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**SHAMING AND BLAMING:
MEDICAL MYTHS, TRADITIONAL
HEALTH PRACTITIONERS AND
HIV/AIDS IN SOUTH AFRICA**

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Shaming and blaming: Medical myths, traditional health practitioners and HIV/AIDS in South Africa

Abstract

This paper examines some often repeated ‘medical myths’ about Traditional Health Practitioners (THPs) in South Africa, in the context of the HIV/AIDS epidemic. Narratives have served many purposes in the pandemic: the stories included here provide specific commentary, often implicitly derogatory or critical, on the role of THPs. The anecdotes can be seen to reflect the uneasy interaction generally prevailing between the traditional and biomedical paradigms in South Africa. The paper first examines some of the reasons for the biomedical presumptions that underlie these narratives. It argues that in attributing blame, the stories exert an unhelpful effect and undermine confidence in the possibility of collaborative medical efforts against HIV and AIDS. In contrast, the paper utilises field evidence to suggest that, given mutual respect, THPs can be successfully drawn into biomedical prevention and treatment interventions, and thereby improve their efficacy.

Introduction

As the HIV/AIDS epidemic in South Africa has developed, narratives have served many purposes – to explain the appearance of the disease, to explain its spread, to avoid disclosure of HIV status (ibid), to critique treatment strategies - and so on. This paper considers what I have called ‘medical myths’ - narratives that are quoted in medical and academic circles, and which provide a commentary, more or less derogatory or critical, on the role of traditional health practitioners in the epidemic.¹ The paper challenges the

¹ The paper is a companion to another that examined AIDS narratives in the context of the THPs’ practice (Wreford 2007). The paper is written not as a rebuke to western medicine, but with the intention of encouraging better cooperation between the sectors.

pattern of blanket attribution of blame evidenced by these narratives, and argues that these stories exert an unhelpful effect on relationships between medical systems that, in the face of HIV/AIDS, should rather be allies than enemies. The paper first examines the reasons behind this negativity, then - in the context of a collaborative initiative established in the Western Cape²- demonstrates that drawing THPs into prevention and treatment interventions in a spirit of constructive engagement and mutual respect can challenge existing stereotypes and foster cooperative relationships.

Three presumptive statements about THPs and their role in the HIV/AIDS epidemic in South Africa are considered. Related by others working in the field of HIV/AIDS, they demonstrate enduring suspicions of traditional healing. The first speaks to the tendency of clients to delay their attendance at clinics and hospitals until they are already in the final stages of AIDS. The paper explores the validity of the assumption that such postponements are always connected to traditional healers. It presents an alternative explanation based in the stigmatisation attached to HIV/AIDS, and related to historic political and social suspicions of biomedical diagnosis and treatment. The second narrative concerns the notorious ‘virgin-cleansing’ myth. The story itself has been frequently analysed and reported it needs little introduction.³ This paper rather concentrates on a critical assessment of the literature on the topic and its unhelpful role in encouraging the demonising of traditional healers, set against the background of gender inequality that continues to characterise sexual relationships in South Africa.

Finally, the paper explores coverage that alleges connections between ‘unproven’ medications or ‘pseudoscience’ and ‘AIDS denialism’. Unlike the previous examples, this is not just a question of medical myths. As the discussion will show however, it does involve negative western medical ‘beliefs’ about traditional healing practice and HIV and AIDS, this time used to promote an exclusively biomedical solution to the pandemic. The discussion interrogates: the validity of this approach in a medically pluralist environment; the extent to which this may threaten the right of patients to make their own treatment decisions; and finally how this attempt at exclusivity affects relationships between THPs and western medicine.

² For detailed coverage of this intervention see Wreford *et al* 2006 and 2007.

³ For coverage in South Africa see Leclerc–Madlala 2001a, 2002.

Fieldwork and methodology: The HOPE Cape Town project

The content of this paper is based in research with the HOPE Cape Town (HIV Outreach Program and Education) Pilot Traditional Healer Project,⁴ an innovative HIV/AIDS collaboration between traditional health practitioners and western medicine that has been running since early 2006. The paper is based on active participation and observation of participants in this collaboration. Data is taken from fieldnotes, supported by in-depth recorded interviews with graduate traditional health practitioners (ixiXhosa: *amagqirha*; isiZulu: *izangoma* – diviner/healers) and initiate healers (*thwasa*). Evidence also comes from field anecdotes and excerpts from interviews with health service personnel and community health workers (CHWs). The data was collected primarily in three peri-urban sites on the outskirts of Cape Town: Mfuleni, Delft South, and Wallacedene. Ethics clearance for the research has been received from the relevant academic authorities.

The tale of late arrivals

The first of the medical myths investigated here features a tale commonly reported by medical staff in the field. In it, medical personnel assume a link between the late appearance of patients suffering the final stages of AIDS at medical facilities, to the ‘fact’ that they have been visiting a THP. As these stories have it, the traditional practitioners, through ignorance or stubbornness, keep their patients too long in their care, fatally delaying their appearance at clinic or hospital. A typical example comes from a clinic Sister-in-Charge, who, obviously frustrated with her clients, remarked that ‘they come in when they are so sick. Yesterday we have another who died’.⁵ Although the Sister did not directly blame the THPs, her observation was made in the context of a discussion of the role of THPs in HIV/AIDS interventions, and her inference was clear: the THP had something to do with it. At a meeting with members of nursing staff at Tygerberg Hospital a

⁴ For detailed studies of the project see Wreford *et al* 2006 and 2007.

