The Modernisation of Traditional Healing in South Africa: Healers, Biomedicine and the State

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Zusammenfassung

Thema meiner Arbeit ist die Modernisierung traditioneller Medizin in Südafrika. Ich habe untersucht, wie traditionelle HeilerInnen ihre Beziehungen mit einer sich wandelnden sozialen Welt erleben und verhandeln, und wie sie sich dabei aktiv in der Arena südafrikanischer Gesundheitspolitik positionieren.

Ein meiner Ansicht nach neuer Zugang zu diesem Thema ist die Verwendung von Webers Rationalisierungskonzept, welches auf einen zentralen Punkt in meiner Arbeit hinausläuft: Es ist unvermeidbar, das die Praxis traditioneller Medizin verrechtlicht wird, um dem Prinzip der Gleichrechtlichkeit zu entsprechen sowie bestimmte Rechte und Verantwortlichkeiten gewährleisten zu können. Mit dem Prozess der Legalisierung ist zwangsläufig die Standardisierung einzelner Elemente traditioneller Medizin verbunden, damit diese zum einen für den Staat, zum anderen für die Wissenschaft lesbar gemacht werden kann.

In der Einleitung diskutiere ich wichtige Modernisierungstheorien, um daraus anschließend meinen eigenen analytischen Rahmen sowie die Kernargumente meiner Arbeit zu entwickeln. Ich zeige, dass ein bestimmtes Konzept von Modernisierung hilfreich ist, um die Dynamiken und Wandlungsprozesse von Praktiken traditioneller Medizin in Südafrika zu theoretisieren. Meine Interpretation davon, was ich als Modernisierung traditioneller Medizin bezeichne, basiert im Wesentlichen auf zwei Konzepten Max Webers: zum einen dem Leitmotiv der Rationalisierung und zum anderen auf der Funktionsweise bürokratischer Herrschaft als Voraussetzung für den Rechtsstaat.

Ich gehe kurz auf die Kritik von Rationalisierung und Aufklärung ein, insbesondere auf Horkheimer, Adorno, Benjamin und Foucault. Alle Autoren widmen sich der Dialektik von Moderne, ihrer sogenannten „Janusköpfigkeit“, die auch schon in Webers Arbeit einen wichtigen Platz einnimmt. Jüngere Arbeiten zum Thema Modernisierung, besonders in der Ethnologie, beschäftigten sich mit der Produktion lokaler Modernen und betonten dabei die Besonderheiten lokaler Verhältnisse sowie die verschiedenen Interpretationen und Praktiken von Menschen abhängig von ihrem sozio-kulturellen Hintergrund. Die meisten AutorInnen bleiben jedoch ungenau dahingehend, was genau diese Praktiken und Vorstellungen als modern definiert, selbst wenn sie sich lokal voneinander unterscheidet. Ich argumentiere

außerdem, dass die Imagination von Moderne überbetont wird wenn AutorInnen versuchen, Modernisierung zu charakterisieren, während strukturelle Faktoren oft außen vor bleiben. Eisenstadt bildet hier mit seinem Konzept der „Multiplen Modernen“ (2000) eine Ausnahme, an der ich mich orientiere. Er definiert einen gemeinsamen Kern von Moderne wobei er gleichzeitig die Vielzahl verschiedener, sich ständig wandelnder, kultureller Programme anerkennt.

Ich komme zum Schluss, dass ich an einer Minimaldefinition von Modernisierung als Prozess, der zu verschiedenen Institutionen führt, festhalten möchte (siehe auch Zapf 1996:32) – diese sind in meiner Arbeit die Professionalisierung, Standardisierung und Legalisierung von traditioneller Medizin. Ich betrachte meine Untersuchung als eine weitere Art von „Multipler Moderne“, eine Darstellung von HeilerInnen in einer südafrikanischen Großstadt, die „modern“ werden. HeilerInnen sind Teil eines Modernisierungsprozesses, der imaginiert und praktiziert, aber auch bestimmt und gelenkt wird durch den neuen südafrikanischen Nationalstaat.

Die verbleibenden Kapitel beschäftigen sich detailliert mit der Praxis und den Vorstellungen traditioneller Medizin im Zuge von Modernisierung. Im zweiten Kapitel geht es um Krankheit und Gesundheit. Ich zeige auf, welche Therapiemöglichkeiten in Port Elizabeth zur Verfügung stehen. Ich analysiere eigenes, erhobenes Datenmaterial zum Thema Krankheit und Therapieerfahrung sowie entsprechende medizinethnologische Literatur. Ich zeige, dass Kranksein relativ ist und verschiedene Dinge für Menschen zu verschiedenen Zeiten bedeuten kann. Die Wahrnehmung eines Leidens wie auch die Art und Abfolge verschiedener Therapien hängt von einer Reihe von Faktoren ab, wie z.B. Glaube oder frühere Krankheitserfahrungen, aber auch der Effektivität einer Behandlung, der sogenannten „*therapy management group*“ (Therapiemanagementgruppe) und die Optionen die dem/der PatientIn zur Verfügung stehen. Es zeigt sich, dass Gesundheit und Heilung Gegenstände komplexer Aushandlungsprozesse sein können. Auch Fragen von Identität und Moral spielen hier eine Rolle. Krankheit kann eine existenzielle Erfahrung darstellen, die soziale Netzwerke und Ordnungen in Frage stellen können. Jede Krankheitsgeschichte hat demnach das Potential die eigenen Erklärungen, Praktiken und Annahmen über Ursachen und Heilungsmöglichkeiten zu verändern. Das Verständnis von medizinischen Praktiken ist daher wandelbar und das Ergebnis von objektiven Strukturen wie Gesundheitsversorgung oder

vorherrschende Diskurse einerseits und subjektiven, internen Definitionen von Krankheit und Gesundheit andererseits.

In Kapitel III gehe ich auf die verschiedenen Beziehungen und Netzwerke der HeilerInnen ein und analysieren die Motive, Ansichten und Probleme der involvierten AkteurInnen. Ich zeige wie HeilerInnen gegensätzliche Prioritäten miteinander vereinbaren und verhandeln: Wenn sie an verschiedenen Workshops oder wissenschaftlichen Tests teilnehmen, streben sie nach Wissen, Prestige und Ressourcen. Gleichzeitig geht es Ihnen darum, eigenes, geheimes Wissen zu bewahren. Sie schätzen die Inkorporierung in das Gesundheitssystem, wollen aber nicht auf ihre Autonomie verzichten. Die Nutzung und Verbreitung von Biomedizin finden sie wichtig, besonders in Zeiten von AIDS, aber gleichzeitig wollen sie selbst eine wichtig Größe im Bereich Gesundheit und Heilung bleiben.

Eine wichtige Debatte innerhalb der Medizinethnologie wenn es um die Begegnung von HeilerInnen und Biomedizin geht, betrifft die Frage, ob zentrale Elemente traditioneller Medizin dabei verloren gehen – ein Prozess der als Biomedikalisierung bezeichnet wird. Ich führe aus, warum das nicht notwendigerweise der Fall ist, selbst wenn sich zeigt, dass HeilerInnen während der Interaktion bestimmte eigene Konzepte oder Begriffe nicht benutzen. Stattdessen argumentiere ich, dass sie für den Zeitraum der Interaktion einen „Metacode“ (Rottenburg 2005) etablieren, der ihnen die Kommunikation mit BiomedizinerInnen ermöglicht oder erleichtert. Innerhalb dieses „Metacodes“ verzichten sie auf die Verwendung bestimmter Konzepte, die sie für unübersetzbar oder nicht anschlussfähig halten. Außerhalb sind ihr Leben sowie ihre Tätigkeit als HeilerInnen jedoch nach wie vor durch die Referenz auf Ahnen oder Hexerei als Krankheitsursache bestimmt. Aussagen über fundamentale, epistemologische Veränderungen durch die Interaktion der HeilerInnen mit der Biomedizin treffen also nicht unbedingt zu. Ich stelle fest, dass es nötig wäre, auch in anderen Arenen epistemologische Veränderungen zu beobachten, nicht nur wenn unter dem situativen Regime des Metacodes operiert wird, um eine umfassende Biomedikalisierung zu attestieren.

Kapitel IV fasst die Ergebnisse der Kapitel II und III zusammen und bringt sie in Zusammenhang mit dem Thema Rationalisierung. Ich führe die teilweise Veränderung der sogenannten „*dual epistemology*“ aus, einer Unterscheidung zwischen „normalen“ und „kulturellen“ Krankheiten, auf die sowohl HeilerInnen als auch PatientInnen Bezug nehmen, wenn sie über Krankheit, verschiedene Therapieoptionen und dem Wechsel zwischen diesen reden. Ich argumentiere, dass die zwei verschiedenen Kompetenzbereiche, die sich durch

diese Unterteilung für HeilerInnen und Biomedizin ergeben, aufgrund verstärkter Interaktion stärker und expliziter betont werden, während es die Unterscheidung zwischen zwei verschiedenen Arten von Krankheiten schon immer gegeben hat. Diese „Schärfung“ kann als theoretische Rationalisierung im Weberschen Sinn erklärt werden. Ich zeige, dass die Schaffung zweier Kompetenzbereiche für den Bereich Krankheit und Heilung zentral ist: HeilerInnen können mit den Ahnen kommunizieren und deshalb Störungen dieser Art beheben, während Ärzte „normale“ oder „natürliche“ Krankheiten behandeln, ohne auf Ahnen oder Hexerei zu verweisen. Die Zuordnung einer Krankheit indessen, in entweder die eine oder die andere Kategorie, ist das Produkt eines komplexen Aushandlungsprozesses zwischen menschlichen und nicht-menschlichen AkteurInnen innerhalb des Netzwerks des/der PatientIn. Abhängig von verschiedenen Begleitumständen kann es zu einer wiederholten Neubewertung dieser vorläufigen Schließung kommen, wodurch verschiedene Rahmungen zu verschiedenen Zeitpunkten einer Krankheit möglich sein können. Meiner Ansicht nach besteht die Bedeutung der *dual epistemology* darin, dass ein eigener Kompetenzbereich für die HeilerInnen entsteht, der von einer Konkurrenz mit der Biomedizin frei ist. Im Bereich der „natürlichen“ Krankheiten wiederum können HeilerInnen biomedizinischen Fortschritt und Erfolg anerkennen, ebenso wie die Gültigkeit von HIV, und die Möglichkeit einer wissenschaftlichen Prüfung ihrer Heilpflanzen. Im Bereich der „traditionellen“ Krankheiten andererseits verfügen sie über die alleinige Heilungskompetenz, was ihre Unentbehrlichkeit im südafrikanischen Gesundheitssystem unterstreicht.

Mit Weber könnte man die *dual epistemology* als ein abstraktes Konzept begreifen, wodurch komplexe Entwicklungen theoretisiert und für spätere Handlungen verstehbar und handhabbar gemacht werden. Weber bezeichnet das als theoretische Rationalisierung. Ich gehe auf Webers Theorie der Entzauberung ein sowie auf ihre Kritik und komme zu dem Schluss, dass traditionelle Medizin mitnichten als Ganzes rationalisiert oder entzaubert wird. Ich stelle die (vorsichtige) Hypothese auf, dass die Unterscheidung zwischen „normalen“ und „traditionellen“ Krankheiten letztere davor bewahrt, biomedikalisiert oder entzaubert zu werden, dass so eine Nische für den Fortbestand traditioneller Medizin besteht.

In Kapitel V geht es um die Legalisierung traditioneller Medizin, dabei insbesondere um die Geschichte und den Inhalt des *Traditional Health Practitioners‘ Act* sowie um die damit verbundenen Diskurse auf lokalem und nationalem Level. Das Gesetz wurde 2004 erlassen. HeilerInnen sind jetzt gezwungen, sich zu registrieren. Teile ihrer Ausbildung sollen

standardisiert werden. Ich beschreibe wie in einigen zentralen Punkten das Gesetz Grundprinzipien traditioneller Medizin widerspricht. Gleichzeitig erfahren die HeilerInnen eine Art von öffentlicher Anerkennung, die sie sich lange gewünscht haben, vor allem vor dem Hintergrund ihrer Erfahrungen im Apartheid-Staat. Ich führe aus, dass der Prozess der Legalisierung traditioneller Medizin als Suche nach einem unabhängigen, südafrikanischen Weg im Bereich von Krankheit und Heilung verstanden werden kann, die verbunden ist mit dem Konzept der Afrikanischen Renaissance und damit Teil eines Prozesses von Nation-building, in dem es um die Schaffung einer post-Apartheid-Identität geht. Traditionelle Medizin hat in Form des Gesetzes, aber auch durch die AIDS-Debatte, in der biomedizinische Konzepte von Präsident und Gesundheitsministerin angezweifelt und stattdessen „Afrikanische Lösungen“ favorisiert wurden, eine Aufwertung erfahren. Dadurch wurde das Konzept der Afrikanischen Renaissance in reale politische Konsequenzen übersetzt. Der essentialisierende Diskurs um traditionelle Medizin in der südafrikanischen Gesundheitspolitik, der diese als Verkörperung afrikanischer Identität entwirft, fällt mit der Selbstbeschreibung der HeilerInnen als ExpertInnen für afrikanische „kulturelle“ Krankheiten zusammen. In den Augen der HeilerInnen verhalf ihnen das Label „Tradition“ dank des Gesetzes und der Rhetorik um eine Afrikanische Renaissance zu einer vielversprechenden Position im neuen Südafrika.

In Kapitel VI untersuche ich die Logik des modernen Staates, welcher auf rational-legaler Herrschaft beruht. Zentral hierbei sind Webers Theorien über die Funktionsweise von Bürokratie. Ich leite her wie eine wachsende Verrechtlichung auf bürokratischen Prozessen beruht, die diese erst ermöglicht und herstellt. Ich gehe auf Webers Ambivalenz gegenüber einer strikt bürokratisch organisierten Gesellschaft ein, in der eine Ausweitung demokratischer Recht für alle an ein stärkeres Ausmaß von Verrechtlichung geknüpft ist, was wiederum zu mehr Regeln und Kontrolle führt. Bürokratie ist demnach beides: eine Garantie für Freiheit und Gleichheit, wie auch deren Begrenzung. Ich setze mich mit der Sekundärliteratur zu Weber und Bürokratisierung auseinander, und komme zu dem Schluss, dass gerade jüngere Literatur den Fehler macht, nicht zwischen der Logik und der Praxis eines Staates unterscheidet, weswegen deren Kritik oft ins Leere läuft. Für mich ist die Erkenntnis zentral, dass ein Staat Dinge nur prozessieren kann, die für ihn lesbar, also standardisiert sind. Ansonsten bleiben sie unsichtbar, weil sie nicht mit seinem Bezugsrahmen kommensurabel sind. Einige Autoren weisen darauf hin, dass im Zuge von Standardisierungsprozessen die

reale Welt von den neu geschaffenen Kategorien geformt wird. Ich betone, dass es sich hierbei um eine empirische Fragestellung handelt. Bezogen auf die Legalisierung traditioneller Medizin kann man dahingehend noch keine Rückschlüsse ziehen. Im Hinblick auf die *dual epistemology* existiert zumindest eine Gruppe von Krankheiten, die „natürlichen", die für den bereits Staat lesbar, und damit operationalisierbar ist.

Ich komme zu dem Schluss, dass ein moderner Staat, der auf Rechtsstaatlichkeit und dem Prinzip der Gleichrechtlichkeit basiert nicht anders kann, als traditionelle Medizin einem Gesetz zu unterwerfen, wobei einige ihrer Aspekte standardisiert werden. Vor dem Gesetz sind jetzt Biomedizin und traditionelle Medizin formal gleichgestellt. Der Mechanismus der Verrechtlichung ist der einzig mögliche, um Gleichheit vor dem Gesetz zu gewährleisten. Nur in der standardisierten Form eines Gesetzes kann traditionelle Medizin, vorher illegal und ausgeschlossen aus dem Wirkungsbereich des (Apartheid-)Staats, lesbar gemacht und „erkannt" werden, um dann in die Arena des neuen demokratischen Staates überführt werden zu können.

Mit meiner Dissertation zeige ich, wie HeilerInnen in verschiedenen sozialen Arenen ihre Identitäten, Praktiken, Ziele und Werte verhandeln – wie und wo sie ihre Moderne entwerfen und leben. Maßgeblich hierbei waren Prozesse von Professionalisierung, Standardisierung und Legalisierung. Vor dem Hintergrund meiner Argumentation zeige ich somit wie HeilerInnen beides möglich ist: „modern" zu werden und Teil des neuen südafrikanischen Staates, jedoch ohne sich notwendig von ihren „Traditionen" abzuwenden.

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1.

Introduction

This study deals with the modernisation of traditional healing in South Africa.[1] Healers, as stakeholders of Africanness and "real tradition", have been playing an increasing role in the discourse on health in general and HIV/AIDS in particular. They participate in workshops aimed at changing their practices, and they are subjected to a law making them equal to their medical counterparts. This thesis examines the place of healers in contemporary South Africa, interpreting and analysing changing healing practices. I hope to show how both healers and the concept of traditional healing are products of modernising processes.

Under the rubric of modernisation, I understand the development of traditional healing practices that has transpired since the end of Apartheid. Modernisation is commonly understood to be a process of socio-cultural transformation linked to technological advance, institutionalisation, rationalisation, and the reformation of certain norms and values that may lead to the mental and physical mobilisation of individuals. Theories of modernity have long taken the West as a point of reference when evaluating other societies. While it seems quite difficult to "think modernity" without relating in one way or another treating the West as a "fixed point", this approach constitutes a conceptual element "holding numerous societies in a kind of permanent transition between a 'traditional' past and a 'modern' future, thereby expunging their present" (Pordié 2003:37). Classical theories of modernity also suggest that certain aspects of the past – referred to as "tradition" – would vanish to give way to modernisation.

Yet, this notion of loss does not adequately represent the image modern people have of their lives. Because of this, scholars in the social sciences have studied the production of local modernities, focussing on how people interpret, transform, and construct modernity in accordance with their unique socio-historical context. In this thesis, I describe fieldwork I conducted in South Africa with traditional healers, in order to uncover local perceptions of modernity, situating these practices between a traumatising Apartheid past and a better future in the African Renaissance. In so doing, I want to focus on how traditional healers perceived

[1] Healing can be looked at from various theoretical angles, e.g., epistemology or gender. I focus on one aspect, namely, on what I call the modernisation of traditional healing, which is nevertheless part of a wider spectrum of perspectives.

and negotiated their relations with a changing social world, and how this resulted in a growing professionalisation, rationalisation, and legalisation of healing practices. I have striven to frame South African healers neither as merely adapting to nor simply resisting change. Instead, I will demonstrate how healers actively positioned themselves in the changing arena of South African health policy to secure a relevant niche for their practices, all within the limits of a given structural and discursive context.

In this introduction, I first discuss dominant theories on modernisation in order to develop an analytic framework and the key arguments of my thesis. I demonstrate why a certain concept of modernisation is useful for describing ongoing changes in South African traditional healing practices. Subsequently, I introduce my field site and discuss my fieldwork methodology.

1.1. Modernisation Theories and Traditional Healing: An Analytic Framework and Key Arguments

Theories on Being Modern

The concept of modernisation is probably one of the most popular themes in social theory and certainly one of the most contested. Nevertheless, in order to describe changes to traditional medicine in South Africa, the concept offered itself as a useful tool to call upon in trying to theorise the dynamics at play. My research focused on the increasing role of biomedicine in healing practices, and the incorporation of traditional healers into the South African health care system. The main processes that became apparent were a professionalisation of traditional healing, and concomitant standardisation as traditional medicine was subjected to scientific scrutiny and legal regulation. My research aimed to observe these processes and to understand the practices, negotiations, and discourses driving them, as well as the imaginations, motives and reservations of the people involved.

As I researched these matters, I increasingly felt that the religious dimension at other times so prominent within traditional healing was being omitted. This led let me to wonder whether Weber's disenchantment postulate might have something to it after all, and whether something like Weberian rationality was indeed penetrating the life worlds of the people I was studying as they "became modern". After all, for some of my interlocutors "becoming modern" meant becoming equal, recognised, and accepted by the law and wider public in

contemporary South Africa. It is against this backdrop that I decided to write about the modernisation of traditional healers in South Africa.

Weberian Rationality

My interpretation of what I call the modernisation of traditional healing is primarily based on two concepts from Max Weber, namely, the leitmotif of rationalisation and the workings of bureaucratic rule. For Weber, rationalisation is the prime mover of historical development, ultimately resulting in the rise of modern societies. For Weber, all spheres of society – economic, legal, political, and religious – are subject to the process of rationalisation. He defines rationalisation as the process through which nature, society, and individual action are increasingly mastered by planning and technical and procedural reasoning (Introduction of *The Protestant Ethic*, Weber 2000[1904/05]).[2] It is this process that I see at work in the evolution of traditional healing practices in contemporary South Africa. Weber's concept of rationalisation presumes that there are two tendencies at play in historical development. First, Weber contends that there is a tendency to increasingly rely on calculation and technical knowledge in order to gain control over the natural and social world. Second, he contends that as a society develops, individuals are increasingly freed from dependence on magical thinking as a means of understanding the world, relying instead on what is given in empirical reality (Morrison 1995:218). I will return later to this disenchantment thesis as I examine if and how central epistemological concepts of traditional healing are changing.

Weber's typology of social action – affective, traditional, instrumental, and value-rational – refers to human capabilities irrespective of historical or cultural constellations (Kalberg 1981:10). Hence, religious rituals are to be understood as equally instrumental as the stock market. Furthermore, modernisation is not to be understood as simply eradicating affective or traditional action (ibid.). In order to analyse and explain patterns in social action Weber theorised four types of rationality: practical, formal, theoretical, and substantive (*materiale)*. These four types are embedded in instrumental (*zweckrational*) and value-rational (*wertrational*) action. Although for Weber, modern societies are characterised by the complete rationalisation of all spheres of society, he contends that all four types of rationality are found in all societies, and thus that rationality is universal (Bendix 1972; Kalberg

[2] Weber discusses the concept of rationalisation at various points in his oeuvre and in different contexts without ever comprehensively outlining or clearly defining its core features. For more on rationalisation as one of Weber's key concepts, see Sprondel & Seyfarth (2000).

1981:12; Parsons 1937). According to Weber, societies differ in the degree to which rationality as an organisational principle pervades all spheres of social life.

Weberian Bureaucratic Rule

Weber contends that the modern state is characterised by the increasing bureaucratic organisation and control of areas of individual and social life that were formerly beyond the state's jurisdiction. That rational law has its basis in bureaucratic rule (Weber 2009[1922]:216) is a point that will prove central to my argumentation about the legalisation of traditional healing. Legal equality and rule of law require a formal, rational mode of organisation as opposed to the personal likings and mercy characteristic of patrimonial rule. I will argue that in order to achieve legal equality, the modern South African state has had no other option than subjecting traditional healing to legal regulation.

American Heydays of High Modernism

Although Weber provided the basis for modernity theory and ever since people writing about modernity in one way or the other relate to him, what we refer to today as modernisation theory developed mainly during the post-war era in the United States. It was Talcott Parsons (1951) who introduced Max Weber to American sociology, albeit in a slightly reductionist version stripped of its ambivalent take on modernisation (Geschiere, Meyer et al. 2008:3). This optimist reading and misrepresentation of Weber fed and epitomised the so-called "heydays" of modernisation theory in the 1950 and 1960s.[3] Its theorists aimed to analyse developmental problems in countries of the then so-called Third World. They sought to identify preconditions of economic growth and of political democratisation. Some of the main assumptions were that modernisation as a global, irreversible process began in Europe with the industrial revolution spreading to all societies after 1945; that this process will transform so-called traditional, particularistic societies into modern, universalist ones; and that this process will proceed in a quite uniform and linear fashion in different societies without too much conflict. (Alexander 1994:168f.; Knöbl 2002:160f.) Talcott Parsons added an evolutionary aspect to modernisation theory with his influential essay on "Evolutionary

[3] To outline early modernisation theory is difficult as there never was a coherently outlined theory. The notion of modernisation was coined later when a few books dealing with its premises had already been published (Knöbl 2002:160). For the first time the notion of modernisation appeared in 1958 in Daniel Lerner's "The passing of traditional society. Modernizing the Middle East" (Lepsius 1977 cited in Knöbl 2002:160). See also Robert Bellah's (1957) influential book on the making of modern Japan which can serve as an example of early modernisation theory and its assumptions being the basis for an empirical study. This empirical emphasis got lost in later modernist thinking, which became increasingly abstract and hardly falsifiable (Knöbl 2002:162). See for example Smelser & Lipset (1966).

universals of society" (Parsons 1964). According to him these universals constitute parameters of a unilinear development of society. Parsons defines evolutionary universals, like a capitalist system or a democratic government, as inventions or developments that are important for the further evolution of a society which is why they occur very likely in different societies under very different circumstances (Parsons 1964:339). They are responsible for upgrading adaptive capacities of certain systems, compared to other less developed ones, which can nevertheless survive in niches or in symbiosis with higher developed systems (1964:340). Social evolution for Parsons is conditioned by the necessity for every society to improve their adaptive capacities to ensure a continuous process of differentiation allowing to adapt to an ever changing environment. Having witnessed the decline of high modernism, with its failure of the development paradigm and its effects in various parts of especially Africa (Cooper and Packard 1997; Ferguson 1994; 2008) his formulations seem hardly plausible. The early Eisenstadt is undoubtedly also indebted to a strong belief in the merits of modern development, even though he formulates his position in far less drastic ways. He lays out the basic characteristics of modernisation as consisting in social mobilisation, social differentiation, the structural differentiation of the major institutional fields of society as well as democratisation and a growth of political equality (Eisenstadt 1966). Nevertheless, he already acknowledges specific contours and developments of certain variants of modernising processes spreading throughout the world; a thought that subsequently led to his famous concept of "Multiple modernities"(Eisenstadt 2000). Ernest Gellner is another representative of orthodox modernist thinking. He described the interrelations between industrialisation, the modern nation state and homogenous high culture (Gellner 1983; 1999[1997]). He states that mankind has passed through three fundamental stages in its history: the pre-agrarian, the agrarian, and the industrial, whereas the latter presupposes a state (Gellner 1983:5). Drawing on Weber he also stresses the importance of rationality and bureaucratic rule with its efficiency, coherence and regularity in the development of industrialisation (1983:20). Furthermore, he stresses the importance of standardised and highly specialised training and education in modern industrial society, as well as the increased necessity of precise communication involving the sharing of explicit meaning transmitted in a standard idiom (1983:27-34). It is especially this proclaimed homogeneity that was later so strongly contested by critics of these earlier studies of modernisation.[4]

[4] After the empirical failure of modernisation in the so-called Third World modernisation theory lost its importance in social theory. With the end of the Communist bloc however, and the rise of the Asian Tiger States

The Modernisation Critique

Around the same time, under the impression of National Socialism, theoretical approaches to modernisation took quite a different turn in Germany. Horkheimer and Adorno's *Dialectic of Enlightenment* (1975[1947]) thereby constitutes one of the most influential critiques of Weberian notions of modernisation and rationalisation. In it, the authors contend that the economic and technical progress of Germany, on the one hand, and racist ideologies of ethnic community and nativeness, on the other, were combined as an extreme form of Western modernisation. Auschwitz was a sign of the potential outcomes of modernisation and an increasingly administered world. Horkheimer wrote in a letter to a colleague, that Anti-Semitism "demonstrates on the example of the minority which is, as a matter of fact, in store for the majority as well: the change into administrative objects" (Wiggershaus 1998:100). Nevertheless, Horkheimer and Adorno hope that reason and moral and cultural goods have the capacity to limit the self-assertion of a fully administered world (1998:101).

Against the backdrop of Nazi Germany and the Holocaust, Horkheimer and Adorno questioned the principle of enlightenment linked to disenchantment and demystification. Their proclaimed dialectic, the idea that the attempt to get rid of superstition provides the ground for new superstition, constitutes the core thesis of their work (Horkheimer and Adorno 1997[1944]:xiii). The "obstruction of the theoretical faculty" paves the way for political delusion as mechanisms of censorship, internal as well as external, deprive people of their means to resist. However, freedom within society is inseparably linked to Enlightenment and its thinking. But in this thinking the seed of the regression of Enlightenment is already contained. "If Enlightenment does not accommodate reflection on this recidivist element it seals its own fate" (ibid.). If the destructive potential of progress is forgotten, "blindly pragmatized thinking" loses its relation to truth, thereby opening the door for despotism of any kind (ibid.). Mythical thinking, nevertheless, remains the core of Enlightenment, as its destruction is so central. "Just as the myths already realize enlightenment, so enlightenment with every step becomes more engulfed in mythology. It receives all its matter from the myths, in order to destroy them; and even as a judge it comes under the mythic curse." (1997[1944]:11f.).

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its "resurrection" began (Knöbl 2002:163). With a few corrections here and there, like the inclusion of conflict and contestation as being part of modernization or the acknowledgment of different developmental paths, the basic tenets were mainly uphold (see e.g. Giddens 1994; and Zapf 1991; 1996). Giddens made the point that contrary to the assumptions of earlier writings only now in the era of globalisation a de-traditionalisation can be observed (1994:105), a point later proven wrong by many.

As Enlightenment attempts to destroy myths and suppress older religious beliefs, both authors write, its totalitarian character become apparent (1997[1944]:6,11). Equality, the central tenet of Western democracy, has the potential to be repressive. Those who are equal have the right to injustice. After the abolishment of all other worship equalisation has become a fetish (1997[1944]:13,17). To create a society of equals by eliminating everyone deviant from the norm constituted the core of the Third Reich.

The principle of dialectic is also central in the work of Walter Benjamin, a close colleague and friend of Horkheimer and Adorno. In his "Arcades Project"[5], a collection of essays about Parisian city life at the turn of the century, he also writes about that which makes modernity mystical, identifying religious mechanisms in consumer capitalist society (in German *kapitalistische Warengesellschaft*). Commodities become cult objects or fetishes and the arcades he describes are temples of commodity capital (in German *Tempel des Warenkapitals*) (Benjamin 1982:86). World's fairs would be places of pilgrimage to the fetish of commodity. Fashion dictates how it is ought to be worshipped (1982:50f.). Even the human body is subjected to system-induced pressure and the universal requirement for valorisation, as Benjamin shows with the example of prostitution (1982:55). The arcades were a prominent architectural form in 19th century metropoles which reflected the lifestyle of the bourgeoisie (1982:45f.). Although towards the end of the century they went out of fashion, it is this phase of obsolescence that Benjamin is interested in. Following surrealism, Benjamin emphasises the revolutionary energy that inhered in something which has just passed (1980[1977]:299). He outlines a theory about the production of collective images in which the collective tries to explain as well as eliminate the shortcomings of society. What comes to the fore within these desired images is the effort to distance oneself from the past. Elements of the primeval past are combined with images of the passing epoch, experiences of past injustices, unrealised dreams and wishes which rest in unconscious form along with images of a novel and utopian future (1982:46f.). Benjamin writes that each epoch dreams the one which follows and forces its awakening. Here the link to Adorno and Horkheimer becomes obvious, for each epoch entails its demise and unfolds it (1982:59). Benjamin makes a similar point in his analysis of Baudelaire's *Les fleurs du mal* and the author's notion of *correspondances.* The latter "record a concept of experience which includes ritual elements" and by appropriating these

[5] Originally intended to be his main work as a historical philosophy of the 19th century, Benjamin could not finish the Arcades Project he worked on for 13 years. It remained fragmentary. The manuscript survived thanks to Georges Bataille, who hid it in the National Library during German occupation. Its edition was first completed in 1982 and then finally published (1981).

“Baudelaire (was) able to fathom the full meaning of the breakdown which he, a modern man, was witnessing” (Benjamin 2009[1939]:50).

A third major contribution concerning the critique of rationality and modernity that I would like to shortly address is of course the work of Michel Foucault. In “Madness and civilization” he analyses the power mechanisms at play in establishing the category of madness as the abnormal, as the other in opposition to reason. This delineation started to establish itself in the 17th century whereby the other was simultaneously excluded and silenced. For Foucault modern reason is unthinkable without its excluded counterpart. Together with normalising medical, juridical and political practices the prevailing rationality in philosophy and the sciences forms a repressive whole (Foucault 1981[1961]:8-10). Foucault writes a history of madness starting from early forms of internment in the 17th century. Chief among them were hospitals utilised to make the poor, delinquents and maniacs disappear (1981[1961]:68-98) and reformed sick asylums where studying, monitoring and controlling patients were aimed to provide a cure or the prospect of normalisation (1981[1961]:482-536). For Foucault, however, these new practices are no less repressive or powerful. They are just more subtle whereas the actual purpose is still to exclude the other.

In one of his lectures on the abnormal Foucault elaborates more fully on how psychiatric estimates, forms of evidence and juridical power come together in convicting murderers at court. Foucault uncovers cases of inaccuracy where expert witnesses as well as judges rely heavily on their own subjective perception when it comes to deciding between guilty or not guilty. For him these shortcomings are not failures, but rather inherent to the system. He calls “grotesque” the inherent, but flawed, punitive structure that characterises modern bureaucracy and other forms of mechanical power. Similar examples of this would be Nazism and Fascism (Foucault 2003[1975]:12f.).

What all these authors have in common is a concern about the dialectic of modernity, its Janus-faced character which was also already found in Weber. From a social anthropological point of view it is intriguing to look at the threshold between productive rationality and bureaucratic logic, on the one hand, and the processes of discipline and control on the other. What myths become dispelled and where and how do new ones emerge? What are the costs and benefits for the different actors when certain practices become bureaucratised, standardised and legalised? The work of these critics also makes clear that modernisation is not a predictable one-way street where one logical step follows after the other, but rather that regressions and deviations are possible in the form of mystifications, totalitarism and

exclusions. The concept of modernity or rather the usefulness of the concept, however, is not disputed.

Modernity in Social Anthropology

Within social anthropology scholars have critically engaged with theories on modernity and modernisation and sought to heterogenise and culturalise the modernity concept. The main aim has been to challenge the notion of Western modernity as a globalising force with other distinct variants such as "alternative modernities" (Appadurai 1996), "vernacular modernities" (Donham 1999), "mythic modernities" (Comaroff and Comaroff 1993) or "multiple modernities" (Eisenstadt 2000). One of the main points of critique is the proclaimed "modern moment" that divided history into modern and past eras (e.g. see Appadurai 1996:3; Geschiere et al 2008:2), implying an opposition between "us" moderns and radically different, backward and still-undeveloped "others". Bruno Latour (1993[1991]) even suggests, that "we have never been modern" and that only the use of this dichotomy is what makes so-called moderns and primitives different. He makes out a so-called "great internal divide" whereby the designation of being modern created two different realms of nature and society (1993[1991]:99). Science was the institution involved in situating certain objects in the realm of either nature or society. This ability to make such a division was just an ideal, however, as he shows with the existence of so-called quasi-objects (1993[1991]:51) that cannot be identified as belonging to either nature or society. We simply have never been modern.

Having had the privilege to witness the course of modernisation and the rarely successful efforts to develop not-yet-modern parts of the world, authors of the 1990s sought to capture how modernity, or the perceived lack of it, was lived and imagined throughout the globe. Instead of talking about the characteristics of modernity scholars now focused on the ideas, the imaginations of the modern (Appadurai 1996), or they acknowledged the discourses on modernity that "generate powerful practices that do actually shape … people's lives" (Geschiere et al 2008:1). Authors coped differently with the challenge to come to terms with a qualitative change in their ways of life, be it imagined, practiced or real. Appadurai for instance acknowledges a rupture dividing history into a modern present and a pre-modern past, but also asserts that this rupture was the work of imagination (1996:3), which, today, is a collective and mobilising faculty that transcends national boundaries (1996:8). He emphasises the role of mass media and migration in spreading "the materials of modernity" worldwide, whereby different societies appropriate it differently (1996:17). Hence, the rupture he recognises between a modern, globalised present and its past reflects a qualitative change in

the workings of imagination and its globalisation. In "The modernity of witchcraft" (1997) Peter Geschiere argues along similar lines, although he avoids talking about a rupture or divide. He also emphasises the importance of "modern techniques" like means of transport and communication enabling processes of globalisation. They "now increasingly involve[d]" "peripheral groups" in the world market "not only as producers but also as consumers" (Geschiere 1997:8). Fashion and trends would "turn up everywhere". His book shows, however, that the result of these processes does not lead to a cultural uniformity, but that practices like witchcraft still persist.[6] Subtly, the notion of a divide between a "now" and a past sneak in when he speaks about the "now increasingly" involvement of people. Yet, Geschiere prefers to not be too specific (or clear). Also Probst et al. (2002) fail to make explicit what it is that distinguishes modern practices, ideas or concepts from others. In their introduction of their book "African modernities", the authors claim they want to follow ideas, concepts and practices of modernity as well as the "implications and consequences of its meaning" (Probst et al 2002:1). They do not explain, however, what it is that makes these practices and ideas modern. This strategy of evasion becomes apparent in the introduction of "Readings in modernity in Africa" (2008) where the authors state the need for a "substantive conception" of the term "modern". This need again would "force" them to consider:

> the relative value of very different dimensions of the 'modern': processes of commodification and monetization; of instituting constitutional government, representative democracy, taxation and/or the civil service; of mass meditization; of reconfiguring personal relationships towards the bourgeois nuclear family and/or the individual; of the demise of religion and the rise of secularism; and so on.
>
> (Geschiere et al 2008:2)

Having said this, the authors doubt the value of such attempts to define modernity because, for one, "definitions easily invoke a kind of clarity and closure" and also "a definition of common modern features poses a threat to our understanding of social dynamism" (ibid.). Instead they propose a relational and genealogical understanding of modernity that reads like the flip side of modernity:

> Instead [of classical thinking on modernity], our relational conception of modernity stresses that modernity developed some of its most characteristic features in the longer history of the relationship between Europe and its others: in the long-distance trade of mercantilism and the original accumulation of capitalism by slave labour in Caribbean agro-industry; in the colonial roots of nationalism in eighteenth-century America, nineteenth-century Ireland and twentieth-century Africa; in the emergence of statecraft or 'statistics' from eighteenth-century expeditions to Siberia or the nineteenth-century

[6] See also Ashforth (2000; 2005), Auslander (2005), Niehaus (1993) and Niehaus et al (1997; 2001), who make the same point with reference to South Africa.

