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SOUTH AFRICAN TRADITIONAL HEALERS' ORGANISATIONS IN THE CONTEXT OF TRADITIONALISM AND MODERNITY

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A Research Report submitted to the Faculty of Arts, Department of Sociology, University of the Witwatersrand, Johannesburg, in partial fulfillment for the degree of Master of Arts.

Johannesburg, 1994

Abstract

This research report seeks to explore the issues surrounding the organisation of traditional healers and how their world-views can be contextualised within traditionalism and modernity. How do they define themselves in contrast to western medicine? How have they modernised their practices? How do they understand tradition? What are the objectives of, and problems with, their organisations? How do the healers view the issue of integration with western medicine?

Researching the subjects of hegemony, culture and world-view requires a method that is both flexible, sensitive and, at the same time, non-intrusive. A combination of three qualitative research methods are used: intensive interviewing, participant observation and content analysis. All three serve as the basis for a case study of two organisations.

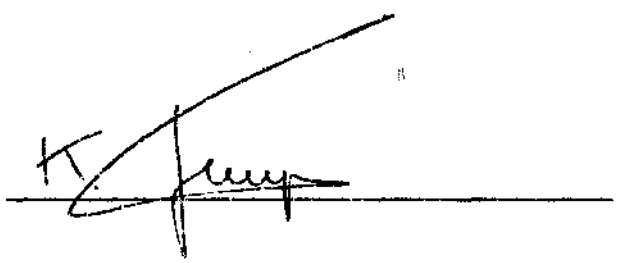
The central finding to this study is that traditionalism and modernity are not to be understood as dichotomies that stand opposite one another but as concepts which are interpenetrating. The fact that "traditional" sectors of society use "western" methods such as organisations reflects this. Although western medicine is clearly hegemonic, the reasons for organising are not to directly realated to countering this. Primarily, traditional healers are interested in gaining recognition for themselves from the government and other authorities through the professionalisation of their healing practices. The organisations are, in most cases, modelled along "western" organisational lines. The question of whether or not integration is desirable and/or possible remains to be answered.

Acknowledgements

First and foremost, I would like to thank my supervisors Belinda Bozzoli and Liz Walker for sharing my enthusiasm for the subject and for offering me constructive guidance as to how to go about completing this research report. I also owe a great debt of thanks to Mr. Mahlaba and Mr. Zungu, the leaders of the two organisations ANHA and THOSA, not only for their open willingness to participate in this research, but also for providing me with access to members, without whom this study would not have been possible. Their friendliness, enthusiasm and hospitality were well recognised and much appreciated. My special thanks goes to Sipo Mcunu, Velaphi Mahlungu and Longway Kwelemtini who, beyond the call of duty, sacrificed many hours interpreting complex conversations and interviews. My thanks to Seth Seroka for accompanying me to the Northern Transvaal and to Conrad Tsiane and his wife Susubelo for accommodating me in Doornlaagte. I also thank Mr. Zungu and Althar Khumalo for making me feel so welcome and secure on my visits to Soweto and for organising a demonstration of traditional healers' ceremonies in Mr. Zungu's back yard on my very first visit. The input from "experts" such as Rae Graham and Melvyn Freeman is also much appreciated. Thank you to Dr. Taylor for proof-reading the final report. Finally, thanks to all the healers who participated in this research. Their honesty, interest, cooperation and insight made the process of this research not only a valuable but also a pleasant experience.

Declaration

I declare that this Research Report is my own, unaided work. It is being submitted in partial fulfillment for the degree of Master of Arts to the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.



(Name of Candidate)

23 day December, 1994

Abbreviations

ANHA - African National Healers Association, headed by Mr. Mahlaba

MASA - Medical Association of South Africa

MEDUNSA - Medical University of South Africa

NASCOTH - National Steering Committee of Traditional Healers

SAMDC - South African Medical and Dental Council

STD - Sexually transmitted disease

THOSA - Traditional Healers Organisation of South Africa, headed by Mr. Zungu

TRAMED - Traditional Medicines Programme for South Africa

WHO - World Health Organisation

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Chapter 1 Introduction

1.1 Aims

The tradition of dichotomising allopathic medicine and traditional healing is beginning to break down. There is a movement towards holistic health, mainly as a result of western medicine's inability to address serious diseases like cancer and AIDS in a manner which yields positive and lasting results. Rosch et al (1985) list the components of the "holistic" health movement, which include an appreciation of the multi-faceted approach to "wellness" which acknowledges the role of nutrition, diet, exercise, behavioural modification, etc. in the enhancement of health and the prevention of illness and a wariness, if not anxiety, regarding the long term consequences of pharmacological intervention as well as the potential hazards of irradiation, thermography, sonography and so on. These authors further claim that, in reality, the "new" relationship between patient and doctor is only the most recent manifestation of the classical psychological bond between mind and body, healer and healed. Furthermore, they predict that the future of medicine may well lie in the happy synthesis of the seemingly disparate approaches to patient care: the art of healing and the science of medicine. To back this up, they point out that publications from prestigious professional journals periodically feature articles devoted to the changing nature of American health care and the renaissance of humanism as a necessary and welcome adjunct to medical science. "The opportunities for physicians to return to the true definition of *doktor* or teacher, as well as healer, certainly exists. At this point in time, western medicine has the greatest potential to achieve this end. [. . .] Medicine has progressed full circle to its origins". If the future of medicine is going this way, it is important to assess what traditional healers think about this relationship, how they have organised themselves, and why.

It is against this background that it would seem important for us in South Africa to assess the current standing of African traditional healing - a clearly "holistic" form of medicine. Significantly, a conference entitled "Recognition and Registration of Traditional Healers - Possibilities and Problems" was held in Johannesburg in September 1991. While we know that traditional healers' associations have long existed and have been subject to much political manipulation, this was the first (known) attempt to bring together such a broad spectrum of opinion to discuss possible roles and structures for traditional healers in the future.

Some leaders of organised traditional healers (see Chavunduka, in Freeman, 1991:11) argue that when traditional practitioners in African countries organise to act as pressure groups for legal changes in health care, they challenge the dominance of modern medicine. Thus, this project is seeking to explore to what extent this constitutes the aims and objectives of healers' organisations.

In addition, this project seeks to examine the phenomenon of organisation amongst these traditional healers in its own right. What are the problems of organising? What are the differences between organisations? How do they see the problems of integrating with western medicine? How do traditional healers define themselves in relation to western medicine and western doctors? What is their world-view on modern and traditional medicine? "How is it that - if all meaning were potentially open to contest, all power potentially unfixed - history keeps generating hegemonies that, for long periods, seem able to impose a degree of order and stability on the world"? (Comaroff and Comaroff, 1991:17). In order to find answers to these questions, we must begin by tracing the history of these organisations and how Apartheid, Christianity and politics in general had an impact on their outlooks and practices. This will lead us to an important question: How do we conceptualise the distinction between "traditional" and "modern"? How does the literature define and analyse these concepts? How do the healers themselves see such distinctions? This topic taps the very heart of the holistic health movement which is to re-

examine the mind-body connection. In this respect, the research also addresses some of these philosophical debates concerning African traditional thought and western science.

1.2 Rationale

The urgency of planning the structure of health care for the Post-Apartheid South Africa has so far directed thinking and research towards the "modern" sector and how this can be transformed to provide more equitable and appropriate care. Little attention has been given to the place of traditional healers in health care (Freeman, 1991). Perhaps out of an awareness of this, and also the growing challenge to the limited ability of western medicine to provide *holistic* care (Chopra, 1987; Huizer, 1987; McKee, 1988; Rosch et al, 1985), members of the modern sector are beginning to stress the need for western health organisations and bodies to liaise and negotiate with a national body which represents all traditional healing in South Africa.

Officially the use of traditional healers in South Africa is outlawed (Freeman, 1992). In 1974 the Health Act forbade healers not registered with the South African Medical and Dental Council (SAMDC) from practising or performing any act pertaining to the medical profession. In reality, however, traditional healers continue to practice and are generally not legally harassed by the authorities (ibid.).

For a number of years healer organisations have been claiming that it is their right to provide health care legally. Their essential argument is that the majority[1] of African patients choose healers as their first contact when they are sick and that they are an effective and accessible health resource and that it is an African's right to have legal African health care if they so choose (ibid.). Moreover, in the light of new hope for political change in South Africa, there are very active attempts by those who wish to retain the status quo and by those who wish to revolutionarise society to make gains for their

[1]This could be as many as 80% of the African population (Oyebola, 1981:87; Said, in Bannerman, 1932:21; Bannerman in Oyebola, 1981:93; Hennig, 1992:40)

own ideological positions, and hereby advance the hegemony of these positions in the future society (ibid.). Thus we are witnessing a climate not only of political change but of new actors appearing on the social stage, of whom traditional healers and their organisations are a part. These healers are making use of current political developments in order to further their own non-political objectives.

There have been few sociological studies of traditional healers and there is little understanding of the broader social, cultural and ideological patterns displayed in this important sector of society. Edwards (1986:1275) urges that continuing ongoing research focusing on traditional and modern medicine is needed in South Africa. Not only do we need to know how they are organised, but we need to grasp their attitudes towards western medicine (see Ballay, 1986, Green, 1984) and their understanding of "natural" and "supernatural" phenomena in order to get insight into their world-views and culture.

This research report observes how western medicine assumes hegemony in a mixed African and Western society. It will be explored to what extent the different organisations are absorbed by this or, alternatively, how they keep themselves outside of it by the virtue of their degree of traditionalism. Modernity and traditionalism are conventionally set out to be dichotomies that are often portrayed as opposite concepts. However, this report shows that there is much interpenetration between traditional and modern world views and practices as applied to the medical profession and, as a result of it, there is scope for integration between the two medical systems. There are also some barriers to this kind of modernisation which implies that in reality there is also some incompatibility between them, mainly because the aims of the two are different and because there are still many traditional elements in healing which are characteristic of a residual culture and which therefore are a potential counter-hegemony to the dominant culture.

pter 2 - Methodology

The methods adopted in this research are almost entirely qualitative. Qualitative research methodologies seek to learn about the social world in ways which do not rigidly structure the direction of inquiry and learning within simplifying, acontextual, *a priori* definitions (Walker, 1985:46). Given the "secretive"[1] nature of much of the work of traditional healers, such an approach is appropriate. These methods allow for the researchers to get close to the data and provide opportunities for them to derive their concepts from the data that are gathered (Burgess, 1984). They allow the researcher to explore the meaning in social situations, i.e. how the healers experience, interpret and structure their practice and how they construct reality. Three research methods were used: intensive interviewing, participant observation and content analysis.

2.1 Sampling

Sample design in qualitative research is usually purposive, that is, rather than taking a random cross section of the population to be studied, small numbers of people with specific characteristics, behaviour or experience are selected to facilitate broad comparison between certain groups that the researcher thinks likely to be important (Walker, 1985:30). A further consideration is that each group should be relatively homogenous with respect to these characteristics that might influence the views expressed (ibid.). In the present study these characteristics included membership of a particular organisation and being a healer. The age group also reflected some homogeneity: the average age at THOSA was 50,7 and 48,4 at ANHA.

[1] See Freeman, 1991. I put this word in inverted commas because it seems to be somewhat of a myth. Traditional healers are reluctant to give out information to potentially harmful people. This caution is justified in light of the historical abuse to which they have been subjected, i.e. the spreading of misconceptions about witchcraft and healers.

Twenty-two semi-structured interviews were conducted in the period of 20 May 1994 to 29 September 1994. Sixteen of these comprised interviews with the members (whom the leaders chose) and the rest with the leaders and various other "experts" in the field. A copy of the interview schedule, used for the members, is reproduced in Appendix 2. In addition, two field trips to the Northern Transvaal were undertaken, the first one in July 1994 (4 days) and the second in September 1994 (3 days).

2.2 Intensive interviewing

Intensive interviewing is compatible with the aim of the research: to understand and interpret the meanings and intentions that underlie every human action rather than to explain human behaviour in universal terms (Mouton, 1988). Burgess (1984) suggests that intensive interviewing is a kind of "conversation with a purpose" which is of greater value than straight question and answer sessions because they provide rich and detailed data. However, there must be some structure to conducting intensive interviews. The process of interviewing is one in which researchers are continually making choices, based on their research interests and prior theories, about which data they want to pick up and explore further with respondents and those which they do not. The making of these choices is the imposition of some structure (Walker, 1985:47). This is precisely why there had to be some uniformity to the questions. It also allowed for comparison between the two organisations, which was intentional. It would not have been beneficial to enter into loose conversation with these healers about some broad topics, since the findings would not have led to the present conclusions.

This research addresses the personal opinions of the healers, which in turn express their culture and ideology and thus it is important to use a research method which is non-threatening, personal and intensive. Intensive interviewing facilitates the creation of a feeling of trust with the subjects. The questions were asked in a non-structured way,

allowing other, seemingly non-relevant, questions and answers to be asked and heard. This way healers felt important and respected. It is also why the questions begin with a discussion about the personal history/autobiography of the particular healer and his or her profession. There is no other method which allows for such flexibility.

The type of questions are related to 6 different themes: Background and personal information (to establish rapport), organisational issues, philosophical issues (which allows for the emergence of world views), western medicine, political issues and integration with western medicine. Through this, the questions aim to establish what the ideology of the organisations and what it is that they aim to achieve in relation to the authority of the healers themselves as well as to that of those who they seen as the ideological opposition (if there are any).

The intensive interview method is extremely adaptable so that it is possible to explore interesting responses and underlying motives in much greater depth (Bell, 1987). Another important reason for using the interview method is that it allows for a smaller degree of misunderstanding between the researcher and the subjects so that a greater degree of accuracy can be achieved. This is crucial for research which tries to establish world views, ideologies and cultural issues. The intensive interview method also provides an opportunity for subjects to defend themselves against any unjust accusations or prejudices. This is particularly important and relevant in this specific research where, as we will see in the literature review (in Chapter 3), many such preconceptions and ideological issues exist.

2.3 Content analysis

Consulting the organisations' documents, where available, has yielded information about the nature and scope of the professional organisation and can be the source of "hard" information. Such documents were freely and willingly offered to me by the leaders of the

organisations. Gilbert (1993) reminds us that documents which are intended to be read as objective statements of facts are *socially produced* on the basis of certain ideas, theories or commonly-accepted, taken-for-granted principles which implies that they are not always objective. For example, many official census statistics are compiled on the basis of certain categories which are derived from a particular theoretical viewpoint (ibid.). Therefore it will be imperative to compare these official documents with the interview findings and to use critical sociological insight in order to support the proposed arguments. There is much overlap between the documents and the interviews. Traditional healers are interested in voicing their views, not in propagating certain theories and principles which are driven by ulterior motives.

Particularly in this research, content analysis is an indicator of how well the associations are organised because the availability of documents reflects this. We must remember that traditional healers' organisations are still new to things like news letters, corporate magazines, in-house journals and the various other types of documents characteristic of western organisations. One of the reasons such documents are not readily available is that the practices of these healers were (and still are, technically speaking) illegal. Furthermore, and deriving from this, there are no official records because there is no book-keeping or any other financial transaction that needs to be recorded for tax purposes. The documents that were available are Conference Papers, outline of the organisation, codes of ethics, certificates and speeches.

2.4 Participant observation

"The participant observer gathers data by participating in the daily life of the group or organisation he studies. He watches the people he is studying to see [sic] what situations they ordinarily meet and how they behave in them. He enters into conversation with some or all of the participants in these situations and discovers their interpretations of the events

he has observed" (Becker, quoted in Burgess, 1984). Thus participant observation facilitates the collection of data on social interaction, on situations as they occur rather than on artificial situations. The value of being a participant observer lies in the opportunity that is available to collect rich detailed data (Burgess, ibid.). The behaviour of people and their way of interacting was observed in order to collect such data. The two field trips were undertaken to this end.

Given the sensitive and personal nature of much of the work of traditional healers, it is important to use a research method that causes little interruption in the social situation and that helps in establishing a trusting relationship. Participant observation is appropriate for this since the subjects will understand that the devotion to the topic by the researcher is real and strong. This technique proved to be particularly suited to this project and it was most successful in terms of creating trust. The amount of time dedicated to participant observation provides a good chance to build rapport with the subjects, where possible.

The field trips to the Northern Transvaal facilitated participant observation but more importantly, they showed the gate keepers that I was willing to experience the "African" rural situation at first hand. This created rapport with the leaders of the organisations who were then willing to allow me to interview their members. They actively encouraged the research process because they appreciated a white person, from a reputable academic institution, showing such interest and recording their views in writing. There were many subtleties involved with these participant observations which I could never have obtained from the interviews alone: for example, I observed how some healers adhere to certain traditions whereas others were more "western" about things.

2.5 Access

I anticipated difficulties in gaining access, given the "secretive" nature of this profession. However, as I found out, this is somewhat of a "myth" because traditional healers want to

be heard and have been interacting with white people for a long time. They are frequently invited to conferences and universities where students and professionals are eager to hear their views Consequently, access was much easier than I had anticipated. The following comments illustrate how willing and delighted members were to be interacting with me: "I am delighted because I know that if we communicate with you, you can perhaps forward the things we have spoken about to higher authorities so that they can help us" (THOSA, 4) and "We thank you for being interested in our point of view on these issues. Thank you for taking us seriously, especially since you are a white person" (THOSA, 5, 6).

Initially, access was gained through Melvyn Freeman, from the Centre of Health Policy, Department of Community Health, University of the Witwatersrand. He provided me with the phone numbers of the leaders of two organisations Thereafter, I phoned both of them and they were most welcoming, assuring me that it would be no problem to conduct this type of research. On our first respective meetings I gave each of the leaders a copy of the research proposal. This showed them the seriousness of my proposed research and it also gave them an idea about my ideological tendencies concerning the morality of the hegemony which western medicine enjoys. On subsequent meetings, these leaders provided me with documents for content analysis and, more importantly, they arranged interviews with their members for me. They also provided me with the services of an interpreter where it was needed, which was much appreciated.

2.6 Problems and limitations

The obvious problem was that of language. Six out of eight members at THOSA and two out of eight from ANHA spoke no English and their interviews were interpreted. Consequently, I could not be sure whether they really understood the questions the way they were intended. This could explain why most of them had difficulties with the more abstract, conceptual questions and why they did not seem to answer the question. Many of

the finer details and intricacies seemed to get lost. It also put a barrier between us so that communication sometimes seemed awkward.

The second problem was that of sampling. As a result of the nature of this research, which wishes to establish the world views and ideologies of members of an organisation, it was up to the discretion of the leaders to arrange interviews with people whom they chose I am not suggesting that they selected those people who would comment favourably about the organisation but that selection of people was subject to availability and convenience. Many members live in rural areas or don't speak a South African language (there were some from Ghana, Malawi and other African countries). Therefore the sample may not be representative, although around many themes there was agreement throughout all interviews.

Another problem is that of a white (female) researcher interviewing black subjects. There is much activity around this issue in the literature, more specifically in the gender context. For example, it is debated whether or not a white researcher is able and entitled to speak on behalf of black subjects because of the cultural gap which results in researchers speaking for themselves rather than for the subjects inteviewed (See Hassim and Walker, 1991). In this study race did not seem to be a problem. All of the people interviewed took me into their confidence, trusted their leader, and in turn trusted me.

Chapter 3 - Review of relevant literature

3.1 Introduction

This chapter aims to highlight some of the issues involved with the topic of traditional healing and western medicine. The introduction identifies existing literature in South Africa on the topic and indicates in which other countries similar research has been conducted. The chapter then explores the concepts of culture, ideology and hegemony and it gives an insight into the current debates in, and notions of, traditional African thought and western science. It then briefly reviews the sparse literature on the organisation of traditional healers, identifying the gaps and silences concerning such organisations. Finally, it engages with the issue of integration and co-operation between traditional and modern health care sectors.

There have been a few historical, anthropological and medical studies of traditional healers in South Africa. For example, La Hausse (1993) traces the historical path of traditional healers in Natal in the 1930s and 1940s. He documents how the herbalist trade developed into one of the key sites of capital accumulation for frustrated African entrepreneurs. Medicine men and herbalists used their power to gain respect and saw their position as a means to challenge political domination. Harrison (1993) investigated how, historically, traditional healers' associations in Transvaal's urban areas represented the ambiguities of their attempts to obtain government recognition for their activities. She argues that traditional healers were a relatively inconspicuous feature of the urban landscape and, consequently, hard evidence on their numbers and spatial existence is difficult to obtain. Nevertheless she found that from as early as 1928, partly as a response to the Medical, Dental and Pharmacy Act of 1928 (which declared the activities of traditional healers illegal) traditional healers' associations emerged all over the Transvaal in an attempt to obtain government recognition for their organisations and to seek protection for their skills.

Research has also been done in other countries such as Nigeria, Swaziland, Zimbabwe, Mozambique, Kenya, Ghana, Nigeria, Zaire, America, Canada and China (See Yoder, 1982, Kimani, 1981, Chavunduka, 1986, Green et al, 1984, Bannerman, 1982, Jingfeng, 1988, Warren, 1986, Neumann, 1982). Here, researchers have focused on integrational issues between the indigenous and modern health care sectors. Some of these address problems of cultural and ideological tensions between the systems, while others trace the history of the emergence of indigenous, organised opposition to the modern system.

3.2 Culture, ideology, hegemony

"Health and illness can be interpreted and explained in terms of personal experience and expectations. There are many ways in which our own health and illness determine what these states mean to us in our daily lives. We learn from our own cultural and ethnic backgrounds how to be ill. The meanings attached to the notions of health and illness are related to basic culture-bound values by which we define a given experience and perception" (Spector, in Jaiyeoba, 1988). Against this definition, it will be a central part of this research to establish how the healers define health and illness, what those culture-bound values are and how they impact on the claims to authority.

Traditional medicine is essentially an outgrowth and expression of culture (Neumann et al, 1982:1817). It must be understood that many of the practices of traditional medicine are designed to preserve cultural institutions and to help the patient live at peace with his family, kin, village and inner self (ibid.). However, culture is not an aggregate of unambiguous and fixed codes for thinking and acting. The ambiguity of culture is due to the fact that it both produces people and is produced by them (Van der Geest, 1992:668). The cultural horizon undoubtedly limits possibilities for thinking and acting but does not determine them (ibid.).

"Hegemony" can be understood as an organising principle, or world view, that is diffused by agencies of ideological control of daily life and this prevailing consciousness is internalised by the masses (Gramsci, in Boggs, 1976). Gramsci stated that as all ruling elites seek to perpetuate their power and status, they necessarily try to popularise their own philosophy, culture, morality, etc. and render them part of the natural order of things. Hegemony supposes the existence of something which is truly total, which saturates society (Williams 1980:37). Williams further argues that in any society, in any particular period there is a central system of practices, meanings and values which we can properly call dominant, effective and not merely abstract but which are organised and lived. That is why hegemony is not to be understood at the level of mere opinion or mere manipulation. It is a whole body of practices and expectations, our assignment of energy, our ordinary understanding of the nature of man and his world (Williams, 1980:38). In relation to this, it is necessary to point to the view that western medicine does have hegemony in most societies:

> Except in revolutionary situations, state policies concerning traditional medicine are largely negotiated and supervised by people trained in modern scientific medicine. The irrational element in this situation derives from the fact that for more than a century the movement to professionalise modern scientific medicine has used the state to eliminate or drastically to curtail and subordinate others from practice. This movement has shaped the education of health professionals to an occupational perspective that distorts their comprehension of other systems (Leslie, 1983 quoted by Chavunduka in Freeman, 1991:11).

Such a view is supported by Comaroff and Comaroff (1991:314) who say that although hegemony is invariably unstable and vulnerable, it is not merely an assertion of order but also an effort to redress contradiction and to limit the constant tendency towards the eruption of alternative meanings and critical awareness. Such a tendency is, however, necessary to hegemony, for we can only understand an effective and dominant culture if we understand the real social process on which it depends, i.e. the process of incorporation (Williams, 1980:38-39).

Wolpe (1990:913) argues that a profession such as medicine is unified by its cultural model of healing - its unique combinations of definitions, theories, values, opinions, myths,

research criteria, prophecies, technologies organisational forms, institutional culture, political affiliations and so on. We may ask whether this "unity" persists as a sort of challenge and interaction as it exists today. Do traditional healers see the western paradigm as hegemonic and if so do they counter-poise their own, constantly erupting, one?

Wolpe (ibid.) further argues that physicians carefully oversee conformity to the cultural model by monopolising educational and licensing institutions, limiting the power of competing medical practitioners, and lobbying to restrict governmental interference in their professional jurisdiction. "Traditional medicine is viewed as a serious rival by those working in the modern sector" (Maclean, 1986:22). To what extent does the organisation of traditional healers oppose itself to this?