⁵ For in depth consideration of another of these stories, this time involving THP practice and allegations of unwelcome interactions between traditional remedies and ARVs, see Wreford 2008: Chap 3.

similar picture emerged. One of the audience asked about home care and the THPs:

‘Do they know when to refer a patient to the hospital or the clinic? They want to be able to cure a patient, but they must also know how to recognise that they should go straight to the clinic. Otherwise we only see patients who are at death’s door.’

This sort of blaming is not confined to HIV/AIDS. The THPs are also implicated in stories that suggest that their inadequate or untimely care contributes to the delayed treatment of childhood diarrhoea and TB. A doctor working with the HOPE Cape Town project admitted that her experience of THPs as a paediatrician had been ‘pretty negative’ as she reported witnessing cases of children suffering severe dehydration following traditional diarrhoeal remedies. The important question of whether western medical personnel might not themselves accept some responsibility for the ignorance about AIDS and other conditions that they generally ascribe to the THPs is addressed later in the paper. It is not the intention here to cast doubt on these personal accounts from practising health personnel, but to question the blanket attribution of blame on the THPs.

What other factors might be contributing to the presumption of guilt? One of the most influential and damaging concerns the tendency of biomedical personnel to stigmatise THPs. Relationships between western medicine and THPs in South Africa have long been characterised by suspicion and mistrust (for example Shapiro: 1987). This unwelcome situation continues to the present, for medical opinion about THPs is typified by diffidence and disinterest, as acknowledged by some members of the medical fraternity (SAMJ 2006) and recognised by the THPs themselves (Wreford *et al* 2006: 14). Patients visiting public health facilities are quite aware of this distrust (Booth 2004: 42; Mongale 1991: 9), and staff employed in the clinics featured in this study frequently acknowledged that their patients very rarely admit to a visit to a THP. This pervasive atmosphere of mutual suspicion is unhelpful to all sides, no matter what medical problem is involved. The following comments from a community health worker sympathetic to traditional healers illustrate some of the effects in the context of HIV/AIDS. Her remarks were offered in relation to the case of a hypothetical patient on antiretroviral (ARV) treatment:

If you say ‘don’t go to a traditional healer’ you’re actually pushing the patients straight into the hands of the healers! And now what is happening he’s not going to tell the THP that he’s

on treatment...that's what's happening you know? Because I was sitting down with them [THPs] and asking them and the other lady said 'they're not telling us'. And I said 'ewe (yes), because you've pushed them away, and they're not going to tell you...they're going to give you the answer you expect!

Asked what happens the other way round, when the patient visits the clinic and is asked if they've been to the THP, she replied:

They'll say No! Because they know already so they're not telling you the truth...they're giving you the answer you want to hear, that's not going to be difficult for your ears. So which is a danger to them because they're not telling the truth you can't give them some sort of advice, what to do, what not to do.

But you can even begin to be able to communicate with the traditional healers. I don't have a problem with [them] in my community.

There is no question that some THPs resist all biomedical interpretations of HIV/AIDS and are determined to prove that they can 'cure' the disease without western medicine.⁶ It is also the case that many people with very advanced immunodeficiency do indeed arrive so late at medical facilities that successful ARV treatment is either impossible or severely prejudiced (Lawn *et al* 2005). Nevertheless, it seems unlikely that the traditional healer scenario offers an explanation for *all* these late arrivals. What is more, given the animosity between the two paradigms outlined above, it is strange that clients who had previously refused all mention of THPs, will suddenly admit to visiting a healer only when seeking relief from the distressing symptoms of late stage AIDS.

Although as yet there is no data to verify this,⁷ I would suggest that there exists a very plausible alternative explanation to the biomedical attribution of blame on the part of the THPs. The following testimony, in which a traditional healer describes one of her clients' response to her life-threatening condition, sets the scene:

⁶ Whilst claims for 'cures' for the disease are usually attributed to charlatans, Wreford 2005: 62-63 gives an example of a recognised healer espousing this position.

⁷ In presenting this hypothesis I appreciate that, given the sensitivity of the issue, it will be very difficult, if not impossible, to obtain testimony supporting the idea. Nonetheless I argue that this is insufficient reason to dismiss its plausibility.

She don't want to admit to the problem. She stays at home. She was busy dying. Then when she becomes too ill her family brought her to me. But I said there is nothing I can do for you – you must go to Tygerberg [Hospital].

Here we see a patient who, as the THP graphically puts it, has been 'busy dying'. Rather than seek treatment, she denies her condition until the very last moment. Only then does she venture out to the THP. Note that it is at the healer's insistence that she eventually visits the hospital.

How often might a similar scenario have been enacted? The patient finally arrives at the clinic or hospital. When asked 'why did you leave it so long?' it is so much easier to say 'I was visiting with the traditional healer' than to confess to her own culpability in the delay. In the story above, of course, such a response would have been broadly true: but it would also have suggested an entirely unjustifiable attribution of fault to the traditional practitioner. Unfortunately, it could all too easily (and perhaps conveniently), be misconstrued by medical personnel already inclined to bias against THPs, to mean that the healer had deliberately delayed the patient's arrival at the clinic.