> administration of India, in the orientalist imaginations of despotism against democracy, or tradition against individuality; in the European invention of racism; and so on. (Geschiere et al. 2008:3)

Geschiere et al. sort of "other" common constructions of modern Europe and the West as ideologically producing a "package deal" that

> sweepingly lumps together capitalism and commodification by monetary exchange value, industrial production, impersonal bureaucracies, taxation and constitutional systems of popular representation, mass politics, state education, institutions of rational calculation, strategic surveillance and statistical discipline, individualist relationships of contract and property, reifications of 'culture', 'tradition' and 'nation', urban divisions of labour, commodified technology, mass media, and secularism paired to privatized or commercialized religion - as if they are necessarily interconnected functions of one indivisible institutional and psychological constitution. (Geschiere et al 2008:5)

Hence, although Geschiere et al. avoid a clear definition of what modernity is or means they manage to produce a certain understanding on the other side of the ledger of what it might be all about.

Eisenstadt was more explicit in 2000 when he laid out his concept of "multiple modernities". He tried the balancing act between holding on to a common core of modernity and acknowledging a "multiplicity of cultural programs" each determined by "ongoing reconstitutions of multiple institutional and ideological patterns … carried forward by specific actors … pursuing different programs of modernity, holding very different views on what makes societies modern." (2000:2). The common core of modern societies is for him an "intensive reflexivity"[7], expressed in an emphasis on human agency that is projected as having the capacity to change the future and to generally question social and political orders as well as given societal roles (2000:3-6). Politics were open to all people and symbols and themes of protest like equality, freedom, justice and identity "became central components of the modern project of the emancipation of man" (2000:6). Eisenstadt makes out three central aspects of modern political processes:

> the restructuring of center-periphery relations as the principal focus of political dynamics in modern societies; a strong tendency toward politicizing the demands of various sectors of society, and the conflicts between them; and a continuing struggle over the definition of the realm of the political. (2000:6)

He points out an "inherently modern tension between an emphasis on human autonomy and the restrictive controls inherent in the institutional realisation of modern life…between

[7] Note that Ulrich Beck makes the same point with his concept of a "reflexive modernity" or the evolvement of a so-called "risk society" (2001).

freedom and control". This was a tension Weber already emphasised as a creative dimension of modernity (Eisenstadt 2000:8). Eisenstadt concludes that:

> the trends of globalization show nothing so clearly as the continual reinterpretation of the cultural program of modernity; the construction of multiple modernities; attempts by various groups and movements to reappropriate and redefine the discourse of modernity in their own new terms. (2000:24)

Premises of modernity can be denied or reformulated, even on anti-Western terms, traditions can be celebrated and even fundamentalist religious movements "cannot be fully understood except within this framework" of modernity (Eisenstadt 2000:22, 26). It would seem that nearly everything is possible in his multiplistic modern world.

It is this last point that I find best encapsulated in James Ferguson's article "Global disconnect" (2008) where he describes the experiences of Zambian mineworkers who once saw themselves as taking part in the world's modern progress, but who today feel dejected. Instead of telling the tale of modernisation he describes for the reader one of the failures of development. He thus depicts, like Geschiere et al., the Janus-faced image of modernity:

> But we might think as well here of health care, where the post-war modernist ideal of a universal grid (epitomized in such things as the campaigns for universal vaccination against polio or small pox) can be contrasted against today's tendency to fragmentation and privatization (which gives us not the polio vaccine, but AIDS combo therapy - managing the disease for those who can pay, while the poor are bluntly notified that it is economically more rational for them to die). Or schooling, where the universal grid of public education is today under siege all over the world. Or public space and the rule of law, where walled communities and fortified private spaces increasingly undermine the social and political promise of a universalistic 'public'. (I note that recent figures show that private police in 'the new South Africa' now outnumber public police by a factor of three to one.) (Ferguson 2008:9)

But it is this dilemma that he wants have taken seriously, or at least understood as being real. He unmasks the scholarly deconstruction of the project of modernity as a "playful intellectual choice" of the First World, whereas for the people he studied modernisation's failure is a dramatic, socioeconomic event (Ferguson 2008:15). He argues that in order to be able to criticise social inequalities and power imbalances and to show responsibility towards poverty-stricken regions we have to find ways to think about progress that reflect the well-known limitations of development and modernism. Unfortunately this is where Ferguson stops. Nevertheless, the dilemma of representation becomes quite concrete in his account. Although there is no doubt that imagination plays a vital role in what modernity is today. What it means to people, what practices it generates, and what values, ideas and conceptions of it travel the world largely depends on its translation into local contexts. The exciting aspect to this,

however, is where "reality kicks in". It indeed makes a difference whether I give a paper at an international conference in Berlin about how ARV-programs in various parts of Africa construct a certain type of citizenship that I can later turn into a valuable publication or I live in Swaziland longing for a functioning state that is able to provide ARVs for its people. It further matters whether one ridicules the modernists' naive belief in progress in the 1960s, whereas people in Zambia's Copperbelt desperately wish they had been right and still vividly remember the promising days of the copper trade.

Towards a Definition of Modernity

One of the main points of my critique of the above-mentioned attempts to explain modernity as a phenomenon is that the persistence of modernity here is only explained in terms of the power of imagination.[8] Yet, the question about why some people feel more modern or even post-modern than others cannot be answered nor for that matter can the ethical conundrums pointed out by Ferguson. A comparably easy way out of this dilemma, and one that may have something to recommend it, would be to focus on the discourses and practices of the interlocutors of modernity. Perhaps the worldwide persistence of ideas about progress, development, liberation and growth should convince social theory disciplines to hesitate before getting rid of the concept of modernisation too hastily or ascribing to interlocutors some false consciousness if they still adhere to an unworthy chimera of the West that "we" have long since overcome. "To become modern" or to do things "the way they ought to be done these days" were indeed framings I encountered regularly when I questioned healers on their motives to join a professional healers' organisation or to visit workshops on book keeping. A rupture was also quite evident insofar as several healers felt that something for them had qualitatively changed after the first democratic elections in South Africa in 1994. This was their main point of reference when they made statements about the "before" and the "now", about how their lives and their practices of healing changed, but also about the public perception towards traditional healing. In short, very much like Eisenstadt proposed, some of the leading figures within the healers' organisations indeed saw themselves as entering the political arena to make something happen, to promote or "uplift" traditional healing. But it is only one part of the story to depict the self-perceptions of people as modern or their

[8] I am not saying that something imagined is less real and should hence be neglected. Rather, I would argue that imagination and practice are linked, so that e.g. projections about a possible better future influence the practices of people at present. What I criticise is an overemphasis on imagination.

discourses on what modernity is and, hence, to focus solely on representations. I would like to portray the healers I studied as being part of a modernising process that is both imagined and practiced, but also limited, determined and facilitated by a modern new South African nation state. This state faces the challenge to include a large number of people that were formerly excluded: to make them modern, because they were formerly left out of political participation; to make them pay taxes and also accountable in case of malpractice; to ensure safety for people using traditional medicine; and, last but not least, to make them equal before the law. It is these structural changes to which the healers are subjected that I would like to describe as a modern process of rationalisation in a Weberian sense. This process involves the inevitability of subjecting the practice of traditional healing to a law that ensures certain rights, accountability, and gives credit to the principle of equal treatment. It also concerns the necessity of standardising certain elements of practice and the scientific tests that are undertaken to translate traditional medicine into the language of science. This, again, gives credit to the principle of accountability when the safety of medications needs to be ensured and the rights of the patients must be represented by the state. In my view, this assortment of new claims and rights make the use of Weber's theories on modernisation both compelling and inevitable.

As I intend to show, one does not need to merely accept the inadequacy of a definition of modernisation or to resort to one that is negative like Geschiere et al. and Ferguson and or, finally, to focus only on the imagination of modernity. Instead, I will argue that one can productively use a minimal definition of modernisation. I take this view for two reasons. First, I am convinced that the persistence of the paradigm of modernity, its continuing popularity and its powerful representations that have similar features worldwide cannot be solely explained by imagination. To juxtapose the project of modernity, especially in the not-yet-developed world, with its failure and negative consequences does not solve the problem of definition. Instead, it makes the change that has happened even more tangible. Second, my interlocutors (and, indeed, I as well) experienced this change as a very real rupture between now and then, against the backdrop of Apartheid. It has been a profound transformation for the healers to have access to the political arena, and be legalised (and thus no longer illegal) and scientised. As I will show later in more detail, Weber, but also Gellner to some degree, predicted this development (calling it modernisation) and delivered analytical concepts to frame and understand it. To conclude, I am convinced a minimal definition of modernisation is justified for the purposes of analysis, despite of the omnipresent critique that nevertheless fails to provide any convincing alternative.

According to this minimal definition, modernisation could be described as a process which leads to certain kinds of institutions (see also Zapf 1996:32). In my study, they are reflected by three dimensions of modernisation which depict the structural changes traditional healing was undergoing. These dimensions will serve as analytical axes that transect my empirical material. The first dimension concerns the professionalisation of healers, specifically the formation of professional organisations that represented the healers' interests as contacts and gate keepers for various institutions like NGOs, university departments, municipal health professionals and the like. I will analyse these organisations as social arenas where healers negotiated their identities, practices, tenets and values, in short, where their modernity was lived and made. The second dimension is the legalisation of traditional healing as a medicinal practice that was regulated, like any other one, by state authority. As I discussed earlier, credit was thus given to the principle of equality before the law and accountability is ensured. Third, I will focus on standardisation processes that are entangled with the legalisation procedure and its bureaucratic logic, but also tied to efforts to prove the efficacy of traditional medicinal plants. In the later chapters, my objective will be to show how each of these three dimensions constitutes the structural frame of healers' practice.

My focus, of course, will be on how these structural changes were dealt with, understood and negotiated and how they are played out on the ground in the everyday life of the healers I encountered. How are they reflected when the fears about medicines being tested and appropriated by pharmaceutical companies came to the fore in discussions with pharmacists? How did they become tangible in workshops on AIDS or during a meeting of a local healers' organisation? And how were they present or rendered meaningless when healers approached the spirits of the river to ask for support or when they detected a bewitching neighbour to be the cause of a family member's accident? The question of what happens to the so-called supernatural will, in fact, be crucial in my thesis. How disenchanted is traditional healing in the South Africa of today with a health minister praising its resources, NGOs offering workshops on how to prevent HIV-transmission, international donor agencies calling for conferences and the WHO proclaiming its integration? In essence, my study shall be a reflection on another "multiple modernity", a picture of traditional healers in a South African city becoming modern.

1.2. Meeting the Healers – Methodology and Key Informants

My thesis on the modernisation of traditional healers and the various changes their practices, discourses and representations were undergoing is based on 13 months of fieldwork in Port Elizabeth, the provincial capital of the Eastern Cape in South Africa in 2003, 2004 and 2005. Port Elizabeth (PE), together with the suburbs Despatch and Uitenhage, today constitutes the Nelson Mandela Bay Municipality which is a huge industrial area very much shaped by its automobile industry with over one million inhabitants (Statistics South Africa 2007). The largest part of its population lives in the surrounding townships that were formerly meant to host only the non-white population. Those townships, in particular the ones inhabited by Xhosa-speaking people[9] where traditional healing promised to still be practised, became my field site.

The study is not based on a statistically representative random sample. The conclusions I draw are based on typical patterns that I found in my material, which was generated over the course of my encounters with numerous healers, patients and representatives of the state or from the sciences. My aim was to gain access to the life worlds of the different actors involved and to enter into a dialogue with them (Burawoy 1991:284) which would then enable me to draw conclusions about the world in which they were embedded (1991:281).

In the following, I will introduce the methodological concept of "social worlds" coined by Anselm Strauss, which helped me to structure my access to the field and to identify important fields and actors to study. These "arenas" built methodological units on a horizontal level whereas the dimensions of modernisation I just described provide vertical, analytical axes that transect them. I will then discuss the methodology of my research. Important issues will concern gaining access to the field, the methods used in producing the data for the subsequent analysis, as well as my use of English as the primary language through which my research was carried out.

[9] Xhosa is one of 11 official languages in South Africa and the second biggest one after Zulu. It is mainly spoken in the Eastern Cape Province. Xhosa, as well as Zulu, belongs to the group of the Bantu languages.

The Social World of Healers and their Social Arenas

The social-worlds framework developed by Anselm Strauss (1978; 1978; 1993; 1994) and others constituted a productive analytical approach for my research. "Social worlds" are defined as "universes of discourse" and "shared discursive spaces that are profoundly relational". They are "groups with shared commitments to certain activities, sharing resources… to achieve their goals and building shared ideologies about how to go about their business". Social worlds are "principal affiliative mechanisms through which people organise social life" (Clarke and Star 2008:113,115). When social worlds interact with one another around issues of mutual concern this emergent interactional field is analysed as an "arena". With regard to my topic, the main issue in question is traditional healing. My thesis centres on how the social world of healers was shaped, along with the arenas in which different actors negotiated the meaning of traditional healing in South Africa today and how healers personally related to them. I structured the course of my fieldwork based on the social world of healers with this terminology in mind. During the first phase of my fieldwork, I identified relevant arenas, i.e. interactional fields and actors that promised to be central to the construction of present-day traditional healing. Health and healing constituted one arena with various options for patients in which the cause, nature and therapy of a sickness was negotiated between different therapists, the patient and his support group. Another arena important for healers was the array of activities they were involved in: workshops, conferences, tourist projects and the scientific testing of their plants. The legal arena wherein a legal framework had to be established and certain standards for traditional healing were set played a significant role. During the fieldwork, I focused on the actors present in these arenas, on their motives, reservations, discourses, ideas and practices. I wanted to trace their networks, their presence in different arenas, and their interrelatedness.

The social-worlds framework focuses on the nature of relations and actions "across the arrays of people and things in the arena, representations…and many sorts of interwoven discourses" (ibid.). When social worlds overlap due to objects or concepts of mutual concern, we can speak of "boundary objects". The establishment of an efficacious and safe medicine is a good example of a boundary object that is a site "of intense controversy and competition for the power to define" it (Clarke & Star 2008:121). But also the case of being sick and having to find a cure can be described as a boundary object as the patient moves between different social worlds, each of them framing his/her sickness differently, which leads to suggestions of different kinds of therapy. Translation is the key process that allows "boundary objects to be

(re)constructed to meet the specific needs of demands placed on it by the different words involved" (ibid.). It is these processes of knowledge transfer and negotiation that interested me the most. I wanted to focus on the coordination capabilities of involved mediators who enable translation (Latour 1987, Rottenburg 2002:254, Schüttpelz 2008:238,248,256). Under what circumstances can one concept move i.e. be translated into another social world? How can the practice of healers, which is heavily determined by ancestral guidance, be translated into a legal framework? Can pharmacists and healers settle on an understanding about what the efficacy or safety of a medicine means and if it has to be ensured?

First Contact

In 2003, I visited the universities of Stellenbosch, Cape Town and PE to find out about a possible cooperation with local healers' organisations. The joint venture of the pharmacy department in PE thus promised to be a good point of entry. Dr. Maryna van de Venter had built up a unit based on traditional medicine where masters and PhD students could do research on the efficacy of traditional medicine, on the one hand, and develop and conduct workshops for healers, on the other. Workshops were conducted about various topics. For one, there were health related themes like HIV/AIDS, diabetes, TB or home-based care. But, healers were also invited to visit the labs where some of plants they had brought were being tested. In 2004, a medicinal garden was established by the department and a local healers' organisation. Various planning meetings were held before it was finally opened in September 2004. In brief, this cooperation was exactly what I was looking for, which was to study the changes traditional healing was currently undergoing against the backdrop of an increasing emphasis in the public discourse on health and HIV/AIDS in particular. I was interested in the interface between biomedicine and traditional healing, how the encounter would look and how different stakeholders would negotiate their views and motives. I wanted to discover the way in which the content of the workshop would translate into some form of practice and why healers might resist or adopt certain elements. Ultimately, I hoped to understand what was at stake for everyone involved.

When I started my fieldwork in 2003, Port Elizabeth the city was not new to me. I had already lived in one of its townships, KwaDwesi, for three months in 1998 with a host family while I was doing an internship with local home building projects and saving schemes. A good friend from that time was still living in PE when I returned in 2004 and helped me to find my flat

mate for the longest period of my fieldwork. Already knowing PE proved to be helpful for a variety of reasons. First of all, I knew my way around, especially in the townships. I was familiar with the main highways connecting the various different suburbs. I also knew the streets to avoid because of traffic jams and how to get around the biggest taxi ranks as one would not have wanted to compete with the fierce local taxi drivers hunting passengers during rush hour. When people told me where they lived, I had an idea about where, which always made people wonder. First conversations started and people would soon put me in a different category than the average white South African, who generally tended to avoid black people's neighborhoods. Another benefit to knowing places like KwaMagxaki, Joe Slovo, New Brighton or N'Joli Square was that I had some notion of people's financial backgrounds. Certain townships consisted of quite well-off and spacious homes and others of newly built but small government houses. But there were also informal settlements, areas built of shacks or brick huts that were hardly accessible by car. I was also familiar with local taxi routes, their stops and hand signals as I had to rely on taxis as a means of transport during my preliminary fieldwork in 2003.

Another important consideration during my stay was safety. I knew where I could go and where I probably shouldn't. Numerous accounts by members of my host family and friends as along with my own personal experiences with crime and mugging cured me of my earlier naïveté about mere "Robin-Hood-Crime" targeting only those "who deserved it". This was finally also the reason why I decided to live in a flat in Central with a university lecturer from Soweto instead of moving to one of the townships where most of my interlocutors, the healers, lived. Not meeting the anthropologist's ideal of living in the field I found sad sometimes and I will discuss the limits my living arrangements placed on my fieldwork at a later point. I was, nevertheless, aware of these constraints, not to mention the residual concerns I had about crime stemming from my previous visit in 1998. It took months until I could walk the streets back home comfortably again without constantly watching my back. Hence, I decided that for the long duration of my fieldwork I would rather live in an environment where I felt relatively safe. What made that decision bearable was that I could at least look back on having had the living-in-a-township experience once, even if just shortly. I had an impression of how family life functioned; how people spent their weekends and evenings; how young and old, male and female related to each other; and, I also knew about some do's and don'ts and what blunders to avoid.

Accessing the Field

The pharmacy department and its traditional health unit in particular were extremely cooperative. Not only was I allowed to take part in all their projects and workshops, but the staff was also willing to do interviews with me. Most importantly, they connected me with the two heads of the local healers' organisations. My personal acquaintance with both women facilitated my work tremendously. I was allowed to attend healers' meetings and ceremonies, invited to their families and met their students and fellow healers. With some healers the relationship would become more familiar than with others. I only encountered mistrust and an unwillingness to cooperate once, specifically, with a woman who claimed aloud during a meeting that I could be some sort of spy who would always know the dates on which meetings, workshops and ceremonies took place. Fortunately, other healers came to my defence and confessed that they were the ones who invited me to the respective get-togethers. Although an unsettling experience at the time, the incident later turned out to not have any real effect on my research.

I attribute the relatively easy access to several factors that I want to take a moment to point out. First of all, the appearance of a European looking young woman visiting people in the townships was greeted with curiosity and delight by almost everyone, something I had already experienced in 1998. To see other white people in the townships was rather uncommon, which made me a welcomed and exotic presence to whom everyone wanted to speak. Being female helped a lot, too. The majority of healers I worked with were women. Probably only one or two in 10 was male. This made socialising with the healers much easier. During family feasts, for example, women stayed together, as did the men. This permitted me to stay close to the female healers I accompanied anyway, and to spend time with other women as well.

Fig. 1: Women at a family feast.

As a male my access would probably have been occasionally limited or I would have only spent time with the few available male healers. I also found that the behaviour of people, especially women, would change dramatically when a white male, such as my boyfriend, was at my side. Female healers, normally cheerful and outspoken, would become shy and less talkative, older women of the family would be nervous and avoid eye contact and nobody would converse. I vividly remember a similar experience in 1998 when I found it highly disturbing that my normally authoritative grannies would not dare to talk to my boyfriend when he came to visit. As a woman, however, I did not encounter any major difficulties, despite the occasional flirtatious attempts of a few men present at ceremonies or feasts. The few male healers that I interviewed, however, were supportive and appeared to take me seriously, perhaps also because I was enough of an outsider to be able to cross normal gender boundaries that would typically divide the sexes, making it difficult, for instance, to visit a man at home without raising rumours.

I also felt that I had the right age. Being 27 at the time, I was young enough to not be looked at as requiring too much deference, but old enough to be taken seriously. Most students of the healers were more or less my age, or slightly older, whereas the majority of healers were above 40 or even 60 years of age or older.

Problems of access, however, could have been related to my connection to the pharmacy department or certain key informants, which might have raised objections or reservations with some people. Although the healers described their cooperation with the pharmacists as positive and fruitful, I did not want to become solely identified with them. I wanted to make clear that I would not necessarily share their goals or objectives, but that, at the same time, I valued their work and the projects they were initiating. I tried to convey that I was mainly interested in spending time with them as healers and learning about their perspectives on their work. Also, the purpose of my stay made it possible for me to spend considerably more time with the healers and I was more flexible over a longer period compared to the pharmacists. Generally speaking, I think the problem of being too closely associated with the pharmacy department in one of the early phases was irrelevant to my fieldwork.

A bigger challenge was to gain access to other healers outside of the healers' organisations, which in some measure pre-determined the field. On the one hand, I mainly wanted to study healers taking part in the encounter with biomedicine, which is why the group of organised healers was my focus. Nevertheless, the perspective of healers outside of the organisations seemed extremely valuable and I wanted to learn why they objected to joining them.

Furthermore, the process of legalisation was affecting every healer and it seemed likely that organised healers would have a different take on things than non-organised healers. From the beginning, I was aware of these limitations on my access. During the course of my fieldwork I therefore tried to gather as much data as possible about non-organised healers. One route of enquiry was the data I collected about patients and their therapeutic choices regarding health. From early on in my study, I wanted to establish alternate route of access besides the pharmacy department and the healers' organisations in order to meet patients and other normal, ordinary people I could talk to. My first attempt to find this alternate route of access was a workshop for health workers that I attended in my second week of fieldwork. I learnt about the workshop from a healer, but she was the only organised healer in attendance, whereas the rest were ordinary women aiming to acquire extra qualifications in case they could someday get compensated for their voluntary work as health and AIDS counsellors. I obtained the contacts of about ten of them, whom I interviewed to get data on their health seeking behaviour. A friendship developed with one of these women. Grace would become my language teacher and I met with her on a regular basis. Through her church, family and friends I managed to build up a small network of people independent from those I came to know through the healers' organisations. At two big family gatherings I attended with Grace I became independently familiar with two groups of healers that I could later interview. Although I had never met them at any of the previous healers' meetings, it turned out they were not affiliated with either one of the organisations. But as they lived farther away, they did not attend the meetings I would usually go to. These two small groups at least provided me with some data for cross checking my findings. Interestingly, Grace's mother was a healer, too, and she turned out to be one of the few who was not interested in becoming a member of the organisation. Due to time limits, however, my contract with the groups I just described was limited, consisting primarily of a single interview. Most of my time was spent with the organised healers. As I was mostly interested in the interface between biomedicine, pharmacy and traditional healing that became apparent during workshops, garden planning sessions and group discussions, I devoted most of the time studying these areas, especially during the first two-thirds of my fieldwork. I met the two separate healer groups mentioned above during the final third of my stay.

Another route of inquiry included friends. Through my previous friend from 1998 and my flatmate I met their circle of friends, who all grew up in either PE or East London. Although belonging financially, for the most part, to the new evolving black middle class no longer in the townships, their families however still lived there. During visits to their homes, I gathered

data about their views on health and health seeking. While some spoke about occasionally visiting a healer, I did not meet any new ones through the families of my friends. What was valuable, nevertheless, were the insights I gained on the status of ancestral worshipping and the practice of customs in general. I learnt about the rituals everyone would perform, irrespective of education or financial background. I used this empirical material for my chapter on people's health-seeking behaviour.

Participant Observation

In the course of expanding my pool of contacts, I conducted participant observations, including numerous conversations and informal interviews in various settings. These can be differentiated in terms of formal and informal contexts. Formal contexts included numerous workshops conducted for healers by either the pharmacy department, the municipality or local NGOs; meetings and group discussions between members of the pharmacy department and healers on the planning of a medicinal garden and the new legislation; meetings of healers' organisations and their sub-branches; two big healers' conferences; and, finally, numerous healers' graduation ceremonies as well as family ceremonies, which included slaughtering rituals.

Informal contexts were quite varied and included, amongst other things, time spent with people at their homes. As I wanted to get an understanding of the everyday lives of healers, I used every opportunity to simply stop by and spend time with them. Occasionally, I would be invited for dinner with the whole family and sometimes I cooked. I was also eager to offer my services as a driver, which allowed me to follow the routes of the healers, their daily routines and their tasks. I drove guests of healers' conferences to the airport, and picked up another healer who came from a conference in Cape Town. Finally, I went grocery shopping for a three-days-graduation ceremony in the bush, picked up traditional dresses for a conference from a tailor, drove people to the hospital and back home, and helped distribute leaflets and collecting condoms from a local NGO. During these occasions there was also plenty time to converse. The insights I gained were tremendously valuable to building the largest part of my empirical material. Another valuable aspect was, of course, that I could make myself useful and offer something in return for people's time and the thoughts they shared that made my research possible.

Regarding the limits of participant observation, the question of security must be addressed again and the fact that I did not stay at a healers' home. Although I tried to spend as much time as possible with the healers, I was usually urged to drive home before dark. For a few graduation ceremonies, however, that involved hours of dancing, drumming, singing and drinking, I stayed late, although not without calling the healers when I finally arrived back home safe. I surely would have acquired a few more insights if I had lived with a healer. One healer, for instance, claimed that a lot of patients would consult with her only in the evenings when I implied that there were hardly any patients when I would see her. Unfortunately I could not verify her claim.

Lastly, it should be mentioned that I did not have access to healers' consultations with patients. They were strictly confidential. Hence, all the information I obtained on how healers treated patients derived from conversations with them on their practice and on the content of their training, as well as from those I questioned on their experiences with traditional healing. But as my focus was not the healing business as such, I did not find this limitation too problematic.

On Sampling and Conducting Interviews

Besides the participant observations and informal conversations, I did a number of interviews with the actors within the different arenas I mentioned earlier. The first and most important group of actors was, of course, the healers. During the first weeks of my fieldwork I became acquainted with more healers as I attended meetings, workshops and ceremonies. Only after some time, when our personal relationship had developed to a certain point, would I ask the healers for interviews. As indicated, however, towards the end of my fieldwork I also did one-off interviews with healers previously unknown to me as I aimed to diversify my data. By that point, I was also more familiar with the realm of traditional healing so that the initial phase of forming personal ties was less important. Also, towards the end I was more interested in determining if any healers would become members of an organisation or not and how they viewed the legalisation process. With regard to more time-consuming and personal issues, like biographies or the nature, cosmology, and beliefs of traditional healing, I had already accumulated enough data by then.

A second group of interviewees were people from the health sector who dealt with healers, conducted workshops and the like. Starting from the pharmacy department, I continued

interviewing people from the municipality and local NGOs. Some of the interviewees of this group I met only once, while with others I had the chance to do follow-up interviews during furture visits to PE. I met, however, the leading figures of the pharmacy department on a regular basis whenever a meeting with the healers was planned, but also sometimes afterwards to discuss our impressions. I also met with the people from the two NGOs, ATTICC (AIDS Training, Testing, Information and Counseling Centre) and Imbewu Community Volunteers more frequently as they would also be present at conferences or certain ceremonies. In Cape Town, I had the opportunity to speak to a German pastor who worked closely with healers and who shared his experiences with me.

The third group of actors I wanted to look at consisted of possible patients, in other words, the ordinary people with whom I became acquainted during the course of my fieldwork. However, I only conducted a small number of proper interviews with people on their therapeutic choices when they or their family were sick. Most of the information came up in informal conversations or occasionally when I raised questions about it, but only rarely within a formal interview setting where my aim was to complete my interview guide. I conducted formal interviews on therapy choices, however, with several women attending a health workers workshop, with a teacher I came to know through Grace, an old man from Thobeka's[10], a healer, extended family and with the caretaker of an old age home where the medicinal garden of the pharmacy department and the healers was built. A valuable source of information on that topic was also the healers themselves. During my interviews I would also regularly ask the healers about their therapeutic choices. These accounts turned out to be extremely helpful in later analysing the healers' views on biomedicine.

Within the group of healers to be interviewed, I tried to follow Werner and Bernard's advice to "maximise variation" between selected key informants in order to increase the quality of the ethnographic sample (Werner & Bernard 1994:8). These considerations played less of a role within the second group of interviewees, the health officials, where it was more important to talk to all relevant people. As indicated earlier, rather than undertaking a process of systematic interviewing amongst the possible patients, I tried rather to get as much information as possible from the people I knew, relying on the fact that this would already provide some variation in terms of education, gender, and age.

[10] All names of healers are anonymised.

As I was mostly interested in the social world of healers, I also conducted the majority of the interviews with them. I further paid more attention to diversifying my sample of interviewees. Three relevant age groups or generations of healers were identified: healers between 40 and 60, in the middle of their professional careers; their "parents"[11], i.e. the healers that trained them, today over 60 years old; and their students or apprentices, who, apart from a few exceptions, were mainly in their 30s. Most interviews were with healers of the first age group (40-60) as they were the most visible and active in workshops and within the organisations. In terms of gender, I tried to adhere to the observed ratio 3 out of 10 regarding male to female healers in the first age group. Regarding the group of students, I was unable to interview a male simply because I did not meet any. The only male I came across at the beginning dropped out of training, apparently (as his teacher told me) due to financial constraints, and was not seen anymore. The rest of the students were female. From the parent generation of healers above 60, very few were visible or available. I therefore kept the three that I was acquainted with.

In total, I conducted 53 formal interviews with 35 people. Depending on the time constraints and the talkativeness of the interviewees, more than one interview was done with several people. I always aimed at completing the set of questions I had prepared for the respective group of respondents. Two people from the municipal health department were the subjects of follow-up interviews in 2005 on the implementation process of the healers' legislation. Within the group of healers, I conducted 32 formal interviews with 19 healers. From these 19 healers, 11 were between 40 and 60 in age (8 female, 3 male); 3 were above 60 (1 female, 2 male); and 5 were students (all female). Within the second group of interviewees – the people from the health sector working or dealing with healers – I did 14 formal interviews with 9 informants. As I indicated above, age and gender were unimportant categories here as I wanted to interview simply those people who worked in some way with healers or who were responsible for establishing relevant policies. For the record, however: most people working in the health sector were female, whereas in the NGOs as well as in the health department the ratio between men and women was fifty-fifty. Regarding the third group – the possible patients – I have already mentioned that I did only a small number of formal interviews, instead relying on informal conversations with people around me. Amongst these interviews (7 in total) 5 were with women, and 2 were with men. This distribution was related to the fact

[11] Students or apprentices refer to the healers who train them as "mother" or "father". Whereas in Xhosa, the older generation is respectfully addressed as "mama" and "tata" anyway, I was told that the relation between students and healers is indeed perceived as being one between parent and child.

that the women I interviewed were met in the context of the health workers workshop. These workshops, at least the ones I had been to, were solely frequented by women. As for the two men one belonged to the wider family of Thobeka and was a healer I had become close with. The other worked in the old age home where the medicinal garden was located.

MiniDisk recordings were made during 33 of my interviews, whereas during the remaining 20 I took notes only. The decision about whether to interview with or without making a recording depended on several considerations. First of all, I wanted to avoid intimidating people I didn't know well by taking out a recorder and a microphone (although small, it had to be put in the middle of the table). Safety considerations such as the fear of getting mugged, especially when I went to unfamiliar areas, played a role, too. Taking out an expensive digital recorder also did not seem appropriate with people who were poor. Apart from the second interview group, the health sector people, whom I interviewed at their places of work, I did most of the formal interviews at individual homes. I conducted only four interviews with healers at UPE because they were able to take place right after workshops being held there. All the interviews with people from the health sector were recorded for two main reasons. First, their time was more limited and I had to take into account the fact that I might not have the chance to follow up with a second interview. I also did not want to lose time due to the need to write. Second, the more formal environment and character of the meeting allowed using a recorder. Sometimes this even seemed to be expected. I had the impression people would feel less intimidated by the fact that they would be recorded. However, when it seemed appropriate, I also recorded my interviews with healers. Of the 32 interviews I did with healers, 23 were recorded. From the formal interviews with patients one was recorded.

Apart from interviews, I also recorded 3 group discussions with healers as well parts of 6 ceremonies and conferences. At the latter two, Xhosa was mainly spoken. I recorded them so that my flat mate can later translate what was being said.

Conducting Semi-Structured Interviews

With regard to the control of the interview exercised by the interviewer, one can define a spectrum beginning with least control and moving toward increasing control. One thus ends up with "conversations", "informal interviews", "unstructured (formal) interviews", "semistructured (formal) interviews" and "structured (formal) interviews" (Bernard 1995:208-288; Flick 2000; Spradley 1979). All of my interviews intentionally fell under the category of

"semistructured interviews". These interviews thus proceed as Bernard (2000:191) characterises this type, namely, through maintaining much of the "freewheeling quality of unstructured interviewing" in getting people "to open up" and letting them "express themselves in their own terms, and at their own pace". After topical excursions, I would also return to my "interview guide," which consisted of "a written list of questions and topics that need to be covered in a particular order".

My decision to conduct semi-structured interviews with selected key informants was based on my desire to produce open yet sufficiently comparable data. In order to ensure that my questions adequately covered locally relevant and meaningful topics, I used my first stay in 2003 and the first month of my long phase of fieldwork in 2004 as an exploratory period before developing and modifying the interview guides for the three identified groups of interviewees (see appendix). The interview guide for healers consisted of seven parts covering the topics biography, training, practice, their attitude towards so-called Western medicine, AIDS, towards being organised and legalised. For interviewing people from the health sector I used two interview guides: one for officials working in the municipality and one for people working with healers, conducting workshops and the like. The one for health officials consisted of questions on health infrastructure in general, on the involvement of traditional healers, the legalisation of traditional healing, and their own behaviour towards health and healing. The guide for other people working with healers included the topics: history and kind of the cooperation, evaluation and motivation of this cooperation, and again their own attitude towards health and healing. My interview guide for patients only consisted of personal questions about profession, age, and questions about health management. It goes without saying that I did not follow the interview guides to the letter. Sometimes the order of the questions would vary if the interviewee had already answered some of my questions on their own in responding to earlier questions. Some of the questions also served as prompts in case people did not really know what I was aiming at. In this case, certain reformulations or examples helped to get the person talking more.

