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# Reach Out and Be Healed

## Constitutional Rights to Traditional African Healing

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University of Cape Town

## ***Reach Out and Be Healed***

### ***Constitutional Rights to Traditional African Healing***

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The introduction of the Traditional Health Practitioners Act 22 of 2007 has made lawful the practice of traditional healing. As everyone has the right of access to health care services, the question of whether the state bears a duty to reasonably provide access to traditional healing as an element of its public health care service, is raised. In a democratic society, law must be responsive to the needs of the populace. Ethnographic fieldwork demonstrates that traditional healing is used not in opposition to, but as a complementary twin of, biomedicine. Considering this, it shall be argued that economically, socially and medically, the incorporation of traditional healing into the public health care service is neither appropriate nor required by the Constitution.

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'Memory is life. It is always carried by groups of living people, and therefore it is in permanent revolution. It is subject to the dialectics of remembering and forgetting, unaware of its successive deformations, open to all kinds of use and manipulation... Memory always belongs to our time and forms a lived bond with the eternal present.'*

*Pierre Nora*

*'Don't you believe in complex lives and reasons?'*

*Haitian patient to Dr Paul Farmer*

'A World in One Country' is a deserving epithet for South Africa. She is home to a great many lives, colours, ethnicities, histories and perspectives. Her additional adoption of constitutional democracy allows this fascinating plurality to translate into her institutional structures. Accordingly, the landscape of organised medicine in South Africa, long rigid, is experiencing the tremor of change.

35 000<sup>1</sup> MB, ChB or M.D. qualified doctors practice in South Africa's conventional, allopathic, science-based biomedical<sup>2</sup> system.<sup>3</sup> Yet it is the approximately 200 000<sup>4</sup> traditional African healers who meet many of the health care needs of the bulk of her population. Defining the scope of traditional healing has proved difficult, due to the varieties of traditional healers that exist. In broad strokes, however, it usually consists of religious, spiritual, personal or supernatural divination to aid in determining the cause of the problem complained of, coupled with the application of, *inter alia*, herbal concoctions, spells and charms, inspired by the wisdom of kin and ancestors, as remedies.

Some estimates conclude that between seventy to eighty percent<sup>5</sup> of South Africans use traditional healers either exclusively or in tandem with biomedicine. This is thought to be due to the fact that traditional healers are, for the most part, more easily accessible, more widely available and are an integral part of much of the population's social and cultural circumstances. Belief in the power of traditional healing is, today, as widespread as ever,<sup>6</sup> albeit not unanimous,<sup>7</sup> and is not confined to

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<sup>1</sup> Health Professions Council of South Africa <http://www.hpcs.co.za/> Local copy: <http://www.hst.org.za/indicators/HumanResources/HPCSA/>

<sup>2</sup> This term will be used in preference to 'Western medicine' or 'modern medicine'.

<sup>3</sup> Additionally, some 100 000 nurses are registered with the South African Nursing Council South African Nursing Council <http://www.sanc.co.za/> Local copy: <http://www.hst.org.za/indicators/HumanResources/SANC/> Downloaded 2007-05-04.

<sup>4</sup> This figure is contested. In 1994, in the South African Medical Association publication *Bridging the Gap – Potential for Health Care Partnership between African traditional healers and biomedical personnel in South Africa* the figure was estimated to be 200 000, a figure repeated in E Pretorius 'Traditional Healers' in *South African Health Review 1999* N Crisp and A Ntuli eds. Durban, Health Systems Trust, 2000. N Gqaleni, I Moodley, H Kruger, A Ntuli and H McLeod 'Traditional and Complementary Medicine' in *South African Health Review 2007* Health Systems Trust, Johannesburg, 2007, pg 178, suggest the figure to be 185 477.

<sup>5</sup> This figure is extrapolated from World Health Organisation estimates for Continental Africa in *Promoting the Role of Traditional Medicine in Health Systems: A Strategy for the African Region 2001-2010* Harare, World Health Organisation, 2000. Other studies have noted the difficulty in establishing how many people consult healers for health-related problems – see N Natrass *Who Consults Sangomas in Khayalitsha? An Exploratory Analysis* CCSR Working Paper No 151, University of Cape Town 2006, while yet others have noted a usage rate of around 50-60% - see D Le Beau 'Dealing with Disorder: Traditional and Western Medicine in Katutura (Namibia)', *Namibian African Studies*, vol. 6, Germany, Rudiger Koppe Verlag Koln, Cologne. 2003

<sup>6</sup> NV Ralushai et al 'Report of the Commission of Enquiry into Witchcraft Violence and Ritual Murders in the Northern Province of South Africa 1 (1996) pg 57

<sup>7</sup> S Mall *Attitudes of HIV Positive Patients in South Africa to Traditional African Healers and their Practices* CCSR Working Paper No. 215, University of Cape Town 2008, pg 8

particular generations or those of a certain education or socio-economic standing.<sup>8</sup> Rather, such beliefs are widely held across social boundaries.<sup>9</sup>

Therefore, South Africa possesses a *de facto* situation of medical pluralism. The minority biomedicine is closely regulated, standardized and legislated for.<sup>10</sup> Traditional healers were, until very recently, legislated against.<sup>11</sup> Consequently, institutionally, South Africa had somewhat of a problem – not only were multiple medical systems functioning, but they were systems that adhered to different and, in many instances, contradictory, philosophies and principles.

The recent introduction of the Traditional Health Practitioners Act 22 of 2007 overturns the provisions of the Witchcraft Suppression Acts,<sup>12</sup> which had outlawed traditional healing. The new law,<sup>13</sup> which makes the practice of such healing lawful, has provoked a variety of reactions. Ire from many doctors, at the prospect of having traditional healers be officially sanctioned to treat patients;<sup>14</sup> applause from traditional leaders, who see it as a vindication of their efforts to gain a greater say in local governance;<sup>15</sup> concern from public-interest health groups for patient welfare;<sup>16</sup> and a mixed reaction from the healers themselves, mostly desirous of emerging from the medical shadows, but wary of state-sanctioned interference in their trade.<sup>17</sup>

Most importantly, however, the Act demonstrates an appreciation of, and a response to, the reality that many South Africans ascribe great importance to traditional healing. The new Act now enables them to engage with it in an open and legitimate manner and without the threat of sanction.

Given that resort to traditional healing is widespread throughout South Africa, and has had as much to recommend it as to condemn it – and probably more – the legalisation of it is neither surprising

<sup>8</sup> J Hund 'Witchcraft and Accusations of Witchcraft in South Africa: Ontological Denial and the Suppression of African Justice' in 33 *CILSA* 2000, pg 384

<sup>9</sup> N Tebbe 'Witchcraft and Statecraft: Liberal Democracy in Africa' in *Georgetown Law Journal* Vol 96, 2007, pg 183, pg 194

<sup>10</sup> Principally by the Health Professions Act 56 of 1974 and the National Health Act 61 of 2003

<sup>11</sup> Witchcraft Suppression Act 3 of 1957 and the Witchcraft Suppression Amendment Act 50 of 1970

<sup>12</sup> *Ibid*

<sup>13</sup> Which came into force on 30 April 2008

<sup>14</sup> C Bateman 'Legal Bone Throwing has Doctors Hopping Mad' in *South African Medical Journal* vol 93, no. 12, 2004 pg 882

<sup>15</sup> *Ibid* pg 883, quoting Philip Kubukeli, Advisory Director of the Western Cape Traditional Healers Association.

<sup>16</sup> M Richter *Traditional Medicines and Traditional Healers in South Africa* Discussion paper prepared for the Treatment Action Campaign and AIDS Law Project, 27 November 2003, pg 24-28 in particular

<sup>17</sup> Personal discussion on 20 April 2007 with Jo Thibeka Wreford, member of the Centre for Social Science Research, University of Cape Town, and practicing traditional healer.

nor unique. South Africa appears to, in its legislative stance, have taken an approach that advocates parallel systems of health care between traditional healing and biomedicine.<sup>18</sup> That is, the two philosophies are allowed to co-exist, but do not have a formal, institutional overlap, and only become intertwined by the peculiar health care seeking practices of the individual patient. Although the details of this endeavour have yet to be worked out, this seems to be the most sensible solution, based on observations of people's health care seeking practices in the country.

However, a fundamental question that appears not to have been considered, at all, is what the constitutional implications of such an introduction are. The state has an obligation, under Section 27(1)(a), read with S 27(2) of the Constitution of the Republic of South Africa,<sup>19</sup> to progressively make health care services accessible to all. Consider the exact wording of the full section.

- 27(1) Everyone has the right to have access to –
- (a) Health care services, including reproductive health care;
  - (b) Sufficient food and water; and
  - (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
- (3) No one may be refused emergency medical treatment.

Furthermore, as S 7 of the Constitution orders

- 7(2) The state must respect, protect, promote and fulfil the rights in the Bill of Rights.

It would appear that the conundrum is this. The state has, as part of its broad plans to improve the health of its citizens, legitimized and given legal empowerment to the philosophy and practice of

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<sup>18</sup> Where the opposing philosophies and methods of biomedicine and traditional healing have both been brought into the popular consciousness, they have frequently been married into health care systems by one of a variety of methods. Nations such as China and Vietnam, relying on the particular characteristics of the traditional healing found indigenously there, have managed to construct a blended conception of medicine, demonstrating both practices to be mutually supportive. A number of African countries, such as Tanzania and Ghana, have preferred to keep the practices separate, but complimentary in practice. Many developed nations have tended to adopt alternative medical practices which are not indigenous to their own borders, and these have usually been allowed to flourish, albeit under the strict watch of biomedicine. See *Legal Status of Traditional and Complimentary Medicine: A Worldwide Review* Geneva, WHO, 2001

<sup>19</sup> Act 108 of 1996

traditional healing. One of the Constitutionally-mandated socio-economic rights accorded to everyone, is that health care services be made progressively accessible, subject to available resources, by reasonable legislative and other measures. Although at no stage within the Traditional Health Practitioners Act is it stated that traditional healing is intended to become an element of state-provided health care,<sup>20</sup> many people employ traditional healing as a genuine health care service.

The question<sup>21</sup> raised is this. Do people have the right of access to traditional healing as a state-provided health care service? The correlative and corresponding question would enquire whether or not the state would be placed under an obligation by the users of traditional healing to not only allow, but *provide* traditional healing as a health care service.

As with earlier legislation that permitted various complementary and alternative health practices, such as homeopathy, aromatherapy and acupuncture, the Traditional Health Practitioners Act recognises and affirms traditional healing without adopting it as a state doctrine. The state is content to acquiesce to its private practice,<sup>22</sup> making patients masters of their own domain. This relinquishment of control is entirely consistent with the liberalist foundations of the Constitution, placing the power of choice in the hands of the individual.

Yet public health care is most definitely in the interest and control of the state. Single standards of biomedicine-organised health structures have proved decidedly effective and efficient in public health concerns, and thus the state would be well advised to maintain this preference for a singular approach.

The effect of the legislation is therefore to bring what was once a manifestly private affair, belief and trust in a traditional philosophy, into the uncontrovertibly wider domain of biomedicine-dominated public health care. Thus, social knowledge, that which is multiple and competitive, meets institutional knowledge, which is clinical and unified. Therefore, we are now presented with a fascinating demonstration of just how treacherous a chasm there can be between the private and the public.

These 'knowledge-s' are competitive in attempting to negotiate authority and power away from the other. Law should be expressive of society. But what of cases where there is a clear competition for

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<sup>20</sup> Presently, only its private practice is recognised.

<sup>21</sup> A host of shorter questions are packed around this principal matter. Should traditional healing be recognized as an acceptable form of public health care? Is traditional healing, for that matter, a form of healing, or an element of medicine, if those arts are different? In terms of resources, would the state be required to, at its expense, train traditional healers, assign them to clinics or remote locations, assist indigent patients to consult with them, provide healers with access to natural resources, endorse their methodology and philosophy and generally include them within the public health care budget?

<sup>22</sup> With an attitude seemingly running along a theme of 'If it's true for you, then it's true.'

what constitutes 'knowledge', 'fact' and 'reality'? Biomedicine and traditional healing are, institutionally, jostling philosophies premised on fundamentally competitive notions of what knowledge *is*, each claiming their own grounding to be the ultimate truth, attempting to displace the other for legitimacy. A competition of correctness is entered into and an institutional clash is sure to result. What is the knowledge, then, that is to be vaulted up and translated to the state – and then inverted and handed down and returned to society?

Traditional healing is a secretive skill and trade. When it does appear in the popular media, it is frequently misunderstood, and, in consequence, much maligned. The general trajectory that will be taken in this paper, therefore, will be to engage in, by anthropological study, a close examination of both the underpinnings of traditional healing and its use in practice by patients. This understanding is crucial, for in a democratic society lawmakers have a duty to be reasonably responsive to the needs of the population, drawing laws that reflect, where possible, the attitudes of wider society. This is only possible through an investigation of the known facts, and the subsequent informing of the law by the facts.

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Analysis of existing ethnographic fieldwork strongly suggests that patients use biomedicine and traditional healing in a complementary, not competitive, fashion. Therefore, laws concerning traditional healing and its use should appreciate the complementary nature of health care seeking in South Africa, so as to allow patients the best possible access to health care services. Yet before this anthropological knowledge may be applied to the principal question, there are three precursor questions to be answered.

First, there is the matter of whether or not traditional healing qualifies as a 'health care service' as anticipated by section 27 of the Constitution. Some would argue that biomedicine is the only true medicine, and that all others are mere imposters. Others would oppose this hegemony, citing the genuine health value that traditional healing brings to the lives of millions of South Africans. A comprehensive, sensitive answer to the question would be one that incorporated both an institutional viewpoint of what constitutes 'good health', *and* a patient perspective on the matter. It is only through a trusting, reciprocal relationship that a healer and a patient may work effectively to potentially restore the latter to health.

Second, if deemed a health care service, is it a service that may reasonably be expected to be provided? Not all health care services are provided by the state, and many that are, are rationed. For example, highly technical and difficult operations tend to be consolidated at urban-area hospitals and

are capped in the number that shall be provided at state expense, a matter already favourably considered at South Africa's highest judicial echelons.<sup>23</sup> South Africa has opted to promote a program of primary health care as its principal health care intervention. Therefore a demonstration that traditional healing is an element of, or supportive to, primary health care, would assist in its consideration for expected provision.

Third, there is no right to health care services, but a right of *access* to health care services. Therefore it must be determined what the term 'access' means for the health care services. Traditional healing and complementary and alternative medicine movements are normally situated in private forums. A move to the public arena brings with it questions that the present understandings of access do not adequately address. It shall therefore be argued that the present understandings are not appropriate for the question under consideration, and that access must be re-interpreted in order to sufficiently meet the proper scope of the Constitution.

The above three questions situate the debate firmly within the confines of S27 of the Constitution. However, the matter goes beyond socio-economic rights. The richly textured social and cosmological underpinnings of traditional healing prompt for a reflection on the accommodation of difference within the Constitutional order. It is for this reason that the values of dignity and equality, which underpin all aspects of Constitutional adjudication, must also be considered. 'Ways of life' rights, those that confer the rights to freedom of belief and freedom to engage in cultural practices, need to be canvassed too.

Mating the anthropology to the law, we will then evaluate the core question posed. Do people have a right of access to traditional healing as a health care service? Hopefully the course proposed will be one that is responsive to the health care needs of society, reflective of the attitudes of South Africans and appropriate for our Constitutional democracy.

This subject has become an important one in South Africa in recent years. Most of her citizens do not have proper access to health care facilities that are equipped to meet their needs. Institutionally, South African public health care, at best, lurches along. Lack of adequate funding, skilled personnel shortages, often poor sanitation and education systems and rampant disease, especially HIV and tuberculosis, make an already difficult task far harder for the dedicated health care professionals in the field. Alongside this general malaisé, traditional healing has remained the alternative choice for the

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<sup>23</sup> *Soobramoney v Minister of Health (KwaZulu Natal)* 1998(1) SA 765 (CC)

majority of South Africa's population, and improving its standing could not but help to assist in alleviating some of the more general institutional damage.

Thus, we begin our journey through the brightly-coloured suppositions and arguments that pervade this fascinating subject.

### *The Other Carers – Traditional Healing in South Africa*

*'The traditional healer was able to tell me why I had this domestic problem and what had caused it. I don't need the traditional healer for my HIV though. I have ARV treatment for that.'* (Male patient, Gugulethu).<sup>24</sup>

*'The traditional healer said that my illness was caused by idiliso (witchcraft). By then I knew I was HIV positive as I had had unprotected sex without using a condom. When the traditional healer gave me traditional drugs I felt no different. There was no need for me to visit a traditional healer again.'* (Female Patient, Du Noon).<sup>25</sup>

The anthropological ethnography employed in this chapter will investigate the orientation of traditional healing and, more importantly, its use by patients. Comparison to other geographical areas, as well as to biomedicine, will also be considered. The principles drawn from here will inform the answers to come in the chapters concerned with law, and, ultimately, the answers provided at the conclusion.

Traditional African healing is a somewhat contentious term – and for good reason. There is no unitary, all-encompassing, continent-wide traditional pattern of thought about the practice of healing the body.<sup>26</sup> Even regionally, within the borders of South Africa, conceptions of quite how a person is to be healed vary widely from healer to healer and patient to patient.<sup>27</sup> Moreover, as new methods of

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<sup>24</sup> S Mall *Attitudes of HIV Positive Patients in South Africa to Traditional African Healers and their Practices* op cit pg 14

<sup>25</sup> *Ibid* pg 13

<sup>26</sup> P Richards *Traditional Healers and Childhood in Zimbabwe*. Ohio Univeristy Press, Ohio, 1996, pg 5

<sup>27</sup> *Ibid* 6

treatment are explored, adapted and adopted, some of which are pragmatic hybrids of biomedicine,<sup>28</sup> the 'traditional' element of traditional African healing seems a less and less appropriate appellation. Yet the term persists in use by most concerned,<sup>29</sup> and whatever peculiar alterations and modifications the belief may have undergone, healers still gain their power to cure through relationships with kin and ancestors.<sup>30</sup> Moreover, the name finds favour with the legislation in question, the Traditional Health Practitioners Act.<sup>31</sup> Thus it remains the most appropriate descriptive noun.

Such healing is not entirely disparate, however, for there do exist some common philosophical threads that run through traditional healing as practiced within the modern borders of South Africa.<sup>32</sup> It is these threads that we will use to define the concepts of health, sickness and healing as they are interpreted within traditional African belief structures.

The first and foremost principal of traditional healing is that the good health of a person is determined not only by the body's own, internal actions, but extends to, and is partly controlled by, the person's social relationships and identities.<sup>33</sup> Hence, the worthiness, or lack thereof, of a person's actions is deemed a significant element in contributing to the health of the individual concerned.<sup>34</sup> This interpretation most probably arises because the majority of traditional social relations are based upon the concept of kinship.

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<sup>28</sup> In *Sithole v Rex* 1939 NPD 192, a traditional healer used a stethoscope in order to avail himself of modern science in the diagnostic phase, an act he believed to be to the benefit of his patients. The Court ruled this an acceptable action, for he was examining only, and not prescribing medicine based on the use of the stethoscope, which the Court held was not an attempt to hold himself out as a doctor, which would have been unlawful. Followed in *Ndhlovu v Rex* 1942 NPD 397. Interestingly, although alarmingly, an anecdote from Professor Mike McGovern of the Yale University Department of Anthropology notes his observation of a traditional healer in the Gambia in West Africa in the late 1980's re-using needles in syringes to inject herbal liquids into patient's bloodstreams.

<sup>29</sup> Certainly many healers regard as a correctly-encompassing term. See J Wreford 'We Can Help- A Literature Review of Current Practice Involving Traditional Healers in Biomedical HIV/AIDS Interventions in South Africa' *CSSR Working Paper 108*, Centre for Social Science Research, University of Cape Town, 2005, pg 2. There, Wreford argues that adoption of the term by the healers themselves constitutes sufficient reason for it to be regarded as an accurate term.

<sup>30</sup> N Tebbe 'Witchcraft and Statecraft: Liberal Democracy in Africa' pg 195

<sup>31</sup> See S1 of the Traditional Health Practitioners Act 22 of 2007, where 'traditional health practice' and 'traditional health practitioner' are used as official terms, and defined thereafter.

<sup>32</sup> E Pretorius 'Complementary/ Alternative and Traditional Health Care in South Africa' in *Health and Health Care in South Africa*, HJ van Rensburg (ed), Van Schaik, Pretoria, 2004, pg 507

<sup>33</sup> Gordon Chavanduka *Traditional Medicine in Modern Zimbabwe* University of Zimbabwe Publications, Harare, 1994 pg 1

<sup>34</sup> *Ibid* 9 and E Pretorius *Health and Health Care in South Africa op cit* 530

Strong, tightly-knit group and familial bonds form the basis of the small societies common in traditional, rural, life.<sup>35</sup> A person's kin not only act as supporters, but as educators and advisors, and, consequently, their role in presenting choices for a person is important.<sup>36</sup> Therefore ensuring that such bonds are cordially maintained is important not only for the figurative health of the group, but the literal health of the individual too.<sup>37</sup>

Kinship relations go beyond the immediate, corporeal world. Appeals are made to another source too, that being deceased kin or ancestors.<sup>38</sup> Ancestors participate actively in the world of the living. Mostly they benevolently care for, comfort and advise one in life.<sup>39</sup> But they can also be malevolent – disgrace upon the kin, or an act violating their memory by the person concerned, will dissatisfy the ancestors.<sup>40</sup> Understandably, in a group reliant upon coherent social relations for its survival, any attempt to ruin those relations, and any act which has the effect of uprooting the kin, shall therefore be punished by those who watch over it.<sup>41</sup> Hence, health and healing, within this philosophy, are inalienable from broader understandings of the intimate cosmological connection between the individual and the social.

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<sup>35</sup> *Ibid* 47 consistently

<sup>36</sup> E Pretorius *Health and Health care in South Africa op cit* 530-533

<sup>37</sup> *Ibid* 533

<sup>38</sup> South Africa is, however, a country in which the majority of the population profess to be of the Christian faith, and at first glance, this may appear to be at odds with the concurrent feature that the majority of citizens also align themselves with traditional philosophies. However, although some sectors of the Church have professed nothing but disdain for the traditional practices, other divisions have not only embraced the traditional beliefs and practices, but, from time to time, adopted them. Belief in the power and endurance of the ancestors has been woven quite intriguingly around fundamental Christian doctrines, originally taught by missionaries in the schools and stations that were established throughout South Africa at the initiation of the colonial era. Such interpretations of Christianity, in essence, adopt the Biblical monotheistic approach of Christianity, but interpret the Bible in a relatively literal sense, placing ancestors within the context of spirits, saints and other Christian icons. Although missionaries tended to keep Christian doctrines and medicine separate, interpreting disease in a rationalist-scientific way, relying on hospitals rather than prayer to solve health problems, literal African interpretations diverged. The Bible, somewhat unpredictably, though entirely understandably, provided validation for the traditional African belief that health and healing are intimately connected to good relations with the spiritual world. By relating feats of victory by the power of the Lord over sickness and death, of mastery over evil spirits, and his ability to heal and perform miracles, Christian symbolism held an appealing shared lexicon for traditional beliefs. For further reading on the subject, see BGM Sundkler *Bantu Prophets in South Africa* Oxford Press, London, 1961 and E Isichei *A History of Christianity in South Africa* Cromwell Press, United Kingdom, 1995, as well as the classic M Volf *Exclusion and Embrace* Abingdon Press, Nashville, 1996. The last-mentioned work provides, amongst other things, a tremendous account of the intricate adaptations of Christianity to suit contemporary political and social needs in diverse environments.

<sup>39</sup> E Pretorius *Health and Health care in South Africa op cit* 531

<sup>40</sup> *Ibid* 532

<sup>41</sup> G Chavanduka *Traditional Medicine in Modern Zimbabwe op cit* 57

As a result, a person is deemed to be in good health when they have a synthesized, balanced relationship within themselves (the individual); between their self and the social habitat (kinship group and beyond) that they live within; and their person and the natural environment through which they move.<sup>42</sup> Disruption of, and discord between, these balanced relationships is the event that leads to sickness and a general state of malaise in the life of the affected individual.<sup>43</sup>

Disruption can be effected either by personalistic or naturalistic means, a point often revealed in field studies, but frequently not appreciated properly. Personalistic ailments are those either 'sent' by others,<sup>44</sup> such as witches in the employ of another person, or are directed by a person's ancestors when they are unhappy with the person's conduct.<sup>45</sup> For many years, it was assumed that personalistic ailments were the only sort of ailment relevant to traditional healing. However, it has since transpired that naturalistic ailments are as important as sources of ill health.<sup>46</sup> Naturalistic ailments are present through no particular social taboo breaking, but are simple matters of fact – infection through dirt, pollution through contact with impure substances and environmental sickness through the air, land and water.<sup>47</sup>

To remedy these disruptions, people will, as any creature would, attempt to engage in some form of health care seeking behaviour. Remedies are sourced either by personal wherewithal or through those who hold themselves out to have sufficient knowledge and skill to put an end to such an ailment – in this case, traditional healers. Two manifestations of healer tend to predominate, those being herbalists and spirit mediums, though there is much mingling of the two arts.

Herbalists are educated through a process of apprenticeship, and are taken in by those already practicing and educated in the properties of various pharmacopeia and their uses.<sup>48</sup> These natural products, usually roots, leaves, bulbs and herbs, are then converted into pastes, brews and rub-on

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<sup>42</sup> JM Janzen *The Social Fabric of Health*, McGraw Hill, New York, 2002 pg 39

<sup>43</sup> Within these relationships, the dual dichotomies of a pure and polluted body, harmonious and discontented mind, and a cool and hot internal energy must be settled. EC Green *Indigenous Theories of Contagious Disease*, Alta Mira Press, London, 1999 pg 12.

<sup>44</sup> *Ibid* 13; Pretorius *Health and Health Care in South Africa op cit* 532; Janzen *The Social Fabric of Health op cit* 64

<sup>45</sup> *Ibid* 13; Pretorius *Health and Health Care in South Africa op cit* 533; Janzen *The Social Fabric of Health op cit* 65

<sup>46</sup> *Ibid* 76; Pretorius *Health and Health Care in South Africa op cit* 534; Janzen *The Social Fabric of Health op cit* 65

<sup>47</sup> *Ibid* 76; Pretorius *Health and Health Care in South Africa op cit* 534; Janzen *The Social Fabric of Health op cit* 65

<sup>48</sup> Lilian Simon *Inyanga – Sarah Mashele's story* Justified Press, Johannesburg, 1993 pg 5; G Chavanduka *Traditional Medicine in Zimbabwe op cit* 24

smears in an attempt to cure the diagnosed ailment.<sup>49</sup> Knowledge of what substances are appropriate is obtained either by experimentation and guess work, or by dreams, coupled to observation of effects.<sup>50</sup>

Spirit mediums, by contrast, are identified as suitable for their role by the occurrence of a calling from their ancestors to become healers. They either begin to practice immediately following this calling, or pass through initiation rites where established healers attempt to assist them in honing and using their skills of communication with the spirit world.<sup>51</sup> They then use these talents to engage with their own and their patient's ancestors, in order to help an individual understand the meaning of events and make choices in life as appropriate.<sup>52</sup> Divination is performed in a number of ways. For example objects that have a particular spiritual significance to the healer will be thrown. By looking at the patterns in which they fall, the pattern representing a particular interpretation revealed through the world of the ancestors, a conclusion is arrived at that will assist in alleviation of the pain or harm complained of.<sup>53</sup>

However, there is much overlap between the two disciplines and the source of power underpinning most traditional healers is claimed to be ancestor, kin and other spiritual relationships.<sup>54</sup> Recognizing this, the Traditional Health Practitioners Act has adopted a more expansive and over-arching definition, where traditional health practice means

'...the performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice and which has as its object-

- (a) the maintenance or restoration of physical or mental health or function; or
- (b) the diagnosis, treatment or prevention of a physical or mental illness; or
- (c) the rehabilitation of a person to enable that person to resume normal functioning within the family or community; or
- (d) the physical or mental preparation of an individual for puberty, adulthood,

<sup>49</sup> Personal communication with Jo Thobeka Wreford, 20 April 2007

<sup>50</sup> G Chavenduka *Traditional Medicine in Zimbabwe op cit* 24 and 71

<sup>51</sup> L Simon *op cit* 6; Personal communication with Jo Thobeka Wreford, 20 April 2007; G Chavenduka *Traditional Medicine in Zimbabwe op cit* 24

<sup>52</sup> JM Jansen *Social Fabric of Health op cit* 206

<sup>53</sup> *Ibid* 206

<sup>54</sup> A Ashforth *Witchcraft, Violence and Democracy*, University of Chicago Press, Chicago pg 294

or pregnancy, childbirth and death...<sup>55</sup>

The defining feature, then, of traditional healing, is that it be based upon 'traditional philosophy', which the Act defines as meaning the

'...indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice.'<sup>56</sup>

Traditional healers are claimed to be effective for a wide range of ailments – not all of which are regarded as such by biomedicine. Some healers profess an ability to cope with evil spirits, unemployment, infertility, penis strength, bad luck, job finding, and HIV/AIDS, amongst other matters.<sup>57</sup> Still others claim an ability to influence court judgments<sup>58</sup> and to protect people from theft and financial struggles.<sup>59</sup> And yet more profess only to be healers in the strict biomedical sense, dismissing the others as 'quacks and charlatans'.<sup>60</sup> With traditional healing so intimately connected with the social structures of life, a broad field of claimed expertise is to be expected. However, such a spectrum of potential matters means that it is difficult to conceive of what should, and should not, be considered a health care - related service. So whilst it may be so that a considerable proportion of the population consult traditional healers, one wonders whether all visits may be considered 'health care' consultations.

Such a practice has proved a little off-putting to many biomedical doctors. Traditional healing is defined as being centred upon belief, rather than empirical fact, which is biomedicine's staple source of knowledge. Indeed, the absence of scientific demonstrations of efficacy is expressly indicated as being

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<sup>55</sup> S1 of the Traditional Health Practitioners Act 22 of 2007

<sup>56</sup> *Ibid*

<sup>57</sup> Such as the flyer advertising for 'Dr Majin-Shaba' Scotts Corner, Rm 501, 5<sup>th</sup> Floor, corner of Plein and Darling Strs, Cape Town

<sup>58</sup> B Maravanyika *Justice the Sangoma Way* Cape Argus July 21 2007

<sup>59</sup> Flyer advertising for 'Dr Hamame' 367 Brooklyn Rd, Ysterplaat, Cape Town

<sup>60</sup> C Bateman 'Legal Bone Throwing has Doctors Hopping Mad' *op cit* pg 883

irrelevant to traditional healing.<sup>61</sup> Consequently, the reaction from the majority of the biomedical community has been one that, while appreciating that a belief in traditional healing is held by people,<sup>62</sup> denies that these beliefs should be either tolerated or accommodated in a viable public health care program.<sup>63</sup> This exclusionary stance has been exacerbated by various and palpable abuses of trumped-up traditional medicines within the context of the HIV/AIDS pandemic, by both state and non-state actors, providing much damning evidence for critics of traditional healing.<sup>64</sup>

Biomedicine, contrary to traditional healing, concerns itself principally with the material aspects of health<sup>65</sup> and has as its goal the promotion and maintenance of life through physical intervention, conducted via empirically verified observation of biological reality.<sup>66</sup> It is premised upon Cartesian Dualism,<sup>67</sup> which separates the physical body from the incorporeal mind. Disease comes about solely as a result of biological causes and only if an apparent cause is observable and objectively measurable is it considered "real".<sup>68</sup> Treatment is therefore correspondingly directed toward ascertainable causal patterns, principally mechanistic in method, viewing the patient as an individual, distinct from the world, but influenced by its physical realities.

This approach is probably the most effective approach to health and healing that has yet been employed.<sup>69</sup> Although some writers have noted the political moves by biomedicine, when in its infancy, to subvert other forms of healing, such as homeopathy,<sup>70</sup> the principle reason for biomedicine being the only form of health care that is universal, is its health-related efficacy and efficiency. Yet, biomedicine, through its very strengths, is also flawed. Biomedicine is designed to regard the patient as a biological entity, rather than as an emotionally-complex human being. Thus aside from a kindly bed-side manner adopted by individual doctors, it is ill-equipped to assist a patient to come to terms with a mystifying and, consequently, frightening world.