The above excerpt also offers evidence of the ways in which the stigma attached to HIV and AIDS in South Africa operates to persuade patients to postpone seeking treatment.⁸ Indeed, the patient here is sufficiently reluctant to 'admit to her problem' that she is almost prepared to die. The question of late arrivals cannot then be considered outside of the denial and secrecy that are employed to avoid stigma. Another healer remarking on the general tendency to non-disclosure pointed out that: 'What they don't want to do for somebody to go and talk about them in other places, they don't want that [because] it's not out yet.' As far as this healer is concerned, the dire consequences of this tactic of concealment are clear:

'People who don't tell about their status spread the virus. If people were to open up in the early stages of their diagnosis they would be able to get help.'

⁸ See for example Ndinda *et al* 2007; Varga *et al* 2005.

Given this picture, it seems very probable that it is often the *patients'* choice (with or without the knowledge of their families)⁹, to hide themselves away, to pretend that there is nothing wrong, until, as the healer graphically puts it, they are actually 'busy dying'. By this time the likelihood of their recovery - ARVs or no - is severely prejudiced (Coetzee *et al* 2004; Lawn *et al* 2005). Thus, when they finally present at the clinic and are challenged about why they left it so late, any mention of a traditional healer is likely to be inflammatory, and the THP, instead of being recognised for their role in encouraging the patient to seek medical treatment, becomes a convenient scapegoat for everyone concerned.

Other social and historical factors may also be at play in these 'late arrival' situations. Not least of these is the symbiotic relationship between biomedicine and colonialism. White, for instance, uncovered dramatic stories of vampires and bloodsuckers connected with colonial medical services in Zambia (2000). Based in fear and ignorance of allopathic medicine, these tales were often encouraged, either by a deliberate, or unconscious obtuseness about medical processes and environments. The case of a youth-worker in Khayelitsha, Cape Town, serves to illustrate a contemporary version of this sort of phobic myth-making in South Africa, and demonstrates its longevity. Although he had been diagnosed as suffering from appendicitis, the young man in question refused until the very last moment to go to hospital. When asked later why this was, he explained that he had been afraid that his blood would be removed there and used 'to make medicines for whites'.

Fears like these may appear completely irrational especially to those familiar with western medical practice. Nonetheless, suspicions about the quality of biomedical services provided to black South Africans have a basis in the harsh facts of the country's divisive history, which saw racist ideology translated into public health provision (see for example Fassin 2007: 134; Shapiro 1987: 236-239; Youde 2007: Chap 4). Throughout Africa, the provision of biomedicine served from the start to support a colonial agenda in which the health of the settler community was prioritised. In South Africa, as the growth of industry led to an increasingly urbanised African population, attention switched to protecting the health of the white community from this racial proximity, although health provision for the

⁹ Campbell *et al* (2005) provide anecdotal evidence of the tendency to hide HIV positive relatives away rather than admit to the shame of loss of 'sexual respectability'.

African community continued to be overlooked or non-existent (Digby 2003). Indeed, it was not until it became obvious that the lack of health services could jeopardise the supply of an adequate labour force, especially in the mines, that steps were taken to consider the health of the 'native' (Shapiro 1987: 235-239). Under these circumstances, it is hardly surprising that black South Africans continue to be suspicious of western medical facilities and practitioners.

Importantly, in the context of contemporary responses of African patients to biomedical interventions into HIV and AIDS, this harsh reality was typical of the early treatment of sexually transmitted diseases (STDs). As Jochelson's historical research demonstrates, sexual disease (in this case syphilis), came to be heavily stigmatised as a direct consequence of steps taken jointly by the administration and medical personnel to control the scourge (1999). In the 19th and 20th century, for example, Jochelson records that a diagnosis of an STD became a severe liability for workers because employers:

tended to dismiss servants with STDs, and without a health certificate a worker was ineligible for a pass and lost his right to live and work in an urban area (1999: 229).

Jochelson goes on to suggest that for Africans 'the continued association between pass controls and STDs treatment can only have reinforced the idea that disease was a crime' (231-232).

In a contemporary version of this scenario, a young HIV positive woman, speaking bluntly and without apparent rancour, described to me the consequences of her voluntary disclosure of her status to her employer: 'She tell me, No, you must go now. She didn't want me there.'¹⁰ Given this response¹¹ it is scarcely surprising that the secrecy that originated in the 'criminalisation' of sexual disease by colonial medical services continues to this day. I would therefore add to Jochelson's conclusion another: that the linkage between disclosure of HIV/AIDS and the possibility of the loss of

¹⁰ Simbayi *et al* record similar testimony about loss of employment as a result of disclosure from people living with HIV/AIDS in Khayelitsha, Cape Town (2007).

¹¹ This is not unusual as Fassin illustrates (2007: 136-140; 159;181).

precious employment reinforces past patterns and encourages secrecy, and the refusal to admit, or even to seek treatment for disease.¹²

But other evidence exists to account for black African suspicions of biomedical motives. Jochelson reminds us that the treatment meted out to African patients – she again uses the example of mineworkers suffering from syphilis - was *itself* partial. Records show that the mining companies considered new chemotherapy treatment - made available to white supervisory staff - too expensive for the mineworkers themselves. Thus:

Africans were given just sufficient medication by district surgeons...so that they were no longer infectious but were not completely cured...[this] inadequate treatment made a worker fit for work in the short term, but could make syphilis latent and lead to tertiary complications many years later (1999: 230).