Wolpe (ibid.) defines *discourse* in the medical profession as a language community, bounded by common ways of expressing problems and, therefore, common ways of thinking about them. A discourse signifies any collective activity that orders its concerns through language. *Ideology* is a discourse seeking to monopolise ways of speaking about the world. In a profession, ideologies are inculcated by the very nature of professional training and by the content of professional work. Competing[1] ideologies try to win the right to determine how people will speak and therefore think about things.

3.3 African traditional thought and western science[2]

There is much disagreement on what traditional African medicine is. Some say that it represents a structured system of ordering, classifying and explaining illnesses, comprising

[1]Ideologies in the medical profession need not necessarily be competing. For example, Nyamwaya (1987) says that the relationship between two types of medicine (western and Kenyan indigenous) is shown to be dynamic and that it can be competitive, supplementary or complementary.

[2] It must be pointed out that the categories of both traditional thought and western science are used here as "ideal types". It is recognised that in reality there is much differentiation in terms of the representatives of each epistemological category. Nevertheless, this section treats these categories in a less differentiated way to enable a broader comparison on a more philosophical and theoretical level.

equally elaborated concepts of treatment (Ataudo, 1985:1346). Others argue that African medicine has roots in "ethno-ecological" theory which states that each ethnic community carries within itself not only its own specific illnesses but also its own cures (Last, 1992:398).[3] According to this theory, medicine is seen not so much as a medical system[4] but as part of the necessary cultural camouflage, like clothing and food, that enables one to survive. There are no "alternative" treatments, only appropriate ones - appropriate to the place where one happens to be (ibid.). African medicine focuses on the person and not the diseases (See section 4.3 in Chapter 4). That is why traditional medicine cannot have a single comprehensive theory to account for all illnesses (Last, 1992:399).

Horton (1967:155) premises his theory of this subject on one key difference: in traditional cultures there is no developed awareness of alternatives to the established body of theoretical tenets, whereas in scientifically oriented cultures, such an awareness is highly developed. "It is this difference we refer to when we say that traditional cultures are 'closed' and scientifically oriented cultures 'open'. Traditional thought has tended to get on with the work of explanation, without pausing for reflection upon the nature or the rules of its work. "Briefly, the traditional thinker, because he is unable to imagine possible alternatives to his established theories and classifications, can never start to formulate generalised norms of reasoning and knowing. For only where there are alternatives can there be choice, and only where there is choice can there be norms governing it (Horton, 1967:162).

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[3] One of the persons interviewed remarked that the differences in diseases are caused by the different regions and whatever organisms you get in that region will determine if you get sick and what kind of diseases (and cures?) you will get (ANHA, 2). See also Haram (1991:173) on healers treating each patient differently, according to specific ethnic, congregational and geographical criteria.

[4] A medical system, according to Last (1992:397), has three distinct characteristics:

1. There exists a group of practitioner, all of whom clearly adhere to a common, consistent body of theory and base their practice on a logic deriving from that theory.
2. Patients recognise the existence of such a group of practitioners and such a consistent body of theory and accept its logic as valid (even though they may not be able to give an account of the theory).
3. The theory is held to explain and treat most illnesses that people experience.

Yoder (1982:1853) defines a medical system as a patterned, interrelated body of values and practices, governed by a single paradigm of the meaning, identification, prevention and treatment of sickness.

In this context it is useful to show that American Indian thought and world view, being similar to traditional African thought, poses certain complications with regard to Horton's view. "If you develop an attitude of acceptance towards the unknown you can make things happen. The Indian is not hung up with controlling nature..."(Steiger, 1984:23). Such a commitment to acceptance *is* characteristic of something that is "closed". In South Africa there is a similar tendency towards accepting beliefs without question. For example, powerful healers often use the Zulu term "Asibuzi! Siyakholwa!", which means "We do not ask, we believe" (Hennig, 1992:40). Thus it is true that traditional healers accept uncritically the theories on which their therapy is based (Hammond-Tooke, 1989:39).[5] The argument is not to dispute that traditional thought is "closed", but rather that western scientific thought, as will become clear in a moment, is not as "open" as Horton would like us to believe. (See also Hammond-Tooke, 1989:39).

Traditional theories, according to Horton, are founded upon a distinctive epistemology, the assumption that knowledge handed down from former generations is necessarily better than new adaptations, as it is "time tested". On the contrary, Western scientific thought is anti-traditionalistic (more recent theories are supposedly better) and resorts to a competitive mode of theorising (In Boyer, 1987:51). The problem with this conception is that rationality and the scientific method are set up *against* the conservatism of the traditional mode (Spiegel, p.50).

> Tradition came to be seen as the product of unreasoned acceptance of beliefs, and indeed 'superstitions', for which there was no evidence and whose claim to authoritativeness came purely from their having been handed down for posterity. Tradition thus came to be regarded as the 'dead hand of the past' and the result was an almost obsessive antagonism, particularly among simpler-minded devotees of the new scientism, towards anything which they might call tradition. Little did they

[5]Haram's findings (1991:167) could also be interpreted as questioning Horton's postulate. He says that both integration ('openness') as well as rejection ('closedness') occur when Tswana medicine meets biomedicine: Although Tswana medicine is an open or rather an inclusive system, allowing elements from the outside to be assimilated, new knowledge does not replace existing notions of "truth" and "reality". Thus there is much more openness and flexibility involved in traditional African thought than Horton would allow.

> realise that their very own antagonism was the product of their having been exposed to and their having learnt the ideas of rationalism as tradition in its own rights (Spiegel, p.51).

If western science were so "open" and competitive in their theorising, then it would not try to control the theories and knowledge of traditional healers.[6] Pearce argues that physicians (and other scientific researchers) control what is to be accepted as medical theories of disease causation and how medical knowledge is organised, evaluated and controlled (Pearce, 1982:1614). They do this by distancing themselves from some of the theoretical premises upheld by indigenous practitioners. In other words, their control stems from an active process of ignoring or disallowing alternative knowledge to penetrate into its scientific language. This is hardly a competitive way of theorising. Feyerabend (in Aakster, 1986:270) explains that in western science there is a natural tendency to believe and support theories that have once proved to be successful. Each finding that supports the theory reinforces the strength of the belief and a disregard for alternatives. Therefore, one invests energy and resources in the existing theory at the expense of serious alternatives. In so doing, the theory becomes more of a religion or ideology. Hammond-Tooke agrees that the medical profession is notorious for its conservatism (1989:46). This is a criticism of modern medicine and not necessarily of western science (the two are not the same because medicine has a real interest in maintain things the way they are in order to promote capitalist interests). However, it is clear that all these authors regard western medical science as hegemonic.

If western scientific medicine were "open", it would not dismiss traditional thought as irrelevant just because traditional assumptions are not compatible with its language of rationality. It would also not disregard the existence of African methods of cure at the Medical Schools (Ngubane, 1992:369). "The general impression given by modern scientists is that whatever is not explicable in terms of modern science must be rubbish"

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[6]For science 'knowledge' that cannot be disproved is unacceptable which, for science, brings under suspicion many of the claims of indigenous healers (Pierce, 1982:1614). Some have suggested that both the techniques developed to gather "objective" facts, and the very facts (content of science) are significantly influenced by more fundamental, cultural/human factors such as world views (Jones in Pierce, ibid.).

(Lantum in Bannerman, 1982:16). I agree with McKee (1988:782) who argues that a major reason why holistic methods are not accorded scientific validity by orthodox western medicine in North America may well be the challenge they pose to the western medical model and to the capitalist system which it serves.

It is true that a great deal of a traditional healer's practice is based on magic which is not subject to observation and control (Welbourn, 1969:17, also Chapter 4, section 4.6). But the fact remains that it works and this is why western science cannot simply dismiss it. "One of the reasons the medical community listens to me is because of results. I don't have a great deal of research yet on how and why it works, but they've already seen that it does work" (Oh Shinnah in Steiger, 1984:59).

Because traditional healing is outside of the language of science, the fault is not with the reality of traditional healing but with the language. Whereas western science and traditional thought are very different and often incompatible in terms of world views and means, there are nevertheless parallel concepts which become revealed when deconstructing some of the language barriers. This will become evident later, in Chapter 4, where we look at how language can be deconstructed to reveal similarities between traditional and western thoughts and understandings (See section 4.8.4 in Chapter 4).

Another distinction between traditional thought and western science is their relationship to the natural and the supernatural. The former is linked to western science and the latter to traditional thought. The latter is concerned with the social cause of disease. For this reason Ross (In Welbourn, 1969:27) is uneasy about the use of the word supernatural "because this presupposes a certain western concept[7] of the natural which I don't think exists in African society, and I think the word 'supernatural' is the wrong word to use. The social

[7] Haram (1991:174) agrees that the distinction of the "supernatural" is a problem for western science: when the Ministry of Health, represented by the clinic people, in their implementation of WHO policy seek ways of closer co-operation with the practitioners of Tswana medicine, they are confronted with ideas which do not belong to the domain of the western concept of health and illness. Sorcery and magic are to them supernatural phenomena to which they would not, or rather cannot, relate as it is something outside the western paradigm of medicine.

concept is what we should be working with, rather than this dangerous and irrelevant one of the supernatural". Thus the social includes everything, even what westerners would call the supernatural, so that natural and supernatural exist together, without distinction, under the general concept of the social.

The "social" thus includes what westerners would call the "supernatural". Welbourn (ibid., p.28) agrees that when one is talking about witchcraft, it is not a reference to the supernatural. "If this exists it is regarded as a purely natural force" Hence the two categories are not distinguished in African thought. For example, in Kenya, Kikuyu diviners ranked natural and God-given origins of disease in the same category and this category was the most important (Kimani, 1981:337). However, in western thought it would be necessary to distinguish between the natural and the supernatural. There is another example of how, in African thought, these two categories are fused: In studying how indigenous Navajo healers (in New Mexico) perceived the causes of and appropriate treatments for cancer, Csordas (1989:481) suggests that "in some sense, the natural elements are fused with the supernatural". The reason why these two categories are fused is that what most westerners would call the "supernatural" has an influence in African life which is felt as central and even determining (Huizer, 1987:420). This extends to the perception of being ill and getting cured. "Disease must be felt and it is cured when the individual feels cured" (Morse et al, 1991:1362). This contrasts with western medicine where patients are required to come for regular check-ups to ensure normality (Morse at al, 1991:1362).

Csordas argues that the category of the "sacred" may be just as fundamental to our understanding of health and healing as the categories of "disease" and "illness". One of the reasons for this is that both medicine and religion address basic existential problems of life and death (Csordas, 1989:481). Hammond-Tooke (1989:43) takes this argument a step further. He says that in a sense magic is closer to science than to religion because both appear to accept that the world is subject to regularities, including forces that, if properly understood, can be controlled and utilised for instrumental, practical ends.

Deloria (in Huizer, 1987:432) notes that the observations and experiences of "primitive" peoples (referring to American Indians) were so acute that they were able to recognise a basic phenomenon of the natural world, such as spiritual energy, witchcraft and psychic power, religiously rather than scientifically. They felt such power but did not measure it. Today we measure such power (for example certain weather conditions) but are unable to feel it except on very rare occasions. We conclude that energy forms the basic constituent of the universe through experimentation, and the existence of energy is truly a conclusion of scientific experimentation. For "primitive" peoples, on the other hand, the presence of energy and power is the starting point of their analyses and understanding of the natural world (ibid.).

3.3.1 Concepts of traditional healing and western medicine[8]

Generally, traditional African medicine is the totality of all knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disequilibrium and which rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing (Ataudo, 1985:1346).

African medicine is concerned with power (Hours, 1986:47). It is based on examining the causes of an illness rather than the symptoms - which themselves tell nothing unless they are interpreted by a therapist or diviner. One view is that the cause of illnesses is usually seen as social, in the sense that it is related to persecution by a third person which often takes the form of witchcraft (ibid.). The techniques and ideologies of traditional

[8] Here again, both traditional healing and western medicine are treated conceptually as ideal types and not as reference to an empirical reality. Of course there is much differentiation in both categories and what is said about them has more relevance on an epistemological level. In real social situations there is much more complexity and contradiction than this section allows. Edwards (1986:1273) puts into perspective: "The distinction between 'modern' and 'traditional' is, of course, absolutely arbitrary when one considers the personal, interpersonal and community variables affecting the interchange between healers and patients within the total healing context. It is, however, a useful, generally-accepted distinction broadly denoting modern, Western-orientated, biomedical, structurally dominant systems in contrast to a more local, culturally relativistic, humoral, functionally strong, traditional healing approach respectively".

healers always implicitly and often explicitly link sickness of any kind with disturbances in the patient's inter-personal relations (Willis, 1969:5). Thus, this perspective suggests that African medicine is concerned with a struggle against the social disorders known as witchcraft (Hours, 1986:47 and 56, See also Ballay, 1986:294).

While this is a popular and a most widely held belief, empirical research demonstrates that, in African medicine, diseases also have their origins in natural elements.[9] They originate from what is impersonal and what can be abstracted from particular cases in the interest of a general theory of actions by direct contact (Welbourn, 1969:16). Although there is a strong belief that disease does not occur at random, in Kenya, Kikuyu diviners tend to give the physical causes of diseases (including both natural and God-given) the most significant weight. Witchcraft, taboos and other cultural beliefs rank second (Kimani, 1981:337). "The Kikuyu approach to disease and illness is not limited to the supernatural and ancestral world. The natural environment, climatic and seasonal changes, water, general bodily weaknesses (or lack of resistance) may be causes of illness to an individual" (ibid., p.338-339).

Traditional healing, in general, has a humanitarian element, tracing the cause and origin of the disease (often social in nature) and by so doing, helping the patient with the ridding of social disharmony. The human face-to-face interaction is important and necessary and most healers have a genuine concern for the patient. It is in their interest that the patient gets well because that will ensure the continued authority of the healers which is derived from their healing powers. At the same time, traditional healers do not take away the responsibility for the illness and thus for the healing process from the patient (See Steiger, 1984:197, Rosch et al, 1985:1407, Morse et al, 1991:1361, Aakster, 1986;268). Rituals and ceremonies help the patient to stimulate the natural healing powers that all living organisms have (Capra, 1983:120).

[9]For example, in Zulu there are two terms to describe the two types of illnesses: "Umkuhlane" is an illness of natural causation and "Ukufa kwabantu" are disorders of traditional cultural nature (Hennig, 1992:40).

Western medicine *as a hegemonic system* is also concerned with power but it derives this not so much from some altruistic ambition to eliminate social disorders or to improve the state of health of humankind.[10] In other words western medicine does not derive its central power from healing. Rather it is often concerned with control of diseases and thereby the control of the patient by specialising the scientific knowledge and by not appointing any responsibility to the patient in his or her process of getting healthy (See Steiger, 1984:193) "Most patients do not understand [the intricacies of illness] very well, but they have been conditioned to believe that the doctor alone knows what made them sick and that technological intervention is the only thing that will get them well" (Capra, 1983:163). Western doctors derive their authority from professional licensing, displaying credentials on the wall (Morse et al, 1991:1362), and not primarily from their ability to heal.

Some authors hold the view that western medicine is concerned with profits, which is pursued by doctors, Medical Aid, insurance and pharmaceutical companies, all of whom form a network to maximise their economic positions (See McKee, 1988). It is the disease which matters, more than the person, because diseases can be measured, quantified and fought. Western medicine's aim appears to be that of any other western business enterprise: to make money. This is facilitated by reliance on hard, expensive technology and drugs. Indeed, western medicine has very high stakes in the economy. "To the extent that technology and drugs are promoted for the purpose of profit at the expense of health need, health suffers" (McKee, 1988:777). [There are many researchers who explain how concern for capital accumulation is at the root of many health problems and how the medical industry promotes profit - see in McKee, 1988:776]. Thus, "the analytical reductionism of western medicine - particularly germ theory - serves the capitalist system, which is based on profit at the expense of health needs: (1) by obscuring the social

[10] This is not true for all western medicine. Obviously there are individual doctors who are deeply concerned with healing people. As Capra (1983:136) notes, there are some very caring family physicians and others who care very little, there are surgeons who are highly spiritual and practise their art with a profound reverence for the human condition, and there are others who are cynical and profit-motivated. There are also variations across different First World countries, with America characterising some of the extremes in the profit motive.

determinants of illness, and (2) by promoting treatment that serves capital accumulation and the commodification of health needs" (ibid.). Holistic ways of treatment are less expensive and this would clearly not be in the interest of big business. That is why multinational pharmaceutical companies are not very interested in traditional medicine and will be opposed to making health care less expensive (Maclean 1986:36).

There is support for this argument. Griffin (in Aakster, 1986:269) shows that the pharmaceutical industry in America, since about 1900, has attempted to influence medical education by financially supporting medical schools. On the other hand, universities that emphasised the role of diet, social and mental aspects in health were not supported, and consequently many of them failed. In western countries there are powerful economic lobbies, such as the pharmaceutical multinationals, which block serious research into the potential of holistic healing (Huizer, 1987:431).

Western medicine's hegemony can be demonstrated as follows: Whereas traditional healing has not received any funding for action programmes or for its promotion, huge funds have been allocated in many Third World countries to fight against it and exploit its knowledge (Maclean, 1986:22, Lantum in Bannerman, 1982:16). In the context of Third World countries, some argue that western medicine as a system of cultural exchange had the imperialist intention of achieving political domination over the colonised people (Jingfeng, 1988:524). "It is quite obvious that political factors play an important role in the developmental history of the natural sciences, including medical science" (ibid., p. 529). All these positions confirm strongly that western medicine is in a hegemonic position in comparison with other health care sectors.

By abstracting disease from its social framework and reducing it to the biological sphere, social conditions are ignored (Berliner et al, 1980:137, Capra, 1983:122). It is now widely proven that many of today's diseases such as cancer and heart disease result from the degeneration of the social, physical and occupational environment. Were the western medical system as a whole concerned with healing, it would direct research and funding

towards the prevention of such diseases by addressing the social, occupational and environmental origins of our current disease structure. But pharmaceutical companies have little interest in this because if people were becoming healthier, the medical industry, together with the interdependent insurance companies, would soon run out of business.

Capra (1983:146) shows how the Medical Schools, especially in the United States, are the most competitive of all professional schools. Like the business world, they present high competitiveness as a virtue and emphasise an "aggressive" approach to patient care. The aggressive stance of medical "care" is often so extreme that the metaphors used to describe illness and therapy are taken from the language of warfare. For example, a malignant tumour is said to "invade" the body, radiation therapy "bombards" the tissues to "kill" the cancer cells (ibid.). Western medical education has the purpose of studying and controlling disease, not of caring for the sick, and Medical degrees are awarded accordingly (ibid., p.161).

The main error of the biomedical approach is the confusion between the disease process (how) and the disease origins (why) (Capra, 1983:150).[11] Western medicine confines the "why" and "how" into one theory. Traditional practitioners are concerned with *why* a particular patient has been affected rather than *how* it has occurred (as is the case with western medicine). (Maclean, 1986:14; Csordas, 1989:457). To provide a social or any other cause for an illness is perceived as one of the great strengths of traditional healing (Yoder, 1982:1854). Welbourn (1969:23) says that if African medicine emphasises the social at the expense of the natural, it may be that we do the opposite.

There is another issue involved here which distinguishes traditional healing from western medicine: the biomedical science of curing is promoted on *universalistic* claims and applications (Young, 1983:1208). Haram (1991) says that, like all medical systems,

[11]It is this refusal by western medicine to provide purpose of illness and death (the why question) which lies at the heart of charges of dehumanisation and the failure to treat the patient holistically (Hammond-Tooke, 1989:36).

Western biomedicine is a cultural system and a product of European history and yet, given the very idea of objectivity and procedures of verification inherent in Western science, biomedicine lays claim to universal validity. In contrast, he maintains, Tswana medicine, or folk medicine in general, is embedded in the culture at large and seems to have an internal structure which permits adaptation to changing cultural and social circumstances (ibid.). The process of healing, as opposed to biomedicine, is predicated on the *particularistic* perceptions and expectations of sick people and the realities constructed by their medical cultures (Young, 1983:1208).

Although there are many differences between the two systems, Rae Graham demonstrates that when disaggregating the "ideal types" of western medicine and traditional healing, there are certain structural and hierarchical similarities:

> A herbalist is like a chemist. In the olden days a chemist made pills and made liquids and made the medicine mixture. So the herbalist is identical to that . . . After the herbalist comes the first diviner, the psychoanalyst called Nyanga and he has a bag of bones and throws them (after the patient breathes into the bag to personalise the throw). So you've got a chemist, a general practitioner, analysing and diagnosing, and then, above them are specialists. They are called Mangomas. You can have a specialist above the waist and below the waist. These specialists have much more depth in spiritual divination. Above the Mangomas, there is another level, they are the Sangomas who do no - necessarily - work with a bag of bones. Their role is to convey the messages from the spirits, they are for communities and for bigger problems (Graham interview, August, 1994).

While such parallels between the structure and hierarchy of western medicine and traditional healing were probably useful some time ago, today they are outdated. The chemist no longer mixes the medicines; the monopoly of pharmaceutical companies has taken care of this to the extent that doctors are completely under their influence. Whatever the medical representatives sell to the doctor is what the patient is going to get. Furthermore, general practitioners are on the decline. A generation ago more than half of all physicians were general practitioners, now over 75% are specialists (Capra, 1983:162). There are two main reasons. Firstly, much more money can be made as a specialist. Secondly, the skill of a good general practitioner would require more than just scientific

knowledge, including wisdom, compassion, patience and therapeutic skills. These are not primarily to be obtained from Medical Schools.

Given these differences and similarities, some people believe that western medical practice and holistic healing can coexist in a given culture because they focus on different aspects of the same disease process (Rappaport, 1981:775). Rather than understanding that the two concentrate on the same disease process, it would be more accurate, however, to distinguish between western medicine's focus on the disease and traditional healers' concern with the person (Neumann et al, 1982:1818, Capra, 1983:137, Ngubane, 1992:368). It is ironic that western medicine's focus on the disease and its neglect of the person generally stretches only as far as its own science is concerned. When western medicine enters the domain of witchcraft, the situation is reversed: in this case the concern is shifted from the disease to the person. Welbourn asks why some societies hold that witchcraft can be as effective as, say, a spear thrust, while scientific society holds that, if ill will is to have any effect, it can be only through the response of the victim. "*It is the victim's worry about the ill will and not the ill will itself, which is the causative agent*" (Welbourn, 1969:21, emphasis added). Therefore, suddenly it is the patient's worry and not the disease itself (i.e. the ill will) that matters. Of course there *are* times when western medicine involves the person, i.e. in psychotherapy for example. But even then it looks for classifications of disorders (e.g. neurosis, schizophrenia, latent desires etc.) rather than observing the patient's total social circumstances and his or her holistic interaction with them.

3.3.2 The state of allopathic medicine in relation to holistic health

The dichotomy between allopathic medicine and traditional healing was very pronounced and evident until very recently. Hammond-Tooke (1989:18) says that the "west, at least since the eighteenth century, has prided itself on its rationality. The supreme example of rationality is found in science, as science seeks to conquer nature, including the diseases which plague humankind. This has resulted in a revolutionary change of attitude towards

nature". He continues to characterise science as a discipline that places extreme emphasis on accurate measurement, to the extent that, if something cannot be measured accurately, it is rejected as inappropriate for scientific study. He maintains that religion and science are diametrically opposite, if not opposed, in their very perceptions of the nature of human beings and the meaning of their existence. "For medical science they are merely members of the animal kingdom, material bodies subject to physical and chemical laws, and even the workings of the human mind are reduced to electrical impulses" (p34).

However, scientific medicine has come a long way from here. More and more authors who are trained in the allopathic tradition, publish books on how the mind, emotions and other, non-tangible aspects of existence influence our health (see for example, D. Chopra *Quantum Healing*, and Robin Blake *Mind over Medicine*). (For a successful attempt to explain the spirit-body connection, see Greenfield, 1987:1095 and also Morse et al, 1991:1363). Huizer (1987:415) states that although the emancipatory potential of magical and paranormal forces as used by indigenous healers has been underestimated by the western scientific establishment until recently, it gradually appears to have drawn world-wide attention and that it may even give invigorating stimuli to the way Western science is dealing with health and wholeness. Capra (in Huizer, ibid.) says that there is evidence that the limitations of modern medical practice and technology are becoming apparent. Holistic and other alternative approaches appear to be needed to deal effectively with affluence-diseases such as some forms of cancer and stress. Even the categorisation of stress as a disease is symptomatic of the western attempt to control disease by naming it.