Language

I conducted my fieldwork in English since during the interactions between healers and biomedicine which were the focus of my research, English was the language that was mainly spoken. Although I had originally planned to learn to speak Xhosa, I did not reach a level that

would have been adequate for communicating about world views, cosmology and medicine and healing. I had language lessons twice a week with a woman I met at one of the workshops for community health workers. The reason why I asked her for help, however, was not only to learn Xhosa. I also wanted to establish some contact to average people outside of the healers' network, for I was interested in people's therapeutic choices and the relevance of traditional healing for people in general. This strategy paid off well as I learned a lot about Grace's family and friends and their look on and dealings with health and healing. My Xhosa reached a level suitable for small everyday conversation. I could introduce myself properly and address people. When people spoke Xhosa amongst each other, although I could not quite follow the conversation, I usually knew what it was about and could catch a few words here and there. The majority of healers with whom I became acquainted, however, had quite a good command of English. Some, especially those who had received secondary education or studied were fluent, which is why most of my conversations and interviews were conducted in English. I also conducted some interviews with the help of an interpreter. Either friends of mine volunteered or Shirley, a pharmacy student who was part of the traditional medicine unit, translated for me. She also accompanied me to various meetings of healers and helped me to follow its content. I was also allowed to record key discussions or meetings and after long translating sessions with either my flat mate or other friends, I would then transcribe them later at home. Mostly, however, it was the healers I had befriended who would stand next to me during a ceremony and explain in detail what was being said and done or who would simultaneously translate praise speeches that were given whenever healers gathered.

1.3. Structure of the Thesis

The aim of my thesis is to provide a picture of traditional healing in today's South Africa, particularly with regard to the transformation and modernisation this profession has been currently undergoing. I will, therefore, first give an overview of traditional healing in practice: how it served as one kind of treatment for people who seek health and healing (Chapter 2) and how it related to various interactions with actors of biomedicine, public health administration and different NGOs (Chapter 3). I argue that these changes can be regarded as a specific form of modernisation that is especially characterised by the rationalisation (Chapter 4) and legalisation (Chapter 5) of traditional healing. The legalisation of traditional healing thereby served as a prerequisite for its integration into the new post-Apartheid state as well as for its equal treatment before the law (Chapter 6).

In the following I will outline the chapters in more detail. Chapter 2 focuses on the arena of health seeking in that it highlights the therapeutic options patients had when they were sick. Depending on a range of factors patients make use of various forms of healing when it comes to the illnesses to be treated. In terms of biomedicine, SA has public hospitals as well as private hospitals and doctors. People also made use of alternative medicine. For Xhosa people this meant visiting a traditional healer or an herbalist. When either the doctor or the healer failed, people tried out the other in order to have various interpretations at hand. A large body of literature attends to this phenomenon, which is called medical pluralism. The process of negotiating the type of a sickness between patient and healer that often also involves the relatives of the patient will be outlined in detail. The options people had when seeking for health and healing and what factors determined their decisions about which practice or practitioner to choose at a particular point in time will become clear. This chapter shall provide the reader with a basic understanding of the setting.

Chapter 3 explores the arena of encounters of healers with a variety of actors. I found that the healers were entangled in numerous relations with the pharmacy department of the local university, the municipality and its AIDS council as well as the local museum. They were busy with the meetings of their professional organisations, various workshops and training sessions and a medicinal garden for tourists. The reasons for the various cooperations were manifold, as were related reservations and complications. The cooperation with biomedicine enabled healers to acquire resources, and also to gain status. Furthermore, they themselves consulted biomedical doctors when sick. To my understanding, this new range of opportunities connected with numerous cooperations with biomedicine weighed more heavily than fears of being exploited, partly also because the healers experienced the government's African Renaissance discourse as quite encouraging and uplifting.

Chapter 4 shall serve as an intermediary chapter, as it will attempt to summarise and interpret the findings of Chapters 2 and 3 before moving on to the legal arena on the state level, where the legalisation of traditional healing as a part of nation building will be discussed. Both healers and patients (and also healers as patients) had an underlying epistemology for interpreting and treating diseases. They allowed for the coexistence of the two spheres – biomedicine, on the one hand, and traditional medicine, on the other – by incorporating biomedical knowledge into their overall belief system without having to directly compete with it. Through adhering to a dual epistemology that distinguished between "cultural" and "normal" sicknesses, domains of competence for both traditional healers and biomedical

doctors were created. Incorporating biomedical ideas about certain sicknesses, about AIDS, too, did not touch the foundation of the dual logic of the healers. It could even be seen as consolidating that paradigm, because even though medicine became more and more advanced, the realm of incurable or chronic diseases did not disappear.

Chapter 5 will focus on the legalisation of traditional healing. In 2007, the Traditional Health Practitioners' Bill has been enacted which legalises traditional healing, providing the healers with an identical legal framework to biomedical doctors. Healers are now forced to become registered and their training is standardised. In crucial points the bill stands in stark contrast to the basic principles of traditional healing. At the same time, the healers experienced the kind of acknowledgement they had always hoped for. These points were vividly discussed within the healers' community. The history of the bill is strongly connected with ideas of "African" identity, "real" tradition and an "own way" of healing contrasting with Western or foreign ones. It was in this atmosphere that healers experienced these changes as something positive and trustworthy. But other motives of the government will be highlighted, too, in part by drawing on examples of other states that have legalised traditional healing. This can also provide a possible outlook on how traditional healing will develop when standardised and incorporated into the health system of the South African state.

Chapter 6will bring the state more into focus, thereby both building on the argumentation of the previous chapter and the African Renaissance and reinforcing it. I will argue, that the incorporation and legalisation of traditional medicine into the South African health system was part of a nation-building process aimed at integrating certain parts of its society into the modern nation state that were formerly marginalised or illegal. To reach this end, I argue, meant the standardisation of traditional medicine and its subjection to bureaucratic logic.

Chapter 7 will finally summarise the major findings of the thesis.

1.4. On Terminology

Traditional healing

Some final remarks about the terminology of this thesis: I opted for using the term "traditional healer" or in short "healer" because this is what people referred to when speaking in English. In Xhosa, a healer is called *igqirha* and in Zulu *sangoma*. The healers I worked with used

these terms interchangeably, no matter if they were of Zulu or Xhosa origin. The term *sangoma* simply became noticeably popular in South African media.

Within the field of Social Anthropology, of course, the use of the term "traditional" is highly contested, which is why I want to point out that I do not intend to locate traditional healing in a static, archaic or ahistorical past. To the contrary: central to my research were the changes that, on the one hand, the practice and, on the other, the concept of traditional healing were subjected to within the course of a growing institutionalisation and legalisation. Furthermore, I want to highlight the instrumentalisation of traditional medicine as a resource by both political actors and healers themselves. Hence, I do not understand the traditional as a remainder of an unchanging past but as a changing phenomenon of the present that is being constantly negotiated in different arenas by various actors against the backdrop of their diverse interests. After all, it is these negotiation processes that are at the centre of my dissertation.[12]

Biomedicine

When I talk about biomedicine, I refer to a tradition of medicine that is based on the natural sciences, e.g. biology, chemistry, physics and others. It is exceptional amongst other medical traditions, however, insofar as it systematically classifies and quantifies the human body (Lock & Nguyen 2010:82), which provides continuous data for its constant revaluation. Its development as a science was intertwined with the formation of modern states which could provide the infrastructure for "applying statistical methods to vast populations and for increasingly sophisticated clinical and laboratory practices" (ibid.). Obviously the way that biomedicine is practiced, taught and negotiated varies from place to place and differs from person to person. When I describe the interactions I studied between healers and doctors or pharmacists I try to make clear that it is individuals who shape them and who negotiate the boundaries and commonalities between different medical traditions. Nevertheless, when I generalise and subsume the knowledge and practices of various biomedical practitioners under the term "biomedicine", I want to demarcate it (and dissociate it) from indeed different medical traditions without assuming that one coherent body of biomedicine exists – just as little as one traditional medicine.

[12] See Pool (1994), Wreford (2008) and Ashforth (2005) who also use the term "traditional healer" and who argue in a similar manner.

2.

The Labyrinth of Health Seeking

In the following chapter, I want to examine the behaviour of patients - of people who perceived themselves as sick or in need of assistance to restore their wellbeing. I want to shed light on how people diagnosed and treated sickness, how they perceived health and the absence of it, what options they had for getting better and how using them depended on various factors and negotiations within their social world.

First, I want to lay out the health infrastructure of Port Elizabeth in order to show what options people theoretically had when feeling sick or in need of help. What modes of therapy existed in the public and private sector? What were the alternatives to biomedicine? And what enabled or restricted people from using the various options they could resort to? At a particular point in time, what factors determined access or decisions as to which practice or practitioner to choose?

After introducing some case studies, I will take a tour through the history of studies on medical pluralism. By carving out certain areas of inquiry, I shall provide several theoretical avenues that help to structure and analyze my findings and illuminate the "labyrinth of health seeking".[13]

2.1. The Quest for Healing – a Variety of Options

Home Medicine

The first option of medical treatment I want to outline is the use of so-called household or home medicine, as this is the first alternative people explored when they feel sick. I would like to stress that this form of medicine i.e. lay, non-professional and non-specialist health care is the most common, although not well studied (Kleinman 1980:50f.). People had a first perception or definition of a disease and might treat it with household remedies first or go to a nearby pharmacy to get over-the-counter medicine. If they were dissatisfied, other health-care options were pursued. This first stage of therapy management, which takes place without the

[13] I borrow this term from Susanna Hausmann Muela et al. (1998) who speak of a "labyrinthic health-seeking path".

consultation of a specialist, is what Kleinman calls the "popular sector" of health care (1980:50). He further distinguishes between professional and folk sectors of health care, whereby the first consists of "organized healing" professionals and the latter of "non-professional, non-bureaucratic" specialists (ibid.).

De Villiers (1984) looks at so-called popular medicine amongst Xhosa farm workers and describes at length the various measures people take, for instances, in case of snake bites, fractures, nose bleeds or when a baby is teething (wearing a bush-buck necklace) (1984:125ff.). Home medicines (*amayeza asekhaya*) can be familiar plants or patent medicines they buy in drug stores or pharmacies (1984:135).[14] The people I questioned about their use of household remedies mentioned ginger and garlic for treating skin rashes as well as citrus oil mixed with cream. An African potato was used to boost the immune system, plain yoghurt to treat thrush and, last but not least, olive oil and garlic for general health.[15] The use of these medicines was learnt from parents, grandparents or others. Sometimes medicine was brewed out of leaves or roots of commonly known indigenous plants (de Villiers 1984:137-143). The use of "Dutch remedies" was also prominent. This medicine was originally taken along by the Vortrekkers in medicine boxes brought from Cape Town (1984:151), e.g. "*Lewensessens*" (Essence of life) used for digestion and headaches or "*Borsdruppels*" (chest drops) to ease coughing and colds (1984:152). De Villiers suggests that these manufactured medicines have become more popular compared to those prepared at home from plants simply because they are readily available (ibid.). Also painkillers, Vaseline, Castor oil and Epsom salts are quite common (1984:153).

Biomedicine

Compared to other African countries, the health care system in South Africa is relatively well developed. Still, the health status of much of the black population remains poor, a reflection their respective level of poverty and other social factors, which impact negatively on peoples'

[14] A recent development taking place in the course of a commercialisation of diverse (semi-) pharmaceutical products involved healers entering the sphere of herbalists by promoting and selling protein or aloe-vera drinks as well as food supplements such as algae or herbal capsules. They appeared to learn about these via advertisements on TV or by coming across sales representatives when visiting a health conference. However, this was not a large scale business at present that was widely practiced but seemed to be a rather minor phenomenon. I assume it depends on the demand of their clients if it becomes a trend.

[15] Adepts of the scene are very familiar with the debacle around ex-health minister Tshabalala-Msimang and her promotion of olive oil and garlic as an option for HIV/AIDS patients. See, e.g., Natrass (2007) and Fassin (2007).

health (Horwitz 2009:28).[16] In talking about biomedical medicine, one has to distinguish between the public and the private sector. Health-related resources are mainly concentrated in the private sector. In Port Elizabeth, there were numerous private clinics, hospitals and doctors. Located mainly in formerly white areas[17] in and around the city centre, their standard of care matched that of European health facilities. However, to use those facilities, at least one member of the family needed to be steadily employed as the prices were relatively high. Health insurance that covers all those expenses was only available to state employees or people working in the formal sector. Therefore, the vast majority of the black population residing in the townships were obliged to make use of public hospitals and clinics. Likewise, they often used mobile clinics that operated in the townships, whose services were free of charge, aside from a small fee of 8 to 12 Rand (1 to 1.50 Euros). Clinics in the townships were mostly run by nurses, with a doctor coming only once a week during consultation hours. The state of those public clinics and hospitals was widely criticised by all my interlocutors, irrespective of profession, skin colour or income. Coming from the German social welfare state, I was taken aback when visiting a hospital or a clinic. While I usually found the state of things rather appalling, for a public hospital in Africa these conditions appeared to be the norm[18]. Staff and supplies of any sort were always inadequate. Patients sometimes had to bring their own blankets and food, and even basic medication such as pain killers was generally out of stock[19]. In conversations on health and health care spine-chilling tales about the hospitals were quite common. One friend of mine told me that when she visited the wife of her cousin at hospital, the floor and the sheets were stained with blood. It was not clean there at all and medication was generally out of stock (Notes, 2004-06-09). Grace, my language teacher, said that something strange was going on at Dora Nginza Hospital in KwaZakhele, although she could not prove it. People who went there would not come out again. Grace said that relatives were immediately given the clothes of a patient to take them back home. This was a proof, she thought, that the person was not expected to leave. She

[16] Horwitz states that although certain features of Apartheid still plague the South African health system, progress has been made nevertheless. Apartheid, and specifically the unequal treatment of people within the health care system, has been eradicated; the professional bodies the Health Professions Council and the Medical Association have been transformed; and there is improved access to health care and greater attention to people's needs and crises like the AIDS epidemic (Horwitz 2009:28).

[17] In the course of Apartheid policy, each city had segregated areas for the so-called White, Indian, Coloured or Black populations. At present, some areas in and around the city centre, formerly white-only areas, are inhabited by a mixed population, while the townships as the outskirts of the city are exclusively inhabited by black, Xhosa-speaking people.

[18] See esp. Benatar (2004) and van Rensburg (2004) on the shortcomings of the health sector in South Africa.

[19] The state-run ARV rollout officially started in 2004 but in Port Elizabeth only Dora Nginza Hospital enrolled patients for ARV treatment, starting with 106 patients in July (TAC 2004). Health-sector employees I talked to during my research awaited the rollout with mixed feelings. Everyone suspected drug supply shortages as well as an insufficient number of trained personnel.

suspected the nurses of letting the patients die so that they could make some extra money from the funeral parlours (Notes, 2004-04-18).

Nevertheless, people cued for hours, starting before sunrise, in order to get attended to. I was frequently asked by my interlocutors for transportation to and from clinics or hospitals. The distances were long and transportation was generally expensive. With the AIDS epidemic, people were especially desperate to find medical aid.

De Villiers also stresses the positive image people had of hospitals. She published her study in 1993, which means that she collected her material before the end of Apartheid. This is possibly one reason why the perceptions of hospitals she describes differ from the ones I encountered[20]. According to de Villiers most people regarded hospitals as a "good place" where one would get help for recuperating. Others would emphasize that this is the place where one could receive maximum treatment or where the doctors would try to find out the cause of a sickness. For some, however, the hospital would be the place people with serious conditions would be referred to as a last resort and hence they feared being transferred there (de Villiers 1993:100f.). De Villiers writes that if the condition is serious, however, other more negative perceptions of the hospital could be supplanted. She offers the interesting example of the "comrades", black youth who would normally try to convince people to refrain from going to the hospital as the "place of whites" and to consult non-Western practitioners instead for "black medicines". When seriously wounded these youth would nevertheless turn to the hospital in need of help (1993:101). Patients would also go to the hospital as "a type of place of safety" when food, money or space was short at home or when they feared an attack by witchcraft, for instance (1993:102). De Villiers further describes the factors that shape people's perceptions of the hospital, like the seriousness of an affliction, the treatment by staff and popular television series, which produce a more positive image of hospitals (ibid.). But to pursue this any deeper at this point would lead us too far astray.

Some of my interlocutors, all of whom were unemployed women in their 30s or 40s, were trained health workers affiliated to a particular clinic. As such, they provided services in home-based care as well as HIV/AIDS counselling and were equipped with the basic means of home care and First Aid. It is important to note that these women did not get paid for their work. Instead, they hoped to gain employment within the health sector after having completed

[20] Only very few people had access to hospitals during Apartheid. It is possible that the conditions in the few existing ones in the townships worsened after 1994 as they were unable to cope with the rush of new patients. People were then free to move from their homelands or the countryside to the cities, which probably led to a rise of patients. Since the new government came into power, the insufficiency of the country's health care system has been a significant policy issue (see e.g. Benatar 2004; Benatar and Rensburg 1995)

workshops and training and gained practical experience. Community-based initiatives like these with a lot of volunteer workers, usually females, were widespread, e.g. there were feeding schemes for HIV/AIDS patients funded by either the churches or the state, where people could get food twice a week and receive counselling.

Non-biomedical Medicine

Turning to the non-biomedical medicine that was used amongst Xhosa-speaking people, two types of healing must be distinguished. One had a religious dimension, which means healing was only possible through either the support of the ancestors of the healer and the patient or through God. The other type of non-biomedical healing could do without a religious component. As I explained in my introductory chapter, the healers at the centre of this study belonged to the first category: their practices revolved around soliciting ancestral support. The ancestors of the healer hinted at the cause of the affliction of a particular patient as well as a suitable therapy. According to healers and patients, the ancestors of the patient were typically at the root of the problem.[21] In some cases, healers only dispensed certain herbs or potions to cure the patient, namely, when their diagnosis showed that no "non-human"[22] actor is involved. Sometimes a simple Aspirin was also recommended.

A second group of healers that incorporates religious faith into their healing practice were the so-called faith healers or spiritual healers. Similar to traditional healers, a calling or a vision had to take place to prove that the particular person is chosen and has the gift to heal through God. Spiritual healers also underwent certain training, but it was generally much shorter than the one for traditional healers. It only took a few weeks for the trainee to get advised on how to perform certain healing rituals, while a traditional healers' training could take up to several years. Students of traditional healing were instructed about the use of herbs and they had to pass certain stages until being fully qualified, which also meant that a lot of rituals had to be performed as well as taught. Spiritual healers healed through water that was said to embody the Holy Spirit or through prayer. Sometimes they were also the heads of a small independent church, holding services that involved healing rituals for their members. I also found

[21] I will come back to a more in-depth description of the negotiation of therapy later. For now, my aim has been to layout the possible therapy options available to ordinary people.
[22] I borrow this term from Stacey Langwick (2011) and will use it hereafter for powers elsewhere referred to as e.g. "supernatural". The latter implies having a position from where a definition over what is natural and what is not, is possible, whereas "non-human" comes closest to the descriptions of my interlocutors about witchcraft and ancestral influence.

traditional healers who worked as spiritual healers at the same time. As I was told, they "have both sides in them, the traditional one and the church one" (Int. A020, 2004-09-16).

The second type of non-biomedical healing was the herbalist, an expert in the use of medicinal plants or, in Xhosa, *inxhwele*. In contrast to the traditional healer, he or she only used herbs to cure people, without having to resort to any non-human support.[23] That is why their profession could be learnt by anybody, and no calling was needed. Herbalists' shops could be found throughout the city, in the townships as well as in the city centre. They functioned as suppliers of the herbs that traditional healers needed for their practice and provided people with medicinal plants, as a lot of plants were known to be household remedies for minor health problems.

Besides the above-mentioned non-biomedical ways of healing, the existence of other "alternative" practices for homeopathy, aromatherapy, acupuncture, traditional Chinese medicine or Aryurveda seemed to mushroom in the more prosperous parts of Port Elizabeth, as they do elsewhere in the Northern hemisphere. As those modes of healing appeared to be rarely frequented by Xhosa people, they did not play a role in my fieldwork. Nevertheless, they belonged to the possible spectrum of therapy options, at least in theory, and should therefore not remain unnamed. It is also quite likely that the growing so-called "new, black middle class" will resort to these healing practices more frequently in the future. However, my interlocutors, who mainly township residents, did not mention these alternatives, nor, to my knowledge, did they use these options. Moreover, even if they had wanted to, few would have been able to pay the high fees demanded by practitioners of these "exotic" healing traditions.

2.2. Different Health Seeking Paths

Having given an overview of the options that people had when they fell sick, or to be more precise, when they needed help concerning their health or well-being, I now want to turn to the following question: What did people actually do when their health and well-being was threatened? I begin by first examining different understandings and terminologies of health and sickness and then present a sample of case studies illustrating how people made use of different therapies in their effort to find assistance for improving their condition. I will finally

[23] See also Jansen (1973:35).

analyse my material relating to two major concepts in medical anthropology: medical pluralism and the therapy management group.

A core premise in medical anthropology is based on the observation that sickness, disease and health mean different things to different people. The illness experience is always culturally shaped and hence always distinct (Kleinman 1988:5). Each body is culturally inscribed, which is why illness is not only a biological fact based on dysfunctions of the body, but also a jumble of philosophical images about a ”best state” that is usually called “health” (Greifeld 2003:13). Acknowledging Viktor von Weizsäcker’s work in psychosomatic medicine and the psychoanalysis of Sigmund Freud at the beginning of the 20th century, we cannot even blame biomedicine to focus solely on the body of patients. Instead, the patient as a whole, his or her perceptions of feeling healthy or sick and the respective social and/or familial dimension of being or feeling sick is taken into account or is at least not unknown. For the Anglophone world,[24] Arthur Kleinman draws attention to the difference between illness – “how the sick person and the members of the family […] perceive, live with, and respond to symptoms and disability” (1988:2) – and disease – “the problem from the practitioner’s perspective”. In doing so, he recasts illness in terms of biomedical taxonomies (1988:5).[25] Decades of studies on the making of biomedicine have shown that this distinction is outdated in medical anthropology, and that the cultural and the social are embedded in seemingly objectified, scientific definitions of disease. In my view, however, the maintenance of the distinction only makes sense when emphasizing the contrast between, on the one hand, an illness perceived by a patient as such, and, on the other, a disease attributed externally by a medical specialist, be it a medical doctor or a healer[26]. In other words, there can be analytical value to the illness/disease distinction, if one wants to differentiate between the self-perception of a patient and the label of disease ascribed to his or her state by specialists. For this reason, I will continue to use this respective terminology in my writing.

In the next step, I will include an ethnographic section in order to make the variety of different types of healing more concrete. For a better understanding, I will undertake a careful classification of the belief and therapy patterns that I encountered, grouping the case stories

[24] In introductory medical anthropology literature, generally only the distinction Kleinman makes is mentioned without acknowledging its European roots (Pfleiderer 1993).
[25] Kleinman introduces sickness as a third term to define a disorder in relation to macrosocial forces. When talking about e.g. tuberculosis and risk factors related to poverty, “we are invoking tuberculosis as sickness” (1988:6). I shall adhere to his use of the three terms in my thesis.
[26] Kleinman suggests using the term disease when referring to biomedical taxonomies and definitions only (Kleinman 1988:5), whereas I do not see why it should not be possible to widen the scope to non-biomedical definitions, too. The additional value Kleinman sought to promote would thus be obtained while bypassing the critique I just outlined.

accordingly. It should be kept in mind, however, that I do not see that classification as rigid and all-encompassing. Rather, it should be regarded as an orientation for newcomers, who should nevertheless be aware that people classified as belonging to a particular category of belief and therapy can under certain circumstances, and at different points of time, leave their category. However, the question of belief leads me to a second issue which I will address briefly, before moving on the issue of ethnography.

On Belief

In his well-known book "Medicine, rationality, and experience", Byron J. Good (2001[1990]) criticises using the notion of belief when describing local interpretations and practices of illness, which then appear as social facts only, whereas Western science is privileged as the standard place for physical facts insofar as it is not portrayed in terms of belief. Today Good´s assertion seems a bit outdated in view of the numerous accounts on biomedical and scientific practices, both in medical anthropology and science and technology studies which have demonstrated the social construction of scientific facts and the beliefs of scientists in viruses (Epstein 1996), gravity rays (Collins 2004) and the validity of soil samples (Latour 1999). Moreover, Good himself also slips occasionally when he mentions biomedicine's "mistaken belief that our categories belong to nature" (2001[1990]:53). Here he takes up a sceptical stance on medical science that he criticises if it is applied somewhere else.[27] Nevertheless, the problem Good raises is to my understanding rooted elsewhere.

In the following on the beliefs of people I studied in South Africa, I reconstruct their native point of view with the aim of communicating and making intelligible this cultural world to readers from different cultural settings. In other words, my main task is cultural translation. This involves coming up with the best approximations to the truth in reference to the subjects featured in my research. To clarify the question of authorship when presenting accounts from the field, I use indirect speech to specify whose point of view regarding an issue is represented. I have to write about what I heard people say, what they believe, what they told me they think and what I saw them doing. Yet, from a metapragmatic point of view, the use of indirect speech is typically interpreted with regard to its relevance as a means of creating distance by the speaker, here the anthropologist. As I see it, this is the problem that Byron J. Good aims to tackle. Anthropology, therefore, might be called the "discipline of indirect

[27] See also the review of Hopper (1998), who raises the same point.

speech" (Zenker n.d.). As a way of revealing the truth of the indirect subject, it inescapably oscillates between having reported speech merely interpreted as an explicit identification of who is talking, and as implicitly indicating, as an indirect subject, the propositional attitude of the speaking anthropologist (his or her "truth"). As anthropologists cannot principally avoid this double interpretation, they should make deliberate use of indirect speech to exclusively indicate who speaks, and, if need arises, to equally make clear their own attitudes towards the propositional content at issue (ibid.). Following this strategy, using indirect speech in concrete instances solely becomes dependent upon the anthropologist's assumed difference or cultural distance between those they represent on a certain issue and those they envisage as their readers. An anthropologist using indirect speech in a certain context should thus do this (and be interpreted as doing this) because he or she assumes that the reader possibly holds differing views. Otherwise the use of indirect speech becomes redundant. At the same time, the use of indirect speech becomes a necessity in contexts of great cultural variation and where there is a huge distance between the represented subjects and the envisioned readers, and in such situations the need to specify who speaks urgently arises. It is at this point that I have to show my colours as an anthropologist, for if nothing that I seek to describe is new or different from what I think the average reader knows and perceives, this chapter as well as part of my fieldwork would have been obsolete. Hence, I would like to describe practices that I indeed find different and worth writing about without exoticising or "othering" them – as indeed phenomenona labelled as medical pluralism or the belief in "other-worldly" powers (Zhan 2009) are not confined to Africa. But this is, in any case, a truism in medical anthropology.

On Searching for Well-being and Health

How people perceived sickness or themselves as being in need of the assistance of a biomedical doctor or a healer to restore their personal well-being depended on to which extent they believed non-human powers may have a direct influence on a person's life. Due to its primary importance, I want to shed light on the belief in ancestors, which is generally widespread in South Africa, including amongst the people I dealt with. Ancestors or ancestral spirits are the dead members of a person's immediate family and of the whole clan, going back to one male ancestor. Whereas Hammond-Tooke (1989:60f.) and Wreford (2008:48f.) point out that only the patrilineal line of descent constitutes one's group of ancestors, many of the people whom I questioned on this matter were less strict on this point. Especially in the accounts of the healers' careers I studied, it was very often a member of the matrilineal kin

that "called" the potential healer to start their training in order to pursue a career as a healer. "My mother was a traditional healer, too" was a common statement made by healers, the majority of them female.[28]

The people I spoke with during my research described their ancestors as inhabiting a separate universe, as "being closer to God, very much like the Saints in the Catholic Church…that you can easier ask for something. And they help you because you are their family." (Int. Lusanda, 2004-06-03). Ancestors "walk with" God (de Villiers 1984: 37). They "interact and are very much concerned with the actions of those they left behind" (Wreford 2008:51). Wreford summarises the account of ancestors given by her key informant Nosibele: "…each of these groups, or layers…act independently or together, as motors, motivators, operators and actors in the here and now world of their living relatives" (ibid.).

All my interlocutors and South African friends said they believe to a certain extent in the existence of ancestors, i.e. deceased family members who in one way or another have an impact on the lives of their descendants. However, the degree of worship varied. To worship ancestors calls for conducting certain rituals that are held on three types of occasions: first, at the life cycle rituals of birth, initiation, marriage and death of an individual; second, in case of sickness; and, third, to thank the ancestors for their support.[29]

Fig. 2: At a ritual to honour the ancestors. In the background a pole with the scull of an ox where the family addresses the ancestors of the house.

[28] There is a whole cosmos of other, more distant denominations of ancestral spirits that play a role in the practice of healers who seek to develop a mode of communication with not only the familial ancestors but also with "the people of the river, the forest and the mountains". Only some feel able to communicate with and be supported by *amakosi*, which are said to be the most senior and powerful spirits (Int. 025, 2004-10-08). For more accounts on Xhosa religion and cosmology, see de Villiers (1984) Wreford (2008) and Buhrmann (1984).
[29] See also Hammond-Tooke (1989:64).

All the rituals involved either the slaughtering of an ox or a goat and brewing traditional beer or, if money was short, only the brewing of beer. Not everyone conducted the rituals in the same way. The ritual slaughtering for a dead parent, however, as well as for the circumcision of young men were universal. [30] Another non-human agency[31] people believed in (indeed, as much as they believed in ancestors) concerns witchcraft. During my stay in South Africa, I did not come across any Xhosa-speaker who did not believe in the existence of witches. However, for some people this belief had no practical relevance in their everyday lives, i.e. they did not feel personally endangered. Hence, their belief in witchcraft, or rather their reluctance to deny the existence of witchcraft per se, did not affect the way they responded to illness. As I will discuss later, the situation differed for people who personally perceived witchcraft as a potential threat.

Coming to different behaviour patterns, the first group people who may believed in the existence of non-human powers yet did not ascribe direct influence by them in their everyday life. It should be kept in mind that people may change their conviction about this issue at some point. As I said earlier, grouping people in this manner helps us understand why people embark on particular therapeutic trajectories at a particular time and in certain situations. It therefore offers more of a snapshot in time than a characterisation of any one person. At a later stage of suffering or when another affliction occurs, people might find different explanations and, thus, different kinds of therapy. Therapy is thus best seen as a process.

It is difficult to make general remarks about what kind of people did not take non-human agency seriously. Roughly speaking, they seemed to be younger Xhosa people, who were better educated than average and steadily employed with a salary that enabled them to lead a life similar to mine, were less likely to be concerned about good relations with their ancestors or the danger of being bewitched. In the interest of not overgeneralising, I should note that I encountered some exceptions. Let me present two examples from the field representing the first group. As I said, I did not come across anyone who was not willing to perform the ritual for a dead parent. After a parent died, their children were supposed to slaughter a cow within approximately one year. The whole family as well as neighbours and friends were invited to

[30] See de Villiers (1984), Hammond-Tooke (1989) and Wreford (2008) for detailed descriptions of how these rituals are conducted. For older accounts, see Monica Hunter (1961[1936]), Junod (1912), Sundkler (Sundkler 1961) and Ngubane (1977).

[31] Another non-human power people generally believed in was God. But people did not refer to Him as being responsible for or causing a sickness, which is why I will not pursue this issue. Furthermore, my data of people going to faith healers in order to get healed is very limited. I therefore cannot go into detail concerning this option of healing.

the ceremony. The festivities lasted for three days, traditional beer was brewed and all the guests haad to be attended to. The aim was to bring the soul of the dead person back to the homestead. For Vuyani, a twenty-nine year old male, conducting the ritual had mostly to do with showing respect. He said: “How can I not do this ceremony for my father? This would be a clear sign of disrespect, after all what he has done for me.” However, blaming his ancestors for a car accident or not being promoted at work would have seemed ridiculous to him. He also went to a biomedical doctor when he was sick. So did Fundiswa Joyi, a 46 year old teacher. For her, using traditional healers was not an option. She said that, as a Christian, she did not believe in their powers and it was otherwise clear that they did not have the power to heal. Her expenses for health care were covered by insurance as she was employed full-time. Her medical aid scheme covered her for a certain amount of expenses for day to day services and medicine, which is around 2,500 to 3,000 Rand per year (330 to 400 euros). If one reaches the insurance limit, one must pay the additional fees. Surgery also would not be included. According to Joyi, the coverage was sufficient. She used a general practitioner in the township that she considered to be very good. And although she sometimes had to wait, it would be much more difficult to get treated in the public clinics or hospitals (Notes, 2004-06-23). To conclude, the first group considered only using biomedicine or herbal medicine as a possibility when it came to treating a sickness. Healers were not needed, as they did not believe in non-human powers affecting their lives directly and hence there was no need to communicate with or to appease them.

For the second group, sickness was not the only problem they sought assistance for, but also for general misfortunes like unemployment, a lack of money or accidents. All of these incidences may, but do not necessarily, have an underlying non-human cause. The task for the traditional healer was to identify the cause of sickness or misfortune and to find a solution. He or she did this by communicating with his or her ancestors, who indicated that either a particular herb was sufficient to heal a sickness or that a non-human agent was involved. As I mentioned earlier, two types of non-human disturbances could occur. One relates to the anger of the ancestors, the other to witchcraft. If the first one was identified as the problem, it effectively meant going through any possible rituals that were left out or mistakes that were made during the conduct of the ritual or thinking of relatives who might not have attended the ritual. In short, the healer first had to find out what the ancestors were angry or annoyed about, and, in the second step, identify the ritual that was required for reconciling them again. However, the healer did not independently decide on the course of therapy management, but rather negotiated possible measures together with the whole family. In the cases I witnessed,

the family negotiated about conducting a ritual in regard to their financial resources. All relevant family members were typically contacted for support, if necessary. If everybody agreed about the expenses, and the extent to which the ritual was carried out, a possible date could be set. If there were no resources available, however, the ritual was indefinitely put on hold and the ancestors were asked for their understanding.

Turning to the other type of non-human agency that could be the cause of a sickness, namely witchcraft, one can distinguish between two modes. One involved the use of substances in order to harm a person. Anyone versed in the uses of plants and herbs could do this. The other mode required spiritual powers in order to direct demons to do evil as well as sending little animals or dwarf-like helpers such as *utokoloshe*. These familiars were quite popular and were featured in a lot of the illness narratives I encountered. In these accounts, snakes, birds or cats were able to afflict people or inhabit their bodies and cause pain.[32] This distinction between a spiritual and a more substantial form of witchcraft recalls Evans-Pritchard's (1935) understanding of sorcery, on the one hand, as something based on the use of medicines and rites, and witchcraft as a solely spiritual act on the other[33]. However, I did not find this differentiation to be of importance amongst Xhosa people, and they also did not use two different terms to distinguish between witchcraft and sorcery. For most people, citing witchcraft as a cause for a problem was sufficient since every necessary measure followed from this determination. The two modes were only explained in deeper discussions with healers about the workings of witches.[34] They did not, however, refer to two different types of witches that were either only able to use herbs to harm people or to direct non-human powers. To make the phenomenon more explicit, I want to give two examples from the field where people referred to witchcraft as the causative agent for misfortune or sickness.

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[32] See Green (1996) on the concept of snakes and pollution, Hammond-Tooke (1989:74f.) on familiars in general and Hunter (1961[1936]:272-295) for the most detailed account on familiars, the use of medicine to do magic and Xhosa mythology. Niehaus et al. (2001:47) write about the emergence of new witch familiars as a consequence of contemporary socio-economic deprivation.

[33] Evans-Pritchard also makes this distinction for methodological reasons when he writes: "Witchcraft is an imaginary offence because it's impossible. A witch cannot do what he is supposed to do and has in fact no real existence. A sorcerer on the other hand, may make magic or kill his neighbours." (1935:417f.). He was criticised for unconsciously following colonial legislation by distinguishing between undetectable witchcraft and provable sorcery (Schönhuth 1992:62).

[34] Hammond-Tooke (1989:73) and Hunter (1961[1936]:275) opt for the validity of the witchcraft/sorcery distinction in South Africa. Hammond-Tooke found that people "if pushed can distinguish between '*ubuthakathi* with little animals' (witchcraft) and '*ubuthakathi* with medicines'. He writes that witches are generally believed to be women, due, it seems, to their domestic role, and sorcerers are believed to be men since sorcery implies a more extroverted activity. Hunter admits that people would hardly note the difference, but that for legal practice the distinction would be necessary. However, my observations differ from theirs and render this distinction as rather unimportant and minor. I found no evidence of women or men being more prone to practice either witchcraft or sorcery.