As illustrated by the story of the young man's appendicitis cited earlier, suspicions of biomedical intentions resonate in the present, and it seems unlikely that historical incidents of callous behaviour by biomedical personnel - particularly their association with sexual disease - have been altogether erased from the collective memory.¹³ But contemporary concerns about quality of care also resound and fuel existing doubts. In a study based in Tanzania and Zambia for example, as she talked about nursing care, a female patient suggested: 'Once they know it is HIV/AIDS, they will not treat a person, they will just let her die' (Baylies and Bujra 2000). In the time of AIDS, narratives such as this serve, no less than the supposed dilatory interventions of THPs, to fuel the fear and distrust that results in 'late arrivals' at hospitals and clinics.

¹² Contemporary research seems to support this conclusion. Ndinda *et al* for example (2007), find that in rural KwaZulu-Natal, men, often the breadwinners, are far more likely to hide their illness than women.

¹³ See Didier Fassin's careful analysis of the personal experiences and collective politics involved with AIDS in South Africa in which he repeatedly points to the connection (often ignored or forgotten in academic and scientific studies) of the effects of memory as an experience that is shared across generations and reverberates into the present (2007)

The myth of sex with a virgin

The ‘sex with a virgin’¹⁴ myth is one of the most pernicious associated with HIV/AIDS. For those not yet familiar with it, the story suggests that to have sexual intercourse with a virgin - in its most harmful form, any uninfected being including young children - will cleanse an infected person of the virus. It is repeated in different forms throughout Africa,¹⁵ with slight variations: although I have discovered only one version suggesting a direct link with a healer’s advice (Wiseman 1999: 153 -154). The rationality behind the notion is always the same: by behaving thus, an infected person (the perpetrators are always portrayed as male) cleanses himself of the virus. The fate of the unfortunate victim is apparently never considered. The story is most often reported, in popular journalism and academia, to have originated with ‘traditional healers’ (see for example (Leclerc-Madlala 2002: 88, Schoepf 2004: 23), even though the ‘evidence’ for this claim – usually based in hearsay - is generally precarious (Matthews 2005: 149).¹⁶

It is by no means my intention here to defend this reprehensible behaviour, or to pretend that it plays no part in the spread of the epidemic. Nor do I wish to contest Leclerc-Madlala’s gendered critique of the notion as part of a wholly outrageous syndrome that places ‘women’s sexuality at the epicenter of blame for the current epidemic’ (2001a: 537). What I will try to do is interrogate the confidence with which the story’s origins are laid at the door of traditional healers. I will suggest that the presentation of the myth in these terms is often misleadingly categorical: comfortingly familiar to scientific scholars perhaps, it reinforces unhelpful stereotypes of traditional healers as ignorant and dangerous.

The certainty that traditional healers are responsible for the virgin cleansing myth is replete with the sort of moral ambiguity that is undeniably attached to traditional healing (Ashforth 2005: 59; Wreford 2008: Chap 8). As the earlier discussion concerning stories of ‘late arrivals’ showed, when asked to account for the uncomfortable truth of a situation, people will often give the

¹⁴ The practice is also known as ‘virgin cleansing’.

¹⁵ I heard my first version of the story, told to me by a building worker, during my first year working in Harare, Zimbabwe in 1993.

¹⁶ It is acknowledged that the notion of ‘cleansing’ is paramount in many African traditions of healing (Wreford 2005: 70-72). This may be one reason why the allegations are so confidently laid at the THPs’ door.

answer that is least ‘difficult for your ears’. Thus, in response to her interrogation of their knowledge about virgin-cleansing, Leclerc-Madlala notes that all her traditional healer informants declared themselves ‘opposed to [the] practice and rejected claims of its efficacy’ (2002: 92). The fact that they ‘all professed to have first hand knowledge’ of THPs who *did* play a pivotal role in spreading the story begs the question: had Leclerc-Madlala managed to discover one of these wayward healers, would they too have professed their innocence? Perhaps we should be looking for an explanation closer to home, as it were.

To speculate on the prevalence of sexually transmitted diseases in Africa before the arrival of Europeans is hazardous.¹⁷ What is known is that the earliest settlers imported several STDs to the continent. Since STDs were rampant in Europe at the time it is not unreasonable to assume that the settlers also carried with them their own myths about the disease: that sex with a virgin would bring about a cure for syphilis, for example (Ball 2007: 234). As anthropologists and historians have long recognised, rumour and myth in the medical sphere are powerful and adaptable¹⁸ and it seems not unlikely that the origin of the virgin cleansing story is a version of that held by Africa’s early colonisers. Modernised, and altered to suit local circumstances, it persists.

But, culpable and offensive as this myth is, it is surely a lesser driver of the HIV/AIDS epidemic than prevailing attitudes and behaviours that encourage male domination of sexual relationships throughout Southern Africa. As Leclerc-Madlala shows, the fable coheres easily with existing gender stereotypes, in which women are inevitably portrayed as powerless. In the context of an inquiry into the apparent impotence of behaviour change messages in South Africa, she writes:

‘in many communities, women can expect a beating, not only if they suggest condom usage, but also if they refuse sex, if they curtail a relationship, if they are found to have another partner...or even if they are believed to be thinking about someone else’ (2000: 29).

¹⁷ Although Mostert notes early settler testimonies which remarked not only on the exceptional good health of the Khoisan of the Western Cape, but of their healing skills (1992: 112-113).

¹⁸ See White 2000.