The holistic perspective of African healers has led to considerable insight and success in treating a wide variety of illnesses that have a psychosomatic component (Green, 1988:1128). Morse et al (1991:1365) agree that the western health care system has a good deal to learn about holistic health care from traditional healing practices. (see also Ballay, 1986:294). Huizer (1987:433) agrees that we will have to go to the Third World to learn, to be taught, and to be enlightened about matters pertaining to spiritual phenomena (which can lead to better understanding of the psychosomatic components of illness). While there

is a movement in modern medicine towards recognising the psychosomatic component in *all* illnesses, most physicians lack both the training and the requisite familiarity with patients' social and family situations to deal effectively with patients' psycho-social problems (Green, 1988:1128).

3.3.3 Attitudes towards traditional healing and western medicine

Nyamwaya (1987:1285) says that on the whole, the attitudes of western health workers to indigenous medical practitioners and practices are very negative, and these are expressed not infrequently in their words and actions. To the western trained medical practitioners the Pokot (Kenyan indigenous) medicine is inferior and mainly magical (ibid.). By contrast, the Pokot do not regard Western medicine as superior or inferior to indigenous medicine. These findings are echoed by many other authors. For example, McKee (1988:776) argues that western critics usually consider holistic therapies and practices to be unscientific and mystical, or at least unacceptable because they have not as yet been proven scientific. Ayensu (1983, quoted by Chavunduka in Freeman, 1991:11) holds the view that the

> educated public in Africa and Latin America still have some way to go in re-educating themselves. I am particularly disturbed by Third World Western-trained doctors who show total disregard and disdain for the importance that herbal medicine plays in the world's health situation. Some of these doctors are even ashamed to admit that their parents relied on these ancient folk remedies to treat and save their lives during childhood. Many of the Western-trained doctors seemed to have been brainwashed into believing that only drugs originating in the developed countries have healing powers.

Harrison (in Anyinam, ibid.) shows that the official attitude to indigenous healers in Nigeria was that they were untrainable because of their superstitious beliefs and because their practice is secret and difficult to evaluate. Another reason for the negative attitudes of the western doctors is given by Rosch et al (1985:1405): Many physicians are reluctant to relinquish their comfortable and familiar authoritarian role and are resistant to recognising their own limitations and those of their wondrous technology. Indigenous healers, by contrast, seem to have quite a different attitude towards western medicine: Ojanuga (in Anyinam, 1987) notes that 81% of the 43 healers interviewed in Nigeria

expressed readiness to undergo further training in biomedical therapeutic methods. Thus the attitude of traditional healers to western medicine is much more favourable than that of western doctors' to traditional healing.

3.4 Organisations

Despite the much cited figure of 80% of African people consulting traditional healers, there have been few accounts in the literature about the professional bodies controlling the practice of traditional medicine. The only published research on this particular topic is Oyebola's work on the professional associations, ethics and discipline among Yoruba traditional healers in Nigeria (Oyebola, 1981:87). It is the first attempt to address the central issue of professional associations in traditional medicine despite the fact that the existence of such associations is not a new phenomenon (Fosu in Oyebola, 1981:95). Oyebola found that herbalist or traditional healers' associations have existed among the Yoruba since the 19th century. These and other, later, associations, had the following objectives: to afford herbalists the opportunity of meeting and knowing themselves; to provide a forum for members to co-operate in their practice by identifying specialists and referring difficult cases to such persons; to provide a forum for the continuing improvement in the knowledge of the herbalists through exchange of ideas and herbal remedies; and to preserve and ensure the growth of traditional medicine. Apart from this, these associations were charged with the responsibility of drawing up codes of conduct according to which erring members could be disciplined, and to issue certificates of proficiency.

Attempts to organise such associations in African countries such as Nigeria and Ghana, at the national level are recent. Such efforts have been slowed down by internal strife for leadership positions and by the difficulties in legitimisation and integration into the national health care system (Fosu, in Oyebola, 1981:96).

According to Bibeau (in Oyebola, 1981:94) there are two main objectives that traditional healers want to achieve with their organisation. These are: firstly, to define themselves and their therapeutic activities within modern society and secondly to force governments to make decisions regarding legal status of traditional medicine and individual licence for practice. It is necessary to provide a permanent minimal structure, e.g. regular meetings with local leaders' associations. The first stage towards recognition of traditional medicine is for anyone who considers himself a healer to seek membership within a local association. Associations do not exist first of all as a prevention against quacks[12] or as a locus for disciplinary action against erring members (ibid.).

3.5 Integration and co-operation

3.5.1 Introduction

Hammond-Tooke (1989:14) has long been preoccupied with these kind of issues: what are the possibilities of an alliance between doctors in the biomedical tradition and the practitioners of indigenous medicine? Are the attitudes and methods of these two categories in fact complementary or do they differ so fundamentally that any form of co-operation is ruled out from the start? What are the factors that encourage or discourage an alliance between them?

Although the prospects of integrating modern and traditional medicine in various African countries have been subject to much, and ongoing, debate over the past decade, there has been little empirical research on the implications of integration and the problems involved (Edwards, 1986:1275). Freeman et al (1992:1187) are of the few who have seriously considered such problems.

[12]Perhaps one of the reasons why the first motivation for an association is not to control quacks is that it is a criminal issue. People who are not registered with the Council are not the Council's responsibility and such people can be charged under the Criminal Act rather than the Health Act (Freeman interview, August, 1994).

Pearce (1982:1612) notes that any programme for integration requires the co-operation of four distinct groups in any nation. These are:

1. The indigenous practitioners
2. The Western-trained practitioners
3. Government agencies and policy making bodies
4. Consumers

This research focuses primarily on the first group, and to some extent on the second (but not from primary research).

The terms co-operation and integration need to be defined. 'Co-operation' implies a better working relationship between the two health sectors whereby appropriate referrals between the two are encouraged and facilitated, certain traditional healing practices are improved, or made safer, and the cultural sensitivity of modern health care worker is increased (Green, 1986:127). The term 'integration' implies a fundamental alteration of both healing systems and in the roles of certain practitioners, although in practice it is the traditional healer who is expected to change. The danger here is that the traditional healer may become a second rate paramedical worker and thereby cease to carry out his or her important social, psychological, spiritual and physical function in the community (Green, 1986:127, Green et al, 1984:1077).

3.5.2 The case in different countries

The success in linking biomedicine and ethnomedicine in countries like China, India and other Asian countries are not strictly comparable to efforts made in African countries because these systems of medicine are not traditional - that is if we accept tradition as the "handing down orally stories, beliefs, customs, etc. from generation to generation" and as a "long established custom or practice that has the effect of an unwritten law" (Said, in Bannerman, 1982:21). Arab, Chinese and Indian medicine have a long written record of

history, principles, practices, experiments, philosophies and concepts, unlike African medicine. For example, in India, the practice of herbalism has an ancient and honourable tradition with written texts dating back thousands of years, well established training centres, professional associations, codes of ethics and mechanisms for reinforcing them (Neumann et al, 1982:1820). In China, western universities have been incorporating traditional Chinese medicine into their curricula and western trained professionals were transferred to rural services for one year (ibid.). Western-trained physicians were encouraged to learn traditional medicine, for example by enrolling in in-service classes (Jingfeng, 1988:526).

Ghana has an example of the successful collaboration between healers and hospital authorities in the Holy Family Hospital, northern Ghana. The healers attend a training course at the hospital which widens their expertise and gives them new skills. They then return to their village practices and have out-patients referred to them. Here healers have successfully been incorporated into a system of health care provisions, but without losing their own status and autonomy (Warren, 1986:2). In another training programme in Ghana the problem of illiteracy was overcome as follows: Since more than 90% of the trainee group was illiterate, written texts could not be employed for examination purposes. The final examination was designed by the Ghanaian instructional staff and consisted of a play, each act of which portrayed one of the principal lessons of the training course (Neumann et al, 1982:1822). Furthermore Ghana has initiated an organised effort to study traditional medicine at the University of Ghana (Neumann et al, 1982:1821).

In Zaire, a unified, although not necessarily intellectually consistent, system of therapy has arisen, a synthesis of both the traditional and the modern. This has been made possible by the extraordinary openness of traditional practitioners and public to new theories and a refusal to be limited by a monistic picture of illness. Western medicine's unique competence was accepted, but not at the expense of tradition-derived therapies (Janzen in Hammond-Tooke, 1989:153). Thus, although Zairian practitioners have differing views on

how illness is culturally constructed and given social significance, a dual use of medical resources is evident (Yoder, 1982:1851).

Similarly, in contemporary Kenya, a variety of health care systems exist side by side but function separately to cater for the health needs of the same population (Kimani, 1981:333). It is argued that the solution to Kenya's health care planning and delivery lies in the co-ordination and co-operation of some selected areas of the modern and traditional health systems (ibid., p. 335). Traditional healers in Central Kenya (where this particular research was conducted) refer difficult cases to hospitals. This referral system is, however, unsystematic and informal since the traditional practitioner is unrecognised by his or her hospital counterparts. There are no existing channels of communication and understandably the patient is reluctant to reveal this to the hospital doctors (ibid.).

In neighbouring African countries, the co-operation/integration relationship varies. In Zimbabwe, attempts made to unite existing traditional healers association suffered from lack of government encouragement, poor leadership, rivalry between organisations and lack of effective financial management (Chavunduka, in Freeman, 1991:13). The Zimbabwe National Traditional Healers Association or ZINATHA (which is the official national association of traditional healers, formed in 1981), argues that the integration of traditional medicine and modern medicine would imply a substantial risk of imposing some of the analytical bio-medical concepts of modern medicine on the traditional healer and so forcing him to abandon those elements of traditional healing which cannot easily be accommodated within the framework of modern medical thinking. This would be a retrogressive step and not a progressive one: it is modern medicine which must continue to widen its analytical framework and conception and learn from the holistic approach of traditional medicine (Chavunduka, in Freeman, 1991:13).

In Mozambique, according to Jurg (in Freeman, 1991:14), after independence in 1975/6, the new leaders decided to follow only a rational and scientific approach to solving the country's problems. As a consequence, traditional practices and concepts in healing were

seen as backward and non-scientific at best, and at worst, as obscure and dangerous. No attempt was made to separate sorcery from traditional healing. All exercise of traditional medicine was officially prohibited and banned. However, intellectuals and medical students continued to show interest in traditional medicine and from 1989 traditional healers started to organise themselves into national associations. Today, as traditional healers increasingly emigrate from their home communities into urban areas, they begin to practise health care in non-traditional ways and it becomes increasingly desirable for them to operate in a rational-legal environment. This could be interpreted as the rationale behind the organisation of traditional healers in Mozambique.

In Swaziland, Maseko (in Freeman, 1991:19) argues, there is greater adherence to traditional healers as they are very respected members of the Swazi community. Traditional healing is regarded by many as being more effective in treating psychological illnesses than modern psychiatry or psychology. However, certain technical capabilities and medicines of the western systems are respected and their patients with diseases incurable to traditional healers are referred to western doctors (Green et al, 1984:1073). The same authors document that most healers expressed enthusiasm for the idea of undergoing some training in modern medicine. The reasons given were a desire to increase their healing skill and to learn more about modern medicine (ibid. p.1077).

It can be concluded that attempts to integrate the two medical models confirm Comaroff and Comaroff's notion (1991:314) that although hegemony is unstable, it is not merely an assertion of order but also an effort to limit the eruption of alternative meaning. Hence many of the African states were at first ill at ease with incorporating traditional healers and even when they did, they made sure that all traditional practices be recognised on the terms dictated by the modern sector. (This was also influenced by the colonial legacy.) This is why it is always the traditional healers who have to "keep an open mind" in order for things to change. It is they who must learn from western medicine and they who must initiate change. These examples also show that incorporation is necessary for the hegemonic process: in many of these cases the incorporation of traditional healers

strengthened the modern system because healers referred patients to western doctors and not the reverse. Moreover, the recognition of indigenous medicine did not in any serious way threaten the existence and flourishing of western medicine.

3.5.3 Problems and prospects

In the South African context, Freeman et al (1992:1185) point to a number of problems with including traditional healers in health care services. These include the harmful effects[13] of traditional medicine, its superstitious nature, that inclusion will mean a "colonisation" of traditional medicine and a threat to the traditional healer's status and remuneration, that traditional healers "disempower" their patients, that traditional explanations are "false consciousness" and that inclusion will involve a number of practical problems which may be impossible to overcome. Moreover, most traditional healing practices are not open to empirical investigation demanded within modern medicine. Traditional healing thus requires its own ethical codes and disciplinary body. It was recognised by delegates at the 1991 conference that modern and traditional healing operated from such different premises and were often so different in their practices that integration of the two streams of health care should not be considered (Freeman, 1991:44).

3.5.3.1 Incompatible paradigms, misunderstanding and dangerous medicines

Green (1986:118) explains that one of the reasons why traditional healers have not been incorporated into the modern health care system up to now is the inherent conflict between the scientific and the magico-religious paradigms of western trained and traditional practitioners respectively. Supernatural belief systems are distinctly alien to and not easily comprehended by many modern sector practitioners (Chavunduka, 1986:63-64,

[13]This view is echoed by Prof. Heyl from SAMDC (in Freeman, 1991:27) who admits that they do not know enough about the practice of traditional healers to assess their value but that they *do* know that many of the herbs and remedies employed by "these" practitioners are undesirable and even hazardous.

Maclean, 1986:31). Other reasons include professional elitism, misunderstandings about traditional beliefs and a genuine concern that indigenous practitioners' practices are harmful to patients.

Related to the problem of differing paradigms is that it is much easier for large health planning organisations to be concerned with the tangible and measurable elements, such as the study of herbs, than with the spiritual, psychotherapeutic and social dimensions of traditional healing (Maclean, 1986:32). This relates to the problem of how traditional healers should be selected, trained and tested before registration if the spiritual and intangible elements are so important. One answer would be to listen to the community who ultimately judge the healer by their patronage (See section 4.3 in Chapter 4) and who popularise and "advertise" the healer by way of word of mouth. Freeman (August interview, 1994) agrees that the community knows best about the credibility of a particular traditional healer.

3.5.3.2 Retardation of progress

Another reason why development planners and western-educated professionals do not agree with integration is that they tend to think of traditional systems as archaic and dysfunctional and to be overcome if there is to be progress and development (Green, 1986:120). There are several writers who have put forward the view that the prevalence of witchcraft and sorcery beliefs tends to inhibit motivation for development. It is argued that, since development implies some people moving socially and economically ahead of others, it creates jealousy and tensions. Given fears of vengeful supernatural attack, people will be reluctant to get into the kind of situation that will expose them to this, and thereby the rate of development will slow down (Jahoda, 1986:47).

3.5.3.3 The impact of education, distance and ancestral opposition

Maclean reports that it has been widely claimed that traditional beliefs are being eliminated by the spread of education and that science and technology have a shattering effect on superstition (Maclean, 1969:47-48). However, her research of university students, and particularly science students in Nigeria, reveals that there was no correlation between length of university residence and the decrease in beliefs and neither were science students more sceptical than others. This may be because traditional healing and superstition are not synonymous and there are many aspects of traditional healing from which the sick can and do benefit and therefore it is wrong to think that traditional healing is contrary to progress.

Chavunduka mentions other problems of integration. Firstly, most traditional healers are illiterate. (See also Jaiyeoba, 1988:181). Secondly, many live in rural areas and are unable or unwilling to travel long distances to register with a national body. Thirdly, some spirit mediums argue that the spirit which they inherited will not allow them to register (Chavunduka, 1986:64).

3.5.3.4 Lack of funds and information

An obvious problem in a developing country is that there is not enough money available for innovations in health care (Maclean, 1986:32). Heggenhougen (in Oyebola, 1981:99) also suggests that many problems of traditional healers associations are understandable in view of lack of money for organisational purposes. "Success [of using traditional medicines in primary health care] will depend heavily on the resources channelled to these endeavours by Member states" (Akerele, 1987:1790).

Foreign donors, planners and administrators usually have little or no understanding of, or access to, African healers and the world-view they represent (Green, 1988:1127). Others also agree that there is a lack of sufficient information about traditional healing which

would enable the health system planners to commit substantial resources to establishing linkages between the two sectors (Neumann et al, 1982:1820). Misunderstanding of traditional health beliefs and practices contributes to resistance to co-operation (Green, 1988:1127).

3.5.3.5 Threats to western medicine and traditional healing

Leslie (in Freeman Conference Papers, 1991:11) argues that when traditional practitioners in African countries organise to act as pressure groups for legal changes in health care, they challenge the dominance of modern medicine. (See under AIMS). Heggenhougen (in Oyebola, 1981:97) comments on the, by now fashionable, criticism of physicians who oppose collaboration with traditional healers: desire for medical monopoly, defence of status and maintenance of superior income possibilities. But he also argues that such physicians are motivated by a direct concern for the welfare of the patient. Fosu (Oyebola, 1981:96) says that the decision of whether or not to accept new professionals is dependent on the attitudes of old ones: it is based on whether the services of the new professionals are perceived as role-elevating or role-threatening to them. In this context, MacCormack (in Green, 1988:1129) says that medical techniques and the use of drugs are the very skills physicians are least likely to relinquish if they perceive themselves as being in competition for patients and general social status.

Threat to traditional healing

Arising from the threat to western medicine's hegemony by traditional healing (i.e. that western doctors may lose patients or that their roles will be threatened), it may be argued that the greatest potential threat to traditional healing practices may not be through being left out of formal health care structures but through being "brought in" and "taken over" by western medicine. The process of inclusion would be a slow but comprehensive "colonisation" of traditional healing (Freeman et al, 1992:1187). This fear is shared by Oyebola (1981:105) who says that there are problems with scientific medicine setting itself

as the reference point in discussing "standards" desirable for African medicine. "The dangers inherent in this approach are many" (ibid.).

The issue of Medical Aid as posing problems was brought up by Chavunduka (1986:70). Traditional healers are lacking both in education and bank accounts and they also live far from post offices and this would make the implementation of the system of Medical Aid extremely difficult if not impossible.

3.6 Conclusion

This literature review has focused sharply on the issues surrounding modern and traditional medicine. It showed how western medicine assumes hegemony and by so doing it labels traditional systems as "closed" when compared to their "openness". Such openness must, however, be questioned when we consider how much effort goes into controlling the emergence of alternative medicine and into dismissing traditional thought as irrelevant. Rationality and the scientific method are often set up against the conservatism of the traditional mode and this can be somewhat misleading. The differences between traditional healing and western medicine have more to do with holistic approaches and a real desire to heal than with rationality and conservatism. The case studies from different African countries illustrated how hegemony operates, i.e. how it tries to limit the eruption of alternative meaning.

Through arguing for the case of hegemony on behalf of western medicine and through an analysis of what African traditional thought and western science is and how they relate to each other, it may be asked to what extent western medicine and traditional healing are compatible. Green (1988:1129) argues that the development of a syncretistic system that would combine the best features of biomedicine and traditional medicine that would best serve human needs is not likely to happen because of a basic incompatibility between the two paradigms.

In the following chapter we will look at how tradition and modernity are defined and how they intersect and how the assumed hegemonic process on behalf of western medicine unfolds itself in real life. We will look at the roles of traditional healers in society and how colonialism and Christianity and politics had an impact on their attitudes towards western medicine. How have they modernised their practices?

Chapter 4 - Traditionalism and Modernity

4.1 Introduction

In this chapter we will become familiar with the world-views of the members. This will have direct influence on how we theorise about hegemony or incompatibility of cultures. The two organisations differed markedly in terms of westernisation and modernisation. THOSA, headed by Chief Zungu, was the more "traditional" organisation with charismatic leadership, a clear structure, less modernisation, few problems of organising and a rejection of political affiliations. By contrast, ANHA, headed by Mr. Mahlaba, showed more tendencies toward modernisation and westernisation. Its structure was less clear and there were many problems with organising and members did not reject political affiliation.

We begin with an analysis of the significant interaction of traditional healers with "civilisation", colonialism and Christianity. It will be shown how the incorporation of Christian values has extended the hegemony of western medical culture but at the same time it has also divided African people themselves on the issue of traditional healing.

To familiarise the reader with traditional healing, we will look at the roles of traditional healers in society. We will compare how the healers define concepts of tradition, health and illness with the documentation. Western medicine and the healers' attitudes towards it will then be presented, followed by an analysis of the differences. Despite the differences, it will be a central argument in this chapter that modern and traditional[1]

[1] The terms "traditional medicine" and "modern or western medicine" need to be clarified because much controversy exists over their usage. For example, Hours (1986:43) claims that "traditional medicine" is the worst description because it sets up tradition as if it were some abstract, unchanging corpus of practices and knowledge whereby we know today that they are evolving in a dialectical relationship of adaptation and competition with what is called "modern or western" medicine. But even 'modern" medicine has outlived its use. Since the beginning of the 1980s the term "cosmopolitan medicine" has become popular (Young, 1983:1265). Some have used the term "cosmopolitan" medicine to refer to its universal application the world over (Jingfeng, 1988:523). Healers interviewed for this research used the term "conventional medicine" most often to refer to "modern or western medicine". They also referred to themselves as "traditional" healers and practitioners. Therefore, both the terms "modern" or "western"

systems and world-views are in a process of interpenetration and therefore there is a real possibility, at an epistemological level, that the two systems may integrate. There are, however, some real barriers to modernisation and therefore it is also possible that in reality the two systems are incompatible.

4.2. "Civilisation", colonialism, Christianity and politics

Western culture and civilisation are often viewed in a positive light by the healers - for example, education and western dress are appreciated. The down side is related to the culture of materialism and of losing respect for the old people. The problem now is loss of parental control, loss of respect and authority in the praise of self control and independence. What is important is that within this setting of losing cultural values, traditional healing still enjoys supremacy (H. B. Zungu interview, May, 1994).

The traditional healing practice is embedded in issues which are difficult for a person with either the Christian or the western approach to comprehend. To date, it is difficult to subject the practice to scientific principles.[2] From this the negative attitudes by westerners and Christians emerge.

> It is unfortunate that the lack of understanding of the [traditional][1] practice is simply dismissed as superstition. What compounds the problem is that c[illegible]ss negatives are labelled against the practice. Members of foreign cultures to the black culture have since their arrival in South Africa been having power and control over resources. They could, therefore, have things get perceived in accordance with their own predispositions. In relating to matters such as the traditional healing practice, and in attempts to explain them, directly concerned people - i.e. blacks - were not consulted, but were rather told. Even wrong things had to be accepted without question, as long as they suited colonialists. That led to another bleak picture of the practice[3].

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and "traditional" will be used throughout this report, despite the acknowledgement that these terms are not necessarily the politically correct ones.

[2] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

[3] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

One of the interviewees explained the relationship between colonisation and the "looking down" on traditional healers:

> Our profession is looked down upon by professional people. For example, the missionaries found out that people had their own religion and culture but they looked down on it. They had to change us somehow. When you want to change people you come up with your own strategy. When you want to promote yourself you have to criticise the other (ANHA, 3).

The "other" is thus an important definitional category for the hegemonic process. Without it there would be nothing against which the dominant culture could define itself.

Christianity is not only concerned with 'winning the hearts and minds' of the colonised people. It also wants to promote capitalist accumulation. Medicine is the best vehicle for this: Jingfeng (1988:524) shows how the logic of this operates (in China): "The best way of introducing Christianity to China is through medicine, while the best way of selling more merchandise in China is through missionary activity. Medicine is the pioneer of Christianity, while Christianity is the pioneer for the promotion of sales" (quoted by Jingfeng, 1988:524). Moreover, Christianity in China (and elsewhere) served political ends: "We are spreading Christianity in China for political purposes rather than religious purposes" (quoted in Jingfeng, 1988:524).

As to be expected, in Africa, Christianity also had a political mission and politics is seen as partly, but significantly, responsible for the fact that many African people have abandoned their culture to follow the white, "civilised" culture. In the olden days, according to the Bible, it was accepted that children should respect their parents.

> But now because of political positions and things like that some of these things were abandoned because they were told that they will follow a stream of political beliefs which means that everybody should work as if they were equal which in actual fact is not like that. Even if the government is at the head of the state, there are positions going down so people would put things in their own ways and as a result children won't go to school now because they were told that the education that was offered

> by the state was inferior, whereas the western civilisation argues that half a loaf is better that nothing . . . So they didn't follow the western culture properly so that the black man is now half and half. He takes half of the western civilisation and half of the African culture. He is sitting on the fence and cannot tell where he is. He is confused.[4] (Interview with H. B. Zungu, 20 May, 1994)

These sentiments are echoed by Mr. Brown, from the Nyangazezizwe Traditional Doctors Organisation:

> The abandonment of culture and the neglect of tradition has put the modern man and his civilisation in a state of total confusion. Confused because his profound, intellectual and idealist theories have failed him. His dilemma, similar to those of the propounders of socialism and Marxism (sic.) [5]

In this state of confusion, the traditional healer seems to have remained the person who is trusted and respected when people have problems.