The son of Thobeka, one of the healers I worked closely with, was involved in a car accident. The car in which he sat was hit by another car that drove off. Nobody was seriously hurt. Thobeka took her son to another healer – healers themselves could not treat family members, she explained – to learn about the cause of the accident through what she calls "being fortuned". "To fortune someone" refers to the ability of healers to communicate with the ancestors to discover disturbing non-human agents that cause harm or misfortune to a person. In her son's case, the healer concluded that the neighbours were jealous. Since he studied and was well off, they wished him ill. His mother was advised to get him cleansed using a special herbal cleansing potion for washing and to get a certain medicine for protection. Thobeka was even sure about who the particular neighbour was but rejected my provoking proposal to send him something evil too. Her ancestors would not allow that, she said (Notes, 2004-06-04). Lulama, a good friend of my language teacher Grace who lived in one of the poorer townships, told me why she had gone earlier to a traditional healer. She woke up one morning with a stiff neck. When she went to the doctor, a general practitioner who had his practice in the township where she stayed, he told her that he could not do anything. She told me about a dream she had had where somebody said to her that she must turn her head to look in a certain direction, and the next morning she could not move her head. The doctor sent her to a healer who told her that somebody tried to kill her. Lulama was supposed to turn her head around until her neck would break. But the ancestors protected her, so her head did not turn completely. The healer gave her an onion-like medicine that she showed to me, and she was supposed to wash with it in order to become clean. Since then, she regularly went to the healer to get the medicine; once every two weeks since this is how long it lasts. When I asked her how long she needed to use the medicine she said she did not know. She was still afraid of being bewitched as she suspected a woman who her boyfriend slept with of wanting to harm her. That woman supposedly also put medicine into his food to make him unfaithful. What I found remarkable here, and what turned out to be a common pattern of dealing with a health problem, is that although the idea of witchcraft appealed to her, she first went to a biomedical doctor to exclude the possibility that her stiff neck might have a simple medical explanation. The process of deciding between a biomedical or traditional path of treatment did not seem to be an either/or decision. They rather went hand in hand (Notes, 2004-09-17).

Therapeutic trajectories such as the one described above were common. The neighbour of Lusanda, a healer I came to often see and talk to, told me about her last visit to a traditional healer. She was 26 years old and had one child who had just started school. She told me she and her daughter were on medical aid, insured through her parents with whom she was living.

She generally went to a private (allopathic) doctor, but insisted that healers are also important. I, therefore, asked her when she had last gone to a healer. She said she had gone just the other week when she had some problems with her menstrual cycle, whose length had increased from three days to more than a week. She went to a doctor who prescribed her some pills. When her next period was again too long, she decided to go to a healer with her mother. The healer told her she had to slaughter a goat. She then waited to see if her next period would be alright. If not, they would then slaughter the goat. She further added that the reason for the irregularities might have been that she had stopped taking the pill only a few months earlier, which seemed entirely possible. It was interesting that she tried to stress the importance of healers or their powers, while simultaneously offering a sound biomedical explanation. On the other hand, one might perceive her actions as an effort to pursue every possible alternative in order to get help. It is also notable that she did not immediately accept the healer's advice, namely, to immediately conduct an expensive ritual to which the whole family would be invited. Perhaps, she wanted to give herself and the medication the doctor prescribed another month to see if the biomedical explanation (referring to her interruption of taking the pill) would prove correct. If not, she would take the path the healer presented to her (Notes, 2004-08-06). Unfortunately, I did not have the chance to talk to her again and therefore cannot relate the end of the story.

Apparently, believing in ancestors and their power to do good or bad and using traditional medicine did not exclude using biomedicine, too. However, what I found surprising was the fact that even healers themselves went to biomedical doctors or the hospital. Lusanda, for instance, explained to me that she would always go to the doctor first just to make sure that they could not find anything. She said it was typical for a human being to try this first and then go onto something else, if necessary. And she was someone who would seek out the doctor quickly. When asked what her children and husband would do in case of an illness, she replied that they would also only use the doctor. They did not take her status as a healer seriously (Int. Lusanda, 2004-06-03). Mr. Kota, a healer in his fifties, would regularly go to get his blood pressure checked at the public hospital since it was the only place where he could have this done, he said. They also kept records of his blood values (Int. Kota, 2004-04-13). Thobeka preferred using medicine from the pharmacy to get rid of colds or headaches. Since I assumed certain herbs were able to cure coughing or flu, I wondered why she did not prepare medicines on her own, seeing that her consultation hut was filled with all types of dried plants and barks. She explained to me that, compared to simply going to the pharmacy to get a pill, it would be too difficult to find the plant in the bush, boil it, and prepare the

medicine. In addition, she said that pills work much more quickly, especially in the case of headaches (Notes, 2004-05-04). Brooke, one of Thobeka's students (i.e. a healer-to-be), told me that in some cases you could not afford to wait for traditional medicine to work because it took too long. Healers therefore would sometimes also refer you to the hospital. The ancestors could also take too long to provide you with an answer on how you will get better and you cannot always wait. They would be busy sometimes. (Int. Brooke, 2004-06-10).

Having just presented some examples on how the use of biomedicine and traditional medicine complement each other, I will now take a look at another common feature of Xhosa belief, Christianity. As discussed earlier, for some people, like the teacher Fundiswa Joyi, being a Christian meant formally rejecting the idea of traditional healing. However, this was not actually necessary for most of the people I talked to. South Africans largely believe in God. Yet, at the same time, I did not meet anyone who denied the existence of ancestors or witchcraft. As I have indicated, the extent of a person's belief in ancestors or witchcraft determined their stance on traditional healing. Christianity did not interfere here. All the healers I interviewed believed in God, too. "The ancestors are closer to God so it is easier for us to ask them for something", was an explanation I heard a lot. Others would say: "As Catholics pray to their St. Johns and Martins, we pray to our ancestors." Praying to God or singing gospels was also very often included in the healers' traditional ceremonies. Meetings were also sometimes started by first praising the ancestors and then offering a prayer to God. Some healers told me, nevertheless, that their churches would not allow the use of traditional medicine, which was why they stopped going to the weekly services. However, Mr. Kota, a healer deeply involved in the local healers' organisation, actually occupied an official position in his church. He served as a secretary responsible for new members, recordkeeping and writing the minutes of meetings. He studied theology at a distance learning university 20 years ago and was a certified minister, which meant he was a committed Christian by the time he received the calling and started the training in 1995.

So far, I have shown how different degrees of belief in the influence of non-human powers shaped people's responses to sickness, healing and misfortune. For people who rejected the idea that angry ancestors or witches might cause harm, perceptions of sickness were reduced to a physical problem of the body that could be cured through a biomedical doctor or a certain kind of medicinal, herbal or chemical treatment. Their health-seeking path seemed self-evident. For the others, however, a sickness or misfortune could have a non-human cause. It was a possibility that had to be checked since special measures typically followed from such a

diagnosis. This is where the traditional healer came into play. Sometimes a health-seeking path ended here when both healer and patient agreed on the cause and solution and the patient was moreover satisfied with the outcome of the treatment. In other cases, the patient simultaneously used biomedical treatment and traditional medicine, but was left unsure as to which one might have led to recovery. People, finally, may also have started with either of the two options, biomedicine or traditional medicine, and then switched between them if the first option failed.

After having shown the various options people had, and how they combined and chose a therapy depending on their personal beliefs and attitudes towards ancestors, God, traditional healing or biomedicine, I now want to analyse some factors that play a role for people in how they decide for a therapy.

2.3. Medical Pluralism Revisited

In order to shed light on therapy patterns or quests for healing, it is useful to have a look at the debates on medical pluralism. The concept of pluralism in medical knowledge and practice goes back to Charles Leslie (1976; 1978; 1980) and has been one of the key concepts in the history of medical anthropology. The observation that people make use of seemingly incompatible practices and theories when seeking health has become one of the central tenets of the discipline. As part of the worldwide rise of modernization, biomedicine did not, as expected by many in the earlier days, eradicate or even marginalize all other forms of medicine. Plurality and complementarity in health and healing remain the norm (Leslie 1980). The observation that patients are pragmatic and see nothing inconsistent about liberally combining different forms of therapy in their quest for healing is commonplace today, thanks to the pioneering work that followed Charles Leslie's lead, such as Janzen (1978), Lock (1980), Kleinman (1980), Nichter (1978) and many others.

In the following, I would like to lay out some of the recurring themes in the discussion about medical pluralism within medical anthropology. Investigations into people's decision-making regarding illness and respective therapies have revealed an important site of negotiating different explanatory models relating to different medical systems. Illnesses and their treatment, constantly negotiated by the patient, his or her family and various practitioners of different traditions, emerge as central elements in the constitution of medically pluralistic

societies and critical areas of inquiry for understanding the sociocultural role of health and healing in society.

Pragmatism and a Division of Labour

One key finding of anthropologists studying health-seeking behaviour is that a degree of pragmatism structures the quest for healing. Several accounts of societies where people use both approaches, traditional healing and biomedicine, suggest a division of labour between the two. In different settings, a common narrative amongst patients as well as practitioners becomes apparent. They ascribe different tasks to traditional healing and biomedicine, indicating that they complement, rather than conflict, with each other (Ahern 1975; Beals 1976; Lock 1980; Nichter 1978). Traditional medicine was said to cure the underlying causes of illness whereas biomedicine treated some symptoms better. This was another prominent theme among the healers and patients I talked to in South Africa. For healers, it was a source of great pride and satisfaction that biomedical doctors could treat some afflictions better due to improved means and infrastructure but were not able to help if non-human agents were involved (e.g. A019, 2004-09-13). In his book "The Quest for therapy in Lower Zaire", Janzen (1978) describes healing patterns among the Bakongo who use biomedicine alongside traditional medicine. According to the author, the motivation of people in the course of their quest for healing was "the question of whether or not the affliction was merely a matter of fact, or whether 'there was something else going on'", like witchcraft, ancestors, etc. as the underlying cause of an illness (Janzen 1992:86). To clarify this question about the root of an illness, visiting a traditional healer was essential.

Also traditional practitioners were viewed as more holistic in their approach while biomedical doctors would act paternalistically or were arrogant and mainly body, instead of mind, oriented and did not have enough time to attend to each patient sufficiently. This, too, was a view widely shared by my interlocutors. "They look down on us. They think because I am black I cannot read or write and therefore they are better than us", described Lusanda the personnel in the hospital (Int. Lusanda, 2004-06-09). Time constraints, waiting hours and language problems were put mentioned, too. Furthermore, traditional medicine was described as natural and safe, whereas biomedical pharmaceuticals were considered to be fast and powerful but potentially harmful due to their chemical ingredients.

The pragmatic aspects in health-seeking behaviour are examined by scholars such as Margaret Lock. Studying the attitudes and practices of practitioners and patients in East Asian medicine in Japan and their cultural significance, she showed how several persistent modes of thought, often radically different, can be detected in one medical system. Lock shows that a belief system is not only plural and tolerant, but also functional. She writes: "The existence of a pluralistic medical system offering a variety of approaches to the alleviation of suffering is highly functional, therefore, in that it can absorb the segment of the population whose problems are labelled chronic or incurable" (1980: 259). Because of the limited capacity of biomedicine to deal with certain afflictions, people who are chronically ill or not satisfied with their indeterminate diagnosis look for alternatives. I found this to be the case for a lot of the illness narratives I collected. Especially in healers' accounts of their calling, the related illness that indicated the ancestors' wish for training to begin was usually something chronic that several specialists, biomedical and non-biomedical too, were unable to cure satisfactorily. Thobeka complained about recurring headaches and dizziness when she was a young girl (Int. Thobeka, 2004-06-04). Lusanda told me she had a constant pain in her arm that no medical doctor or orthopaedic could explain or cure. When she started her training to become a traditional healer, the pain vanished. But now it had returned, she said, probably because she was not proceeding fast enough. Due to financial and time constraints because of her job and family, she could not attend mandatory rituals and feasts and had to postpone her graduation ceremony indefinitely (Int. Lusanda, 2004-06-03).[35]

It is the Social that Matters

Another theme in the discussion of medical pluralism concerns the sociocultural functions of medicine in the lives of people. Much more is at stake than the simple restoration of the physical body when people seek help. Diagnoses and therapies are relied on to convey moral meanings that are supposed to help people heal from social wounds. Numerous studies show the link between illness and the transgression of social norms. Janzen (1978) showed that in Congo illness could evolve from certain breaks of taboo like promiscuity, family disputes about the distribution of resources or the infringement of marriage rules. Therefore, therapies

[35] How chronic suffering can lead people to turn to alternative modes of healing they did not adhere to before has been widely studied in Western societies, too (Kleinman 1988). Jean Comaroff shows how parents whose children suffer from leukaemia frequently rehearse their past actions in order to pinpoint the moment when they did something wrong in their nurturing. To allocate responsibility and establish meaning become crucial in situations of sudden crisis, suffering and shock (Comaroff 1982; Comaroff and Maguire 1981).

were not only expected to cure a disease but to restore the social order. Various studies on witchcraft have given evidence on how unequal access to wealth can lead to afflicted people to be diagnosed as having been bewitched (Ashforth 2005; Auslander 1993; 1935; Evans-Pritchard 1970; Geschiere 1997; Marwick 1952; Niehaus 1997; Richards 1935; Yamba 1997). Other studies have shown that the persistence of the belief in witchcraft does not conflict with modernity. Witchcraft can be modern (Comaroff and Comaroff 1993; Geschiere 1997; Taussig 1980; Taussig 1997) because innovation is also a core attribute. It is constantly reinvented (Bastin 2003; Kapferer 2003). Although one might be accused of having a limited functionalist perspective, it needs to be acknowledged that accusations of witchcraft occur in settings of tension, poverty and social inequality. In his book "Witchcraft, violence and democracy in South Africa", Adam Ashforth (2005) gives evidence of how the aftermath of Apartheid, characterised by crime, violence, a growing consumerism, envy, HIV/AIDS and the decline of community spirit in Soweto, provided the context for a growing "spiritual insecurity" that resulted in growing accusations of witchcraft. Kinship bonds of reciprocity were under growing stress. In his earlier book "Madumo: a man bewitched" (Ashforth 2000) the picture is even more dire, as people are described as living in constant fear. Beneath a surface of togetherness and familial bonds lies a pervasive hatred that is manifested in the belief in witchcraft. Madumo, the main character of the book, is accused by his family of having killed his mother. Ashforth thus disproves here the myth that kinship provides a reliable social network which cushions the worst effects of poverty. Likewise, Isak Niehaus et al. (2001) explains the increase of witchcraft accusations and witch killings in the South African Lowveld, along with growing social tensions around new forms of wealth and inequality that are attributed to the occult power of witches. However, his account seems to be more differentiated than Ashforth's as he points out that social tensions would not necessarily lead to accusations. Emic evidence such as dreams, divination and other mysterious events might be enough for a suspicion of witchcraft even in situations where no social tensions were present (Niehaus, Mohlala et al. 2001:112f.).

In my view, the dark picture that Ashforth describes, notably in regard to the spiritual insecurity, seems inaccurate for my field site. I would not describe my interlocutors or my acquaintances as having had a constant underlying fear of witchcraft. The topic arose occasionally in conversations on possible causes for disease. As in Grace's case, which was referred to earlier, witchcraft was one possible reason for affliction that needed to be checked out with a traditional healer. But her first visit was in fact to a biomedical doctor. It was only when he proved unable to help her that she sought a traditional healer whose diagnosis (that

her boyfriend's lover allegedly bewitched her) she accepted. Lusanda, a friend of mine with whose family I stayed in 1998, once wondered if her difficulties in her new job might be caused by a colleague who competed against her for a promotion. He, accordingly, might have used magic to turn other colleagues against her so that she would leave the firm. When I asked her if she was thinking of consulting a traditional healer for help she said: "Maybe". She did not seem too concerned about it, however, and the issue never came up again. She and her cousin enjoyed telling me in the evenings stories about witches and their familiars, but I sensed that it was more for entertainment. That does not mean that they did not believe in the existence of witches, but they were not in constant fear of them, contrary to what Ashforth suggests with his concept of spiritual insecurity (2001:208). When I questioned people about their therapy paths, witchcraft was referred to as one cause of illness amongst others. In a process of elimination, people looked for a plausible diagnose and eventually for a cure, for symptoms to disappear and for a restitution of their wellbeing. In certain cases people accepted the diagnosis of witchcraft, whereas others continued looking for alternate explanations and therapies. Witchcraft, based on my observations, did not carry greater weight than others as an explanation of disease, like ancestral conflicts or biomedical causations.

Family Matters

Another strand of inquiry informing studies on the negotiation of health, healing and meanings is the role of the wider social network of a patient, especially his or her family. The concept of the therapy management group has proven to be highly useful for grasping the (rarely uncomplicated) entanglement of family relations, friendships, illnesses and cures offered by various specialists. The concept was introduced by John Janzen (1978) in his ethnography "The quest for therapy: Medical pluralism in Lower Zaire"[36]. Therapy management is a process that involves the diagnosis and negotiation of illness identities, the selection and evaluation of therapy options and the support for the afflicted person. Also Kleinman (1980) in his in-depth analysis of health care practices in Taiwan emphasises the importance of the family and their role in organizing and labelling illness. In South Africa, I was able to follow cases in a rather similar manner. Due to the costs associated with conducting a ritual for the ancestors, the wider family of the patient may decide if, when and

[36] Janzen acknowledges Talcott Parson's "sick role" as being the basis for his concept of therapy management (1978:7).

how the ritual will take place. Thus it was usual that several family members accompanied the patient to the healer. I gathered large amounts of material regarding this issue by collecting life stories of healers about how they started their training. Again, the beginning of a healer's career usually started with a sickness that indicated that the person had been called by his or her ancestors to become a healer. Symptoms of such a calling were usually described to me as general tiredness, nervousness, the inability to concentrate on things, nasal bleeding, low blood pressure, constant pain or the paralysis of body parts. Every healer or student told me that first they would go to a biomedical doctor to see if they could get help. Many of them had never believed in the power of traditional healing and even rejected the idea of becoming a healer themselves. When the symptoms reappeared, the family of the person usually took him or her to a healer who diagnosed that the sickness was a calling from the ancestors demanding that their descendant become a traditional healer. In order to get healed, the person had to start the training to become a fully qualified healer. The process of becoming a healer is therefore also thought of as a process of healing. This is why many healers told me that their profession was not actually a matter of choice. If they had not accepted their calling, their health would have worsened or they might have even died. Once the family had the healer's diagnosis, they called a meeting of the extended family members to report the outcome of the visit. Generally, the family of the patient asked for support as the training was quite costly and required conducting several rituals and slaughtering animals. Sometimes the parents of the healer-to-be were not completely convinced by the diagnosis and let some time pass before taking other measures. Some healers I talked to told me that their health worsened because their parents rejected the idea of letting them be trained as a healer. Often they went to another a healer who would arrive at the same diagnosis or to members of the extended family, who would convince the parents to accept the diagnosis and pay for the training. A similar diagnostic situation is described by Hammond-Tooke, who notes that people either agreed with the healer or would take their money and leave (1989:113).

Another intriguing example was how Linda, a 60 year old woman and student training to become a healer, treated the biomedical diagnoses of her childrens' psychological problems. Her daughter Thabisa (32) was diagnosed with bipolar mood disorder when she went to a clinic to be treated for her depression. In addition, her son Sivuyile (20) received injections once a month for schizophrenia. After having heard about the sort of sicknesses healers suffered from before starting their training, it seemed that both Thabisa's depression as well as Sivuyile's schizophrenia could well have been interpreted as indicating a calling of the ancestors. Her mother Linda, however, made a distinction between the two. For her son, she

accepted the psychiatrist's diagnosis and thus considered sending him to a special day hospital. However, for her daughter she favoured training as a traditional healer. Thabisa objected to this idea by saying she met a lot of other women in the clinic who suffered from the same symptoms. Linda, nevertheless, was convinced that because she herself was meant to be a healer, along with another aunt on her mother's side, Thabisa would have to follow the family's traditions. During the discussion, Thabisa tried to find a loophole, suggesting that first they have to wait to see if the goat-slaughtering ceremony planned for the following year would bring any improvement. Here it can be seen how sickness and treatment are negotiated between mother and daughter and how this discussion determines different therapy paths the children have to consider.

Nichter (2002) develops Janzen's concept further by showing how poverty determines health care decisions and how illness may lead individuals to re-examine their relations with kin when it mobilises a therapy management group and puts strains on family ties. He focuses on the multidimensional character of therapy management (Nichter 2002:81) by being attentive "to disagreement as well as to the building of consensus, the privileging and manipulation of truth as well as the acceptance of ambiguity, and changes in knowledge about diagnosis and treatment which effect thinking about possible courses of action" (2002:82). Especially in the context of poverty, households may be considered not only sites of cooperation but sites of conflict (2002:99) as the cases involving accusations of witchcraft within families have shown (Ashforth 2000; Geschiere 1997)[37]. Nichter writes that "illness challenges a sense of order in one's world and tests the integrity of social relationships" (2002:101). The case of Linda and her daughter Thabisa appears to be an example of such a conflict arising out of two conflicting explanations for an illness. As Thabisa did not have her own income, she had to find some sort of an agreement with her mother, who would either pay for a psychiatrist or the training to become a traditional healer. For Lusanda, who was also a healer in training, her decision to become a healer put a strain on her marriage. Her husband not only prohibited some of the weekend gatherings regarding healers' graduations she was supposed to attend. Also financially her progress with the training depended on his goodwill. The pace of her training was slow due to her financial constraints, and she suffered of chronic pain in her arm that she attributed to this delay.

[37] Geschiere says that "witchcraft is still the flip side of kinship" (1997:25) and "as long as the family remains the main basis of social security, the enigmatic discourses on witches and their secret forces will continue to mark people's reaction to modern changes in Africa" (1997:214). As I already discussed earlier, I find this view a bit too extreme and my observations tend to differ.

The challenge HIV/AIDS presents to family relations and their economic as well as emotional resources, and the fact that women especially carry the burden to care for the sick or for their children has been widely studied (see e.g. Basset and Mhloyi 1991; Baylies 2002; Baylies and Bujra 2000; 2001; Esu-Williams 2000; Leclerc-Madlala 2001; Montreevat 1998; Mwale and Burnhard 1992; Wallman 1996). The number of unfortunate stories related to me was overwhelming. During the time of my fieldwork, ARV medication was not yet available in the public sector. And although the Treatment Action Campaign (TAC)[38] had a local branch in Port Elizabeth, their work consisted mainly of education and training.[39].Pilot programs like those in Khayelitsha or Lusikisiki (Robins 2005; 2006) where ARVs were given out to the wider public to prove their feasibility without expensive health care facilities and doctoral monitoring did not exist in PE. People were therefore without any lifesaving medication at that time. Nearly every family I spent time with was affected in one way or another with the deadly disease. Friends of mine seemed to have at least one funeral per month. Some spoke to me about their fear of becoming infected and tested their blood on a regular basis. Meanwhile, for people in the townships the effects were more manifest. Similar to Nichter's findings I could observe how family ties were strained by members being infected. This situation could either lead to the mobilisation of resources by involved family members to support the sick person or to conflict about priorities concerning how to distribute scarce finances, time and care. Stigma was also an issue. Sometimes people were afraid to disclose their illness to their parents and instead took siblings, cousins, uncles or aunts into their confidence.

I generally experienced family relations as being more supportive than at odds. Positive stories of care outweighed those of neglect or disinterest. There was a grandmother who took care of her sick granddaughter and her two kids, a cousin who organised transport each time a visit to a hospital was necessary and a sister who adopted her niece and nephew after the death of her brother. Traditional healing did not play a role in those severe cases of suffering.[40] Thobeka and numerous other healers I knew well asserted that they would always

[38] The TAC has become a key player in AIDS politics in South Africa. They sued the government for not providing Nevirapine, lobbied for the nationwide provision of ARVs and conducted pilot programs together with "Doctors without borders" (MSF) to treat as many HIV-infected people in poor settings as possible. For more on their work and political impact, see (Fassin 2007; Nattrass 2006; Redfield 2005; Robins 2005; 2006; Steinberg 2008).

[39] TAC approached Nyangazezizwe and I witnessed two meetings between healers and a TAC worker. The healers were supposed to be trained in treatment literacy. But I witnessed a very early stage of this cooperation only. The healers just became familiar with TAC.

[40] In total, I only came across two healers who told me they would be able to cure AIDS, one in Stellenbosch, one in PE. And although it could be argued that most healers would probably simply not feel comfortable making the same claim to me, my observations and lengthy conversations with healers, but also patients, suggest that people turn rather to biomedicine when it comes to AIDS and that healers also refrain from treating it.

send people to the hospital when they showed symptoms of an HIV infection. “It is not good if somebody dies in your hut”, I was told (Notes, 2004-06-09). Some healers had a cream they used to treat rash or mycosis, common symptoms of AIDS. But when the course of sickness advanced my experience was that healers were rather hesitant to promise any success from the treatment. They sent people to the hospital as “traditional healing cannot do much” about AIDS (Int. Lusanda, 2004-06-09). Brooke, a student that was being trained by Thobeka to become a traditional healer, fell sick while I was there and eventually died. The symptoms and their development seemed to me very much like an HIV infection. Lusanda, another student of Thobeka, said she did not know if it was AIDS. Thobeka, for her part, was so struck by the death of her student that she did not want to talk about it at length. She said that she had sent Brooke to get tested but did not know if she actually went. When I asked if ancestors or witchcraft might have had anything to do with the death, she said she would not know.

Back to the Roots

Another factor that is investigated in studies of medical pluralism relates to the role revivals of traditional medicine might have played in its growing popularity among patients. Especially in India, Japan and China traditional medicine has been part of national agendas aimed at revaluating local traditions in the face of growing modernisation. For example, Ayurvedic medicine (Leslie 1974), traditional Chinese medicine (Unschuld 1985), Tibetan medicine (Pordié) and Kanpo medicine (Lock 1980) all experienced revivals, both amongst patients and on a national level. They institutionalisation and regulation were explicitly carried out to preserve distinctive cultural heritages. This development reflects the desire to preserve local traditions as markers of modern, albeit different national identities. Following the studies on Asia, medical pluralism was on the macro level in part a product of identity-formation, an effort to define the boundaries of the nation and the values and norms of its citizens. The respective medical systems were not simply embedded in a cultural matrix that defined its ideals, values and beliefs (Lock 1980). They also strongly shape their context. As discussed earlier, a medical system embodies a specific lifestyle and behavioural norms (Unschuld 1985). Ways of thinking and acting in regard to health and healing are not simply a matter of cultural predispositions. Instead, they play a role in shaping social worlds in particular ways. Unschuld writes that “the success of a healing system…rests only partly on its objective success; it is equally important for this system to support the socio-theoretical

concepts of a population or political group" (1985:249). For the case of South African this assertion holds true. Several authors (Chipkin 2003; Oomen 2000) argued that South Africa has been a site of nation building where, after decades of Apartheid depriving cultures and the beliefs of a majority of the state's population, a new identity of a Rainbow Nation is being created that re-evaluates "African tradition". Not only is traditional medicine experiencing greater public awareness and state recognition. Customary law and traditional courts are also undergoing a shift. I will elaborate more on the role of Thabo Mbeki's health policy agenda for the country in general and in particular for the history of the Traditional Health Practitioners' Act which legalises and regulates South African traditional healers (Chapters 5, 6). At the moment, I am more concerned with how therapeutic choices have been influenced by an overall societal revivalist movement that seeks to redefine what it means to be South African after decades of Apartheid. Studies suggest that traditional healing has enjoyed growing popularity since 1994 (Ashforth 2005). This may be partly due to a change of legislation. All forms of divination and, by extension, traditional healing were illegal before the democratic elections of 1994. But as Ashforth writes (2005:286), and also numerous healers I questioned confirmed, healers at the time were not prosecuted for practising. However, the number of traditional healers today has exploded in the townships. "In every street you can find a traditional healer" (Int. Thobeka, 2004-06-04). Traditional healing also experienced a huge surge of interest in the public discourse. Local newspapers would cover the joint ventures between the healers' organisations, municipality, and the pharmacy department. Whenever a health-related event took place, such as a conference, the opening of a clinic or a meeting of the city's AIDS council, representatives of the organisations were invited. The ex-health minister Manto-Tshabalala Msimang repeatedly underlined the importance of traditional medicine as opposed to the effectiveness of ARVs in treating HIV/AIDS and she regularly visited healers' gatherings throughout the country. Her stance, along with president Mbeki, on the biomedical explanation for and therapeutic response to the pandemic caused a big stir internationally. Both advocated for more research on the capacity of traditional medicine as a cultural heritage dating back thousands of years (Mail & Guardian 2008).[41] The healers were well aware of the public's perception and quite pleased about this shift. In previous years, they told me, newspapers would write only about their profession in

[41] In Chapter 5, I will elaborate more on the African Renaissance and its role in health policy, particularly in the so-called AIDS-causation debate triggered by Thabo Mbeki. At this point, only the impact of this culturalist agenda on the public perception and on people's therapy paths shall be highlighted.

connection with *muthi* murders[42], ritual killings or people dying after having been treated by a healer. Their reputation changed for the better after the elections of 1994 (e.g. Int. A019, 2004-09-13). It is quite likely that patients' decisions about therapy paths have been influenced by the improving image of traditional healing. Seni Hlabisa, a man in his early thirties working in the Bayworld Museum in town, claimed that the belief in ancestors as well as in the powers of healers was bound to increase.

> People always have had a dual life. They would go to church but they would also slaughter a cow at home. And with the whole movement of African Renaissance people develop a pride in their heritage, and healers are directly linked to the ancestors. The democracy opened doors and now people go back, look and explore things. 'This is ours, let's bring it back!' They attach value to it. (Notes, 2004-09-21)

Mr. Jonas, from the old age home in Zwide, agreed on the importance of giving value to "traditions" when it comes to choosing a certain type of therapy. He said: "White people never gave value to black customs…so now people are doing it, because it is their thing and to show it" (Int. Jonas, Notes 2004-08-06).

About not Knowing

Investigations of health-seeking behaviour further indicate that the epistemological underpinnings of the different medical options were unimportant. As Young (1976) argues, in lay understandings of illness and disease theoretical consistency is not necessarily given or sought for. Rather, the health-seeking paths of patients reflected pragmatic and contingent assimilations and particularizations of medial beliefs organised around an illness episode (ibid.). Murray Last (1992) wrote an article on "The importance of knowing about not knowing" in which he tries to answer the question about how much people know and care to know about their own medical culture. As it turns out, they cannot give a full account of their medical knowledge and they do not care. He calls not-knowing an attitude of mind being very important for medical culture. This "Babel of ideas" is an adequate means for people to cope with illness (1992:402). He states that medical information is layered. The more deeply the anthropologist looks for answers, the less certain that knowledge is (1992:393). He concludes that the concept of the medical system therefore has to be reconsidered and instead termed

[42] Mutilated bodies are regularly found in different parts of South Africa. Human body parts are said to be used in highly potent witchcraft *muthi* (Xhosa and Zulu for medicine). News media occasionally report on the prosecutions of healers in connection with *muthi* murders, indicating that there is a black market for these practices (Asforth 2005:72, 138).

"medical culture". In a similar vein, based on his study of patterns of resort in Tanzania, Feierman writes that "it is the need for help which is central. And it is the need for help that widens the range of therapy" (1981:359). Janzen (1978) also observed how individuals together with their kin in particular situations of illness practiced a "case-relevant therapeutic quest" based on the immediate problem without necessarily having a comprehensive view of the whole explanatory model. Like Last, he observed that few of his informants could fully articulate their system of medical knowledge. According to him "the whole question of legitimacy shifts with the perspective of actors in different situations and various medical practices coexist in an unstable, evolving relationship" (Janzen 1978:57). This means that for each illness the health-seeking path can be different. How people act when they are sick, where they turn to first and where second can vary at different times. For this reason, my categorisation is based on grouping people according to what extent they believe that their lives are influenced by non-human powers. Due to various reasons, people's convictions may change – especially in existential situations when health or well-being are at stake and every option is likely to be explored, no matter the theoretical incompatibility of certain medical practices. The story of Mr. Jonas demonstrates this quite well. He confessed to me that he wonders sometimes why he performs the rituals for his ancestors and let his son be circumcised even though he is not sure about the powers of the ancestors. He added that he certainly does not believe in the power of traditional healers. Still, Mr. Jonas confessed that a "kernel of doubt" (Goody 1996) remains and he explained that people want "to be on the safe side" when they opt for a particular therapy. To help me to understand, he told me a story from his youth. He was mugged and stabbed in 1962 and he has been paralysed since. People would always tell him he should have gone to a healer and that he would be fine today. He cannot move his hand properly and limps. He said: "There is that little something inside of me that tells me I should have done it." Yet he continues to provide himself with another explanation. The doctor he went to let him be treated by his assistant, who was new and young and did not adequately focus on him. Maybe if he had received physiotherapy he would be fine now. (Int. Jonas, Notes 2004-08-06) Similar to the example of Lusanda's neighbour, who stopped taking the pill and complained about irregular periods, a biomedical explanation does not erase the chance that a non-human agent might also be involved. People want to make sure and therefore explore every option when their health is at stake. Mr. Jonas regretted not having tried a healer earlier despite questioning their competence in healing. Lusanda's neighbour, for her part, looked into both options and gave biomedicine some time

to work, while still having the option to slaughter as a possible alternative (Notes, 2004-08-06).

Agency and Power

So far, my analysis has focused on practices and the perceptions of them, whereas constraining as well as enabling structures at the macro level were scarcely considered. My intention was to first provide an overview of the marketplace of medicine[43] and healing and to then move on to structures limiting the patient's seemingly free choice amongst various medical practices and beliefs. Furthermore, the research history of medical pluralism developed very much in the same way. Indeed, there has been a notable shift[44] in the theorisation of medical pluralism in the 1980s and 1990s, whereby findings from earlier work were not put aside or proven wrong, but rather served as a basis for studying the critical implications of the sociopolitical and historical dimensions of medicine. Drawing on political economic perspectives as well as on Foucault's concepts of biopower (1983[1977]) and governmentality (2010[1982/1983]), the relationships of power as they are experienced, enacted and contested within the medical arena became the main points of interest. Biomedicine was not only viewed as a cultural system, but as a means of social control and governing populations. Also, the production of knowledge and truth in the arena of medicine was looked at. Questions such as what counts as truth, who has the authority to produce legitimate knowledge, how it is negotiated and determined and how truths are enacted and resisted, became relevant (Lock and Nichter 2002:4).

On a micro level, this shift of perspective can offer interesting insights. Medical decisions and interactions emerge as sites for balancing social obligations and personal interests, the management of identity and exercising agency within difficult economic realities shaping people's lives (ibid.). Encounters with medicine can be described as an empowering resource as people draw on and use its discourses to negotiate changing social conditions and to actively participate in the construction of meaningful lives. To make these points more tangible, returning to some of my examples from the field are instructive. In the case of Linda and her daughter Thabisa, both were negotiating the meaning of Thabisa's psychic problems

[43] The term is borrowed from Meyer's "marketplace of religions" (2002).
[44] This shift was due to a rapidly changing socio-political landscape that impacted heavily on local sites of study and was caused by growing globalisation and neoliberalism (Appadurai 1990; 1996). The connection between political, cultural, economic and social reality was emphasised and power and inequality became central issues in social anthropology in general (see Knauft 1996).

and the therapy for them. Whereas Linda wanted her daughter to follow in her footsteps, which meant accepting her affliction as a call from the ancestors, Thabisa preferred the diagnosis of bipolar mood disorder. In order to stay in the clinic for psychotherapy, something she seemed willing to do, she would need to get money from her mother. Those two very different diagnoses can be seen as representing two different ways of life. As a healer Thabisa's life would consist of rituals with dancing and drumming, communication with and myths about the ancestors, collecting and preparing herbs, etc. It would also involve an alternate style of dress, facial painting and a different demeanour. Thabisa, who grew up in Germany and spent her entire youth there until she was 24, certainly was not very fond of that idea. She saw herself working in a new hotel at the beachfront in town. This was the profession she had trained for in Germany and had experience in. She spoke several international languages, had applied for the job and was waiting for a response. Yet, the opening of the hotel had been delayed several times and the manager put her off from week to week. For her to accept her problems as a calling from the ancestors meant giving up a life with, a career in the hotel business and a decent salary that would allow her to move to a flat of her own in town outside of the township. She would be able to emancipate herself financially from her mother and pursue any therapy she chose. In terms of her identity, she felt she had more in common with the other young women she met when she first went to the clinic – their problems and their lives – than with the women her mother spent time with during her training to become a healer. The two modes of existence reflected a "Western", emancipated, modern lifestyle, on the one hand, and a life of custom, tradition and the guidance of ancestors and elders, on the other. She tried to buy herself some time, saying that she would maybe consider a certain ritual to appease the ancestors in a year. Until then, she would continue hunting for a job.

Lusanda serves as another example of how therapeutic choices can have an empowering aspect. She had started the training to become a healer against the will of her husband. Due to financial constraints, she could not proceed as fast as she wanted with the training and the rituals it entailed. The pain in her arm was a sign to her that the ancestors were not content with her progress. So she went back to her old job as a legal secretary, which she had given up years ago, in order to look after her children. From the income this job generated, she was able to pay for her daughter to go to the technical university and gained a greater sense of independence with regard to her husband. This enabled her to continue with her training as a healer.