If, as Leclerc-Madlala reports, it is taken for granted that ‘males are biologically programmed to need sexual relations regularly with more than one woman’ (30),¹⁹ most women (ironically including those who are married), can have virtually no expectations of controlling the behaviour of their male partners. Living under the yoke of such archaic discourses, women must almost expect to be violated and abused.

The prospect of violation persists in different guises in contemporary *mores*. In an apparently unconscious and highly paradoxical reversal of the ‘one man, many women’ situation, Leclerc-Madlala also discovers young, sexually active women being portrayed (by men) as acting ‘like men’. Unlike their male counterparts however, these exhibitions of female sexuality are vilified as ‘dirty and dangerous’ (2001b: 43), subject to male critique, and often to a violent reaction.²⁰ Meanwhile, in rural KwaZulu-Natal adolescent boys insist on their right to have sex ‘in order to prove that [a] girlfriend was still a virgin’ (Harrison 2001: 72), a particularly illogical assertion of male sexuality – and an ironic inversion of the sex-with-a-virgin myth.

In the face of this aggressive masculinity in the arena of sexual relationships,²¹ I suggest that the question of where the virgin cleansing story originated is considerably less clear-cut than is usually implied. Is the virgin cleansing myth any more pernicious than the braggadocio of HIV positive men who, after discovering their status, respond with threats to ‘hunt for others’ or insist that they are ‘not sleeping’, but are ‘on a mission to spread [the virus] everywhere’ (Ndinda *et al* 2007: 96-97)? Is it any less destructive than the portrayal of virgins as ‘safe’ - interpretations that lead to the conclusion that ‘meat to meat’ [unprotected sex] is secure with a virgin ‘because the assurance [sic] that no previous sexual encounters would have led to infection’ (Tillotson and Maharaj 2001: 92)? Is it not simply a perverse development of versions from Nigeria and Liberia quoted by Green (Green 1992: 122), or of the Kenyan story that insists that ‘if a man has [an STD or HIV] having a negative wife will be medicine’ (Booth 2004: 40)?

¹⁹ A notion epitomised by the adage “the bull cannot share the kraal with just one cow.”

²⁰ Looked at from this perspective the virgin cleansing story might be subconsciously operating not only to cleanse the known infected person, but to force a cleansing on his intended female victim.

²¹ In making this statement I also acknowledge the consequences, largely undocumented, of the history of South Africa and especially its pernicious effects on patterns of behaviour, not least in the realm of male sexuality (Fassin 2007; Wills 1997: 217).

And finally, where is the hard evidence to identify the source of these stories with traditional healers?

Let there be no mistake, all of these tales are dangerous, advanced from an arrogant masculinity. Many THPS are male, and some may indeed be implicated in the spread of these myths. What is required to change the destructive behaviour encouraged by the virgin-cleansing stories is less a 'witch hunt' against traditional healers than, as Leclerc-Madlala unambiguously declares, 'a transformation of the sexual attitudes and practices of young and middle-aged men' in Southern Africa (Leclerc-Madlala 2000: 30). Deeply unpopular as this may be, it will ultimately achieve far more than any number of articles demonising traditional health practitioners.²²

Treatment choices, drug interactions and 'pseudoscience'

In the final example of medical mythologising considered in this paper I offer a perspective on the long-running, and often acrimonious dispute about the treatment of HIV and AIDS in South Africa: specifically, the extent to which patients should be entitled to treatment decision-making. Unlike the previous examples, this is not so much a matter of medical myths as such. Rather it results from the exploitation of the sorts of scientific certitudes that fuel those myths. It features medical 'beliefs' about traditional healing practice in relation to HIV and AIDS, utilised in the pursuit of an exclusively biomedical solution to the pandemic. The discussion first touches upon the history of the debate, and its context,²³ and notes some examples of the rhetoric that often characterises 'scientific' coverage of the dispute. The same scenarios are then explored from the traditional healers' perspective to suggest that, in their haste to 'scientise' treatment, medical professionals and their supporters have missed many more subtle nuances of the situation. In so doing, they are in danger of once again alienating the traditional healers and so prejudicing the potential of an alliance with this powerful cohort in the fight to stem the pandemic.

²² As traditional leaders, the THPs could be useful allies in the promotion of such a campaign.

²³ For more detailed coverage see Wreford 2005: 57-68.

The attitude of medical doctors towards traditional practitioners in South Africa is generally characterised by indifference and suspicion, even occasionally, animosity. This standoff situation produces a relationship at a remove, such that, although some biomedical practitioners acknowledge the potential advantages of collaboration with the traditional sector, examples of collaboration have been few (SAMJ 2006). The importance of ‘an open exchange of information and experiences...[with] fellow health-care professionals’ has been accepted by international organisations (UNAIDS 2006:6). But this sort of reciprocity in bi-sectoral medical collaborations is yet to be understood in South Africa. Consequently, those initiatives that have taken place have generally been one-sided and uni-directional, so that even those THPs involved in them become disillusioned (Wreford 2005b).

This scientific bias is particularly evident in the debate about treatment for HIV and AIDS, where academic and medical coverage displays a resolute determination to promote an exclusively biomedical solution to the pandemic. Arguably this situation is linked to medical frustration over the fragmentary implementation of treatment policies in South Africa, not least the dilatory roll-out of antiretrovirals (ARVs). As has been reported by academics and popular commentators alike, the government response to HIV and AIDS has been characterised by confusion and prevarication (Fourie 2006: 159-163; Makgoba 2000; Natrass 2006). Denialist declarations from the President and the Minister of Health have together prejudiced the administration’s commitment to confront the pandemic (Whiteside and van Niekerk 2005: 34), attracted local and international opprobrium, and continue to the present.