It is important to stress that while the rejection of traditional healing has often been attributed to colonial and white arrogance, research in Africa, including my own, shows that it is often black practitioners within the modern sector who object most vociferously to traditional healers as an acceptable health resource (Freeman, 1991:2). Green (1988:1126) also mentions that traditional healers have been regarded by African physicians as a threat to their own professionalism. Therefore they have opposed initiatives that would result in official recognition of, or increased power among, indigenous healers.

Comaroff and Comaroff (1991:311)offer some insight into why opposition may come from the colonised people themselves. Colonised people frequently reject the message of the colonisers, and yet are powerfully and profoundly affected by its media. Such a view is supported by an interviewee:

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[4] This is similar to what happened to American Indians: "I think as far as the Indian tribes are concerned, they have been given a way of life, a religion, a belief, a philosophy, or whatever it is; and if they have lost it, then certainly they will have some difficulty in getting it back" (Wanatee, quoted in Steiger, 1984:205).

[5] Nyangazezizwe Traditional Doctors Organisation & Cultural Self Help Project - a document by Innocent Brown on "The Role of Traditional healers in the Modern Health Care Setting".

> We can't put all the blame on western people. There were many good things that they brought. We need to complement each other. *We have accepted many of their ways and lived with them* so we can't go back in time (and run around with no clothes on for example) (ANHA, 6, emphasis mine).

As a result of the opposition to traditional healing from African people themselves, interviewees expressed very negative opinions of Dr. Motlana, a westernised African doctor, working in modern health care who referred to traditional healing as "mumbo jumbo":

> I am very much annoyed about people like him. He is maybe too westernised - that is the problem with African people. They help to confuse other professionals. Children are scared to be laughed at when others see the razor incision on their wrists (that is why I often do the incision on the head.) This is a lost generation, they want to take over, ever since 1976. The whole process has been looked down upon. Children listen to people like Motlana. Western culture has swept them [away]. We want to mix our culture with westerners but we leave something behind. But certain things we should not leave behind like lobola and circumcision (ANHA, 5).

This is also an example of what Williams (1980:40) would call "residual culture". As the dominant paradigm exists, i.e. is hegemonic, there are still some experiences, meanings and values which cannot be verified or cannot be expressed in terms of the dominant culture, but are nevertheless practised and lived, for example, circumcision and lobola. What emerges from the following responses is that Motlana represents a hegemonic position by trying to limit the eruption of an alternative awareness, i.e. that of traditional healing:

> I am quite angry about that man. I know his place, where he was born, they use traditional medicine in his own back yard. He said [that traditional healing is 'mumbo-jumbo'], I think, because he wanted to draw attention internationally, he wanted to save the image of the western doctors but he is doing a wrong thing. (ANHA, 4).

> What he says is out. Traditional healers are there for the benefit of the nation. His main reason for saying so was to persuade people to not go to traditional healers so that they go to him. He is too westernised in term of education (ANHA, 6).

Several interviewees attempted to explain why African people themselves turn against traditional healing and thus against their own culture. It is related to the way in which these people have been affected by and incorporated into the hegemonic order, even though these people do not have the power to impose that structured order. They have taken on the attitudes of those who did have such powers, i.e. the white rulers. That is why these respondents do not feel threatened by such people but dismiss it as "jealousy":

> I can't understand why they give us a bad name. People have diverted from their culture, they look down on it as primitive. That is why there is communication break down. It is jealousy, they feel they are inferior. They say our culture is nothing. They say I betray them if I talk to white people, giving away our secret. There is too much jealousy (THOSA, 4).

> It is just a criticism which is not based on fact. It is jealousy, trying to advocate the western way of healing. These people have gone to higher institutions to which traditional healers haven't gone, so they think they are smart (THOSA, 5, 6).

Obviously such antagonism is a legacy from the past, including Christianity and Apartheid which rejected ancestral beliefs.:

> To be colonised meant that the Bible has washed away a lot of our country. Because for someone like Motlana to call us those bad names, some of our good stuff has been stolen. To be called witches, only the bad of our people were put into the white papers, the good things were taken away. They have taught people to say we are witches. Apartheid has dismantled traditional healing. We could not tell the truth. Even today, elected people still have the attitude like that of Motlana (ANHA, 4).

This is an example of how, in hegemonic society, selectivity plays a major role: the way in which from a whole possible area of past and present, certain meanings and practices are chosen for emphasis, certain other meanings and practices are neglected and excluded (Williams, 1980:39). Even more crucially, some of these meanings and practices are reinterpreted, diluted or put into forms which support or at least do not contradict other elements within the dominant culture (ibid.):

> Apartheid played a certain role. Whites did consult traditional healers but they tried to advance the western side only, looking down on anything coming from blacks, for example slaughtering goats was seen as barbaric (ANHA, 6).

> There are some conventional doctors who have performed operations and given injections and the patient died. In our case it can also happen but because it is traditional healing it is looked down upon and is publicised (ANHA, 4).

Christianity is however not condemned by these healers. Their ideas conform to what we described in the previous chapter, i.e. that non-European people tend to recognise a basic phenomenon of the natural world religiously rather than scientifically (In Huizer, 1987:432). That is why some saw the influence of Christianity as fitting in with their own religious tendencies:

> The Christian people believe that you should pray but then they go further and criticise people who go to healers. The two clash only in the mind of the people, in reality they go together. Herbs were created by God. They think that people don't come to church because they cling to the old ideas of traditional healing (ANHA, 6).

Most people said that despite opposition to or rejection of traditional healing by African people, these individuals visit the healers "at candle times" as they are afraid to be seen at the day time because they would then be accused of practising double standards (H. B. Zungu interview, July, 1994). These people are apparently confused between which culture they should follow. It is possible that they have been taught to believe that the dominant culture (western) is what they should follow but deep inside there still lurks the residues of their own culture. A residual culture is usually at some distance from the effective dominant culture, but one has to recognise that, in real cultural activities, it may get incorporated into it (Williams, 1980;41). This is what seems to be happening to those people preaching one thing during the day but reverting to their culture at night:

> These people come by night but preach something different during the day (ANHA, 6).

> Some of those people who claim not to consult traditional healers come to us by night, those who are Christians (ANHA, 6).

Rappaport et al (1981:776) agree that "apparently embarrassed by the remnants of colonial attitudes towards traditional healing, Westernised Africans tend to conceal or

joke about their use of the medicine man". Kimani also notes that such an attitude in Kenya dates back to the penetration of European missionaries (Kimani, 1981:333).

However, there are some more personal reasons why some African patients do not visit traditional healers:

> Yes, there are Africans looking down on traditional healing. There are several reasons. Maybe a person has never had a problem with which he had to go to a traditional healer. Maybe she got help from a quack or got sexually harassed and she thought they are all like that. For example, some request you to strip naked, even if it is not necessary (ANHA, 6).
>
> Now people see there is a difference between witches and healers. We used to heal those people who were propagating Apartheid but instead of coming back to pay us, they go and give you a bad name, just to get away from paying. With us we cure people first, then he pays (THOSA, 7, 8).

There were also healers of the opinion that even though opposition to traditional healing came from African people themselves, Apartheid was not to blame for this.

> There was no link between the previous government and trying to degrade our healing methods. The bad name comes from black people (THOSA, 5, 6).
>
> I cannot blame Apartheid. It emerged from our own people, telling behind our healers' backs that they should not be given legislation. It is a pretence (THOSA, 4).
>
> I have not come across that (Apartheid adversely affecting traditional healers and their profession). I have been curing all these years and I have had no problems (with Apartheid), I have not been hindered, except that for all you do you need a document, like travelling (ANHA, 7).

These are the people for whom the dominant culture is not all-penetrating and who are able to recognise their own culture as truly alternative or even oppositional. For these people the area of social life which they are involved with, i.e. healing, was left alone. They did not feel that the previous government interfered with their lives as healers.

4.2.1 Retardation of progress

Development planners and other western-educated professionals often claim that the promotion of anything that is "traditional" is a step backward. Yet none of the interviewees saw traditional healing as hindering progress, quite on the contrary.

> Traditional healing is very much part of human progress (THOSA, 4).
>
> Traditional healing is progress if traditional healers are allowed to practise freely (THOSA, 7).
>
> Those who say it is against progress don't understand a lot of things. Traditional healing does not hinder progress, it helps progress. It can hinder progress if you do not go to a traditional healer (ANHA 7).

Nobody, except one person, thought that traditional healing retards progress. However, we have seen previously that it is mostly African people who oppose traditional healing and most healers thought that this was because they are jealous. This is supported by Jahoda's claim (1986:47) that development implies that some people move socially and economically ahead of others and thus jealousy is created. In turn, this means that people will fear vengeful supernatural attacks which could explain why African people give traditional healing a bad name. However, it could be argued that such people were influenced by the coming of Christianity which collapsed all traditional practices into the "evil" category, failing to distinguish between witchcraft and healing. Therefore it is not traditional healing itself which can be blamed for the retardation of progress but Christianity and white "civilisation". At the same time it must be remembered that some healers in the past, before the event of controlling bodies, did give in to requests of bewitching people, mainly for financial gain.[6] But since there have been professional associations, such practices are more and more weeded out. If traditional healers use their powers to bewitch people and to make money out of it, then, yes, the practice of

[6] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

traditional healers is a step backward because it confirms the suspicions of the early missionaries. However, none of the healers I interviewed showed tendencies of such sort.

Only one person saw a problem with the issue of traditional healing promoting progress. He said:

> Traditional healing is a problem. We do things that are passed. The new generation says why do these people do these things that are pas. They are interested in politics (ANHA, 1).

However, this person also felt that it is important to promote traditional healing to the new generation, otherwise the system will die, together with the cult e and the power of healing.

Thus it is not supported by the findings that traditional healers are guardians of the traditional moral and religious order, and are, in some Marxist sense, reactionary purveyors of the "opium of the people" (Green, 1988:1127). What such a view fails to recognise is that traditional systems may be well-suited to the social and psychological needs of participants in these systems and that "traditional sys may be a great source of comfort to Africans undergoing rapid cultural change, prov security and continuity in an unpredictable, changing world and that traditional systems tend to be genuine functioning systems whereas the same cannot be said of the modern-urban alternative" (Green , 1988:1128, see also Ngubane, 1992:366). This is also why Huizer (1987:419) says that traditional healing in developing countries does not disappear: "This may be due to the fact that this form of health care satisfies certain needs which are not covered by modern medicine".

4.3. The Role of the traditional healer

Technically speaking, there are at least 5 different types of healers, all with distinctive roles. These are: the Nyanga, the Sangoma, the Setshupsa, the Dreamer and the Faith Healer. The Nyanga throws the bones and then diagnoses a problem and finds

prescriptions for it. However, not all who throw bones can diagnose and prescribe. Some can diagnose but not prescribe and vice versa. The Sangoma (who is usually female) dances to the beating of drums in order to diagnose and treat a problem.[7] Her role is to convey the messages from the spirits, she is for communities and for bigger problems (Graham interview, August, 1994).

The role of the Sangomas can be seen in terms of religion whereby they rid the community of the collective guilt and redeem the soul, confessing the sins by making sacrifices to the ancestors. This is comparable to western religions, seen through their own cultural terms.

The Setshupsa is a traditional practitioner who neither dances nor uses bones but who has visions about a patient. He is usually a gifted man and grew up in a family where there has been a traditional practitioner [8]. A Dreamer is a traditional practitioner who diagnoses a problem and finds treatment for it in his dreams (ibid.). Lastly, Faith Healers and diviners are prophets and use prayer, candle light and water to diagnose and heal. There are healers who are gifted in more than one of these categories and the distinctions are not always as clear.

We have seen in the previous chapter that health is a cultural phenomenon. This is supported by the findings of this research: culture is the heart and being of a society and the spiritual heartbeat and backbone of a people. It gives identity. In the past culture and tradition provided answers to all human problems, and facilitated communication between man and ' 's ancestors [9]. "The medicine man is, by virtue of his profession, the backbone and pillar of his race" (La Hausse, 1993:213). The traditional healer is the guardian of culture. He or she is the link between the living and the ancestors and people of all ranks, including chiefs. It is worth noting that the whole issue around culture is strongly

[7] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

[8] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

[9] Nyangazezizwe Traditional Doctors Organisation & Cultural Self Help Project - a document by Innocent Brown on "The Role of Traditional healers in the Modern Health Care Setting".

emphasised by ANHA and this can be seen from their logo - 'ANHA - Health through cultural heritage'. (See copy of certificate in Appendix 3). Also, one of the documents used[10] introduces the topic of traditional healing with the opening sentence of: 'Culture is the backbone of every nation, without which a nation is not a nation'.

The role of the traditional healer cannot be separated from the community he or she serves. It is a multi-faceted role and it includes training, passing on knowledge, and the ability to serve in a number of medico-religious functions such as herbalist, seer, ceremonial leader, physician, spiritual leader, psychologist, priest and mystic all rolled into one (H. B. Zungu interview, May, 1994).

> A traditional practitioner leads a clean (exemplary?) life and by doing so he or she is looked up to by the community. A traditional practitioner's duties are: to cure diseases, play a preventitive role, counsel patients, guide and advise them, reconcile families, make people's lives run smoothly by solving their money problems, love problems, work problems, sexual inefficiencies, addressing mental disturbances and the list is inexhaustible[11].

The traditional healer was, and is, the person who is most trusted and respected in the community (H. B. Zungu interview, May, 1994). He or she has a particular status in traditional communities (Freeman interview, August, 1994). His or her claim to authority is a result from a demonstration of the continued ability to heal. This is contrary to Hammond-Tooke's (1989:147) notion that the healer's authority comes from his or her close association with the ancestors. It became evident from the interviews that healers have authority because they can heal and not because they are attuned to the spiritual world of the ancestors. That is why the community is the supreme judge of a healer in terms of his or her reputability:

> [A good, respectful healer can be seen] by people patronising that healer (THOSA, 4, 7).

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[10] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

[11] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

> You can always deduce [the respectability of a healer] from people's actions. When patients comment badly about a healer, you know he is no good. You can always judge from their facial expressions and appearances (THOSA, 8).

Reputation is by word of mouth:

> Some of the people if you treat them, they will talk to each other, we don't advertise these services (H. B. Zungu interview, July, 1994).

> There is no advertising. Members can hear from one another that you can get help from that side (Mr. Mahlaba interview, August, 1994).

Linked to the claim to authority is the idea that medical power, which provides insights, strength and spiritual power may not include the ability to heal, although the latter is usually a natural by-product of total spiritual attunement (Steiger, 1984:50). Thus a healer needs determination and conviction. Mr. Mahlaba agrees that

> You don't have to have all the supernatural and hereditary things to be able to heal. All you need is interest and love (Mr. Mahlaba interview, September, 1994).

4.4 Traditional healing - the concepts of tradition, health and illness

Tradition was presented by Horton as a closed system whereby fundamental ideas do not change and where the traditional thinker sees no alternatives to his theories. This way of understanding tradition was not supported by the research findings. Interviewees found that tradition had to do with time, culture, beliefs and holistic healing rather than with certain theoretical assumptions:

> Traditional is when someone is practising the indigenous methods as opposed to western medicine which uses advanced methods and tested techniques (ANHA, 3).

> Traditional medicines are made at home, from the very roots of the process but they are not scientifically proven. Traditional means going back a long time (ANHA, 4).

> Traditional is when somebody talks about culture (THOSA 5, 6, 3).

> Traditional: when something has been there and practised and going on since Africa was Africa, before western orthodox doctors came along to tell us about medicines (THOSA, 2).

In this context it is important to note that many traditional healers interviewed found this question difficult. One of the reasons for this was that they could not think in abstract or conceptual terms, they had to relate it to their experiences, to what they did.

> Tradition implies using skins and bones (ANHA, 6, 7).
>
> Traditional means you do things your way, you are an Nyanga or a Sangoma (THOSA, 4).

This is somewhat similar to Hours's findings that the concept of "tradition" made no sense to almost all those interviewed [in his research of traditional healers in Swaziland] (Hours, 1986:50). It may be that we are asking the wrong question. The fact that so many healers could not readily attach meaning to the concept of "tradition" negates the very premise of Horton that traditional thought has a set of theories. The proposition that a traditional thinker is unable to imagine possible alternatives to established theories is thus problematic because he does not have established theories to begin with. Moreover, many of the healers expressed a keen interest in learning from western medicine which shows that they can imagine alternatives to their way of thinking.

Chapter 3 has shown that the "openness" of western science can be questioned since it dismisses anything that does not fit its language of rationality. (See Lantum in Bannerman, 1982:16 and Freeman et al, 1992:1186). Compared to this, the healers interviewed showed an explicit interest in learning about western medicine:

> Laboratory tests of medicines, how they are made into tablets and how to mix chemicals (ANHA, 1).
>
> Penicillin - it works for everyone (ANHA, 2).
>
> First Aid is number one (ANHA, 4).

> To extract teeth, to perform operations, the way they give help to pregnant women (ANHA, 5).

They also stressed that they refer patients to western doctors. This is an example of how incorporation works as an effective buttress to the dominant culture because it ensures that the western system is expanded and that it maintains its dominance by not reversing the process of referral. Other research confirms these findings. Green (1988:1128) notes that surveys of African healer attitudes have consistently shown willingness on the part of the healers to learn more about western medicine. Such findings are common: "The majority of [healers] interviewed [in Central Kenya] express deep interest in co-operating with modern medical practitioners" (Kimani, 1981:335). Thus it could be argued that traditional healers have no problem including alternative knowledge in their repertoire of techniques (and thereby they incorporate their world-views into that of the dominant culture)(See Hammond-Tooke, 1989:39). This would reject Horton's assumptions.

Horton could reply that such healers are "modernised" and that the more traditional ones are less eager to learn the western ways. To some extent there is support for this as we have seen in the introduction to this chapter. From the more "traditional" organisation, THOSA, it emerged that the one cannot just learn from western medicine without consulting the ancestors. Others said that they could not understand what western doctors were saying and thus left it at that. Moreover, some thought that western medicine will never surpass the power of traditional healing. All this implies that there are certain barriers to wanting or being able to learn from western medicine, but it does not imply an outright rejection of the principles of western medicine, the way western medicine rejects the "unprovable" aspects of traditional healing. Where do we draw the line between modern and traditional? I could find no answer to that within the framework of this research and existing theories on the subject. The closest answer I could accept came from Boyer's conclusion that "if 'tradition' is to be conceived as a meaningful analytical concept, the stuff tradition is made of is neither symbols nor theories: it consists

of memories" (Boyer, 1987:65)[12]. It seemed to me that "tradition" is a classificatory term and not an explanatory one. It is the "other" of modern and means nothing without the latter in the same way as the "other" or "alternative" culture is an essential category against which the dominant culture defines itself.

For the healers interviewed, the concepts of health and illness were just as difficult to ascertain as that of tradition. Again, the healers had no ready-made definitions and related their understanding of these concepts to direct experience. Thus "healthy" and "ill" were often seen as "something that I can tell from the bones". Or alternatively, "I can look at a person and tell whether or not he is healthy" (THOSA, 3, 4, 7, 8).

> Sick is when you cannot feel happy, you are not feeling free. Healthy is when all the time you have power (ANHA, 1).
>
> When we say a person is sick, in our culture it does not just mean that we have a physical problem. All the bad luck, the social, marital and mental and emotional problems are considered to be part of the "disease" that I had which western doctors could not cure or understand (ANHA, 5).
>
> An ill person is someone who is not free, who is worried, something does not go the way it used to. A healthy person is someone whose body and spirit has no problems (ANHA, 4).
>
> You can foresee, some power tells you that somebody is going to come your way needing help. That is how you define health and illness. The definition is through the ancestors, telling you what is wrong with that person (THOSA 5&6).
>
> If you are not free, you are not healthy (THOSA, 1).

These are all examples of a holistic[13] way of defining health and illness because they take into account the patient's whole organism, his social environment and psychological well-being. African medicine is holistic because the medicines do not simply deal with the

[12]Tradition applied to traditional healing is not even a system of beliefs because wholeness is not sought in the system of beliefs but in the patients themselves (Hammond-Tooke, 1989:147).

[13]"Holistic" refers to a concept derived from the Greek "holos" ("whole") which can be understood as reality in terms of integrated wholes whose properties cannot be reduced to those of smaller units (Capra, 1982:21). Holistic health practices are those that are counter to scientific medicine in that they attempt to view the patient as an integration of body, mind and spirit (Berliner et al, 1980:133).

physical symptoms. They supply personal strength and power, they provide protection against the malevolence of Gods and spirits and the enmity of close human rivals. They can also be used to influence the behaviour of others, to win a person's affection or to induce them to do a favour (Maclean, 1986:10).

We have seen in the literature review that in African medicine, diseases have their origins in both natural and spiritual causes. This perception is supported by the healers interviewed:

> Disease is both natural and ancestral. They can be caused by witches, stress, nature. In white culture there is no such distinction (THOSA, 3).
>
> Any disease comes in its own way, in many different ways (THOSA, 4, 7, 8). You can immediately tell the difference (THOSA, 7, 8).
>
> It may be germs or a spiritual problem (ANHA, 3).
>
> People get sick through germs, evil spirits, i.e. in different ways (ANHA, 6).
>
> There are naturally caused diseases like a cold or a fever or STDs. It is logical that if you expose yourself to certain conditions, like extreme cold, you will feel certain effects. When you have an ancestrally caused disease, you realise that things are just not going well for you (ANHA, 4).

What is emerging here is that conventional notions of what is "traditional African medicine" are not diametrically opposed to notions of "modern" medicine. Moreover the distinction between "closed" and "open" systems of thought and world views is problematic. It will be shown later how the interpenetration between the "modern" and the "traditional" is manifested in the views of traditional healers. Having said that, there are however very distinct differences in the aims and objectives of the two medical systems which bears relevance on how the two can be incorporated.

4.5 Science and western medicine

In relation to western science, it became apparent that scientific progress is very much needed, encouraged and supported, not to replace traditional healing but to complement it. Research is where western medicine had an advantage over traditional healing (H. B. Zungu interview, May 1994).

Also, the reason why science and western medicine is seen to be so powerful is that they are given powers by the government to use anything they like to help human survival. This is at the heart of the hegemonic process. It is also why western doctors now have an advantage over traditional healers, who are condemned for using animal and human parts in their healing (Mr. Mahlaba interview, June, 1994).

But science and western medicine are also regarded as a dynamic process:

> In the past when visiting a western doctor you could be sure that you would be cured. We confided so much in western medicine but now it seems that something is lacking and it is lagging behind (THOSA, 1).
>
> In the olden days [western doctors] were more altruistic but not today (THOSA, 2).

This is important in terms of the decline of western medicine and its changing nature, i.e. it may not always have been as exploitative as it seems to be now.

There are a few concerns that Mr. Mahlaba expressed about western medicine and western doctors: The western system does not approve of the traditional healers use of animals, they tell them that it is a dangerous thing. But "culturally we feel quite happy" (July interview, 1994). Thus there is an imposition of an alternative culture, one that could even challenge the dominant one. In addition, western doctors are seen to be enjoying an unfair advantage, such as funding. Moreover, they are divorced from the process of medicine manufacture which conveniently allows them to bypass the unpleasant parts such

as killing and experimenting with animals, so that they enjoy the end product, without having to identify with the whole process:

> They know how to use medicine but they don't know where it comes from. Somebody else has to make medicine for them. They will never accept that they are having a problem when somebody is not healed, they are not worried and that is a problem (ANHA, 4).

If traditional healers are, despite this, willing to learn from western doctors, the question now is how willing western doctors are to learn from traditional healers? The research could not answer this question from primary sources since that was not the aim. However, from the perceptions of traditional healers it found that western doctors, and whites in general, are developing a new interest in what traditional healers do. From those who did interact with western doctors, even if it was at an elementary level, it emerged that such an interest in South Africa is not politically but scientifically motivated. It is encouraged by the opening up of new political gaps.

> Yes, they are interested. It started long before the new government came into power. They already indicated that if we come together as a team we can cure more diseases than each could heal on his own (THOSA, 4).

> That is why now we are called to universities. Western people want to know more about healers (THOSA, 2).

> White people come to traditional healers to get better because western medicine is not helping them (THOSA, 1, 5, 6).

> It is not a question of politics but realising that these people are healing people (THOSA, 7, 8).