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<sup>61</sup> S1 of the Traditional Health Practitioners Act 22 of 2008

<sup>62</sup> O Meissner 'The traditional healer as part of the health care team?' in *South African Medical Journal* Vol 94, No. 11, November 2004, pg 901

<sup>63</sup> C Bateman 'Legal Bone Throwing has Doctors Hopping Mad' *op cit* pg 882

<sup>64</sup> C Bateman 'Government encouraging snake-oil salesman Rath' in *South African Medical Journal* Vol 95 No. 6, June 2005, pg 372

<sup>65</sup> A Kleinman *Writings at the margins* UC Berkeley Press, San Francisco, 1995 pg 27

<sup>66</sup> *Ibid* pgs 27 - 30

<sup>67</sup> As premised on the writings of René Descartes. For a contemporary commentary, see GP Baker and KJ Morris *Descartes' Dualism* Routledge, New York, 1996

<sup>68</sup> E Pretorius *Health and Health Care in South Africa op cit* 507

<sup>69</sup> P Farmer *Infections and Inequalities* UC Berkeley Press, San Francisco, 1999 pg 5

<sup>70</sup> A Kleniman *Writings at the margins op cit* 37

With this flaw, idiosyncratic human behaviour can contemplate an alternative to the demonstrable success of biomedicine. One of the real successes of biomedicine has been its ability to resolve complicated matters – cancer, heart problems, lung defects, kidney ailments and so on. However, these problems are less common than the simple ailments that affect and blight the lives of most people – colds and flu, tuberculosis, skin rashes and so on. So for millennia hardy people were able to survive with traditional medicine, because, through trial and error, it worked, and kept them healthy till the age when more serious problems came along – and then they died, because traditional medicine had reached its ceiling of efficacy. Biomedicine then entered the fray and was able to extend life expectancy though dealing with those more complicated problems.

Today, traditional healing is demonstrably effective in many simpler matters, and this has ensured its survival. Many traditional remedies have, upon confirmation of their efficacy, been patented and transformed into biomedical drugs, indicating that the active ingredients present in the traditional remedies do have genuine health value.<sup>71</sup> Even when they do not, the well-documented placebo effect of thinking oneself to health probably plays a large part in the success of traditional healing, for despite the best efforts of biomedical doctors, the human mind remains a mysterious and ill-understood frontier, creating a real need for traditional support and health.<sup>72</sup> Given the emphasis it places on moral attribution to ill-health, traditional healing seeks to make explicable the grand human questions that follow misfortune – ‘Why me?’, ‘Why do I deserve to suffer?’<sup>73</sup> Failing that, the comfort derived from simple, caring, person-to-person sharing and understanding undoubtedly assists a person in bringing themselves to confront, accept and ultimately overcome ill-fortune and sickness.

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<sup>71</sup> The examples of this are too numerous to elucidate fully. Consider, however, the recent trials and use of *Sutherlandia Frutescens*, to assist people living with HIV, and the employment of *Hoodia Gordonii* in weight-loss programs. Both are plants indigenous to Southern Africa, have been in use for millennia, and are now being marketed, with biomedical approval, in both the biomedical and complementary and alternative health sectors. See SM Harnett, V Oosthuizen, M van de Venter ‘Anti-HIV activities of organic and aqueous extracts of *Sutherlandia frutescens* and *Lobostemon trigonus*’ in *J Ethnopharmacol.* 2005 Jan 4;96(1-2):113-9.

<sup>72</sup> This is well documented. For some of the early writings on the matter, consider H.K. Beecher, ‘Experimental Pharmacology and Measurement of the Subjective Response’ in *Science*, Vol.116, No.3007, (15 August 1952), pp.157–162 and H. K. Beecher ‘The powerful placebo’ in *Journal of the American Medical Association*, (1955) 159:1602–1606. For more up-to-date writing, see TS Barfod ‘Placebos in medicine: placebo use is well known, placebo effect is not’ in *British Medical Journal* (2005) 330:45 and M. E. Hyland ‘Using the placebo response in clinical practice’ in *Clinical Medicine* (2003) 3, 347–350.

<sup>73</sup> E E Evans-Pritchard *Witchcraft, Magic and Oracles Among the Azande* 1976 pg 1

## Crossing Bodies, Crossing Boundaries – Traditional Healing in Comparative Perspective

South Africa is not a land alone. Traditional healing remains a vital social cog in lives throughout the world. Responding to encouragement from the World Health Organisation (WHO),<sup>74</sup> many nations that operate biomedical health care systems also recognise the existence and practice of complementary and alternative forms of healing. Unsurprisingly, therefore, South Africa has sought the assistance of the international community in her efforts to adopt traditional healing in the proper sense, hoping to benefit from the wisdom of the community of nations.<sup>75</sup>

Medicine, though steeped in, and advanced by, experimentation, is not a science apart from society. It is both a scientific endeavour and a social practice, for it has as its purpose the preservation of the wellbeing of people. This much is encapsulated in the World Health Organisation's (WHO) definition of health, which is stated to be 'complete physical, mental and social well-being of the individual and not merely the absence of disease or infirmity in the body.'<sup>76</sup>

This broad, expansive definition of health is unmistakably one that is intended to acknowledge, accommodate and even encourage the incorporation of a variety of healing methods into state and supra-state health care policies. In 1972, the WHO passed the Declaration of Alma Ata,<sup>77</sup> the first such agreement explicitly considering traditional healing to be a viable element of health care. In it, it was stated that

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Primary Health Care -

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7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional

<sup>74</sup> Following the WHO Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

<sup>75</sup> W Jasson Da Costa 'SA consults China, India on traditional medicines' in *Cape Times* Thursday July 5, 2007

<sup>76</sup> Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

<sup>77</sup> WHO Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.’<sup>78</sup>

Prior to the Declaration of Alma Ata traditional healers had failed to merit even a mention in international health literature. Admittedly, the reference to traditional healing practices is made only in passing, and places it as an adjunct to biomedicine. Yet, the importance of their mention lies in the fact that traditional healers were acknowledged by the WHO as having the capacity to be recognized due to their status and influence in local communities. This warranted consideration for their inclusion in primary health care interventions, those being low cost, preventative and pre-emptive applications of biomedical knowledge.<sup>79</sup>

Gradually, with the support of increasingly more expansive meanings<sup>80</sup> being read into this interpretation of Alma Ata, traditional healing began to be officially adopted in a number of countries, both developing and developed. There it served, and continues to serve, not only as an adjunct to biomedicine, but, in appropriate cases, as an alternative form of health care, although not entirely for biomedically-indicated reasons.

In developing nations such as the People’s Republic of China and India, gripped in the post-war years by nationalizing rhetoric and policy, the promotion of traditional healing was due as much to the nationalistic significance of ‘owning’ a particular form of healing, as it was to the demonstrable efficacy of the healing practices. Yet, as it would transpire, the traditional elements of indigenous healing practices were not quite as abundantly used as advertised. China, in particular, made much of its ‘bare-foot doctor’ policy, frequently portrayed as using indigenous knowledge to maintain appropriate standards of health in her burgeoning rural provinces.<sup>81</sup> Closer inspection reveals a different story, bare-foot doctors being the historical equivalent of the contemporary primary health care worker. The amateur application of good, biomedical practices such as ensuring clean drinking water and proper

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<sup>78</sup> *Ibid* S VII para 7

<sup>79</sup> JM Janzen *Social Fabric of Health* op cit 72 and 81

<sup>80</sup> See generally in *Western Medicine as Contested Knowledge* A Cunningham and B Andrews (eds) Manchester University Press, Manchester, 1997

<sup>81</sup> China’s Barefoot Doctors in *New England Journal of Medicine* 15 June 1972 1294-5

sanitation around living areas, so as to ensure minimum levels of good health, were the real tactics of the barefoot doctor brigades.<sup>82</sup>

Where Asian forms of healing were, in fact, genuinely used, they tended to have an interpretation that was entirely compatible with biomedical approaches to the body. This made the philosophical leaps of logic between the two a little less problematic. This meant that not only was the promotion of traditional healing possible, but fairly unproblematic for practitioners of both disciplines. For instance, in Chinese traditional thought, the body is controlled by energy flows or *chi*, and proper and correct passage of this energy is necessary for wellbeing.<sup>83</sup> This is not altogether different from a biochemical conception of the workings of the blood, lymphatic and nervous systems in biomedicine. Hence, patients, healers and doctors were able to relate their interpretations of fact in a relatively mutually-intelligible manner.<sup>84</sup>

As a result, Asian nations began to find a specific niche in their health care systems for traditional healing. Use came principally in the primary health care or chronic care settings, often in response to such ailments as rheumatism, sciatica, haemorrhoids, hypertension, pain control and general weakness. None of which are life threatening conditions, but are sufficiently problematic so as to encourage a person afflicted by one of them to seek assistance.<sup>85</sup> Practice of traditional healing was permitted after appropriate study of the forms of healing at a state-run university,<sup>86</sup> during which time the written, richly investigated and highly codified healing systems, created, like biomedicine, through observation and experimentation, were taught to students.<sup>87</sup> Traditional medicines were extensively tested by biomedical laboratories before being officially sanctioned, and, once approved as being safe and efficacious, became part of the prescription armoury of both traditional healers and biomedical doctors.<sup>88</sup>

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<sup>82</sup> *Ibid* 1294

<sup>83</sup> A Kleinman *Patients and Healers in the Context of Culture* University of California Press, Berkley, 1980 pg 158

<sup>84</sup> *Ibid* pg 158

<sup>85</sup> CK Ong, G Bodeker, C Grundy, G Buford, K Shein *WHO Global Atlas of Traditional, Complimentary and Alternative Medicine* Volume One (Text) WHO Centre for Health Development, Kobe, Japan, 2005 pg 187-197

<sup>86</sup> However, this process has taken time. Hue University in Vietnam has begun introducing a degree in traditional Vietnamese medicine from 2009 onwards, as gathered from personal communications with staff and students of Hue University, 15-22 March 2008.

<sup>87</sup> CK Ong et al *WHO Global Atlas of Traditional, Complimentary and Alternative Medicine op cit* 187-197

<sup>88</sup> *Ibid* 187-197

Later, under the guise of the title 'complementary and alternative forms of medicine' traditional healing methods came to be utilized in the social mainstream of nations where such practices had not previously existed, as was particularly apparent in wealthy, industrialized nations.<sup>89</sup> In the United States, for instance, practices such as acupuncture, therapeutic massage and homeopathy became increasingly popular, although strictly as adjuncts to biomedical care. More invasive practices such as homeopathy were and are only permissibly practiced by qualified biomedical doctors.<sup>90</sup> This growth in alternative options to biomedicine was due to the dissatisfaction of patients with the limits and problems associated with biomedicine's mechanistic construction.<sup>91</sup>

Today, the practice of mixing these differing conceptions of health care into one system is both widespread and highly lucrative.<sup>92</sup> Yet, this medical pluralism is not quite as all-embracing and pluralistic as it may seem. As has already been indicated, some alternative forms of healing are not dissimilar to biomedicine in their conceptions of the functioning of the body and the means by which a person falls sick. This fact has not only helped ally the systems, but has allowed biomedicine to firmly subordinate alternative forms of healthcare in two manners. First, requiring all alternative health care practices to be validated by biomedicine. Second, by limiting the legal use of alternative health care practices to matters either deemed less medically material and serious, or having substantially less consequential impact upon patient's bodies.

Consequently, while supporters of traditional African healing often champion its wider and official use on the basis of the success, both medical and political, that Asian forms of healing have had, this approach is problematic. Although it has been demonstrated many times that medical pluralism not

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<sup>89</sup> *ibid* 300

<sup>90</sup> CK Ong et al *WHO Global Atlas of Traditional, Complimentary and Alternative Medicine op cit* 300. In addition, all complementary and alternative remedies, with the exception of dietary supplements, must meet with Food and Drug Administration Approval, subject to biomedical testing, prior to use in the open market. See <http://nccam.nih.gov>

<sup>91</sup> See generally in G Bodeker and G Burford (eds) *Traditional, Complimentary and Alternative Medicine: Policy and Public Health Perspectives*, Imperial College Press, London, 2007. Note also the extensive access via the internet to the official service groupings for these practices – Chiropractic: [www.americhiro.org](http://www.americhiro.org) ; Acupuncture: [www.aomalliance.org](http://www.aomalliance.org) ; Homeopathy: [www.homeopathic.org](http://www.homeopathic.org) ; Massage: [www.americanmedicalmassage.com](http://www.americanmedicalmassage.com) ; and Naturopathic: [www.naturopathic.org](http://www.naturopathic.org)

<sup>92</sup> For instance, 1997, \$21.2 billion was spent by US citizens, \$12.2 billion of that not covered by insurance, on visits to complementary and alternative health practitioners. WJ Cromie 'Alternative medicine is booming, study shows' in *Harvard Gazette* November 12, 1998, available at Harvard Gazette Archives <http://www.hno.harvard.edu/gazette/1998/11.12/altmed.html> The National Centre for Complimentary and Alternative Medicine, a division of the U.S. Department of Health and Human Sciences provides a list of such products that receive this endorsement at <http://nccam.nih.gov>. See generally A Kleinman *Patients and Healers in the Context of Culture op cit*

only exists, but is successful, the peculiar circumstances of the relationship that a certain form of alternative healing has had with biomedicine that have rendered that pluralism entirely feasible, may not necessarily apply in all cases. Traditional African healing practices, or, at least, those found within South Africa, have at least two fundamental distinctions that separate them from other forms of alternative healing.

First, unlike many Asia-originating traditional healing practices, traditional African healing is not an open, written system, subject to robust critique over millennia. Rather, its so-called 'genealogy of knowledge' is based far more on individual and highly secretive master-apprentice systems, allowing a myriad of understandings about the body to build up, often in contradiction of each other.<sup>93</sup> There is, then, no single discourse of traditional African healing, as there is with biomedicine, traditional Chinese healing or Indian Ayurvedic medicine.<sup>94</sup>

Therefore, without the presence of peer-review, or a collated history, proponents of traditional healing have been hard-pressed to persuade the biomedical community that sweeping affirmations of their remedies may be made. Without a uniform, shared process and interpretation of procedure, it is difficult to ensure that each and every patient is being subjected to the same careful review and treatment.

Second, again in opposition to Asian forms of healing, the concept of personalistic or 'sent' illness is a major, if not dominant, feature of traditional African health beliefs.<sup>95</sup> This is also entirely at odds with the biomedical conception of how people succumb to an ailment. Ailments in biomedical reasoning are entirely morally or ethically neutral, with no blame to attach to a person by reason of them being ill. Thus traditional philosophies may result in a perpetuated stigma against an individual for the ailment by which they are afflicted. That is not to say that societies ascribing exclusively to biomedicine are free of placing blame on a person – but that tends to be a social, not a medical reaction, and a reaction roundly condemned in medical circles.<sup>96</sup>

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<sup>93</sup> P Richards *Traditional Healers and Childhood in Zimbabwe* op cit pg 22

<sup>94</sup> CK Ong et al *WHO Global Atlas of Traditional, Complimentary and Alternative Medicine* op cit 187-197

<sup>95</sup> E Green *Indigenous Theories of Contagious Disease* op cit 12, 13 and 67

<sup>96</sup> Stigma on the basis of a state-of-health has been most readily discernable in South Africa with reference to the HIV/AIDS pandemic. Given its fatal results, and that sexual intercourse is the most common reason for transmission of the virus, it is understandable that a morality is often perceived as being intricately linked to a person's HIV status. See on the topic of this being exploited the work and writings of the Treatment Action Campaign, [www.tac.org](http://www.tac.org)

Not all forms of traditional healing, then, are comparable. Nor are they comparable in their relationships with biomedicine. Thus, from an institutional perspective, great care must be taken in applying principles from one to the other. However, as we are about to see, this is not so for patients. Human behaviour is as uniform as it is timeless— and it is no different in this matter.

It is now time to move from the foundations of traditional healing, to the coalface – its use by patients. Frequent mention has been made of the great differences in scope, opinion and direction between traditional healing and biomedicine. These distinctions produce what might, at first pondering, be considered counterintuitive actions. However, as we are about to discover, medicine is not dogmatic. Rather, it is unfailingly eclectic, thanks to one special ingredient – people.

### *Notes from the Field*

*'I am so confused. The Traditional Healer tells me I am sick because my ancestors are calling me to become a traditional healer. The clinic tells me I am sick because of a virus called the HI Virus. The traditional healer does not advise me to come to the clinic. Instead he advises me to drink Xhosa beer, slaughter goats and cows. When I feel better, I am not sure if the clinic is helping me or the bottle of traditional medicine that the traditional healer has given me... The traditional healer gave me medicine to clean my blood and to make me stronger and suggested I perform a ritual for her ancestors. The traditional drug regimen helped me a lot. The traditional healer knew I was HIV positive and I told the traditional healer I was taking ARV drugs. I take the traditional drug regimen at the same time that I takes her ARV drugs. I know that my life has improved on ARV drugs but I still experience TB, rashes as well as anxiety. This is why I visit the traditional healer. Because of my anxiety and my confusion.'*  
(Female Patient, Du Noon).<sup>97</sup>

### **Of Doctors and Healers – The Complementary Use of Traditional Healing**

Till now, traditional healing and biomedicine have been portrayed as direct opposites. The philosophies that underpin them, and the practices that drive them, seem not to permit inclusion of the other. It would therefore be expected that the use of traditional healing and biomedicine is not only mutually exclusive, but perhaps even competitive. But this is not so. The few fieldwork ethnographies and personal interviews with patients that have been done in Southern Africa, have shown that the two

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<sup>97</sup>S Mall *Attitudes of HIV Positive Patients in South Africa to Traditional African Healers and their Practices* op cit Pg 16

systems are generally utilized by patients in a very different fashion. Not only are they compatibly used, but they are employed in a complementary and mutually supportive fashion.

One may well wonder why this is so. Perhaps regimented behaviour is uncommon, and foraging becomes the order of the day, because a 'if it works, then it works' attitude is adopted. Successful strategies, regardless of their underlying principles, become adopted into a patient's armoury for use in future. Of course, one will usually begin with a known course. Should that prove ineffective, there will be a temptation to change one's strategy, and this is where a blending of methodologies occurs – more of that later. But, in the beginning, it is the known that is adopted first and foremost. And that beginning is informed by the world view of the self. That being the perception that is personally conceived and adopted from external sources, that assists in dictating their response to any personal or social stimulus.<sup>98</sup> An interpretation of what it means to be of poor health is no different.<sup>99</sup> Therefore, although the physiological experience may be uniform amongst people, the psychological experience of health and healing is undoubtedly shaped by personal understandings of the world. Thus the interpretation of the reasons for, and the meaning of, the experience may differ entirely from person to person.

These world views or explanatory models inform and define both the belief held, and the action that that belief inspires. Thus a healer's explanatory models allow them to discern the nature and cause of the complaint, time and mode of onset of symptoms, course of sickness and treatment.<sup>100</sup> For patients, such explanatory models assist in perceiving what the problem is, whether or not it warrants attention, and what the appropriate attention is.<sup>101</sup> Upon embarking upon a course of treatment, these models allow a person to consistently evaluate whether the prescribed remedy is advantageous and acceptable to their explanatory model, and if it is, further, geographically available and financially accessible, whether it is adoptable for future use.

Consider some of the more recent studies on the subject. Between 1996 and 2003, a relatively in-depth study focused on the health care seeking habits of a group of 362 of the inhabitants of Katutura, the largest township in Namibia, lying on the outskirts of the capital city of Windhoek.<sup>102</sup> From the findings, it was evident that the inhabitants of Katutura consulted both biomedical doctors and

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<sup>98</sup> A Kleinman *Patients and Healers in the Context of Culture* 159

<sup>99</sup> *Ibid* 158

<sup>100</sup> *Ibid* 159

<sup>101</sup> *Ibid* 159

<sup>102</sup> D Le Beau 'Dealing with Disorder: Traditional and Western Medicine in Katutura (Namibia)', *Namibian African Studies*, vol. 6, Germany, Rudiger Koppe Verlag Koln, Cologne 2003.

traditional healers. 42 percent of respondents noted that they had consulted a traditional healer in addition to a biomedical doctor. Most of those (32% of the 362) used traditional healers after having consulted with a biomedical doctor. Very few consulted a traditional healer only. Therefore, a significant minority of the population focused their health seeking behaviour on different, and perhaps competing,<sup>103</sup> paradigms.

Another study,<sup>104</sup> conducted in the rural valleys of Northern KwaZulu Natal in South Africa, using 974 respondents as a test group, also found that a significant number of patients had resorted to a dual approach.<sup>105</sup> Virtually all respondents consulted biomedical doctors when in ill health. Importantly, just under half of the respondents used both a biomedical doctor<sup>106</sup> and a traditional healer when ill, despite the fact that this tended to increase the amount of money spent on a single health problem to close to R1100.<sup>107</sup> If using only a biomedical doctor, the average amount spent was R243, whereas the use of a traditional healer alone produced an average cost of R433 for visiting a herbalist, or R371 for a consultation with a spirit medium.<sup>108</sup> An earlier study in the Orange Free State had also demonstrated a considerable cost difference between biomedicine and traditional healing, the latter tending to be twice as expensive as the former.<sup>109</sup>

Examining the available studies, it is fairly clear that a significant number of the patients polled, consulted, for the same problem, healers representing different medical paradigms. We shall term this 'dual health care seeking behaviour'. This is a choice that they make consciously.<sup>110</sup> It is also a widely-observed practice that is encountered the world over.<sup>111</sup> The critical question, then, is why this occurs. Perhaps patients are uncertain of what to do. Perhaps they are desperate and are willing to try all measures. However, examination of the Katutura study would support another reason entirely.

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<sup>103</sup> In particular see *SAMJ* May 2006 Vol 96 Issue 5 and the accompanying supplement entitled 'Bridging the Gap – Potential for a health care partnership between African traditional healers and biomedical personnel in South Africa'

<sup>104</sup> A Case, A Menendez and C.Ardington 'Health Seeking Behaviour in Northern KwaZulu Natal' *CSSR Working Paper No 116*, Centre for Social Science Research, University of Cape Town, 2005

<sup>105</sup> *Ibid* 7

<sup>106</sup> Either privately or at a local clinic.

<sup>107</sup> A Case, A Menendez and C.Ardington 'Health Seeking Behaviour in Northern KwaZulu Natal' *op cit* 7

<sup>108</sup> *Ibid* 7.

<sup>109</sup> E Pretorius, G De Klerk and HJ Van Rensburg *Die tradisionele heler in Suid-Afrikaanse gesondheidsorg* HSRC Publishers, Pretoria, 1991, pg 42

<sup>110</sup> M Mander, *Marketing of Indigenous Medicinal Plants in South Africa: A Case Study in KwaZulu Natal* Rome, Food and Agriculture Organisation, 1998, pg 15

<sup>111</sup> UA Igun 'Stage in health seeking: A descriptive model' in *Social Science and Medicine* 1979 1; 13

If dual health care seeking behaviour resulted purely from uncertainty or desperation, one would expect to find one of two results in the Katutura study. One, all ailments resulted in a roughly equal number of people consulting both biomedical doctors and traditional African healers. Two, particularly serious ailments tended to generate greater dual health seeking behaviour, given the greater desperation that this would presumably foster in patients.

However, interestingly, when health seeking behaviour presented in the Katutura study was broken down by disease, a different trend emerged. Certain health problems (and not necessarily the most serious ones) made it substantially more likely that a respondent would consult a traditional African healer either exclusively or in addition to a biomedical doctor. Infertility, intestinal problems, bleeding nose/mouth and, most of all, mental illness and epilepsy, resulted in the most dual health care visits.<sup>112</sup> The latter two matters sometimes encouraged exclusive use of traditional healers. The relevant figures are displayed in Table A at the end of this paper.

By distinction, infectious diseases such as sexually transmitted infections (including HIV) and tuberculosis were regarded almost entirely by the participants as problems exclusively for biomedical doctors.<sup>113</sup> Moreover, biomedicine was, usually, overwhelmingly utilised as the first port-of-call, the only exceptions being those ailments that tended to attract dual health care seeking behaviour, when biomedicine and traditional healing vied fairly evenly to be considered the first philosophy engaged by the patient.<sup>114</sup>

When read together with studies on 'indigenous contagion theory'<sup>115</sup> and the concept of an internal 'snake', or *nyoka*, an intriguing trend of dual health care seeking behaviour emerges. As indicated earlier, ethnographic research is increasingly demonstrating that witchcraft is not regarded, in African societies, as the only cause of an ailment. Rather, naturalistic sickness, via the environment<sup>116</sup>

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<sup>112</sup> A fact supported by two other studies, namely LR Schwartz 'The Hierarchy of resort curative practice: Admiralty Islands, Melanesia' in *J Heath Soc Behav* 1969; 10;200-9 and J Lesson 'Traditional medicine: still plenty to offer' in *Afr Rep* 1970; 15; 24-5

<sup>113</sup> Epilepsy, in particular, suffers from stigma universally. For another South African study, see H Foyaca-Sibat, A.I. Del Rio-Romero, and L de F Ibanez-Valdes 'Prevalence of epilepsy and general knowledge about neurocystierosis at Ngangelizwe Location South Africa' in *Internet Journal of Neurology* 2005 4(1): 906-16.

<sup>114</sup> D Le Beau 'Dealing with Disorder: Traditional and Western Medicine in Katutura (Namibia)' *op cit*

<sup>115</sup> Green *op cit* 13

<sup>116</sup> Green himself breaks down indigenous contagion theory into three separate components. However, though this division is noted, the author feels that the components are closely interwoven, and can be discussed together. See *ibid* 13

within which a person lives, may make a person ill.<sup>117</sup> This is termed 'indigenous contagion theory.' However, the agent of the ailment is not regarded as the cause of the ailment, but as a catalyst for the ailment.

The *nyoka* (internal snake) is a popular concept throughout Africa.<sup>118</sup> It is said to be an invisible serpent that resides in a person's torso, and, when disturbed by imbalances, it 'punishes' its host.<sup>119</sup> Thus, the *nyoka* is responsible for the ailment. The punishment of the host by the *nyoka* is, apparently, manifested in the form of, *inter alia*, infertility, intestinal problems, mental illness and epilepsy. These are the same ailments that resulted in the largest percentage of dual health care seeking behaviour in the Katutura study.

In contemporary ethnographic accounts and studies,<sup>120</sup> traditional healers have responded that the appropriate response to such contagious elements, was to administer 'black'<sup>121</sup> medicine as a 'purgative', followed by 'white'<sup>122</sup> medicine, which was used to sooth the *nyoka*. In some instances, this practice was reversed, the *nyoka* first being soothed, before the purgative was administered.<sup>123</sup>

The fact that only a few, select ailments tended to have large numbers of patients engaging in dual health seeking behaviour, combined with the overlapping of those ailments with indigenous contagion theories and the concept of the *nyoka*, appears to indicate that the prime reason for dual health seeking behaviour, is this. Patients recognize that biomedical doctors and traditional healers have different and distinct roles to play in patient health. This is because biomedicine and traditional medicine are effective on different aspects of a person in two manners. First, certain ailments are regarded, by the patient, as having an element that must be alleviated by a biomedical doctor, and then another element that must be tended to by a traditional healer. Second, some ailments are exclusionary in that they are viewed as being treatable only by traditional healing or by biomedicine.

This pluralism<sup>124</sup> is given particular resonance when one chooses to recognize and make a distinction between the terms 'disease' and 'illness'.<sup>125</sup> 'Disease' refers to the scientifically-proven,

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<sup>117</sup> In particular, see *Ibid* 16 and 21-54. When regarded as 'pollution', notes Green, the concept of disease is not all that different to the biomedical concern with pathogens.

<sup>118</sup> *Ibid* 89

<sup>119</sup> *Ibid* 91

<sup>120</sup> As published *Ibid* at 97

<sup>121</sup> Medicine that has a purgative effect to rid the body of evil, *Ibid* 97

<sup>122</sup> To restore the functioning of the body once the evil has been removed, *Ibid* 97

<sup>123</sup> Last M and Chavunduka G *The Professionalisation of African Medicine* Manchester University Press, Manchester, 1986.

<sup>124</sup>

empirically observable, biological agent of poor health, such as a bacteria or a virus.<sup>126</sup> 'Illness', by contrast, is a social, context-dependent, people-based construction of the personal experience of poor health.<sup>127</sup> For the purposes of this paper, the term 'ailment' has and will be used to cover both elements when necessary.

It may well be that, in short, biomedical doctors are utilized in order to treat what traditional societies regard as 'disease'. Traditional healers focus on the 'illness', helping to alleviate the psychological stress of an ailment by providing a moral vocabulary<sup>128</sup> that people will use to answer the fundamental questions behind such pain, reducing it to a known and confronted entity.

This conclusion does not seem to have gathered much attention before, but it seems more than possible.<sup>129</sup> If so, the studies demonstrate that health care seeking behaviour is both biologically and socially determined, in that both the 'disease' and the 'illness' need to be tended to. Perhaps it was put

<sup>125</sup> See generally, but in particular the wonderful writings of Susan Sontag in *S Sontag Illness as Metaphor*, Penguin, England, 1977. Other works include S DiGiacomo 'Metaphor as Illness: Postmodern Dilemmas in the Representations of Body, Mind and Disorder' in *Medical Anthropology* Vol 16, 109-137; M Weiss 'Signifying the pandemics: metaphors of AIDS, cancer and heart disease' in *Medical Anthropology Quarterly* Vol 11, 456-476

<sup>126</sup> D Lupton *Medicine as Culture: Illness, Disease and the Body in Western Societies*, Sage Publications, London

<sup>127</sup> *Ibid*

An example of this dual conception is readily apparent in the affliction of cancer. The disease component is the explosive and uncontrollable multiplication of cells, leading to, possibly, the death of the individual. Cancer as an illness, on the other hand, is the experience of cancer which is peculiar to each person. It may involve feelings of self-doubt, the classic 'Why me, why now?' questions, perceptions of stigma being levelled against a person for having cancer, and acts that have the effect of re-defining one's identity as a 'person with cancer', rather than as a 'person'.

Despite its biological basis, disease itself may, in fact, be socially triggered and socially upheld, meaning that people's biological state of health emerges from the basic organization of their lives. For example, cholera, a disease, does not simply appear by magic, but is rife in areas of poor sanitation, a feature common to many poverty-stricken socio-economic environments which do not provide adequately for the needs of their inhabitants. Therefore, contracting the disease of cholera is usually premised upon being exposed to poverty and poor living conditions.

See J Iliffe, *The African AIDS epidemic: a history*, Oxford University Press, Oxford, 2006 at pg 91. For the best, most well known examples of this, consult S Sontag *Illness as Metaphor and AIDS and its Metaphors*, Picador USA, New York, 2001. The book is a compilation of her two most well-known essays on health.

<sup>128</sup> N Tebbe 'Witchcraft and Statecraft: Liberal Democracy in Africa' *op cit* pg 197

<sup>129</sup> Several studies, however, have suggested that people tend to choose a form of therapy based on earlier experiences and what they believe the ailment will respond to. See UA Iguan 'Stage in health seeking: a descriptive model' in *Soc Sci Med* 1979; 1; 13, MA Jaspan *Traditional Medical Theory in South East Asia* Hull, University of Hull, 1969, UNA Maclean *Magical Medicine: a Nigerian case study* London, Penguin Press, 1971 and PA Twumasi *Medical Systems in Ghana*, Accra, Ghana Publishing Corporation, 1975

best by a patient who stated, when asked whether or not she had consulted a traditional healer, 'Sangomas are there to help people with problems. Like jealousy and witchcraft. Not HIV.'<sup>130</sup>

It would probably be prudent to pause here for a moment and recall the fact that some claims of healers fit into the biomedical paradigm, such as remedies for influenza and fatigue. Others, for good luck and job promotions, for example, do not. To call one 'medical' and the other 'non-medical' would be prejudicial to traditional healing, in that it is being interpreted strictly through biomedical terminology, rather than with regard to its own understandings of itself. However, using the terms 'disease', for, say the influenza and fatigue matters and 'illness' for good luck and job promotions would not have the same effect. The WHO recognises that both disease and illness are complementary components of health. Therefore, responses to each are equally valid as a health care service.

It is clear that patients use the two systems of healing interchangeably and are comfortable with such use, deriving contrastive but complementary gratification. As one Haitian patient who exercised similar foraging between philosophies put it to the doctor-cum-medical anthropologist and author Paul Farmer, 'Don't you believe in complex lives and reasons?'<sup>131</sup> This mixing of philosophies, though not worrying patients terribly much, yet seeming incomprehensible from an institutional perspective, is not peculiar to Southern Africa. In fact, it is a fairly common human practice – prayer and surgery have ever been unlikely bedfellows in hospitals around the world.

### International Observations

The decision to begin with a known route toward good health has been canvassed. Equal measure has been given to demonstrating that patients will, when facing an ailment, experiment with other remedies in an attempt to see what works best. What we have not examined, is what prompts patients to shift philosophies when shifting treatment.

Social foraging is far starker in times and places of great social upheaval. Where world views and social orders compete violently for adherents to their ideology, it is only natural that, faced by confusing choices, people will tend to, in their exposure to multiple orders, absorb and replicate parts from each. South Africa, and the continent of Africa in its near entirety, is a good example of this. Competing colonial and traditional societies have shaped a set of societies that, today, exhibit traits ordinarily unique to each.