Several authors highlight the potential of medical pluralism in negotiating identity and social relations. Especially in times of rapid social change, where established social orders were being disrupted, a diagnosis and associated medical therapies can be used in the social reconstruction of the meaning of illness, even in ways that redefine ethnic identity and socio-political status (Crandon 2003). In her study on healing soul loss in the Andes, Greenway shows how therapy decisions can be an act of political resistance and a way to reassert ethnic difference (2003:103). As I found, this aspect plays a role in South Africa, too. Notions of Africanness and blackness, authenticity and a common past can now, following the dark age of Apartheid, finally be cherished and were often highlighted in conversations on traditional healing. For healers themselves, the idea of being custodians of African tradition (A019, 2004-09-13) was self-affirmative and empowering as it carries with it certain legitimacy and connoted a distinct role that only they could fill. Even if it is hard to tell if patients actually sought to reassert their ethnic identities when they opt for traditional healing, it is evident that this manner of therapy carries another meaning than it did before 1994. Moreover, when the quests for healing are recounted in narratives to different audiences they convey certain information about one's identity (Nordstrom 1988:487). Today, in certain settings, people can present themselves as being at ease with the notion of visiting a healer or slaughtering a cow to honour the ancestors, which further indicates one's stance on custom and tradition. A therapeutic decision and its communication can thus serve as a way to negotiate identity, to position oneself towards others. Much more, in any case, is communicated than just information about one's sickness or therapy path. Brodwin underlines how moral claims are reaffirmed in medical narratives as people are able to present themselves as "ethical actors who have made the right choice among competing moral worlds" (1996:14). The choice of therapy and the narrative of the illness experience itself each contain claims to moral authority and leading a "good" life.[45] In this way, people do have agency in the medical arena. Another relevant aspect in this context is the power patients have as agents who challenge and contest medical experts. They actively seek, combine and discard alternatives, selecting certain components, and thereby design their own idiosyncratic versions of treatment (Lindquist 2002). Medicine can be seen as a powerful resource that can be strategically co-opted and used by people who not only want to get cured but to (re)order their lives in a meaningful way, especially in times of sociocultural change. Medicine in this instance offers a space for the negotiation and assertion of both morality and identity.

[45] For more on the function of medicine in defining morals, see also Ferzacca (2001), Davis (2000) and Lo & Schroer (2005).

But this positive aspect of medicine and seeking treatment, where people are able to create their identities and affirm their moral standing, should not cause us to lose sight of its downside: the constraints, power games and limiting structures of medical traditions. The same authors that highlighted the agency of patients in identity formation and the negotiation of moral claims also recognised how encounters with medicine can create a limiting normative space within which identity making takes place and that medical practices are embedded in a web of power relations. It could hardly be maintained that the medical arena is some kind of liberal market place where people of all backgrounds have the free choice of their preferred treatment and where biomedicine is just one equivalent option amongst others. The question here is mostly a matter of where one chooses to place the focus: on structure or agency. The challenge of how to adequately give credit to both factors certainly is not unknown in social anthropology (Abu-Lughod 1990) or sociology (Bourdieu 1977; Giddens 1976; 1984). Other scholars focus more on the macro-level forces at work in the production of medical pluralism, emphasising the hegemonic role of biomedicine in society. Building on earlier studies about the linkage between nationalism and the revival of traditional medicine, these authors focus on the role medicine plays in determining national identity. Following Foucault, the foregrounding of certain medical theories and practices is described as a form of state rule. Medicine is understood as a device of governmentality which serves the interest of the state "through the everyday projects of regulation of bodies and spaces that they devise, in discursive battles over the boundaries and categories of social life and institutions, and in struggles over the power to represent what is deemed to be in the best interest of citizens" (Lock and Nichter 2002:8). In order to define a distinct national identity in the context of modernisation, studies have shown how countries like China, India, and Japan emphasised their forms of traditional medicine as markers of an authentic, highly valued history that is relevant in the present. The case of South Africa stands very much in line with these examples, a point that I will elaborate on in later chapters. Recent studies from Mongolia (Hilliard 2003) and Indonesia (Ferzacca 2002) show that this phenomenon is not confined to the 1970s. As Hilliard writes, after the end of the Soviet Union, the Mongolian state sought to "transform its national persona" (Janes and Hilliard 2008:36). Similar to the situation in South Africa, Mongolia tried to revive traditions that had been suppressed. Thus traditional medicine was reconstructed and thoroughly integrated into the contemporary health care system as a complement to biomedical care. Thus "it was not only deployed as an inexpensive resource to address the needs of a crumbling health care system, it was mobilized as a symbol of cultural authenticity and a shared national heritage" (ibid.). Mongolian medicine has been

adopted as an important state resource in the articulation of a new identity. Similar to the accounts I collected among South African patients and practitioners, in Mongolia traditional medicine "was described as 'our medicine', developed from 'our soil', appropriate for 'our bodies'. Yet, contrary to Alter (2005) and, to a lesser degree, Hilliard, I am less inclined to assert that 'imagined communities' are constructed and reinforced in a top-down disciplinary manner. Instead, the people's own perceptions of their history, tradition and authenticity appear to be intertwined with such inventions of national identity from above. Given this relationship, it is hardly true that anything goes. Especially in South Africa, most people I talked to expressed a strong sense of unity that derived from the Apartheid past and, in particular, the collective fight against its oppressive policies. Likewise their trust in a black government representing the interests of "their" people was strong. The question as to how much of a sense of a common tradition was already present and how much needed to be constructed from above is not easy to answer. Moreover, it should also be kept in mind that not everyone praises and makes use of traditional medicine, which again raises doubts about the disciplinary capacity of a nationalist discourse to revive traditional medicine.

Other scholars choose to turn the Foucauldian thumbscrew even further by suggesting that the state is using medical discourses and practices not only to construct the nation but also to produce disciplined people as subjects of power. Adams (1992) remarks that the Sherpa in Nepal internalise different representations of the self by means of medical discourses. These discourses serve to mediate between the state and self-control. Adams argues that the state comes into existence through the individual's encounters with medicine. Ferzacca further writes that the Indonesian state appropriates "authentic" Javanese culture by using traditional medicine as a potent signifier in cultural politics. Although agents such as practitioners and patients creatively transgress discursive and practical categories, they also merely reproduce them in doing so (2002:36). I disagree with Ferzacca's view that the capacity for individuals to develop agency is limited to such an extent.[46] Furthermore, I find the self-positioning of the author as having a bird's eye view of the whole picture that enables him or her to see hidden processes at work that real life actors cannot see problematic.[47] Also, to me it seems that the extent to which interlocutors can refute the theoretical apparatus of the anthropologist is rather limited. Lastly, I find a portrayal of the state as one uniform actor that governs through certain

[46] To my understanding, this is one of the weakest points in his study and in Foucauldian analyses in general. For a thorough critique of Foucault's work and the inflationary use of his concepts, see Nancy Fraser (1994).
[47] The issue of the theoretical impossibility to think outside of disciplining, power-reproducing discourses leaves us with the question of how it is possible that the author is able to uncover hidden agendas without being trapped in other hidden ones.

means too simplistic. I prefer to understand the state as an apparatus that works through legal authority (*legale Herrschaft* in a Weberian sense) and bureaucratic logic.[48] Assessing the medical pluralism in South Africa in terms of Foucault the picture looks as follows: people have multiple options for curing their afflictions and, similarly, the respective factors determining people's choices are manifold. When moving between practitioners of biomedicine, traditional medicine or any other form of healing, people are less free in their choices than they might realise. I do not just mean to refer here to constraining factors such as financial resources, education or family ties whose relevance no one would deny. Rather, I intend to point to the discursive and practical categories that they reproduce through their practices which end up supporting state rule and governance (see Ferzacca's 2002:36). The revival of traditional medicine as part of the Rainbow Nation building surely has an impact on people's choices of therapy. Yet, the potential of people to reject traditional healing as one mode of healing does not indicate the power of all encompassing categories that, even when rejected, only become stronger in supporting state rule. This shows the limits of the power of the government's discourse to affect the revival of black healing traditions for black people.

These issues ultimately concern finding a balance between, on the one hand, taking accounts of interlocutors serious while, on the other, having more complete academic knowledge of the socio-economic, historical and political processes informing the analysis. This is the challenge scholars have to meet. On a theoretical level, when we want to answer the question of how self-determined a choice of therapy can be, we return to the structure-agency problem. As this issue will be a recurring theme in my thesis, I will shortly discuss it now before coming to a close in this chapter. The relationship between structure and agency has been discussed extensively in the social sciences, most prominently by Bourdieu (e.g. 1977; 1990) and Giddens (1976; 1979; 1984).[49] Both of these authors tried to synthesise subjective, actor-centred approaches and objective structure- or system-centred approaches. For Giddens, agency is the capability to act differently in the continuous flow of events that the individual reflexively monitors, a flow he calls action (1984:9). All actions are simultaneously made possible by and form the reproductive basis for rules and resources, which he subsumes under the notion of "structure." The subjective agency of actors and the objective structural properties of social systems thus come together in the "duality of structure" in the sense that "structural properties of social systems are both medium and outcome of the practices they

[48] What this means in connection with health policy and the legalisation of traditional healing will be the subject of Chapters 5 and 6.
[49] See also Archer (1988; 1995) and Mouzelis (1995).

recursively organize" (Giddens 1984:25). In contrast to Giddens, for whom actors continually scrutinise their actions through reflexive monitoring, ex post rationalisations and (occasional) discursive motivations, Bourdieu sees the mediation between practices and their surrounding objective structures as dominated by what he calls "habitus". The habitus – as the subjective structures within agents, consisting of the internalised objective structures of the actors' environment – predisposes actors to a certain range of practices, which only seem to be intentionally goal-oriented because they are so closely adjusted to the requirements of the very environment they end up reproducing (ibid.). Habitus is shaped predominantly by the class structures in which the actors are embedded. Bourdieu's approach is therefore more deterministic than Giddens' in the sense that his actors cannot act differently, or at least not in terms of transgressing class boundaries. For Giddens, as well as Bourdieu, structure and action mutually implicate each another. Thus structural features are at once the basis and the outcome of individual actions. In other words, practices can be conceived as simultaneously being action-structures. Translated to the issue of medical pluralism this means that patients and medical practitioners act in terms of health and healing within a certain framework which structures or limits their choices. Importantly, this framework is not to be regarded as deterministic. Instead, what people do in case of affliction is the outcome of a complex interplay between their agency and various other factors that I tried to outline above when discussing different strands of inquiry within studies of medical pluralism.

2.4. Summary

As I have shown, the behaviour of people in the case of affliction as well as their respective beliefs or interpretations are constantly in flux, and, as Kleinman has put it, culturally constructed forms of a transactional, negotiated, enacted and internalised social reality. These exist by virtue of socially legitimated norms that determine the ways in which individuals and their social environments respond to sickness (Kleinman 1980:38).

At the beginning of the chapter, I gave a brief overview of the health infrastructure in Port Elizabeth, where I conducted my fieldwork. I described the different options people had when they were in need of help to restore their well-being. I also made clear that being sick is a relative variable that can mean different things to different people at distinct points in time. The perception of affliction as well as the mode and order of therapy depend on certain given beliefs, but also on a treatment's effectiveness, a possible therapy management group and

available options. I wanted to explain that health and healing are complex sites of negotiation, compromise and change. Furthermore, their determinants can be manifold, ranging from economic as well as emotional resources, pragmatic considerations as well as family matters, the provision of local health care facilities and the construction of national identities. It should now be plain that there exists no coherent theoretical body that explains peoples' treatment practices for illness. The assumption that epistemic bodies of knowledge about health and healing exist to which anthropologists can somehow gain access is a Western epistemological assumption in itself (Farquhar 1987). Rather each episode of sickness has the potential to transform one's explanations, practices and perceptions about causes and strategies of resort and healing. In that sense, sickness can be an existential experience that challenges one's sense of social order and/or the capacity of one's social network.

The discussion on medicine and narrations about it as a tool for negotiating identity and moral order has shown that the plural medical landscape is fluid, constantly shifting and at times contradictory (Brodwin 1996:16). The hybridity within medical traditions clearly demonstrates the social processes at work. Medicine and medical knowledge are not only important when healing the sick but also for identities in the making (Ferzacca 2001:5). Seen in this way, medical practices are both the outcome of objective, determining structures like nationalist discourses, on the one hand, and of subjective, internal definitions about health, well-being and (morally) good ways of living on the other.

3.

Healers meet Biomedicine

In this chapter, I look more thoroughly at the arena of encounters between traditional healers and biomedicine. Of central importance will be the biomedical workshops the healers took part in, their motivations for attending and the consequences of their involvement. In what way was new knowledge incorporated and why? How did practice change and, moreover, were epistemologies altered as a result of healers' exposure to biomedical theories?

After giving a brief historical review of the encounters between healers and biomedical practitioners in South Africa, I want to consider the different interactions between the healers I studied in Port Elizabeth and biomedicine. Afterwards, I will discuss other relevant studies on the topic, which has attracted much scholarly attention. Common themes include the processes that are usually framed as biomedicalisation. It is often claimed that essential aspects of traditional healing here are lost. I will take up the thread of these discussions in trying to analyse the validity of these concepts in terms of my own material. To what extent is it possible to describe the eventual epistemological changes on the side of the healers as processes of biomedicalisation? And under what conditions does the concept of code-switching or the necessary establishment of a metacode for the communication with practitioners of a different epistemological background suffice to describe the processes at work when traditional healers encounter biomedicine?

My primary concern is twofold. First, I want to show that during their encounters with biomedicine healers refrained from certain explanations or concepts which they considered to be untranslatable or incommensurate in order to facilitate communication. This "trading language" can be described as a metacode. The desire to save face in Goffman's sense played a role, too, both on the side of the healers as well as on the side of biomedical personnel. In a second step, I will argue that in order to claim an overarching biomedicalisation, whereby essential elements of traditional healing get lost, it would be necessary to note epistemological changes not only during collaboration but in other arenas as well.

3.1. A History of Encounters

On Settlers, Missionaries and Plants

Sources on workshops or any other collaboration between healers and biomedical personnel during or even before Apartheid are scarce. Karen Flint's compelling book "Healing traditions" (2008) and Anne Digby's detailed historical work on "Diversity and division in medicine" (2006) provide us with two outstanding accounts of how health care in South Africa developed from the early days of colonialism. Flint studied encounters between healers and colonial rule between 1820 and 1948, particularly in what is now KwaZulu-Natal. Digby includes all regions within South Africa, although focusing in greatest detail on the Cape, which today is divided into the provinces of Western, Northern and Eastern Cape. She writes on the evolving practices of missionaries, doctors, nurses, healers and patients using both archival material as well as oral histories. Both authors describe how medicine in the 19th century could sometimes open and mend relations between Africans, European traders and missionaries (Digby 2006:63, 88, 100, 296f.; Flint 2008:94f.). In the 18th and early 19th century, European travellers to the Cape were mainly interested in the medicinal plants of the Khoi people, e.g. Buchu, Wild Fig, Kanna, Fennel and Aloe, as well as in San hunting poisons and their antidotes. They expressed their frustration about the therapeutic secrecy they encountered (Digby 2006:304). With regard to Natal, Flint notes a fruitful exchange involving medicine and healing between all parties involved – newly arriving settlers, doctors and missionaries and Zulu people and their healers (2008:94f.). Lacking suitable remedies for local ailments, missionary doctors sought the assistance of healers and even borrowed their remedies (ibid.; see also Etherington 1987). Digby goes into considerable detail in describing how particular missionaries were interested in the potential of medicinal plants that were used by healers. They collected them and studied their effects systematically (2006:339 ff.). The Moravians, in particular, whom she describes as being less evangelistic since they did not use medicine as a strategic tool to convert people, developed a medicinal blend that combined indigenous and German homeopathic treatments (Digby 2006:339f.). Flint cites several examples of how European settlers worked as healers by using household remedies from Europe together with local therapies, without however necessarily being trained medical doctors. Some of them attained lofty reputations in the Zulu kingdom, for instance as result of treating King Shaka successfully. In such cases, land would often be granted to the settlers or missionaries (Flint 2008:96). During feverish epidemics that affected the coast in the 1850s, the demand for European pharmaceuticals amongst the Zulu population was great and

"Africans besieged missionaries…for medicines" (2008:97). Missionaries and traders helped to create a market in the late 19th century that allowed people to obtain European medicine even in the countryside (ibid.). Healers developed hybrid medications by adding pharmaceuticals to their herbs and attracted more patients (Digby 2006:296). Also the herbs used by the settlers that had adapted well to South African soil were adopted by local people. For example, the male fern used by the Boers against tapeworm or for horse manure was used locally to prevent childhood fevers (ibid.). Flint suggests that in the early days European medicine could be incorporated relatively easily into African ways of healing because it was detached from biomedical doctors and institutions and furthermore seen as a supplement to rather than a replacement of local remedies (2008:98).[50] The Comaroffs (1989; 1991; 1993), on the other hand, show most impressively how medicine and proof of its effectiveness could serve the missionary endeavour and colonisation as a whole by demonstrating the superiority of European civilisation.[51] Their main argument is that by taking over certain ideas and practices of the Europeans whole epistemologies were being altered. In their words, the people's "consciousness (was) being colonised" (see esp. Comaroff and Comaroff 1989). In the following chapter, I will show that this is not necessarily always the case. What seems most likely is that, to a certain extent, the effectiveness of European theories and practices helped to constitute and further consolidate the image of Western superiority as contrasted to local inferiority and backwardness. By analysing the diaries and letters of missionaries, Digby shows that this was indeed the objective. Most missionaries were trained in medicine and Africans also later received medical training in the hope that traditional healing would be replaced (2006:101f.) Hospitals were seen as serving this end, although it should be further kept in mind that mission hospitals filled huge gaps in the availability of health care in South Africa, especially after 1948 when mission-based health care grew even more rapidly in response to the government's neglect of the health needs of rural Africans (Digby 2006:136).

By the early 20th century, Flint discovers a transformation in doctors' attitudes towards healers. The doctors voiced increasing scepticism about the healers' methods, labelling them as "unscientific" and "ineffective" (2008:95). Flint attributes this shift to the British colonial officials' growing negative stance towards healers due to their role in identifying and sometimes killing alleged witches. Witchcraft and especially the mobilising power witch-

[50] Of course people also used and reinterpreted biomedicine according to their notions of efficacy, which means the regiment or duration of a particular medication could be altered or discontinued. Hence, although biomedicine was quite popular, people did not necessarily meet the expectations that missionary doctors had for how compliant patients should be (Flint 2008:98).
[51] See also Vaughan 1991 and Ranger 1981.

finding entailed was perceived as a threat to colonial rule, and quite rightly so in view of the numerous revolts in Xhosaland from the early to mid 19th century (2008:102-110). One prophet, Mlanjeni, who became famous for his ability to identify and cure witches, assured local chiefs and farm workers of the support of the ancestors in fighting the British. This promise resulted in a war from 1850-1853. Xhosa historian Jeff Peires (1987) describes in detail the famous Xhosa cattle killing in 1856 triggered by the prophecies of a young girl, Nongquawuse, which were attested by local healers to be legitimate and reliable. Flint thus writes: "Not surprisingly, British attention to witchcraft cases subsequently switched from concern for the alleged witches and punishment of those who killed them to a focus on and decision to outlaw healers themselves" (2008:106). Colonists further realised the important role healers played in upholding the power of certain chiefs or undermining the status of others. From the 1860s onwards, the British passed several laws and punishments that made the healers' practices illegal. As a consequence, healers were forced to do their work in secret (2008:109). Another aspect that worsened the relationship between biomedical doctors and African healers was the unique licensing of *inyangas* (herbalists)[52] in the province of Natal in 1891. Not only did this new legislation result in a split within the African healing profession between herbalists and healers. Biomedical doctors, themselves just starting to professionalise within South Africa, felt especially threatened by the influx of herbalists into the cities as this meant increasing competition for patients (Flint 2008:128-157). To summarise, the initial encounters between the colonialists, European healers and doctors and African healers were mostly cooperative and supportive. With the progress of the colonial endeavour, however, competition within the healing business as a whole increased, as did the exercise of control over African healers by colonial rule.

Colonial Rule and Public Health

By 1910, one-third of all doctors in the Cape were on public appointments working full- or part-time as district surgeons (DS), sanitary inspectors, inspectors of African locations, medical officers of health or on hospital boards. An "all-embracing network of colonial bureaucratic control" had been established (Digby 2006:158), reflecting growing health

[52] Note that only herbalists were legalised, as opposed to healers who needed ancestral support for their practice and who are central to this dissertation. Again, the legislation process will be topic of Chapter 5.

concerns after the outbreak of bubonic plague in 1901[53] in Cape Town and other cities, as well as an increasing anxiety over "African diseases" because of growing black urban migration. In rural areas, one of the first encounters people typically had with science, medicine and the state was with the district or colonial veterinary surgeon who functioned as "the prime agent working to advance imperial civilisation by combating disease and unsanitary habits" (Digby 2006:171). African residential areas as well as their cattle kraals were seen as a threat to neighbouring farms and towns. Hence, the DS ordered huts to be burnt down if they had housed smallpox patients or sick people to be transported to leper colonies, lunatic asylums or hospitals (ibid.). While some of these measures only occasionally provoked active resistance (ibid.), they certainly led to the negative reputation of biomedicine in the long-run. A century later, many social anthropologists attribute the difficulties in HIV/AIDS prevention and even Thabo Mbeki's denial to a deep-rooted suspicion amongst black people in South Africa towards public health campaigns that goes back to earlier experiences at the beginning of the 20th century (Gevisser 2007; Youde 2005; 2007). I will return to this issue in Chapter 5.

During the 1930s, public concerns over the state of health care in the rural Cape grew. Hence, black health personnel[54] were appointed in community health services to support the outreach system of district surgeons. Their number in black areas grew, albeit slowly, and district nurses, school nurses, and health visitors were employed by municipalities (Digby 2006:265). Black nurses fulfilled a role as "cultural brokers" (Digby and Sweet 2002) by "acting as the patient's advocate, diplomat and facilitator between different cultures" (2006:270). They could also help to bridge the distance between biomedicine and traditional medicine. Digby provides details from several interviews she conducted with former nurses in which they describe their encounters with healers either in hospitals, when the latter would come to visit stationary patients, or during visits to local communities. One nurse recalls how she delivered a baby together with a healer in the 1950s. She emphasises the importance that tact had in dealing with her and states that the healer "responded very well to the partnership idea" (Digby 2006:272). Another nurse describes how she scrutinised her own attitudes towards healers and became more open towards them. She sees her role as being a bridge between

[53] For a thorough analysis of the "sanitation syndrome", a metaphor for black settlements as a threat to public health that led to the first segregation laws, see Swanson's famous article from 1977.

[54] Following a long discussion about the desirability of black health personnel serving the needs of the rural black population, the South African Native College at Fort Hare offered a training scheme for medical aids in 1938 (Digby 2006:194f.). The prominent mission school of Lovedale taught medicine to black students as early as 1878. Among other things, it was supposed to provide a worthwhile career option for the "educated and ambitious native student" (2006:192). Also, it was hoped that the belief in witchcraft and superstition would be overcome by providing medical training for Africans (ibid.).

Western and traditional medicine, since she "keeps going back to the roots of the past of the people she helps" (2006:273). Some of the district nurses gained considerable respect and support in the communities they served e.g. by starting welfare projects with locals like crèches or lunches for school children (ibid.). In Port Elizabeth, a public hospital was named after district nurse Dora Nginza, who worked in New Brighton township from 1919 until 1954. She ran a small hospital with a group of nurses caring for 6,000 people (Digby 2002:263).

The well-known Gluckman Report from 1945 marks the beginning of a new form of public health in the provision of primary health care. The government headed by Jan Smuts set up the National Health Services Commission under Dr Henry Gluckman as a response to the rapid effects of urbanisation (Horwitz 2009:6). The "radical and visionary" report (ibid.) criticises quite strongly the unacceptable level of ill health due to bad socio-economic conditions and recommends preventive educational health programs as well as community based health centres[55]. Central for this strategy was the training of health assistants recruited from the communities that were to work in health education, rural sanitation, child-rearing and so on (Phillips 1993:1038).[56] The health assistants as an additional resource for health care were frequented a lot in the rural countryside. Digby reviewed reports of the Botha's Hill Health Centre near Durban, concluding that its director adopted a cooperative attitude regarding the work with traditional healers. The director viewed healers as influential allies in promoting health in the communities and advised nurses and doctors to avoid criticism of traditional healing and to adhere to a "policy of non-interference with healers' work" (Digby 2006:398). Dutch researcher Nieuwenhuijsen (cited in Digby 2006:398), who worked on Zulu healers, found in 1960 that healers quite often referred patients to the health centres. In 1968, even healers and their families sought treatment at the Botha's Hill Health Centre for themselves. Meanwhile, doctors and nurses were quite aware of their patients' multiple consultations with practitioners of different backgrounds (2006:399), a phenomenon I covered in the previous chapter.

[55] The prototype for this concept of health centres, later copied worldwide and taught within Public Health curricula, had been initiated in 1940 in Pholela, a rural area in Natal, under the direction of Drs. Sidney and Emily Kark. Sydney Kark was an advisor to the Gluckman Commission. (See Jeeves 2000, Marks 1997, Pillips 1993, Susser 1993 and Yach & Tollman 1993 for more on the Pholela model and the work of Drs. Kark.)

[56] Whereas this model received wide recognition in the UK, the USA and Israel, and was reflected in the famous WHO declaration of Alma Ata of 1978, its further implementation in South Africa came to a halt when the National Party came into power in 1948 and Apartheid began (Harrison 1993:682f., Horwitz 2009:7, Marks 1997:455). Having faced an increasingly dismissive attitude and growing resistance on the side of the government, but also from the MASA (Medical Association of South Africa) by the mid-1960s, the last remaining health centre out of an earlier total of 40 had to close (Harrison 1993:682).

Growing Collaboration and Institutionalisation

One of the few examples of collaboration between biomedical health care workers and healers during Apartheid could be a conference that Simonne Horwitz (2009) highlights. In her paper "Health and health care under Apartheid", written for an exhibition of the same name at the Adler Musem of Medicine in 2009, she mentions one particular Traditional Healers Conference that was held in 1971 at the All Saints Hospital in the rural Transkei. As part of the hospital's health education outreach program, the conference initiated a monthly workshop for a six-month period between six hospital doctors and six traditional healers. Horwitz describes the cooperation as "an invaluable experience for both groups with great co-operative potential" (2009:5), but it is not clear how she reaches her evaluation[57]. Digby mentions a similar conference and seminar series at All Saints Hospital in 1973 (2006:440). In the early 1990s, rural hospitals started to invite healers to discuss themes of common interest. Universities established traditional medicine units and broadened their curricula for medical students by introducing them to patients' medical pluralism (ibid).

Another field of inquiry is the history of the Traditional Health Practitioners' Act[58] or the process of professionalisation in particular. Healer's efforts towards professionalisation reach back to the 1930s (Flint 2001). Individual healers as well as professional associations addressed the Departments of Health and of Native Affairs to request official recognition (Rüther 2002:45). According to Kirsten Rüther, who did extensive archival work on the respective communications, the most articulate and persistent association was the South African Bantu Dingaka Herbalist Midwives Sangoma Society based in Sophiatown. The group "virtually bombarded state authorities with requests, resolutions and information between 1937 and 1939" (2002:46). While not being particularly successful in their quest for official recognition at the time, it is documented that scientists were invited to witness circumcision ceremonies. This is the oldest evidence I could find of an effort to initiate a collaboration with representatives of science or medicine (Rüther 2002:47). In the 1980s, in connection with HIV/AIDS, the question of a professionalisation of healers received new impetus before the demise of Apartheid and the issue was widely debated in the media. Rüther speaks of this transitional phase as one characterised by a popularisation of traditional healing (2002:52). After 1990, and against the backdrop of a changing political climate that

[57] Horwitz uses one photograph of that particular conference that is part of the Piper Collection housed at the University of Fort Hare in Alice, South Africa (2009:5).
[58] Chapter 5 attends to this more thoroughly. Here, only the history of encounters and the beginnings of an interest on the part of biomedical doctors in traditional healers shall be looked at.

later culminated in the discourse of an African Renaissance, healers gained increasing importance due to their cultural prestige as promoters of indigenous knowledge. Already mentioned in the National Health Plan of the ANC in 1994 as having to play a pivotal role in the reform of the country's health system, the process of a large scale professionalisation and legalisation of traditional healing finally gained momentum. The healers' organisations were the stakeholders the state and its agencies as well as numerous NGOs needed when the desire was expressed to include healers into programmes on HIV/AIDS and other health-related topics. Also the AIDS debate triggered by Thabo Mbeki and the health minister on the appropriate treatment of the disease further enhanced the status of traditional healing (Zenker 2010). The following chapters will deal with these issues I now just shortly mentioned.

3.2. On Workshopping

Healers are Doing it for Themselves – They Organise

The starting point for the healers' joint projects with biomedicine was their professional organisations. They served as gatekeepers between institutions willing to offer trainings or workshops, on the one hand, and participants (on the part of the healers) on the other. In Port Elizabeth, two big healers' organisations existed. One was called "PE Traditional Healers", the other "Nyangazezizwe" (Xhosa: Healing the Nation). To become a member in either one, registration or a fee were sufficient. The recruiting of new members went on through old members. This was to ensure that the registration of a person who was not a "true" healer was virtually impossible. Usually the traditional healers knew each other due to their network, consisting of former trainers and students, and they met frequently at various ceremonies, where students passed their stages of training or completed it altogether with the according ritual. The PE Traditional Healers were linked to the Provincial Health Department in Bisho, the provincial capital of the Eastern Cape. This was where the applications were sent, together with 100 Rand entry fee, and the new members in return received a registration card with photo and registration number. The healers were now able to present themselves in front of their clients as officially registered by the state. The cards were consequently pinned on the walls of their consultation rooms, clipped onto their jackets or proudly presented during an interview.

Nyangazezizwe was a little different. The countrywide organisation was founded in 1989 by Merci Manci, herself a Xhosa healer (see also Campbell 1998). On numerous occasions, I had

the opportunity to talk to her as she was a regular guest in several healers' workshops and ceremonies in PE. She explained to me that she came upon the idea of forming an organisation in a dream (Notes, 2004-09-30). Her aim was to bring healers together to address professional concerns, share information and conduct training programmes. International donors supported the organisation, especially in its fight against HIV/AIDS (Campbell 1998:106). Nyangazezizwe had branches in various cities, but was not linked to any governmental institutions. Members received a membership card that resembled more of a business card. It did not have a registration number or a photo. Nyangazezizwe members were therefore usually officially registered within the PE Traditional Healers as well. In contrast to the PE Traditional Healers, the members of Nyangazezizwe perceived themselves as forming more of an interest group than simply an organisation that one should be registered to. They met more often, organised conferences or projects together and took part in each other's graduation ceremonies. The relations amongst members of the PE Traditional Healers seemed more casual and less based on the shared motivation to achieve a common goal. The main reason that healers mentioned to me for joining one of the organisations was the necessity "to speak with one voice" (Mr. Kota, Notes, 2004-04-13). Also, having an organisation would be necessary since the government, which now represented everyone, wanted to work with healers, too, and "cannot deal with just one healer" (Int. Lusanda, 2004-06-03). Linda explained that the government would now want healers to be registered with an organisation, so she felt she had to. She also added that learning about diseases like AIDS or diabetes through the workshops that were offered was important (Notes, 2004-10-02). Joe Gumede also liked having a "code of conduct" as a member of an organisation, which would hinder "malpractices", e.g. "people saying you can cure meanwhile you can't." (Int. A010, 2004-06-22) Mr. Tekile, secretary of the PE Traditional Healers, expected that there will be resources from the government that organisation would have access to. He said: "You can do everything because we are organised and recognised by the SA government...We can even contact the government as an organisation, and build up a university of traditional healing." (Int. A019, 2004-09-13) And Thobeka, the head of Nyangazezizwe PE, emphasised:

> Without being a member, you would just sit at home, being a healer. Now there are conferences, you meet other healers, hear about projects and gardens, meet with doctors, learn about T-cells and all those things. And you get free training. Normally you have to pay for everything you learn but the organisations can offer it for free. (Notes, 2004-06-04)

As my main entry point for meeting and getting to know the healers I wanted to study was the pharmacy department that initiated the workshops, the majority of healers I encountered were affiliated with one of the two organisations. However, most of the people I became acquainted with who were not healers or pharmacists knew healers in their neighbourhoods or even had them in their families. Although I did not get to know them well or met them often, I nevertheless had the chance to do several interviews with healers who were not members of an organisation. One of them, the mother of my Xhosa teacher, Grace, lived in Motherwell, one of the most remote townships of PE. When I asked her why she was not a member of an organisation, she answered that while she knew about them, she also thought that one should not talk openly about one's practices or exchange ideas on the matter. "It is something between you and your ancestors and it gets just confusing when you try to compare with other methods. You cannot learn those things." She added that members were supposed to bring their own medicine to the meetings, too, because the others would want to know which one you use. She did not want to give knowledge away, she said. "Everybody has her own medicine and you mustn't tell that to anybody" (Notes, 2004-03-18). Compared to other healers I knew, she was much poorer. She lived in a one-room brick house with hardly any furniture; her clothes as well as her children's were tattered. For Sivu, on the other hand, time constraints were the reason why he had yet to join an organisation, but he was planning to in any case. The former student of Thobeka was the head of a post office in Zwide and worked full-time.

Both organisations had their councils and chairpersons democratically elected by their members. Regular meetings headed by their "tasks teams" and elected chairpersons were held concerning fund raising, workshops or similar projects, and conferences were planned and hosted. Members of the organisations would also try to recruit new members from townships farther out of town by calling meetings together for healers in the respective community halls. By explaining the objectives, the possible connections and benefits of being a member, they tried to canvass areas where people might be interested in joining their organisation. The PE Traditional Healers had a representative attending the AIDS council of Port Elizabeth that met several times per year and consisted of representatives of local enterprises, educational institutions, clinics, hospitals and NGO's. The aim of the council was to establish a network for developing a policy towards AIDS on the municipal level.

Rivalries, splinter groups and competition for members are topics often written about in relation to the professionalisation of traditional healers (Devenish 2005; Last 1996; Ngubane

1992). In the context of the two organisations I studied in PE, rivalry between them was not a significant issue. This was because Nyangazezizwe was more of an interest group that also urged its members to be officially registered with the PE Traditional Healers. There was, nonetheless, a dispute about the legitimacy of the chairmanship for the PE Traditional Healers amongst two women, which resulted in one breaking off to form her own group. Feeling forced out by Thobeka, Lindiwe decided to leave the organisation with a few supporters. This splinter group proved less successful in acquiring access to workshops or to funds, which was mostly due to the different personalities of the two rivalling women. Thobeka possessed superior communication and motivational skills, spoke better English, and appeared to be a more organised and ambitious person. "She knows what she wants and follows her issues. Lindiwe attends the events more for prestige reasons. She decides about a meeting depending on who else is going", explained Shirley, a pharmacy student who had served for years as an interpreter between the healers and the pharmacists (Notes, 2004-02-18). One could even say that Thobeka had more social capital in Bourdieu's sense (1984) in that she was better connected, had more valuable social relationships and a more extensive network.

Various actors offered workshops for traditional healers. The municipality conducted numerous workshops and trainings for traditional healers on topics like first aid, diabetes, home-based care, tuberculosis, counselling and, of course, HIV/AIDS. The pharmacy department offered trainings on similar topics. ATTICC (AIDS Training, Testing, Information and Counseling Centre) held workshops on HIV/AIDS for healers several times a year. The aim of these trainings was primarily to re-educate and change the practice of traditional healers to accord with Western medical standards. Those workshops were highly attended, an indication perhaps that one reason healers decided to join the PE Traditional Healers was because the chairperson would announce in their meetings upcoming workshops the healers could participate in. When the split occurred within the PE Traditional Healers between the old chairperson and her followers and the remaining healers, the flow of information was a key issue. The old chairperson, Lindiwe, was accused of not having "reported back" from any meetings of e.g. the city's AIDS council she attended. "She was sitting on the information", Mr. Mvimbeli told me (Notes, 2004-04-06). During a meeting of the PE Traditional Healers where the matter was discussed, Mvimbeli, who became the new chairperson, also told the others about the content of one polio workshop he had attended. Mrs. Nxele then stood up, saying this was the first report she had ever heard. She therefore backed the committee's claim that the old chairperson did not share information with the group (ibid.). The meeting then returned to its normal agenda. The secretary, Mr. Tekile, reported on the AIDS-council

meeting he attended, summarising the main ways of transmission and emphasising the importance of educating the people on AIDS. Thobeka spoke to the others about a conference she attended in Johannesburg the week before. She also explained what was planned for a two-day conference two weeks later that would be hosted by the group and invited everyone to come. The meeting was concluded after Mvimbeli reminded everyone to be present on next day's AIDS meeting.