This exemplifies the process whereby western medicine incorporates alternative knowledge. "In a particular phase of the dominant culture there is a reaching back to those meanings and values which were created in real societies in the past, and which still seem to have some significance because they represent areas of human experience, aspiration and achievement, which the dominant culture undervalues or opposes or even cannot recognise" (Williams, 1980:42). The dominant culture is now attempting to incorporate

the alternative knowledge of these healers and thereby extending hegemony. For example, the desire to find a cure for AIDS is perceived as reason for western interest in traditional healing:

> Whites and westerners are very much having a new interest in the profession of traditional healers. It is not due to politics, many African countries have been freed for a long time and the interest is only now. The killer disease of AIDS is now on the cards. That made all conventional doctors seek for new remedies so that this new interest is scientifically motivated because western medicine is struggling with this killer disease. This made conventional doctors think beyond themselves, to get someone to give a hand in solving this problem of AIDS (ANHA, 4).

However, this interest on behalf of western doctors is related more to self-aggrandisement than to a true desire to share with traditional healers:

> For example AIDS - [the western doctors] are not looking for a cure but for personal fame (ANHA, 3).

The perceptions of, and attitudes to, western medicine reflect a positive way of thinking but this is typical more from ANHA than from THOSA. The responses from ANHA show that these healers are willing to accept the hegemony which western medicine presents mainly because they can identify the similarities between themselves and the western doctors and because they do not see their own healing as counterpoising an alternative hegemony.

> I think it is good, we should mix both medicines. I can use my traditional medicine after western medicine and balance the two. I don't see any problem with western medicine - they can cure a lot of people (ANHA, 1).
>
> The conventional doctors are just like us, they have a zeal for working and have confidence and then there are others who are doctors just because they have certificates. There are those who are successful and those who are not (ANHA, 4).
>
> I believe in western medicine (ANHA, 6).
>
> Even if it is western medicine, it cures, it has the same aim to heal, regardless of process or type of treatment (ANHA, 7).

> It is good, some are very good, like Chris Barnard. Patients with TB you must send to the western doctor. It needs the machines and experiences of western medicine Our healers are good with mental problems[14] (THOSA, 2).

While such perceptions are generally very positive, there are certain problems with western medicine. The most pressing issue is that western medicine does not treat patients holistically. The fact that traditional healers are concerned with why a particular disease has occurred is one of the perceived great strengths of traditional healing and the most serious weakness in western medicine. It is seen as the greatest strength because by looking at the cause, the root of the problem can be eliminated:

> There are certain times when western medicine does not cure the diseases properly, from the inside. Injections do not take out the root whereas we do (ANHA, 7).

> Take a simple venereal disease. They inject you but it does not go away for good. We give you a mixture and it goes away in its totality, from the inside (THOSA, 7).

> They can use injections but not heal the person completely (THOSA, 5, 6).

> You can take a tablet, use it, but after maybe 4 months you are going to have the same problem of STDs even if you don't sleep around. Thus, the cure of western medicine is not forever (ANHA, 1).

Unlike Nyamwaya's findings of the Pokot in Kenya, who did not regard western medicine as either inferior or superior, *some* healers did regard western medicine in an inferior way. This was typical mainly for THOSA members (as individuals and not as the organisation as a whole) and it exemplifies how their ideology can be seen as potentially creating a counter hegemony to the dominant culture. They are more reluctant to be incorporated into the hegemonic system.

> Western medicine is of a lower rank than traditional healing. We do have a good opinion about western medicine but it will never surpass the power of traditional healing (THOSA, 5, 6).

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[14] It is generally excepted by various authors that indigenous healers have an important role to play, particularly in the fields of psychology and psychiatry (Edwards, 1986:1275).

> No, western medicine is not more powerful. It cannot supersede our natural way of healing (THOSA, 7).

Some interviewees from THOSA believed that traditional way of healing has no limitations (THOSA, 5) and that traditional healing was somehow superior before the arrival of whites. These are the people who recognise the hegemonic order as brought about by colonialism:

> Our ancestors who were practising traditional medicine, their standards were higher because there were no white people and they could work freely (THOSA, 8).

There are other problems associated with western medicine. Again, it was THOSA members who recognised those negative aspects of western medical care which were pointed out in the previous chapter, i.e. that western medicine's primary aim is not to cure:

> They have no welfare of the heart of people, no time for patients, no devotion, sympathy, empathy. They get impatient when you don't get healed, they are always in a hurry (THOSA, 1).

> Operations and injections. They operate carelessly and they don't have after care, especially for women who have given birth. Some of us are allergic to injections but they don't care. Because there is plenty of us, they want to get rid of us, they have no time for patients (THOSA, 3).

There were also some responses which pointed to western medicine's concern with money:

> The interest of western doctors is more in terms of finding out traditional healers' prices and regulations (ANHA, 3).

This research also found that, in the minds of traditional healers, western doctors also have a calling of some sort to become doctors but also, that there are those who are in it for the money:

> Western doctors do have natural calls, they are the genuine ones and you get others who just want to make money (ANHA, 7).

> They go to school for that. They take it as a profession to earn a living, that's all. Becoming a doctor means that you will have lots of money and you won't starve (THOSA, 2).

The previous chapter provided a distinction between traditional healing and western medicine in that western medicine is said to be universalistic. This is not what the respondents thought.

> There are diseases that western medicine cannot heal, for example if somebody is possessed by evil spirits (THOSA, 5, 6).

In contrast to this view, traditional medicine is supposed to be more particular. However, while it may be true that traditional healers need to consider the particulars of their culture and patients, *all* healers interviewed agreed that their healing power is universal, that they can cure anybody, irrespective of place or race or culture. By contrast, they all agreed that western medicine is unable to cure ancestrally caused diseases:

> Western medicine does not have all the answers. Witchcraft does exist and western medicine can never cure them (ANHA, 5).

> If a person gets bewitched, the witches can create conditions where a western doctor will never see what is wrong. For example, he will never see anything on an X-ray (THOSA, 3).

Generally, people have more confidence in Western drugs than in the doctor (Nyamwaya, 1987:1279). In addition, Haram's findings (1991:173) seem to confirm the rejection of the universal claims of western medicine as interpreted by traditional healers (in Tswana medicine). He says that the BaTswana consider biomedicine to be just one of many varieties of medicine and are not limited by the paradigm of biomedicine which defines medicine as a cure which is generally and universally valid for the same disease. Hence, the Tswana healers do not consider the new and different explanations and treatments they encounter as providing new, more valid krowledge.

Western medicine is widely admired for its ability to cure certain diseases. Thus it is often believed that western medicine has the same goal as traditional healing (ANHA, 6, 7). Some interviewees prided themselves in the superiority of traditional medicine and thus saw no hegemony by western medicine. Only one person felt that western medicine had to criticise traditional healing in order to promote itself (ANHA, 3). One person voiced his concern about western medicine's dominance in society and said that "we oppose the power of western medicine" (ANHA, 1). But, in general, it was not felt that western medicine is hegemonic. Even in those cases where it was felt as such, there was no resemblance to an organised "counter-hegemony" which the healers created. They thought that both systems had the same goal of healing people and that consequently there was no competitive spirit (ANHA, 4, THOSA 1, 7, 8).

The research wanted to establish how traditional healers thought western doctors perceive them. On the whole a rather negative picture emerged. Ironically, it was the more modernised association, ANHA, where members were more negative. They were the ones who thought that western medicine is hegemonic but it was also they who were more readily willing to be absorbed by such hegemony rather than counterpoise their own.

> I do feel respected. But western doctors have power, we don't have power, we don't have a place to operate, they have surgeries, we have no finance. If we can have finance, we can have power (ANHA, 1).

> 80 - 90% look down on traditional healers. Many western doctors say traditional healing is rubbish - 'mumbo-jumbo'. They may know that traditional medicine is effective but I think they are jealous. They call it inferior because traditional healers don't know biology and chemistry. Western people think in terms of education (ANHA, 2).

> It is important to me. They need to know and understand what we think of them. We think that they have been mislead about what we can achieve. They need to get closer to us so that we can open our secrets to them. They don't know the intricacies of traditional healing. They look down on us. We do get that feeling, not because we have an inferiority complex but because they do look down on us. They ask us things with suspicion, they do not accept what we do. Companies don't accept doctor's notes from traditional healers (ANHA, 3).

> During a dialogue they end up exchanging words without addressing the problem. They try to distract from your opinions. They don't take us seriously, they don't listen to us, both black and white (THOSA, 3).
>
> They look down on me as a traditional healer who knows nothing (ANHA, 7).

It is important, however, that western doctors were seen as a differentiated category where some are positive, and others negative, towards traditional healers. It shows that in real social situations it is obscuring to label western medicine, with all its interdependent social actors, as a hegemonic system. There are some real differences among those representing the system:

> They are different in that respect. Many look down on us, they belittle us, pass funny remarks. Some are prepared to learn about what we are doing (ANHA, 4).
>
> Western doctors are not the same. Some take you on an equal level, accepting you as a traditional healer and others look down on you, they think you are not trained, they believe you are fake, that you are only after the money. Of course this is true for some. Maybe their perception is that old witch doctors are dirty and oily (ANHA, 6).

At THOSA, most members had a firmer-established, alternative awareness of their traditional practices and felt at ease with it. That is why some did not care what western doctors thought about them:

> I don't really care because I am doing my job and it works but they do look down on us (THOSA, 3).
>
> Some look down on us but there is mutual respect. Many want to work with traditional healers (THOSA, 1).
>
> They accord us respect now but it is quite recent. Especially white professors are interested in traditional healing (THOSA, 2).

Despite these negative perceptions many healers stressed that they feel competitive spirit between themselves and the western doctors.

4.6 Differences between traditional healing and western medicine

The obvious difference is that African traditional healing means restoration to health by traditional ways, and not by scientific methods.[15] Too many phenomena in the traditional practice are not subject to scientific investigation.[16]

Training of the traditional healer is very different from the training that western doctors receive. "Western doctors believe in the printed page that you must learn and understand. Traditional healers do not have a standardised training as in western medicine and they have to follow a call which is not a voluntary process".[17] "Becoming a traditional practitioner is not out of choice. It is out of a call, which, if not heeded, coercive measures get taken by ancestors".[18]

This important difference was mentioned by the interviewees: whereas western doctors choose their profession,

> with us you cannot choose, it happens (THOSA, 5, 6).
>
> Western doctors go to schools and traditional healers have visions through ancestors (THOSA, 2).

A traditional healer has to learn from an experienced healer. There are no written exams, the Principal Sangoma will send a proper Sangoma to check if the graduate is treating the people correctly. If the people are not happy with what has been done, they will ask the

[15] Speech by H. B. Zungu, president of THOSA, for Dr. Anne Wright
[16] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture
[17] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture
[18] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

Principal Sangoma to do the diagnosis (H. B. Zungu interview, May, 1994). Recognition of a traditional healer for membership of an association requires:

> We have a certain committee which checks people who are knowledgeable about healing, who can easily find out if a person is a real healer or a quack, especially H. B. Zungu. They are tested and have to throw bones. During discussion you can easily find out when somebody is not right (THOSA, 2).

According to the healers interviewed, western doctors approach the issue of healing very differently. They are in a hurry and they do not give the patient enough care and attention, the way the traditional healer does. Some thought that traditional healers carry out a more difficult task:

> Because there are diseases which are ancestrally caused. In western medicine there is no such thing (ANHA, 1).

Also, reference was made to using unscientific, unproved, traditional means:

> We use the old type of methods of healing, i.e. we throw bones and use techniques that are not scientifically proven. They use modern methods. We are still putting our medicines to the test (ANHA, 4).
>
> Western medicine is tested and traditional medicine is not (ANHA, 1).
>
> We as traditional healers use razor blades whereas western doctors don't (ANHA, 6).

Furthermore, it was stressed that the major difference lies in the diagnosing:

> A western doctor will ask you questions about yourself and start examining you. He gets the answers from you. We as traditional healers throw the bones and check what is wrong. Then you just verify with the patient (ANHA, 6).

Related to the issue of diagnosing is the different perception of diseases such as cancer and AIDS.

> There are certain diseases that we want to treat such as AIDS. Up to now we only treat each person for the complaint that he or she has but nobody has brought a patient and said he's got AIDS. So we may well have treated patients with AIDS and cancer but we don't diagnose it as such. We treat AIDS like other diseases - there is no western concept of a dormant virus. It is the same as cancer - we may call it something else (ANHA, 8).

There are parallels again with American Indian medical concepts. For example, Csordas (1989:463) explains that in the Navajo language (New Mexico) there has never been a large list of named diseases, but rather a series of connotatively overlapping ways of referring to and describing sickness and pain. Thus, there is no an immediate necessity for cancer to be distinguished as a discrete disease.

While these differences were mentioned, it was nevertheless clear that most traditional healers found it easier to relate to the "similarities". Through a demonstration of the similarities between the concepts of the two systems, we can establish an interpenetration between the "modern" and the "traditional". In so doing it emerges that there are strong differences in attitudes between the two organisations. ANHA is more absorbed into the hegemonic order, while THOSA represents an alternative culture by adhering to residual culture. THOSA takes tradition much more seriously.

4.7 Changes in and modernisation of practices

This section clarifies some of the differing attitudes of the two organisations. At ANHA, members were generally more "modernised", at THOSA more "traditional".

Traditional healers do not like the term "modern sector" when used to compare it to their sphere of influence because they say that traditional medicine has also kept up with modern aspects (Freeman interview, August, 1994). This is supported by the findings.

Healers use "modern" techniques For example, there is an increased support for the use of condoms and other hygienic measures as a result of an awareness of AIDS.[19]

> I use prepared medicine and I support contraceptives (ANHA, 7).
>
> Precautionary things like condoms are a good idea. I give them out to avoid STDs (THOSA, 1).
>
> Today we sterilise blades to prevent AIDS[20]. It is important to give primary health care and to give out condoms (THOSA, 3).

All this is an example of the incorporation of the dominant culture into the dominant one.

There are, however, other ways in which the practice of traditional healers have been "modernised". At times it is directly related to how their culture is being absorbed into the controlling one.

In the past there was a much stricter demarcation between the roles of the different types of healers i.e. Nyanga, Sangoma, Dreamer, Faith Healer/Diviner etc.

> The different categories of traditional healers were specialists in their fields and used to refer the patients to each other. But today that doesn't happen anymore. A Sangoma also takes on a healing role now, mainly because of the unemployment in this country and thus each wants to earn an income from healing and thus not refer patients to another type of healer (Mr. Mahlaba interview, June 1994).

In terms of training new healers, there has also been a change.

> For example, in the olden days, if a person was an apprentice, he was told that he must get up early in the morning, never mind when it is winter and then he must go and sweep the yard and go draw water from the well and things like that. Those things were the things of the past. We must correct those people and not do that because they charge money at the completion of the course from this person and that

[19] It is interesting to note that THOSA has a "corporate" T-shirt which bears the "DUREX" logo, possibly because the T-shirts were sponsored by them. I had the honour of receiving one as a gift.

[20] The issue of AIDS is still an ill-understood one. "Even as organisations we don't understand what AIDS is all about" (Mr. Mahlaba interview, June, 1994).

> money must be used for hiring people to take care of the house of the Principal Sangoma. (Interview with H. B. Zungu, July, 1994).

Another change is that healers are now interested in learning about symptoms of diseases treated in the clinics when they come together with nurses. Previously this exchange was limited or non-existent.

Some of the members, especially those practising in the rural areas, (and ANHA members) exhibited definite western tendencies. They give out numbers to the patients who are waiting to avoid quarrels over who came first, they do not request patients to take off their shoes before entering the "surgery" (unlike at H. B. Zungu's "surgery"), they sit across desks and on swivel chairs when consulting patients, they write sick notes on letter-headed papers, they keep a track of each patient's visit and they display considerable wealth as fruits of their labour (big houses, big cars, expensive clothes, luxury items like a cellular phone).

> I write things down, I don't make people take their shoes off. If I mix my experience with modern things, it's o.k. I mix modern and traditional. There are times when you concentrate on the traditional (powers from ancestors) and times when you mix the two (ANHA, 1).

In comparison with the older organisations, ANHA has more western characteristics.

> Those who started this thing want[ed] to be the kings and they want[ed] to tell us how to behave and what to do. The reality of the work is not produced. They [didn't] worry about writing, talking [to western people], they still ask 'why you talk to whites, what do they want to know, they want to take our own profession', you know, it is boring because it doesn't improve the image of traditional healing. They think that we are giving the ideas of Africa away (Mr. Mahlaba interview, July 1994).

Thus education, writing, reading and interacting with western doctors are all important changes in the practices of traditional healers.

> The difference is that of working with western doctors. The 'modernised' traditional doctors stand a chance to correct themselves and to go in a correct direction (ANHA, 4).
>
> Our parents never wrote things because they never went to school. Today we have labels for containers whereas before they knew by touching or tasting. But today we have to test and label medicines (ANHA, 5).
>
> We have moved away from the 'old traditional doctors' who believed more in dignity and respect. We buy medicines, we use different equipment now to pestle and mortar. Now there is more communication and sharing with others, there is reading of the latest journals. A modern healer needs to know what is happening on the other side (of the world). Reaching out to each other is what has changed most (ANHA, 3).

Compared to ANHA members, healers from THOSA were opposed to modernisation and more specifically to the mixing of modern and traditional medicines. Their adherence to traditional culture was much stronger.

> No, modernisation is not the way, we are not concerned with that. Not much has changed for me. I haven't diverted from the way I treat people. I concentrate on my old ways, they have paid dividends (THOSA, 4).
>
> Our culture does not allow [modernisation]. You can't follow the western way of healing. I know those who use primary health care and they are deterring from the traditional way of healing (THOSA, 7).
>
> During those past years, our old traditional healers did not have any knowledge of viruses. They used to concentrate on the ailment of the person and then rely on ancestors to help. Unlike today where you ask the patient to confirm treatment with western doctor (i.e. you now concentrate on the disease, not the person). Most of them, when diverting to the western way of healing, they realise that ancestors are no longer with them because they have deserted the ancestors. The western ways are not the ways to do things. Mixing with western medicine is not in our culture. There is nothing modern in our practice (THOSA, 8).

Opposition to modernisation is not only a matter of personal choice. Traditional healers, when acting as a spirit medium for the ancestors, are constrained by the latter from adopting western ways:

> I cannot just go to a western doctor and learn. First I must find out from my ancestors whether I can learn from western doctors. You cannot just do things on your own, without consulting your ancestors (OSA, 4).

Thus we conclude that traditional healers do not represent a homogenous group but that their attitudes towards western medicine and modernisation differ widely. (Western doctors are also seen as a differentiated group by these healers). Those who are more open to modernisation have accepted the hegemonic order. Those who are more closed to it have found a different way to live and they wish to be left alone with it. They do not openly wish to change society according to their residual culture. Recognition of this fact is one of the reasons given for healers' organisations. In the next section we look at interpenetration of modern and traditional world-views. Each sub-section discusses an area where it is meaningless to make rigid distinctions between the two modes of thinking. This will bear relevance on how we think about hegemony or incompatibility.

4.8 Interpenetration of "modern" and "traditional" systems and world views[21] as perceived by traditional healers

4.8.1 Similarities

It is argued that when comparing the two systems at a conceptual level, there are many similarities which manifest at the practical level:

> When a traditional healer does not have the answer to a particular problem, he/she will seek the vision by consulting with the Great Creator and Spirits of deceased relatives to find solutions. During this time the healer can see into the future. There is an opportunity for western people to share in the knowledge of traditional healing. So the regalia you sometimes see the traditional healer use in ceremonial rituals are not simple fetishes for magic, mumbo jumbo and trickery, they are actual physical

[21] Hammond-Tooke (1989:33) defines world view as all attempts to make intellectual sense of the world and of life, so that in the broadest sense it involves theories of explanation. It purports to explain or interpret, and this is frequently done by making use of symbolism. Whatever else a world view is, it is essentially a (cognitive) attempt to make sense of the world, and to impose meaning on it.

> and spiritual powers, "tools of trade" being employed in much the same way a modern physician uses a stethoscope, X-ray machine, ultra sound or lab tests. [22]

It is a useful comparison because in a way western doctors do use these "scientific" measures to see into the future so that they can predict what is going to happen and hence to prescribe the correct treatment.

Similarly:

> There are similarities between conventional medicine and traditional practice. Both need an aid in diagnosing a problem; traditional healers use bones and western doctors use stethoscopes and the like. While the conventional medical practitioner uses an injection to administer treatment, the traditional practitioner uses a razor blade - both being instruments which are used on the body. [23]

From this same source other parallels are evident:

> There are certain aspects of western medicine and the western way of teaching which applies to traditional healing. Firstly, traditional healing is systematic because before treatment can be prescribed, the problem has to be diagnosed first and the treatment has to be tested first for its appropriateness. Secondly, whereas before traditional practitioners have been practising without the knowledge of anatomy and physiology, there is now a general feeling among traditional practitioners that human anatomy and physiology would be relevant subjects. Thirdly, although it is not a prerequisite to have an academic background for becoming trained as a traditional practitioner, it has been found that trainees who have been to school learn quicker.[24]

From the healers themselves it appeared that the similarities are more prominent than the differences. But these were seen to be related to the common aim of both and not to the similar concepts. This is in line with Haram's findings (1991:174) that the Tswana healer addresses the "clinic people" (i.e. western doctors) by emphasising the more superficial similarities between the two cultures: "Whereas you are having your medicine, we have

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[22] Speech by H. B. Zungu, delivered at the Wits Business School to the Graduate School of Public Development Management, about traditional healers and their services and roles

[23] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

[24] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

our specialities, and both of us are dealing with health and illness; hence we are all doctors" (ibid.). Similarly, the healers in this research addressed the similarities between western medicine and traditional healing at the same superficial level:

> The two are more or less the same - we both see to it that people are healed (THOSA, 1).
>
> The final aim is to heal people so we are together somehow (ANHA, 7).
>
> All what we both are striving for is to cure people (THOSA, 7, 8).

The end is thus the same, it is the means which differs.

> We differ in style, not content (ANHA, 3).

But even some of the means are the same -

> If a person has broken joints or bones, we use "mhlabelo" which is just like a cast (THOSA, 4).

While the methods are different, stress is laid on the fact that they are curing the same *person*.

> We will heal differently with different medicines but we are healing the very same person [as western doctors do] (ANHA, 4).

Thus, whereas western medicine would categorise the same diseases and symptoms within its domain, the holistic approach of traditional healers becomes apparent when we consider that they treat the *person* rather than the *disease*.

4.8.2 Patient's choice of doctor

The assumption that in African thought there are no alternatives to established theoretical tenets and therefore no choices (Horton, 1967) leads us to an important question: To what extent is the belief in African medicine contingent on the availability of choices?

It is often argued that African patients consult traditional healers because other forms of health care are not available to them. Millions of African people rely on traditional practitioners, for choice or from lack of alternatives (Fyfe, 1986:1). Kimani (1981:334) found that in urban Kenya the availability and accessibility of modern health care does not influence the user's patterns of utilisation of traditional services. Similar research findings are reported in Ghana (Jaiyeoba, 198.180). Patients tend to go back and forth between cosmopolitan and traditional healers (Heggenhougen, in Oyebola, 1981:98).

The present research found that choice is not dependent on alternatives and that it is not so much a cultural decision as a personal one:

> They are eager to get cured more than anything else. People go to both. First, they believe in getting cured (ANHA, 3).
>
> They don't come to us because they have no alternatives. We share the work with western doctors (THOSA, 5, 6).
>
> It is an open choice and not dependent on alternatives (ANHA, 7).
>
> They believe it regardless, otherwise they would not visit healers in urban areas (THOSA, 2).

This is similar to what Kimani (1981:335) found in Kenya: rural traditional medicine among the Kikuyu appears to be in the process of decay, while it is thriving in the urban centres such as Nairobi. This would lead us to conclude that patients do not go to traditional doctors because they have no choice but because the traditional doctors can truly alleviate their problems.

Some of the healers did think that it is a culturally influenced choice rather than a purely personal one:

> 80% visit a traditional healer because of their culture, it is a way of living (THOSA, 1).

> The difference is the cultural background (ANHA, 6).

Only one person mentioned that in the townships people believe more in western doctors than in the rural areas where they believe more in traditional healers (ANHA, 6). I asked this person whether this is not because in the rural areas there are not so many clinics or because people have less access to them. She said no, clinics are also there but those people naturally believe in traditional healers. One possible explanation is that there is a stronger cultural influence from families, more witchcraft, more interaction between those who get healed by traditional healers and new patients, more spread of success of traditional doctors and maybe a stronger adherence to certain ethics, like no sexual harassment, than in urban areas, more respectable traditional healers because they can't get away with dishonourable conduct as easily as their urban counterparts. In the rural areas there is less influence of the dominant culture. It could be argued that it is not a lack of alternatives which keeps a belief system going. It is precisely these available alternatives which give rise to the potential eruption of counter hegemonies, diffused by agents such as education. In this case the choice of belief is a result of social enforcement. This is why the new generation, growing up in urban areas, has a different view:

> The African people believe in the culture. The new generation believes in the western things because education does not talk about traditional things and traditional medicine (ANHA, 1).