Take for example, the HIV/AIDS and STIs National Strategic Plan 2007-2011 (NSP 2007). Produced by the TAC with the then deputy Minister of Health and other social activists but without the involvement of the Minister of Health,²⁴ this apparently reinvigorated plan was much appreciated. But hopes for the improved treatment regime presented in the NSP 2007 were dashed when the President summarily dismissed the deputy minister in questionable circumstances (Bateman 2007). Given that a revitalised Minister of Health has since attempted to defend the government’s AIDS policy as being ‘on track’, while pointedly ignoring all mention of the 2007-2011 Strategic Plan (Tshabalala-Msimang 2007), the future of the NSP 2007 remains in jeopardy.

²⁴ The minister was for several months confined to hospital by ill health.

Needless to say, the administration's resistance to implementing a comprehensive treatment roll-out as envisaged by the NSP 2007 has further strained relationships between the TAC and medical doctors working in the field. Equally damaging, especially to their relationships with traditional healers, has been the minister of health's repeated advocacy of 'traditional' remedies for HIV and AIDS, and her apparent encouragement of entrepreneurial treatment interventions that cynically exploit the vulnerable and desperate.²⁵ It is hardly surprising that - convinced by the minister's often misapplied use of the 'traditional' label - some THPs have supported false claims of 'cures' for HIV/AIDS, but this has only added to the alienation of both the TAC and the medical fraternity from traditional practice.

The TAC and the AIDS Law Project are to be congratulated for their mobilisation of a national grass roots movement demanding timeous treatment for all South Africans living with AIDS. That the TAC envisages that treatment exclusively in terms of western medicines – and in particular ARVs – is not surprising. However, in the light of South Africa's pluralistic health system, their singular endorsement of 'proven' western medicines against 'untested substances' is peculiarly myopic (Hassan and Heywood 2007). Even in the context of an environment more hegemonically biomedical, rhetoric that implies restraints on the patient's freedom to choose treatment would be questionable. In the pluralist health context of South Africa, where traditional practitioners continue to provide a vibrant and parallel service to the majority, including those living with HIV and AIDS, it appears to threaten the right of patients to make their own treatment decisions based on their understandings of health and illness.

It is important that both medical paradigms are absolutely transparent about HIV/AIDS treatments, and to acknowledge that neither system can presently cure the disease. While this situation prevails, the issue of treatment choice is significant, especially in the earlier stages of the disease. During this time, when biomedicine has relatively little to offer patients, many already prefer to consult a traditional healer.²⁶ Indeed, at this early stage, when there are no documented contraindications between biomedical and traditional therapies,

²⁵ The case of the Rath Foundation in Khayelitsha, Cape Town, is notorious, but it should be noted that the case of a less than scrupulous academic who was tempted to claims of 'anti-HIV' remedies received far less attention (Thamm 2006).

²⁶ I have elsewhere described this as the 'treatment gap'. See Wreford 2005: 66.

it might even be preferable to employ traditional herbal remedies over antibiotics, for example, with their depletive effect on the immune system. To argue, as the TAC and biomedical personnel frequently do, that traditional medicinal preparations should be denounced simply because they are untested evades the issue.²⁷ Likewise the ‘tit for tat’ categorisation of traditional remedies as ‘deadly’ (Geffen 2007) is surely just as unhelpful as the minister of health’s characterisation of ARVs as ‘poison’ (Garrett 2002). Meanwhile the tendency to equate *any* reservations regarding ARVs with AIDS denialism arguably makes a broader and more democratic debate on the subject of treatment impossible.²⁸ As Fassin puts it, in his considered discussion of the differences between the ‘orthodox’ and ‘heterodox’ camps, ‘the first know; the second believe’, a dichotomy that tends to an unhealthy reductionism in the debate (2007: 76).

THPs and their supporters could be forgiven for interpreting this medical fundamentalism from the TAC and its allies as hostile, and in its own way, denialist. There is no shortage of evidence pointing in this direction. First, the scientific position implicitly denies the healers’ knowledge and experience of HIV and AIDS. Secondly, in all the discussions about ‘choice’ there is a disconcerting tendency to patronise patients for their decision (not without reason, as the earlier parts of this paper have demonstrated) to prefer to put their trust in traditional practice over scientific medical solutions. Blanket accusations that traditional remedies ‘[do] harm to others’ (Geffen 2007: 18-19) ignore the fact that it is the patients who, in the event of any illness, pilot their own healing itinerary,²⁹ often using traditional and biomedical solutions interchangeably.

²⁷ The NSP for instance notes the lack of research into the traditional pharmacopoeia and urges scientific investigation of ‘the efficacy of traditional and complementary medicines for HIV treatment and OI prophylaxis’ (2007: 108).

²⁸ A panel discussion titled ‘Mortal Combat: AIDS Denialism and the Struggle for Antiretroviral Treatment’ (2007) held at University of Cape Town (UCT) in September 2007, and chaired by Nathan Geffen of the TAC, illustrates this point. At the meeting Dr Judith Head, Dept of Sociology, UCT, offered a counter-narrative to the scientific defence of ARVs presented by the rest of the panel. She argued that other factors such as the links between poverty, hunger and problems with ARV regimens, and practical issues like the lack of infrastructure in treatment facilities, or the difficulties of patients in accessing them, should also be taken into account. Before making her presentation she emphasised that in raising these points she was not espousing the denialist camp.