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<sup>130</sup> S Mall *Attitudes of HIV Positive Patients in South Africa to Traditional African Healers and their Practices* op cit pg 10

<sup>131</sup> T Kidder *Mountains Beyond Mountains* Random House, New York, 2003

This pattern appears to be replicated in other geographic regions, too. Throughout the many archipelagos, large and small, that dot the Pacific Ocean, there are a plethora of communities of indigenous peoples. All practice various forms of traditional healing alongside biomedicine as introduced by their past colonial masters.<sup>132</sup> What makes the Pacific a particularly interesting area of study in this regard, is that the inhabitants of many of these islands have points of great historical social similarity with the peoples of the African continent. More importantly, the healing practices indigenous to the Pacific are near-identical to those found in Africa, a fact that has apparently never been previously noted. The course of health care on these islands is therefore especially interesting to us.

Many of the islands and atolls, inhabited as they were by small, tightly-knit populations, were stumbled upon by the fleets of sea-faring European states.<sup>133</sup> With disease rife on such vessels, the sailors, upon disembarkation, brought diseases to the islands the likes of which the immune systems of the islanders had never before encountered. Predictably, the compromising of their health brought swift and wide-ravaging doom to the local inhabitants.

Following these early, and sadly often deadly encounters, Christian missionaries flocked to the islands. They brought with them early modes of biomedicine, in addition to religious texts. Over the years, for either naval-strategic or mineral extractive purposes, many of the islands came to be dominated by colonial powers, just as much of Africa was. Similar suppression of indigenous ways of life and the social status of the native inhabitants generally by colonial systems was gradually but actively sought.

Just one of these indigenous practices that faced exclusion was traditional healing. In contradistinction to the open and highly codified medical systems of Asia, healing practices throughout the Pacific tended to be secretively taught and interpreted ailments as being either naturalistic or personalistic, just as traditional African health beliefs did. Healing was usually accessed through divination or herbal remedies applied as appropriate, with the intention of, as African philosophies, restoring the fundamental equilibrium of the social fabric to and amongst the inhabitants.

Although the detailed beliefs concerning health care differ from Melanesia to Micronesia and to Polynesia, and even from island to island, such fundamental points of similarity between the peoples

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<sup>132</sup> CDF Parsons (ed) *Healing Practices in the South Pacific* University of Hawaii Press, Honolulu, 1985 provides the best account, incorporating Melanesia, Micronesia and Polynesia. W. Whistler Arthur *Polynesian herbal medicine*. Honolulu, Hawaii 1992 describes the pharmacopeia in use.

<sup>133</sup> For a good, generally-orientated account, see AP Vayda (ed) *Peoples and Cultures of the Pacific* Natural History Press, New York, 1968

inhabiting these islands, as expressed above, exist. Consider, then, two case notes, one a historical observation in Samoa, the other a present-day commentary on Timor-Leste.

The recorded history of Samoa provides a fascinating insight into the development of what might be termed 'a healing consciousness'.<sup>134</sup> At the time of the Samoan's first contact with European seafarers, there existed on the island the belief that all illness, no matter the severity or the symptoms, was 'sent'. It was a manifestation of an ancestor's displeasure with the ailed individual concerned.<sup>135</sup> However, when Influenza was introduced to the islands by European sailors who dropped anchor offshore, so a new set of variables arose with which the Samoans had to work. Noting that the new illness had been encountered exclusively with the Europeans, Samoans rapidly began to identify Influenza as a European illness, sourced from Europeans, but with the ability to infect all people on the island, regardless of identity or moral status.<sup>136</sup>

As these thoughts were evolving, the local missionary practices were demonstrating the possibility of a simultaneous belief in an omnipotent power, and in the purely physical nature of illness.<sup>137</sup> However, just as on the African continent, Christian doctrine became wrapped up with existing beliefs in deities, as did the use of the medicines with which they brought with them, which at that stage were not yet particularly successful. Thus a hybrid philosophy was adopted and adapted by the Samoans in manners not predicted by their colonial masters.

Consequently, a new health matrix was created, whereby illness was recognized as having a distinct geographical cause, either Samoan or European, which, in turn, affected the source of healing, again, either Samoan or European, which was required to be adopted in order to be healed.<sup>138</sup> This practice quickly spread, with a good rule-of-thumb being that patterns of health care seeking depended upon whichever philosophy was deemed 'correct' in each instance. Therefore, efficacious, biomedical, germ-theory orientated interventions took their place alongside a socially supportive and highly complex personalistic system.<sup>139</sup>

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<sup>134</sup> CDF Parsons 'Samoa' in *Healing Practices in the South Pacific op cit* 74

<sup>135</sup> *Ibid* 75

<sup>136</sup> *Ibid* 78

<sup>137</sup> *Ibid* 78

<sup>138</sup> *Ibid* 84

<sup>139</sup> As one, unnamed healer from the Cook Islands put it 'God is applied to through prayer – but the spirits may be manipulated! Observed in Honolulu, Hawaii, June 2008.

In more recent times, a similar marriage between biomedicine and traditional healing has been observed in the newly independent state of Timor Leste.<sup>140</sup> The horrific violence witnessed during the exhaustively long conflict that aimed to separate her from Indonesia, especially in the last days of the insurgency, saw a total collapse of the health care system.<sup>141</sup> Without secondary or tertiary health care available, Timorese caught in the fighting lived brutal, sickness-ravaged lives.<sup>142</sup> Large numbers of trauma victims, high infant mortality, astronomical maternal and mental health problems and a complete absence of supportive or rehabilitative medicine plagued the island.

The U.N. Transition Administration for East Timor, which subsequently took over administration of the area, following the cease-fire with Indonesia, managed to reconstruct many of the local services around the capital, Dili. However, they were unable to extend services to all areas of the mostly-inaccessible jungles that dominated the island.<sup>143</sup> Hence, traditional healing has become a critical element of health care in these areas. Even in Dili, patients at the local U.N. administered hospitals frequently brought their own herbal medications and performed their own spiritual rituals in the wards.<sup>144</sup> As it transpired, these traditional interpretations of healing had existed for many generations and had been strengthened during the conflict. Native fighters had often adopted traditional medicines for use in the jungle, alongside imported medical supplies. In the pro-independence, nationalistic vein of thinking, traditional healing was an element of life that could be owned, separate from incursion by the Indonesian military.<sup>145</sup>

Timorese healing, like many other such practices throughout the Pacific, acknowledges healing to be that action which cures both the body and the so-called body social – that element of the individual that moves through society.<sup>146</sup> Hence, in times of conflict, where the social fabric of society suffers a complete breakdown, efforts dedicated toward reconstituting it are to be expected. Accordingly, traditional methods of problem resolution, psycho-somatic health and social healing were

<sup>140</sup> Personal communication, Andrew McWilliam, Department of Anthropology, Australian National University, Canberra

<sup>141</sup> G Povey and M Mercer 'East Timor in Transition: Health and Health Care' in *International Journal of Health Services*, Volume 32, Number 3, Pages 607–623, 2002 pg 612 and World Health Organization. Role and function of WHO in East Timor: Plan for 2001 (pamphlet). 2000.

<sup>142</sup> *Ibid* 607

<sup>143</sup> *Ibid* 612; World Health Organization. East Timor health sector situation report: January-June 2000.

<http://www.who.int/eha/emergenc/etimor/14082000.html>

<sup>144</sup> *Ibid* 613; World Health Organization. East Timor health sector situation report: January-June 2000 *op cit*

<sup>145</sup> Personal communication, Andrew McWilliam *supra*

<sup>146</sup> *Ibid*

heavily utilized.<sup>147</sup> Post-conflict, such methods are equally important in providing a means to coming to understand and accept the past and its injustices.

Considered in these appropriate social contexts, the engagement of dual health care seeking behaviour, becomes, although not necessarily adoptable, certainly a great deal more understandable and acceptable. In the pursuit of 'Total Wellness', then, a person will hunt for medically complementary practices that create and fulfil an effective framework for understanding sickness *for them*.

This reality forces us to acknowledge a central point that is important to the rest of the paper. There will always be two conceptions of health care – that of the patient, no matter which or how many medical authorities they subscribe to, and that of the health care institution. Health care systems are designed to revolve around the latter, with deferral to the wishes of the former only in the concerned health care worker-to-patient interaction that occurs in an individual consultation.

However, in situations where patients have become health care foragers, such deference often does not take account of the health care seeking practices of the patient beyond that particular consultation. For example, a doctor will treat a patient with particular drugs without knowledge of the patient's simultaneous use of a traditional healer's remedies, which may be counterproductive. Such ignorance could have grave consequences for the patient. Thus it becomes essential for health care workers, be they traditional healers or doctors, to appreciate the competing beliefs held and practices exercised by their patients, if they are to give them optimal care. This is especially true where there not only exists a belief that dual health care use is sensible, but where there is evidence to demonstrate that such use may indeed be beneficial.

The ethnography collated above, from South Africa to the South Pacific, has been most instructive. As is plain to see, people adopt otherwise competitive healing strategies in complementary fashions. Each methodology has its place in repairing the fragile body of a person and then restoring them to society. This reliance upon dual health care seeking is not only fascinating from an anthropological perspective, but is essential to the soon-to-come legal debate. Without a firm grasp on the day-to-day practices of people, laws cannot respond legitimately and effectively to the contentions at hand.

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<sup>147</sup> *Ibid*; A Rogers *Treating Child Illness in Dili: A Household Level Analysis - Preliminary Report of Findings* Yale University, Progress Report, August 2001 pg 8

## Placebo Politics

*'I think the patients are lying to you when they say they don't use traditional medicine. They have scars and no little finger. This means they are seeing traditional healers all the time.'* (Patient, Gugulethu).<sup>148</sup>

### The validation of healing

It is into this fascinating and highly convoluted human story that the Traditional Health Practitioners Act has stumbled. The particular and detailed history of its conception is perhaps slightly beyond the scope of this paper. Yet, it was evident from early position papers on plans for a future health care system that traditional healing would be included.<sup>149</sup> Quite how, though, was never very clearly formulated. And yet, the need to appreciate traditional healing remained manifest. There were three driving features in this regard. First, it was widely recognized that the formal health care system in South Africa did not cover the whole population adequately. Second, there were increasing problems, outlined by the Ralushai Commission,<sup>150</sup> of violence associated with witchcraft accusations. Third, there was increasing support for an 'African Renaissance' influx of indigenous ideas to percolate into South Africa's social structures.<sup>151</sup>

Apartheid-era health care profoundly affected both people's access to health care and the quality of that care. Recognizing the glaring health care inequalities it inherited, the new government was understandably anxious to increase access to available health care resources.<sup>152</sup> The task set was to create a 'unified' health care system capable of delivering quality health care to all citizens efficiently and in a caring environment. The principal procedure by which this would be achieved was through primary health care interventions, adequate at the point of first contact.<sup>153</sup> Although 'unified' was a term more directed at the union of the country's widely separated public and private health care systems, the term has since come to mean the inclusion of other varieties of healing practices.

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<sup>148</sup> S Mall *Attitudes of HIV Positive Patients in South Africa to Traditional African Healers and their Practices op cit* Pg 19

<sup>149</sup> The White Paper for the Transformation of the Health System in South Africa *op cit*, published in 1997, is perhaps the most influential of these.

<sup>150</sup> NV Ralushai et al *Report of the Commission of Inquiry into Witchcraft Violence and Ritual Murders in the Northern Province of the Republic of South Africa* 1996

<sup>151</sup> A Ashforth *Witchcraft, Violence and Democracy op cit* 285-86

<sup>152</sup> The White Paper for the Transformation of the Health System in South Africa *op cit*

<sup>153</sup> *Ibid*

Traditional healers, given their numbers and wide dispersal throughout the country, were an obvious source of additional health care providers. They were envisaged as having a tasking in tandem with their biomedical counterparts. Under the government health plans then being drawn up, traditional healers would have been *de facto* subsumed into the formal health care system as entry-level primary health care workers.

In the narrow sense of improving access to health care, distinct from quality of health care, this would not have been an appropriate action.<sup>154</sup> As we have seen, traditional healers compose an element of a person's health care seeking habits, rather than the sole source. Thus to employ them in place of biomedical personnel would have been counterproductive. Furthermore, to employ them as low-level interventionists would not sufficiently respect their eminent status in their home communities.<sup>155</sup> However, use alongside biomedical personnel would certainly have alleviated the burden of work required upon individual patients.

At the same time, the government was, correctly, becoming quite concerned with the high rate of violence surrounding witchcraft in the rural areas of the country. The effect of the Witchcraft Suppression Act of 1957, an apartheid era statute, had been to outlaw all public manifestations of the occult – that is, the practice of witchcraft, the practice of traditional healing, and the accusation of a person of performing witchcraft.<sup>156</sup> Since traditional healers were often used to 'sniff out' and detect witchcraft, and heal its results, all of their practices became subject to harsh laws which denied the practice of the belief entirely. Consequently, with this important element of belief all but denied, people had begun to turn to vigilante methods to kill suspected witches and witchdoctors, actions which had spiralled into violence of frightening proportions.<sup>157</sup> The legalization of traditional healing would, perhaps, mean accusations of witchcraft being made in the court, leading to, it was hoped, lower levels of violence.<sup>158</sup>

Beyond the practical relevance of assisting state initiatives, introducing traditional beliefs into the formal structures of the law was an element of the increasing migration of such thoughts into

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<sup>154</sup> However, some success has been had in making this an ancillary role of traditional healers. See M Colvin, LGumede, K Grimwade and D Wilkinson 'Integrating Traditional Healers into a Tuberculosis Control Program in Hlabisa, South Africa' in *Medical Research Council Policy Brief No4*, December 2001

<sup>155</sup> Wreford J, Hippler S and Esser M *Facilitating relationships between African traditional healing and Western medicine in South Africa in the time of AIDS: A case study from the Western Cape* CSSR Working Paper 170, University of Cape Town, 2006

<sup>156</sup> N Tebbe 'Witchcraft and Statecraft: Liberal Democracy in Africa' *op cit* 186

<sup>157</sup> *Ibid* 193

<sup>158</sup> *Ibid* 193

broader South African society, under the guise of, some would say, an 'African Renaissance'.<sup>159</sup> Thus, despite many unresolved tensions, African customary law and traditional leadership were adopted into the Constitution of the Republic of South Africa.<sup>160</sup> Various pieces of legislation<sup>161</sup> and court decisions<sup>162</sup> have also appreciated these sways. This enhanced the existing common-law perspective whereby traditional beliefs had frequently been encountered by the courts, gaining some consideration and even respect, if not adoption, in some matters.<sup>163</sup>

Although the above considerations were no doubt important, the stated purpose of the Traditional Health Practitioners Act is to improve the quality of health care services in South Africa.<sup>164</sup> Sensibly, in the White Paper on the Transformation of the Health Care Service,<sup>165</sup> it was noted that medicine is not the key to a healthy nation. Rather, improved social standards are, and therefore health care is predicated on society being healthy through various social measures. But people will fall ill regardless. And, as any life form would do, they will endeavour as far as possible to restore themselves to better health. Thus shoring up of the population's health occurs by a myriad of means. Since healing appears in many forms to the sick, a variety of perspectives need to be contemplated. The Traditional Health Practitioners Act turns its attention to one of these.

The essence of the Act is to, first, protect the public from abuse by charlatans and ignorant healers,<sup>166</sup> and, second, to promote good health care practice among healers,<sup>167</sup> consistent with universally accepted health care norms and standards.<sup>168</sup> It authorises the creation of a council,<sup>169</sup> with whom all traditional healers, whether currently or aspiring to practice for gain, must register.<sup>170</sup>

<sup>159</sup> A Ashforth *Witchcraft, Violence and Democracy op cit* 285-286

<sup>160</sup> Chapter 12 of the Constitution recognises the institution of traditional leadership

<sup>161</sup> Such as the Recognition of Customary Marriages Act 120 of 1998 and the Traditional Leadership Governance Framework Act 41 of 2003

<sup>162</sup> Most recently, and at the highest level, in *Bhe v Magistrate, Khayelitsha and Others* 2005 (1) SA 580 (CC)

<sup>163</sup> *R v Mbombela* 1933 AD 269, *R v Fundakubi* 1948 (3) SA 810, *S v Nxele* 1973 (3) SA 743 (A), *S v Malaza* 1990 (1) SACR 357 (A), *S v Netshiavha* 1990 (3) SA 331 (A) and *S v Ngema* 1992 (2) SACR 651 (D) all present interesting responses from the Benches concerned with regard to the place of witchcraft in criminal proceedings. *Mbombela* and *Netshiavha* held it to be relevant to intention, *Fundakubi*, *Nxele* and *Malaza* believed it to be relevant to extenuation of sentence and *Ngema* inserted it in the objective test of negligence.

<sup>164</sup> S2(c) of the Traditional Health Practitioners Act 22 of 2007

<sup>165</sup> White Paper for the Transformation of the Health System in South Africa, Department of Health, 1997. Available at <http://www.doh.gov.za/docs/policy-f.html>

<sup>166</sup> Preamble, *Ibid*

<sup>167</sup> Preamble, *Ibid*

<sup>168</sup> S5(h) *Ibid*

<sup>169</sup> S4(1) of the Traditional Health Practitioners Act 22 of 2007

<sup>170</sup> S5 and S6 *Ibid*

Registration is contingent upon their ability to demonstrate, *inter alia*, an ability to heal.<sup>171</sup> Such qualifications may be prescribed by the Minister of Health to be obtained via examinations conducted by an accredited healer.<sup>172</sup> The necessary qualifications, at the time of writing, had yet to be made public. Furthermore, questions of how it would be determined who was, and who was not, a valid and capable traditional healer, had not been resolved, nor how such adjudications would be supported. Following their registration, traditional healers will be required to submit their practice to the council for scrutiny.<sup>173</sup>

From a liberal democracy perspective, the Act is to be approved. First, it appreciates that, whatever the truth of the spirit world, the belief itself is real enough, and recognising it is crucial to the promotion of equality between citizens.<sup>174</sup> Ignoring such beliefs would only have served to perpetuate the present inequality in terms of regard for ways-of-life.<sup>175</sup> Second, since traditional healing practices constitute a frequent practice for so many, recognising their presence demonstrates a commitment on the part of the state to be democratically responsive to the needs of its population. Allowing people to conduct their private affairs in peace and without state interference is central to the liberal-democratic premise.<sup>176</sup>

### Some unwelcome tangles

Laudable in some respects, the Act is less so in others. South Africa's health laws and, indeed, her whole legal system, through its foundational legal document, the Constitution, are predicated upon a rough association with liberalist writings.<sup>177</sup> Under this interpretation, the individual is of fundamental importance, and personal autonomy is a cherished staple of society. It is a principle that is violated only to preserve public health and safety, order and the life of the nation. Therefore, for instance, patients are entitled to refuse blood transfusions,<sup>178</sup> or other operations, even if medically mandated as

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<sup>171</sup> S21 (2) (b) (iii) *Ibid*

<sup>172</sup> S22 (1) *Ibid*

<sup>173</sup> S21(1) *Ibid*

<sup>174</sup> N Tebbe 'Witchcraft and Statecraft: Liberal Democracy in Africa' *op cit* pg 134

<sup>175</sup> Parliament of the Republic of South Africa, National Council of Provinces: Report of the Select Committee on Social Services on Traditional Healers 1998 pg 3

<sup>176</sup> N Tebbe 'Witchcraft and Statecraft: Liberal Democracy in Africa' *op cit* pg 136

<sup>177</sup> N Tebbe 'Witchcraft and Statecraft: Liberal Democracy in Africa' *op cit* pgs 204-207

<sup>178</sup> *Phillips v De Klerk* unreported 1983 TPD and *Hay v B* 2003 (3) SA 492 (W) both ruled that a Jehovah's Witness, where capable of giving consent, was fully entitled to refuse a blood transfusion. This is backed up by S7(1) of the National Health Act 61 of 2003, which places responsibility for consent in the patient's hands, unless otherwise indicated.

necessary, provided such a refusal does not cause undue harm to another.<sup>179</sup> Furthermore, patients may voluntarily adopt complementary and alternative health care practices such as aromatherapy and acupuncture, provided it is in a private, non-state supported setting.<sup>180</sup> Actions in the private sphere tend to be left to the wisdom of the person concerned. This exemplifies deference to individual autonomy, enabling people to, *prima facie*, utilise any form of healing that they are able to access.

But what happens when private matters enter the public forum? Granting people a right of access to traditional healing, until now a private matter, as a public health care service, breaches the divide. When in public, the debate is no longer one concerned principally with personal autonomy. The diversion of resources from biomedical projects to traditional healing initiatives, in order to properly fulfil the apparent duty that the state may to people who choose to practice and utilise traditional healing, will have wide-ranging consequences. This shift from a private, personal matter, to one that influences public health, makes the problem far more complex.

It is one matter to accommodate the belief of another; quite something else to be required to act on that belief yourself. Furthermore, when such an action means that healers and doctors are required to present to a patient reasons and meanings that they themselves cannot believe in, then it would appear that the healer-patient relationship has been reduced to a charade.

Undoubtedly, this clash at the institutional level is partly what made the inclusion of traditional African healers so difficult a proposition for the biomedical establishment to accept. A philosophy of healing that appears to contradict flatly a proven and universally utilized practice was being acknowledged as not only having points to recommend it, but sufficient viability to be recognized as an alternative manner of healing a person.

Almost as important in engineering this state of animosity, however, was the complete lack of direction from those instituting the legislation as to how the biomedical establishment would have to interact, if at all, with traditional healers. There is no clear indication as to how traditional health care philosophies will be assessed when they either complement or clash with biomedical principles. With no hierarchical outline, there is little to guide one on conflict resolution.

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<sup>179</sup> S7(1)(d) of the National Health Act 61 of 2003

<sup>180</sup> Chiropractors, Homeopaths and Allied Health Service Professions Act 63 of 1982 and the Chiropractors, Homeopaths and Allied Health Service Professions Amendment Act 50 of 2000

Pitting parallel philosophies of health against biomedicine has already generated numerous conflicts within South Africa. Witness the debacles over the cause of HIV/AIDS and the promotion of garlic, lemon juice and vitamins as alternatives,<sup>181</sup> not adjuncts to, anti-retroviral drug treatment. Similar tussles have been encountered with the promotion of so-called 'traditional remedies' to HIV, such as the fascinating and disheartening battle over *Ubhejane*.<sup>182</sup> Without a clear indication of how the two philosophies are to interact, such conflicts, as colossal as they are tragic, will, unfortunately, continue to occur.

Structural failings exist, too. In form, the Traditional Health Practitioners Act is not dissimilar from the Health Professionals Act,<sup>183</sup> which regulates the conduct of doctors and dentists. Furthermore, it is similar to Chinese and Indian legislation that authorizes the use of traditional healing in those countries – despite being based on entirely different principles.<sup>184</sup> As already mentioned, the biomedical, Chinese and Indian healing systems are all based on open and shared knowledge, and therefore possess a certain body of esoteric knowledge that may be dispersed, whilst traditional African healing is highly secretive and 'fact' differs not merely from region to region, but healer to healer. This is a major oversight in the writing of the Act, for quite how a traditional healer must demonstrate, in a written form needed to qualify as capable to practice, that they are capable of communicating with their ancestors, as an example, is unclear. Until this problem and others are resolved, the registration of healers that the state desires will remain difficult and fraught with contradiction.

Let us not be detained by these problems here. It is time to move on to the matter at hand. Traditional healing is a vital element of the lives of many. The field studies have shown that, on the available evidence, people utilise traditional healers and biomedical doctors in a complementary fashion. It is suggested that the former are utilised to heal the illness, and the latter, the disease. This much we have been able to deduce from the available ethnography.

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<sup>181</sup> For particularly well-placed criticism, see The Wits Aids Law Clinic at [www.alp.wits.ac.za](http://www.alp.wits.ac.za) as well as the Treatment Action Campaign [www.tac.org](http://www.tac.org)

<sup>182</sup> See C Bateman 'Taking Ubhejane by the Horns' in *SAMJ* Vol 96, No 5, May 2006. In short, *Ubhejane* is a brew composed of 89 ingredients picked according to the dream one truck driver, a Mr Zebulon Gwala. He sells the brew with the claim that it is able to cure HIV/AIDS, informing patients it cannot be taken in conjunction with Anti-retroviral treatment. Both the National Health Minister and the MEC for Health in KwaZulu Natal Province have endorsed the brew. The Medicines Control Council has found no demonstrable efficacy in its use. *Ubhejane*, however, continues to be sold.

<sup>183</sup> Act 56 of 1974

<sup>184</sup> CK Ong et al *WHO Global Atlas of Traditional, Complimentary and Alternative Medicine op cit* 187-197

Thus we turn away from anthropology, the study of the way things are. We turn our attention to law, the study of the way things ought to be.

### *The Language Of 'Ought To Be'*

*'I knew an epileptic patient who was dissatisfied with his epilepsy medication that was given to him at Somerset hospital. This patient consulted a traditional healer and was satisfied with his session.*

*However when he was diagnosed as HIV positive, he took ARV treatment without a fuss. He proceeded to use traditional medicine for his epilepsy.'* (Male Patient, Gugulethu)<sup>185</sup>

*'The sangoma (traditional healer) said I was bewitched by my neighbours' family. I once woke up one morning with my hair dreadlocked on one side and went to my church to find out the meaning of this. At the church they told me that the ancestors want me to become a sangoma but I didn't believe them.'* (Female patient, Du Noon).<sup>186</sup>

### **Rights for the people**

The law cannot mean whatever we wish it to.<sup>187</sup> It has a narrower scope, informed by the history of its drafting, and the contemporary circumstances in which it finds itself. In the following chapter, we examine the relevant laws as they stand. Socio-economic rights; the meaning of the right of access to health care services; the foundational values of the Constitution – all are important. We have the facts at our disposal, and now it is time for the legal language with which to interpret the facts.

The Constitution of the Republic of South Africa has consistently borne the description of being amongst the most progressive legal documents of its kind, anywhere in the world. Forging it from memories of an anguished history, and mindful of the promising future that it was intended to protect, the drafters of the Constitution constructed it to be the cornerstone of democracy in South Africa. Today, the Constitution enshrines the rights owed to and owned by all. It affirms the fundamental values

<sup>185</sup> S Mall *Attitudes of HIV Positive Patients in South Africa to African Traditional Healers and their Practices* op cit pgs 20-21

<sup>186</sup> *Ibid* 12

<sup>187</sup> *S v Zuma* 1995 (4) BCLR 401 (CC) para 17

of human dignity, equality and freedom, vital as they are to a fully democratic, human rights-based society.<sup>188</sup>

A key feature of the Constitution, and an aspect found in only a handful of other Constitutional democracies,<sup>189</sup> is the attention given to socio-economic rights. These are rights concerned with the basic necessities for human survival. An onus is placed upon the state to make available access to land,<sup>190</sup> housing,<sup>191</sup> health care services,<sup>192</sup> sufficient food and water<sup>193</sup> and social security.<sup>194</sup> Apart from land, which was reserved only for citizens, everyone inhabiting the Republic is entitled to such necessities. These rights are to be realized progressively, by way of the state taking reasonable legislative and other measures, within the available resources at its disposal.<sup>195</sup> In addition to these rights, everyone is acknowledged as having, further, the right to basic education<sup>196</sup> and the right to use the language,<sup>197</sup> and participate in the cultural life of,<sup>198</sup> their choice, provided that such rights are not exercised in a manner inconsistent with the Bill of Rights.<sup>199</sup>

Such socio-economic rights, in South African jurisprudence and beyond, are premised upon the alleviation of poverty. They seek to bestow upon people what they themselves are unable to provide and yet require for life. Poverty has the stunting effect of preventing people from fulfilling their personal aspirations, and continued poverty precludes their ability to grow into engaged, participating members of society. This is a fact for which a society as a whole is the poorer. The cherished value of dignity is, according to the Constitution, inherent in all persons, and is not an entitlement accorded by the state.<sup>200</sup> And yet, when a person is without a home, education or basic sustenance, they suffer from, quite literally, impoverished dignity.

<sup>188</sup> As adapted from S7(1) of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>189</sup> Sri Lanka, Hungary, Lithuania and Portugal being the others

<sup>190</sup> S25(5)

<sup>191</sup> S26(1)

<sup>192</sup> S27(1)(a)

<sup>193</sup> S27(1)(b)

<sup>194</sup> S27(1)(c)

<sup>195</sup> Common to Ss 25(5), 26(2) and 27(2)

<sup>196</sup> S29(1)(a)

<sup>197</sup> S30

<sup>198</sup> Ss 30 and 31(1)(a) and (b)

<sup>199</sup> Common to Ss 29(3)(a)-(c), 30 and 31(2)

<sup>200</sup> *Government of the Republic of South Africa v Grootboom* 2000 (11) BCLR 1169 (CC) para 23, hereinafter referred to as *Grootboom*. Personal communication with Neelima Khetan, chief executive of Seva Mandir, a grassroots NGO in Rajasthan, North Western India, Monday, October 9, 2007; Recorded in *Yale Daily News* October 10, 2007

Petitions to the Constitutional Court that are based on the various socio-economic rights are founded not upon desire, but upon need. Therefore they allow people to claim access to what should be, and is, rightfully theirs as human beings, merely in order to survive. As we shall see later, though, the Court has not adopted so-called 'minimum core' entitlements within those rights,<sup>201</sup> preferring to forego adjudicating what, quantifiably, constitutes sufficient nutrition or reasonable social security, for instance. Rather, an assessment of what is 'reasonable in the circumstances' has prevailed.<sup>202</sup>

The South African Constitution, then, is intended not only to limit a potentially abusive excess of state power, as many constitutions are wont to do, but also to be transformative. It does this through harnessing state energy to advance the progressive social and individual ideals upon which it is founded. In sum, a legal duty rests upon the state to fulfil the rights provided.

The long and colourful history that has characterized the interactions and arguments that have sought to promote either one or both of civil and political or social and economic (socio-economic) rights is beyond the scope of this paper. It suffices to say, however, that South Africa had been in something of a pickle when it came to agreements upon how to understand socio-economic rights. Initially it was feared by some that these rights would not be deemed justiciable, that is, capable of being heard and adjudicated upon by the courts, should a litigant attempt to have them enforced. This was due to the separation of powers doctrine adopted in South Africa. This doctrine prevented the different state organs, namely the executive, legislature and the judiciary, from interfering with each other's work, and so deprived them of too great a set of powers. Judicial decisions that encompassed socio-economic rights would, it was long noted,<sup>203</sup> have had a profound impact upon the state's allocation of finances, a task most definitely outside the set of responsibilities that were Constitutionally-mandated to the judiciary.

However, the Constitutional Court affirmed in its confirmation of the Constitution, *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa 1996*,<sup>204</sup> that such rights were, indeed, justiciable.

'...In our view it cannot be said that by including socio-economic rights within a bill of rights, a task is conferred upon courts so different from that ordinarily conferred upon them by a bill of

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<sup>201</sup> *Grootboom op cit* para 33

<sup>202</sup> *Ibid* para 44

<sup>203</sup> The term reputedly originates with Baron de Montesquieu. For a useful summary, see Stanford University's philosophy website at <http://plato.stanford.edu/entries/montesquieu/#4>

<sup>204</sup> 1996 (4) SA 744 (CC) at paras 77-78, hereinafter referred to as *First Certification*

rights that it results in a breach of separation of powers...we are of the view that these (socio-economic) rights are, at least to some extent, justiciable.<sup>205</sup>

In any event, adjudications over other, non-socio-economic rights also bore financial implications for the state. Moreover, a right remained a right, whatever the contrary feelings on the matter. Much ink has been expended by many<sup>206</sup> in support of this point of view, and it is today considered good law and jurisprudence that socio-economic rights have the same stature in our law as civil and political rights, for

“The Constitution entrenches both civil and political rights and social and economic rights. All the rights in our Bill of Rights are inter-related and mutually supporting. There can be no doubt that human dignity, freedom and equality, the foundational values of our society, are denied those who have no food, clothing or shelter. Affording socio-economic rights to all people therefore enables them to enjoy the other rights enshrined in Chapter 2.”<sup>207</sup>

This favourable attitude toward socio-economic rights was consistently upheld in the quartet of cases concerning socio-economic rights that have come before the Constitutional Court, namely *Soobramoney v Minister of Health (KwaZulu Natal)*,<sup>208</sup> *Government of the Republic of South Africa v Grootboom*<sup>209</sup>, *Minister of Health v Treatment Action Campaign (2)*<sup>210</sup> and *Khosa v The Minister of Social Development*.<sup>211</sup>

And yet, the extent to which a court may enforce such rights is a little less certain.<sup>212</sup> The Court in *Grootboom* was careful to note that the rights in question could be ‘negatively protected from improper invasion’. However, the judges were somewhat hesitant about where the appropriate boundaries lay when they were called on to decide the extent of the state’s positive obligations to its citizens. Ergo, the Court has reconciled itself to the conservative and perhaps sensible approach adopted

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<sup>205</sup> *First Certification* para 77-78

<sup>206</sup> The writing on this is legion. For a useful hopping off – point, see S Liebenberg ‘Socio Economic Rights’ in M Chaskalson et al (eds) *Constitutional Law of South Africa* 1998

<sup>207</sup> *Grootboom op cit* para 23

<sup>208</sup> 1998(1) SA 765 (CC)

<sup>209</sup> *Op cit*, but for ease of reference 2001 (1) SA 46 (CC)

<sup>210</sup> 2002(5) SA 721 (CC)

<sup>211</sup> 2004 (6) SA 505 (CC)

<sup>212</sup> *Grootboom op cit* para 20

by Yacoob J in *Grootboom*. There, he noted that '(t)his is a very difficult issue which must be carefully explored on a case-by-case basis.'<sup>213</sup>

### The socio-economics of traditional healing

Socio economic claims are, as we have noted, based upon need. And yet, one wonders if this is really a classic socio-economic rights case? Poverty, as it turns out, is not the direct cause of people utilising traditional healing. It was once commonly thought that people resorted to traditional healers for three principal reasons. First, because they either had no physical access to biomedicine, second, because they were too poor to afford biomedicine, or, third, because they did not accept biomedicine as an element of their worldview of what is appropriate to heal their ailments. But, as we saw, field work has shown,<sup>214</sup> time and again, that traditional healing utilisation rates are the same in rural areas and in urban areas. Traditional healers and the remedies that they recommend are quite often more expensive than biomedical doctors. Finally, traditional healers and biomedical doctors are often consulted in conjunction, rather than in opposition, for patients see them a complimentary light, with each fulfilling a particular role. All three of the old grounds are refuted on the facts.