Farrand (1984:780) found that patients in South Africa choose their healers according to the diseases they have. Illness is seen to fall into two categories - some can only be treated by western doctors, others are only treatable by indigenous healers. However, there was

little agreement as to which illnesses fall into which categories.[25] This research supported this - it was clear that patients consult different types of practitioners.

> You can say that such and such a disease can be helped by a white person or a black person. The diseases are the same. The difference is the cultural background (ANHA, 6).

However, the consultation of both kinds of practitioners was not only the result of the different types of diseases needing different practitioners but also of the incomplete cure offered by the western doctors.

> Even if they go to a western doctor they feel that it is not enough and they go to a traditional healer (THOSA, 1).

But this works the other way around too:

> If we can't help a person we send him or her to a western doctor (THOSA, 5, 6).

Some believe that the patient first goes to the traditional healer and only after his or her treatment fails, does the patient go to ospital (Hennig, 1992:41). But the research found that either type of healer could be consulted first.

> They go to a traditional healer before or after they have been to a western doctor (ANHA, 3).

What emerges from this is that there is no clear distinction in the minds of the patients as to what is supposed to be "traditional" and what is "modern". They combine the use of both health care systems without any problems and the healers do not find this surprising, it means that "African traditional thought" is interpenetrating western thought and thereby extending its hegemony.

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[25]Usually it is agreed that diseases such as TB and flu are best treated by a western doctor whereas mental and ancestrally caused diseases can be treated only by a traditional healer. (See also Ballay, 1986:291). But it was most insulting to ask if there is a difference between a 'white man's' disease and a 'black man's'.

4.8.3 Faith

> For those who have faith in [the medicines], they can be profoundly supportive (Maclean, 1986:10).

This brings us to an important point: to what extent is the success of traditional healing dependent on the faith of the patient? Joyce (in Welbourn, 1969:18) has shown that the belief of both doctor and patient are active agents in successful treatment. Many authors support this view (Lantum, in Bannerman, 1982:17, Steiger, 1984:196). However, it became evident from the interviews that a distinction has to be made between faith in the healer and faith in the ancestral beliefs. As to the former, the healers most commonly agreed that faith was necessary.

> The patient must believe (ANHA, 1, 6).

> Yes, you as the patient have to believe in this traditional healing for it to work, you have to believe in the treatment in order for it to work (THOSA, 5, 6).

However, this was not regarded as something peculiar to traditional ways of healing. The fact that a patient will seek the help of any medical practitioner (whether western or traditional) shows that the patient has some faith in him or her.

> You are putting the healer to the test, just like with a western doctor (THOSA, 8).

> You only go to a person when you have faith in that person, regardless whether he or she is a traditional healer or a western doctor (THOSA, 8).

> The patient must believe in the doctor, like our own western doctors (Graham interview, August, 1994).

> To some degree in *all* psychoanalytic treatment consists in the patient's positive expectations, in his trust in the healing power of the procedure and that of the therapist (Rappaport, 1981:777).[26]

> Charisma is important in *all* kinds of medicine (Last, 1992:404). (Emphasis added).

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[26]There is much support for this phenomenon, for example, Capra says that the patient's psychological response to the physician is an important part, perhaps the most important part, of every therapy (Capra, 1983:141). "Some doctors seem to make people well, while others, regardless of their expertise, have high rates of complications. The art of healing cannot be quantified: (in Capra, *ibid.*).

However, faith in the ancestral beliefs is not necessary for the cure to be effective. It is the ancestors of the healer and *his* or *her* belief in them that counts.

> Faith is not the main thing. I can do the healing because I talk to my ancestors to assist me (THOSA, 7).
>
> You can be cured even if you don't have complete faith because the ancestors have power to give to the healers (THOSA, 8).
>
> The ancestors give me power so I can solve problems for people from another culture (ANHA, 1).

Therefore, the concept of faith is not only relevant in traditional healing but in any form of patient-doctor interaction. Another example of how ordinary concepts in the western medical language are similar to those used in traditional healing becomes evident when we deconstruct some of the language barriers:

4.8.4 Language

It has been proposed that since traditional healing is outside of the language of science, the fault is not with the reality of traditional healing but with the language.[27] (See section 3.3 in chapter 3). In studying traditional healing a prime necessity is to penetrate and translate the symbolic and metaphoric language in which statements about traditional healing are made in African society (Willis, 1969:7).

For example, the mind-body dichotomy cannot be inferred from the language these healers use. But this does not mean that there is no such distinction. What seems to resemble the western distinction between the physical and the mental is the notion of

[27] That is why the problem with interacting with western doctors is due to a lack of understanding of the language. In meetings with western doctors, some of these healers do not know what is going on because they do not understand the language, so they start to feel uncomfortable and reluctant to meet them again. (H. B. Zungu interview, July 1994.)

"inside" and "outside". So something that is "outside" pertains to the physical body while something that is "inside" is more related to the mind.

> From the bones I can tell that a person is healthy on the outside but still has a problem, for example an emotional one, like a broken love affair (ANHA, 6).

But these concepts of "inside" and "outside" must not be spatially understood as belonging to either the mind or the body. What is *inside* the physical body can still be a "physical" problem. For example, diseases that western medicine would term as "physical" as opposed to "psychological", for example cancer, is, in traditional medicine, an "outside" disease in the sense that even though it may be inside the body as such, it can be treated with herbs once it is brought to the outside using special methods.

> Some healers are good at dealing with cancer. They use substances when it is inside to get it onto the surface and then they can cure you (THOSA, 2).

This demonstrates that it is the language and not the concepts themselves that differentiates the two systems and that therefore, what appears to be a difference, is actually a similarity.

The reason traditional medicine does not have a coherent theory is that it does not have a unified language, an agreed medical vocabulary both among the patients and the practitioners (Last, 1992:399). A large proportion of medical words have no standard meaning. This is why one respondent pointed out that in traditional society everyone does their own thing, nothing binds people, apart from their ancestors.

> It is unconventional and has no system. Western, by contrast, implies systematising the practice, make it universal (ANHA, 2).

Again, the main point of departure is that traditional healing concentrates on the person and thus it cannot systematise because people are not uniform. Western medicine concentrates on the disease and by grouping different symptoms together, it can devise a uniform language system for standardising the practice. But this does not necessarily imply that western medicine is better at healing, quite to the contrary: By standardising the practice, there is no scope for analysing the social factors of individuals and the result is control and not healing.

One reason why there is such a great deal of separation between western medicine and traditional healing is that, as explained in the literature review in chapter 3, there exists a false dichotomy between "traditional" and "scientific" and between the "natural" and the "supernatural".

5.8.5 The problems with dichotomies

It is a misleading step to dichotomise traditional thought and western science because the two do not exist in a mutually exclusive way. For example, the Tswana healer has worked under the impact of western medicine for more than a century (Haram, 1991:171).[29] This research shows that even though many healers perceive tradition as something cultural and from the past, this did not mean that their practice as traditional healers did not evolve along "modern" lines. We have seen in section 4.7 how the modernisation of traditional healers is manifested in their practice.

Huizer (1987:430) agrees that especially from the way Third World people are reacting to their worsening conditions, it is clear that the real dilemma is not the choice between 'wholeness' and science, between spiritual and material forces, or spiritualism and

[29]This is reflected in the expansion of the Tswana set of divining bones which started out as 4 basic ones to represent senior male, junior male, senior female and junior female. As the universe of meaning and causality changed under the impact of colonialism, the set was greatly enlarged to include bones for "non-Tswana blacks", "whites", and "God". As a result it made possible and increasing ray of diagnoses and explanations for affliction (Reyneke in Comaroff and Comaroff, 1991:157). Thus tradition, culture and world views are dynamic concepts, changing and adapting to new circumstances.

materialism or even a combination of these. Either of these can have effects favourable or unfavourable to human well-being. While some forms of spiritualism and spiritual healing have emancipatory effects particularly for the poor, others, which remain merely folkloristic, can foster submission to dominating and repressive power structures (ibid.).

From this research it emerged that respondents found this distinction between the supernatural and the scientific difficult to conceptualise. Perhaps the question was not designed properly because it tried to elicit a response concerning the difference between the "supernatural" and the "scientific" as opposed to the "supernatural" and the "natural". Many healers did not understand what I meant. But on further prompting and explaining, many were able to put things into perspective. "Science" was identified with the physical plant, and the "supernatural" with God. The intervening variable was the ancestors and thus the healer, through his or her connection with them.

Most healers agreed that the two were together, not separate.

> White people believe in the separation of the body and the spirit but this is a misunderstanding. They say that two must be separate, but they are connected, i.e. the supernatural and the scientific. Here, due to supernatural powers, science works. The supernatural are things you can't believe but they are there (ANHA, 4).

This is exactly what Ross and Welbourn (1969:28) meant when referring to the way in which African people connect the two under the general category of the social.

> Yes, there is a connection between the supernatural and the real, physical herbs because the ancestors will tell you to use a certain herb and then it will work (THOSA, 5, 6).

> It is a combined process. God is supernatural and has given powers to ancestors (ANHA, 3).

Subsequently, the ancestors give power to the healer to make the plant work in healing patients.

> The plants have supernatural qualities in the sense that they were created by God. Plants have natural curative properties but because you have supernatural powers, they go together. The ancestors show you what to do (ANHA, 6).

> s, they do have connections because the spiritual powers guide you to take certain medicines which is going to heal a patient. The herbs have spiritual powers (THOSA, 3).

Here again, the "natural", i.e. the plants and the medicines are directly connected to the "supernatural", i.e. the spirits. There is an interdependence between the living (the real) and the dead (the ancestors and spirits) (Hennig, 1992:40).

Another way in which the interpretation of the interviewees highlights this connection is their understanding of why the bones are right, why it is not a coincidence:

> Because it is from the ancestors. At night they say different people will come. The bones are there to satisfy the people but we get calls at night. When you throw the bones, the ancestors come to you to solve the problems (ANHA, 1).

> The bones are right. If I go according to what they have diagnosed, the person gets cured so that is why it is not a coincidence (ANHA, 7).

> If I can teach someone, they are not a coincidence. It's like when you read a letter, how can they be wrong when I teach them the correct way. We put the bones to the test. I have heard many people ask this question and they talk of taking a chance, of a coincidence but when people are healed, they say nothing (ANHA, 4).

The bones serve to confirm for the patient what the healer already knows. It is important to realise that the healer has not chosen his or her profession, it is a calling and hence he or she is a medium through which spiritual and psychic powers operate:

> When you throw the bones you correlate what you read to your visions. I can tell you a story without bones. Before we throw bones we already know what you are suffering from. The bones confirm it to the patient (THOSA, 1).

> When you throw the bones the ancestors talk through you, it is not you, so it is right. You have to convince the patient, to make him understand the situation. The bones will direct you in diagnosis (THOSA, 3).

> The bones are in me. I have been trained. They point out what a person is suffering from. I can compare the throwing of the bones and reading them to your writing

> skills. You have been trained to write, you have been through it and you can read what you have written to me and others and we have to listen, we can't read it ourselves (ANHA, 6).

What emerges from this is that the diagnosis from the bones is a process which is guided by the ancestors. The treatment will then work, so it can't be a coincidence. Again, the ancestors are the intervening factor between the "supernatural" (bone pattern) and the "natural" (patient is cured). By comparing it to a tangible skill, writing, the "supernatural" element is completely eliminated and throwing and reading the bones is as "natural" for them as it is for me to write this report. There is nothing "mystical" about it, although it requires rigorous training and practice. Therefore it would be incorrect to assume that traditional healing is mysterious or supernatural because in the minds of the healers their skill and profession is as much part of the natural order of things as the skills and profession of a western doctor.

A further example of the interpenetration of western and traditional thought is the way in which the healers saw western doctors receive a call to become doctors:

> They do have callings but they don't use it because of their culture (THOSA, 3).
>
> Nobody has no calling" (THOSA, 4).
>
> This gift does not only belong to African people. Maybe [the western doctors] are not following it up. I wouldn't say that they don't have a call. The talent might have escaped you by not having followed it up. Each of us has an assignment from God and you choose whether you follow it or not (ANHA, 3).
>
> [Western people do not have a calling to become healers] because they had to cut it off with the event of writing and literacy. They started to pass on knowledge from generation to generation through writing, so they got away from the spiritual side of things. Writing took the place of verbal communication. But for me it is the same thing, it is working both ways (ANHA, 2).

This again shows that the dichotomy between traditional and western thought is problematic if we consider how the healers themselves perceive these issues. The dilemma which arises out of this interpenetration leads to a serious concern: Are we to evolve a

new theoretical language transcending what is acceptable in our traditional thought categories, as the physicists have learned to live with the idea of energy combining properties of wave and particle? Or do we simply accept the coexistence of incompatible world views and, basing ourselves solidly on scientific empiricism, carry on gathering as much data as we can while suspending judgement on their significance? (Willis, 1969:1). My suggestion is to evolve a new theoretical language that incorporates the two. This is shared by Aakster (1966:272), saying that we need to redefine concepts like health, disease, diagnosis, cure, in order to build up a new health system. "This requires that we redefine reality".

4.9 Conclusion

Historically, Christianity, "civilisation" and politics have split African people apart. Those African people who are opposed to the ideas of traditional healing are engulfed by the dominant, hegemonic culture. Consequently they have to treat those remaining in the residual, more traditional culture, as the "other". They look down on them and ridicule their practice as "backward". However, those African people who reject traditional healing exhibit signs of confusion because at night they still come to see traditional healers. Therefore they have not completely rejected their own culture.

Christianity also has a political mission which is responsible for many African people having abandoned their culture to follow the white "civilised" culture. This has led to a state of confusion because the idealist theories of the dominant culture have failed the "modern man". The westernised people are seen to limit the eruption of an alternative awareness, that of traditional healing, so that the dominant culture may flourish. Historically, traditional healing received a bad name because of the selectivity of hegemonic society: they chose to emphasise only those negative aspects which, when taken out of context, would confirm the negative perceptions of members of the dominant culture.

This chapter established how the healers themselves would take issue with these historical legacies and what their world-views were so that conclusions could be drawn about the relationship between modernity and traditionalism, as exemplified by the healers' attitudes towards western medicine and traditional healing. For example, the concepts of tradition, health and illness were difficult for these healers to define because they did not have ready-made theories in which to place these concepts. What was clear, however, is that they were keenly interested to learn from western doctors without giving up their own notions of truth. There was little difficulty in the minds of traditional healers when relating their profession to that of western medicine mainly because they do not have preconceived ideas or a structured set of concepts. They want to get on with the practicalities of healing.

The two organisations differed, however, in terms of degrees of modernisation and acceptance of modern methods of healing. At THOSA, members adhered more strictly to tradition than at ANHA.

The healers' holistic world-views allow for much more interpenetration of the "modern" and the "traditional" than conventional notions would allow so that notions of what is traditional are not diametrically opposed to modern ideas. There is much overlap between the two which is exemplified by the similarities between the two, how patients choose their doctors (healers and western doctors), how faith is necessary in both systems of healing, how language can deconstruct some of the apparent differences, and how dichotomies such as natural/supernatural, real/mystical and choice/calling seem problematical in the minds of these healers.

In the next chapter we examine some reasons for traditional healers' organisations. Such organisations are a direct consequence of the interpenetration of traditional and modern world-views and practices - which is why the concept of organising (in the western, "rational" sense) is in no way contradictory to "traditional" practices such as healing.

Chapter 5 - Organisations

5.1 Introduction

Against this background then, it will become apparent why traditional healers organise, what problems they encounter as organisations and what their attitudes are towards integration with western medicine. As a result of the interpenetration of "modern" and "traditional" world views and practices, the idea of organising, which is a western concept, is not a new one and neither is it incompatible with traditional healing. In addition, traditional healers respect the western ways of doing things so that organising is very much within the boundaries of their attitudes, world views and practices.

In this chapter we present the reasons given for organising and see that these reasons and objectives are a strong unifying factor for traditional healers. After exposing some of the problems of the organisations, it will become clear that there are common problems that face all new groups. The two organisations - THOSA and ANHA - are then compared and certain differences presented. However, their common goal seems to override such differences. Finally, the important issue of integration and co-operation is discussed. In conclusion we attempt to answer the significant question: Are the two systems complementary and is it possible or desirable to integrate them?

5.2 Reasons for organising

Historically, because the missionaries suppressed traditional healing and jailed healers and because they could not differentiate between traditional healing and witchcraft, traditional healers, from as early as the 18th century, organised themselves into small associations. "Prior to 1890 they organised themselves into associations to *resist* injustices meted on

them"[1] (emphasis added). Today, the resistance goes on. Traditional healers organise because they want to get government recognition for their practices and to clear up the old confusion between traditional healing and witchcraft.

> It is imperative to join an organisation so that legislation is given so that we can work freely (THOSA, 1).

Some argue that witchcraft has been oppressed, not because of its own effect but because it was a means to express popular resistance to political oppression and inhumane conditions (Huizer, 1987:422). In other words, the dominant culture wanted to weed out resistance from these healers, which is why the latter organise:

> To get over the old days of being called witch doctors, to be recognised by the government, to have code of ethics, to identify common interests, to talk as one voice to the government (ANHA, 4).

> We don't want to be classified like in the olden days (THOSA, 5, 6).

Traditional healers saw then, as they do now, that living in a western-influenced world means that western types of means have to be employed to reach certain ends. For this reason, they look at how and why western medicine and other western interest groups organise themselves. What emerges is a need to bring interested parties under one umbrella body and thus to anchor traditional healing to a professional ground and to avoid doing things unsystematically. In so doing, the public acknowledgement of their social status and the protection of the public is ensured.

> It is important to join to have code of conduct of healers. Medical Aid can be facilitated, it enables you to work the right way. It is easy to pick up on quacks (THOSA, 2).

> When you are curing people, you feel that you need to belong somewhere (ANHA, 7).

[1] Overview of NASCOTH, by H. B. Zungu, about the history of traditional healers' organisations and practices

> When you work alone, you don't have that much power. You need to co-operate and communicate with other organisations It is necessary to share information, secrets, knowledge (ANHA, 3).
>
> We don't want to do things at random: (THOSA, 1, 2)

All these findings confirm those of Green (1988:1126) that healers (in Swaziland) who belong to associations are especially interested in learning more about modern health care, they want to work in co-operation with the modern sector and they want to change the popular image of traditional healers as "primitive witch doctors" so that they can become respected by government officials. They organise because they want to share their healing knowledge, learn from one another and increase co-operation among themselves (ibid.).

An example of an attempt to unite all healers under one umbrella body is NASCOTH (National Steering Committee of Traditional Healers) which was constituted Pretoria in May 1993. This document details the criteria for the registration with NASCOTH, the regulation of traditional healers, the objectives of NASCOTH, disciplinary inquiries and offences, penalties and other judicial matters. It appears that this is the first known attempt in South Africa to form a single body or council which will regulate all traditional healers and their associations, comparable to that of the SAMDC and MASA. The objectives of NASCOTH are summarised as follows:

1. To assist in the promotion of the health of the population of the Republic.
2. To control the practice of traditional healers and to investigate in accordance with the provisions of this ACT complaints relating to the affairs of traditional healers.
3. To control the registration of persons considered traditional healers and to set standards for the training of intending traditional healers; and
4. To advise the minister on any matter relating to traditional healers[2]

Aspirant members who are illiterate or are not South African citizens shall not be appointed as members of the council. Meetings shall take place at least once a year and "all acts, matters or things authorised or required to be done by the council shall be

[2] Discussion Document regarding Regulation of Traditional Healers, NASCOTH

decided by a majority vote at a meeting of the council at which a quorum (six members form a quorum) is present.[3]

Out of the central motive of gaining government recognition and forming an umbrella body for all healers, others arise. These include the sharing of ideas, associating with professional bodies such as universities and research institutes, creation of unity, the controlling of quacks[4], creating a workers benefit scheme[5] parallel to Medical Aid, collective wisdom, ethics and qualifications, to pass on knowledge to future generations, i.e. to invest in the future, to record things in writing.

Extracts from content analyses and from interviews with the leaders of the two organisations will illustrate the reasons for the organisation of traditional healers: "Traditional doctors have over the years been trying to come together and have one governing body that would set standards of qualification and code of ethics to give the practice a professional image and to protect the public at large".[6] This is identical to Oyebola's findings (1981:92) that herbalists in Nigeria, like the western-trained doctors, have tried to protect the interest of society they serve by having ethics that bind the practice of their profession. Here is a summary of the objectives of ANHA:

1. To obtain recognition from the South African government.

[3] Discussion Document regarding Regulation of Traditional Healers, NASCOTH

[4] Being a genuine healer seemingly equips one with the qualities needed to single out such people. We have seen in Chapter 4 that at THOSA there is an ethics committee which is in a strong position to block such individuals from joining their association. But it is up to the community, i.e. the clientele, to make life for such people difficult because the word will spread that such and such a person is no good, he is only after the money, etc., and then, by word of mouth, the message will be to avoid such charlatans.

[5] To make this scheme viable, there are at least 4 criteria that will legitimise a traditional healer to practice:

1. He must use herbs and not witchcraft and sorcery as medicine.
2. He must have a consultation room and not store the medicines under his bed for example.
3. He must observe a certain standard of hygiene.
4. He must have a good reputation in the community itself, because we don't put up notices on the doors. People must speak about this traditional healer (e.g. on the public transportation networks). If he is famous, the members of the public will tell us about that. (Zungu interview May, 1994).

[6] Overview of ANHA, by S. Mahlaba, about the organisation - strengths and weaknesses, members' benefits and objectives

2. To obtain recognition from the SAMDC and other relevant associations of Southern Africa and WHO in order to ensure future understanding and mutual co-operation.
3. To set the standards of registration as traditional doctors and issue certificates of qualification and practice.
4. To obtain recognition from medical aid societies in order for patients to be reimbursed for treatment and prescribed medicinal products by traditional doctors. Also to obtain recognition from employers and employer associations by accepting sick notes issued by traditional doctors who satisfy clause 3 mentioned above.
5. To improve the standard of qualification of traditional doctors through continued training.
6. To improve the efficiency of consultation, diagnosing and treatment by continuous communication of latest medicinal practice.
7. To ensure that proper standards and ethics are adhered to.
8. To ensure that medical products available for use by traditional doctors are of a high standard and carry the mark of the ANHA.
9. To provide advice.
10. To improve the standing and recognition of traditional doctors in all communities.[7]

This includes all the objectives of traditional healers' organisations that are perceived by the ANC:

- Formal and legal recognition for the profession (using a referral system, to overcome discrimination
- Promote traditional medicine by overcoming old attitudes to witch doctors
- Finance (But the ANC has other priorities, such as free care for children under 6 and no financial support will be given to traditional healers), (Freeman interview, August, 1994).

The following shows why it is necessary to have an association:

> The need for an association lies in the passing down of knowledge, to look after the future, to make sure that the families of the members are all right should something happen to the member. If a very powerful healer dies, all the knowledge dies with him, at least, this is what happened in the past. That is wrong and that is why we must have an association. We should take an example of whites who invest in human resources and pool their knowledge for the benefit of their children and others

[7] Overview of ANHA, by S. Mahlaba, about the organisation - strengths and weaknesses, members' benefits and objectives

> in the profession. It makes us all weak if we don't get together and share our knowledge. It is for collective bargaining of knowledge and to share information. The past has been bad. Associations formed after associations but there was no tangible benefit, no delivery. Our forefathers were in the limelight but when they died they left nothing. This is the world of education, we don't need to be secretive any more. So we found this association to come together and share the knowledge, to deliver the goods to the people. We can't do this in isolation. We need all people together (Mr. Mahlaba interview, September 1994)

Some members joined because they wanted to feel "secure" and "protected" and to be informed (THOSA, 7) and to avoid doing things at random. This latter reason is a sign of adapting western type rationalism. Others joined because their "mentor" joined and because they felt that they must follow that senior's path. Thus, the members' motives for organising were to be incorporated into the dominant paradigm and not to oppose it. Hence:

> Our disadvantage is that if we don't become scientists in our own field, we will never be able to protect even our own medicines (ANTIA, 2)

Thus it is the healers who have to prove themselves in the language of the dominant paradigm, never the reverse (western medicine subjecting itself to holistic principles).

Because traditional healers look to the west for organisational examples and because they admire and respect western doctors, they are not organising to resist western medicine. Freeman (August interview, 1994) agrees that even though there is a problem with incorporating traditional healers into a system that is dominated by western medicine, traditional healers are not concerned with challenging western medicine through their organisations because they realise that western medicine is an alternative form of health care and that people should have the right to choose.