²⁹ As Ries points out, unlike western medical practitioners, THPs are generally sanguine about this situation (2002:100).

Moreover, this negative approach appears to consciously deny the reality that many THPs are genuine, are desperately concerned about the ravages of HIV/AIDS in their communities, and are committed to providing the best care possible to their clients. As one healer put it to me: ‘We need more knowledge. You must know what you want to do for the people.’ Finally, whilst western medicine is quick to place the blame for ‘harming’ on the ignorance of the traditional practitioners, its practitioners continue to be reluctant to engage their traditional counterparts - health professionals in their own right and recognised within their communities - in a respectful and useful debate about differences in medical interpretations and practice as they relate to HIV and AIDS.

How have the traditional practitioners involved in the collaborative project that informs this paper experienced this situation? The following episode occurred at a local clinic where a generally constructive relationship has gradually developed between the healer in question and the medical staff. At a regular liaison meeting the healer brought up the story of one of her clients, whom she had referred to the clinic for HIV testing. It appears that following the test, the client had been told by one of the medical staff ‘don’t you go back to the healer. You stick with us now.’ The healer was understandably incensed at this suggestion. After all, the first approach was made to her: had it not been for her counselling work, the client would probably never have visited the clinic. Moreover, since the client was diagnosed HIV positive, but not yet ready for ARVs, there was no possibility of contraindications with any follow-up treatment that the healer might have suggested. Faced with this medical chauvinism in the face of her own commitment to collaboration, the healer not unnaturally felt cheated and let down.

Another example exhibits the divisive potential of medical myths becoming reality. In some of the more common stories relating to traditional health practitioners and which inform rhetoric about ‘deadly choices’, the question of the ‘dosage’ prescribed by THPs figures prominently. In these versions, because the amounts given by THPs are ‘scientifically’ unmeasurable, they are therefore automatically dangerous and pernicious.³⁰

³⁰ It is true that THPs do not generally have access to scales, or weights and measures, it should not be overlooked that their prescriptions are often also based in experiments and experience verified through a chronicle of previous treatments.

But the issue of dosage is not quite so clear cut. Take for example, historical changes to traditional practice brought about by increasing urbanisation. In rural settings, especially in the case of a severe illness event with persistent symptoms such as HIV/AIDS, it was generally accepted that a patient would remain with the healer until they had recovered. In this way the practitioner was able to supervise treatment and dosage.³¹ In the peri-urban settings characterising this study, this is possible only on rare occasions. Patients have family and work commitments and frequently receive diagnosis and the remedy for the situation at the same sitting. Thereafter they return to their homes. This is not an ideal situation, for self-medication might obviously have deleterious consequences such as the possibility of overdosing, missing or incorrect doses, the sharing of treatments, and so on.³² In addition to this, urbanisation (and the inadequacy of public health services) has seen a growth in traditional pharmacies or 'African chemists' where patients frequently purchase remedies, *with or without recourse to a THP* (Cocks and Dold 2000; Digby 2005). In one study in the Eastern Cape Province a review of the symptoms most commonly presented by the clientele of these pharmacies suggests that the patients may well be seeking relief for TB or opportunistic infections related to HIV/AIDS (Cocks and Dold 2000: 1509).

Unfortunately, myths about THPs, as well as inadequate research into the role of the 'African chemist' (Cocks and Dold 2000: 1505-1507), ensure that the THPs often take the blame for problems associated with self-medication. One clinic Sister in Charge was unusual in simultaneously admitting that the negative stories about THPs were often untrue:

'From time to time we hear of children ending up in hospital after seeing a traditional healer. But there are a lot of myths, and sometimes people use their own stuff and blame the healer when things go wrong.'

The sister then described a specific case in which a mother had given her child Jeyes Fluid to drink³³ and then blamed a THP for 'telling her' to do so. The mother had apparently tried to implicate the healer to avoid accepting her own responsibility for administering a dangerous substance to her child.

³¹ Personal communication from the author's THP teacher.

³² As treatment regimens for TB and AIDS have realised, medical practice is not immune to this situation, and DOTS and DOTS-HAART regimes are specifically designed to try to avoid it (Moatti *et al* 2004; Coetzee *et al* 2004; Farmer *et al* 2001).

³³ Jeyes Fluid, a drain cleaner, is a popular cleansing remedy although I have only heard of its use, diluted in a bath, as an external wash.

‘I didn’t believe her,’ reported the sister, and, in marked contrast to the attitude of most practitioners in the biomedical and scientific fraternity, her response to the story was admirably practical and inclusive:

‘You’re not going to wish them [THPs] away. We should try to work with them rather than against them.’

Discussion

The remainder of the paper considers these tales in the context of the promotion of better relationships between medical paradigms in the time of HIV/AIDS, for, whilst this is not always explicit, the repetition of medical presumptions about THPs can be seen to play an important part in the success (or failure) of HIV/AIDS interventions.