This particular meeting was exemplary of how healers learned about upcoming and past events. If certain healers could not attend, others would call them or stop by. I gave lifts to people who wanted to pass along information to others or to leave invitations to that particular two-day conference taking place in PE. The pharmacy department also put out a newsletter that kept the healers informed about the state of their cooperation. Mea was responsible for maintaining its address list, and some healers would complain to her that the newsletter had not been delivered to their homes. This was a persistent problem that was difficult to solve and blame was generally placed on the unreliable postal delivery in the townships.

In total, I witnessed 13 workshops during my fieldwork in Port Elizabeth that were either for or with traditional healers. The first one was on the Health Train that stopped in Port Elizabeth for one week in February 2004 (Notes, 2004-02-13). The idea behind the Health Train, sponsored by Transnet, South Africa's biggest freight transport company, was to ride throughout South Africa and stop for a week in every large city to offer health care for free to people in need. Doctors, nurses and medical students volunteered on the train for two weeks at a time. There was a dentist, an optometrist, and a clinic, along with psychological sessions and workshops in different wagons of the train. Dozens of people cued in front of each, waiting to be attended to. The last wagon hosted a workshop on counselling. In conducting plays, the participants would exercise their conversational skills and afterwards discuss their impressions. Some of the women in attendance were so-called community workers. Although unemployed at the time, they hoped that one day a paying job would be the result, a product of their unpaid work as HIV/AIDS counsellors, health or social workers. Two women and a man present were traditional healers of the PE Traditional Healers. Only later did I learn that they (Thobeka, Lusanda and Mr. Kota) belonged to the core group of this organisation and Nyangazezizwe and would be present at nearly every workshop I would attend afterwards. One week later I met Lusanda and other women from the Health Train in a church in Swartkops, a nearby township. A one-week workshop was held there on home-base care, HIV/AIDS and first aid that was funded by the Department of Labour. Lusanda told me she

preferred this workshop as they would not simply converse the whole time but would do more "quiet work and serious studying" with exercise books (Notes, 2004-02-16). Other workshops that followed were on the Traditional Health Practioners' Bill, the medicinal garden project of the university's pharmacy department and HIV/AIDS.[59] During my stay three large healers' conferences were held in PE where several representatives of local and national healers' organisations gave talks about their activities and collaboration with state agencies, local as well as international NGOs and research institutes. Over 100 people gathered on those occasions for several days consecutively using the event to network and to exchange ideas and experiences.

Fig. 3: Healers' conference in PE.

While I was there, Thobeka also went to several conferences outside of PE that I did not attend. In March 2004, she attended the African Traditional Healers Conference in Johannesburg together with another PE healer. She learnt about the conference from Maryna van de Venter from the pharmacy department of UPE, who was called by the MRC (Medical Research Council) to appoint two healers from PE to visit the conference. Following her return, Thobeka told me one of the conference's topics was the opportunities and challenges with regard to working together with physicians. The health minister, Manto Tshabalala-Msimang, was there, too, and talked to them about the importance of nutrition in relation to

[59] Two workshops were held on the Traditional Health Practioners' Bill, five on the medicinal garden project of the university's pharmacy department and four on HIV/AIDS.

AIDS.[60] A further topic dealt with the upcoming ARV rollout.[61] Thobeka was invited to another conference in Cape Town on healers' responses to diabetes, organised by the MRC. I picked her up from the airport when she came back, and she told me she was the only healer who had been invited. She had gone together with Maryna van der Venter from the UPE pharmacy department and others from UPE. The government wanted to start programs on diabetes and, therefore, invited pharmacists, biologists, botanists, social workers and Thobeka herself to talk about the cooperation with UPE.[62] Thobeka described the atmosphere in Cape Town as positive and friendly. People were happy to have had her there, she recalled. She was allowed to burn *imphepho* and to praise the ancestors before the conference started, which she described as a "big success". She said she had approached the people there to tell them she would be doing this. "Imagine, Julia, I was allowed to pray to the ancestors." She was beaming (Notes, 2004-10-22, Int. A031).

Mingling with the Pharmacists

Besides the numerous workshops healers attended, another collaboration was also very significant during my research. The pharmacy department at the University of PE conducted pharmacological research on the detectable effects of medicinal plants used by healers. The healers were asked to bring some plants to the department in order to get them tested in the laboratories. They were also invited to observe the testing process itself. Some plants, for example, were shown to have some impact in the treatment of diabetes (Huyssteen, Reddy et al. 2004). This interaction was characterised by both sides as an "exchange of knowledge": the pharmacists were able to get some insights on traditional plants while healers obtained some Western medical training in various workshops. The motivation of the department was to "uplift" the reputation of traditional healing by scientifically verifying the efficacy of the plants it uses and to preserve what is seen as an important part of Xhosa culture. The healers were not only motivated to participate in this process by the access they gained to workshops, but also because they acquired scientific proof of the efficacy of their practices which could improve their public reputation. The scientific testing of medicinal plants used by healers was also given national attention. In 1998 the National Research Foundation was chartered to foster science and technology, and traditional knowledge in particular (Ashforth 2005:151).

[60] Thobeka said it was the second time she had met the health minister. She also talked to her during the National Condom Week when she visited PE. "She likes mixing with us healers", Thobeka explained to me (Notes, 2004-04-02).
[61] The nationwide ARV rollout started in 2004.
[62] Mea, a PhD student of the department, had once published an article about the active ingredients particular plant healers used to treat diabetes (Huyssteen, Reddy et al. 2004), featuring Thobeka and the cooperation.

The Medical Research Council (MRC) also started doing research on traditional medicine.[63] Another example is TRAMED, which was established in 1997 as a research project on traditional medicine by the Universities of Cape Town and the Western Cape with the support of the MRC to create a database of traditional medicines for eastern and southern Africa. They conducted laboratory screening of traditional medicines for malaria and tuberculosis and developed systems for the scientific understanding of the action and uses of essential traditional medicines in the prevention and treatment of diseases.[64] Jo Wreford, a trained sangoma herself, studied healers in and around Cape Town and hence also some who were directly involved in the collaboration with the MRC and TRAMED. She criticises the lack of consideration of the spiritual aspects of the healers' practice, the obscure status of intellectual property rights and the mode of sharing the expected outcomes of this research (Wreford 2008:86ff.). I will come back to these issues later in this chapter when I talk about the problems of interaction more thoroughly. Also my assessment of the motives of both sides will be more detailed.

In PE, the starting point of that collaboration between the pharmacy department and the healers turned out to be the World AIDS Conference in Durban in 2000. Thobeka, the head of Nyangazezizwe PE went to the conference with Mike Pantsi, a local NGO health worker. There were a lot of healers from South Africa present discussing their experiences and projects. Pantsi[65], inspired by the vision of an all-encompassing community health project fighting HIV/AIDS and motivated by what he learnt in Durban, had the idea to bring local pharmacists and healers together and hence facilitated a meeting between interested scientists at UPE and local healers. "People were dying like flies, so every option had to be explored", he explained (Int. A022, 2004-09-23). It was also Pantsi who came up with the idea of establishing a medicinal garden together with the healers and the pharmacists. He said the knowledge about the plants people used should not be forgotten and also that it would be better for conservation reasons to establish a garden instead of having people collect plants from wherever they might find them. He found a piece of land at an old-age home in Zwide, one of the townships of PE. When it was opened on 30 September in 2004 representatives from the municipality and local NGOs attended the ceremony as well as the vice chancellor of

[63] As part of the research group LOST at the Max-Planck-Institute in Halle/Germany, Julie Laplante studied the scientific testing of medicinal plants at the recently established laboratories of the MRC in Cape Town, focusing on the negotiation and translation processes taking place when a plant travels from a traditional healer via the lab to its effective use in a capsule.

[64] See their website: http://www.mrc.ac.za/Tramed3/.

[65] He came to know Thobeka through a nurse he had worked with. Thobeka introduced him to Merci Manci, head of Nyangazezizwe South Africa, who was teaching healers on AIDS at a workshop in PE. Together with Thobeka, he then founded the local branch of Nyangazezizwe (Int. A022, 2004-09-23).

the university. There was, of course, also a large number of healers present. In the near term, the garden was supposed to provide a source of income for the healers who didn't cultivate their own medicinal plants. They could guide groups of tourists through the garden and explain the principles of traditional healing. Relevant contacts to township tours and the tourist department existed already.

Fig. 4: Opening of the medicinal garden. Vice Chancellor of UPE with the chairperson of Nyangazezizwe PE (middle) and the chairperson of Nyangazezizwe South Africa

Prior to the opening of the garden a group of healers had met regularly since February 2004 with Mea, a masters student from the pharmacy department who was in charge of the collaboration with the healers. In the starting phase of the project, Mea discussed with a management team consisting of eleven healers, all female, the location of the garden, its design and possible contacts for funding. Subcommittees were formed for the themes of culture, plants and cultivation.

The issue of conducting scientific testing on the plants played a big role on the local as well as on the national level. Nevertheless, this "exchange of knowledge" was obviously not always free of conflict. The healers were highly concerned about their intellectual property rights, especially since the media revealed that some pharmaceutical companies had profited by producing drugs based on traditional plants. The pharmacy department, however, emphasised that they were not related to any pharmaceutical companies but exclusively interested in scientific research as an end in itself. During a group discussion between several healers, Mea and another pharmacy student at the old-age home in Zwide, the disparate positions came to

the surface. Originally the meeting was meant to be on HIV/AIDS in preparation for an upcoming AIDS workshop at the university. While debating the possibility that a cure for HIV/AIDS would be found either by biomedical doctors or traditional healers, the present healers insisted on the need to keep any medicine they use in this regard secret. The medicine, they noted, would come from the ancestors and, therefore, they could not allow giving the ingredients away. The ancestors also could draw off the potency of a medicine, punish a healer by withdrawing their ability to heal, or even kill them. The necessity of scientific testing was also hotly debated. Lusanda asked: "Why do they [the government] want to know the ingredients? Why can't the medicine just be tested to see if it works?" Mea replied that the government wants proof for the efficacy of the medication and that the exact ingredients were needed for analysing and testing. Trust was furthermore an issue. "Western doctors have the tendency to take things for themselves and then tell that they have found it on their own. They don't want to share", Lusanda explained. "Healers have never being recognised and now healers are really afraid." Mea in turn emphasised the need to work together and remarked that recognition only works through the process of getting the plants tested. It should not be forgotten, however, where the information came from, she said. "That's why you should work with us. We can prove that your medicine is working. And instead of purchasing expensive medicine from overseas, medicine containing genuine plants could be produced which would be cheaper. And the healers would be able to heal their own people." Thobeka's and Lusanda's counterproposal was to let healers treat patients in the hospital and then evaluate the outcome. Another healer present added that she would not give her ingredients away. It was part of their culture and if it were taken away from them their culture would die. "You must follow not trying to lead us. Be patient. If not we will run away", she concluded. The debate found a conciliatory end when, due to time constraints, the healers proposed getting back to the AIDS questionnaire so that the two pharmacy students could get the answers they needed (all from Notes, 2004-04-07).

On Motives

Preservation, PR and the Creation of a Better Image

In one of the planning meetings for the medicinal garden that took place at the old-age home, Thobeka advocated for more participation among their colleagues and in favour of the importance of the garden project by invoking discourses of culture, indigenous knowledge and Xhosa identity. "We healers must work on our image", she remarked insistently. I was impressed by the impact her motivational speech appeared to have on the other healers present. They seemed to awaken after having rather passively listened to Mea's suggestions and been silent when she asked for ideas and opinions. They nodded in approval while Thobeka was talking; they made comments and asked questions. She passed around a sketch she had made showing the possible design of the garden, while emphasising the need to "uplift traditional healing" and to "teach Xhosa culture to overseas tourists". She further contended that "children [referring to school classes] must learn about their culture because this is where they are coming from" (all from Notes, 2004-02-19). It was in later conversations that I learnt about the healers' concerns about how their image in the media, which used to be primarily negative, was only now slowly changing for the better. Kirsten Rüther (2006) studied the representation of healers in South African media during Apartheid. Especially after the Soweto Uprising in 1976, magazines and newspapers increasingly wrote about healers in connection to "muti murders", "body butchering" and "cannibal 'witch doctors'" (2006:148, 151). Drum magazine was especially unrelenting in relating healers' practices to witchcraft and manipulative medicines, delivering to its young readership a rather "one-directional sensationalist message of scurrilous 'killer inyangas'..." or "zombies" (2006:159f.).

"To upgrade African traditional healing", was an objective often mentioned in interviews and conversations when I questioned healers on their motives for taking part in the projects (e.g. Int. A019, Tekile, 2004-09-13). Thobeka stressed the importance for healers to "work on their image" when she tried to motivate her colleagues to participate in the medicinal garden together with the pharmacy department of the university (Notes, 2004-02-19). She had worked out a concept for the garden which consisted of a sketch of the variety of different growing patches in the garden and several keywords she had noted down. The reasons to join the collaboration were all couched in terms of "African identity", "culture", and "indigenous knowledge". The other eight healers, all women mostly in the fifties, listened attentively and nodded approvingly (ibid.). During a meeting of the PE Traditional Healers, the secretary, Mr.

Tekile, emphasised the importance of the cooperation with the pharmacy department - the "working together of the two institutions" - by referring to the country's previous ten years of democracy and noting "that we are one people" (Notes, 2004-04-06).

Interestingly, issues of preserving Xhosa culture and knowledge and cultivating the image of healers were also often brought up by pharmacists of UPE. When I asked Dr. van der Venter, who is head of the traditional medicine unit in the university's pharmacy department, about her motives for working together with healers, she said the pharmacists would aim "to strengthen the community" and "to give something back to the community", as traditional healing was "such an important aspect of their culture". Also, in relation to the testing of plants healers used, Mea explained to me that she hoped she could scientifically prove that the plants would have a positive effect, that "they are doing something good" and that healers are important. She said she "really want[ed] to improve their reputation", "to prove the value of their work". For Mea, her work with the healers was not just a professional issue, but a matter of the heart. After one particular meeting with the healers that did not go well (more precisely the one with the other student in the old-age home in Zwide I just referred to), she was close to tears because of her disappointment. "This whole project of working together with the healers is my life", she said to me (Notes, 2004-04-08).

Improving Practice

I found healers to be generally open to proposals directed towards complementing their practice with biomedical techniques. The workshops were quite popular and neither Mea nor Thobeka had difficulty finding healers willing to participate, as I noticed on various situations when Thobeka had to put a certain number of names on a list to register future workshop participants to the pharmacy department or the municipal health office. The healers then discussed amongst themselves whose turn it was to attend a workshop or who had already had the opportunity to attend a workshop on a similar topic. Although one might suggest that they were primarily interested in attending the workshops because of the catered food or the T-shirt they would sometimes receive,[66] I was able to observe that the majority of healers who desired to participate in the workshops were rather well off financially. Although I do not want to completely dismiss this incentive per se, I gained a different impression during conversations with healers after the workshops and through taking part in various events myself.

[66] See Veronika Fuest (2007) who has published on this, although not in the context of healers, but with regard to workshops on health for people in general.

Fig. 5: Workshop on high blood pressure at UPE.

In September 2003, for instance, I attended an HIV/AIDS-workshop at the University of PE. It took place in a big lecture hall and approximately 60 healers were present. Three medical doctors from the medicine department of the university stood up front, talking alternately about the virus, the various ways of transmission, testing, AIDS symptoms and possible therapies. I can remember my astonishment about the in-depth nature of the content of the workshop and the detailed biomedical knowledge that was taught. The image of the virus and its structure, projected over head, were especially impressive. Since I was still at the beginning of my research, some of the facts about CD4 counts and the role of T-helper cells were particularly informative for me. The healers were mostly women of all ages and, sitting around me, they followed attentively. Some took notes or depicted the image of the virus on their paper. Everyone was highly attentive. When they had the chance to ask questions, most were concerned about practical issues regarding the counselling of HIV patients. Discussions arose about how best to persuade patients who were suspected of being positive to get tested. "People refuse to know", one woman said. Another was concerned about the likelihood that women would be able to negotiate the use of condoms with their partners. Violence was mentioned in this context along with patients' reluctance to talk about sex. One younger healer explained that she would show patients how to put on a condom using a banana. Everyone laughed in response. In the break, coffee, tea and biscuits were offered and I had the chance to talk to some of the participating healers. Most of them said they liked the workshop, especially the images on the overhead projector, which were new to them. One male healer said he had never seen such a detailed picture before and that he liked the comprehensive

explanation of the workings of the virus in patients' bodies. Others said that they were bored, claiming to have already heard everything before (Notes, 2003-09-10).

When I returned to continue my research in 2004, I had the chance to interview various healers about their views on the trainings and workshops they had participated in. Mr. Tekile remarked in reference to the workshops: "They tell us about diseases and how to counter-attack them. They give us awareness. They help us to inform about the diseases that we are not so much informed about." He expressed his favourable opinion of the workshops at UPE by saying: "The ones at UPE are the best. They were like school and we learnt more." He used the example of a mechanic who needs to learn everything about the engine from an expert first. When I asked him if he had changed certain things in his practice due to what he learnt in the workshops, he answered: "If you get something better you take it additional to what you have." Furthermore he told me about "a guy from the Western side", a physician he is "working together with" and two whom he refers patients that have symptoms of HIV/AIDS. "He also advised me about AIDS (and) what I must not do with my patients." Hence, for Tekile, learning and improving his practice was essential. During our interview, he seemed confident of his practice, saying he had become one of the most successful healers in the "Metropole area", having trained three generations of them since he started in 1977. He described the relationship to the doctor he works with as positive and that he would trust him. "He is a good guy. He has sympathy for the patients. Tells them that HIV is not the end of the world. Other people get shot or stabbed or die in a car accident. HIV does not mean you gonna die tomorrow" (Int. A019, 2004-09-13). Joe Gumede was also of the opinion that Western and traditional medicine should be combined to fight against AIDS, as "two spears against one enemy". Although he added that Western medicine would not care for this approach. "They have this thing in mind, we are half baked, we don't have degrees" (Int. A010, 2004-06-22).

As I noted earlier, when conferences or meetings of the healers' organisation were held, people would report on what they had heard and learnt to those who did not attend the workshop. This information was hence perceived as something of importance. Furthermore, I observed that healers also implemented the contents of workshops in practice. One day I went with Thobeka to an American NGO in Zwide where she asked for more condoms, as her supply had run out. People there knew her and she introduced me to some. We left with a paper box full of condoms. In her treatment hut I also saw a box full of rubber gloves. She told me she would use them when she had to cut people's skin in order to apply certain herbal

medicines.[67] In connection with this, she explained to me that she had also learnt that she needed to use new razor blades each time she cut into somebody's skin (Notes, 2004-09-02). Finally, the practice of referring patients to the hospital to get tested for HIV, or to a physician as in Mr. Tekile's case shows that healers take what they learn in the workshops quite seriously, especially when it comes to AIDS. However, Nomvumisa had a slightly different take on the matter. She said that although her ancestors would tell her if a patient were HIV positive, she would still send them to get tested. She would want to get a confirmation, she said. People also tend to get angry when they find out they're positive. So she would therefore prefer to not be the one to give the diagnosis (Int. A029, 2004-10-14).

I would like to emphasise that the impact of HIV/AIDS and especially its severity in South Africa cannot be overestimated. As I discussed in the last chapter, even relatively well-off friends of mine who were not township residents would go to funerals on a weekly basis. In the townships, the AIDS pandemic was even more acute. In numerous interviews, healers told me about their concerns in relation to AIDS and how desperately they asked the ancestors for support in these hard times (e.g. Thobeka, Notes, 2004-06-04; Brooke, Notes, 2004-06-10; Lusanda, 2004-06-09). All of them knew someone in their own family or amongst friends who were either sick with AIDS or showing symptoms. They were scared about the pervasiveness of the epidemic and the fact that no cure was available yet. Suzanne Leclerc-Madlala suggests that because of the "sheer scale of the problem" HIV/AIDS programs involving healers prove to be successful in contrast to other programs' organisations such as the World Health Organisation (WHO) and the United Nations' Children's Fund (UNICEF), which have for many years attempted to make an impact in Africa (Leclerc-Madlala 2002). The first programmes in South Africa were run by two USAID-funded projects, AIDSCOM (AIDS Communication) and AIDSCAP (AIDS Control and Prevention) from 1991 to 1993. Following the snowball principle, 30 traditional healers were trained who were then each supposed to train another 30 healers. Although not all of those originally trained continued to adhere to the program, a considerable number of healers were reached. Leclerc-Madlala (2002) and also Green (1999; 1995) both conclude that there is much potential within such programs for healers to reach large numbers of people. In PE, the first workshop with healers launched by the municipality on HIV/AIDS started in 1999. Dr. Pailman from the health department in PE said that "AIDS necessitated the more direct involvement of healers, to

[67] This practice is well known throughout Africa (see e.g.West 2006), also for cleansing and curing witches (Marwick 1950). This type of "vaccination" has become a common component of the repertoire of many African healers (see e.g. Ashforth 2000:48; 2001:213; Marwick 1950:104; Whyte, Geest et al. 2003:112; Yamba 1997:214f.).

make sure there were not other possibilities for the disease to spread. Same with the traditional surgeons." Healers would be the primary source for identifying STDs and referring patients to the nearest clinic or hospital. Positive experiences could be pointed to with healers working as DOT (directly observed therapy) supervisors for TB patients to ensure the latter would regularly take their medication. Pailman considered that a similar effort could be undertaken by healers with regard to ARV medication (Int. A023, 2004-10-07).

Laurent Pordié (2003:42) writes about healers in Tibet and describes them also as being open and interested in workshops and trainings. He explains their openness with the social symbolism of biomedicine, suggesting healers would participate in the workshops mainly for reasons of prestige. While I agree, it should also be asked why power or prestige is attached to biomedical objects and terminology. Since I will talk about the takeover of biomedical symbols later on, here I want to suggest that despite the prestige biomedical objects might carry as part of a powerful, hegemonic discourse, the power of biomedicine to heal, quite effectively even, should be acknowledged, as should healers' or people's ability in general to judge its benefits. In the previous chapter I showed how healers themselves and their families sought treatment or medication at hospitals and clinics for various reasons. In this chapter, I aim to show that this appreciation for biomedicine in treating certain diseases is also reflected in the healer's general endeavour to improve their practice and to complement it with knowledge gathered from the workshops. If healers acknowledge a certain superiority to biomedical knowledge with regard to some illnesses, it also appears reasonable to them to try to appropriate some of it and to learn something more about specific sicknesses, like HIV/AIDS or TB. The next chapter will focus more fully on the effort to combine traditional healing and biomedicine, its interpretations and epistemological consequences.

Quest for Scientific Proof

In the following I would like to argue that the healers' quest for scientific proof for the efficacy of their plants can be regarded as an attempt to appropriate a new discourse that promises to carry with it increased status and/or a source of income if an active ingredient of one of their plants eventually leads to the patenting of a drug. A few medical anthropologists studying healers discussed similar issues. Similar to the tendency to scientifically prove the efficacy of plants amongst healers that I observed in South Africa, Laurent Pordié (2008) shows in his study of the appropriation and manipulation of Intellectual Property Rights (IPR) discourses by practitioners of Tibetan medicine in India how individuals can draw on distant knowledge systems to strengthen their own position in relation to a changing socio-political

landscape. The IPR of a particular medicine would be used as a symbolic resource one could refer to affirm their status, their ethnicity, but also their connectivity and the global translatability of their discourse. This was also the case with the quest to prove the efficacy of certain medicines amongst the healers I worked with. The scientific testing of traditional plants was something new that had been triggered by the ANC government after 1994, as was the question of legalising traditional healing. Chapter 5 will deal more in-depth with the government's attempt to rehabilitate traditional healing as part of a larger project of nation-building. The possibility of acquiring scientific proof for the efficacy of their medicine opens up a whole new arena for traditional healers where status, difference and legitimacy can be renegotiated. As discussed above, the rehabilitation of the value of traditional healing after the end of Apartheid was important to the healers. Scientific proof was perceived as one vehicle for achieving this. At the same time, the possibility of entering into a larger global market of "natural" medicines has been opened up. Interestingly, as Pordié shows, by emphasising the importance of IPR, practitioners of Tibetan medicine framed biomedicine as both a threat to their practice and a testament to their credibility and their knowledge. I found the healers in PE faced with a similar dilemma. The description above of the AIDS discussion in the old-age home clearly shows this ambivalence. On the one hand, healers like the idea of having scientific proof for the efficacy of their plants, and thereby for their practice as a whole. On the other hand, they are afraid of their secrets being taken away for the profit of others. Nonetheless, while they may be appalled by the "mistrust" of the government, which, in not believing in their medicine, requested the usual scientific testing before licensing it, the possibility of finally passing that very testing seems too promising to not to take part in the whole endeavour.

Aumeeruddy-Thomas and Lama (2008) highlight a similar circumstance when showing how healers in Nepal use discourses on bio-conservation and sustainable management of medicinal plants to emphasise and demonstrate the legitimacy of traditional knowledge and practice. Through collaborating with a WWF-UNESCO People and Plants Project, they managed to advance their own interests on a state level where they had previously felt invisible and irrelevant for policy makers. In view of the conservationists support in erecting along with them the Traditional Health Care Centres, the authors describe the encounter as a positive one for the healers involved. Against the backdrop of criticism about the scientifisation of so-called ethno-ecological knowledge and the allegation of extracting local knowledge from its specific cultural context, they claim that such questions very much depend on the nature of these processes (Aumeeruddy-Thomas and Lama 2008:180). They contend that the issue of

learning constitutes a key issue, but also particular individuals taking up the fight in the healers' interests on the side of the conservationists "facilitated a largely positive encounter" (ibid.). With regard to the situation in PE, the authors' arguments would seem to be very well founded. As I showed earlier, the aspect of learning the healers rather saw as a supplement to their practice and not necessarily as a replacement. Also, I would like to underline the influence of particular individuals who have facilitated collaborations like the one between the pharmacy department of UPE and the healers. Mea, the driving force behind the cooperation on the side of the pharmacists showed a persistent interest in the project that she started already in 2002. The healers came to trust her over the years, calling her "our friend". She was invited to their homes and graduation ceremonies. She also helped out with facilitating transportation, correcting formal letters and printing up documents with the computer.

The study Vincanne Adams presents in her article "The sacred and the scientific" (2001) explores a politically different setting. The ambiguous relationship between Tibetan medical practitioners and science in the Autonomous Region of Tibet in China is strongly influenced by the politically charged nature of religion. Some practitioners utilise science to corroborate the scientific nature of their practice. As science is a universal epistemology and neutral mode of inquiry, Tibetan medicine, although bound to religion, can nonetheless be presented as politically safe (2001:543). In India, on the other hand, where the link between Tibetan medicine and the Buddhist religion is not dismissed, translation projects like "science for monks" provide Buddhist monks with a basic scientific education. Gerke argues that science, as a result, "is more readily interpreted within Buddhist world-views" and that these projects "provide the translation of Tibetan scientific vocabulary more of a religious grounding" (Gerke 2011:133). Hence, the political environment shapes the stance healers or, in this case, Tibetan health practitioners take on science and attempts toward mutual translation. Adams claims that these encounters do not necessarily allow for conclusions to be made about changing epistemologies on the part of the Tibetan medical practitioners. They appear, rather, as a political strategy and a legitimate way of understanding, although in practice their content and epistemology was not necessarily implemented (Adams 2001:570f.). It is this last point that I would like to strengthen in relation to my material. The quest for scientific proof was embedded in the government's attempt to create an African way of healing that differed from biomedical agendas stemming from the West. Chapter 5 addresses in detail Mbeki's AIDS denialism in connection to his African Renaissance discourse. My argument here is that the healers who took part in scientific testing perceived this new trend as being politically

legitimate and "en vogue". It also represented a new path for gaining prestige and resources, as it was backed by a powerful media discourse on the African potential to heal differently, and to even find a cure for AIDS. As Adams has shown, these developments per se do not permit any determinations to be made about changing epistemologies on the side of the healers. In my view, this is an empirical question which requires not only data about encounters that have occurred, but also about changing ideas and practices of healing. Especially outside of the arena of encounters it would have to be empirically demonstrated that new emerging epistemologies are replacing older ones. I will come back to this point towards the end of this chapter.

Problems

It has not been my intention, however, to suggest that an encounter between healers and representatives of biomedicine was always smooth. Thus, this section shall focus on problems a bit more closely. One can distinguish between problems on a more mundane, practical level and misunderstandings and conflicts that arose on the level of epistemology. I will first attend to the practical problems I came to observe during my fieldwork. The following quote from Joe Gumede highlights the most important points:

> The only reason why we backed away is that they wanted to teach us. On AIDS. Fine. Then we said, they must sponsor us. Give us 5,000 Rand to teach our people in the townships, in our language. They would not budge. You see? People [healers] said let's leave them. They only want to teach you, they don't want you to teach others. Every year they want to teach us on AIDS. You find everything is the same: gloves, condoms, every year the same. For instance in my house I have got [condoms], although I give them out to guys who come to cleanse themselves. I have about 60 condoms that I got from Bristor house [office of ATTICC, the municipal AIDS centre] (Int. A019, 2004-09-13).

Gumede clearly seems bored about being lectured on AIDS all the time, and although workshops on other issues are offered, too, he apparently never went to one. Another aspect that is evident here is the impression some healers voiced of not being treated with respect – of being looked down upon either because of not having "no degrees", of "being half baked" as Gumede called it (ibid.), or because of an absence of belief in the workings of their medicine. This was a key issue in the discussion in the old-age home when the present healers boiled down the issue of testing to the fact that they were not trusted enough. If pharmacists, doctors and the government would trust them, they thought, they would not require any tests. Tekile said the following about the workshops:

> Those are not good that tell us we are not clean, how to do our performances according remedy making. Where is your dignity and autonomy? [The] first workshops were useless and humiliating, round about 1994. They did not know that one day we will be recognised; they thought traditional healing would end and the government would destroy us. (Int. A019, 2004-09-13)

Tekile also came back to the question of respect. Earlier I quoted him on what he thinks makes a good workshop: "They tell us about diseases and how to counter-attack them. They give us awareness. They help us to inform about the diseases that we are not so much informed about" (ibid.).

One main point of dissatisfaction was the lack of funding that Gumede, for instance, pointed out when he said that it was not possible for them to be paid peer educators to teach other healers on what they had learnt in the workshops. Several healers expressed their frustration with not being paid by the government to be e.g. health workers or AIDS counsellors. Tekile also mentioned the lack of funding. He said: "We want surgeries. The government must subsidies us, we will contact them. We want to be like other doctors. We want cleanliness, our dispensaries to be exposed, that everybody can see" (ibid.). However, despite these complaints and the hope for more funding, I had the impression that refusing to take part in these workshops was not a feasible option because it was only through being part of these encounters that healers had the opportunity to access any resources at all in the first place.

A more fundamental level of concern was where epistemological incompatibilities arose which put into question the whole notion of a joint project between pharmacists and healers. The discussion at the old-age home offers an instructive example of this. For the healers in attendance, two points seemed nonnegotiable. The first relates to the aspect of secrecy. A healer, they asserted, is not supposed to give away the knowledge given to him by his or her ancestors. Otherwise one would risk their anger or revenge, resulting in a withdrawal of support or worse. The second point that was raised pertained to the belief that the ancestors are responsible for a particular plant's power at a particular point in time. This implied, in other words, that a plant during testing could suddenly be found to have no efficacy whatsoever. As Lusanda said during the discussion to Mea: "Imagine I give you a medicine and it works and then the next time you test it, it won't. What are you going to think of me?" These two points appear to be incompatible with the principle of patenting medicine according to scientific standards for ensuring safety and limiting liability. Mea had to explain that the pharmacists need to know the exact plants that were used by the healers in order to test them properly. As mentioned above, Lusanda and Thobeka had proposed that patients

might simply be sent to them for treatment and then afterwards one could determine the results. Mea explained that for safety reasons no patients could be subjected to a treatment unless it had already been proven safe. This statement, however, was again regarded as proof that the healers were not being trusted. So there was not really a way out of this vicious circle. The question arises as to how any collaboration at all is possible when these epistemological questions remain unresolved. Two facts may provide a basis for an explanation. For one, discussions like these were not common. During my stay, I may have witnessed only two or three occasions when a conflict was present like the one at the old-age home. Usually, issues that could trigger misunderstandings, or incompatibilities, were avoided as both sides were interested in having a good working relationship. Having discussed the motives for both sides earlier, and intending to return to this practice of bracketing certain issues later on, I would now like to highlight another aspect that involves uncertainty on the side of the healers: the behaviour or attitude of the ancestors regarding the testing. This issue is evident in statements made by Lusanda, who first asks: "Why can't the medicine just be tested to see if it works? Why do they want to know the ingredients?" (Notes, 2004-04-07), and then later explains that the ancestors can withdraw the healing power from a plant during testing. Clearly Lusanda's last contention rules out any form of testing, also the one she suggested earlier herself. I would argue that this flexible agency of ancestors can serve as an explanation for why cooperation with the pharmacists can be continued, despite the conflict. The relation with ancestors was explained to me as something that was open. A healer would ask his or her ancestors for understanding and support if he or she wished to be part of a project with UPE. Depending on the nature of his or her relationship, the ancestors would offer their approval. This arrangement provides an opportunity for working together that nevertheless can always be denied, a point that has been raised by the healers.

A lot of authors have emphasised the incompatibilities just outlined. Pordié, for example, critiques the naïve view of some anthropologists who merely see the collaboration as a simple synergistic project, thereby underscoring the "thorny problems of paradigmatic incompatibilities" as well as "epistemological transformations that can call into question the efficacy of a given medicine" (2003:42). What Pordié claims is happening with Tibetan healers in the region of Ladakh in India is that the religious dimension of their profession becomes insignificant within the process of professionalisation. The situation he describes, however, appears to differ on some crucial points from the conditions in South Africa. At the Central Institute for Buddhist Studies (IBS) it is possible to acquire a Bachelor of Tibetan

Medicine and Surgery after five years of study.[68] Although students acknowledge the importance of religion in their practice, it is not part of the curriculum (Pordié 2003:45). Moreover, a prerequisite resembling a calling from the ancestors, as in the case of South Africa, is not necessary. Becoming an *amchi*, a Tibetan traditional doctor, is like learning a profession (at least at the school to which Pordié refers). This stands in contrast to South Africa, where processes of institutionalisation or professionalisation do not necessarily lead to a detachment from religion during the training, which Pordié says occurs in Ladakh (ibid.). Workshops here are seen as supplementary to the normal training and religion is inseparably rooted in the profession, despite the changes it undergoes, because of the tradition of being called by the ancestors that marks the beginning of the training to become a healer.

3.3. The Biomedicalisation Critique

As indicated, the most fundamental critique, or at least the one most commonly raised by other authors, in regard to the collaboration between healers and biomedicine is that the core of traditional healing – the spiritual realm, the religious aspect – vanishes or gets lost. Either it is downplayed or not mentioned in particular situations and settings or the presumption is that due to processes termed biomedicalisation the spiritual will gradually degenerate into insignificance over time. I will examine both of these issues in the following with reference to my own material as well as other examples. After giving a brief overview on the history of the concept of biomedicalisation, its main points of critique regarding the development of traditional medicine will be considered. I will then conclude that although certain features of the situation in South Africa, and particularly the setting I am describing in Port Elizabeth, can be characterised as biomedicalisation, this process is not necessarily one that bears comparison to a "technoscientific tsunami that will obliterate prior practices and cultures" (Clarke, Mamo et al. 2003:184f.). By utilising Richard Rottenburg's argument of the metacode as a trading language (Rottenburg 2005:270) that facilitates cooperation, as well as Erving Goffman's ideas on tact and face work as the basis of any successful communication, I hope to relativise rather homogeneous critiques of biomedicalisation and thereby put healers' agency into more perspective.

[68] Pordié focuses on the institutionalisation of traditional medicine in an urban setting. In villages, the situation might be different. Pordié writes that village-based students of traditional medicine justify their professional choice by "motivations of a religious or moral order" (2003:45). He does not dwell on the difference between urban and rural. The processes of biomedicalisation he describes seem to take place in an urban environment and are linked to efforts to institutionalise traditional healing, turning it into a subject at the CIBS.