If poverty is not the critical problem, then surely this is not genuinely a socio-economic rights question. Although requests for health care services are, in most cases, framed as socio-economic rights, this is only true when the health care service sought is deemed a basic need. An example would be the case of *Treatment Action Campaign*, where the drug requested, nevirapine, was named a 'lifesaving'<sup>215</sup> medicine. The Council on Economic, Social and Cultural Rights (CESCR), constituted to interpret the provisions of the International Covenant on Economic, Social and Cultural Rights,<sup>216</sup> or ICESCR, the principal U.N. instrument in this regard, agree. According to their interpretations, a state is in violation of their obligations under the Covenant when persons lack 'essential primary health care'.<sup>217</sup> Although the Constitutional Court has differed from the Council on many points, this is not one of them – there

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<sup>213</sup> *Grootboom op cit* para 20

<sup>214</sup> *Le Beau op cit* and *Ardington et al op cit*

<sup>215</sup> *Treatment Action Campaign op cit* para 73

<sup>216</sup> International Covenant on Economic, Social and Cultural Rights Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966; entry into force 3 January 1976,

<sup>217</sup> *The nature of States parties obligations (Art. 2, par.1)* 14/12/90 CESCR General comment 3, para 10

appears to be a right only to basic or primary health care services, in order to ensure equitable and manageable distribution of resources.

In this particular matter, traditional healing is not sought, at least at face value, as a basic or essential health care service by necessity. Rather, it appears to be sought out of desire. Therefore, patients have chosen to adopt traditional healing, rather than that they actually require it for physical survival.<sup>218</sup> It is not as obvious that people require traditional healing in the same way that they may require shelter or a pension. Many would argue that biomedicine takes care of a person's basic health care needs adequately.

This departure from a needs-based rationale runs counter to the principle of need that is espoused by socio-economic rights litigation. It would seem, then, that this is a problem more along the lines of other constitutional problems, such as freedom of belief, as encountered in, say, *Prince v The President of the Law Society of the Cape of Good Hope*.<sup>219</sup> It is a problem concerned with accommodation – what is to be accommodated in public society,<sup>220</sup> and what is to be either excluded entirely or, at the very least, confined to the private sphere.

As always, though, the problem is not quite so simple. Poverty may not be the immediate cause for people utilising traditional healing. However, poverty probably acts as the principal underlying cause. The vast majority of people in South Africa who utilise traditional healing have been born into, and continue to be bound by, a life with few or no chances for social progression. They were, and continue to be, bypassed by the successes of the minority, victims of what one might call 'structural violence'.<sup>221</sup> This is a violence that is not physical, although, of course, there was much actual violence perpetrated against them in other fashions, but a set of societal and institutional organisations and paradigms that preserve unequal power relations between people, thereby causing harm.<sup>222</sup>

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<sup>218</sup> M Mander *Marketing of Indigenous Medicinal Plants op cit* 15, where 97% of the patients surveyed utilized traditional healing by choice, and not as a result of access or cost issues.

<sup>219</sup> *Prince v President of the Law Society of the Cape of Good Hope* 2002 (2) SA 794 (CC). The applicant had been prevented from practicing as an attorney because he indulged in marijuana use, a fact that meant that the Law Society deemed him not to be a 'fit and proper person' to practice law. He challenged this as an infringement of his right to religious freedom, guaranteed under S15 of the Constitution. The applicant failed in this regard.

<sup>220</sup> Or, as Sachs J put it in *Prince* at para 149 when evaluating whether or not to accommodate the religious convictions of a minority, as was the case in that matter, that the difference between judges would be how much 'trouble each feels it is appropriate to expect the state to go to, in order to accommodate (them)'.<sup>220</sup>

<sup>221</sup> A term first attributed to Johan Galtung in "Violence, Peace, and Peace Research," *Journal of Peace Research*, Vol. 6, No. 3. (1969), pp. 167-191. This has made it into the medical lexicon principally through the writings of Dr. Paul Farmer, especially in the book *Infections and Inequalities* UC Berkeley Press, 2001, for which it forms the basis.

<sup>222</sup> P Kelly *Fighting for Hope*, Consortium Books, Germany, 1984

In former times, the days of apartheid, this was explicitly done under the auspices of the state. Laws were passed that embraced and explained structural violence, a violence that positioned people in society on the basis of particular personal characteristics. The emphasis was on race in particular, but extended to include gender, sex, sexual orientation and much else besides. Despite the formal end of such an era, inequality and disparity of opportunity persists in the social context of many people's public and private lives.

It is perhaps this structural violence that has, perversely, allowed such institutions as traditional leadership to gain much strength in recent years. Many traditional leaders were either installed into their positions of power by, or, at the least, co-opted into acting with, the apartheid state.<sup>223</sup> This was a major element of preserving the principle aim of apartheid, that being separate development of the different population groups. However, despite this tainting of their reputation, traditional leaders did not disappear from the contemporary social and political scene – in fact, their position strengthened through express provision for them in the Constitution<sup>224</sup> and in various forms of legislation.<sup>225</sup>

One of the better answers to the natural question of why such a turn of events came to pass, seems to be that although many of the traditional leaders may have been reviled, traditional leaders fulfil a service position role that, in many instances, the state has yet to take up.<sup>226</sup> Hence, by necessity, the people that are subject to the rule of the traditional leaders choose to do so for lack of an alternative. This is not a definitive reason – nor is it intended to be. It is merely an illustration of how structural violence has forced alternative practices to the state norm to be utilised where the state does not provide.

Although traditional healing is used together with biomedicine, and not as a 'resort out of necessity', its enduring widespread practice, even when it was outlawed, can probably be attributed not only to its capacity to be effective medically, but to provide culturally sensitive care. It provides a means of coping with the devastating impact of the horrible circumstances that many South Africans are born into. It does this by orientating its practices to accommodate comfort by kin and family, social reference

<sup>223</sup> B Oomen *Chiefs in South Africa* Palgrave, New York, 2005, pg 157

<sup>224</sup> §12 of the Constitution makes such provision.

<sup>225</sup> Such as the Traditional Leadership Governance Framework Act 41 of 2003

<sup>226</sup> Oomen *op cit* pg 199. See also C Crais 'Custom and the Politics of Sovereignty in South Africa' *Journal of Social History* Spring 2006, pg 734. There it is asserted that the regions of the country that naturally fall under chiefs have become areas of 'state ungovernance'

points that have sustained people for many hundreds of years. Therefore, when exposed to difficult personal circumstances, brought about by destitute poverty and a poor social fabric, traditional healing, by being a sensitive and familiar icon, provides a source of solace, comfort and meaning in people's lives. It would not require too much imagination to conclude that spirit mediums, for instance, are sought after in order to provide answers to life's dilemmas, just as many people throughout the world seek similar answers from priests, therapists and, importantly, friends and family.

Internalised forms of dehumanisation and prejudice need to be overcome, for malaise and social inequality contribute markedly to a traumatised and unhealthy society. Recognising and accommodating other world views upon life is central to this effort. This is as much about social reconstruction, then, as it is about health. Looked at from this perspective, since poverty is the underlying cause, or at least a precipitating cause of the continued use of traditional healing, this matter is at least partly a socio-economic rights issue. Yet simultaneously it is a constitutional values issue – questions of how far society is to go in publicly accommodating freedoms of belief and cultural norms are equally relevant, both in and of themselves, and as far as they assist in representing the more woolly, amorphous values of dignity and equality.

In this, the particular matter goes somewhat further than the socio-economic rights cases that the Constitutional Court has been asked to consider in the past. In those matters, it was manifestly demonstrable that the provisions of the Constitution, and simple considerations of humanity, required the requests to be considered with grave seriousness – access to renal dialysis,<sup>227</sup> to shelter from the harsh winter rains,<sup>228</sup> to essential drugs<sup>229</sup> and to sustaining pensions.<sup>230</sup> Life without these simple things was deemed<sup>231</sup> to be contrary to a life lived with rich dignity and substantive equality between people. Therefore, whether or not the state was made to provide, be it progressively or immediately, became a question of resources, not values, since that was the only object that stood in the way of the realisation of such basic human needs.

At present, the questions of access that have faced the Constitutional Court have been binary – who has access and who has no access to housing,<sup>232</sup> pharmaceutical drugs<sup>233</sup> and social security?<sup>234</sup> The

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<sup>227</sup> *Soobamoney op cit*

<sup>228</sup> *Grootboom op cit*

<sup>229</sup> *Treatment Action Campaign op cit*

<sup>230</sup> *Khosa op cit*

<sup>231</sup> For other wording, see *Grootboom op cit* para 83

<sup>232</sup> *Grootboom op cit*

<sup>233</sup> *Soobramoney op cit* and *Treatment Action Campaign op cit*

question of traditional healing, though, located as it is within the broader context of biomedicine being the official and endorsed philosophy of healing, is somewhat otherwise. Deciding whether or not to provide traditional healing is a question of degree, not exclusion. If one accepts that traditional healing is a health care service, and notes that everyone is entitled to access to health care services, then *prima facie*, a right of access to traditional healing services exists. Whether or not it must be provided<sup>235</sup> by the state, is another matter.

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<sup>234</sup> *Khosa op cit*

<sup>235</sup> Interestingly enough, as accepted as socio-economic rights have become, state actions and attitudes towards socio-economic rights appear to remain premised on another formulation. Measures to protect people from discrimination in the civil and political sense have been forceful, eloquent and addressed as rights-based issues within a constitutional paradigm. Conversely, the response of the state to pleas by the general population to have their basic needs met, has been to speak of 'service delivery', rather than respond that it has a legal obligation to fulfill rights. In itself, there is nothing untoward in the term 'service delivery'. Indeed, the provision of services is the method of implementing socio-economic rights.

Yet, to frame an issue as 'service delivery' implies that the state interprets the action as a self-created promise that is autonomously and independently made on assumption of governance, and not one that it is bound to by law. Thus it is not so much a legal right as an expectation on the part of the populace that, as a result of their vote, they shall receive certain guarantees in return. What such an interpretation means, is that, when taken as a 'service', rather than a response to a right, the state is able to shift its resources and priorities as it sees fit when determining what services to provide, rather than be held to particular obligations by law. However, as it was stated in *Grootboom* at para 94

'I stress however, that despite all these qualifications, these (socio-economic rights) are rights, and the Constitution obliges the state to give effect to them.'

That is not to say that rights may not be limited – the Constitution clearly provides for this – but it does mean that such socio-economic claims may only be turned away from after proper legal consideration, and not just on government policy.

This disjunctive approach of the state, taking civil and political rights as genuine rights, and their socio-economic bedfellows as 'service delivery' issues, was, for many years, most apparent in the state's response to the disastrous HIV/AIDS pandemic.

The state was particularly careful, both in legislation and in policy, to jealously guard the rights of people living with HIV/AIDS when they are deemed civil and political. Discrimination against people on the basis of their HIV status was an anathema to the state. Numerous pieces of legislation, as well as government policies, made an effort to address the discrimination people living with HIV/AIDS commonly face. Labour laws, school admissions and insurance policies had been articulated in a manner so as to be blind, as far as possible, to a person's HIV status. The state had, furthermore, not designed its policies or manifested its practices to exclude people from anything of civil and political rights substance – voting, freedom of movement and association, or of expression remain as open to people living with HIV/AIDS as anyone else. However, steps to take action against the virus itself, had been somewhat less than forthcoming. Rights to effective treatment, seemingly part of the right of access to health care services, were not been championed by the state for a disgracefully long period.

The struggle to provide anti-retroviral and other, supportive, treatment, a component of the socio-economic right to health care services, was been a tortuously long and frustrating process. The state portrayed it as a matter of cost and policy, rather than a matter of rights-fulfillment, an argument that failed to appreciate the nature of the

## Pondering points

With socio-economic rights considerations so integral to the problem, it would be appropriate to begin by grappling with S 27(1) of the Constitution, the section concerned with rights relating to health care, food, water and social security. An investigation there shall provide clues as to whether or not traditional healing lies within the scope of the right of access to health care services.

Our principal questions, set out in fuller detail in the introductory chapter, are three. First, is traditional healing a health care service, as understood in the context of the Constitution? In order for there to be a right of access to it as a health care service, it must fall within the appropriate definition.

Second, not all health care services are covered by the state, and those that are, are often rationed. Therefore, we need to examine whether or not traditional healing qualifies as being capable of reasonable provision.

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claim. The state's perspective ignored (or, more cynically, was all too aware of) the fact that access to health care is a right of every person, and there exists a legally enforceable obligation upon the state to act in a manner that facilitates this. Even if treatment for people living with HIV/AIDS were prohibitively expensive, that could only be used to justify a limitation of rights, not to buttress a refusal to engage with them at all. The state was not engaging in service delivery (which can be subsumed to other needs) but in rights fulfillment, which must occupy centre stage. Again, that is not to say that rights cannot be limited – they can – but on their face, they form part of the law, and the state bears more than an ethical duty to see to their fulfillment. This disjunctive approach had the effect of undoing much of the legislation designed to negate discrimination against people living with HIV/AIDS.

The same separation is apparent in the Traditional Health Practitioners Act. It is not legislation of socio-economic ilk, despite appearing so. Rather, it is aimed at civil and political ends. That is, the legislation enables, after some hoop-jumping, the practice and receipt of traditional healing. It sets out to remove the discrimination that traditional healers and their patients may have faced from various facets of society – the biomedical community for one. But it goes no further – that is, it does not take traditional healing to the people. It makes it possible to engage with it without making it probable that access will be facilitated beyond that trade which already exists.

And yet, even if the intention of the state has been to make a civil and political statement, such a legislating can only have the dual consequence of invoking socio-economic rights, given that the legislation is concerned with the provision of health care services, in their role as socio-economic rights. However, the apparent lack of will within the state to see socio-economic rights as rights, and rather as matters of service delivery, probably stymies this.

See L London 'Health and Human Rights: What Can Ten Years of Democracy in South Africa Tell us?' *Health and Human Rights* Vol 8, No 1, 2004, pp 1 -24; R Jennings, J Mulaundzi, D Everatt, M Richter, M Heywood "Discrimination and HIV/AIDS" Available at [www.alp.org.za/resctr/rpapers/pdf/200210\\_Research.pdf](http://www.alp.org.za/resctr/rpapers/pdf/200210_Research.pdf); R Smart and A Strode 'South African Labour Law and HIV/AIDS' in *AIDS Analysis Africa* 10/3 (1999); Department of Education, Draft National Policy on HIV/AIDS. Notice Number 1926 of 1999 (Pretoria, Department of Education, 1999); G Soloman 'What new policies should South Africa's life insurance industry adopt' *AIDS Analysis Africa* 6/6, 1996; Heads of Argument submitted by the state in *Treatment Action Campaign supra*, available from [www.constitutionalcourt.org.za](http://www.constitutionalcourt.org.za)

If the answer to both of the above questions is 'yes', we come to our third question. Affirmative answers would confirm that traditional healing falls within the scope of S27 for consideration as a right to be enjoyed in public. However, we need a reasonable idea of what the meaning of the word 'access' is, in its Constitutional sense. It may be that the term requires the practice of traditional healing in public, in which case there will be a right to it. Alternatively, it may necessitate its practice in private, denying the right sought. This is important both to the evaluation of present practice, and whatever future practices may concern traditional healing.

These questions are important for affirming that the debate is one that has some genuine merit to it. It is not immediately clear that traditional healing is covered by the scope of S27, and so we must first locate the debate within the correct rights parameters. Then we may proceed to match our ethnography to the law, and produce an answer to the core question.

### **Is traditional healing a health care service?**

Everyone is guaranteed the right of access to health care services under S27 (1) of the Constitution. However, it is not overtly clear that traditional healing qualifies as a health care service, as that term is understood in the context of the Constitution. Thus we need to chart out a meaning for the term 'health care service', and examine whether or not traditional healing is compatible with this. There is no desire to submit an authoritative definition of what constitutes a health care service. Rather, we will examine what is commonly perceived to constitute such. More important, however, is the weight that we will accord to the practice of health care, as opposed to the theory. Drawing on the anthropology of the previous chapters, and employing the structures of the law that we are presently engaging, a satisfying answer can be reached.

Let us begin with general and work our way to the specific. The WHO has defined good health to be 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.<sup>236</sup> This broad definition clearly contemplates a state of health that transcends a person's biological good health. In creating this dual biological-and-social interpretation of health, the WHO recognises and incorporates the long held, medical anthropology-influenced distinction between 'disease' and 'illness', a difference that we have already noted.<sup>237</sup>

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<sup>236</sup> Preamble to the Constitution of the World Health Organization

<sup>237</sup> See generally, but in particular the wonderful writings of Susan Sontag in *S Sontag Illness as Metaphor*, Penguin, England, 1977. Other works include S DiGiacomo 'Metaphor as Illness: Postmodern Dilemmas in the

It is axiomatic that a health care service structured to be consistent with the WHO's principles, would be that institution that catered for the provision of good health, as it is understood by the WHO. South Africa is generally so orientated. Interestingly, however, in contrast with the WHO's definition, neither the term 'health' nor 'health care service' was defined in the governing legislation of the health care system, the National Health Act.<sup>238</sup> At least, nothing outside of a reference to 'health services' as being that which 'is contemplated in...the Constitution'.<sup>239</sup> Yet the Constitution is silent on the matter too, resulting in a circular and unhelpful path.

However, the term 'health establishment' was defined in the National Health Act, this being an institution that 'includes inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing and rehabilitative, palliative, convalescent and preventative health services.'<sup>240</sup> The Traditional Health Practitioners Act adopts precisely these words to define a 'health care service'.<sup>241</sup>

From a legislative perspective, it would appear that, from the little indications that there are, an emphasis has been placed upon defining health care services by their institutional design, rather than incorporating patient perspectives on what constitutes a health care service. This is peculiar, since a health care service is not isolated unto itself, but one that exists with the sole purpose of improving the health of its patients. A properly conceived health care service is that which is composed of both institutional and patient interpretations. A health care service should be an entity that regards itself as a health care service and has the effect of providing health care, and is regarded by patients as such.

The court rooms have been equally spotty in their appraisal of the matter. Despite having been considered twice by the Constitutional Court, in *Soobramoney*<sup>242</sup> and in *Treatment Action Campaign*,<sup>243</sup> the term 'health care service' has yet to have acquired anything near a meaning in the Constitutional Court. It appears that the fear of the Court in *Treatment Action Campaign* was that to have defined

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Representations of Body, Mind and Disorder' in *Medical Anthropology* Vol 16, 109-137; M Weiss 'Signifying the pandemics: metaphors of AIDS, cancer and heart disease' in *Medical Anthropology Quarterly* Vol 11, 456-476

<sup>238</sup> National Health Act 61 of 2003

<sup>239</sup> S1 *Ibid*

<sup>240</sup> S1 National Health Act 61 of 2003

<sup>241</sup> S1 Traditional Health Practitioners Act 22 of 2007

<sup>242</sup> *Soobramoney v Minister of Health (KwaZulu Natal)* 1998(1) SA 765 (CC)

<sup>243</sup> *Minister of Health v Treatment Action Campaign* 2002(5) SA 721 (CC)

'health care service' would have contravened the decision, made in *Grootboom*,<sup>244</sup> to exclude minimum core obligations from socio-economic rights jurisprudence.<sup>245</sup> By giving precise meaning to the concept, the Court may have worried that this may have encouraged claims against the state, claims that arguably could not have been met.<sup>246</sup>

However, as it was noted in *Grootboom*,<sup>247</sup> and is clear to see, questions concerning what something *is*, and what someone is entitled *to*, are, though related, different. The first sets the definitional boundary. The second relates what is to be expected within those boundaries. In the cases of *Soobramoney* and *Treatment Action Campaign*, it was assumed that the factual scenarios contemplated were concerned with health care services. The first was absorbed with renal dialysis, the other with the drug nevirapine, respectively. Both clearly fall within the biomedical realm, and, consequently, were taken to be part of a health care service. There was no argument on this point. Therefore they were adjudged under the second question – that of what one is entitled to. However, the effect of not deciding the first question,<sup>248</sup> that of what health care is, is that it remains unclear whether or not traditional healing is a health care service.

Taking the anthropological observations of traditional healing as it is practiced and employed by people allows an effective response. Appreciating that biomedicine and traditional healing are employed in a complementary, rather than contradictory, manner by patients, goes a considerable way to solving the question posed, that of whether or not traditional healing is a health care service.

Separate from its definition of a health care service, the Traditional Health Practitioners Act notes the concept of 'traditional health practice' as a 'function, activity, process or service based on a traditional philosophy'.<sup>249</sup> Now, this does not necessarily set traditional healing apart from the broad term 'health care services' – rather, it serves to set it apart from biomedicine, which would be, and is by the Act, defined as science-based. This is a necessary separation, given the different theoretical bases for the two practices.

<sup>244</sup> *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC)

<sup>245</sup> *Ibid* para 33

<sup>246</sup> Part of the so-called 'minimum core' obligations, allegedly owed by the state to inhabitants of South Africa. They were unsuccessfully argued for in both *Grootboom* and *Treatment Action Campaign*.

<sup>247</sup> *Grootboom op cit* para 40

<sup>248</sup> Admittedly, it was unnecessary to have done so in these cases. Nor was it requested.

<sup>249</sup> S1 Traditional Health Practitioners Act 22 of 2007

The creation of a new professional council to oversee Traditional Healers, separate from the Health Professions Council of South Africa (HPCSA),<sup>250</sup> which assists in regulating biomedical processes, is important. Though both falling under unified National and Provincial Departments of Health, the disciplines maintain a distinct instructional separation from one another. This is a fairly reliable indication that traditional healing and biomedicine, though mandated to work together by the Traditional Health Practitioners Act, will remain separate disciplines in practice, too. This is similar to the way that doctors under the HPCSA are separate from alternative health practitioners of the Allied Health Professions Council<sup>251</sup> and the pharmacists of the Pharmacists Council.<sup>252</sup>

By setting itself institutionally apart from biomedicine, traditional healing allows itself to take on a complementary role. Therefore, it is unsurprising that, when describing its practice, the Traditional Health Practitioners Act is careful to couch its words so as to be complementary to biomedicine. Thus it holds, as biomedicine does, that its aim is the maintenance or restoration of the physical or mental health or function in a person, through diagnosis, treatment or prevention of that physical or mental illness.<sup>253</sup>

The aim, then, of traditional healers is no different to the aim of biomedical doctors. Nor is the purpose of the patients who visit traditional healers and doctors any different – at least in the broad sense of the term. Indeed, patients who choose to use the two interchangeably are being pragmatic in accepting that, to put it succinctly, healing is as healing does, and they will choose the method as is deemed appropriate by themselves, and surrounding society.

Remembering the disease-and-illness dichotomy, it is evident that when a patient employs biomedicine and traditional healing in tandem, that they are from the patient's perspective mutually supportive in restoring a person to health, as that term is understood by the WHO. Therefore, to call the one a health care service and the other not, patently goes against the actions of a considerable proportion of the population and denies the complementary disease-illness dichotomy that comprises 'health'.

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<sup>250</sup> As created in S2 of the Health Professions Act 56 of 1974

<sup>251</sup> Chiropractors, Homeopaths and Allied Health Service Professions Act 63 of 1982 and the Chiropractors, Homeopaths and Allied Health Service Professions Second Amendment Act 50 of 2000

<sup>252</sup> S2 of the Pharmacy Act 53 of 1974

<sup>253</sup> S1 *Ibid*

Traditional healing is clearly used by the majority of the population as a health care service, regardless of whether or not it actually *is*. The purpose of health care, healing, medicine – whatever term or concept one may prefer, is undoubtedly one that is not premised upon institutional self fulfilment or being an end in itself. It is a service created by, designed for and employed to enhance the lives of human beings. Consequently, a patient-perspective of the scope of health care is imperative. If patients regard and employ traditional healing as a health care service, as it has been demonstrated that they do, then it should be regarded as such.

And yet, even from an institutional perspective, traditional healing practices would appear to constitute health care efforts. The Medicines and Related Substances Act defines ‘medicine’ to be

‘...any substance or mixture of substance used or purporting to be suitable for use or manufactured or sold for use in -

- (a) the diagnosis, treatment, mitigation, modification or prevention of disease, abnormal physical or mental state or the symptoms thereof in man; or
- (b) restoring, correcting or modifying any somatic or psychic or organic function in man, and includes any veterinary medicine.’<sup>254</sup>

This definition, placing the emphasis on the use and prescription of the substance, rather than its actual effect, was referred to in both *Treatment Action Campaign v Matthias Rath*<sup>255</sup> and *Reitzer Pharmaceuticals (Pty) Ltd v Registrar of Medicines and Another*<sup>256</sup> where it was successfully argued in the former that

“...in certain circumstances a substance will be a medicine if it is used for the defined purpose or if it purports to be suitable for use...(if it is said that)...the substance is good for the purpose of treating or preventing...(a disease).”<sup>257</sup>

<sup>254</sup> S1 Medicines and Related Substances Act 101 of 1965

<sup>255</sup> *Treatment Action Campaign v Matthias Rath* Case No 12156/05 (C)

<sup>256</sup> *Reitzer Pharmaceuticals (Pty) Ltd v Registrar of Medicines and Another* 1998(4) SA 660 (T)

<sup>257</sup> *Treatment Action Campaign v Matthias Rath* op cit para 31

There is no doubt that traditional healers market their trade and the substances that they use as having medicinal properties. Equally, they are intended to be used for medicinal purposes by the patients whom receive them. This brings traditional medicines within the above legislative definition, on the authority of the High Court concerned. Therefore, the context and circumstances of the use of a substance defines its status as a medicine, not its biomedical properties.<sup>258</sup>

It is also evident from the Constitution that the meaning of 'health care services' extends beyond curative actions directed against a state of poor health. Health care services must also be proactively preventative of ailments and protective of good health. This broader interpretation is given credence by the explicit inclusion of reproductive rights under health care services,<sup>259</sup> a set of rights that most certainly relate to preventative and protective medicine, and not curative. Traditional remedies are equally as wide in their scope.

Thus, whether or not the biomedical definitions of health care are accurate, traditional healing institutionally and from a patient perspective appears to be a health care service. There has been a political and social *fait accompli* that has achieved a legitimate place for it in the health care order. Thus they cannot be entirely excluded on any reasonable basis since it is not the place of the law to determine a practice's objective centrality to a person's life.<sup>260</sup>

Therefore, it would be consistent with the facts of the matter to regard the term 'health care services' to have a broad, liberal, all-encompassing meaning and purpose. Such a meaning should afford people the full measure of fundamental rights and freedoms.<sup>261</sup> This interpretation of the term 'health'

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<sup>258</sup> This would appear to conform to the position taken by the WHO. Even within its own interpretation of the definition of health, the WHO has retrospectively included reference to traditional healing. More recently, this was strengthened through the United Nations General Assembly, where Article 24 of the Declaration on the Rights of Indigenous Peoples explicitly states that

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

South Africa's 1997 White Paper on Health, which adopted the same pattern of recognition and endorsement, followed suit on the WHO's moves.

<sup>259</sup> S 27 (1) (a) of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>260</sup> *MEC for Education: KwaZulu Natal v Pillay* Case CCT 51/06 paras 87 and 88

<sup>261</sup> *S v Zuma* 1995 (2) SA 642 (CC) para 14 encourages purposive interpretations of the text of the Constitution.

in 'health care services' would probably result in the acceptance of traditional healing as a health care service, on the strength of the results of the investigations into its use. Therefore it is submitted that this should be adopted.

Arthur Kleinmann, one of the doyens of the field of medical anthropology, once wrote that there was 'no essential medicine.'<sup>262</sup> Kleinmann was probably mistaken in one regard, and that is that we all do, in fact, have bodies that are biologically or corporeally constituted in the same way. But beyond that singular sameness, he was quite right. One of the beauties of human life is that it is frequently *not* capable of being reduced to simple biology. It is far more nuanced. At the margins, the undefined, the unknown and the idiosyncratic, we are forced to admit that there is no practice that is omnipotent in its ability. Healing is as healing does, to reprise our earlier observation, at least at the borders, and that is enough.

Health, then, is an intimate issue, not immediately definable for society, but known to each person individually in terms of what they desire. It is, then, perhaps best to be pragmatic and approach health not from a constitutive or definitional standpoint, but from a purposive perspective. Acceptance of traditional healing as a health care service does not necessitate either a belief in it or an endorsement of it. All it is, is the recognition that it exists to provide for people's good health, and in the context and circumstances, is used as such. And that fact should be sufficient to deem it a health care service.

### **On offer to the public**

As we have noted, there is a considerable distinction between what something is, and what someone is entitled to. The question that we have just assessed is grounded in the former. The question which we are about to address, goes to the latter. Not all health care procedures are provided under a right of access to health care services. Whether or not traditional healing is one that is, is the focus of our next investigation. It will soon become apparent that basic necessities are more likely to be provided than complex and expensive procedures. It would be in the interests of traditional healing if it could so fashion itself. Let us proceed.

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<sup>262</sup> A Kleinman *Writing at the Margin* UC Berkeley Press, San Francisco, 1995 pg23

Again, we will begin with the general and move to the specific. International law is littered with references to, in varying degrees, the right to health.<sup>263</sup> Principally organised around the WHO, various global and regional groups and unions address health concerns. At the heart of this is the Universal Declaration of Human Rights (UDHR), which states in article 25 that

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.<sup>264</sup>

This is expanded and improved upon by the ICESCR, the terms of article 12 stating that

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
  - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
  - (b) The improvement of all aspects of environmental and industrial hygiene;
  - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
  - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.<sup>265</sup>

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<sup>263</sup> Universal Declaration of Human Rights Art 25; International Covenant on the Elimination of All Forms of Racial Discrimination Art 5(e) (iv); International Covenant on Economic, Social and Cultural Rights Art 12; International Convention of the Elimination of All Forms of Discrimination Against Women Art 12; Convention on the Rights of the Child Art 24, amongst others.

<sup>264</sup> Article 25 of the Universal Declaration of Human Rights. South Africa has both signed and ratified the UDHR

<sup>265</sup> Article 12 of the International Covenant on Economic, Social and Cultural Rights South Africa is a signatory to the ICESCR, but has not ratified it.

Note carefully that, whereas the UDHR gave everyone the right to an 'adequate' health, the ICESCR bestowed the right to the 'highest attainable standard' of health. It is the ICESCR's scope that has more commonly been followed in the wording of similar, subsequent articles.<sup>266</sup> The CESCR, in accordance with their charge of expanding the definition, re-affirmed in their General Comment 14 that

"Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization, or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable."<sup>267</sup>

At the outset, it should be noted that a bald 'right to health' cannot be guaranteed, for much that impacts upon the health of an individual is beyond control by the state. The natural environment, hereditary abnormalities and individual choice conspire against it. Rather, the term 'right to health' means that those responsible for health – the state and its duly designated organs and mandated private groups – are entrusted with the obligation to provide particular freedoms and entitlements. This would include such things as diagnostic, preventative, curative and rehabilitative services necessary for the attainment and maintenance of good health.<sup>268</sup> Again, the CESCR holds that

"The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection

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<sup>266</sup> See the International Convention of the Elimination of All Forms of Discrimination Against Women, Adopted by the United Nations General Assembly on 18 December 1979 and the International Covenant on the Elimination of All Forms of Racial Discrimination, Adopted by the United Nations General Assembly on December 21, 1965,<sup>[2]</sup> and entered into force on January 4, 1969.