It is clear that even though it is recognised that historically traditional healers' associations formed to resist the injustices of the colonial government, there is no direct relationship

between the need to organise and the rejection of western medicine.[8] This is because western medicine and white colonialism are not necessarily in direct relationship. Indirectly, however, we can say that in their need to affirm their identity in opposition to witch doctors, traditional healers organise in an attempt to gain recognition for their services and in order to clear up the old (but still existing) confusion between witches and healers. The two were in the past regarded as one but in reality the "concepts of shaman [and therefore witchcraft] is associated with sorcery which is diametrically opposed to that of the traditional healer".[9] Oyebola's findings (1981:103) confirm this "indirect" resistance to western medicine on behalf of healers in Nigeria as they have seized every available opportunity to convince western-trained doctors and relevant government functionaries of the efficacy of their treatment and the need to afford them official recognition.

5.3 Problems with organising

5.3.1 General

In his overview of ANHA, Mr. Mahlaba sums up the weaknesses of the organisation:

1. High level of ignorance
2. High illiteracy rate
3. Insufficient research [Yoruba herbalists have called for the establishment of a herbal research unit (Heggenhougen, in Oyebola, 1981:98). This is similar to ANHA's attempt to collaborate with initiatives such as TRAMED[10]].
4. Lack of funds

[8] We have seen in Chapter 4 that traditional healers did not think of western medicine as hegemonic. Even though they recognise that western doctors look down on them, this is not the main reason for organising and they did not counterpoise their own hegemony.

[9] Speech by H. B. Zungu, delivered at the Wits Business School to the Graduate School of Public Development Management, about traditional healers and their services and roles

[10] TRAMED stands for Traditional Medicines Programme for South Africa and it is an attempt by the Department of Pharmacology at the Medical School of the University of Cape Town (UCT) to investigate traditional herbs for their pharmacological activities.

Additionally, one of the perceived "threats" is the existence of numerous associations claiming to represent traditional doctors.[11] In this context, some members mentioned that the problem with other associations is the following:

> Some are led by people who haven't even passed as a traditional healer. Some choose leaders by virtue of wealth, some don't know what a constitution is, what a set of code of ethics is. Here, at ANHA, most people are learned, they are somewhere, they have passed Std. 6 at least (ANHA, 4).

5.3.2 Individualism and Power seeking

The problems traditional healers experience in their organisational attempts have been highlighted in chapter 3. This research confirms that the main problem here is the seeking of power by individuals, and thereby ignoring the collective motive for organising:

> Well, in organisation, we can put it this way, especially the black people have not understood properly what is going on. It is very difficult to have the unification of the traditional healers, it takes some time. Because even if you talk of unification there is, we can say, power hunger. Some of the people think that if they come and join under one organisation, they are going to lose their position because in their association they become president, when they come to this controlling body, they may lose that because they become ordinary members or because they won't be elected in those positions. That is why it is very difficult to have the unification of the traditional healers. (H. B. Zungu interview, July 1994).

It is worth noting that this power struggle has been singled out as the only real problem. The beliefs are not a problem because the healers' religion is the same, they believe in the creator and their ancestors, that they have to get powers from those bodies. "It is power struggle only, nothing else". (Ibid.)

Some of the members expressed similar concerns when considering the unification of all healers:

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[11] Overview of ANHA, by S. Mahlaba, about the organisation - strengths and weaknesses, members' benefits and objectives

> There are those who think they will lose power if they affiliate to one body (THOSA, 2).
>
> It would be a good thing but I don't think it is possible. It is like ANC and PAC. They all want their own power (THOSA, 3).
>
> There are problems of power play and of 'who is who' (THOSA, 4).
>
> The problem is that everyone will want to bulldoze over the whole set up, wanting to have their own way (THOSA, 5, 6).
>
> The problem is that all of us want to be chiefs, each would seek their own power. They all want to go to Cape Town, even those who have no qualifications to be in Parliament (ANHA, 7).

The problem is that whenever an organisation gets established, individual financial motives supersede the initial motivations. As a result of this research I experienced an example of this where a particular members used the association for personal advantage:

> People like X don't think of future of knowledge but of the future of their own material things. They join to get certificates and cards so that the police and the chiefs don't hassle them but they don't even pay for the certificates. They don't regard the association as fulfilling a collective role to ensure that future generations can benefit from the knowledge of today but they use it for their own selfish and material benefits. They don't know what an institution is, they feel threatened, they don't understand that we mean well (Mr. Mahlaba interview, September, 1994).

5.3.3 Standardisation and unity

The problem of unification of all healers encompasses other dimensions too. This can be traced to the way in which communication networks are established among traditional healers. There is a problem of unification because of the differences in ancestral callings, where there is no standardisation, and as a result there are many personal differences.

The example of NASCOTH illustrates this problem. For example, a traditional healer is defined as "a person trained or qualified as a traditional healer in a African context". It is apparent that this definition is fraught with difficulty because there is no tangible, unified or standardised way of training a traditional healer and therefore of testing his or her skills. However, this council could appoint senior traditional healers who would be in a position to decide on such.

One of the members at ANHA thought that the unification of all healers will be difficult.

> The problem is that we as traditional healers must learn how to do administration, how to draw up laws for traditional healers, to follow codes of ethics so that traditional doctors are recognised. We must know exactly what it means to have a standardised qualification, like your Master's degree - you are on the same standard as all other Masters students. There must be standardisation of traditional healing (ANHA, 4).

The ANC also sees problems of unification:

> Lack of unity (different organisations want different things) is a big problem. The disagreement may be about small issues such as who will control traditional medicine, how people will be elected, who will be recognised as a traditional healer, how new healers should be tested - science for herbs but not for those involving their ancestors, whether or not to include non-South African citizens (Freeman interview, August, 1994).

5.3.4 The government

Some of these problems can be linked to political issues. There are organisations which have had political and/or military motives. Those particular organisations that have supported the ANC are enjoying a situation whereby the ANC has been particularly receptive to them (Freeman interview, August, 1994). However, the leader of THOSA was rather skeptical about what political parties can do for such associations:

> [Associations that have political affiliations] were taken up by this political wave which is the promise that political organisations can do a lot for them, which they cannot. So instead of coming together to sort things out among themselves, they now

> put all their hopes to these political organisations. They are now expecting the goods to be delivered. When they find out that they can't deliver the goods, because prior to the elections, some were told that they must follow them, some voted for them, as a result, thinking that they are going to do something. The declaration has been made. Now in order to take control, these people must be initiating something. The political parties all know that it must come out of the circle of the traditional healers themselves, how they want to be governed by this council of traditional healers (H. B. Zungu interview, May, 1994)

The leader of the other organisation, ANHA, agrees that traditional healers should not expect political parties to deliver the goods, not only because they won't do this, but also because it would mean that traditional healers are once again told what to do:

> With the coming of the new government somebody has to take the initiative and if the healers can't organise they will end up having to subject themselves to a central control and we will be back at the times when the previous government was in power where traditional healers had no say (Mr. Mahlaba interview, June, 1994).

There is also the perception that if all healers came together under one umbrella body, the government would be threatened by this:

> We would really appreciate [the formation of an umbrella body] but it's something that won't happen, like in politics and church, everywhere. You need to have people to differ with what you are doing, among your own practices, in order to strengthen thinking because if we are all one thing, there is the potential danger to the government. I don't think that the government would like to see a large group coming together. They want to deal with this issue at a provincial level, they don't want this whole thing to become too strong. But we would like to become one large body (Mr. Mahlaba interview, August, 1994).

An example of how the formation of the new government hinders progress for the organisation of traditional healers is that of the breaking up of NASCOTH. The reasons for this break up are not entirely clear but they have something to do with the formation of the new government and the consequential loss in comparative relevance of the healers' interests:

> NASCOTH is an example of people fearing to lose power when a statuary body for all traditional healers is formed. It was abandoned because when the new

> government took over they felt that we should start all over. They haven't brought us together. They are trying to organise the regions - but we are not happy with that because it demarcates our power and patient- interaction (THOSA, 2).

ANHA also expressed concern at the government's proposal to address the organisation of traditional healers at a provincial level because this means that the government is running away from the problems (Mr. Mahlaba interview, August, 1994).

> I think the government is really trying to ditch us, they really do. They don't want to address traditional healers. That's a serious problem (ibid.).

It is felt that the government is not doing its job and they are still building clinics and hospitals (ibid.).

The problem is that nobody has experience in political talk and traditional healers cannot understand the political aims and objectives of political parties and other international organisations, like WHO.

5.3.5 Funding

Funding is strongly related to government issues and it is also an area where some of the differences between the associations are highlighted. For example THOSA is highly concerned with the recognition of traditional healers in Parliament.

> The population of the traditional healers community is 500 000 in the whole country. Yes, it is a huge percentage which also needs representation in Parliament when certain bills about health services and relevant matters are debated in Parliament, like labour unions who are represented in Parliament. [12]

However, THOSA has no expectations of financial support from the government. "There is no problem with the money for this organisation because there are membership fees

[12] Speech by H. B. Zungu, delivered at the Wits Business School to the Graduate School of Public Development Management, about traditional healers and their services and roles

that are paid, especially when there are some important events, then the members will be asked to make a contribution. Very seldom do we go out for donations." (H. B. Zungu interview, July, 1994) The big conferences are sponsored, for example by institutions like Medunsa, WHO and Wits Medical School

This is markedly different to ANHA, who, although not expecting the government to help financially, blames lack of funds for many of its problems:

> The ANC isn't going to do anything, we must get up and do things ourselves. . . We can't put our ideas into practice because we spend 80% of our time scavenging around to find the means to pay the rent and the phone bill (Mr. Mahlaba interview, September, 1994).

From the members' point of view the problems of organising involved an interpretation of the particular organisation to which they belonged. Arising out of this is a situation whereby the differences between the two organisations is apparent. Almost all members interviewed at ANHA blamed the problems of the organisation on lack of funds:

> The biggest problem is that we don't have money, we have no sponsors (ANHA, 1)
>
> No problems, except for financial support. Like universities, we need backing (ANHA, 3).
>
> There is a serious lack of funds The lack of money is the source of all evil ANHA, 4).

Thus the perception is that with money the organisation would have a better chance to reach the levels of the dominant culture; they would be in a better position to be heard and have their claims justified. Compared to this, not one person at THOSA mentioned any problems that they might experience be it financial or otherwise. This might have to do with the security Chief Zungu, as the charismatic leader, offers the members. It is also related to the way in which THOSA is more representative of the residual culture and therefore resists incorporation into the dominant culture. Being well organised and having a powerful leader seems to be more relevant for success than having large financial power:

> Not one problem, I am enjoying myself, I am very free. We are not worried at all (THOSA, 1).
>
> Not one. Once the leadership is right you can handle any problem. With other members there are sometimes problems of 'position mongers', they feel they should have been given my position (as secretary) but then they don't execute duties properly (THOSA, 2).
>
> Ever since we started with him, we never encountered any problems" (THOSA, 5, 6, 7, 8).

There are many other aspects which differentiate the two organisations and which the members think differentiate their organisations from others:

5.4 Different organisations

The differences between the two organisations THOSA and ANHA can be categorised in terms of leadership, structure, strong and weak adherence to tradition, problems of organisation, political affiliations and interest in business.

5.4.1. Leadership

At THOSA, leadership is charismatic. This became apparent from the interviewees who said that they joined this particular organisation because of the appeal of its leader, H. B. Zungu. Moreover, most members were Zulu speaking which may be a strong unifying element.

> I realise that Chief Zungu is one of the thousands of traditional healers who is honest, good-hearted and charges little. He is very strict and does not ever let anyone get away with mistakes, i.e. make a right out of a wrong. That is why I respect him and why I decided to be under his wing. It gives me comfort and I never have to suffer (THOSA, 1).
>
> Zungu is open, transparent, who can explain things to you. He will tell you when you are doing something wrong. He has special potential in leadership. He can handle serious situations and work with different people harmoniously. He is the only person I know who can do that (THOSA, 2).

> I feel most secure under his control because he is an honest man, he won't flatter you (i.e. be too accommodating towards your mistakes). He tells us about the latest happenings, he tells us how to do things, we have guidance (THOSA, 7).

Most members at THOSA described the "model" traditional healer as somebody who is like H. B. Zungu. Many of the members interviewed thought of their life as healthier and of themselves as having found the right person (i.e. H. B. Zungu) and organisation (the two are often seen as interdependent and coexistent).

At ANHA, charismatic leadership is not apparent. Mr. Mahlaba's authority stems from his breaking away from the "old", more conservative organisation and thus having established his own. Most people joined this organisation because they saw it as powerful and up to date in terms of having strong connections with other organisations and academic institutions and because it would offer them protection from police and conservation bodies. Members saw their belonging to this association as affording them an opportunity to gain more knowledge about their profession and to meet important people. None mentioned that since joining ANHA they feel "secure" (under the wings of the leader) and "healthier". There was no obvious unity or uniformity of language groups and maybe because of this there was less unity among members concerning the responses to the interviews.

5.4.2 Structure

The structure of the THOSA is well-defined: there is a national organisation, formed in 1986, chaired by H. B. Zungu, to which, according to him, 144 000 members belong. This national body meets once or twice a year. Then there are regional associations, of about 100 - 200 members each. Usually there are about 4 associations per region and they arrange meetings monthly. They discuss how they can help each other and how to become self sufficient. The activities of these associations also include matters that are not directly related to health issues:

> Because these members are traditional healers, they don't only care for health purposes, they also join hands with the community. They may be involved with school committees, in the community welfare to help members of the community. They intermingle with the community. They also develop certain programmes like teaching the children traditional dancing, to take them off the street, and they make some hand works, how to decorate themselves, they dance, etc. (H. B. Zungu interview, July, 1994).

In H. B. Zungu's words the structure of the organisation is as follows:

> It starts from the grassroots; there will be no office bearers if we haven't got the grassroots. We recruit members into associations, all the healers. Among themselves they have office bearers, then they make an election among themselves, they call all the healers and they elect people on their own. Now these people will serve the people at the grassroots. It does not mean that if they are the office bearers that they are above these people. They are not. Only that they have been charged with responsibility for the healer community. Then these associations will join organisations so that they learn more and have collective wisdom, they will learn more if they are expanded, if they are with other people, that is why we say that we must meet nationally. Presidents from associations learn about meetings, procedures, things which they don't do locally but by coming together, that is a collective wisdom, that is what is happening now. (H. B. Zungu interview, July 1994).

Despite the fact that THOSA, at this moment, has no proper office, it is well organised with a clear structure and a clear purpose. The leaders are democratically elected and are thus held responsible for their jobs.[13] There appears to be proper top-down communication, facilitated mainly by H. B. Zungu, and members have a sense of "knowing what is going on" or being updated on the latest happenings. Membership fees are R20 per annum which qualifies one for a certificate (displayed in Appendix 3).

ANHA was founded in 1989 and it forms a network of nationally paid up member of about 500 - 8000 members. The members from the different provinces meet once a month. Even though ANHA operates from a proper office, in terms of structure and organisation

[13] In Nigeria, the choice of leaders in the association is usually decided by popular vote amongst members. A healer's chance to lead and his being elected in such a democratic process are so closely interwoven with the healer's fame that the two cannot be separated (Oyebola, 1981:103). This is certainly true for H. B. Zungu.

it appears somewhat less structured than THOSA. Meetings are irregular, there are no elections and hence no portfolios for members:

> We haven't had any elections for the past 4 years. The reason being is that people cannot come and elect where there is no financial institute. Because we have no financial strength and facilities, people are in their positions ever since we started this organisation (Mr. Mahlaba interview, August, 1994).

Meetings go unrecorded and thus there is no kept record of the history of the organisation. Membership fees are R100 per annum and this includes a certificate (displayed in Appendix 3) and access to certain benefits[14].

5.4.3 Modernisation

In chapter 4 the modernisation of the practices of traditional healers was discussed. In this context, THOSA is the more "traditional" organisation because it was here that members often explicitly opposed "modernisation", claiming the western way of doing things is not the right way. There was a strong awareness of AIDS and STDs and as a result many members promoted the use of contraceptives (more specifically the condom). But in terms of modernising their practice on the whole, members not only preferred to adhere to their customs and culture but found it a necessity in terms of their profession. Some vehemently

[14] These benefits include:

1. To get protection from police harassment when digging herbs and when transporting such herbs to his place of practice.
2. Access to wild game parks and conserved natural areas where he will be permitted to exploit the resources.
3. To be able to open accounts at stores, banks and building societies.
4. To be afforded the opportunity to act collectively and to make representations to various bodies, e.g. Department of Health and Population development, and can have associations with various professional bodies, e.g. SAMDC, Chamber of Commerce and Industries, etc.
5. Eligibility to be trained on the code of ethics and attend literary programmes.
6. To get better prices from the marketers who will give discount to this market.
7. To be afforded the enhanced status of traditional doctors.
8. To receive a newsletter every month. (Overview of ANHA, by S. Mahlaba, about the organisation - strengths and weaknesses, members' benefits and objectives)

Although this sounds ambitious and professional it is only a piece of writing and we have seen that members did not join because of these benefits, probably because they don't know about them or because they do not yet exist. It appears that many of these benefits are still being implemented, for example the newsletter and the literacy programmes.

oppose the adoption of the western way of healing and even wary of the negative consequence which such a cultural deviation might bring. In other words members are generally more traditional in their understanding of healing and medicine.

Unlike THOSA, the modernisation of the traditional practice is much more evident at ANHA, together with the appraisal of western medicine. There is no worry over diverting from culture or the potentially negative consequences of adopting western ways. This is contrary to the finding of Swantz (in Rappaport et al, 1981:777) that virtually all traditional healers function in a conservative way to preserve the traditions of the culture. There is an aspiration towards learning western medicine's way of using drugs, mixing medicines and towards learning and education. It must be noted that this has probably got something to do with the evolution of ANHA from a much more "traditional" organisation (i.e. as a reaction to the old traditional ways and attitudes) and with the relative youthfulness of the leaders.

5.4.4 Problems with organising

As a result of H. B. Zungu's personality there is unanimous agreement among members that there are no organisational problems or personal problems of power seeking by individuals at THOSA:

> In this organisation there is oneness, we work as a team, there is no pointing at each other, no jealousies, nobody is talking badly behind anybody's backs. I wanted to work with Zungu and Mcunu because I realised they were honest. We have never turned against each other (THOSA, 4).

5.4.5 Political affiliations

At THOSA, because of the negative influences of politics, healers were expected to distance themselves from it.

> I have no affiliation to politics because that would put you in a corner because you have to treat everyone. Once you are affiliated to politics only those supporting the same party will come to you (THOSA, 1).
>
> We as healers are not supposed to affiliate to political parties because you are supposed to treat everybody, regardless of their political activities. It would make you partial and as a healer you must be impartial (THOSA, 2).

By contrast, at ANHA, affiliation to politics was not something to be avoided:

> We believe in the ANC, we elected them and we want to work together with them (ANHA, 4).

Even when political affiliation was rejected, it was not for the same reasons as THOSA members' rejection:

> Traditional healers are not interested in politics because they oppress us now (ANHA, 1).

5.4.6 Relation to business

Lastly, the commercialisation of the practice as well as of the herbs is strongly rejected by all the members at THOSA:

> No, that is not the way, we don't want that. It is exploitation of our healers. Advertising is no good (THOSA, 4).
>
> We don't believe in business interfering with us. It is a form of oppressive behaviour. Business should not take over this (THOSA, 5, 6).

This is in stark contrast to ANHA's relationship to business. Although the association claims to be "self-financed" in terms of getting the money from the members, it has also been mentioned that some of the revenue derives from marketing certain medicines in conjunction with pharmaceutical companies. The problems of being paid royalties and

protecting one's medicines by patenting the labels, as well as protecting information by copyrighting it are recognised by some.[15]

Contrary to the aspirations of THOSA, a conscious effort is made at ANHA to establish a working relationship with business interests. As part of the "benefits" of the organisation, the following commercial benefits are offered: Direct and easy access to the market, increased distribution for marketers, advertising opportunities for marketer, opportunities for research, test market, product launches and feedback from the market.[16] In a sense this aspiration can be viewed as an attempt to overcome the existing problems with muti chemists and hawkers on the street selling stale products that have lost their potency. In addition, most owners of muti shops do not have the knowledge required to run the business properly:

> Imitations also get sold, and this gives a serious problem to a traditional practitioner who does not know the product he wants too well. It is a serious problem in the sense that usage of the imitation in question yields results which are not expected - sometimes such results are fatal.[17]

The positive affiliation to business is also reflected in the views of some of the members:

> That is very important, if we can write things down about traditional healers. It will give us power if business sells our medicines if we get some benefits (ANHA, 1).
>
> It is promoting traditional healing, they must go commercial (ANHA, 4).
>
> Business wants to learn more so that the nation can be cured so I have no problem with it, it promotes traditional healing (ANHA, 7).

[15]Dr. Matthe who has a Ph.D. in pharmacology said the following on the question of business interests popularising medicines: "If traditional healers knew how to protect their medicines it would be fine but because they don't know, they lose out. If they understood intellectual property, it would be all right. But they are emotional, they want to know where they are" (Interview with Dr. Matthe, August, 1994).

[16] Overview of ANHA, by S. Mahlaba, about the organisation - strengths and weaknesses, members' benefits and objectives

[17] Conference Paper by Conrad Tsiane and Solomon Mahlaba presented in Lesotho, about Health and Culture

Despite all these differences, it is noteworthy that the leaders of the two organisations know each other well and that they also get on well. They often come together in those gatherings where leaders from other organisations meet. There is no rivalry between them and the relationship is healthy. They are fighting for the same cause: to get government legislation for traditional healers and to ensure that proper regulation and control is instituted concerning the practice of traditional healers.

5.5 Integration with western medicine

Western medicine is generally accepted as something positive. It has been shown throughout this report that the leaders of these two organisations are committed to having a relationship with western medicine:

> We are co-operating with western medicine and we would like to see interaction between the traditional and the western medicine, working together (H. B. Zungu interview, July, 1994).

It is possible for western doctors and traditional healers to work together if Act No 56 of 1974 and Act No 63 of 1982 Health Services which forbid the western doctors to work together with traditional healers in this country are scrapped. A good example of working together is the establishment of the traditional and western medicine clinic in Bulawayo, Zimbabwe in April 1991.[18] However, the ANC's priority is not that of promoting traditional healers. There is no new legislation. Despite the promises of the Health Plan, nothing has been taken to Parliament (Freeman interview, August, 1994).

[18] Speech by H. B. Zungu, president of THOSA, for Dr. Anne Wright

5.5.1 The impact of education, distance and ancestral opposition

Chavunduka (1986:64) listed the problems with integration, i.e. illiteracy, long distances and prohibition by ancestors. All of these problems were brought to light by some of the interviews. Although only one person mentioned the problem of no education in an explicit manner ("the problem is that most of us are not educated") (ANHA, 7), it was apparent that many of the healers had little formal education. Green et al (1984:1077) found a similar concern among traditional healers in Swaziland that "their lack of education would make 'communicating with doctors' difficult". The problem of access to urban centres was brought up by one person.

> They were reared on farms and they don't have access and thus can't meet their counterparts (THOSA, 3).

It was easy to observe the validity of this problem as ANHA had difficulties with finding suitable subjects for me to interview, either because they did not live nearby or because they could not speak English. Finally, a number of informants attributed the lack of a desire to belong to organisations to a fear of the ancestors:

> [Traditional healers] believe in ancestors who tell them what is wrong; we are dealing with our own ancestors and they are not used to white [western] people; it is a fear they got from the ancestors or spirits; some are controlled by ancestors (ANHA, 1,2,3,6)

5.5.2 Lack of funds and information

This problem has been discussed at length in section 5.3.5 above. In addition, lack of knowledge by western doctors was often mentioned in the interviews:

> They should learn and respect our customs, culture and religion. By doing so we could go further (ANHA, 3).

> They don't understand how people are suffering from ancestral diseases (ANHA, 4).

5.5.3 Threat to traditional healing and western medicine

5.5.3.1 Threat to western medicine

A few healers (four) felt that western medicine is threatened by the new interest which traditional healing is enjoying:

> They feel that we are getting too popular (THOSA, 8).

This could be interpreted as a challenge to the hegemony of the dominant culture. Some said that the reason western doctors look down on the profession of traditional healing is because they fear competition. Moreover, western doctors are interested in their prices and regulations, which is indicative of a perceived threat and a willingness to oppose it. However, because the majority did not think that western doctors were threatened by their presence and because many admitted that they were not in a position to offer their opinions ("I am not sure, I don't know. I can't speak for them. I don't know what is going on at the back of their heads", THOSA, 4) it is hardly the case that western doctors are threatened and that their hegemony is crumbling.