History of the Concept of Biomedicalisation

Biomedicalisation refers to "the increasingly complex, multisided, multidirectional processes of medicalisation that today are being both extended and reconstituted through the emergence of social forms and practices of a highly and increasingly technoscientific biomedicine" (Clarke, Mamo et al. 2003:162). Primary components of biomedicalisation are research and knowledge production, as I described, for instance, in regard to the increasing trend toward testing traditional medicine. The concept builds on the older concept of medicalisation that goes back to Irving Zola (1972), Peter Conrad (1976) and Thomas Szasz (1970; 1973), among others, and connotes the expansion of medicine and its institutions into areas which were previously considered non-medical. That medical authority was a force of social control was not thought to be new (Foucault 1965), but it was argued that increasingly advancing medical technology had extended its potential. The 1970s and 1980s saw a lot of literature on the expansion of illness categories leading to a medicalisation of human life. It was argued that medicine problematised former "natural" processes people now could no longer cope with on their own (Ehrenreich and English 1978; see e.g. Illich 1977; Navarro 1981). The biomedicalisation thesis extends former claims of medicalisation by adding the aspect of the inseparable connection between technology, biomedical science and the formation of new industrial complexes and areas of knowledge. Together with diverse marketing practices new forms of consumer bodies and identities were constituted. Clarke et al. argue that such transformation of the medicalising landscape is not to be likened to a "technoscientific tsunami" erasing former practices and cultures" (2003:184f.). Rather it is a development in which we see new forms of "agency, empowerment, confusion, resistance, responsibility, docility, subjugation, citizenship, subjectivity and morality" (ibid.). They call for case studies that attend to precisely the heterogeneities of biomedicalisation practices and effects in different settings.

Case Studies

Regarding the transformations of traditional healing, studies focusing on Tibetan medicine have again proven to be paramount. Craig Janes (1995), for instance, shows how some Tibetans, despite being integrated, standardised and incorporated into a state health system, view traditional medicine as a forum where they can express resistance to rapid changes and political hegemony. Sienna Craig (2008) provides an interesting account of practitioners of

Tibetan medicine, *amchis*, in Nepal that has many parallels with the situation of healers in South Africa. She describes *amchis* as "carving out a conscious middle way" (Craig 2008:82) – between revitalising and preserving their practice, being standardised and having to guard their secrets, and working with NGOs and trying to portray themselves as authentic purveyors of traditional knowledge. She concludes that although the *amchis* actively shape their encounters with the state and NGOs, they cannot completely do so on their own terms. Yet it is this paradox that is essential for how *amchi* medicine is formed and reformed in Nepal. Stacy L. Pigg (1995) examined training programs of birth attendants and shamans in Nepal and writes about how a "globalised vision of 'traditional medicine'" determines those development projects. She diagnoses a medicalisation of these local healers, claiming that due to the nature of the training the trainees are required "to fragment their practices, to distinguish between the 'medical' and the 'social' aspects of what they do" (Pigg 1995:59). However, she also maintains at the same time that, "Training is more likely to teach trainees how to sound 'modern' than to inst[a]ll new practices". Villagers would thus "learn what 'modern' people are supposed to do and say" (ibid). "In order to get the resources they want they have to frame themselves in the way development had told them traditional people should be." (Pigg 1995:61f.) Pigg's findings rather appear to suggest that local healers acquire a certain vocabulary that enables them to attend the workshops, as official development activities are perceived as being prestigious (1995:53). To conclude: to state a medicalisation would require similar data from other arenas instead of just showing how locals take on a different form of speaking with development workers. She makes the important point, however, that the mere fact of the existence of training programs communicates a message (1995:59). My qualification here would be that it *could* communicate one, but that it also has to be shown empirically what message, to whom, to what extent and how relevant this message would be in different contexts.

Regarding recent changes of so-called traditional medicine, certain features have garnered special attention. Pordié refers to the biomedicalisation of traditional medicine as a process that is characterised, first, by the desire for scientific evaluation of its efficacy, second, the employment of biomedical terminologies in the explanation of anatomy and certain pathologies (immune system, diabetes, cancer, viral load, CD4-counts etc.) and, third, the use of biomedical symbols like stethoscopes, gloves or white doctors' coats (Pordié 2003:42ff.). The issue of the desire for scientific proof was discussed earlier when I highlighted the motives of the different parties involved in the collaboration between healers and pharmacists. In the

following, I will therefore briefly discuss the use of biomedical terminology and symbols, which I will then locate in the anthropological debate on mimicry.

Terminology

The aspect of employing biomedical terminologies should be considered first. Against the backdrop of the AIDS epidemic, healers talk about "CD4 counts", "viral loads" of patients, "VCT" (Voluntary Counselling and Testing) and the "need to know your status". These English terms would frequently come up in conversations otherwise carried out in Xhosa amongst healers or in speeches during certain rituals and the like. When explaining to me the applications of particular plants like *umthlonyane* (Artemisia Affra) or *cancerbush*, healers would emphasise their capacity to "boost the immune systems". Some healers explained in detail the transmission of HIV and how the "virus docks onto the helper cells", resulting in a weak immune system that can be easily attacked by other diseases. Sometimes the helper cells were referred to as "blood soldiers". Healers were equally well-versed in several opportunistic infections related to HIV/AIDS, again applying English terminology, e.g. thrush, blisters, rash or TB. Going beyond the mere use of English vocabulary was the translation of certain biomedical concepts or terms into Xhosa. This could be interpreted as an appropriation of foreign concepts, whereby metaphorical explanations were often used that supposedly would make better sense in the Xhosa language and culture. AIDS could be called in Xhosa *gawulayo*, which literally means "to be chopped", and in Zulu *ingulazi*, "the killing one".[69] A virus could be translated as *intsholongwane* ("bug") and *unentshologwane kagawulayo* would mean "you have the virus of AIDS". In Xhosa, it is also common to use the prefix "i-"[70] when using an English word that is not easily translatable into Xhosa. *Ivirus, irash* or *iAIDS* would be used in conversations or speeches[71].

Symbols of Biomedicine

Another aspect of a biomedicalisation is the symbolic use of biomedical elements in traditional medical practice. Certificates of attended workshops were displayed, white medical doctors' coats were worn, stethoscopes decorated the ceiling of the consultation hut, and medicine was kept in plastic apothecary bottles with labels describing its content.

[69] See Steven Robins on the translation and "vernacularisation" of biomedical knowledge during treatment literacy programs of MSF and TAC (2009) in rural Lusikisiki in the Eastern Cape Province.
[70] Like Swahili, Xhosa has noun classes, each having a different prefix and grouping nouns according to what they refer, i.e. people, colours, food, animals etc.
[71] This phenomenon is quite typical for Bantu languages and does not only occur in the field of health and diseases but also in everyday language (*imoto* for car, *iticketi* for ticket or *istemp* for stamp).

Fig. 6: Look into a healer's hut where two healers prepare for a ceremony.
In the background a white doctor's coat, a stethoscope and plastic bottles on the shelves.

Pordié mentions the use of "certain organizational modes and modalities" (2003:43) by healers stemming from biomedical settings. Healers in Port Elizabeth would also apply supposedly new modes of practice like referrals to doctors, emphasising the principal of "professional secrecy" when referring to the patient-healer relationship, issuing certificates of illness or discussing intellectual property rights and the use of pharmaceutical testing on active ingredients in their medicinal plants. West writes about healers in Mozambique wearing rubber gloves, or keeping records in a patients' file (West 2006:31f.). He suggests that they did this to set themselves apart from their competitors. Gloves constituted a more official uniform that would also enhance their credibility with potential clients. They would enhance their professional identity as a "doctor" (2006:31). Gerke presents the case of a Tibetan medical practitioner who finds it helpful to have the blood test results and blood pressure parameters of his patients at hand to be able to communicate better with those who have been more exposed to biomedicine than to Tibetan medicine. She argues that anthropologists too hastily draw conclusions about the "scientisation" of (in her particular case) Tibetan medicine. They would thus often overlook local perspectives on science that are possibly guided by different motives (2011:146).

On Mimicry

When trying to interpret the use of biomedical symbols by healers, clearly the main point of reference is the anthropological debate on the concept of mimicry. To narrow down what is at stake, one could say that the answer to the question of why healers use medical terminology, dress in lab coats and collect stethoscopes may be located in the oscillation between two poles. At the one pole, there are the path-breaking urban studies of anthropologists of the Rhodes-Livingstone Institute who studied the influence of colonialism on African cities and reported a very strong interest of urban Africans in gaining material goods and the social manners of the European colonisers. Clyde Mitchell and A.L. Epstein (1959), for instance, connected the popularity of European cultural forms with their function as distinctly marking a higher status within black society. Europeans were, according to Mitchell and Epstein, a reference group against which urban Africans measured their own success and status. The authors I have mentioned are relatively reluctant to offer a meaningful interpretation. Their depiction of an acquisition of foreign clothes and styles by Africans does not go beyond merely describing it. This is very different from the opposite pole, whose representative is Franz Fanon. Very much in the tradition of the Marxist concept of false consciousness, Fanon critiques the colonised African in his influential book "Black skin, white masks" (1967) for having internalised some forms of self-hatred due to his attraction to European culture. Out of an inferiority complex, Africans try to imitate the cultural code of the coloniser – a phenomenon that is even more apparent amongst better educated Africans who have the means to acquire European goods. Other authors who have written on the related phenomena of adaptation, imitation or mimicry might be placed somewhere between these two extreme poles. Godfrey Wilson (1941), for instance, documents the importance of dance clubs in a mining town in Northern Rhodesia, where couples in full evening dress compete in ballroom dancing. He describes the acquisition of European-style clothes and elaborate formal wear as being widespread and common amongst urban Africans. According to Wilson, the reason Africans appropriated these dress codes was their desire to be respected by Europeans. Clyde Mitchell's famous "Kalela dance" (1956) describes the integration of stereotypical European personae, like the nurse or the doctor, into a dance of mine workers of the Copperbelt. According to Mitchell, the Kalela dance, portrayed as a joking relationship in Radcliffe-Brown's sense (1940), fulfils a double function in society in that it allows for the articulation of social conflicts while at the same time diffusing their potential in everyday life. Mine workers, who were men from different ethnic backgrounds, would process tensions they have both among each other and with the European colonisers who are responsible for their

hardships in the mines. Instead of acting it out, conflict and aggression could be channelled into mocking statements and chants while the respective character in a dance would be mimicked in front of an audience. With this interpretation, Mitchell builds on Max Gluckman's structural-functionalism laid out in "Custom and conflict in Africa" (1955).

A similar understanding seems to be evident in the interpretation of the Hauka movement in Ghana and Niger, which became famous as a result of Jean Rouch's ethnographic film from 1955 "Les maîtres fous". In its ceremonies and dances the participants mimicked and performed as the military of their colonial occupiers while at the same time acquiring its power (Stoller 1984). The movement itself was suppressed by French and British colonial officials. The latter also subsequently banned Rouch's film because it ridiculed a British governor. Anthropologists mainly interpreted Hauka as an example of cultural resistance trough parody and appropriation. It contested colonial authority by drawing on white cultural forms, ritually stealing their powers and appropriating them according to the terms of their own cultural system. Hauka served as an example of disobedience and autonomy that was even present in the very act of imitating the colonial master (Kramer 1987 :135f.,246; Stoller 1984; 1989; 1995; Taussig 1993:240ff.).[72]

One author who has become inextricably linked with the discussion on mimicry is Michael Tausig. His book "Mimesis and alterity" (1993) is based on ethnographic material from the South-American Cuna and their European look-alike figurines. Taussig argues that mimesis, the way people adopt another culture, and alterity, the way they distance themselves from that culture, are two sides of the same coin. He describes how although Cuna shamans chant to wooden figurines resembling European stereotypes to support women in obstructed labour, the inner substance of these figures remains nourished by local spirits. Taussig argues that the shaman, in combining mimesis and alterity, the outer with the inner, acquires power over what his figures portray. At the same time, he preserves mastery over his own cosmological world. Hence, mimesis is always a process of becoming something else, of becoming the other (1993:36).

In trying to link these interpretations of imitation to the healers who wear white lab coats, a whole variety of different questions emerges. Do healers make fun of physicians by dressing

[72] Another example of a similar approach on imitation could be Jonathan Friedman's work on the popularity of Parisian fashion in Brazzaville, Congo (1990; 1992). Also, he argues strongly that what the people are doing is not "Western", but only the actual cultural material is. At the core of the practice of young men displaying fashionable clothes in a performance is an indigenous cosmology in which life force can be extracted from powerful others through wearing their clothes.

like them? And does this release some sort of tension that they feel they cannot express otherwise? Is there a connection between their desire to be part of the privileged system of biomedicine and their adoption of doctors' attributes? Last but not least, could their use of white coats be an attempt to obtain the power of biomedicine by appropriating it in terms of their own cultural background, by turning something "Western" into something "African". The healers combine mimesis and alterity insofar as they take over certain artefacts, alienate them and create something new that is entirely different from the original. Although they look like physicians, they become other. For Taussig this is a way for them to keep mastery over their own ever-changing world. For the authors I have just discussed, finding the most appropriate interpretation for the use of originally "Western" symbols or artefacts is not so much an empirical question. It rather seems to be a question of positing. The voice of the subject appears to be most irrelevant for Fanon's thesis. But also in the accounts of the other experts on mimicry, explanations of the imitators are missing.

In his insightful review of the anthropology of imitation, James Ferguson (2002) demonstrates how the act of mimicry became an object of embarrassment and even scandal in social anthropology, which in turn influenced its interpretation by many authors. Social anthropologists in the latter part of the 20th century mainly shared an anti-imperialist stance and were thus highly critical of the colonial, civilising project which aimed to mould subjects according to the European image. "The scandal of Africans who 'want to be like the whites'…was …that they threatened, by their very conduct, to confirm the claim of the racist coloniser: that 'African' ways were inferior to 'European' one." (Ferguson 2002:553) Ferguson claims that "the dominant anthropological solution to the embarrassment of African mimicry" has been to interpret these phenomena as parody and resistance to colonialism (2002:554). He also criticises the notion of authenticity that comes up in mimicry studies when Taussig (1993) or Friedman (1990, 1992), for instance, make out an internal logic within the acts of imitation that make them "entirely African" and certainly "other" from their European image. What these interpretations lose sight of, Ferguson argues, are the claims of urban Africans to belong to modern society. As Wilson already recognised in 1941, when writing about the adoption of European forms of dress and manners, Africans sought to assert their claims to a civilised status, to be respected by Europeans and to become "members of the new world society" (Wilson 1941:19-20, cited in Ferguson 2002:555).

Returning to the material I presented throughout this chapter I would now like to interpret the appropriation of biomedical symbols and terminology. Similar to what Ferguson suggests

about the claims of Africans to belong to modern society, the healers in my particular setting appeared to want to demonstrate that they were part of the modern world. The earlier sections on motives and problems should have made clear that healers want to be recognised, respected and trusted. They aim for higher status in different arenas where health and healing are being negotiated. They would want funding to train other healers on biomedical knowledge they themselves consider relevant. Hence, it is important for them to spread this knowledge further. They would want space in their own hospitals or within existing ones to treat patients. Finally, they would want to be referred to by doctors and be part of the official health system. Despite serious reservations and incompatible truth claims, even the prospect of their medicine being scientifically tested and proven effective is considered a worthwhile strategy. A possible gain in this case for the healers would be the translation of traditional healing into the arena of science. Last but certainly not least, healers also quite strongly voiced their desire to learn. This involved improving their practice, avoiding HIV transmission, fighting HIV/AIDS whose impact they witness every day and to possibly find a cure for it together with the pharmacists. In the following chapter, I will show in more detail how healers are able to acknowledge the superiority of biomedicine in certain domains without marginalising themselves. They also consult with clinics or hospitals when they expect to be more adequately treated there for certain conditions. Hence, learning about and knowing certain aspects of biomedical practice seems worthwhile to many healers.

Another aspect I would like to draw attention to concerns the relationship between healers and their patients. In several interviews, I was told that patients are treated according their beliefs and their culture (Gumede A010, 2004-06-22; Sivu A028, 2004-10-29; Kota 2004-04-13). Mrs. Nxele, who is not only a traditional healer but also a so-called faith healer said, that depending on her patients' preferences, she may also pray to God to cure them (Int. A020, 2004-09-16). By displaying workshop certificates, stethoscopes, or plastic containers from the pharmacy containing herbal medicine, the healers appear to portray themselves as also being open to biomedical ideas. They show that they know about them. In this way, they also present an option for people who normally would prefer biomedical practice. Because they know certain things about it, they can speak the language of biomedicine and, when certain symptoms occur, advise patients to get tested. The use of symbols and certificates of biomedicine gives evidence to this effect.

3.4. Seeing Things Differently

Having laid out certain areas where biomedicalisation can be said to take place, i.e. the quest for scientific proof, the application of biomedical terminology and symbols, I would like to argue in the following that through this process the spiritual does not necessarily vanish. Instead, in certain settings healers will choose to "speak another language", something that Richard Rottenburg refers to as a metacode. Furthermore, I will argue that in order to claim an overarching biomedicalisation, whereby essential elements of traditional healing might be lost, it would be necessary to note epistemological changes not only during collaboration but in other social arenas where the healers are active.

Richard Rottenburg's work (Rottenburg 2003; 2003; 2005; 2009) on processes concerning the translation of ideas and practices in the field of development aid is particularly helpful for the study of science and medicine in Africa. He provides a theoretical framework for a thorough examination of processes of knowledge transfer (e.g. in the workshops I am discussing) between actors with different epistemological backgrounds. His study on the practice of development aid projects involving politicians, consultants, state bureaucrats, development planners and anthropologists shows in detail how constant negotiations and interpretations shape the everyday life of their work. The prerequisite for the collaborations he studied, but also for the joint ventures I am describing, is the establishing of a metacode everyone can relate to (Rottenburg 2005), a common language or vocabulary for all the different actors in their objective to reach a higher, mutual goal. The metacode resembles a language used for trade, enabling its users to communicate all necessary information while excluding irrelevant and potentially disruptive knowledge. People involved in a collaboration must agree on certain truth criteria and definitions of reality that must remain valid for the purpose and duration of the joint effort. (2005:270) Drawing on Rorty's notion of the bazaar, Rottenburg writes:

> The bazaar metaphor suggests a constant debate between various models of meaning and reality. Actors are no "cultural dupes"; they are competent enough to anticipate the expectations of others, to recognise these expected expectations as such, and to reflect on them. Most importantly, though, the actors are able to avoid negotiations over matters which would deviate from their purpose at hand. (Rottenburg 2005:267)

The issue of witchcraft might make the argument of excluding untranslatable concepts for the duration of the interaction more plastic. During the workshops I participated in witchcraft was not mentioned as a possible cause for sickness or misfortune. When I asked about the reason

for this, one healer explained to me that "they [pharmacists] would not understand. They don't know about it." Another example could be the ancestors who in other contexts are described as powerful actors that guide healers' therapies and trainings. Although the ancestors would be praised at the beginning of some workshops, they were hardly referred to as a relevant source for disease. The only occasion when the power of ancestors was openly discussed with pharmacists was in the discussion on scientific testing in the old-age home. This discussion can serve as an example of an unsuccessful communication where relevant truth criteria were not agreed upon. In fact, truth criteria were at the heart of the matter, as the necessity of scientifically testing the active ingredients of traditional medicinal plants was hotly debated. A consensus could not be found, which consequently left all the participants feeling uncomfortable, disappointed and dissatisfied. Hence, I would argue in this case that healers, but also their biomedical counterparts, decide on a way of speaking with each other that is likely to not offend or irritate the other group, and they do so in order to facilitate the relationship and keep the cooperation going. In the first instance, the primary purpose for using a metacode everyone feels comfortable with is the maintenance of communication and goal-oriented interaction. The motives of the different actors involved in the workshops have already been discussed above at length.

Goffman's notion of face-work (1963) is helpful for further strengthening the argument of the metacode. "Face" is understood here as the positive image of self that individuals have when interacting with others. It is "a sociological construct of interaction … neither inherent in nor a permanent aspect of the person" (1963:5). By doing face-work, Goffman refers to actions taken by a person to make whatever he is doing consistent with face. Goffman argues that people in everyday life – and this holds true for communication between individuals in particular – seek to maintain their face because "it feels good" and we have an emotional attachment to the face we maintain. Disruptions of this self-image, or "losing face", results in a loss of the internal emotional support that protects a person in a social situation (1963:9). The feeling of shame or being out of place arises. Hence, the audience or the counterpart in a conversation is normally interested in helping someone to maintain, or save, face in order to keep the conversation going and to ensure a productive and supportive atmosphere. Tact is part of this. Returning to the encounters between healers and representatives of biomedicine and science, I would like to argue that the aspect of protecting one's face is crucial, as the example of the old-age home shows. Healers were offended by the way one of the pharmacy students spoke to them. They felt that she was not treating them with the same kind of respect as Mea.

There are other examples of how both healers and biomedical professionals try to adhere to certain rules of tact they consider appropriate. Pharmacists would for instance greet the healers in a certain way, shaking hands as the Xhosa do. They would also ask about the well-being of the healer's family. Sometimes, at the beginning of a meeting, time and space would be given for the healers to thank their ancestors and perform certain rituals to receive the ancestors' blessings for the collaboration. All in all, I had the impression that the whole body language of the pharmacists and their way of talking to healers was warmer and kinder in comparison to colleagues or myself, for instance.

Richard Rottenburg writes that the epistemological bridging during the cooperation can result in uncertainty that has to be tolerated. The participants can commiserate afterwards, when they are amongst their peers. Hence, the participants of the workshop can be described as alternating back and forth between a metacode during the encounter and their own frame of reference (Rottenburg 2005:274). In their lives outside of their workshops, healers would never refrain from discussing topics like witchcraft or ancestral guidance. To the contrary, their practice of healing certain afflictions, the determination of causes, the structure of training of new healers, and the calling to become a healer itself are all described as being guided by ancestors. As appeared to be the case in Stacy L. Pigg's example from Nepal, where healers became well versed in the modern vocabulary of the development planners, they also managed to enter a new arena by acquiring the necessary metacode. And although certain symbols and terms entered the practice of traditional healing, its core and religious foundation stayed untouched. I would therefore like to make a methodological claim against the tendency to proclaim an overarching biomedicalisation too hastily. Following the metacode argument, one might argue that if the metacode were present in other contexts as well, it would be possible to then claim that the religious dimension, the core of traditional healing, is vanishing due to an all-encompassing biomedicalisation. But this would need to be shown empirically, which is where a lot of the literature claiming the predominance of biomedicalisation seems to fall short. If the metacode is only used in certain contexts, these claims would thus seem to be exaggerated.

3.5. Summary

This chapter gave an overview of the encounters between traditional healers and representatives of biomedicine that were studied during my fieldwork. It began with an

historical overview of encounters between traditional healers, settlers, missionaries and doctors. From the early beginnings, this interaction was shaped by desires from all parties to gain the respective medical knowledge of the other group. Healers were regarded as important for both, having knowledge of potent plants and for being mediators to their people, who were to be converted, governed, and/or cured. Biomedicine was from the beginning regarded as an effective means for combating certain diseases. But also public health campaigns in conjunction with increasing segregation policies shaped the image of biomedicine in the long run.

In PE, the healers were involved in manifold interactions. Starting with their own organisations, I tried to provide a picture of the activities the healers took part in, shedding light on their motives, their outlook on their encounters as well as on the problems they were facing. I wanted to show how healers tried to negotiate opposing priorities: the desire to acquire prestige and resources from scientific testing against the need to guard their secrets; the interest in becoming part of the health system against keeping autonomy; and, finally, the willingness to use and promote biomedicine, especially in times of AIDS, against remaining important agents in the field of health and healing.

I discussed briefly how certain practices and discourses of healers could be interpreted as a form of biomedicalisation. I showed how during the encounters with biomedicine healers refrained from certain explanations or concepts which they considered to be untranslatable or not relatable in order to facilitate communication. This “trading language” can be described as a metacode. Healers would shift into the metacode during their collaboration, but their “normal” life as healers was still very much determined by referring to ancestors or witchcraft as causes of sickness. Hence, claims about fundamental epistemological changes through the healers’ interactions with biomedicine do not necessarily have validity. I then laid out how saving each other’s faces in Goffman’s sense plays a role, too, both on the side of the healers as well as on the side of biomedical personnel. Finally, I argued that in order to claim an overarching biomedicalisation whereby essential elements of traditional healing would get lost, it would be necessary to note epistemological changes, not only during collaboration under the situational regime of the metacode, but in other arenas as well.

4.

The Dual Epistemology of Patients and Healers

This chapter shall attempt to combine and analyse the findings of the two previous chapters, which focused on two arenas of the healers' involvement: treating people's afflictions, on the one hand, and taking part in various projects with representatives of biomedicine, on the other.

I will argue that healers and patients had an epistemology for two different forms of affliction. As I will describe, various terms were used by my interlocutors to refer to afflictions that were either deemed "normal", "natural", "random" or "just happened" or, by contrast, as "cultural", "traditional" or "Xhosa". As a review of the literature shows, this epistemological distinction has been made for some time. Through the accelerated influence of and interaction with biomedicine, what I call a "dual epistemology" is not fundamentally transformed. Nonetheless, the domains of "normal" and "cultural" sicknesses have been theorised and delineated more explicitly as different realms of competence for biomedical and traditional medicine. Whereas in the realm of "normal" sicknesses an interaction with biomedicine is possible due to commonly shared epistemological premises, the realm of "traditional" sicknesses has been framed as being the exclusive area of competence for healers. It can ultimately be convincingly demonstrated that the growing theorisation could reflect a transformation in the sense of Max Weber's theoretical rationalisation.[73] I also want to take a moment to elaborate on Weber's famous concept of disenchantment and show that this process does not necessarily take place, even though some aspects of the healers' practice could be described as having been rationalised. Since a vast array of literature attends critically to this aspect of Weber's work, I will briefly elucidate its core arguments.

[73] As I do not have diachronic data to trace this transformation fully, however, this will have to remain a hypothesis.

4.1. Dual Epistemology

In Chapter 2, I described the different options people had when they needed help to restore their health or to re-establish their relations with the ancestral world. I also made clear that the state of being sick is relative: the interpretation of illness as well as the mode and order of therapy depends on each person's beliefs at a particular point in time. It became evident that health and healing are complex sites of negotiation, compromise and change. Furthermore, their determining factors can be diverse, ranging from economic as well as emotional causes, pragmatic considerations, family matters, the availability of local health care facilities and the construction of national identities. I was able to conclude that each episode of sickness has the potential to transform one's explanations, practices and perceptions with regard to causes, strategies of resort and healing. Sickness can thus be an existential experience that challenges one's sense of social order and/or the capacity of one's social network.

However, one basic distinction of sicknesses, between "natural" and "traditional" ones, was often evoked as being determinative in informing the negotiation of people within their various networks regarding their choices of therapy. I laid out how patients in relation to other human and non-human actors, and depending on the resources they had to cope with an affliction, decided on a point by point basis for one particular mode of therapy, which could be administered by a general practitioner, a healer, or the individual him or herself with medication from a pharmacy. This decision, again, could be revisited later, which might have lead to another interpretation and a different therapy path. The original decision was hence not fixed, but provisional. This enabled patients and their network to proceed more pragmatically with their respective therapy. They had to decide where to turn to and what to do next when the first option proved ineffective, i.e. symptoms persisted or reappeared or new complications developed. People who considered ancestors or witchcraft to be the possible cause of an affliction had to decide if their illness was biomedical in nature, in which case they would most probably have seen a GP, or if they should first consult a healer who could identify either the ancestor or witch responsible. Hence, different sets of actors and the patient established and negotiated the identified mode of affliction, which determined the subsequent therapy path.

Definition of Dual Epistemology

The central concern of this chapter is the different kinds of knowing and knowledge – emerging in the formation, negotiation, alteration, and translation of networks comprising variously constituted human and non-human actors involved (Latour 2005)[74]. Geissler and Prince (2009) point out that a notion of knowing and "knowledge-ability" as universal faculties is too narrow. Instead, they suggest that other forms of knowing exist (2009:601). "The value of knowledge can be assessed not only with reference to reality, but also in relation to its effects; and, ... the effects of knowing change when operations of knowing are moved between contexts" (2009:601). Knowledge is something relational, a movement which transforms both the object and the knower with unintentional effects (2009:602). Also Stacey Langwick stresses that "healing knowledge emerges in unpredictable and unexpected ways through complex sets of relations", as it very much depends on the potential mediation skills of a healer who must establish a productive relationship with non-human actors to generate his or her knowledge (Langwick 2011:102). Also patients judge the abilities of a healer by the strength of his or her relationships with the non-human world, which is why healers prove their credentials by recounting their healing biographies many times and in great detail to potential patients (2011:105). In the following, I would like to argue that the different constitutive elements of the relationships between healers, patients, doctors, pharmacists, disease entities and other non-humans processually, and over time, stabilised into an assemblage of two different modes of knowing and acting. To describe them, I will use the term "dual epistemology". "Epistemology" here is understood in a historical sense (Rheinberger 1997; 2008), implying a stabilised form of perceiving and knowing the ontologies of various diseases and the related options for intervention. The dual epistemology that historically emerged among Xhosa healers in PE refered to and activated two different kinds of knowledge. These, in turn, incorporated two different ways of knowing and modes of interfering. In the domain of "cultural" sicknesses, medicinal knowledge and its transformational capacity was not attributed to entities as such. Instead, it was a product of the relations between them – the outcome of negotiations between humans, their ancestors, their afflictions and their therapists. By contrast, in the domain of "normal" sicknesses, reference was made to an objective reality with comparable entities with individual properties and capacities. In this reality for instance, sicknesses could be reliably treated with certain

[74] For an overview of Latour's theory of translation, see Rottenburg (2008), who also pays particular attention to its blind spot concerning the difference between effective and in-effective hybrids (2008:417, 422), i.e. between correct and incorrect knowledge.

medicines on the basis of expected causes and effects. As I will show later, it is the latter realm of "normal" sicknesses which provided a common foundation for interactions between healers and biomedicine, and thereby allowed the dual epistemology of healers to persist despite healers' increasing interactions with biomedical practitioners and their incorporation into the public health system.

Talking about it

Patients

In addition to drawing upon my empirical data, I cite the supporting accounts of two authors who have researched the Xhosa people, the issue of health, and the topic of disease causation. As I did not systematically study the perceptions of patients, their work is of particular importance. The first author is Stephné de Villiers (de Villiers 1984; 1985; 1993), who wrote both her Master's and her PhD thesis on Xhosa patients' perceptions and behaviour in relation to health and healing. The other author is G. Jansen (1973), a medical doctor, who wrote a book on the doctor-patient relationship focusing on Xhosa people in the Transkei. These authors represent two of the apparently few scholarly resources on Xhosa health beliefs. Monica Hunter (1961[1936]) has also written about the Mpondo, a Xhosa subgroup, devoting a few general chapters on religion and beliefs and thereby only occasionally touching upon the topic of traditional healing. She does not go into too much detail regarding the topic of disease causation. Nevertheless, some of her findings support my argument that a distinction should be made between two types of sicknesses, which I will elaborate on this later. Hammond-Tooke (1989) has further written on health and healing in South Africa, although only in general. I will also come back to some of his findings later. John Henderson Soga is the only author I discovered who strictly opposes the otherwise prevailing opinion that Xhosa people consider "natural" causes of illness, too (1931). He states that the Xhosa would never explain sicknesses in terms of "natural" causes (1931:179). He also describes them as superstitious and incapable of rational reasoning (1931:170). Soga does, however, mention herbalists who treat stomach problems and headaches with herbal remedies (1931:178), without any reference to ancestors and witchcraft. This contradicts his stark claim about the absence of "natural" causes of disease.

During my research, some of the people I talked to about their therapy management made a pronounced distinction between an illness treated by a healer and one treated by biomedicine.

Lulama, for instance, who suspected that witchcraft was responsible for her stiff neck, said she goes to a healer more frequently than to a clinic or hospital. She was quite clear in differentiating between the two domains of biomedicine and traditional healing, their limits and capacities. Sharp pain, she said, is something healers cannot treat. "Drips", moreover, were only available at hospitals. High blood pressure, on the other hand, and diabetes could be healed through traditional medicine. The latter would be extremely important for protecting your house and your car. Also, whenever she felt she had bad luck or sudden acne, she consulted a healer for the cause. For a simple cough, however, a healer would not be necessary (Notes, 2004-09-17). Although she did not use a specific terminology, it is evident in Lulama's account that there were two distinct spheres of healing she was referring to, each with separate capabilities.

Similar to the evidence in my findings, Stephné de Villiers writes that people make a distinction between conditions that are responsive to biomedical treatment or those that have a "mystical cause" and are called *ukufa kwaBantu* (illness of the Bantu), *ukufa kwamaXhosa* (illness of the Xhosa) or "African disease" (de Villiers 1993:2f.). Jansen makes a related claim. He refers to *isifo sesiXhosa* or *isifo sabantu* (*isifo* is another word in Xhosa for illness) (Jansen 1973:34). As with the interviews I conducted with healers, de Villiers asked people which afflictions belonged to which group of sicknesses, when they would consult a healer, and in what cases they would turn to biomedicine. She describes in detail people's various perceptions of certain sicknesses and how they are best treated. Tuberculosis, for instance, was sometimes blamed on unhygienic conditions, though some people knew about the possibility of contracting the disease from another person. Since medication was available, the belief that the lightening bird *impundulu* could cause Tuberculosis by kicking a person between the shoulders decreased (de Villiers 1993:130f.). Cancer, on the other hand, was thought of as being caused by witchcraft. Some of de Villiers' informants indicated that people who were diagnosed with a fatal disease like cancer would consult a healer because they had difficulties accepting the diagnosis (1993:131). Diabetes was explained as a genetic disease by one patient that de Villiers interviewed, whereas another said it was brought by "white people"[75] and the sweet things they had introduced into the diets of black people (1993:134). No non-human cause was referred to in relation to diabetes. Furthermore, to explain pneumonia people would refer to not being dressed properly or cold weather

[75] Hypertension would be another example of a sickness that was introduced by white people, according to one of de Villiers' informants (de Villiers 1993:135f.).

(1993:137). Skin problems, however could hint at the presence of witchcraft (1993:138), as Lulama also mentioned. Ailments referred to as "Xhosa illnesses" are regarded as especially dangerous and thought to lead to death if not treated (de Villiers 1984:60). One example for a typical Xhosa illness de Villiers mentioned and one that I also recall from my interviews with healers is *amafufunyana*, a form of spiritual possession where Zulu voices speak out of the patient's stomach (de Villiers 1984:61; see also Jansen 1973:47 and Ngubane 1977:144).

In her study on farm workers from 1980–1982 de Villiers goes into even more detail regarding the interpretation of illness and disease causation. She found that the workers made a distinction between a "random illness" and a "Xhosa" one. The first group of illnesses was called *isifo* in Xhosa, the second *ukufa* when the illness was more serious and could lead to death (de Villiers 1984:56f.). De Villiers lists a number of other categories of illnesses people referred to with specific terms, but all of them, she says, were clearly distinguished from so-called "Xhosa sicknesses". One category e.g. would be *umkhuhlane* for any illness involving fever-like influenza, hay fever, coughs, colds or diarrhoea. Some of de Villiers's informants attributed seasonal changes to an illness of that category, which could be "contagious and usually is infectious" (de Villiers 1984:58). All of her informants agreed that they could be treated by "Western medicine". Illnesses caused by unclean blood or childhood illnesses were other categories of "random illnesses" (1984:59). A major category, however, she writes, is "Xhosa illnesses" that were caused by ancestor spirits or witches. The farm workers she worked with would explain these as "illnesses typical of Xhosa-speaking people, but not understood by Whites, nor are they generally responsive to Western medical treatment" (de Villiers 1984:59, see also Jansen 1973:34). "Random illnesses" are something people would get "without a custom". They affect people everywhere, not just the Xhosa. "It appears that people expect such illnesses to happen, for example to catch a cold or get influenza during winter is natural and happens every year" (de Villiers 1984:83). Farm workers would also mention bad eating habits or climate changes when travelling as reasons for illnesses. Also stress or fear could result in self-inflicted illnesses like high-blood pressure or heart failure (1984:85). Jansen writes that apart from colds, "diseases whose genesis is evident to the patient", like burns, would also not be regarded as reasons for consulting a healer (1973:40).

Healers

In my interviews with the healers on their practice they clearly differentiated between sicknesses they felt capable of treating and those that biomedicine could treat more successfully. A successful practice was in part based on, first, coming to a consensus with the

patient and the ancestors involved about whether a sickness should be regarded as either "normal" or "cultural" and then affirming this consensus as being relatively stable and persistent. Again, this negotiation was always based on the communication the healer was able to establish with his or her ancestors. Not only the knowledge about non-human actors being responsible for a disturbance in the patient's life derived from the visions of the healer. The perception of an affliction as being "normal" or "natural" was also the outcome of a dialogue the healer had with his or her ancestors. Hence, people were advised by the healer's ancestors to go to a hospital for help, to get tested for HIV or to try a certain medication, be it herbal or a manufactured drug. The knowledge generated during the encounter of diagnosis was therefore always relational. This means it was based on the temporal journey of a healer to the non-human realm (see Langwick 2011:111) and the negotiation of its results with the patient, his or her ancestors and the therapy management group. It was also highly individualised and situational.