<sup>267</sup> Para 1of the 'The Right to the Highest Attainable Standard of Health' CESCR General Comment 14, 22 session, Geneva, 2000

<sup>268</sup> H Hannum 'The UDHR in national and international law'(1998) 3(2) *Health and Human Rights* 145 at 153

which provides equality of opportunity for people to enjoy the highest attainable level of health.”<sup>269</sup>

The ability to determine a desired state of health, then, is left to the individual, in accordance with the respect for personal autonomy that medical ethics and societal mores decree. Of course, in cases where there may be serious social implications, such as plague or highly contagious and dangerous airborne pathogens, this ability may be limited by laws designed to protect public health. However, in order to place a person in the position whereby they have the ability to determine, to the furthest extent possible, their good health, the state must ensure the availability of resources, goods, services and the facilities necessary for people to engage in behaviour to affect this need.<sup>270</sup>

Yet, within the broadly framed right of access to health care services, there would appear to be a general consensus, both in South Africa and abroad, that this does not mean that the state can reasonably be expected to provide all health care services to all persons immediately upon demand. Limits upon disposable resources preclude this. Therefore, even when recognised as a health care service in the Constitutional sense, traditional healing would not necessarily be supplied as a health care service within the framework of the right of access to health care services via state-sponsored health care. It is trite that there is a limited amount of money that is allocated to health care services. It may yet be that it is deemed that traditional healing is a service that is deserving only of a pittance, if anything, of the health care budget’s distribution.

Within the realm of socio-economic rights jurisprudence, where claims are based on need, there is a general recognition that health care services are provided on a rationed basis.<sup>271</sup> Those in greatest need come first. The answer to the question of who is in greatest need, however, is not all that straightforward. Circumstance is critical. A highly complex and expensive neurological operation may be medically necessary in order to save the life of a patient. Conversely, a set of essential yet inexpensive vaccinations against various childhood diseases, administered to an infant proactively, is equally necessary. The question is which of the necessities should be given priority? If one were to adopt the principle of *Grootboom*, that ‘those most in need’ are to be given priority,<sup>272</sup> who would be in greater

<sup>269</sup> CESCR General Comment 14 *op cit* Para 8

<sup>270</sup> C Shinn ‘The right to the highest attainable standard of health: Public health’s opportunity to reframe a human rights debate in the United States; *Health and Human Rights* 4(1) (1999) 115 at 119

<sup>271</sup> *Soobramoney op cit* para 26

<sup>272</sup> *Grootboom op cit* para 31

need – those who have a more pressing, immediate complicated medical concern, or those that have no access to basic health care at all, but may be relatively healthy at present?

Adjudicating where to emphasise resources on a policy basis is difficult. It is not the task of the courts. But courts must hold the state to the law of the land. If the law dictates attention to be directed in a particular manner, that must be upheld. And it may yet do in this matter.

Patients are individuals, and thus entitled to individual consideration. Judge Sachs plucked out the hazy notion of equal consideration in health care matters rather well when he observed a UNESCO opinion with favour

‘Even in the industrialised nations where public tax-supported research has made a private biomedical technology industry possible, the literal provision of equal access to high technology care...would inevitably raise the level of spending to a point which would preclude investment in preventative care for the young and maintenance care for working adults. That is why most national health systems do not offer, or severely ration (under a variety of disguises), expensive technological care such as renal dialysis or organ transplants.’<sup>273</sup>

South Africa’s health care service is no different, as the plaintiff in *Soobramoney* was to learn. His plea for renal dialysis treatment programs to be expanded to include patients such as himself, who did not meet the medical criteria for selection into the program, was turned down. Writing in his own, concurring judgment with the majority, Sachs went on to deduce that this meant that

‘The inescapable fact is that if governments were unable to confer any benefit on any person unless it conferred an identical benefit on all, the only viable option to confer no benefit on anybody’<sup>274</sup>

The aim, then, would be to build a system orientated not towards cutting people out intentionally, but defining the appropriate times that a right may be fairly and effectively enjoyed by the

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<sup>273</sup> Brody *Biomedical Technology and Human Rights* UNESCO, Paris 1993, cited by Sachs J in *Soobramoney op cit* para 53

<sup>274</sup> *Soobramoney op cit* para 53

most. That would necessitate limiting the right to others.<sup>275</sup> When this is to transpire, or how, is a difficult question. Regarded duly as individuals, each patient can rightly claim that they should be accorded the best available treatment. Medicine is, after all, a practice that is orientated towards the preservation and relieve of the life of the individual. Since we all have an interest in our good health, and access to health care is made open to all, we all have an interest in having a health care service that entitles us to equal consideration. In consequence, current South African medical and bioethical thinking has deemed that primary health care shall be paramount,<sup>276</sup> proactively and aggressively keeping people healthy, for it is claimed to be more effective than a response to an acquired ailment. However, significant resources will be devoted to complicated procedures too, although of a severely limited number.

The approach predominating has been to leave such questions of who is entitled to care, in the hands of medical professionals. They make judgments that they consider *medically* appropriate, rather than politically or legally motivated. The tricky, case-based nature of clinical medicine would appear to make this a sensible choice. As Chaskalson P penned in *Soobramoney*

‘A court will be slow to interfere with rational decisions taken in good faith by the...medical authorities whose responsibility it is to deal with such matters.’<sup>277</sup>

This was following the reasoning adopted in the English case of *R v Cambridge Health Authority, ex parte B*, where it was held that

‘Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make.’<sup>278</sup>

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<sup>275</sup> As adapted from Sachs J in *Soobramoney op cit* para 54

<sup>276</sup> White Paper for the Transformation of the Health System in South Africa, Department of Health, 1997.

<sup>277</sup> *Soobramoney op cit* para 29

<sup>278</sup> *R v Cambridge Health Authority, ex parte B* [1995] 2 All ER 129 (CA) at 137 d-f

A similar approach was taken in *Van Biljon and others v Minister of Correctional Services*

‘As to...(the)...applicants, it appears that no medical practitioner has thus far prescribed anti-viral treatment for them. An order to the effect that they are entitled to be provided with the drugs that they claim would, therefore, in my view, again amount to an instruction to a medical doctor as to what he should prescribe...I do not believe that this Court is empowered to grant such an order’<sup>279</sup>

These are distinctly pragmatic approaches to a difficult and complex ethical problem. Provided that the decisions are taken in good faith and rationally, with an absence of bias and proper application of their mind, courts have taken their cue to avoid interfering with such medical matters.

In the delicate balancing act of rationing resources for health care, there are few hard and fast principles that can be conjured to be utilised at all times. It is largely a matter of what the circumstances of the particular instance dictate. Perhaps the only principle that can be carried forward, though, stems from modern interpretations of equality jurisprudence. While a health care service can never be truly equal to all in its application, it can be equal in the consideration that it gives.<sup>280</sup> Although there may not be an entitlement to equal treatment, there is an entitlement to equal consideration. This is the notion of substantive equality, prevalent in latter day South African jurisprudence.<sup>281</sup> The value of equality is adjudged as not only requiring individuals in like situations to be treated alike, but takes appreciation of outcomes.<sup>282</sup>

Equal consideration of patients, by health care professionals, is a pre-requisite to their conduct being considered to have been performed rationally and in good faith. And, though it may not make the balancing process of where to apportion finances any easier, the application of such a principle does ensure that no-one is granted or denied treatment without reason.

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<sup>279</sup> *Van Biljoen v Minister of Correctional Services* 1997 (4) SA 441 at [37]

<sup>280</sup> *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 CC para 41

<sup>281</sup> J De Waal, I Currie, G Erasmus *The Bill of Rights Handbook* 4ed, Juta, Cape Town, 2001, pg 200

<sup>282</sup> *Ibid* 200

*Soobramoney* provides a vivid example of this. Though the interests of the population at large played no small part in swaying the judges in that case to find against the plaintiff, he was most certainly afforded fair consideration, both at the hospital<sup>283</sup> and in the court.<sup>284</sup> Indeed, they were sympathetic to his plight as an individual,<sup>285</sup> and would not have denied him access to appropriate health care services, had it not been for the presence of a compelling social interest in having as many people as possible receive basic medical services,<sup>286</sup> after equal consideration. And thus Mr Soobramoney was unsuccessful in his request for renal dialysis to be provided for him at state expense. If all those who suffered from chronic renal failure, or all those who required highly expensive medical treatment, were fully provided, as the precedent that would have been set, had Mr Soobramoney's appeal been upheld, the state would have little to spend elsewhere, or so the argument went.

The problem for traditional healing proponents, though, is that, thus far, leaving such decisions in the capable hands of health care professionals has meant leaving them in the hands of *biomedical* professionals. A continued deference by the courts and the legislature to such opinion, as appropriate as it may have been in the past, may now prove problematic in a pluralistic health care forum. Doctors, so often dismissive or suspicious of traditional healing will inevitably disagree with traditional healers as to how much or little a role herbal treatment and spiritual divination should play in the treatment of a patient. Who, then, is to make the choice of whether or not to accommodate traditional healing into the state-sponsored health care devoted to a particular patient – or set of patients?

However, there is a distinction that should be drawn here. The role of medical opinion distinguishes who, of those under equal consideration, should be attended to. It is the social opinion that directs what options are available from which to choose. That social opinion has directed that the most effective method for repairing the populations generally poor state of access to health care services, is to focus upon preventative, primary health care interventions.<sup>287</sup>

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<sup>283</sup> *Soobramoney op cit* paras 2 and 33

<sup>284</sup> *Ibid* para 28

<sup>285</sup> *Ibid* para 31

<sup>286</sup> *Ibid* para 31

<sup>287</sup> White Paper for the Transformation of the Health System in South Africa, Department of Health, 1997.

In 1978, at the very same conference where traditional healing was first recognised as having a role to play in biomedical-based health care systems, the Declaration of Alma Ata, Article VI stated that

Primary health care is essential health care based upon practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that community and country can afford to maintain at every stage of their development...It forms an integral part of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community<sup>288</sup>

Primary health care was a proposal to bring simple, appropriate health care services to the rural areas, where the bulk of the world's population lived. It promoted good health through providing preventative, curative and rehabilitative care to people. This would be effected through public education, the promotion of proper nutrition, the provision of adequate sanitation, concern for maternal and paediatric health, widespread immunization against infectious disease, treatment of common disease and the provision of essential drugs.<sup>289</sup>

South Africa, in her watershed adoption of the 1997 White Paper for the Transformation of the Health System in South Africa, adopted comprehensive primary health care as the strategic approach

<sup>288</sup> Article VI of the WHO Declaration of Alma-Ata International Conference on Primary Health Care *op cit*

<sup>289</sup> Article VII of the Declaration of Alma Ata states that Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

guiding the creation of a unified health system, capable of delivering quality health care to all. This was borne out of recognition of the enormous social and socio-economic challenges blighting the lives of most of the inhabitants of South Africa.<sup>290</sup> The only sensible method of addressing the profound inequalities between rich and poor was to structure the health care service in such a manner as to provide for the most, first. Those who had the ability to provide for themselves, were expected to carry that burden through the private health care sector, hopefully freeing the public sector for those whose finances and geographical situation offered them a limited choice of care-givers.<sup>291</sup>

The principles of primary health care in both the Declaration of Alma Ata and the 1997 White Paper emphasise the necessity of the equitable distribution of a system predicated upon accessible, safe and socially adoptable health care. The large and widely-dispersed number of traditional healers, occupying, as they do, a particular niche in the social world view of many, are important in this regard.

Traditional healers are geographically available and culturally accessible to the majority of the population that would intend to use them.<sup>292</sup> They employ their powerful position and pervasive influence to make sense of the bewildering mysteries that plague the lives of their patients, and for this they continue to find themselves welcome. At times they form part of the disease-and-illness dichotomy constructed by patients. In other capacities they serve as effective conduits for simple biomedical treatments. And in yet more moments, their own remedies provide relief and alleviation from common complaints.

These qualities allow them to be both complementary to, and a component of, primary health care. If primary health care is to be given preference, then traditional healers can expect that they have a reasonable prospect of being an incorporated element of state provided health care. There are existing hurdles, though.

The area remaining to be deciphered is that of safety. The Declaration of Alma Ata deemed that health care methods validated by biomedicine as scientifically sound were definitive as 'safe'.<sup>293</sup> The Traditional Health Practitioners Act, on the other hand, refers to scientific validation in a more oblique fashion. It requires the Traditional Health Practitioners Council to ensure the quality of health care services<sup>294</sup> and promote the interests of the public,<sup>295</sup> whilst ensuring that traditional healing complies

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<sup>290</sup> Department of Health Annual Report 2007

<sup>291</sup> White Paper for the Transformation of the Health System in South Africa, 1997

<sup>292</sup> *Ibid* and The Declaration of Alma Ata *op cit* Article VII section 7

<sup>293</sup> The Declaration of Alma Ata Article VI

<sup>294</sup> S5(b) of the Traditional Health Practitioners Act 22 of 2007

with universally accepted health care norms and values.<sup>296</sup> It does, however, specifically exclude science as a basis for traditional healing.<sup>297</sup> This should be a major obstacle in the path of traditional healing to acceptance, given the fragmented, secret and individual structures inherent in traditional healing. To head this off, two diametrically opposing approaches have been taken by the state.

Initially, collaborative efforts between a cluster of government-sponsored research institutions resulted in the creation of the groups who had the charge of scientifically establishing the safety, quality and efficacy of the herbal extracts utilised in traditional remedies. The intention was to protect patients through the investigation of claimed medicinal substances and subsequently regulate their use.<sup>298</sup> It was hoped that this would foster health, scientific, cultural, environmental and socio-economic benefits, derived from the development and sustainable use of Southern Africa's medicinal plants.<sup>299</sup>

Oddly enough, the opposite practice has also been engaged in – approving traditional remedies without any scientific basis or any thought given the safety of the remedies. This has happened through political will and may yet happen legislatively too. Despite many valiant challenges to the practice in the courts of the land,<sup>300</sup> many substances advertised as being for medicinal use continue to be so sold without any demonstrable safety, let alone efficacy or efficiency.

Failure to demonstrate the safety of traditional remedies will mean continued opposition to them from the biomedical establishment. However, that failure does not mean that traditional healing cannot be considered an element of primary health care. The dual health care seeking practices by patients of traditional healing places their role squarely within that of primary health care. Thus, by recognising their relevance in a primary health care setting, and by actively promoting private use of their services, the state has tacitly acknowledged that, at the very least, there is a basis for their inclusion in state health care plans.

Shorn of the uncertain moments of how or when traditional healers will interact with the biomedical sector, the simple implications are clear. Traditional healers are recognised as being instrumental to primary health care efforts. Since South Africa's health care system is premised on

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<sup>295</sup> S5(c) *Ibid*

<sup>296</sup> S5(h) *Ibid*

<sup>297</sup> S1 *Ibid*

<sup>298</sup> These include the Department of Pharmacology, University of Cape Town, the School of Pharmacy, University of Western Cape, the Department of Arts, Culture, Science and Technology, the Medical Research Council, the University of Pretoria, the National Botanical Institute and the Council for Scientific and Industrial Research.

<sup>299</sup> National Reference Centre for African Traditional Medicines: A South African Model. Available from the Medicines Research Council at <http://www.mrc.ac.za/traditionalmedicines/national.htm>

<sup>300</sup> Particularly by the Treatment Action Campaign and the Wits Aids Law Project.

delivering a competent and comprehensive primary health care service to all, the logical deduction is that traditional healers are, at the very least, entitled to genuine and hard-thought consideration as an element of the state-sponsored health care services. This plateau is sufficient.

Thus it is time to turn to the last aspect of S27. And that is to properly understand what it is to 'access' health care services. It is not as apparent as the plain English may suggest.

### **To access healing**

'Access' in its Constitutional sense has been considered before by the Constitutional Court. However, as it shall be argued, its meaning is not appropriate for the present situation. It was mentioned earlier that socio-economic rights before the courts have been those of have or have-not access, and that this is not one of those. This is a matter of degree of access. As we shall see, this changes matters substantially.

Let us begin with the conventional definition, however. The right set out in S27 (1) of the Constitution does not afford people a 'right to healthcare', as the ICESCR does.<sup>301</sup> Rather, there is a right of *access* to health care. Much has turned on this subtle distinction in wording, and it would appear that much will continue to be made of it. In the present debate, interpretations of the meaning and effect of 'access' could mean that all the state would need to do for traditional healing, is legislate for its legitimate status. Alternatively, it could, at the other end of the spectrum, require the state to take traditional healing to the inhabitants of the country, installing healers in hospitals and supporting existing healing endeavours.

Speaking in the context of a right of access to housing, Yacoob J defined access thus

"The right delineated in section 26(1) is a right of access to adequate housing, as distinct from the right to adequate housing encapsulated in the Covenant (of Economic, Social and Cultural Rights). This difference is significant. It recognises that housing entails more than bricks and mortar. It requires available land, appropriate services such as the provision of water and the removal of sewage and the financing of all of these, including the building of the house itself. For a person to have access to adequate housing, all of these conditions need to be met: there must be land, there must be services, there must be a dwelling."<sup>302</sup>

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<sup>301</sup> Article 12 section 1 of the International Covenant on Economic, Social and Cultural Rights *supra*

<sup>302</sup> *Grootboom op cit* para 35

This definition has not been questioned in subsequent cases. It goes beyond a quantitative standard, and imposes qualitative rules upon what would be considered 'access'. In form, this would appear to be correct – it is an interpretation that gives tangible meaning to the rights in the Constitution. And yet, in substance, it is a most puzzling definition. It appears to depart entirely from the plain English meaning of access. The term 'access' ordinarily means 'having or gaining the ability to do something'.<sup>303</sup> Contrast this to 'adequacy', which in its plain form means 'a level that is sufficient to satisfy'.<sup>304</sup> It is the latter word that bears a closer resemblance to the definition that Yacoob was seeking to pin down.

Yacoob was making reference it would seem, to the 'adequacy' element of the right to adequate housing. He was not addressing the 'access' component. For instance, the presence or absence of water and sewerage systems, the examples used by the Justice himself, go to determining whether or not the house is capable of being deemed adequately habitable. They do not determine whether or not a person has access to that house.

Yacoob's definition, moreover, was grounded entirely with reference to housing. It was not a definition of what 'adequate' or 'access' is meant to mean in the broader, principled sense. It has no direct relevance, therefore, to what may be deemed 'adequate' health care services or, more importantly 'access to health care services'. Perhaps, then, a differing approach to the meaning of access in the right of access to health care services is warranted not only through disagreement, but through distinction.

It is proposed that, to give a person access to a resource is to make that resource available by placing it reasonably within their reach, provided that they are prepared to make a proportional effort to obtain the resource. Access is stretched between two poles – what is provided, and what is received. It is not as direct a right as the right to a resource *per se*, for to place something within reach is to make it geographically, economically, socially and physically proximate to people, rather than hand it to them directly. It is submitted that this is a far more appropriate and practical interpretation of the meaning of 'access'.

This interpretation is also driven by a purposive<sup>305</sup> reading of the Constitution. With resource constraints, interpreting access as having this meaning allows greater flexibility in government policy

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<sup>303</sup> 'Access' in the standard Oxford English Dictionary

<sup>304</sup> 'Adequate' *Ibid*

<sup>305</sup> A form of reading encouraged by *R v Big M Drug Mart Ltd* 1985 18 DLR (4<sup>th</sup>) 321, 395-6

and budgetary allocation. That is, the state may take activities that, while not in and of themselves enhancing health care services, have an effect that is productive in that regard. Some examples may illustrate the pragmatism allowed in providing access to health care services, rather than health care services.

A small proportion of the population have the financial security to access good quality health care. The state could not be made to provide state funded health care services to them. This would be a waste of resources when so many do not have. However, the state would be required to allow the construction of private health care sector operated hospitals in the geographic areas of those who could afford health care. Such a system of indirect state responsibility, where, in appropriate circumstances, individuals are encouraged to take responsibility for their own health, if they have the means and ability, reduces the infrastructural and financial burdens upon the state.

Alternatively, a small and remote village may not have sufficient infrastructure and inhabitants to warrant the construction of a clinic. However, the inhabitants are still entitled to access health care services. Therefore, the state may be required to construct an airstrip outside the village and arrange for a 'flying doctor' service, whereby a doctor from the nearest large town visits the community by means of light aircraft, and has the authority to airlift particularly ill patients to distant hospitals.

These examples exist in practice already. Access to other socio-economic rights has been addressed in a similar fashion internationally. Two examples would be the right of access to food and water, respectively.

Although the right of access to sufficient food has yet to be utilised in South Africa, international law gives some substantive comment. Following the UDHR<sup>306</sup> and the ICESCR,<sup>307</sup> both of which declare a right of everyone to adequate food, the CESCR notes that

'Accessibility applies to any acquisition pattern or entitlement through which people procure their food and is a measure of the extent to which it is satisfactory for the enjoyment of the right to adequate food.'<sup>308</sup>

Quite what needs to be done in order to guarantee access to food, will differ fairly substantially depending upon the peculiar facts confronted. In some cases, food may be proximate to the population, but they may be unable to afford it. In other cases, the facts will be reversed. Therefore access is then

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<sup>306</sup> Universal Declaration of Human Rights *op cit* Art 25

<sup>307</sup> ICESCR Art 11(1) and (2) *supra*

<sup>308</sup> CESCR General Comment 12 para 13 *supra*

further divided by the CESCR into economic and physical forms. Economic access to food by a person means that staple food stuffs are not priced beyond their means, a fact within the control of the state when it exercises its influence over food production and costs. Physical access, by contrast, refers to geographic proximity of people to a food source, a matter again within control of the state, because of its ability to dictate where food may be sold.<sup>309</sup>

The extent and magnitude of the state's specific task may also radically differ. Depending upon the circumstances, the state may be required to either facilitate access for those that are otherwise capable of accessing food, or actively provide access to food for those that are entirely unable to obtain their own. It is dependent upon what is necessary to meet its obligations to respect, protect, promote and fulfil<sup>310</sup> the right of access to adequate food under the Covenant. In order for access to be facilitated, the CESCR recommends that states not tax basic foodstuffs, monitor the price of food relative to inflation levels and engage in market regulation, subsidisation and price control of various food stuffs.<sup>311</sup> For those that need more active assistance, food stamps and possibly direct access to food as part of a broader social assistance package must be made available.<sup>312</sup>

The right to water has been assessed similarly. Shockingly, given its fundamental importance to human survival, a right to water was not included in the early and foundational texts of international law. Only in 2002 did the CESCR state, which it has done at some length since then, that an independent right to water for personal and domestic use exists in Article 11(1) of the ICESCR. This is because the phrase used below, is not exhaustive when referring to

'...the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing...'<sup>313</sup>

Such rights have also been inserted into other, supportive international conventions.<sup>314</sup> Using this legal base, the WHO and UNICEF have jointly prescribed objective standards for what is considered adequate. That is, 20 litres of safe drinking water, per person, per day, located within a reasonable distance from the household.<sup>315</sup> 'Reasonable distance' is a term that goes directly to interpreting

<sup>309</sup> *Ibid* 12 para 13

<sup>310</sup> The same wording, not coincidentally, as used in S7(2) of the Constitution of the Republic of South Africa

<sup>311</sup> CESCR General Comment 12 para 28 *supra*

<sup>312</sup> *Ibid* para 28

<sup>313</sup> ICESCR Article 11 (1) *supra*

<sup>314</sup> Convention on the Elimination of Discrimination Against Women Art 14(2)(h); Convention on the Rights of the Child Art 24(1) and (2)(c).

<sup>315</sup> *Global Water Supply and Sanitation Assessment 2000 Report* World Health Organisation – UNICEF (2000) pg 77.

'access', and has been interpreted variously to mean 'within 200 metres of a home in an urban area',<sup>316</sup> 'in the home or within 15 minutes walking distance'<sup>317</sup> and 'not requiring a rurally-based housewife to spend a disproportionate amount of time fetching water for the family needs'.<sup>318</sup>

Moreover, in adopting the economic and physical distinctions that are applied with regard to access to food, the CESCR has stated that, economically, water, its facilities and services, must be affordable for all and state parties must adopt

'[T]he necessary measures that may include, *inter alia*, the use of a range of appropriate low cost techniques and technologies, appropriate pricing policies such as free or low cost water and income supplements.'<sup>319</sup>

With reference to physical access, water must be within the safe and immediate physical vicinity of all.<sup>320</sup> This can be fostered by building the necessary infrastructure for piping water, ensuring that it is clean, unpolluted and drinkable, and preventing powerful entities from monopolising resources which may prevent equitable distribution of water.<sup>321</sup>

These international attitudes to similar basic socio-economic rights do not accord to the definition adopted by the Constitutional Court in *Grootboom*. With respect, they are of a similar vein to the suggestion that access means ensuring that, should people make a reasonable and proportional effort, they be able to gain what they seek for their needs.

And yet, there is something nagging about Judge Yacoob's definition that makes it necessary to reconsider. Unlike the other socio economic rights in the Constitution, those to housing,<sup>322</sup> food, water<sup>323</sup> and social security,<sup>324</sup> the right of access to health care is not accompanied by the term 'adequate' or 'sufficient'. These terms have the quantitative and qualitative aspect envisioned by Yacoob when he was attempting to define 'access'. This makes the right of access to health care services a textual outlier to the other socio-economic rights provisions.

<sup>316</sup> Pan American Health Organisation – [www.cepis.org.pe/muwwww/fulltext/aguabas/mideca.medica.html](http://www.cepis.org.pe/muwwww/fulltext/aguabas/mideca.medica.html) (accessed 11 April 2008)

<sup>317</sup> World Bank – [http://poverty.worldbank.org/files/4237\\_annex\\_s.pdf](http://poverty.worldbank.org/files/4237_annex_s.pdf) (accessed 11 April 2008)

<sup>318</sup> *Ibid*

<sup>319</sup> CESCR General Comment 15 para 12 *supra*

<sup>320</sup> *Ibid* 15 para 8 *supra*

<sup>321</sup> A Kok and M Langford 'The Right to Water' in D Brand and C Heyns (eds) *Socio Economic Rights in South Africa*, Pretoria University Law Press, Pretoria, 2005 pg 201

<sup>322</sup> S 26(1) of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>323</sup> S 27(1)(b) *Ibid*

<sup>324</sup> S 27(1)(c) *Ibid*

This stands in stark contrast with the international instruments that speak to the question. As we have noted, the dominant documents in this regard, namely the ICESCR, the CESCR General Comment Fourteen and the Convention on the Rights of the Child all call for no less than the 'highest attainable standard of physical and mental health' as a fundamental human right. The CESCR, in follow up, considers that health care services must be 'available, accessible, acceptable and of appropriate quality'.<sup>325</sup> The UDHR, their progenitor, calls for an 'adequate standard of health'.<sup>326</sup> All standards indicate a qualitative and quantitative standard buttressing what it is that is accessed.

The Court has yet to note this textual aberration. And yet such language has been used by the Court when referring to health care services. In *Soobramoney* it was held that

"[m]illions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to *adequate* health services. These conditions already existed when the Constitution was adopted . . ."<sup>327</sup> (emphasis added)

Other courts have also chosen to read a quantitative and qualitative element into rights of access to health care.<sup>328</sup> In *Strydom v Afrox Healthcare*,<sup>329</sup> it was held by the Pretoria High Court that the Constitutional right of access to health care means that patients have a legitimate expectation that when they access health care services, that those services are performed with skill and care by professional and trained health care personal. Although the Supreme Court of Appeal later overturned the decision of the court,<sup>330</sup> they left open the point about whether or not S27 (1) imposed minimum standards of care.

Moreover, the Constitution itself mandates such a qualitative and quantitative approach in another section that deal with health care, S35, which relates to arrested, detained and accused persons. The relevant subsection reads as follows:

Everyone who is detained, including every sentenced prisoner, has the right –

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<sup>325</sup> CESR General Comment 14 para 12 *supra*

<sup>326</sup> UDHR Article 25

<sup>327</sup> *Soobramoney* para 8 *supra*

<sup>328</sup> *Westville Prisons and Van Biljon v Minister of Correctional Services* 1997 (4) SA 441 (C)

<sup>329</sup> *Strydom v Afrox Healthcare* [2001] All SA 618 (T)

<sup>330</sup> *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA)

...(e) to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment.<sup>331</sup>

By inference, then, adequacy, or some variant thereof, seems to have already percolated into the manner in which access to health care is defined. And thus a claim that the term 'access' in the right of access to health care incorporates adequacy into its definition is entirely consistent with current legal principle.

Access to, and adequacy of, health care appears to be mutually supportive. Each places the other in context. What good is access to substandard health care? Why construct a medically-fit health care system out of reach of the population it is meant to serve? In order for the state to fulfil its fundamental obligation, that is to respect, protect, promote and fulfil the rights in the Bill of Rights, its duty under S7(2), the two elements must be paired in tandem for a coherent understanding of the right of access to health care services.

Therefore, Yacoob's definition of what is perhaps better described as adequacy, is still highly relevant. Although factually concerned with housing, health care equivalents can be extrapolated from his definition. Where Yacoob urges provision of water and the removal of sewerage, we can substitute in, for example, the training of competent health care workers and immunization against the major infectious diseases.

Therefore, access in its plain English meaning means that, with measures taken on the part of both the provider and receiver, that there is a reasonable prospect of there being a delivery of the service. Access in this sense, though, means that and more – adequate access to the health care system and access to an adequate health care system. Legislation that permits the practice of traditional healing certainly facilitates access. Whether or not it facilitates access to the extent required by the Constitution, is a matter to be addressed later.

### **Falling within the boundaries**

We may conclude, then, that traditional healing falls within the parameters of socio-economic rights litigation. Not only is traditional healing a health care service, but it is one that is capable of provision within the identity of primary health care. It is clear that merely legislating for its lawful

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<sup>331</sup> S35(2)(e) of the Constitution of the Republic of South Africa Act 108 of 1996

existence may not be sufficiently progressive an action for the state to be held to have discharged its obligations under the Constitution, given the definition of 'access' that we have adopted.

People may, consequently, make the demand that traditional healing practices be made available to them through state resources. However, falling within the scope of S27 does not yet mean that there is a right of access to traditional healing in the public sphere. Nor does it mean that there is an obligation on the state. All it means is that there should be a consideration of whether or not such a legal status should exist. The foregoing was strictly concerned with examining the possibility of this, not an evaluation of what should happen. This shall follow shortly.

But before we proceed, there is another matter that requires attention. Twice we have mentioned that that access to traditional healing as a state sponsored health care service is a matter of degree. It is a matter of degree because it is fully sanctioned in private, and its entry to the public sphere is partly blocked by the values that do – or do not – surround it. We cannot evaluate traditional healing on the basis of resources alone, as most socio-economic questions may. The values inherent in the Constitution are as important, and help to define to what degree we do accept traditional healing.

The decision to engage in traditional healing practices is a personal choice, informed by an opinion of what is effective and necessary in order to restore or improve one's health. What the presence of choice in the matter also influences, however, is the public regard that may be given to a particular issue. If traditional healing was resorted to by a person out of necessity alone, it would be difficult to legitimately deny it to them in the public sphere, for it is something that they patently need. However, when the decision of whether or not to use traditional healing is a matter of choice, contingent upon a particular lifestyle, an inevitable weighing of values will occur. This should not be taken to indicate that an act of choice is any less valuable than an act of necessity, however.<sup>332</sup>

For the most part, states have allowed the practice and engagement of traditional or complementary and alternative healing, provided that it is done outside of the public sphere.<sup>333</sup> South Africa is no different. The value accorded to personal autonomy has ensured that those who practice alternatives to biomedicine are able to lawfully engage in this practice in private.

Should traditional healing be brought into the public sphere, however, that personal choice will directly impact on the choices and lives of others, many of whom may not ascribe to the ways of traditional healing. If the state is to be required to provide traditional healing, resources will, inevitably,

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<sup>332</sup> *MEC for Education: KwaZulu Natal v Pillay op cit* paras 62-66

<sup>333</sup> CK Ong et al *WHO Global Atlas of Traditional, Complimentary and Alternative Medicine supra*

be diverted from other state schemes, including biomedical health care services. Hence, the values that influence the choice of use of traditional healing must be weighed against those that advocate for biomedicine alone, in order to apportion fairly between the two.

The right to engage with one's cultural practices<sup>334</sup> and the right to a freedom of belief,<sup>335</sup> both what one may term 'ways of life' rights, are underpinned by the fact that all persons have inherent dignity<sup>336</sup> and are entitled to equal consideration,<sup>337</sup> values that lie at the core of the new South African order. Employing a philosophy of healing, be it biomedicine, traditional healing or a combination of the two, will be predicated upon one's particular and peculiar world view. The world view that will be public, and adopted by the state, and the world view that the state shall designate to be practiced in private, will be determined by that juggling of values.

