related illnesses, *sutherlandia* for cancer, tuberculosis, diabetes, influenza and depression. Both have also been used by traditional practitioners in the treatment of HIV/AIDS-related symptoms (Mills *et al*, 2005; Oloyede, 2010). While remedies containing *sutherlandia* (Seier *et al*, 2002) and *hypoxis* (Mdhluli *et al*, 2004) were originally shown, in trials overseen by the South African Medical Research Council, to be non-toxic, evidence of their efficacy in the treatment of HIV/AIDS remains anecdotal. Moreover, both have subsequently been shown to interfere with the efficacy of ARVs (Van den Bout-Van den Beukel *et al*, 2006).

When *uBhejane* was shown to have no effect on the treatment of HIV/AIDS in 2005, tensions between clinical regulation and biomedical best practice, and political emphasis on the African Renaissance and the search for African solutions to African problems came to something of a head. *UBhejane* had garnered a set of high-profile advocates that included Health Minister Tshabalala-Msimang, and, critically, members of the KwaZulu-Natal political elite like Peggy Nkonyeni, a senior provincial health official, and Obed Mlaba, mayor of eThekweni, the heavily-populated municipality incorporating Durban, the province’s largest city. By 2005, Mbeki had stepped back from the AIDS debate, but Tshabalala-Msimang continued, in the face of heavy criticism⁶, to emphasise the advantages

⁶ As a result of statements intimating their effectiveness in fighting HIV/AIDS, Tshabalala-Msimang gained media notoriety as ‘Dr Beetroot’ and ‘Dr Garlic’.

of healthy eating over ARVs for people living with HIV/AIDS. She went on to accuse the biomedical establishment of undermining confidence in the mainstreaming of African traditional medicine, arguing that ‘Western models’ of testing and ‘getting bogged down with clinical trials’ was unnecessary (*Mail and Guardian*, 24/02/2008).

Conclusion: towards the meaningful accommodation of traditional healthcare within the formal healthcare sector

Widespread continued support for traditional practitioners means that the complexities of their role within healthcare provision demand urgent consideration, particularly since the sub-Saharan biomedical healthcare infrastructure remains in desperate need of augmentation. For the potential contribution of traditional practitioners to be utilised fully, there must be some degree of engagement and collaboration between the two sectors, but while such sentiments may be, in a sense, almost incontrovertible, the practicalities of accommodating the informal within the formal are less clear cut.

The demands of the HIV/AIDS pandemic have borne some collaborative fruit – the Ugandan THETA, Tanzanian TAWG and the South African THO initiatives are cases in point. However, to a certain extent, the success of such collaboration is dependent on the ability of the formal healthcare sector to impose a more biomedical mindset on the traditional sector. This, while clearly a positive step in the above cases, hardly represents a meeting of minds or a dialogue between equals. As Wreford (2005b, 2008c) has argued, there is very little evidence of true exchange because the success of such collaborations is dependent on traditional practitioners more-or-less acknowledging the supremacy of the biomedical paradigm. In basic terms, this is medical missionary work. Biomedical practitioners’ repeated acknowledgement of the scope and influence of traditional practitioners remains lip service only.

Wreford (2008c), herself both anthropologist and trained traditional practitioner, has argued that the first step towards meaningful accommodation would be a change in the biomedical mindset; for the biomedical establishment to view traditional practitioners as allies. Wreford (2008a: 15) maintains that ‘if the communication that does take place insists on scientific supremacy and refuses reciprocity, the effort is likely to disappoint’ and that ‘it is vital...that western trained medical personnel start to make serious, and respectful efforts

to connect intellectually with the ideas that underline traditional practice'. Any partnership platformed by condescension is unlikely to bear dividends.

At the same time, for biomedical practitioners, for whom issues of qualification, standardisation and training are largely clear-cut, attempting to assess traditional practice in comparable terms is perhaps nigh on impossible. After all, in terms of current regulation, traditional practitioners can be 'chosen' by the ancestors and called to the profession by spiritual forces, and their remedies can be determined by supernatural rather than pharmaceutical qualities, which renders the notion of establishing equivalence largely meaningless. Likewise, to outsiders, the criteria for identifying genuine traditional practitioners are unclear. That traditional practitioners who claim cures for HIV/AIDS are not necessarily operating outside either the parameters of the cosmology or the best practice of the profession is indicative of the dilemma.

South African state-supported initiatives to determine clinical evidence for the efficacy of traditional medicines in treating HIV/AIDS have yielded no quantifiable data to suggest that any of these remedies are in any way useful. At best, they may be non-toxic. In addition, past governmental support for traditional remedies for HIV/AIDS has, in some respects, created confusion in the minds of those seeking effective treatment, to the extent that many South Africans perceive ARVs to be merely one treatment option out of many (Chopra *et al*, 2006).

However, it is arguably the differences in cosmology that remain the major stumbling block to formal accommodation. The Enlightenment perspective allows little room for elements of the supernatural; for the most part there is a clear differentiation between mysticism and medicine. Accordingly, the significance of underlying cosmologies and value-systems within the many societies in which mysticism and medicine go hand in hand has tended to be overlooked or skirted around by policymakers. The most practical focus for those attempting to legislate for a greater degree of equivalence between the sectors must be the extent to which such a diametrically-opposed system might be realistically accommodated within the formal healthcare infrastructure.

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