5.5.3.2 Threat to traditional healing: Medical Aid

While many participants in the research were positive and thought that Medical Aid would be ideal so, many were aware of the problems: lack of education, many unpopular and untrained healers, dispersed nature of healers' residences, no controlling body for traditional healers, no reference numbers, lack of knowledge on behalf of traditional healers about the workings of Medical Aid. This leads to a situation in which patients continue to support the western system, and thereby the dominant culture, because their Medical Aid will pay only for that

5.6 Conclusion: Complementary systems and co-operation?

Despite all these problems of integration there is general agreement both in the literature and within the interviewed healers that the two systems are somehow complementary (See Hours, 1986:57. Pelulin in Bannerman, 1982:20, Bannerman in Oyebola, 1982:93). "The western and traditional systems are complementary and should be constructed to function alongside one another" (Rappaport et al, 1981:774). It was demonstrated earlier that although many of the healers could point out certain differences between traditional healing and western medicine, the stress was nevertheless on the similarities.

> Somehow we complement each other (ANHA, 3, 6, 7).

There is a strong commitment to working with western doctors and many refer patients to western doctors in cases where they feel that their treatment is limited or where the problem is beyond their capacity to treat. The system of referral is well supported and encouraged by all. The two systems complement each other and the one helps out where the other is powerless (for example, western doctors are powerless when it comes to curing ancestrally caused diseases and many traditional healers are powerless when it comes to diseases such as TB and flu, diseases that require antibiotics).

> We refer our people to western doctors if we can't help them, for example to use penicillin. I hate the stuff but I still advise people to see a western doctor. There is no use trying to compete with one another or to outride each other (ANHA, 3).

Because neither modern medicine nor traditional medicine has adequately met the community's health needs, there needs to be some form of co-operation between the two (Kimani, 1981:335). The strengths and weaknesses of each is said to result in a possible complementary system (Pelulin in Bannerman, 1982:20). Traditional healing, in Africa and elsewhere "has provided a culturally meaningful system of treating illness that ... is complementary to modern medicine" (Greenfield, 1987:1106). So the two systems are everywhere regarded as complementary, "yet nowhere does this seem to develop into

effective co-operation that acknowledges the fundamental legitimacy of both systems" (Hanlon in Maclean, 1986:21). I would argue that the reason for this is the differing aims and goals of the two systems. The one is concerned with healing while the other with profit and control. In theory the two systems might be complementary because they can fill the gaps that each has.[19] In practice, however, this complementary argument is misleading because we are comparing two things which are not equal and not the same.[20]

Integrated medical policy is based on the conviction that both systems are aiming at a common target, the curing of disease, only they take different approaches and have different interpretations concerning the mechanisms of disease (Jingfeng, 1988:526). But because western medicine and traditional healing do not have the same aims, integration will not be possible, unless one or both change their objectives - and it will not be western medicine which will retrieve altruism. Rather, traditional healing will follow the profit mode of western medicine. This is not even necessarily a strictly "modern" phenomenon. La Hausse (1993:204) shows that in South Africa, in the 1930s and 1940s, the herbalist trade developed into one of the key sites of capital accumulation for frustrated African entrepreneurs. In addition, Harrison (1993:4) also found that traditional healing, from as early as 1928, was a well-established and lucrative occupational niche in urban South Africa. She argues that the emergence of traditional healers' associations may partly be explained as a response to the threat of being deprived of a potentially remunerative urban career.

[19] Jingfeng (1988:527) also argues that some diseases that are treatable with partial success by either western or traditional medicine alone, can be cured in a more economical, simpler and quicker way when integrated medical techniques are applied. However, the argument in this section is exactly that it is *not* in the interest of western medicine to make treatment either quicker or cheaper because that would defy the purpose of profiting from illnesses and diseases that humans have.

[20] Last (1992:394) shares a similar view: "instead of treating [the two systems] as isolated or even as competing equals, I rank them in a hierarchy of organisation and access to government funds. For it is clear that the different methods of treatment vary widely in the extent to which they are systematised and recognised as a system by practitioners and patients". This is why it is crucial to address the current state of organisation of traditional healers and what they aim to achieve through their organisations.

Disagreement over the commonality of goal is supported by Pearce (1982:1614) who says that in the USA physicians insist on controlling the activities of the budding group of physicians by making sure that the latter were under their control. Thus University-trained physicians will view integration as competition from yet another group of health workers seeking control over certain types of medical activities. His research findings of western trained physicians in Nigeria indicate that active and widespread participation in any official integration programme would be resisted by these doctors (ibid p.161). He suggests that this is partly attributable to a claim of science which protects doctors and ensures their economically powerful position in society. "To open its door to indigenous medicine would be threatening and the fear of losing some of the prestige gained through science is no doubt present" (ibid., see also Maclean, 1986:15).

It is argued, however, that although this incompatibility between the two health care systems is apparent today, with the organisation of traditional healers, it is likely that, in the future, traditional healers will be adopting western strategies and losing traditional ones so that the two systems will be more compatible. Significantly, it is the traditional sector which absorbes the dominant culture and not the modern sector which adopts holistic principles, so that the enabling of compatibility is apparently an uni-directional process.

Chapter 6 - Conclusion

Western medicine, as a system, has gained hegemony in modern society. The literature reflected this situation by revealing how it labels traditional systems as "closed" in comparison to western science's "openness". Such openness should, however, be viewed with caution because much effort has gone into controlling the emergence of alternative medicine and into dismissing traditional practice as unfit for the language of rationalism, and therefore, rendering it irrelevant. Through a discussion of case studies in different African countries, it became clear that this hegemony is not merely an assertion of order but, as such, is also an attempt to curtail alternative ideas. Hence, in many of these countries incorporation of the traditional health care sector was initially resisted. Even where it did show signs of success, it was the traditional sector which had to comply with the terms dictated by the modern sector. Historically, traditional healing has received a bad name because of the selectivity of hegemonic society: only negative aspects are emphasised, which, when taken out of context, would confirm the negative perceptions of the dominant culture.

History generates hegemonies that remain stable for long periods by limiting alternative ideas and by incorporating some of the culture of more traditional people. Consequently, Christianity, "civilisation" and politics have divided African people. African people who are opposed to the ideas of traditional healing are absorbed by the dominant, hegemonic culture. Consequently they, like their western counter-parts, treat those remaining in the residual, more traditional culture, as the "other", and ridicule their practices as "backward". However, the incorporation appears to be incomplete, as African people who reject traditional healing appear to still consult traditional healers surreptitiously.

Rationality and the scientific method are often contrasted with the conservatism of tradition. The differences between traditional healing and western medicine have more to do with holistic approaches and a real desire to heal than with rationality and conservatism

or "openness" and "closedness". Western medicine, in this context, was perceived by some healers as unholistic, uncaring and, to some extent, profit-motivated. The main difference between the two is that traditional healing concentrates on the person, their social circumstances and the reason for their disease or misfortune, western medicine confines the "why" and "how" of the disease in one theory. Consequently, by standardising and grouping together different symptoms and diseases, western medicine shows more concern with their control than with healing.

Modernity and traditionalism are often portrayed as opposing concepts. However, this report has shown that, despite the differences, there is much interpenetration between traditional and modern world views and practices in the medical profession. For example, there are similarities between the two in terms of their predictive qualities, and diagnosis before treatment. Moreover, patients consult both kinds of doctors, depending on their needs and faith. Faith is a necessary component in both systems of healing. By deconstructing the use of language, some of the apparent differences become similarities. Dichotomies such as natural/supernatural, real/mystical and choice/calling are not recognised by these healers and there is consequent interpenetration. Finally, the mere fact that they are organising in a western fashion shows that the rationality of the west is not completely incompatible with their traditionalism. However, there is some resistance to this kind of modernisation which implies that in reality some incompatibility exists, mainly because the aims of the two organisations are different and because there are still many traditional elements in healing which are characteristic of a residual culture and which are a potential counter-hegemony to the dominant culture.

The two organisations differed, however, in terms of degrees of modernisation and acceptance of modern methods of healing. At THOSA, members were usually reluctant to modernise, faithfully adhering to their tried and tested traditional methods, although they did favour certain innovations such as sterilisation of razor blades and recommending condoms to avoid STDs. At ANHA, there were many members who have adopted western ways and who did not feel that by doing so they would be rejecting their culture

(which is what many THOSA members felt). Then ANHA could be perceived as being in the process of being absorbed into the dominant culture whereas THOSA is more a reflection of a residual culture and an alternative awareness to the dominant culture. Despite not openly challenging the dominant medical culture, THOSA members would find the two medical models incompatible.

It was expected that the reason for traditional healers' organising would lie in their opposition to western medicine's hegemony. However, the main reason these healers organise is recognition by the government. They want to professionalise their practice and to come together under one controlling umbrella body, similar to western medicine, so as to gain public recognition. They also want to share their healing knowledge and to increase co-operation among themselves, and between professional bodies and themselves. The problems of organising are mainly related to individualism and power-seeking, lack of funds and education, difficulty with standardisation and unity, lack of co-operation and support from the government and a dismissal of their traditional practices by the authorities as unscientific and irrelevant. The differences between the two organisations arise in their leadership, structure, adherence to tradition, organisational problems, political affiliations and relationship to business. The problems of integration with western medicine include a lack of the necessary legislative structure allowing such integration, geographical distance, illiteracy, resistance from ancestors, lack of finances and a threat to western medicine as well as to traditional healing. Despite all these problems, this research found that most healers accept western medicine and think of the two systems of health care as complementary.

It is argued that although there is currently incompatibility between the modern and the traditional health care systems, with the organisation of traditional healers, this may change. Already traditional healers are adopting the western practice of profiting financially from their practice. Moreover, some were motivated to join an association because that would ensure them respect. Thus there is a real possibility that with the organisation of traditional healers, their authority in society will be derived more from

their belonging to an association and from dispalying certificates on their walls, than from their healing powers. Furthermore, with the modernisation of traditional healers, urbanisation and political change, the all-in-one role of the healer is giving way to situation where traditional healers in South Africa are becoming increasingly specialised and differentiated (Edwards, 1986:1273).

Appendix 1 - Code of Ethics

ETHICAL CODE GOVERNING & CONTROLLING ALL MEMBERS OF T.H.O.S.A.

THE ETHICAL & QUALIFICATIONS COMMITTEE FOR TRADITIONAL HEALERS ORGANISATION OF SOUTH AFRICA STIPULATES AS FOLLOWS:

1. *RENDER DUE RESPECT TO ALL THOSE IN AUTHORITY.*
2. *TREAT ALL PEOPLE COMING TO YOU WITH HERBS IRRESPECTIVE OF RACE, CREED OR COLOUR.*
3. *THE USE OF MAGIC AND HARMFUL HERBS WHICH CAN CAUSE ANY FORM OF INJURY TO THE PARTS OF THE BODY OF OTHER HUMAN BEINGS ARE NOT PERMITTED, AS THEY ARE ASSOCIATED WITH SORCERY.*
4. *WHEN A PATIENT IS NOT SATISFIED WITH TREATMENT GIVEN TO HIM/HER, MONEY PAID BY THAT PATIENT MUST BE REFUNDED ON HUMANITARIAN REASONS.*
5. *PRACTICE OF DECEIT AND RIPPING OFF PATIENTS IS FORBIDDEN. IF FOUND GUILTY OF OFFENCE, IT IS PUNISHABLE BY PAYING BACK TO THE PATIENT TWICE AS MUCH.*
6. *TREAT GRATIS THOSE WHO DESERVE GRATIS SERVICE.*
7. *WHEN THERE ARE LIMITATIONS REFER PATIENT TO THOSE WHO ARE IN A BETTER POSITION FOR CONTINUED CARE OF THE PATIENT.*
8. *BE HONEST IN EVERYTHING YOU DO.*
9. *NEVER USE ONE RAZOR BLADE TO MORE THAN ONE PERSON. INSTEAD ADVISE YOUR PATIENTS TO BRING THEIR OWN RAZOR BLADES FOR FINAL TREATMENT.*
10. *CO-OPERATE WITH ALL HEALTH WORKERS FOR NEW FACTS OF LIFE.*

CODE OF ETHICS.

I, SOLOMON MAHI ABA, a traditional practitioner, dully registered with the African National Healers Association, subscribe to the code of ethics or standards set out by the said association below:

1. I shall be religiously dedicated to the practice of my profession above all else, and shall meet all its demands.

2. I shall act in the interest of all patients in all respects, irrespective of class, race, colour or creed.

3. I shall treat all my patients with utmost respect, and shall observe their basic humaan dignity and worth.

4. In my practice, I shall do nothing else, but promote health by way of uplifting the physical, mental, social and spiritual well-being of mankind.

5. I shall refrain from attempting to cure ailments for which I have not been properly trained to cure.

6. I shall acknowlegde my limitations in my practice and shall refer patients to whoever may have demonstrated the know-how or is qualified to cure the ailment which I am not able to cure.

7. I shall give advice to patients.

8. I shall allow a patient or any person acting lawfully on his behalf to choose whoever he/she may consider professionally capable to

   he/she wishes to consult such person for his opinion or treatment.

9. I shall play a reconciliatory role in families or communities which I shall serve.

10. I shall play the educative role in the community on health matters.

11. I shall share knowledge and information with my colleagues.

12. I shall embark on continued learning or training in order to improve my standard of qualification as a traditional practitioner so as to improve my efficiency of consultation, diagnosing and treatment.

13. I shall keep my place of practice in a clean, orderly and sanitary condition.

14. I shall refrain from all forms of evil, particularly witchcraft.

15. I shall not allow any person to induce me to indulge in practices which may lead to hurting any person or practices which may be

detrimental to any institution, organisation or the society at large and the image of my profession.

16. I shall not misrepresent my patients, the entire society, my profession and the African National Healers Association.

17. I shall observe the principle of confidentiality, and shall divulge information which came to my attention as a result of my practice on explicit permission given to me by the patient, if he/she is a major, the parent or guardian of a minor patient, the surviving spouse or minor of the deceased patient, when instructed by the court of law or where I am legally compelled to do so or in the explicit interest of the patient who is not able or is unfit to grant permission himself/herself.

18. I shall not express myself in public regarding matters of traditional healing without permission granted to me by the African National Healers Association.

19. I shall not advertise.

20. I shall not permit my name to be used in a professional capacity in connection with advertisements of medicinal products or instruments, and in connection with advertisements or appeals to the public on behalf of a sick benefit society or any commercial organisation.

21. I may not tout or canvass, either personally or through an agent or in any other manner, for a patient or for myself or for another practitioner.

22. I shall not accept or insist on any commission or remuneration, pecuniary or otherwise, from manufacturers or dealers in medicinal products, remedies or any equipment, apparatus, instrument appliance or material used in the course of my practice or prescribed for patients.

23. I shall not pay or give any commission or remuneration, pecuniary or otherwise, to any person for the recommendation of patients.

24. I shall not accept any commission or remuneration, pecuniary or otherwise, from any person for the recommendation of patients.

25. I shall not share any fees charged for a service with any other person other than a partner, unless such sharing is commensurate with the scope of such other person's participation in the rendering of such service.

26. I shall not have financial interest, whether by way of a fixed salary or otherwise, in sick benefit clubs, institutions or associations which canvass members by way of advertisements.

27. I shall not use any form of treatment, apparatus or process which is secret or is claimed to be secret in my practice.

28. I shall not use any form of treatment, apparatus or process which proves upon investigation by the African National Healers Association to be incapable of fulfilling the claims made in regard to it.

29. I shall not use any diagnostic and treatment methods which do not comply with the accepted standards of my profession as determined by the African National Healers Association from time to time.

I shall not perform any act which is an unacceptable act, standard or method, as from time to time may be determined by the African National Association and which is brought to the attention of the practitioners.

31. I shall enter into a partnership or maintain a partnership with a person who is:
    31.1. registered as a practitioner with the African National Healers Association;
    31.2. registered as a medical practitioner in term of the Medical, Dental and Supplementary Health Service Professions Act, 1974; or
    31.3. registered in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974, in respect of a supplementary health service profession which is approved by the African National Healers Association as an acceptable profession for the purposes of a partnership

32. I shall not co-operate or enter into or maintain a service contract with a person who is:
    32.1. not registered as a practitioner with the African National Healers Association;
    32.2. not registered as a medical practitioner in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974; or
    32.3. not registered in terms of the Medical, Dental and Supplementary Health Service Professions Act, in respect of a supplementary health service profession which is approved by the African National Healers Association as an acceptable profession for the purpose of a service contract;
    32.4. not practising in terms of the Medicine Control Act;
    32.5. not practising in terms of the Pharmacy Act, 1974; or
    32.6. not practising in terms of the Nursing Act, 1978

33. I shall recognise the Medical and Dental Councils, Department of National Health and Population Development, the World Health Organisation, Department of Law and Order and other professional bodies.

34. My professional stationery shall bear the following information:
    34.1. My initials and surname and/or that of my partner(s);
    34.2. my registered profession and abbreviations in respect of Association;
    34.3. my practice address and telephone numbers;
    34.5. my consulting hours, where applicable;
    34.6. my other professional associations to which I am affiliated; and
    34.7. my practice number.

35. In my consulting room, I shall display:
    35.1. Those certificates, diplomas and degrees relevant to the profession for which I am registered;
    35.2. membership certificates of professional associations to which I am affiliated; and
    35.3. the registration certificate issued to me by the African National Healers Association.

36. I shall promote the image of my profession and shall lead an exemplary life.

I, SOLOMON MAHLABA, the undersigned, hereby declare that I understand

the abovementioned CODE OF ETHICS, as set out by the AFRICAN NATIONAL HEALERS ASSOCIATION (Association not incorporated for gain, registered under Section 21 of the Companies Act 61 of 1973), and consider such to be binding upon my conscience.

SIGNED AT.....ON....OF.....199...

WITNESS:.....WITNESS:.....

Appendix 2 - Interview Schedule[1]

1. Background and personal information

1. Tell me a little bit about yourself - your age, place of birth, language, where and how you grew up, sex, family relationships etc.

2. How long have you been a traditional healer?

3. Where do you practice?

4 What kind of people come and consult you? (Rich, poor, old, young, male, female, professional, farmers, factory workers, domestic servants?)

5. What diseases do they have? What diseases do you treat the most?

6. Tell me about why and how you became a traditional healer, what training did you have to undergo?

8. What is the most joyous aspect of your profession? What is the most distressing or unpleasant?

2. Organisational issues

1. When did you join this organisation?

2. Why do you think it is necessary to join an organisation? Why did you decide to join this organisation? Why this particular one?

3. What are you hoping to achieve by having joined this organisation?

4. What is your role in this organisation? Who do you have to report to, about what kind of issues? How often?

5. What has changed for you in the last few years, since you joined this organisation? How was it before and how was it after you joined? Have some of your wishes, aspirations been fulfilled? How are you benefiting by having joined this organisation? What were or are the disappointments or drawbacks?

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[1] These questions served as a guide. Each interview was approached with flexibility so that not all questions were asked and sometimes other were added. It depended on the individual and his or her expertise in a specific field.

6. Do you encounter any difficulties with belonging to this organisation? What conflicts do you experience?

7. Do you think that western medicine is more powerful in society than traditional healing?

13. What do you know about other organisations? What are their strengths and weaknesses?

3. Philosophical issues

1. Do people believe in traditional healing because other forms of health care are not accessible to them?

2. How do you understand the connection between "supernatural" (e.g. ancestral spirits or God) and "scientific"? Are the two separate? Are the traditional medicines imbued with supernatural powers?

3. What is you view about universalistic claims? Do you think that your healing powers would work with everybody, all over the world?

4. Are there days or times of the day when your healing powers are stronger than at other times or days? Do you have to be in a special state of mind to be able to solve problems?

5. Do patients have to have faith in the healing process and be part of a particular culture to be able to be cured or would they be cured even if they were from another culture and other belief systems?

6. Does this depend on the kind of disease? Give an example.

7. Why are the bones right? How do you know it is not co-incidence?

8. How would you define health and illness and healing?

9. Is there a difference or a "split" between modernised healers and traditional ones? If so, what are they? For example, along age lines or living in urban or rural areas?

10. When I talk about "western" medicine, what images come to mind? In contrast to that, what do you understand by the term "traditional"?

11. Tell me about the healers you know who do not want to belong to organisations and who are not interested in interacting with western people. Why is that so?

12. I have observed some traditional healers who use western methods in their practice. For example, they teach patients about primary health care, they give numbers to the patients who are waiting, they sit across a desk to communicate with patients, they use syringes, they observe strict hygienic measures, they sell prepared medicine, use assistants and nurses, dress formally and so on. What is your response to that? How does it work in your practise? What is traditional and/or modern about your practice?

13. In your opinion, how would or should a good, respectful, up to date traditional healer practise today?

14. What has changed in your practice in the last 5 years? For example, are you treating different types of diseases than before?

4 . Western medicine

1. What is western medicine? What do western doctors do? What do you understand about it? What is your opinion about western medicine?

2. Do you feel that there is anything you could or want to learn from western medicine?

3. Do you feel that there is anything western medicine could or should learn from you?

4. What are the biggest problems with western medicine?

5. What are the biggest problems with traditional healing?

6. How do you think western doctors perceive you? Does it really matter to you?

7. Do you interact with western doctors? If so, for what reason and how did it go, what happened?

8. *If you interact with western doctors*, do you get the feeling of mutual respect and communication or do you sense an imbalance of power? Have you ever felt intimidated or disrespected by western doctors?

9. How do you see the most important differences between western medicine and traditional healing?

10. How do you see the most important similarities (if there are any)?

11. I heard that some African people say that traditional healing is mumbo-jumbo (Mr. Motlana). What is your response? Why do you think he said that?

12. Do African or western people give traditional healing a bad name? If so, what and why?

13. What is the relationship between apartheid and the bad name traditional healers are given as witch doctors? Elaborate.

14. Do you think that whites and westerners are having a "new" interest in your profession? (*If yes*, to what extent is it politically or scientifically motivated?).

15. *If yes*, Do you think western medicine is threatened by this "new" central attention which traditional healers are enjoying?

16. How do you feel about business interests popularising and commercialising your herbs and medicines? Is it a good or a bad thing? Is it a promotion or an exploitation of traditional healing?

17. Why do you think western people do not have callings in their dreams to become doctors or healers?

18. Is there a Divine will causing people to become sick? Is this selective for certain diseases?

19. Is there a distinction between "white man's diseases" and your own ones? Colonialism? Was it not there before? Were they caused by white people? Can they be treated only by western doctors?

5. Political issues

1. Is traditional medicine and its promotion part of human progress? Is it against the development of African people?

2. Some members of the ANC claim that traditional healing should be banned because it has no scientific grounding, because it does more harm than good and because it ensures that African people do not progress into the white world. What is your response to this?

3. What do other parties say about traditional healing? Are they more supportive of healers and what they do?

5. The ANC seems to prioritise western medicine and the building of clinics and hospitals. What is your response to that?

6. What is your view about the ANC health plan? Do you think that it is sensitive towards traditional healers?

7. What do you think would be the proper role of the government concerning traditional healers and their practices? What would you like to see the government do?

8. Do you think that the ANC's policy of addressing traditional healers at a provincial level is a good idea? Why/why not?

9. Does your organisation get involved with politics, does it make specific demands, does it interact with government officials? If so, elaborate.

6. Integration and co-operation

1. How do you feel about the incorporation into one large body of traditional healers? Do you think it is at all possible? Why would it be difficult or problematic?

2. How do you see the future of medicine in terms of the integration between traditional healing and western medicine? Should the two systems become one (how) or should they remain separate with different codes of ethics? What are the problems with that?

3. What is your view on the claim that traditional medicine is potentially harmful or dangerous?

4. How do you think the process of medical aid will work in the future?

Appendix 3 - Certificates of Membership

Traditional Healers Organisation of South Africa: (Thosa)

We certify that _____

having subscribed to the objects and aims of the Thosa and having complied with requirements of this organisation's ethical and qualifications committee to perform the function of healer has been issued with the final certificate to practice certified at the congregation of the organisation.

on the _____ day of _____ 19____

President _____

Chairman of
Ethical and
Qualification
Committee

AFRICAN NATIONAL HEALERS ASSOCIATION

(ASS. INCORPORATED UNDER SECTION 21 ACT 61/73) REG. NO. 89/02294/08

HEALTH THROUGH CULTURAL HERITAGE

This is to Certify that

_____

has completed a Study Course in and acquainted him/herself with

a. The application and uses of Tradional Healing with Traditional Medicine

b. Elementary Human Anatomy

and has been awarded this Certificate of Competence

Certificate

Given this ..... day of ..... 19.....

Registrar: .....

S. MAHLABA T/DR S.A. M.D.

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Author: Fenyves Katalin.
Name of thesis: South African traditional healers' organisations in the context of traditionalism and modernity.

PUBLISHER:
University of the Witwatersrand, Johannesburg
©2015

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