### Of dignity and equality

Dignity is a difficult concept to define. Most would know it when they felt it. Nonetheless, the Constitutional Court did take a stab, believing dignity to be the

'...intrinsic worth of the human being: human beings are entitled to be treated as worthy of respect and concern.'<sup>338</sup>

'Equality', her partner, does not mean quite what it suggests. Perversely, blind equality between people undermines dignity. That is, in recognizing blind equality, all persons are deemed to be equal. In recognizing dignity, the distinctive nature of each person is to be accorded respect. Therefore one is promoting the 'sameness of people' as equally important as 'the difference in people'. These are contradictory notions. Thankfully, South African jurisprudence has interpreted the rights and values of 'equality' and 'dignity' in a manner that is a little more complex – and mutually supportive.

Consider the far more nuanced perspective that is evident from the judgment of Judge Ackermann in the Constitutional Court's decision in *Prinsloo*

'Equality, as that concept is enshrined...means nothing if it does not represent a commitment to recognizing each person's equal worth as a human being, regardless of individual differences...'<sup>339</sup>

<sup>334</sup> Ss 30 and 31 of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>335</sup> S15 *Ibid*

<sup>336</sup> S10 *Ibid*

<sup>337</sup> S9 *Ibid*

<sup>338</sup> *Grootboom op cit* para 83

And, in *Hugo*

'At the heart of unfair discrimination lies a recognition that the purpose of our new constitutional and democratic order is the establishment of a society in which all human beings will be accorded equal dignity and respect regardless of their membership of particular groups.'<sup>340</sup>

'...although a society which affords each human being equal treatment on the basis of equal worth and freedom is our goal, we cannot achieve that goal by insisting on identical treatment in all circumstances...Each case, therefore, will require a careful and thorough understanding of the discriminatory action...to determine whether its overall impact is one which furthers the constitutional goal of equality or not. A classification which is unfair in one context may not necessarily be unfair in a different context.'<sup>341</sup>

Equality is therefore not the recognition of a bland 'sameness'.<sup>342</sup> It is the recognition that everyone has equal worth *irrespective* of their differences. When constructing the ambit of the right in this manner, the court tандems equality and dignity into mutually-supportive rights. Equality and dignity are mutually-supporting to the extent that equality has to value and accommodate difference if it is to be meaningful. Correspondingly, dignity is given proper effect by the recognition that, irrespective of difference, we are all equal.

Thus, the key to South African interpretations of equality is that people are recognized as being entitled to equal consideration, for differently situated people must be treated differently to accommodate their peculiar needs, since

'...the dominant theme of the Constitution is the achievement of equality, while considerable importance is also given to cultural diversity and language rights, so that the basic problem is to secure equality in a balanced way which shows maximum regard for diversity.'<sup>343</sup>

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<sup>339</sup> As borrowed from *Egan v Canada* (1995) 29 CRR (2d) 79 at para 35; *Prinsloo v Van der Linde* 1997 (3) SA 1012 (CC) at 32

<sup>340</sup> *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 (CC), as cited in *Prinsloo op cit* para 32

<sup>341</sup> *President of the Republic of South Africa v Hugo op cit* para 41

<sup>342</sup> R Fletcher 'Feminist Legal Theory' in *An Introduction to Law and Social Theory* R Banaker and M Travers (eds), Oxford Publishers, Portland, 2002, pg 149-150 comments on this particular manner of interpreting the term 'equality'.

<sup>343</sup> *Ex parte Gauteng Provincial Legislature in re Dispute Concerning the Constitutionality of Certain Provisions of the Gauteng School Education Bill of 1995* 1996 (3) SA 165 (CC) para 52

Underlying the Constitution as they do, these two ‘super-rights’ inform the interpretations of all rights enshrined within the Bill of Rights. But they have a meaning as they stand alone, too.

Undoubtedly, the Traditional Health Practitioners Act, in recognizing the value inherent in traditional healing, attempts to restore faith in traditional healing. This appeal is a necessary step in appreciating the importance of diversity. Diversity is intimately linked to both dignity and equality – enriching the former; giving nuance to the latter.

However, in this paper we are more concerned with the influence of the super-rights in determining the scopes of other, more immediately ascertainable rights. It gives our investigations more substance. Particularly pertinent to the exercise of traditional healing, are the rights to, first, freedom of belief, since one is placing one’s trust in a particular philosophy of healing and, second, the right to engage in the cultural life of one’s choice, because of the intertwining of traditional healing with other traditional African beliefs.

### **Belief and opinion**

Faith in the divine is as pervasive as it is timeless. Given the eclectic nature of humans, differing interpretations of the nature of this divine power are legion, and yet all societies have shared, and continue to share, a common understanding. That is, that there exists an entity that holds a power beyond our comprehension, and due reverence is accorded that spiritual body. Many would assert that this faith is perhaps the most cherished element of their self.

Judge Sachs put words to a profound truth when he remarked that

‘...the right to believe or not to believe, and to act or not to act according to his or her beliefs or non-beliefs, is one of the key ingredients of any person’s dignity.’<sup>344</sup>

The Constitution, founded, as we have noted, upon the values of fundamental human dignity, equality and freedom, consequently guarantees that

15(1) Everyone has the right to freedom of conscience, religion, thought, belief and opinion

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<sup>344</sup> *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC) para 36

15(2) Religious observances may be conducted at state or state-aided institutions, provided that –

- a) Those observances follow rules made by appropriate public authorities
- b) They are conducted on an equitable basis; and
- c) Attendance at them is free and voluntary<sup>345</sup>

There is also a third section, dealing with marriage, which does not concern us in this paper. The text is an affirmation of the International Covenant on Civil and Political Rights (ICCPR), which in article 18 finds that

- 18(1) Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.
- 18(2) No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.
- 18(3) Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals of the fundamental rights and freedoms of others
- 14() The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to ensure the religious and moral education of their children in conformity with their own convictions.<sup>346</sup>

Although the text of the ICCPR is substantially longer and more detailed than that of the Constitution, South African courts are required to interpret legislation in a manner consistent with international law,<sup>347</sup> unless such an interpretation would result in a breach of the Constitution.<sup>348</sup>

Chaskalson CJ, writing in *S v Lawrence*, affirmed the definitions in 18(1) and (2), via their application in the Canadian case of *R v Big M Drug Mart*, where it was stated that

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<sup>345</sup> S15 of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>346</sup> ICCPR *op cit* Article 18

<sup>347</sup> S 39 (1) (b) of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>348</sup> S 233 *Ibid*

'The essence of the concept of the freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination.'<sup>349</sup>

Freedom of religion, in the broad sense intended by the Constitution – that is, including conscience, thought, belief and opinion – is a critical aspect of the debate relating to the legalization of traditional healing. Traditional healing is, to a large extent, premised upon principles that are not empirically verifiable. Indeed, the definition of traditional healing by both the WHO<sup>350</sup> and in the Traditional Health Practitioners Act<sup>351</sup> takes explicit notice of this. The philosophy of belief in, *inter alia*, spirits and ancestors, is therefore correctly classified as exactly that – a belief. Whether or not such a belief qualifies strictly as a religion is not important, for the Constitutional protection extends beyond a potentially narrow definition of religion, which, incidentally, has yet to be created.

Critical to this debate, is whether or not the acceptance or denial of traditional healing in the public health care service in any way interferes with the fundamental right of freedom of belief. Certainly, the Traditional Health Practitioners Act affirms the protection of the belief-based philosophies and practices of traditional healing. This was denied by its previous outlawing. But is this enough? Is permissible private practice of traditional healing sufficiently respectful?

It may well be that the state would be required to afford further assistance to the practice of traditional healing, in order to be deemed suitably in compliance with its obligation under the Constitution to respect the rights afforded by S15. Perhaps only by increasing funding and making traditional healing an element of state health care, ensuring that the poor have access to it, would the state be fulfilling its duty.

What are the principles to which the state is held? Although the rights accorded to citizens by S15 have been defined, the corresponding obligations placed upon the state are far from comfortably settled.

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<sup>349</sup> *R v Big M Drug Mart op cit* para 97, as cited in *S v Lawrence; S v Negal; S v Solberg* 1997 (4) SA 1176 (CC) para 92

<sup>350</sup> *World Health Organisation Traditional Medicine Strategy 2002-2005 op cit* pg 7

<sup>351</sup> S1 of the Traditional Health Practitioners Act 22 of 2007

It was accepted by all eleven justices in *S v Lawrence*, as well as in the subsequent Constitutional Court matters of *Christian Education* and *Prince*, that everyone has the right to hold, express and display their beliefs. The corresponding obligation upon the State is to respect such beliefs by, at a minimum, refraining from coercing people to do otherwise. The precise definition of 'coerce' has generated some disagreement internationally, and the court in *Lawrence* was not any clearer in resolving this.

Chaskalson CJ indicated that the Constitution prohibited the state from actively coercing or constraining a person's religion, which meant employing measures that 'force people to act or refrain from acting in a manner contrary to their religious beliefs'.<sup>352</sup> O'Regan J thought that more was meant by 'coerce' and that more was required of the state than that it refrain from forceful measures. In her view, the Constitution also required the state to act 'equitably' to all religions, the learned justice writing that, in the absence of fairness, indirect discrimination could occur, even when there was no overt coercion.<sup>353</sup> Sachs J went further. It was, in his view, impermissible for the state to endorse any particular religious practice.<sup>354</sup>

The implications of this disagreement concerning what it means to 'coerce' are great. If Chaskalson CJ is right, the state need do no more than refrain from actively coercing people to adhere to one set of beliefs, as opposed to another. Therefore recognizing that traditional healing exists, and consequently making provision for it to be practiced legally in private, may be deemed sufficient accommodation. Then again, if the state is required to act as O'Regan or Sachs would have it, it may be that the state will be required to provide greater backing for traditional healing. Otherwise, it may be seen as too staunchly protecting the Cartesian dualism that underlies biomedicine. Should the state fail to do that, it will be preventing people from accessing an important aspect of their world view. Thus, if these latter arguments are accepted, it would be coercing them contrary to their belief, contrary to S15.

Curiously, Sachs J himself applied a little judicial sandpaper in filing off the rougher edges of this disagreement by adopting Chaskalson CJ's reasoning when writing for the Court in *Christian Education*.<sup>355</sup> Gone were his and O'Regan's objections to Chaskalson's view of state obligations. Instead, the Chief Justice's opinion was inserted as settled law. In fact, Chaskalson had, in *Lawrence*, been writing for the minority. A similarly deferential approach was adopted by all the justices in *Prince*, the last case

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<sup>352</sup> *S v Lawrence op cit* Para 92

<sup>353</sup> *Ibid* Para 128

<sup>354</sup> *Ibid* Para 79

<sup>355</sup> *Christian Education op cit* paras 18-20

to come before the Constitutional Court which concerned the claimed infringement of S15 rights. Quite where this leaves the scope of the obligation is yet to be decided. Have the justices adopted Chaskalson's reasoning, or have they adopted his words, but chosen to leave the question of what it is to 'coerce' a person for another time?

Perhaps, though, some of this debate is unnecessary. Should one read other Constitutional provisions into the debate, then a few answers are provided. O'Regan's concern with equitable treatment of the religions is correct. Surely, however, the free-standing equality clause in the Constitution, as well as the subsequent Promotion of Equality and Prevention of Unfair Discrimination Act mandate such considerations of equality anyway?<sup>356</sup> Irrespective of the full extent of the state's duties under S15, those instruments read equality into all aspects of our law, meaning that equitable treatment of differing beliefs would automatically be considered in tandem with the right of freedom of belief.

In sum, the state does not adopt particular religious beliefs itself. Benign neglect best characterises state-and-religion relations.<sup>357</sup> The state is comfortable to acquiesce and adopt an approach that lets individuals maintain their views to their heart's content, provided that they neither interfere with the state's ability to govern nor harm or coerce<sup>358</sup> another person. The state is most certainly not under any obligation to look over-favourably on a belief.<sup>359</sup> Where called upon to make a material concession to, or promotion of, a particular belief, the state tends to do so only if it is, first, a matter that materially influences a person and, second, it does not greatly inconvenience the state.<sup>360</sup> Thus the freedom of belief is the freedom to hold and express it, not have it handed to one. In consequence, Chaskalson's view, narrow as it is, is probably the best interpretation of the state's duty toward its citizens in this regard.

However, before we proceed, there is an interesting aside. Some may maintain that, since it is legislated for, the traditional healing is being recognised over other beliefs, and that this constitutes unfair promotion. The answer to this, is 'no'. Legislative recognition of traditional healing in private restores it to the same regard as any organised religion or pattern of thought. There is no favouritism

<sup>356</sup> De Waal J et al *Bill of Rights Handbook op cit* pg 301

<sup>357</sup> S15(2)(a) of the Constitution of the Republic of South Africa

<sup>358</sup> *Ibid* S15(2)(c)

<sup>359</sup> *Ibid* S15(2)(b)

<sup>360</sup> See *Prince and Christian Education*, for example. Both matters involved a limitation of rights that was partly predicated upon the desire and need for the state to maintain control over its vital interests.

there. Thus, in accepting traditional healing in private, the state is not endorsing it. It is recognising the reality of its practice and the entrenched belief in its success and potency. Legislating for its practice in private allows people to continue with their daily lives without fear of persecution for it. It is crucial to recognise the importance of traditional healing in the fabric of the lives of so many individuals and recognise that it means more than the ability to gather and consume a root.

Therefore, we can acknowledge that the duty of the state is limited with regard to the freedom of belief. Mostly, it is required to refrain from coercing people to act otherwise to their beliefs. There are some occasions when it is entitled to assist physically, but it must do so on an equitable basis. In consequence, in order for proponents of traditional healing to receive state assistance under S15, they would need to demonstrate that they are manifestly unable to access healing without state support. However, one has the feeling that the safest policy on the part of the state, to avoid accusations of bias, is to stay put. A disinterested Leviathan here would rankle the passions of its populace the least.

### Cultural Rights

It was nearly inevitable that, with South Africa's heterogeneous population, 'group' rights would be made mention of in the Constitution. Accordingly, membership of particular, ascertainable and defined communities bestowed collective rights upon the individual and that group. Sections 30 and 31, responsible for these rights, were some of the most difficult to negotiate in the formulation of the Constitutional Principles.<sup>361</sup> However, this particular area of Constitutional law has not received much direct attention, despite its importance to South Africa. The relevant sections read as follows

30. Everyone has the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision in the Bill of Rights.<sup>362</sup>

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<sup>361</sup> N Tebbe *Religion, Culture and Liberal Democracy in South Africa* PhD dissertation, University of Chicago, 2006 pgs 99 – 115

And See Heinz Klug, *Constituting Democracy: Law, Globalism, and South Africa's Political Reconstruction* Cambridge University Press, Cambridge, 2000, pg 109

<sup>362</sup> S 30 *Ibid*

31(1) Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community -

- a) To enjoy their culture, practice their religion and use their language; and
- b) To form, join and maintain cultural, religious and linguistic associations and other organs of society

(2) The rights in subsection (1) may not be exercised in a manner inconsistent with any provisions in the Bill of Rights.<sup>363</sup>

It is important to acknowledge that these rights are bestowed upon the individual so that they may act in concert with others.<sup>364</sup> The particular practices are valuable because of their communal, shared meanings.<sup>365</sup> Therefore, they can neither be acted out in isolation, nor held in the mind only. They must take place in fact and deed in the presence of others who understand, validate and share the experiences. Before we try to define the relative concepts, it should be noted that these are intangibles, with little precedence or guidance.

Quite what constitutes 'cultural life' or 'a community' is not immediately intuitive. In international law, albeit using the term 'minority', a 'group' is distinct and distinguishable from other entities on the basis of a fundamental characteristic, such as race, religion or language.<sup>366</sup> Furthermore, the group must manifest a sense of community and desire the preservation of that community, requiring rights to protect it because, being a minority, it cannot yield sufficient political power to do so.<sup>367</sup> Thus the rights protect otherwise vulnerable practices from intrusion and dismissal.<sup>368</sup>

Not every group that practices particular and peculiar activities can claim to be a cultural grouping worthy of Constitutional protection.<sup>369</sup> Nor do activities that are manifestly unlawful or

<sup>363</sup> S31 *Ibid*

<sup>364</sup> General Comment Adopted by the Human Rights Committee under Article 40, Paragraph 4 of the International Covenant on Civil and Political Rights, No 23(50), Article 27, 26 April 1994, paragraph 6.2

<sup>365</sup> See generally *Lovelace v Canada* (1985) 68 *International Law Reports* 17

<sup>366</sup> J De Waal, I Currie and G Erasmus *The Bill of Rights Handbook* 4ed, Juta, Cape Town, 2000, pg 474

<sup>367</sup> *Ibid* 474

<sup>368</sup> Kriegler J found it to be the 'bulwark' in this regard, whilst writing in *Ex parte Gauteng Provincial Legislature in re Dispute Concerning the Constitutionality of Certain Provisions of the Gauteng School Education Bill of 1995* 1996 (3) SA 165 (CC) para 39

<sup>369</sup> J De Waal et al *The Bill of Rights Handbook* op cit pg 475

prejudicial to society gain protection, merely by their performance by a group.<sup>370</sup> However, shared understandings and themes that contribute to the creation of an individual's identity, are strong indicators of aspects of cultural life that will gain Constitutional protection.<sup>371</sup>

Next to the public structure of the group, there is the membership. The individual concerned who claims rights under these sections must actually belong to the supposed group. This means some substantial tie to it, although quite how much is uncertain. It appears that there should be a demonstrable history of shared experience and identification with the linguistic, cultural or religious community in question.<sup>372</sup>

Does traditional healing benefit from the protections conferred by these sections? Traditional healing is grounded in social relationships, and thus people who place their faith in it utilize it, at least partially, to make sense of their orientation in society. To properly engage in traditional healing, however, mere belief in it is not enough. There must be an acting-out, which requires others, for it is an activity premised on both belief and action. So far, it would seem that traditional healing falls squarely into our definition.

However, it is quite difficult to conceive of traditional healing as an activity that receives such protection as a community right. For one, it is practiced by the majority, rather than the minority, to whom such rights ordinarily apply. For another, with the multiple manifestations of traditional healing that exist, pinning down all people who subscribe to any particular part of the practice and claiming them to be in community with one another is somewhat tenuous. Thus from the group perspective, traditional healing perhaps lacks sufficient coherence to be named a community engagement. Therefore, given that the language of S 31 places emphasis on the existence of a community, traditional healing does not qualify as a practice to be given protection under the section.

All is not lost, however. S 30 is of somewhat different construction. From the perspective of an individual, traditional healing, in whichever or whatever form it finds itself manifested, most certainly is a lifestyle of a particular cultural orientation, engaged in voluntarily. The language of S 30, by contrast with S 31, is orientated more toward the individual than to a group. Thus, while traditional healing may not be a community activity, within the Constitutional scope of the notion, it would appear to be an

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<sup>370</sup> Although see generally G McLean 'Freedom of Religion and State Neutrality: A Philosophical Problem' 114 *South African Law Journal* 1997 pg 174-186

<sup>371</sup> R Thornton 'Culture: A Contemporary Definition' in E Boonzaaier and J Sharp (eds) *South African Keywords* 1989 pg 26

<sup>372</sup> J De Waal et al *The Bill of Rights Handbook* pg 475

element of a person's cultural life. Thus, while traditional healing itself may not be a protected activity, participation in it may be. On initial appraisal, this may appear to be a semantic difference. However, as we shall see later, the disjunction shall become important.

Therefore, in accordance with S30, traditional healing must be given the necessary attention that an individual may freely participate in it. Whether the private practice of traditional healing is sufficient to sustain this, is a subject for the next chapters.

### **The challenge of responsiveness**

We set out at the beginning of the paper that, in a Constitutional democracy, law must be reflective of, and responsive to, the society she serves. Only by being inclusive, can the laws be deemed legitimate in the eyes of the majority of the populace. The pages of this chapter have set out the relevant laws as they are. We have affirmed the validity of socio-economic rights; demonstrated that traditional healing falls squarely within the boundaries of S27; and examined the values and 'ways-of-life' rights that legally underpin our treatment and regard for people.

With both the relevant law and the anthropological ethnography gathered, it is time to move to our crucible. Our answer should reflect the product of applying the canvassed law to the facts. An effective law would, where possible, uphold the existing health care seeking behaviour. It is to this task that we turn.

### **Testing the Limits**

*'I visited a traditional healer because I felt I wasn't getting any better by using ARVs. I thought the ARVs were making me feel worse. The traditional healer that I visited gave me some medication. I vomited. I had diarrhoea. I was eventually hospitalised at Somerset hospital because of all these complications. But I still don't know what can help my headaches.'* (Male Patient, Du Noon).<sup>373</sup>

*'I tell the patients that if you decide on traditional medicine, then don't take ARVs. I am pro choice when I advise the patients but I stress that the interactions between traditional medicine and ARV treatment are very bad for the body...'* (Health Care Professional, Cape Town)<sup>374</sup>

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<sup>373</sup> S Mall *Attitudes of HIV Positive Patients in South Africa to African Traditional Healers and their Practices* op cit pg 15

Wary of pronouncing on a whim, judicial decision-making has long been informed by various ‘tests’. The design and implementation of such yardsticks is meant to enable one to judge fairly the facts that have been laid out. As we are about to discover, the complex meshing of socio-economic and civil and political rights in this matter means that existing methods are not entirely appropriate. A new design is needed.

By now, we have canvassed the facts relevant to traditional healing. We have also affirmed the place of socio-economic rights in our Constitutional order. People may practice traditional healing in private. But a public obligation shall only fall upon the state if it is clear that the Constitution requires this. Thus, to the tests we shall use to evaluate the question.

We will begin by looking at the traditional evaluative criteria sections in the Constitution – the internal and external limitations clauses. When rights and obligations are challenged, these come to the fore. They do so equally here. But, unusually, we will not be using one or the other. The multi-faceted nature of the problem requires their complementary use. However, whereas S36 is an old warhorse and is highly codified, and thus needs little description, S27 (2) is not. Thus we will need to establish how S27 (2) is used as an internal limitations clause. It is principally concerned with reasonableness – unsurprisingly – but this is a notoriously nebulous concept. Therefore we will attempt to pin down a better and more substantial meaning.

### **Section 27 and Section 36 – betwixt and between**

To keep traditional healing a private art, as opposed to bringing it into the public sphere, would have the effect of limiting the right to it. This is not unusual. The right of access to health care services, like any other right contained within the Bill of Rights, may be limited, or, in other words, justifiably infringed upon. Limitations may only be made for compelling reasons that are in accordance with the founding principles of the Constitution, respecting human dignity, equality and freedom. Such important issues as health, welfare, civil order and safety, amongst other matters, are examples of matters that may provide a reason for limiting the rights of the individual.

The principal instrument for such limitations is S36 of the Constitution, the so-called ‘limitations clause’. This functions as a general brake on any right in the Bill of Rights. Additionally, however, there exist internal limitations clauses, all of which are attached to the sections dealing with socio-economic

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<sup>374</sup> *Ibid* pg 19

rights, limiting the degree to which a right may be enjoyed. We are concerned with S27 (2) in this particular matter. Quite how that section and S36 interact with each other is still somewhat of a mystery. The sections are inscribed as follows

- 27(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these (socio-economic) rights.
- 36(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including –
- (a) the nature of the right
  - (b) the importance of the purpose of the limitation
  - (c) the nature and extent of the limitation
  - (d) the relation between the limitation and its purpose; and
  - (e) less restrictive means to achieve the purpose
- (2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

The distinction is important. S36 provides a detailed explanation of the necessary conditions and considerations for its employment, and its frequent use by the courts has seen a considerable wealth of jurisprudence grow up around it. The internal limitations clauses are, by contrast, Spartan in their descriptions, and have seen little engagement by the courts. Given that they are, furthermore, concerned with regulating the obligations relevant to socio-economic rights, and that this is an infrequent area of adjudication, courts have been reluctant to read too much into them. This is evidenced by the Constitutional Court's rebuffing of efforts to create minimum core entitlements.

In *Soobramoney*, *Grootboom* and *TAC*, where violations of socio-economic rights were charged, the internal limitations clause of S27, S27 (2), was utilized without any mention of S36. In *Khosa*, on the other hand, which concerned socio-economic rights, but was argued and evaluated as an infringement of the right to equality, S36 was used in S27's place. In that judgment the potential problem of having

two elements of the Constitution that appear to perform the same tasks, was made mention of. First, Mokgoro J noted that

“There is a difficulty in applying section 36 of the Constitution to the socio-economic rights entrenched in sections 26 and 27 of the Constitution. Sections 26 and 27 contain internal limitations which qualify the rights. The state’s obligation in respect of these rights goes no further than to take “reasonable legislative and other measures within its available resources to achieve the progressive realisation” of the rights. If a legislative measure taken by the state to meet this obligation fails to pass the requirement of reasonableness for the purposes of sections 26 and 27, section 36 can only have relevance if what is “reasonable” for the purposes of that section, is different to what is “reasonable” for the purposes of sections 26 and 27.”<sup>375</sup>

This was followed by Ngcobo J, stating that

“The obligations of the state under section 27(2) are limited to taking “reasonable legislative and other measures.” The main judgment regards this as an internal limitation on the right of access to social security. I agree. But is it possible to find that a measure is reasonable within the meaning of subsection 2 yet not reasonable and justifiable under section 36(1), the limitation clause?”<sup>376</sup>

Perhaps it should be noted that the actual standards of reasonableness are almost certainly not what the justices are discussing here. It is not a matter of ‘reasonableness’ versus ‘gross unreasonableness’. Rather, the justices were concerned with the appropriate subject matter for contemplation as reasonable or unreasonable.

In the case, no real attempt was made to decide the matter. Yet, when read together with earlier socio-economic rights-based matters, the Court does appear to take a position on the issue, albeit implicitly. In *Soobramoney*, *Grootboom* and *TAC*, the parties and the Court concerned themselves

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<sup>375</sup> *Ibid* para 83

<sup>376</sup> *Ibid* para 105

with the content of the right contested, that is, what people were entitled to by the right. *Khosa* did not do this. There, the pertinent question was who had access to the right, and, hence, the matter evolved from a socio-economic background into a problem that placed identity and therefore equality, at its centre. The equality clause, S9, has no internal limitations clause, and therefore S36 was utilised.

What this appears to indicate, is that the 'type' of right involved will determine which limitations clause is invoked. Matters argued on a socio-economic rights basis will be adjudicated with assistance from the internal limitations clause, whilst all other rights will have the limitations clause applied. Therefore, the two sections perform an identical task on differing rights. There certainly does seem to be some basis for this argument, but one wonders why, if the application and use is the same, a distinction need be made between socio-economic and other rights.

One argument is that the absence of a law of general application, the presence of which is a prerequisite for the use of S36,<sup>377</sup> prevented the application of S36 in *Saobramoney*, *Grootboom* and *TAC*. Those cases concerned state policies, rather than enacted laws.<sup>377</sup> *Khosa*, being concerned with the Social Assistance Act 59 of 1992, a law of general application, could have S36 validly applied to it. This is certainly correct in the particular instances of the earlier cases. However, it seems doubtful that this was the intention of the drafters of the Constitution.

*Khosa* could have had S27 applied to it too, had the parties chosen to contest it as a socio-economic rights matter, and not one concerned with equality. That would mean that the presence or absence of a law of general application would not settle the matter of whether to use S27 or S36 when enquiring whether or not a right has been justifiably limited.

An alternative argument would be that since 'reasonableness' is included in the defining parameters of S27, a S36 enquiry, which utilises reasonableness in establishing the justification of the limitation, would be self-defeating. One would be arguing for the reasonableness of a measure already

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<sup>377</sup> De Waal et al *The Bill of Rights Handbook* pg 451

demonstrably unreasonable.<sup>378</sup> Therefore, one would need use only one of the two sections. Again, however, this does not address the question of *why* there exist internal and external limitations clauses.

A more comprehensive solution goes back to the subject matter for consideration.<sup>379</sup> Specifically, the internal and external limitations clauses apply to different aspects of the enquiry. S27's internal limitations clause concerns itself with the plan for the realisation of the right. It asks whether the state's actions reasonably discharge their obligations.<sup>380</sup> So one is not concerned with the reasonableness of limiting the right, for the right is not under consideration, but the reasonableness of the action taken to realise the right.<sup>381</sup> S36, by contrast, where one is examining the right itself, is designed to assist in matters where one has to balance and choose between rights.<sup>382</sup>

The two sections, then, are complimentary in the socio-economic rights setting. S27 examines the defined boundaries of the obligation, whereas S36 examines and sets the limits of the right. This is why there exist internal and external limitations clauses. Each speaks to a particular side of the argument.

We have a complex web of rights and obligations bound up in this problem. No binary matter, as it was put earlier. Thus, the competing aspects need to have complementary solutions to them. And therefore the test that is most suitable for this problem is neither S27 nor S36 alone. Rather, both together are required together, each suited for different aspects of the enquiry.

### Section 27 (2)

Since socio-economic rights arose as the first consideration, it is appropriate to deal with the internal limitations clause first. It is not just a matter of the numerals. S27 (2) is needed to evaluate what the appropriate duty is upon the state that best suits the place of traditional healing in the democratic order. There are two parts of our final question that it will ultimately be used to answer.

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<sup>378</sup> *Ibid* pg 451

<sup>379</sup> K Illes 'Limiting Socio-Economic Rights: Beyond the Internal Limitations Clauses' 20 *South African Journal on Human Rights* 2004 pp 448-465

<sup>380</sup> *Ibid* pg 455-456

<sup>381</sup> *Ibid* pg 456

<sup>382</sup> *Ibid* pg 456

First, there is the matter of whether leaving the practice of traditional healing to the private realm sufficiently meets the obligation imposed upon the state. This is best answered by asking, as the section does, whether the measures taken in response to the right are reasonable. Second, any expansion of the health care services will entail significant budgetary implications – and those considerations are best handled by the caveat to the state’s obligation that the right be made available ‘subject to available resources’. Both of these critical questions are squarely obligations-based, not rights-interrogative.

The key to answering these questions, is an understanding of ‘reasonableness’, since the measures taken by the state must be, according to S27, ‘reasonable’. More specifically, we need to know what constitutes ‘reasonable access’ in a more general Constitutional sense, as well as in the particular circumstances. Consider, for a start, this definition, drawn up in *Grootboom*

‘To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realize. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by measures aimed at achieving realization of the right...the Constitution requires that everyone must be treated with care and concern. If the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test (of reasonableness).’<sup>383</sup>

This interpretation of reasonableness was crucial to the later decision in *Treatment Action Campaign*. There, although the state had demonstrated that it passed legislation, and was taking progressive steps to halt the transmission of HIV from mother to child by use of the drug nevirapine, the state was deemed not to have discharged its obligation to the people. This was because the state had failed to demonstrate how long it would be before they expanded their program beyond the initial test-sites, and made the required drugs available to those most in need, an action deemed unreasonable by the Court.<sup>384</sup>

The Constitutional Court, though, also recognised that a measure may not necessarily be reasonable if encased in words alone. In *Grootboom*, where only a state-sponsored and engineered housing project would truly remedy the matter complained of, the Court put it thus:

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<sup>383</sup> *Grootboom op cit* para 44

<sup>384</sup> *Treatment Action Campaign op cit* para 141

'Mere legislation is not enough. The State is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programs...these policies must be reasonable both in their conception and their implementation. The formulation of a program is only the first stage in meeting the State's obligations. The program must also be reasonably implemented. An otherwise reasonable program that is not implemented reasonably will not constitute compliance with the State's obligations.'<sup>385</sup>

Yet, in evaluating the actions taken, a court considering reasonableness must be careful to

"...not enquire whether other more desirable or favourable measures could have been adopted, or whether public money could have been better spent. The question would be whether the measures that *have* been adopted are reasonable."<sup>386</sup>(emphasis added)

Reasonableness, then, extends right from the empowering legislation and policies, to their subsequent and necessary implementation, should this be imperative at the time. Therefore there must be dual reasonableness in the present matter: what is structurally reasonable, a technical question, and what is reasonably included, a value-laden question, going to the core of the values of the constitution. Proper access therefore is that which is legislatively empowered and reasonable in practice, having a marked effect.

What would be a guideline for reasonableness in this matter? Reasonableness itself is, even with indication such as that given above, an ill-defined notion and S27, unlike S36, provides no detailed, interrogative questions. We need to mould it into a more manageable concept. The help requested is quite close at hand.