I have said that the tendency of western-trained staff to blame the healers for their perceived inadequacies, ignorance, or wilful mistreatment in the face of HIV/AIDS, originated from and perpetuates, the awkward relationships that characterise relationships between medical paradigms in contemporary South Africa. Some medical practitioners have recognised a responsibility for the continuing mistrust between themselves and traditional healers (SAMJ 2006). But the persistent repetition by medical personnel of stories such as those examined in this paper, suggests that - on surgery floors at least - this responsibility is slow to be acknowledged. It is a truism that many traditional healers lack the scientific expertise required to comprehend the complexities of western medical understandings, of HIV/AIDS, or of other diseases. But I suggest that it is the diffidence exhibited by western-trained staff towards traditional healers that, of itself, maintains, and by default actually promotes the ‘ignorance’ and ineptitude of which traditional practitioners are accused.

It is surely somewhat hypocritical for doctors to blame THPs for undermining the objectives of western medical interventions - delaying the arrival of HIV/AIDS patients at the clinic or hospital so that treatment is compromised for example - whilst they simultaneously refuse to engage with the THPs and their understandings of illness and disease. It is vital (particularly so in the context of HIV/AIDS) that western trained medical personnel start to make serious, and respectful efforts to engage intellectually with the ideas that underline traditional practice. As I have

explained elsewhere, any attempts at collaboration with THPs should be based in reciprocity and a degree of humility, to avoid the sort of disappointment that, as others have recognised, can be destructive of better cooperation (UNAIDS 2006: 6).³⁴

At this point, in the context of the ‘blaming’ narratives discussed here, it is worth considering what attempts those who promote them have made to reach out to the practitioners in their areas of work to explain their concerns. What responsibility if any, do they feel for ensuring that the THPs recognise the signs and symptoms of HIV/AIDS in order to avoid erroneous diagnoses? The healers involved in the collaborative project which backgrounds this paper are not alone in having often (and enthusiastically) endorsed the idea of interacting with scientific medicine and understanding how it sees the treatment of HIV/AIDS, STDs, TB, and so on (Kayombo *et al* 2007: 8). Yet, despite professional calls for interaction - to ‘bridge the gap’ - examples of cooperation are lamentably rare. This is unfortunate, because collaboration can pay dividends.

Take for instance, the testimony of a Sister in Charge at a local clinic in Delft South, Western Cape Province, where a THP liaison for HIV/AIDS testing and treatment has been successfully established. As a ‘coloured’ woman she admits that she has no personal experience of traditional health practitioners, and had been doubtful of the advantages of collaboration. Nonetheless, after several months of cooperation she is clearly impressed with the traditional healer and has become an enthusiastic supporter of the idea of an expanded collaboration with other healers in the area. A black nurse at the same clinic remarked: ‘I think it is a good idea because our people do go to traditional healers and some of them [healers] they don’t believe in HIV so if there are traditional healers who are working to encourage people to come to the clinic to test, that is very good.’

In another of the local clinics associated with this project the Sister in Charge, also a ‘coloured’ woman, frankly acknowledged her ‘ignorance’ about traditional healing. Nonetheless, she could see the advantages of having the traditional healer involved in counselling for HIV/AIDS, and was already looking further into the future:

‘Some people believe in them. Sometimes for example, let’s say a child gets medication from the clinic for something. Then

³⁴ See Wreford 2008: Chap 3 for examples.

if it hasn't cleared up in a few days they will take the child to a traditional healer and he/she might say 'throw that away and use this instead.' Now if we were working in partnership it would change.'

A recent outbreak of childhood diarrhoea in this township has prompted the sister to initiate an interaction with the THP to help the clinic to liaise with other healers about the symptomology and treatment of diarrhoea. It seems likely that if this sort of liaison is successful, other collective activities will develop.

A critique of the findings presented in this paper may be that there is insufficient testimony from biomedical doctors.³⁵ To a large extent this is explained by the realities of staffing at the local clinics that feature in this study. Despite the fact that each of the three clinics serves up to 4,500 patients per month, the allocation of doctors to the facilities is limited, in each case, to one practitioner, who is in attendance for half a day per week. As if this minimal provision were not severe enough, according to the nursing staff the duty of these doctors is restricted to the enrolment of new TB cases and the supervision of ongoing TB medication.

The absence of doctors is doubly unfortunate: as a restraint on the service that the clinics can provide, and also for the promotion of collaborative bi-sectoral projects. As the previous examples make clear, many of the nursing staff are more than willing to implement local changes to practice and procedure, and, despite already suffering an immense workload, are doing what they can to alter procedures at the clinic level. But they simply do not have the power and authority – which would be vested in the doctors - to change or instigate the sorts of fundamental alterations in practice and procedure that would be required to implement this sort of scheme on a wider scale.

Conclusion

Narratives have served many purposes in the HIV and AIDS pandemic in South Africa. This paper has examined some 'medical myths' about

³⁵ The absence of testimony from doctors and health administrators is regrettable. It is intended that future researches will make good the deficiency.

Traditional Health Practitioners, stories which, often implicitly derogatory or critical, provide specific commentary on the generally indifferent and even antagonistic relationship between western medicine and traditional practitioners. The paper has suggested that in adopting an attitude of blame the narratives are unhelpful, and undermine confidence in the possibility of collaborative medical efforts against HIV and AIDS. After examining some of the reasons for the biomedical presumptions that underlie these narratives the paper has provided some examples of constructive engagement and mutual respect working successfully to draw traditional health practitioners into the prevention and treatment of HIV and AIDS to the advantage of both medical paradigms and their patients.

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