### **Defining reasonableness in S27 (2)**

The trio of *Soobramoney*, *Grootboom* and *Treatment Action Campaign* have at least one element in common in their argumentative reasoning concerning reasonable access. Each chooses, quite consciously, to read S27 in conjunction with S7 (2) of the Constitution.<sup>387</sup> Therefore, that degree of access that allowed the 'respect, protection, promotion and fulfilment of the rights in the Bill of Rights'

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<sup>385</sup> *Grootboom op cit* para 42

<sup>386</sup> *Ibid* para 41

<sup>387</sup> *Soobramoney op cit* para 9 makes an oblique reference, via footnote n3 to this; *Grootboom op cit* para 20; *Treatment Action Campaign op cit* para 4

is that which is reasonable. Considering the preceding arguments, it would appear that the correct answer to the question of what constituted sufficient and reasonable access to traditional healing as a health care service would be no different.

Admittedly, it is a rather broad, over-arching test, one that sees oblique use in many cases before the Constitutional Court. It is a requirement that is foundational to all requests for the realisation of rights under the Bill of Rights, and is the obligation placed upon the state in all matters by the Constitution.<sup>388</sup> Therefore, one may wonder quite why this section is chosen, as opposed to a more particular area of the Constitution, or of common law, for that matter.

The reason is this. The drafters of the Constitution, during its construction, drew on a great many sources for assistance. One of these sources was international law and, in particular, the various major international covenants. S 7(2) is a near replica of the levels of obligation imposed on states by the ICCPR and the ICESCR, albeit synthesised into one sentence, rather than arising in distinct paragraphs. Therefore interpretations of meaning of such terms on the international stage are highly relevant for South Africa, especially considering S39 (1)(b) of the Constitution, which orders that

‘When interpreting the Bill of Rights, a court, tribunal or forum

(a)...

(b) Must consider international law’<sup>389</sup>

Such interpretations with reference to access to health care services have been authoritatively written in great detail by the CESCR whilst developing the ICESCR. Thus, the responsibilities for states that they have asserted<sup>390</sup> provide some guidance for South African jurisprudence in the relevant area. With no other readily available examination for what constitutes reasonable access to health care services, their interpretations would appear best-placed to assist.

The duty to *respect* would appear to require the state not to interfere with the enjoyment of rights.<sup>391</sup> The state may not, except where good, well reasoned motivation, backed by law, exists, deprive or unduly obstruct people from exercising existing rights and abilities. Hence, arbitrary evictions

<sup>388</sup> S 7(2) of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>389</sup> S39(2)(b) of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>390</sup> *The nature of States parties obligations (Art. 2, par.1)* 14/12/90 CESCR General comment 3, commenting on ICESCR Article 2 para 1

<sup>391</sup> D Brand and C Heyns *Socio Economic Rights in South Africa* Pretoria University Law Press, Pretoria 2005 pg 9

or deprivations of land, besides contravening other constitutional and statutory provisions, would violate this duty. The CESCR frame it as the responsibility to

‘...refrain from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases.’<sup>392</sup>

The duty to *protect* is similar to the duty to respect, except that, in this case, the state is bound to prevent private third parties from interfering with the access to, and enjoyment of, rights. Therefore, for example, the private health care industry is subject to state regulation to the extent that the state will prevent exploitation or denial of patients' rights. The CESCR describe it as

‘...the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States

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<sup>392</sup> CESCR *General Comment 14 op cit* para 34

should also ensure that third parties do not limit people's access to health-related information and services.<sup>393</sup>

Some immediate deductions may be made about the choice of terminology in S 7(2), when read with the CESCR's interpretations of the ICESCR. The first two terms, 'respect' and 'protect', suggest a negative obligation on the part of the state. Simply put, a negative obligation is one that obliges the state to stop conduct that harms a person's constitutional rights – that is, not to interfere with the actions of a person acting within their constitutional rights. Although traditionally applied to civil and political rights, where, for instance, the state is barred from passing deliberately retrogressive legislation that would prevent people from voting, negative obligations may also extend to socio-economic rights. For example, the state would be duty bound, under the Constitution, not to pass a law prohibiting access to water resources. Taken a little further, laws passed that led not to an ending, but a decline in the quality of the enjoyment of the right, such as a law that progressively detracted from a person's living conditions, rather than improved them, could also be deemed a failure by the state to uphold its negative obligations to the person concerned.<sup>394</sup>

This was highlighted in *Grootboom*, where at least part of the obligation that the state owed to the litigants was couched in negative terms. There, a group of landless people had moved onto private land that was to be utilized for low-cost housing. The subsequent eviction, ordered by a magistrate, had taken place a day earlier than authorized, and involved the destruction of the people's homes and possessions. This premature and excessive action was deemed a violation of the negative obligation that the state owed to people to make adequate housing available.<sup>395</sup>

Negative obligations are, however, the most minimal of obligations that a state may incur.<sup>396</sup> Hence, the Court in *First Certification* noted that, with regard to socio-economic rights, negative

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<sup>393</sup> *Ibid* para 35

<sup>394</sup> Maastricht Guidelines on Violations of Economic, Social and Cultural Rights 1998 20 *Human Rights Quarterly* 691

<sup>395</sup> *Grootboom* para 88

<sup>396</sup> However, as Alec Stone Sweet of Yale Law School has demonstrated over the last two decades, the distinction between the two is largely illusory. All rights, both negative and positive, require some sort of conduct on the part of the State. In this, the author agrees. However, since the matter has been so adjudged by the Constitutional Court, and nothing drastic turns upon the distinction, the conventional and Court-sanctioned use shall be applied.

obligations should not, and did not, constitute the ceiling of the state's obligations to people.<sup>397</sup> Giving meaning to the rights enshrined in the Constitution, by ensuring that they were realized, would, in the case of socio-economic rights, require that the State be required to take at least some positive obligations upon itself.

Positive obligations are those that require the state to take appropriate actions, usually with financial outlay, to fulfil the duties that are placed upon it by the Constitution. The relevant provisions in the Constitution which require the state to, by reasonable legislative and other measures, subject to, available resources, make socio-economic rights progressively realized, both affirm and constrain this positive obligation.

Under these definitions, it may appear that the passage of the Traditional Health Practitioners Act was a positive action – and it is. Yet it has the effect of a negative obligation, in that instead of encouraging persecution of its practice, it allows for the creation of an environment in which the practice of traditional healing to go reasonably unhindered.

Legislation that has the effect of allowing the practice of traditional healing may most certainly be said to respect and protect traditional healing. It allows for the particular world view that endorses traditional healing to not only exist, but be perpetuated in private. Thus even though the state may not be adopting a perception of the world, it respects the closely-held beliefs that do, and allows them to continue. Furthermore, by recognising traditional healing as legitimate, unnecessary interference with the practice and belief as they are, is discouraged.

However, the terms thereafter, 'promote' and 'fulfil' have, just on a plain English interpretation, a distinctly different meaning attached. They appear to encourage a fair bit more action on the part of the state, in order to discharge its obligation.

The interpretation of the meaning of the duty to *promote* is a little tricky, for there are two apparent meanings. Thankfully, these are complementary, whilst still being distinct. One interpretation is that the state is required to raise awareness amongst the public of the rights that they have, and promote enforcement of such rights.<sup>398</sup> Another interpretation is that the duty to promote elevates

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<sup>397</sup> *First Certification* para 77-8

<sup>398</sup> S Liebenberg 'The interpretation of socio-economic rights' in M Chaskalson et al *Constitutional Law of South Africa* 2<sup>nd</sup> Ed, 2003 Ch 33 6

socio-economic rights considerations to a position of primacy in discretionary decision making.<sup>399</sup> This is not unlike the consideration given to children, where, as the Constitution indicates, in any matter concerning a child, the child's best interests are the principal concern.<sup>400</sup> These interpretations are complementary in that the first encourages people to empower themselves, whereas the latter places this duty upon the state. Utilised together, they lead to shared responsibility. The CESCR does not adopt the term 'promote' as its own category.

The duty to *fulfil* requires the state to 'adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures'<sup>401</sup> that enable those that do not enjoy the physical manifestations of rights to gain access to them. The CESCR assert that an

'...obligation to *fulfil* requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies

<sup>399</sup> G Budlender 'Justiciability of socio-economic rights: Some South African experiences' in YP Ghai and J Cottrell (eds) *Economic, social and cultural rights in practice. The role of judges in implementing economic, social and cultural rights* (2004) 33 337

<sup>400</sup> S28 (2) of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>401</sup> CESCR *General Comment 14 op cit* para 33

aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services.<sup>402</sup>

However, more meanings are also read into the term fulfil, by the CESCR, arguably broadening it to include the term 'promote' that is used in the South African Constitution.

The obligation to *fulfil (facilitate)* requires States *inter alia* to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to *fulfil (provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to *fulfil (promote)* the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

These obligations must be engaged with in a constructive fashion by the state by it ensuring that the health care that is provided by these measures is properly available, accessible, acceptable and of good quality. That is, that health care and related services are available in sufficient quantity, that they are accessible in that they are neither discriminatory, physically inaccessible, overly expensive nor incomprehensible, acceptable in that they are ethically and culturally endorsed and of good quality in that it is medically safe and appropriate.<sup>403</sup>

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<sup>402</sup> *Ibid* para 36

<sup>403</sup> *Ibid* para 37

The duties to promote and fulfil have a decidedly and distinctly actionable, positive slant to them. The CESCR even uses the term ‘positive action’ to describe their implementation. Thus, whereas ‘respect’ and ‘protect’ were concepts concerned with whether or not a person had traditional healing available to contemplate, ‘promote’ and ‘fulfil’ seem to anticipate the degree of access required to ensure their legitimate fulfilment. This suggests that the act of making traditional healing legal in the bare sense is not a sufficient act to discharge the state’s obligations in this regard.

What is immediately apparent from the interpretations above is that there cannot be a hard-and-fast rule as to what must be carried out. All that can be affirmed is that the state must, where the law permits, engage in respecting, protecting, promoting and fulfilling the rights to the extent necessary for them to be adjudged to have discharged their obligations. In one matter, legislation that permits a practice may be enough, and, in another, an entire infrastructure may be required.

Furthermore, what is necessary to ensure that the public’s right of access to traditional healing is properly realised, is not determinable solely from a legal perspective – indeed, the legal perspective provides the framework of elements that must be considered, rather than dictates what is necessary. The peculiar circumstances at hand inform how one is to act. This acknowledgement is evident from the Supreme Court of Appeal’s judgment in *Pharmaceutical Society of South Africa v Tshabalala-Msimang* where it was stated that

‘One has to agree that the right of access to health care includes the right of access to medicines although this right is not without limitations.<sup>404</sup> It is also correct that the prohibitive pricing of medicines may be tantamount to a denial of the right of access to health care. All that is really common cause.<sup>405</sup>

One is really dealing with the balancing act implicit in the right of access which, as mentioned, encompasses positive and negative obligations on the state. Affordability is not the only dimension; access is just as important. Cheap medicines available at two hypermarkets provide cold comfort to the poor living in a township or on the platteland. This means that, in order to be appropriate, the fee must be such that affordable medicines do not become inaccessible.<sup>406</sup>

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<sup>404</sup> *Soobramoney and Treatment Action Campaign op cit*

<sup>405</sup> *Pharmaceutical Society of South Africa v Tshabalala-Msimang; New Clicks South Africa (Pty) Ltd v Minister of Health* 2005 (3) SA 238 (SCA) para 42

<sup>406</sup> *Ibid* para 77

When this particular matter was later taken before the Constitutional Court, Moseneke J agreed, writing that

‘It seems self-evident that there can be no adequate access to medicines if they are not within one’s means. Prohibitive pricing of medicine, the SCA correctly found, would in effect equate to a denial of the right of access to health care. Equally true is that the state bears the obligation to everyone to facilitate equity in the access to essential drugs which in turn affect the quality of care.’<sup>407</sup>

It is not out of keeping with current jurisprudence, then, to make the claim that access to a service is not garnered merely by legislating for the lawful practice of that service. Just as, for example, the courts have agreed that keeping medicine prices at a level out of reach of the bulk of the population is a denial of real access,<sup>408</sup> so is inaction by the state after the passing of legislation. S27 specifically requires the state to take ‘legislative and other measures’ in effecting socio-economic rights access. Therefore, acknowledging that traditional healing exists, and unbanning it, does not, *prima facie*, constitute a sufficient action to discharge the obligation that the state bears to its citizens. We can thus establish that, while the passing of legislation to legalise traditional healing must be welcomed, it does not necessarily discharge the state of its obligation to provide such health care services to everyone.

### Section 36

S36 is altogether different. It is rights-interrogative. Therefore, it will be employed to evaluate how the particular status of traditional healing influences the enjoyment of existing foundational and ways-of-life rights.

The section is constructed so as to assist in the evaluation of rights, and has seen much action. Therefore, there is no need to extensively investigate its meanings. It can be applied straight to the problem with assistance from case law where necessary.

### Progression

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<sup>407</sup> *Minister of Health v New Clicks South Africa* 2006 (2) SA 311 (CC) para 706

<sup>408</sup> *Minister of Health v New Clicks South Africa* *op cit*

And so it is that we have our tests. In what follows, there will not be detailed, painstaking reference to each word and term that has been uncovered in both the extension of S27 (2) and S36. There are not clear lines between the particular issues, and to draw them artificially would lead to compartmentalized answers that are not reflective of the true state of affairs. Rather, a more 'holistic' argument, incorporating all of the issues, shall be made.

The tests drawn serve, instead, as nexus points. Constant reference will be made to their presence to enforce the arguments that will be made. Thus they are sources of justification, rather than initiation. This is probably the fairest way of giving due regard to the competing arguments.

Finally, our evaluation is ready to commence. We are aware of the facts of the matter, the particular laws on the subject and the evaluative elements that we shall use to judge what is appropriate in the matter. Our answer should be informed by the health care seeking practices of patients, attentive to the laws, and consistent with the designed tests. To the end, then.

### *A Right to Traditional Healing in the Public Sphere?*

*'Only our HIV negative clients as well as clients who do not know their HIV status can use traditional medicine. We send our HIV positive clients to the clinic for ARV treatment. We only used traditional medicine ourselves before starting ARV treatment. We have the ability to recognise opportunistic infections such as TB in many of our clients. We refer clients suffering from these to the clinic as well.'* (Male Patient, Gugulethu).<sup>409</sup>

Dual health care seeking behaviour has been the mantra of our factual analysis. It has been pointed out at length that patients do not use biomedicine and traditional healing in exclusionary fashions. They are employed together in a complementary manner. A law properly responsive to the needs of the population that it is designed to govern would be reflective of this. Do people have a right of access to traditional healing as a public health care service? If it is appropriate to accommodate medical pluralism.

First we shall examine the technical aspects of the question – resources, infrastructure and quality of service that can possibly be delivered. It will become apparent that pragmatism is a virtue in a developing nation, perhaps the most reasonable thought process that can be upheld in these matters.

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<sup>409</sup> *Ibid* pgs 14-15

That does not mean to say that lower standards should be accepted, certainly not when shuffling with literal life-and-death matters. But lateral standards may just be, ensuring adequate quality and reasonable availability.

Second, we turn to the values inherent in the question – the border of the public and the private, the place of the individual in regulating their own life, and needs of the state. Do state actions, beyond the manifestly power-wrought, really impress much upon the citizens? In a developing nation, concerned with social welfare, it would seem that such actions do. Not, perhaps, in this sphere, however.

### **Socio-economic rights and infrastructural design**

As explained previously, there is an important difference between a bald right to health care services, and the right of *access* to health care services, within which a right of access to traditional healing would be contained. Just as with biomedicine, direct provision of traditional medicines may not necessarily be the most appropriate action. The state is confronted by a plethora of economic and infrastructural challenges;<sup>410</sup> so creative solutions need to be dreamt up.

Consider the earlier example of the flying doctor service to a small town. There, effective access to health care was provided at a lower cost by instituting a pragmatic plan, rather than by building a hospital and staffing it. Similar procedures in principle could as easily be designed for provision of traditional healing.

There are a number of ways in which this could be achieved, some of which are set out below. Each is ends-, rather than means-based, engaging the relevant stakeholders in the endeavour – patients, doctors, healers and civil society. None appear to lower the standard of access that has been deemed appropriate, which is that a resource is both reasonably available and of adequate quality.

First, cross-cultural education of biomedical doctors in the anthropology and basic cosmology behind traditional healing, as well as the disease-illness dichotomy, would do well to assist them in understanding the perspective of many of their patients.<sup>410</sup> This could be comfortably inserted into short

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<sup>410</sup> For extensive fieldwork and exploration, see the quartet of papers by Jo Thobeka Wreford, a practicing traditional healer *We can help! A literature review of current practice involving traditional African healers in biomedical HIV/AIDS interventions in South Africa* CSSR Working Paper 108, University of Cape Town, 2005; *Facilitating relationships between African traditional healing and Western medicine in South Africa in the time of AIDS: A case study from the Western Cape* CSSR Working Paper 170, University of Cape Town, 2006 (also with S Hippler and M Esser); *Myths, masks and stark realities: traditional African healers, HIV/AIDS narratives and patterns of HIV/AIDS avoidance* CSSR Working Paper 209, University of Cape Town 2008 and *Shaming and blaming:*

courses during university training, or take the form of professional development courses. It is intuitive that when doctors are ignorant of other health care measures in which their patients are engaging, that they cannot give them optimal care.<sup>411</sup> Making them aware of such features, such that they may discuss them with their patients, could not help but to improve the biomedical care given to patients that select care from both paradigms.

Second, the reverse procedure is equally attractive. Traditional healers could enlist to receive education in the basic principles of biomedical education, helping them to, where possible, refer patients to biomedical doctors, where they note specific diseases. Of course, this would have to be done in a sensitive fashion, so as to be careful not to undermine the power of traditional healers, who occupy an important role in traditional societies. They have much to offer their patients apart from referral to a biomedical clinic or herbal remedies that have been validated in a biomedical laboratory. Successful examples of this have been demonstrated numerous times, especially with regard to tuberculosis treatment<sup>412</sup> and, more recently, HIV/AIDS interventions.<sup>413</sup>

Third, the work that has been begun at numerous scientific and biomedical institutes, concerned with investigating the properties of the herbal remedies, should continue. Though there need not necessarily be science-based validation for various remedies before they are allowed to be used, it is important that the use of manifestly harmful substances, or advice that falsely and unduly promotes cures where there is no such truth, be stifled before it is accessed on a wide scale by the public. Interestingly enough the Traditional Health Practitioners Act is quite clear about the latter element, stating that

49. (1) A person who is not registered as a traditional health practitioner or as a student in terms of this Act is guilty of an offence if he or she -

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*medical myths, traditional health practitioners and HIV/AIDS in South Africa* CSSR Working Paper 211, University of Cape Town, 2008.

<sup>411</sup> This has been recorded at length. For a recent sampling on one particular matter, the use of citrus fruits along with biomedical drugs, see VJ Louw 'Citrus aurantium – beware of the bitter orange' *South African Medical Journal* July 2008, Vol 98 No 7 pg 496, as well as the supporting studies I Meijerman, JH Beijnen and JHM Schellens 'Herb-drug interactions in oncology: focus on mechanisms of induction' in *Oncologist* 2006, 11: 742-752; JS McCune, AJ Hatfield and AA Blackburn 'Potential of Chemotherapy-herb interactions in adult cancer patients' in *Support Care Cancer* 2004, 12: 454-462; and A Fugh-Berman, A Myers 'Citrus aurantium, an ingredient of dietary supplements marketed for weight loss: current status of clinical and basic research' *Exp Biol Med* 2004, 229: 698-704

<sup>412</sup> M Colvin, L Gumede, K Grimwade and D Wilkinson 'Integrating Traditional Healers into a Tuberculosis Control Program in Hlabisa, South Africa' in *Medical Research Council Policy Brief No4*, December 2001

<sup>413</sup> J Wreford *Facilitating relationships between African traditional healing and Western medicine in South Africa in the time of AIDS: A case study from the Western Cape supra*

- (g) (i) diagnoses, treats or offers to treat, or prescribes treatment or any cure for, cancer, HIV and AIDS or any other prescribed terminal disease;
- (ii) holds himself or herself out to be able to treat or cure cancer, HIV and AIDS or any other prescribed terminal disease or to prescribe treatment therefor; or
- (iii) holds out that any article, compound, traditional medicine or apparatus is or may be of value for the alleviation, curing or treatment of cancer, HIV and AIDS or any other prescribed terminal disease.<sup>414</sup>

The prohibition only extends to those traditional healers whom are not registered in terms of the Act. This implies that those who are registered may perform such actions with impunity. This should only be allowed to occur with concurring validation of the treatment by biomedical sources, given the serious nature of the issue. Interestingly enough, if the state were to proceed with public support for traditional healing, a contradiction would manifest itself in this field. Due to the lack of standard sourcing, the vagaries of growing pharmacopeia and so on, traditional remedies cannot hope to be conclusively validated by biomedical standards. Thus the state would be in the position of requiring rigorous testing of biomedical drugs on one hand, and not setting the same high standards for traditional methods of healing, a clearly problematic stance.<sup>415</sup>

Still, the general properties of much of the herbal and other extracts employed are demonstrable. And irrespective of whether or not traditional healing is provided in public, the state incurs a public health duty. The state has an obligation to ensure that those healers who do register under the Act, provide safe care to their patients, and to this it must be held regardless.

Last, as with any public health education initiative, information in the appropriate media and language could be circulated to inform the public of their health care options. In particular, a more open

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<sup>414</sup> S 49(1)(g) of the Traditional Health Practitioners Act 22 of 2007

<sup>415</sup> This contradiction has not stopped the state in the past. C Bateman 'Taking Ubhejane by the Horn(s)' *supra* notes that both the National Health Minister and the Provincial MEC for Health in KwaZulu Natal have recommended traditional remedies without their being tested.

relationship between traditional healing and biomedicine could be encouraged. Although it is difficult to gauge the success of these projects, they most certainly have been widespread, and much of the population has been exposed to the information disseminated on, for example, HIV.<sup>416</sup>

International reactions are supportive of the above suggestions. Numerous WHO and UN documents call for access to health care services to be promoted through research,<sup>417</sup> culturally appropriate care<sup>418</sup> and support for people making informed choices about their health through easily available information.<sup>419</sup>

Each of the above examples, admittedly short and of no detail, highlights an existing area of South Africa's health care infrastructure that could be enhanced and given greater nuance. To do this would probably go some way to achieving the same goal as the potentially prohibitively expensive process of introducing an entire, state-funded traditional healing apparatus. Therefore the claim may be made that keeping traditional healing a private activity does not reduce access to it, especially when there are other ways to ensure that it is made available to people.

It will be recalled that we divided 'access' into two components – availability and adequacy. The steps recommended above interfere with neither. Traditional healers are prevalent numerically and widely spread throughout the country, and thus physical proximity to patients does not appear to be a problem. There is no pressing indication that putting them in hospitals would change this. Therefore, providing traditional healing itself is not strictly necessary in order to promote and fulfill the obligations to those who practice and engage in traditional healing. There are other means that are reasonably achievable that do not reduce access to traditional healing and yet simultaneously promote the dual health care seeking behaviour in which many patients engage. Matters of adequacy are a little different, however.

Improving the knowledge that biomedical doctors and traditional healers have of each other will intuitively lead to better patient care of individuals who practice dual health care seeking behavior. This shores up the adequacy element of access. However, it is not immediately apparent that keeping traditional healing in private necessarily improves this – at least, not until the ancient process of triage is adopted.

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<sup>416</sup> Trawl South Africa's major roads for any length of time and one is bound to come across large billboards advertising HIV testing, condom usage and the like.

<sup>417</sup> CESCR General Comment 14 *op cit* para 37(i)

<sup>418</sup> *Ibid* para 37 (ii)

<sup>419</sup> *Ibid* para 37 (iii) and (iv)

### **Socio-economic aspects of medical resources**

The above argument implicitly made reference to medical rationing. This is not only finance-based, but appears to make sense from a patient perspective too. In times of scarcity, it would seem that the rationing that inevitably occurs has to be done on some sort of triage system. On the one hand, there is the triage of the patients – who may receive and how much. On the other, there is the triage of the actual technology. Let us leave aside the former, as that is a medical decision, and look at the latter, a social matter.

When forced to choose between therapies on offer, efficacy, cost and efficiency are the most important considerations. The more ‘bang for the buck’ the better. A medicine like this would be an affordable one that predictably works well and quickly for most people, most of the time.

Part of the reason for biomedicine’s success around the world has been its ability to function independently of ways-of-life. Biomedical interventions upon, say, influenza work as well in South Africa as they do anywhere else in the world, regardless of personal or societal perception. That is not to say that it is unfailingly effective. There are many inherent limitations with its procedures, and sometimes, for reasons unknown, patients fail to respond appropriately. However, the normal outcome is one that is successful. Traditional healing also has much to recommend it in observation. And yet, such remedies may not offer the same curative benefits outside of their peculiar social circumstances.

To use the language defined earlier, biomedicine tends to treat disease; traditional healing illness. This is not true all of the time. But it is true most of the time. Both concepts, combined, constitute the ambit of the meaning of the word ‘health’, and yet there is a difference. In terms of its scope, biomedicine tends to those problems that most commonly need attention in order to ensure the survival of the patient. It preserves life. Traditional healing, by healer’s admission, is less about survival, and more about quality of life. This is partly what makes traditional healing so valuable, in that traditional healing is premised upon promoting a fuller, richer sense of life and thus plays a valuable role in ameliorating the bitterly harsh lives lived by the majority of South Africans.

This value is also what pushes it to the margins in public spending, however. Although the Constitutional Court has declined the opportunity to define a measurable and quantifiable ‘minimum core’ of socio economic entitlements to be accorded to all, the Court has accepted that

‘The state has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society.’<sup>420</sup>

Though that statement, made in *Soobramoney*, concerned one man and not a group within society, the principle is the same. Matters of illness are particular to each, rather than matters of disease that are universal to all. That which is most essential, most readily useable by the most must take preference. And that, in this matter, is biomedicine’s combating of disease. This is so even in communities that practice traditional healing. As the field work that we have elucidated has shown, people use traditional healing in a complementary fashion to biomedicine, not in preference. In most cases, biomedicine is utilized as a sort-of ‘essential base’ of care, resorted to first, whilst traditional healing then restores the person to full individual and social wellness.

And yet, some may wonder, with considerable justification, why high technology, complicated and expensive systems are maintained when so many struggle to access the most basic medicines. Perhaps it would be more equitable to drain resources away from complex fields such as neurology or cardiology, rather directing them to more accessible services, such as primary health care – or even to traditional healing. But this is not so.

To deny everyone the ability to access a service, on the grounds that, ‘if all cannot have it, no-one can have it’, is defeatist. It would mean that every social project would grind to a halt, for there will always be deficiencies, despite everyone’s best efforts. What is far fairer to the population is to acknowledge that whilst not everyone who needs a particular treatment will obtain it, if everyone is afforded an equal chance to receive it, there is no bias. In that way, at least some proportion of the population will benefit, and they will have done so in a fair, equitable and just manner. Therefore, those in need of tertiary biomedical care, which ordinarily works well irrespective of life choices, should be given an equal opportunity to have that care.

But how much of an impact is, in fact, made by the monetary resources? The latest figures put health care expenditure in South Africa at about R100 billion, of which 47.5 billion is spent by the state.<sup>421</sup> Out-of-pocket and medical scheme payments account for the difference. The economics of the traditional healing sector are not well established. A recent study suggests that the trade in raw plant

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<sup>420</sup> *Soobramoney* para 32 *op cit*

<sup>421</sup> National Treasury Budget Review 2007, available at [www.treasury.gov.za/documents/budget/2007/reviews/isbn.pdf](http://www.treasury.gov.za/documents/budget/2007/reviews/isbn.pdf)

materials, a small element of the industry, is worth R2.9 billion per year.<sup>422</sup> Exponentially multiplied to cover the numerous facets needed to install traditional healing as a viable public sector-provided service, the cost is high.

Presently, then, it is almost certainly not within the state's present ability to provide traditional healing, not without dismantling some other area of substance. Therefore the request for traditional healing to form an element of state-sponsored health care is unlikely to be granted. This would lead to a *Soobramoney*-style conclusion: that limited resources exist, that the state is doing what it can, and therefore it cannot be held to have breached its obligations by failing to cover every possible area. Better then, to leave traditional healing in private.

This triage is not only centered on general medical effectiveness, however. It is also reflective of patient health care practices. Patients appear to employ biomedicine and traditional healing in a dominant-adjunct manner. It is entirely reasonable of the state to do the same. A reflective response to dual health care seeking behavior would be to give priority to the needs of the patients.

However, as was noted in earlier argument, this matter is only partly socio-economic character. It is also a question of Constitutionally-protected values and ways-of-life. The case for these may be sufficiently strong that the conclusion is one of a *Grootboom* nature. The state's paucity of resources is acknowledged, but is not held to constitute sufficient reason for inaction, and thus it must move progressively to realize a request, as funds permit, due to the nature of the rights involved. A question of cost or a question of resources should not be the final determinant in the matter – it a matter of 'the right thing to do', too.

### Balancing Values

An open and inclusive democracy, such as that promoted in South Africa, should be embracing rather than denying. Thus the principle of 'reasonable accommodation' of difference between persons has been adopted. As it was put in the case of *Christian Education*

'The underlying problem in any open and democratic society based on human dignity, equality and freedom in which conscientious and religious freedom has to be regarded with appropriate seriousness, is how far such democracy can and must go in allowing members of religious communities to define for themselves which laws they will obey

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<sup>422</sup> Mander M, L Ntuli, N Diederichs and K Mavundla 'Economics of the Traditional Medicine Trade in South Africa' in *South African Health Review 2007 op cit* pg 194

and which not. Such a society can cohere only if all its participants accept that certain basic norms and standards are binding. Accordingly, believers cannot claim an automatic right to be exempted by their beliefs from the laws of the land. At the same time, the State should, wherever reasonably possible, seek to avoid putting believers to extremely painful and intensely burdensome choices of either being true to their faith or else respectful of the law.<sup>423</sup>

So society must determine how far it should go to accommodate all means and ends. An act that has an unduly marginalizing effect is not befitting a place in the laws of the Republic. But note the insertion of the word 'unduly'. There must be some material difference brought about by the influence of that act – a minor shiver will not alter the course of the state.

Human dignity, as we have seen, is considered to be what gives a person their intrinsic worth.<sup>424</sup> Respect for a person's dignity includes respect for their personal autonomy, and therefore their ability to make choices for themselves.<sup>425</sup> As Sachs J put it, with reference to the right to vote

'The vote of each and every citizen is a badge of dignity and of personhood. Quite literally, it says that everybody counts.'<sup>426</sup>

Individual choice may separate people from each other in one sense, but, in another, it binds them in that each is recognized as having the ability to do so freely. Therefore, irrespective of choice, each person retains a status equal to all others. As it was noted in *Prinsloo v Van der Linde*

'In our view unfair discrimination...principally means treating persons differently in a way which impairs their fundamental dignity as human beings, who are inherently equal in dignity.'<sup>427</sup>

And, of more particular relevance to traditional healing, the decision in *Prinsloo* was affirmed in *President of the Republic of South Africa v Hugo* where it was stated that

'At the heart of the prohibition of unfair discrimination lies a recognition that the purpose of our new constitutional and democratic order is the establishment of a society in which all human

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<sup>423</sup> *Christian Education op cit* para 35

<sup>424</sup> De Waal 231

<sup>425</sup> *Ibid* 231

<sup>426</sup> *August v Electoral Commission* 1999 (3) SA 1 (CC) para 17

<sup>427</sup> *Prinsloo v Van Der Linde* 1997 (3) SA 1012 (CC)

beings will be accorded equal dignity and respect regardless of their membership of particular groups.<sup>428</sup>

If traditional healing is to be considered a socio-cultural practice, to make its private practice lawful is to accord it a status equal to other cherished and widely-held beliefs or ways of life practiced in South Africa. That means that state indifference to its employment is no more enhancing or demeaning to traditional healing than to any other practice. In a constitutional democracy that embraces difference, maintaining equality between these practices is essential to foster confidence in the state, quite apart from the fact that it is the law of the land.<sup>429</sup>

But if one considers traditional healing to be a health care service, rather than a socio-cultural practice, then one may well wonder why it and other complementary and alternative health care practices should take a backseat to biomedicine. By practicing biomedicine in the public health sphere, but not traditional healing, the state is making access easier to one than the other. It appears to be a case of the state preferring the practice of one particular group to that of another. Sometimes such a preference is acceptable, such as excluding practices that are manifestly harmful to others. But if the practice is already accepted as legitimate in our constitutional democracy when conducted in private, what merits its public exclusion when we profess to be an equality-based society that is inclusive, rather than exclusive?

As has become apparent, however, traditional healing is irrevocably intertwined as both a socio-cultural practice and a health care service. And this entanglement is no different for biomedicine. Life and health are intimately connected, each utterly dependent upon the other. Thus one can never dub traditional healing, biomedicine or any other form of health care to be exclusively a socio-cultural practice or a health care service. They exist for the preservation of life of a sociable species - us.

Some may maintain that biomedicine is the only 'known' of the practices as it is premised on observed fact – the others are more belief- than knowledge-based. Thus, they would assert that biomedicine is a more genuine candidate to be considered the exclusive manifestation of state interest in public and private health. Perhaps it could be advocated that it is a more genuine form of health care, one that leans more toward being a health care service than a socio-cultural practice, though still bound up in the latter to a great extent.

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<sup>428</sup> *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 (CC) para 41

<sup>429</sup> S15(2) of the Constitution of the Republic of South Africa Act 108 of 1996

But to those that practice traditional healing, and those that consult traditional healers, traditional healing too *is* knowledge, cultivated through centuries of practice and learning. For them, it is as real as any biological entity is to a biomedical doctor. It is, to them, inferior neither as a socio-cultural practice nor as a health care service. And, if the elegant words of the preceding Constitutional Court judgments are to be taken heed of, the life orientation of those who practice it should not be the basis for discrimination against them.

From an external perspective, however, there are times when the circumstances in which traditional healing is utilized could be said to be more socio-cultural, such as when a person consults a traditional healer in order to gain the ability to ensure a promotion at work, or convince a potential partner to fall in love with them. At other times, the interaction is more health care orientated, such as when a healer prescribes for a patient a remedy for mental illness or perhaps epilepsy. Part of the problem in analyzing traditional healing, is that such instances are heavily intermingled in the traditional philosophies that govern traditional healing. But let us separate them for the purpose of considering them.

In the first example, of promotions and love, the practice is no different to any other religious observance or cultural practice. Assistance in life is prime subject matter for the prayers of many faiths. Therefore, there should be no state assistance in those circumstances that would have the effect of preferring traditional healing to other practices of faith. This is a clear directive from the Constitution.<sup>430</sup>

It is the second example, of mental illness and epilepsy, which proves more difficult, however. If traditional healing is complementary in a health care sense, then it most certainly does fall for consideration as a health care sense and public support. Perhaps one could allow such a cleavage to carry over to practice, whereby some practices of traditional healers are adjudicated to be available by state provision, and others not.

And yet, even to speak of these matters in separate circumstances is to conceive of traditional healing in a biomedical sense. Therefore, who would be the referee to decide whether a practice is sufficiently 'medical' or overly 'social' – a doctor, traditional healer or neither? This does, though, appear to be a matter that is worthwhile for investigation. Although tricky to separate, state support for traditional healing that is of a more health care-orientated persuasion certainly has a greater likelihood of being acceptable as a public health care resource. Then again, many biomedical doctors would prefer the opposite, that traditional healers ally themselves only with social circumstances and leave the actual

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<sup>430</sup> S15(2) of the Constitution of the Republic of South Africa Act 108 of 1996

medicine to biomedical interpretations. To them, what would be more acceptable is for traditional healers to answer the patient's social questions that they themselves cannot. But that would be an action closer to faith and belief, a practice that the state may not promote unless it provides equitably for all faiths and beliefs.

That conclusion would only be arrived at, however, if one were to accept that according preference to biomedicine over traditional healing was, actually, an act of discrimination. As the evidence has shown, traditional healing is usually used by patients, by choice, as a complementary practice to biomedicine. This is so in two senses. First, they may intermingle in one issue, such as the healing of a person following an automobile accident. Second, they respond to different issues too, biomedicine to tuberculosis and traditional healing to mental health problems, for example.

Such a complementary state-of-affairs naturally raises the following point. Surely if biomedicine and traditional healing are utilized together, and the former is endorsed and funded by the state, the latter should be too? The definition of 'health', set down by the WHO, that health is not merely the absence of disease or infirmity in the body, but the complete physical, mental and social well-being of the individual,<sup>431</sup> certainly suggests that equal regard be given to both. Constitutionally, the state may be accused of not responding to the proper needs of the population, should it adopt only one of the healing strategies.

Fieldwork suggests that there is more to the matter, however. Whilst it may be so that biomedicine and traditional healing are utilised in a complementary fashion, the structure of that usage suggests a distinct preference on the part of patients to use biomedicine, most of the time, as the principal health care strategy, with traditional healing as a firm adjunct when possible. Let us return to the studies for a moment.

Just as designing successful health care projects can only be achieved after sufficient attention to the practice of patients,<sup>432</sup> so it is with the law. The previously-mentioned study<sup>433</sup> set in the very poor and rural magisterial district of Umkhanyakude in Northern KwaZulu Natal, which examined the health care practices of 974 people prior to their death, is instructive in this regard. The area is beset by appallingly high HIV/AIDS infection prevalence and incidence rates and has few biomedical facilities to

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<sup>431</sup> As adapted from the Preamble to the Constitution of the World Health Organization *supra*

<sup>432</sup> A Case, A Menendez and C Ardington *Health Seeking Behaviour in Northern KwaZulu Natal op cit 2*

<sup>433</sup> *Ibid*

cater for the population.<sup>434</sup> In spite of this, 97 percent of ill all persons, prior to their deaths, consulted biomedical doctors and nurses. 50 percent saw both a biomedical professional and a traditional healer. Only 4 people had, prior to their deaths, consulted traditional healers without seeing a biomedical professional. This allows a telling concluding statement from the authors

‘...traditional healers...appear to be a complement to, rather than a substitute for, western medicine.’<sup>435</sup>

On the strength of the figures of this study, and that done in Katutura, with particular reference to the patient interviews in the last, it is manifestly evident that traditional healing is not only used in a complementary fashion, but in an adjunct fashion to biomedicine. Therefore, if the population who consult traditional healers ‘rank’ them against biomedical professionals, the appropriate response of the state would be to do so too. This would support the legitimacy of a health care service that allowed both forms of health care, but provided only the one. Note that this is a similar argument to the one employed for triage resource allocation – for it is premised on an appreciation of the true nature of health care seeking behaviour in South Africa.

It harms neither dignity nor equality, on this account, to practice traditional healing in private as opposed to in public. On the contrary, it respects the quotient that patients themselves practice. It maintains rights. Similar arguments apply to the ways-of-life rights.

Chaskalson CJ’s interpretation of the right to freedom of belief, eventually adopted as we have seen, meant that the state could not ‘force people to act or refrain from acting in a manner contrary to their religious beliefs.’<sup>436</sup> If a refusal by the state to provide traditional healing had this effect, there may be some grounds for the further promotion of traditional healing. But as the evidence has demonstrated, many people are constantly and consistently engaging in the practice of traditional healing despite its expense, and the practice does not seem to be abating.<sup>437</sup> If anything, because of biomedicine’s inability to find a satisfactory solution to, for example, HIV/AIDS, traditional healing only

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<sup>434</sup> For a fascinating contemporary account of the region, see N Itano *No Place Left to Bury the Dead*, Atria Books, New York, 2007. Further research data is available from the Africa Centre for Health and Population Studies, [www.africacentre.ac.za](http://www.africacentre.ac.za).

<sup>435</sup> A Case, A Menendez and C Ardington *Health Seeking Behaviour in Northern KwaZulu Natal* *op cit* 6

<sup>436</sup> *S v Lawrence* para 92

<sup>437</sup> D Le Beau ‘Dealing with Disorder: Traditional and Western Medicine in Katutura (Namibia)’; A Case, A Menendez and C. Ardington ‘Health Seeking Behaviour in Northern KwaZulu Natal’ and M Mander *Marketing of Indigenous Medicinal Plants* *all supra*

grows in prominence.<sup>438</sup> In a country blighted by inequality it is perhaps callous to suggest, but it would appear that the current state practice of not providing traditional healing is hardly 'forcing' people to 'act in a manner contrary to their beliefs.'

Indeed, if the state were to put itself in the position of providing traditional healing, it would necessitate the creation of a single-value system for traditional healing. This would clash the unitary institutionalism that we spoke of earlier, with the muddles of social reality. It would destroy traditional healing for what it *is* worth.

To exclude traditional healing from a public health initiative would, therefore, probably not be contrary to the right to hold a belief freely. There is no coerced action to act otherwise, nor does it prioritise one group of beliefs over another. It leaves the affairs of the intensely private to the individual concerned.

Recall that we noted, in the section on cultural rights, that there appears to be a difference between cultural rights in S30, which are aimed at the individual, and community rights in S 31, directed toward particular groups. It was noted that this meant that whilst traditional healing may not be a protected activity, participation in it may be, and that this was an important distinction. The importance is this.

The practice gives value to the institution, which has no inherent value. By protecting the participation in the practice of traditional healing, rather than the institution of traditional healing, people are protected to engage in it. Therefore people are encouraged to utilise traditional healing for their own needs, and in private, placing an obligation upon the state to see that such potential exists, but not creating an obligation to accord traditional healing a public status.

Therefore, from a cultural and community-rights, 'way of life' perspective, although traditional healing is protected, it is only partly protected, that being insofar as it relates to its private practice. Its public presence does not garner the same attention.

But are we encouraging one way of life over another? Earlier, the argument was made that biomedicine is as much a way of life as traditional healing is. To actively support this complementary action, however, seems to propel traditional healing somewhat higher than other forms of

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<sup>438</sup> See generally *Collaborating with Traditional Healers for HIV Prevention and Care in sub-Saharan Africa: suggestions for Programme Managers and Field Workers* UNAIDS Best Practice Collection, UNAIDS/06.28E, available from [www.unaids.org](http://www.unaids.org)

complementary care to biomedicine. State sponsorship of traditional healing then appears to be unequal treatment in a different fashion. Equality, though, does not mean sameness. It means equal regard – and some may argue that many of the adherents of traditional healing are substantially worse off in life circumstances than those who employ biomedicine exclusively. Thus, they are entitled to be accorded more. But this is not so in this case. For those in poor health, life is difficult for each, regardless of whether that observation is taken from a subjective or an objective perspective. History and general life circumstance do not alter the devastation of illness.

So it would seem that there exists no right of access to traditional healing as a public health care service. But the word 'seem' is used deliberately. And it cannot be abandoned for ever after. This is a wavering matter yet. It is likely that this question concerning the extent of the state's obligations will not, in the end, receive a 'principled settlement', but, rather, will continue to be interpreted as the circumstances deem appropriate.

The move to recognize traditional healing is an act that, while not endorsing traditional healing, appreciates its worth to people, and the very worth of the people whom hold it close. However, the current lack of its provision in the public health care sector means it is less accessible, financially and, probably, geographically, than biomedicine. Therefore, though appreciative, it may not be as appreciative as it could be, so to speak. This is brought about by some of the considerations that have been set out above.

The pressing question, then, is to define quite what is appreciative enough. Thus one is forced into contemplating what action *sufficiently* respects the dignity and rights of those who practice traditional healing. The question then becomes one of 'how much corporeal action is required in order to satisfy the incorporeal respect requested?' This is not a question that bears a precise answer.

The few studies that do exist are that indeed – few. It is not appropriate to assume definitive answers with so little upon which to draw. It would take many years before such a wealth of data existed that one could point, authoritatively, to particular usage patterns. And therefore this is a question without answer, certainly in the theoretical framework of a legal opinion without a case before it. The truth of the matter is that these questions before society do not suffer answers – they are too complex a trick to decipher. Cautious and conservative planning, responsive to what is observed in health care clinics across the country, is what is needed. And that is why, in the end, whilst traditional

healing can only be encouraged, it seems public adoption may only be granted through a political process and mandate, for there is no definitive legal right to traditional healing in the public sphere.

## Concluding Remarks

*'I have seen HIV positive traditional healers at the clinics. I know they are HIV positive because they have the beads and white substance smeared all over their faces. I think they have a good influence over their clients who are HIV positive as well. Some of them come (here to the clinic) very ill and after taking their ARVs properly, make a miraculous recovery. This has to have a good, positive influence on other HIV positive people in the community.'* (Health Care study participant, Gugulethu).<sup>439</sup>

*'Sangomas make you ill. They give you herbs. They don't know what is going on. They don't test their medication. They just give it to you.'* (Male Patient, Gugulethu).<sup>440</sup>

This befuddling and vexing problem is representative of a larger issue by which liberal political states, such as South Africa, are consistently confronted. All people bear equal significance before our law and all are therefore due equal regard. Thus an expectation naturally arises that our society has developed sufficiently to allow a diversity of principles, practices and beliefs to be asserted equally within the public and private domains that constitute social environments. And yet, even in the most progressive of orders, boundaries are drawn. Particular knowledge-s and truths do dominate over others, violently at times. Although equal regard and thought may, at the best of times be given, accommodation is rarely so.

There appear to be three common means of dealing with difference. Either set it aside as an exception, and make particular provision for it privately; ignore it and scythe it out; or try to habituate it alongside the existing norm. They are detailed below.

No society is entirely homogenous in person, thought and deed. Hence exceptions are made here and there to the norm. Exceptions tend to be granted only when necessary, for reasons sufficiently

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<sup>439</sup> S Mall *Attitudes of HIV Positive Patients in South Africa to African Traditional Healers and their Practices* op cit pg 10

<sup>440</sup> *Ibid* pg 11

intrinsic to a group or individual's way of life. The creation of such a system of exceptions bears a more realistic chance of ensuring that everyone is treated with equal regard.

Yet the elasticity of law stretches, like its physical brethren, only so far. Exceptions can only be exactly that. Beyond a tipping point, a great number of exceptions will leave some to wonder quite why a particular action was prescribed as a norm and as the law in the first place. It may be better to throw away that rule, and draw up another which is more inclusive.

And then there are those that lose the political and legal debates. These are holders of views that may possibly come into vogue, but are not presently, and do therefore not form part of the law. Hence, the dissenters frequently continue to voice their views, lobbying for an exception to the rule that has dismissed them. The emotive issues of abortion and the death penalty presently find favour and not, respectively, with our laws, though dissent on each abounds.

Traditional healing falls in neither category. No exception has been requested. Nor is there a plot to stifle it, for it has emerged from, rather than entering, a banned state of existence. Rather, a normalization is sought, whereby it becomes a regular, acceptable practice that exists alongside biomedicine. But the procedure here is not the normalizing process that is usually employed.

Ordinarily, the popular approach to the appreciation of multiple social orders is to leave them to their own devices. Within the political structure of the state, many groups follow their own rules – religious faiths, private clubs and schools being examples that readily come to mind.<sup>441</sup> Though they, together, constitute a single society, each follows their own set of rules, under the umbrella of a single, state-originating law.<sup>442</sup> In those instances, there is still a single state-backed law, but the state chooses to leave particular areas of social life unregulated, and those gaps are taken by these other authorities.

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In this matter however, it is somewhat otherwise. In passing the Traditional Health Practitioners Act, the state has indicated that it most certainly does not wish for this approach with regard to the healers themselves. The state wishes for appropriate oversight of them, in order to improve the health of the population. The state wishes to have an explicit say in the conduct of traditional healing. To what

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<sup>441</sup> J Griffiths 'What is Legal Pluralism' in (1986) 24 *Journal of Legal Pluralism* pg 14

<sup>442</sup> *Ibid* pg 39

<sup>443</sup> J Waldron 'Status versus Equality: The Accommodation of Difference' pg 129-155 in OAP Shabani (ed) *Multiculturalism and Law*, University of Wales Press, Cardiff, 2007.

extent is unclear. If they wished for control only of the formation of the institution of traditional healing, it could remain a private endeavour in practice. But if the state desired to, additionally, take an active role in the employment of the institution, it would necessitate a more public display.

Certainly, the Traditional Health Practitioners Act is to be welcomed. It serves to demonstrate that the state takes a *forcefully* active interest in its citizens, for they are the lifeblood of the nation. It aims to contribute not only to the good health of people, but recognizes that continued blanket exclusion of a core element of life of many citizens was at odds with reality. Removal from legal protection and empowerment is a damning feature that disables many from effectively participating in society and, therefore, enjoying its benefits.<sup>444</sup>

In an open and democratic society, patients must be able to access the health care of their choice, and the onus that the state takes upon itself, is to see that this is not entirely harmful to them, by attempting to remove charlatans and poorly-practicing healers. There is no exemption or exception to the ordinary rules in this case, then – at least in the private sphere, and in the legal sense. It is a deferment to the judgment and autonomy of the individual, as it is with other health care practices – and, therefore, an alignment of the treatment of traditional healing with the norm.

The guiding principle in this regard is that the state may control the private domain where it is in the public interest.<sup>445</sup> It has been noted that the segregation<sup>446</sup> of those suffering from infectious diseases may be justifiable,<sup>447</sup> in spite of the very high level of protection ordinarily given to intimate

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<sup>444</sup> See the definitive modern text on the subject *Making the Law Work for Everyone* Report of the Commission on Legal Empowerment of the Poor and United Nations Development Programme, 2008, for more on the effect of exclusion by law.

<sup>445</sup> *Davies and Others v Ministry of Land, Agriculture and Water Development* 1995 (1) BCLR 83 (Z)

<sup>446</sup> Powers afforded to the Minister of Health, initially under the old Union Public Health Act 36 of 1919. Many of its sections are maintained as regulations today. The Health Act 63 of 1977 and the National Health Act 61 of 2003, read together, now regulate these powers. In South Africa, it is the responsibility of the Department of Health to administer, guide and implement public health policies, rules, measures and directives. The Minister of Health has wide powers to restrict public and individual rights and freedoms in order to control the spread of disease. The purpose of these powers, is to preserve the well-being of wider society. This is ensured through the determination of the source of the infection, halting its transmission to others, and curing infected individuals. In some cases, placing oneself within the care of the health care authorities is compulsory.

This heavy-handed approach has always been (and still is) justified on the basis that a society is only as healthy as the health of its constituents. Only through reliable observations, reporting and treatment can proper measures be instituted to safeguard the life of the nation. Communicable diseases are therefore documented and given priority attention. So self evident is the need for these measures that many academic texts mention the necessity in only the briefest of terms.

<sup>447</sup> *Coetzee v Government RSA* 1995 (10) BCLR 1383 (CC) and *ANC v Council of State* 1994 (1) BCLR 145 (CK)

rights in the personal sphere of an individual, due to the potentially serious effects to wider society, should a particularly vicious disease be released into the population.<sup>448</sup>

In more intimate matters, the state is respectful of the limits of personal autonomy. Matters of life and death of a person are left to that person, or their next of kin – necessary blood transfusions may be refused,<sup>449</sup> so-called ‘do not resuscitate’ orders given<sup>450</sup> and organs donated.<sup>451</sup> Clinical opinions from doctors are certainly translated to patients, but, whether or not the doctor(s) agree with the course of action, the final decision is left to the patient.<sup>452</sup>

And therefore, quite understandably, the Traditional Health Practitioners Act has been passed in order to recognize the private practice and use of traditional healing. The legislation does not seek to over-regulate, from the patient’s perspective. Rather, by un-banning traditional healing, it creates a free forum for it, and, by attempting to regulate the practitioners, makes for the hope of a safer and more predictable handling of cases. Therefore, from a patient perspective, the legislation is empowering in that it gives people what they have been given by biomedicine for some time – patient autonomy.

Where the legislation is restrictive, is at the other end, just as the legislation upon other practitioners is – and upon anyone who provides a service that could possibly endanger someone’s wellbeing. That is, that care must be taken to act in the patient’s best interest. Appropriate standards and measures for traditional healing in the private sphere have yet to be decided, and until those issues of safety and quality are resolved, traditional healing will remain the weaker bedfellow in biomedicine’s eyes.

But how far may such a state of affairs proceed? In plain view the real area for such discussion, is not in the court rooms, but the parliaments. Difference accommodation is the business of the political, made not for an inherent legal reason, but because one is careful to include as many people as possible as actors in the political process. But, from a Constitutional perspective, the legal support for the

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<sup>448</sup> *Bernstein v Bester* 1996 (4) BCLR 299 (CC) see also G Pozen (ed) *Legal Aspects of Health Care Administration* 7<sup>th</sup> ed, Aspen Publishers, Maryland, 1999 at 337

<sup>449</sup> *Phillips v De Klerk* unreported 1983 TPD; *Hay v B* 2003 (3) SA 492 (W). See also SA Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* 1991 pg 29

<sup>450</sup> S 7(1) of the National Health Act 61 of 2003 places such responsibility with the patient, giving legal support to the notion of the ‘living will’. For explanations of the concept, see *Report on Euthanasia and the Artificial Preservation of Life* (1998) RP 186/1999, submitted by the South African Law Reform Commission to the Minister of Justice.

<sup>451</sup> S 55 (a) and (b) of the National Health Act 61 of 2003

<sup>452</sup> S 7(1) *Ibid*

political debate would be this: legal recognition of traditional healing is entirely consistent with our foundational democratic principles, but so is its place as a private, not public, endeavour.

Understandable is the need to use resources where most effective. Biomedicine has proven effective the world over, and is utilized the world over for matters that patients name 'disease'. It is not just a science, but a social value, one best practiced in public. It is both a way of life and the 'essential medicine', the existence of which Arthur Kleinmann had dismissed,<sup>453</sup> that has the capacity to heal outside of hope or expectation. Thus, it is not entirely wrong to label biomedicine as our objective standard of health care. It is most certainly the standard practiced most frequently. As a member of the community of nations, then, all of which use biomedicine as their standard, South Africa should be quite entitled to do the same, utilising traditional healing in a valuable complementary fashion.

A liberal Constitutional democracy, which is what South Africa is, does not make it its business to favour one group over the next. Rather, the state, attempting as far as possible to be neutral, places power in the hands of the individual to choose how to lead their lives, shielded, where appropriate, from harm. Thus, the state has no obligation to provide traditional healing and this neither demeans the dignity of, nor makes less equal those who engage in traditional healing. Yet it does have a duty to take a particular interest in traditional healing, source of comfort to many of its constituents. It must appreciate that whatever the truth in the subject of the belief, the belief itself is real enough, and should therefore be accommodated in a manner that is fair to both its adherents and those that shun it. The value of traditional healing is not appreciably depreciated by its placement in private – indeed, it may be best left there. Thus quite acceptably is space created for people to engage in healing practices that the state appreciates but does not endorse itself.

Therefore, in conclusion, people do not have a right of access to traditional healing as an element of the state health care service. However, traditional healing is to be welcomed and encouraged to the fullest extent possible. In the private lives of many, traditional healing offers hope and comfort, making explicable the world. But there it must remain, as, legislatively, it does at present. The real contribution of traditional healing to both society and the individual is the respect that it fosters for personal autonomy and the way of life of millions. Whilst so doing, traditional healing gives intricate meaning to life where its complementary partner, biomedicine, cannot. Prejudice against benevolent knowledge is prejudice unfounded.

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<sup>453</sup> A Kleinmann 'What is Specific to Biomedicine?' *op cit* pg 23

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Table A: Health-seeking behaviour (first and second resort) by type of illness. Representative survey of Katutura, Le Katutura, 1996; Le Beau 2003

	Biomedicine		Traditional healer		Treat at home	
	1st resort	2nd resort	1st resort	2nd resort	1st resort	2nd resort
Asthma	87.7	86.1	0.5	5.9	11.8	8
High blood pressure	88.8	89.6	1.9	4	9.3	6.4
Recurring fever	41.6	72.8	1.3	3.7	57.1	23.5
Frequent dizziness	74.7	76.3	6.2	14.2	19.1	9.4
Persistent cough	40	69.3	1.3	4.5	58.7	26.1
Headaches	60	69.1	10.4	20.3	29.6	10.7
Impotency	86.3	83.3	8.5	13.5	5.2	3.2
Infertility	63.8	55.6	31.2	40.8	5	3.6
Intestinal problems	43	48.1	39.8	46.5	17.1	5.3
Stomach problems	68.5	73.5	8	17.1	23.5	9.4
Liver problems	90.3	93	2.7	3.2	7	3.8
Mental illness	52.9	46.5	42	51.3	5.1	2.1
Menstruation problems	81.6	86.4	1.1	4.5	17.3	9.1
STDs	91.5	90.1	3.5	5.1	5.1	4.8
Tuberculosis	94.4	93.9	0.5	1.9	5.1	4.3
Malaria	91.2	96	0.5	1.6	8.3	2.4
Childbirth	74.3	88.3	8.7	4.1	17.1	7.6
Diarrhoea	33.8	82.7	1.9	4.3	64.4	13
Bleeding nose/mouth	53.2	61.6	19.7	31.5	27.1	6.9
Sore eyes/ears	78.9	86.3	1.6	8.6	19.5	5.1
Epilepsy	54.5	48	39.8	47.7	5.6	4.3
AIDS	93.4	90.1	2.1	5.4	4.5	4.5

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## ***Reach Out and Be Healed***

### ***Constitutional Rights to Traditional African Healing***

#### **Argument summary**

'A World in One Country' is a deserving epithet for South Africa. She is home to a great many lives, colours, ethnicities, histories and perspectives. Her additional adoption of constitutional democracy allows this fascinating plurality to translate into her institutional structures. Accordingly, the landscape of organised medicine in South Africa, long rigid, is experiencing the tremor of change.

35 000<sup>1</sup> MB, ChB or M.D. qualified doctors practice in South Africa's conventional, allopathic, science-based biomedical<sup>2</sup> system.<sup>3</sup> Yet it is the approximately 200 000<sup>4</sup> traditional African healers who meet many of the health care needs of the bulk of her population. Defining the scope of traditional healing has proved difficult, due to the varieties of traditional healers that exist. In broad strokes, however, it usually consists of religious, spiritual, personal or supernatural divination to aid in determining the cause of the problem complained of, coupled with the application of, *inter alia*, herbal concoctions, spells and charms, inspired by the wisdom of kin and ancestors, as remedies.

Some estimates conclude that between seventy to eighty percent<sup>5</sup> of South Africans use traditional healers either exclusively or in tandem with biomedicine. This is thought to be due to the fact that

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<sup>1</sup> Health Professions Council of South Africa [http://www.hpcs.co.za/Local copy: http://www.hst.org.za/indicators/HumanResources/HPCS/](http://www.hpcs.co.za/Local%20copy%20http://www.hst.org.za/indicators/HumanResources/HPCS/)

<sup>2</sup> This term will be used in preference to 'Western medicine' or 'modern medicine'.

<sup>3</sup> Additionally, some 100 000 nurses are registered with the South African Nursing Council South African Nursing Council <http://www.sanc.co.za/> Local copy: <http://www.hst.org.za/indicators/HumanResources/SANC/> Downloaded 2007-05-04.

<sup>4</sup> This figure is contested. In 1994, in the South African Medical Association publication *Bridging the Gap – Potential for Health Care Partnership between African traditional healers and biomedical personnel in South Africa* the figure was estimated to be 200 000, a figure repeated in E Pretorius 'Traditional Healers' in *South African Health Review 1999* N Crisp and A Ntuli eds. Durban, Health Systems Trust, 2000. N Gqaleni, I Moodley, H Kruger, A Ntuli and H McLeod 'Traditional and Complementary Medicine' in *South African Health Review 2007* Health Systems Trust, Johannesburg, 2007, pg 178, suggest the figure to be 185 477.

<sup>5</sup> This figure is extrapolated from World Health Organisation estimates for Continental Africa in *Promoting the Role of Traditional Medicine in Health Systems: A Strategy for the African Region 2001-2010* Harare, World Health Organisation, 2000. Other studies have noted the difficulty in establishing how many people consult healers for health-related problems – see N Natrass *Who Consults Sangomas in Khayalitsha? An Exploratory Analysis* CCSR Working Paper No 151, University of Cape Town 2006, while yet others have noted a usage rate of around 50-60% - see D Le Beau 'Dealing with Disorder: Traditional and Western Medicine in Katutura (Namibia)', *Namibian African Studies*, vol. 6, Germany, Rudiger Koppe Verlag Koln, Cologne. 2003

traditional healers are, for the most part, more easily accessible, more widely available and are an integral part of much of the population's social and cultural circumstances. Belief in the power of traditional healing is, today, as widespread as ever,<sup>6</sup> albeit not unanimous,<sup>7</sup> and is not confined to particular generations or those of a certain education or socio-economic standing.<sup>8</sup> Rather, such beliefs are widely held across social boundaries.<sup>9</sup>

Therefore, South Africa possesses a *de facto* situation of medical pluralism. The minority biomedicine is closely regulated, standardized and legislated for.<sup>10</sup> Traditional healing was, until very recently, illegal.<sup>11</sup> Consequently, institutionally, South Africa had somewhat of a problem – not only were multiple medical systems functioning, but they were systems that adhered to different and, in many instances, contradictory, philosophies and principles.

The recent introduction of the Traditional Health Practitioners Act 22 of 2007 overturns the provisions of the Witchcraft Suppression Acts,<sup>12</sup> which had outlawed traditional healing. South Africa appears to, in its legislative stance, have taken an approach that advocates parallel systems of health care between traditional healing and biomedicine. That is, the two philosophies are allowed to co-exist, but do not have a formal, institutional overlap, and only become intertwined by the peculiar health care seeking practices of the individual patient. Although the details of this endeavour have yet to be worked out, this seems to be the most sensible solution, based on observations of people's health care seeking practices in the country.

However, a fundamental question that appears not to have been considered, at all, is what the constitutional implications of such an introduction are. The state has an obligation, under Section

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<sup>6</sup> NV Ralushai et al 'Report of the Commission of Enquiry into Witchcraft Violence and Ritual Murders in the Northern Province of South Africa 1 (1996) pg 57

<sup>7</sup> S Mall *Attitudes of HIV Positive Patients in South Africa to Traditional African Healers and their Practices* CSSR Working Paper No. 215, University of Cape Town 2008, pg 8

<sup>8</sup> J Hund 'Witchcraft and Accusations of Witchcraft in South Africa: Ontological Denial and the Suppression of African Justice' in 33 *CILSA* 2000, pg 384

<sup>9</sup> N Tebbe 'Witchcraft and Statecraft: Liberal Democracy in Africa' in *Georgetown Law Journal* Vol 96, 2007, pg 183, pg 194

<sup>10</sup> Principally by the Health Professions Act 56 of 1974 and the National Health Act 61 of 2003

<sup>11</sup> Witchcraft Suppression Act 3 of 1957 and the Witchcraft Suppression Amendment Act 50 of 1970

<sup>12</sup> *Ibid*

27(1)(a), read with S 27(2) of the Constitution of the Republic of South Africa,<sup>13</sup> to progressively make health care services accessible to all. Consider the exact wording of the full section.

- 27(1) Everyone has the right to have access to –
- (a) Health care services, including reproductive health care;
  - (b) Sufficient food and water; and
  - (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
- (3) No one may be refused emergency medical treatment.

Furthermore, as S 7 of the Constitution orders

- 7(2) The state must respect, protect, promote and fulfil the rights in the Bill of Rights.

It would appear that the conundrum is this. The state has, as part of its broad plans to improve the health of its citizens, legitimized and given legal empowerment to the philosophy and practice of traditional healing. One of the Constitutionally-mandated socio-economic rights accorded to everyone, is that health care services be made progressively accessible, subject to available resources, by reasonable legislative and other measures. Although at no stage within the Traditional Health Practitioners Act is it stated that traditional healing is intended to become an element of state-provided health care,<sup>14</sup> many people employ traditional healing as a genuine health care service.

The question raised is this. Do people have the right of access to traditional healing as a state-provided health care service? The correlative and corresponding question would enquire whether or not the state would be placed under an obligation by the users of traditional healing to not only allow, but *provide* traditional healing as a health care service.

Traditional healing is a secretive skill and trade. When it does appear in the popular media, it is frequently misunderstood, and, in consequence, much maligned. The general trajectory that will be taken in this paper, therefore, will be to engage in, by anthropological study, a close examination of

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<sup>13</sup> Act 108 of 1996

<sup>14</sup> Presently, only its private practice is recognised.

both the underpinnings of traditional healing and its use in practice by patients. This understanding is crucial, for in a democratic society lawmakers have a duty to be reasonably responsive to the needs of the population, drawing laws that reflect, where possible, the attitudes of wider society. This is only possible through an investigation of the known facts, and the subsequent informing of the law by the facts.

Analysis of existing ethnographic fieldwork strongly suggests that patients use biomedicine and traditional healing in a complementary, not competitive, fashion. It may well be that, in short, biomedical doctors are utilized in order to treat what traditional societies regard as the biological 'disease'. Traditional healers focus on the social 'illness', helping to alleviate the psychological stress of an ailment by providing a moral vocabulary<sup>15</sup> that people will use to answer the fundamental questions behind such pain, reducing it to a known and confronted entity.

Therefore, laws concerning traditional healing and its use should appreciate the complementary nature of health care seeking in South Africa, so as to allow patients the best possible access to health care services. It shall become apparent, and be argued, that the complementary use of biomedicine and traditional healing necessitates that biomedicine take precedence within the public health care service.

Traditional healing, for its part, is to be welcomed and encouraged to the fullest extent possible. However, it must remain a private undertaking, as, legislatively, it does at present. Therefore, people do not have a right of access to traditional healing as an element of the public health care service.

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<sup>15</sup> N Tebbe 'Witchcraft and Statecraft: Liberal Democracy in Africa' *op cit* pg 197