Reference was made to the dual epistemology in numerous conversations with healers, mostly also terminologically. Sometimes they would name certain diseases being curable with biomedicine only. Joe Gumede, for instance, explained that there are certain things like TB or AIDS that he cannot cure, which is why he would send his patients to the clinic if he recognised any symptoms. On the other hand, he did not know of any white person who knew how to use witchcraft (Int. A010, 2004-06-22). Tekile distinguished between "hospitality", which for him was healing in "the way of hospital", and healing according to "the way of ancestors". Some patients needed treatment at the hospital, others would have to be treated "in the traditional way", he explained. Asthma, rheumatism and TB are afflictions for which he would send his patients to the hospital. Surgeries such as for the removal of gall stones also could only be done at hospitals (Int. A019, 2004-09-13). When I questioned Sivu on the limits of traditional medicine, he mentioned operations and TB, but also the power of penicillin (Int. A028, 2004-10-29). Nomvumisa spoke of "white" and "Xhosa" diseases. Xhosa diseases are those that concern "witchcraft, lifting curses, bad medicine and if you have to do something for the ancestors, like slaughtering" (Int. A029, 2004-10-14). Mandy, a student of Thobeka, also gave operations as an example of things that can only be done at hospitals. She added that if a person is "really sick", she sends them to the hospital. In hospital they can "make people breath again", which she cannot do. "They can give you a drip too, that gives you power." There are a lot of things she cannot treat, but the reverse was true as well, she said. (Int. Mandy, Notes, 2004-06-13) Linda, a healer I came to know through Grace, my language teacher, did not refer to two types of sicknesses using specific terms. Instead, she gave the

example of a person who "had the river", which means the ancestors cause a sickness that cannot be treated in hospital. Another example would be someone who is losing strength and is supposed "to wear the beads", i.e. this person has to become a healer him/herself. When I asked her about the sicknesses she cannot treat and must therefore send patients to the hospital for, she named arthritis, diabetes, TB, high blood pressure and heart disease (Int. Linda, Notes, 2004-10-02). Of course, healers did not necessarily share the same views on such issues. Each evaluated their competencies differently with regard to certain complaints or problems. Thobeka, for instance, was convinced that she can treat diabetes. As I discussed in the previous chapter, through the scientific testing that had been done at UPE, Mea could identify the active ingredients in a plant the healers had brought that were helpful in treating diabetes. Thobeka, for her part, was happy to refer to these findings.

Dual Epistemology in Practice

In the following, I want to show how the distinction between the two different modes of sickness I just described plays out in practice, how it guides people's therapy management as well as the collaborations healers take part in. Another area where the distinction is important is in the healers' training. I will touch on this topic more towards the end of this section.

Patients

The case of Mr. Jonas that I described in Chapter 2 shall serve as one example of how therapy management can be seen as an attempt to finding the right category for an affliction. Mr. Jonas, again, could not move his hand properly and limbs because he was injured during an assault in 1962. Back then, he decided to undergo only a purely biomedical treatment. He went to a doctor and was treated by his assistant "who did not do a good job". The assistant was not very attentive and did not invest much time in the examination. Although other people told him to do so, Mr. Jonas did not consult a healer because he did not believe in their power. Sometimes, however, he wonders if he had made a mistake and whether he should have tried out a healer as well – just to be on the safe side (Notes, 2004-08-06). He, accordingly, contemplated later on if his categorisation of trying solely biomedicine was the right one. And if it was, he thinks that maybe he should have also done additional physiotherapy. The domain of biomedicine thus also presented one explanation as to why the treatment in 1962 was a failure.

De Villiers draws attention to an interesting aspect in this regard. She writes that "patients do not only consult a different practitioner for alternative treatment, but also to obtain information that provides different perspectives of their conditions. Thus patients who practice dual consultation do so for different purposes and to obtain different results which, in turn, mean that they have different expectations of each practitioner." People aim to maximise their chances of recovery (de Villiers 1993:277). Mr. Jonas wonders decades after his injury if maybe he should have pursued all the available options back then "to be on the safe side", to have increased his chances of a full recovery. A visit to a healer might also have alerted him to a possible ancestral interference or witchcraft. Thus, even though he stated that he did not believe "in such things", as I explained in Chapter 2, certain experiences of illness have the potential to reorder and change one's perceptions about issues of religion, the non-human world, fate, guilt or the meaning of life.

Another example I referred to in Chapter 2 already relates to Thabisa, who negotiated the meaning of her psychic problems with her mother, who was herself a student of traditional healing. They struggled to find the right category for Thabisa's problems. The mother opted for a "traditional" reading which suggested that Thabisa should start healer's training. She interpreted Thabisa's problems as representing an ancestral calling indicating Thabisa was supposed to become a healer like her. Thabisa, on the other hand, was not convinced. She preferred to find a proper job in town that would ensure her financial independence. Her psychic problems, she said, were tied to bipolar mood-disorder and the idea of psychotherapy or medication appealed to her. She also had the impression that she had a lot of things in common with other young women she had met previously in the clinic. For her, interpreting her problems in Western, modern, biomedical terms was a question of preferring a different lifestyle. Her case shows (as elucidated in Chapter 2) how the categorisation of illness is linked to ideas of self and has consequences far beyond the mere subject of healing.

Healers

Regarding the healers' practice, it is worth noting that through adhering to a dual epistemology that distinguishes between "cultural" and "normal" sicknesses two domains of competence were established for both traditional healers and biomedical doctors. As my quote of Joe Gumede showed, the realm of "cultural" sicknesses to which witchcraft belongs was one where only healers can claim competence. This exclusive purview was something most healers emphasised and were proud of. As indicated earlier, most of the healers I talked to attributed a certain superiority to biomedicine regarding the realm of the "normal" sicknesses

due to better technical means. In Chapter 2, I cited various examples of healers consulting private medical doctors or hospitals. Several healers told me about their "blood-" or "body-check" that they would regularly go to the hospital for. As I wrote earlier, the reasons given for this were that "in hospitals they would be good in record keeping" and overall they seemed to have the better means to heal, at least in some cases. "Medical doctors have microscopes to see the virus", for instance. They also have syringes to inject medicine directly, the means to conduct operations and measure blood pressure or take x-rays and "their medicine works faster because it is in pill form". Healers also told me that they would refer patients to the hospital, if they had not been there already, to get tested, for instance, for HIV. Expressing the view that their colleagues at the hospital were better in treating certain diseases was generally not perceived as problematic.

As I showed in the previous chapter, healers were also generally quite motivated to "improve their practice" by taking part in workshops in order to acquire biomedical knowledge. Their wish to obtain additional education was voiced strongly, especially in connection to HIV/AIDS. Chapter 3 gave an overview of the encounters between the traditional healers and the representatives of biomedicine that I studied during my fieldwork in PE. Through an historical examination of encounters between traditional healers, settlers, missionaries and doctors, it became evident that this interaction was shaped early on by the desire of all parties to obtain their counterpart's medical knowledge. Biomedicine was regarded from the beginning as a potent means of combating certain diseases. Healers were regarded as important for both having knowledge of potent plants and for being mediators to their people.

Regarding their various activities, I wanted to show how the healers tried to navigate their way between the promise of prestige and resources that would develop out of scientific testing and the need to guard their secrets; between becoming part of the health system and keeping autonomy; and between using and promoting biomedicine, especially in the time of AIDS, and still being important agents in the field of health and healing. During the encounters with biomedicine healers refrained from certain explanations or concepts which they considered untranslatable or not immediately relevant in order to ensure or to facilitate communication. I introduced Rottenburg's notion of the metacode (2005) to describe this "trading language". I explained how healers shift into the metacode during the encounter, but that in their "normal" life as healers they switch back into their cultural code. I concluded that claims therefore about fundamental epistemological changes through the healers' interactions with biomedicine do not necessarily have to be valid.

It should be emphasised that these interactions I have described, the knowledge healers sought and the scientific test results about the efficacy of their plants all took place solely within the realm of "normal" sicknesses. Within this realm, healers did not have a problem admitting biomedicine's superiority. Healers wanted to increase their knowledge of "normal" sicknesses. I analysed their motives in the previous chapter. Improving their practice and learning to cope better with certain diseases were clearly central. I underlined the importance of HIV/AIDS in that regard. The scientific testing made the healers' practice translatable to other social worlds. If successful, so the healers hoped, one of their plants could be transformed into a capsule and used all over the world. At the same time, the reputation and the prestige of traditional medicine would increase. Again, the concern here is with the realm of "normal" sicknesses, wherein the superiority of biomedicine was already acknowledged. So, in a way, the healers had nothing to lose. Healers dominated in the domain of the "cultural" diseases because they were the only experts there and did not have to compete with their biomedical counterparts. Biomedical doctors did not have any means of addressing this entire area of sickness. Some of the healers I talked to even felt superior to their biomedical colleagues because they were the exclusive experts in communicating with the ancestors and therefore for dealing with the sicknesses caused by them. Incorporating "Western" ideas about certain sicknesses, including AIDS, did not undermine the foundation of the healers' dual epistemology. It could even be seen as consolidating this paradigm, because although medicine advances,[76] the realm of incurable or chronic diseases remained – and the healers themselves were proof for that. Their belief in "cultural" sicknesses and the causality of the ancestors was fundamental for them because it refered to their very own biography of being called, of becoming a healer. Most of the sicknesses that the healers had suffered from that were evidence of having been called could not be cured by modern medicine. The healers were themselves living evidence of the dual epistemology.

A closer analysis shows that in the everyday practice of traditional healers the categorisation of sicknesses according to this dichotomy was open to negotiation and that there was no terminological consensus about how to refer to this dichotomy. Not every healer or patient necessarily used the terms of "cultural" and "normal" sickness. When I focused during my interviews on certain types of sickness that required either traditional or biomedical medicine, I found instead that the healers shared a concept of dual epistemology without necessarily

[76] One elder healer could still remember the time when tuberculosis could not be cured by anybody. Only now that TB medicine was widely available could the disease be defeated, he explained. This can be seen as proof of healers acknowledging biomedical progress, which leaves the realm of cultural diseases, i.e. the field of activity for the traditional healers, untouched.

having a respective terminology. In other words: for each patient searching for a cure, the healer had to decide on whether to treat his or her sickness as a "normal" one, which would have meant advising a consultation with a biomedical doctor, or if the sickness was a "cultural" one, involving the ancestors. The case then fell under the exclusive care of the healer. This process of negotiating the type of a sickness between patient and healer, which also often involves the relatives of the patient, was very complex, as discussed in Chapter 2.

Margaret Lock and Vinh-Kim Nguyen refer to the interplay between practitioners of different healing traditions, patients and their network and the constant renegotiation of diseases and their treatment as hybridity (see e.g. Lock and Nguyen 2010:30,64f.). The focus here is on the processual aspect of searching for the right mode of therapy as well as the simultaneous use of "entities taken from the material and spiritual worlds" (2010:30). Referring to China, Lock and Nguyen stress that patients switch back and forth between Chinese medicine and biomedicine. Here, there are not only different types of medication involved but also hybrid ways of thinking on the part of practitioners and patients "between what is associated with tradition on the one hand and with modernity on the other" (2010:65). Stacey Langwick argues similarly, focusing on how the management of malaria and *degedege* draws together and coordinates collectives consisting of the afflicted, their families, doctors, nurses and healers (Langwick 2007:111). Patients and their families would "enact ontic differences central to therapeutic negotiations in Tanzania" (2007:112). Whereas nurses and doctors claim malaria and *degedege* to be the same thing, healers insist that they are different (2007:111). The material Langwick presents shows how the conflict over the power to define certain illnesses is one where legitimacy and areas of competence are at stake. Against the backdrop of the dual epistemology I described, one could argue that Tanzanian healers claim *degedege* to be a "traditional sickness"[77] that therefore belongs to their realm of competence. Struggles about definitions are thus also existential struggles. Langwick stresses the situatedness of these negotiations between these "interdependent therapeutic ecologies" which compose "hybrid bodies and disease entities" (2007:112). Steven Feierman coined the notion of a "diagnosis by addition" (Feierman 2000:14, 17) whereby he highlights that people in Ghaambo in Tanzania did not want to narrow down the cause of an illness to a single one, but rather explore different layers of causes. Hospital medicine can sometimes only be effective

[77] In fact, as Langwick reports, people in Tanzania also make a distinction between "two sides" of possible treatment – hospital vs. traditional medicine. Also the category "traditional" disease, as a standing term itself, is referred to in connection with (in this case) *degedege* (Langwick 2007:94).

when a disturbance with the ancestors is treated first.[78] Furthermore, "each individual defined her own therapeutic universe, but not under conditions of her own making" (2000:332). Not only the disease itself, or ancestors influence the success of therapy, but also wealth or poverty play a significant role as either enabling the patient to conduct certain rituals or putting them out of reach.

Dual Epistemology in the Training

Regarding the examination of the healers' different kinds of medicinal knowledge, their training proved to be a valuable line of inquiry. A large part of healers' training revolved around the establishment of productive ties to the non-human world. Throughout the training period the apprentice learned how to interpret his or her dreams together with the instructing healer. Visions were transferred into actions in the human world, the knowledge gained was applied in practice and, over time, the apprentice gradually learned how to "talk" directly to his or her supporting ancestors (see also Langwick 2011:111). In this process, the prospective healer was guided by the teacher, a more senior healer. However, in contrast to Stacey Langwick's findings on healers in Tanzania who "refrain from highlighting relationships that might imply that they learned their medicine as a set of skills" (2011:112), the healers I worked with explained to me that knowledge about the effects of herbs formed part of their curriculum. Patients also drew on empirical knowledge, i.e. knowledge which is based on experience, e.g. when they purchased medicinal substances from an herbalist without having consulted an expert. Cocks and Dold (2000) underline the importance of self-medication amongst Xhosa in the Eastern Cape. People there know about certain herbs and their potential and pass this knowledge on to the next generation. One example of someone who participates in this process was Thobeka's father: while I was sitting in the lounge in their house chatting to Mr. Magxabi, an old ANC veteran and relative of the family, he gave the latter a plant to ease his coughing. Mr. Magxabi had suffered from asthma ever since his time in prison on Robben Island. The plant looked a bit like camomile, but he denied that it was. He told Magxabi he should pour boiling water on it and drink it whenever he felt like it. When I asked Thobeka later about whether her father was a healer, too, she said he was not. He just knew about some of the medicines they had always used (Notes, 2004-04-02).

It is worth noting that self-medication is only possible when a realm of illnesses is known to "just happen" without further reason, such as ancestors who have withdrawn their support or

[78] This phenomenon has been referred to by Muela et al., too (1998). During my research I did not encounter similar accounts of courses of therapy.

another person is practicing witchcraft. These illnesses can thus be treated without a healer who is able to communicate with ancestors. The very fact that herbalists have long been known and written about shows that certain afflictions were responded to in a very empirical and straightforward manner. Luckily, for those illnesses that "just happen", there is an herb or a ready-made medication for them that makes consulting a specialist unnecessary, be it a local GP or a healer. A biomedical practitioner might be looked at as just a better, more advanced type of herbalist who can cure certain illnesses with the appropriate medication, therapy or operation and the problem might be solved pretty soon.

In my interviews with the healers, I tried to gain as much information as possible on how teaching and learning, and the transfer of different kinds of knowledge from healer to student, takes place. Lusanda, one of Thobeka's students, said Thobeka would never reveal everything to her. She could not witness any of Thobeka's sessions because of the confidentiality between a doctor and a patient. Thobeka also did not tell her what happened during the consultation or how she treated the patient. Lusanda explained to me that healers may use different plants for the same thing because their ancestors tell them to. I asked her whether she would learn about what herbs to use for ailments like coughing or other minor health problems. She said that Thobeka told about her plants and when to use them in the very beginning, but only briefly and not again afterwards. She could not remember everything. Lusanda also knew some things from her grandparents, such as what herb to use for a cough. "But sangomas are like this when it comes to their medicines", she explained. "They never give it away" (Int. Lusanda, Notes, 2004-06-03). When pressing further on the issue by asking quite pointedly if there is a difference between small diseases, where one just knows what herb to use, and serious diseases, where advice is required from the ancestors, she simply agreed. When I suggested that she probably knew after some time what would help a fever or coughing, she again accepted my explanation. Through my questioning, Lusanda seemed to start thinking about the issues or was even forced to try to arrive at plausible explanations. The bottom line was that she was not really sure: there was no sense of "either you know it or you dream it" (ibid.).

I subsequently had the opportunity to question Lusanda's teacher in a related manner. When I asked her why a healer needs training at all if the ancestors tell him or her everything, she answered: "Healers dream and get taught by a teacher, it is both ... You learn from the teacher, you even can write it down in a book when you come home, what he told you about the different plants. But the ancestors do also tell you. It is both" (Int. Thobeka, Notes, 2004-

06-09). She said that a teacher would “underline” what you are dreaming and analyse your dreams. “It is like reading a book at school. You can read it, but the teacher gives an underlining.” As with Lusanda, I wanted more clarity. Did she always have to dream in order to treat a patient or did she know after some time what to give a patient because she had learned what to use? She said that she could help some of the patients who would come to her without dreaming. Some, on the other hand, would come whom she had dreamt of before. In such cases, she would then know how to treat their sicknesses. The ancestors, however, always talk to her when a patient comes. At this point, I asked again what a teacher was for. She said: “You need it. The call is inside of you, you are born with it and you can’t put it aside. But it needs a teacher” (ibid.). In an earlier interview, Thobeka had told me about other things that she would teach her students. She explained that she had to tell them what to do “at the river”. She referred to one of the rituals students have to undergo together with representatives of their families in order to appease the ancestors of the river. Although the students would dream that they have to go and perform the ritual, they would not know what to do there. She also tells them what they must not eat before they go to the river, namely *ulusu* (sheep insides), milk, coffee and butter. If the students did not follow those rules, the ancestors would become angry and not tell them anything, she explained. Having intercourse a week before you go to the river, even if you are married, is also forbidden. An important part of the training was also the interpretation of dreams. The students would come to her regularly and report to her on their dreams. Furthermore, she said she also told them about diseases, such as how they “see” diabetes and how they can treat it. She further taught them about AIDS and “that they must be careful with the blood and cuts” (Notes, 2004-06-04).

Fig. 7: Healers praising the ancestors of the sea during a graduation ceremony.

Mandy, another one of Thobeka's students, told me she would regularly go to an herbalist to purchase herbs. Unlike most healers I interviewed, she said she could also treat family members, although she might have been referring to administering herbal medicine to them, i.e. treating "natural" sicknesses instead of discovering whether witchcraft was the cause of their troubles. Mandy would also ask the herbalist what to use because "they also know. … Sometimes you hear from others what they use for what and you write that down not to forget it" (Int. Mandy, Notes, 2004-06-04). For her, gathering knowledge on herbs as a future healer seemed normal.

These accounts clearly show that, despite certain contradictions regarding the question of how much direct advice about the use of herbs comes from the ancestors, the knowledge of herbs forms an integral part of healers' training. This indicates that ancestral guidance is not always regarded as necessary for healing a patient. Krige similarly concludes for the South African Lovedu that their detailed knowledge and effective use of the vegetation shows that they recognise and are guided by empirical facts when it comes to health and healing (Krige 1952:50). The transmission of knowledge based on experiences and empirical learning within a family and between a healer and his or her students can be regarded as further proof that a realm of sicknesses exists that is understood as being free from any other-worldly influence. People believe in the efficacy of a variety of herbs or manufactured medicines. To treat a minor illness, they sometimes even use them without consulting any specialist at all.

4.2. Literature on Dual Epistemologies

Since the mid 1970s, there has been a tendency in the studies on medical pluralism by various authors to overemphasise the ritual aspects of non-biomedical healing and the culturally-bound syndromes of certain communities (Cocks and Dold 2000:1507; Pool 1994:108f.; Singer 1990:179f.). Pool even speaks about "a crusade to prove that Africans traditionally recognise a separate medical domain in which they interpret illness primarily in empirical and practical rather than in social and moral terms" (1994:108). Not all authors mention accounts on medical behaviour in Southern Africa concerning the realm of "normal" sicknesses, those that "just happen" without a non-human agent being involved. For Hammond-Tooke, the group of non-mystical illnesses is not traditionally Xhosa. He suggests that only old age was known as a "natural" cause of illness and death (Hammond-Tooke 1970:34). He later changed

his view, however, writing that "there is a range of illnesses that in fact are believed to 'just occur', to be in the nature of things" (Hammond-Tooke 1989:56). These illnesses could be minor ailments like coughs, colds and stomach disorders, but also more serious ones such as dysentery and malaria (ibid.) He cites the Kriges (1943:223) who report that amongst the Lovedu epidemics of smallpox, measles and influenza are said to be caused by "winds" that "just come" (Hammond-Tooke 1989:56). As I described in Chapter 2, depending on the course of therapy and on the success or non-success of the treatment these complaints can be re-interpreted later as having been caused by witchcraft or the ancestors. According to Monica Hunter, although the Mpondo did not recognise leprosy or tuberculosis as being infectious, they would explain these illnesses in "natural" terms, meaning they were not "sent" (Hunter 1961[1936]:273). Elsewhere, she describes the tasks of a healer as twofold: discovering the underlying cause of an illness, accident or death, and treating sick people (1961[1936]:336, 340). Hunter presents a list of herbs and techniques that healers use to treat certain ailments (1961[1936]:304). When explaining the difference between herbalists and healers, she explains that healers have the same knowledge as an herbalist, whose profession can be learnt, whereas healers for their part are called to heal. This enables them to additionally treat everything linked to witchcraft and ancestral interference (1961[1936]:341, 344). Monica Hunter contrasts her findings in rural Pondoland with research she had also done amongst Xhosa people who had moved to towns or worked on farms far away from home. In this case, she seemed to have found evidence of people making a clear distinction between "natural" and "Xhosa" diseases. People would also increasingly rely on biomedicine, which was as easy to come by as healers in towns. The number of diseases that were explained with "natural" causes would increase, Hunter states (1961[1936]:501). However, people explained to her that "Europeans don't understand" some causes of sicknesses and that a healer needs to be consulted (1961[1936]:542).

Benedicte Ingstad also writes about a distinction people make in Botswana between "Tswana sicknesses", which are caused by ancestors, pollution or witchcraft, and "other sicknesses", which "just happen" or are thought to have appeared with colonisation. So-called modern medicine is preferred for "other sicknesses", she writes (Ingstad 1989:252). With regard to Hunter's findings, it is also worth noting here that colonisation might have indeed affected disease causation in the sense that some afflictions only became treatable with the emergence of biomedicine. Therefore, one can reasonable surmise that only then did these afflictions became visible. They became mentionable and nameable conditions which could be separated out from the bulk of undifferentiated ailments previously known to people. This phenomenon

can be read as evidence of Weber's disenchantment argument: once a particular affliction gets explained, treated and is thereby freed of mystical causes, it becomes demystified or disenchanted.[79] Hence, the number of treatable, known and named so-called "other", "modern" or "Western" diseases increases.

In regard to the Tonga in Zambia, Mogensen (1997) and Gausset (1998) report a similar distinction between "normal" and "traditional" sicknesses. In Northern Mozambique, West (2006) did research on healers who incorporated foreign concepts and symbols into their healing practice. Koran pages, rubber gloves, geometrical figures scribbled on a paper and foreign spirits like jinns played a role in several of the sessions he describes. One healer stated she would be able to heal both "God's illnesses" and "victims of sorcery" (West 2006:35), thereby also distinguishing between illnesses that are sent to a particular person by someone else and illnesses that just happen randomly.

Jo Wreford, herself a trained sangoma, proves to be rather uncertain on the issue of disease causation. On the one hand, she presents to the reader the well-known dichotomy between traditional healing, based on ancestral connection and spiritual power, and biomedicine, which excludes the spiritual and separates mind and body (Wreford 2005:58f.).[80] On the other hand, she explains how people differentiate between "natural" and "unnatural" illnesses. "Natural" illnesses have environmental causes, like "bad weather" or "smoke in the air", whereas "unnatural" ones are caused by the ancestors (2005:76). Wreford also cites a healer who explained that AIDS was a "modern" disease, which is why she and other healers would not have a cure for it (2005:63). Towards the end of her paper she reinforces her first statement by saying that traditional and biomedicine should strengthen their ties, so that the patient would have the underlying cause of his or her illness identified, the healer would feel included in the process and the doctor would be assured that ARVs are being taken properly (2005:77). Following the dichotomy Wreford identifies, traditional healers are hence responsible for the spiritual realm, whereas biomedical doctors are welcome to ensure patients' necessary medical compliance.

Like Wreford, Edward Green studied the potential for collaboration between traditional and biomedicine, but comes to a more positive conclusion. Instead of focusing on the large divide

[79] Of course this process is not irreversible. Numerous studies have shown that, in case of biomedical failure, people tend to resort to or look for explanations outside of the scientific realm. One could say that a re-enchantment can take place. I will focus more on this dialectic later.

[80] I find her dichotomy too stark and reductive as it leaves out, first of all, "normal" sicknesses known by healers that other authors have extensively elaborated on. Moreover, the importance of psyche, i.e. mind, for healing processes is hardly news in biomedicine.

between the two areas, he points out the common ground they share. He distinguishes between "impersonal" and "personalistic" theories about illness causation. In the case of "impersonal" explanations, such as pollution theories or naturalistic infections, everyone can become infected. "Personalistic" theories, by contrast, are those involving witchcraft or spirits. Here, one particular individual is targeted by a "superhuman" force (Green 1999:70). In fact, Green points out the parallels between biomedical theories about contagion and indigenous pollution beliefs, while emphasising their importance for teaching HIV/AIDS prevention (1999:72f.).

It should be clear by now that the dual epistemology indeed played a vital role in the understanding of health and healing. My empirical data, gathered amongst patients and healers, and the earlier and contemporary literature I have cited, show that people commonly alluded to the distinction between "normal" and "traditional" sicknesses when they decided for a certain therapy path and that, for healers, this distinction proved to be crucial for the identification and marking of their own realm of competence in distinction to biomedicine. This proved to be especially significant with the growing influx of and numerous encounters with biomedicine. I argue that a categorisation between "natural" and "traditional" sicknesses has always been present. The existence of herbalists and their competence to treat with herbs strongly supports this claim. But the necessity arose in competition with biomedicine to draw a line between, on the one hand, simply treating an ailment without taking otherworldly agents into account and, on the other, the necessary communication with ancestors about the underlying cause of a person's problem. The categories solidified, so to speak. Its boundaries became existential to secure a separate realm for Xhosa custom and sickness.

4.3. Rationalisation

As outlined in the introduction, I want to empirically analyse and substantiate in this dissertation three major themes that could be characterised as the prime features of the modernisation of traditional healing, namely professionalisation, legalisation and standardisation. Again, the main trigger for these modernising processes is, according to Weber, the principle of rationality that penetrates all the spheres of society – whether economic, legal, political or religious. He distinguishes four types of rationality: practical, formal, theoretical and substantive (Kalberg 1981). For Weber, rationality is universal. All four types can be found in each society, although the degree to which society's spheres are

rationalised differs (Bendix 1972; Kalberg 1981; Parsons 1937). This chapter will focus on theoretical rationality, as it deals with thought patterns, theories of causation and the compartmentalisation of sicknesses that determines therapy management. According to Weber, this type of rationality involves a conscious mastery of reality through conceptual reasoning and the construction of unified patterns or concepts rather than through action (Kalberg 1981:14; Morrison 1995:223). It aims to penetrate the limits of daily routine and practical reality by understanding worldly processes with the aid of abstract concepts which may or may not be meaningful according to some value standards (Morrison 1995:223). Worldviews of any kind could be an example for theoretical rationalisation, as could philosophies or sciences explaining the workings of nature and society. Even though theoretical rationality attempts to master reality through thought, and can thus introduce patters of action only indirectly, Weber asserts that the abstract rationalisation of systematic thinkers played a decisive role in the disenchantment of the world (Weber 1988[1920/21]:567ff.).

The Dual Epistemology as a Coherent System

The dual epistemology, as I showed, was important in terms of its ubiquity in the domain of health and healing for both patients and healers. Biomedical advances could be incorporated as well as the necessity of traditional healing; the usefulness of scientifically testing traditional plants as well as the existence of "traditional" diseases which biomedicine cannot cure. What I would like to stress here is the fact that biomedicine and the realm of "normal" sicknesses were based on a common epistemology and that both could be part of the dual epistemology, instead of existing as alternatives. The influences of biomedicine can be seen as compatible or coherent with this epistemology. The compartmentalisation of sicknesses into "normal" and "traditional" allows for an inclusion of biomedical concepts within the realm of "normal" sicknesses, whereas the "traditional" realm stays unchallenged. In the previous chapter, I explained how the metacode (Rottenburg 2005) enabled actors to cooperate through pragmatically excluding controversial issues. On an epistemological level, analytical philosopher Donald Davidson provides an explanation for the acceptance of biomedical truth claims. According to Davidson, a proposition is true if it coheres with a certain system of beliefs (Davidson 1986:309). Hereby, it is important to note that not "any arbitrary set of propositions" can constitute the belief system that an apparent truth would cohere with (Walker 1989:3). Indeed, a main point of criticism in regard to coherence theory in general

has been that allegedly anything goes, that "virtually any proposition can be fitted to some coherent set" of beliefs (ibid.). However, Davidson makes aptly clear that knowledge which is believed in, i.e. truth, presupposes people who believe in it, who share or cohere to a consistent set of propositions (Davidson 1986:308). Coupled with another one of Davidson's tenets, one could read him as follows: like Quine, Davidson also adheres to the principle of charity (1986:316) which assigns reason and logic to our fellow human beings. Hence, his argument seems to be that the limit on what propositions are possible or can make sense depends on how many people adhere to a certain belief.[81]

Applied to the case of the dual epistemology, its validity rests on two premises. One concerns its coherence, the other its acceptance among the healers and patients I studied and the extent to which their actions are accordingly affected. Starting with the latter, the way healers and patients explained afflictions, how they made sense of them and how these considerations determined therapy paths and ways of treatment was at the core of my research. As I laid out in Chapter 2, the distinction between complaints being "normal" and treatable by biomedicine or herbs, on the one hand, and conditions possibly having a "traditional" cause like ancestral anger or witchcraft, on the other, structured the method and order of treatment. I showed how this distinction was at the heart of how diseases were interpreted and coped with. However, I tried to stress that a constant reinterpretation and shift between these two poles can occur and also that various factors like financial resources, the influence of a therapy management group or the success and failure of a treatment might lead to a reevaluation of the chosen therapy path. Hence, the distinction between "normal" and "traditional" diseases is not fixed and can vary over time or depend on the different settings the afflicted person talks about in regard to his or her disease.

Remarkably, in terms of the question of coherence, biomedical propositions, biomedical failure and success, but also healers' as well as biomedicine's errors and accomplishments were accommodated within the conceptual scheme of the dual epistemology. As I discussed in Chapter 3, healers' excursions to the lab, their predominant acceptance of the HI virus as well as their own use of biomedical facilities took place within the realm of "normal" sicknesses and hence did not represent a problem for their own competence. Progress, new ways of treatment, new medication and new viruses or diseases were all located within the realm of "normal" sicknesses, leaving the realm of the "traditional" sicknesses relatively

[81] False beliefs, however, are still possible for Davidson of course. For more on his argumentation about how to think of coherence theory in terms of a certain correspondence to reality, see his essay (1986).

unchallenged. I also found some healers acknowledging this "progress": on the one hand, by using biomedicine in practice for themselves and their family and, on the other, by recounting biomedical success stories about e.g. tuberculosis, which was once unknown, had no name and became treatable only later. Even if the number of "traditional" diseases were to decrease, as more afflictions turned out to be better treated by biomedicine[82], the healers themselves offer evidence of the existence of "traditional" sicknesses because their calling is expressed in various symptoms of disease. In the case of the calling of a prospective healer, only his or her completion of the training would lead to a cure.

It should be noted, however, that the epistemological differences between biomedicine and traditional medicine are not based on fundamental misunderstandings or different logics but rather quite simply on different opinions. They differ on the possible agents of disease causation: whereas traditional healing includes ancestral shades or witches in their therapeutic reasoning, these are not valid within biomedicine. The mutual bone of contention is thus the realm of "cultural" sicknesses. What should be avoided, however, is the notion that there are different conceptual schemes that healers or physicians adhere to. Davidson (2001[1974]) convincingly shows that the idea of radically incommensurable, untranslatable theories cannot be rendered intelligible. He points out the paradox of a necessary common ground from which a "conceptual contrast" could be judged. The result is a case of "dramatic incomparability" (2001[1974]:184). In other words, the difference in how the groups interpret "cultural" sicknesses is not one of a mutual lack of understanding, but rather a difference of opinion with regard to perfectly understood alternative epistemologies of certain sicknesses. In sum, and paraphrasing Davidson with regard to "cultural" sicknesses, it is reasonable to conclude that biomedical doctors and traditional healers are perfectly able to agree to disagree.

The Theoretical Rationality of Healers' Knowledge

In the following, I will elaborate on the theoretical implications of the dual epistemology that I have explained so far in terms of its terminological and practical uses. I will also examine the dual epistemology from a historical perspective, before I focus on Weber's ideas about the disenchantment of the religious sphere, which in his view goes hand in hand with rationalisation.

[82] Taking into account the fact that patients everywhere use so-called alternative medicine when biomedicine does not fulfill its healing promise or when they are not satisfied with it.

When looking at various activities healers in PE took part in, the creation of the two different spheres of competence I have just discussed can be seen as having played a decisive role. Again, Weber's theoretical rationality underlines a conscious mastery of reality through conceptual reasoning and the construction of unified patterns or concepts that later determine the course of action. The dual epistemology can be understood in the same way: it constitutes a method for coming to terms with and mastering changing worldly processes with the aid of abstract concepts. Healers were able to take part in numerous activities and collaborations without having their realm of traditional disease, and their own competence in it, challenged. Adhering to that concept allowed healers to agree e.g. to the scientific testing of their plants. The issue of scientific testing played a big role on the local as well as the national level. In the previous chapter, I described the testing of plants at the pharmacy department in PE as part of a collaboration with healers' organisations. The motivation of the researchers was to "uplift" the reputation of traditional healing by scientifically verifying the efficacy of their plants and to preserve what is seen as an important part of Xhosa culture. The healers were not only motivated to participate in this process because it gave them access to workshops, but it also allowed them to obtain some scientific proof of their efficacy, which could only help their public reputation. This testing of medicines and the eventual positive results would strengthen the belief in the healers' competence within the realm of "normal" sicknesses. In a domain where healers compete anyway with herbalists and biomedical doctors, they would achieve a certain credibility regarding the efficacy of their plants, which could lead to their financial benefit. It could also improve their standing amongst biomedical practitioners during various joint ventures. Some healers maybe aspired being taken more seriously by biomedical staff or that at least some newspaper headlines would report on the merits of traditional medicines. While being integrated into the realm of "normal" sicknesses may be regarded as an added incentive for healers, it did not fundamentally challenge or change the perception of traditional healing. In all of this, the realm of Xhosa sicknesses remains undisturbed. No matter how the test results turn out, the realm of "traditional" sicknesses continues to be strictly the domain of healers. Moreover, their own biographies relating to how a sickness marked the beginning of their own careers is proof for the existence of "traditional" sicknesses that only a healer could cure. Hence, despite the scientific results of the testing done on their plants, the exclusive competence of healers in treating "traditional" sicknesses stays unchallenged.

It is interesting to consider whether this differentiation is something that evolved with the influx of biomedicine and also if it becomes more pronounced or important in reaction to it.

De Villiers suggests that the "designation *ukufa kwamaXhosa* became current following contact with Western medicine after which Xhosa-speaking people claimed specific categories of illness as typically theirs" (1984:60).[83] Monica Hunter also speaks about a growing number of "naturally" caused sicknesses amongst Xhosa-speaking town people (1961[1936]:501). Unfortunately, none of the authors here substantiates this point very much. But Jansen and de Villiers both occasionally present empirical evidence that the practice of patients and healers might have changed over time. For instance, regarding farm workers de Villiers has the impression that they would increasingly regard illnesses as having "natural" causes. She attributes this trend to the growing influence of Christianity, the availability of biomedicine and the comparably high fees of healers. She cites the example of healers and midwives who were consulted in earlier times when difficulties occurred during child birth. Nowadays, as the farm workers de Villiers worked with reported, people would be hospitalised (de Villiers 1984:103). De Villiers concurs with Jansen (Jansen 1973:38f.) that the question of who caused a certain affliction seemed to have been much more prominent in earlier days and has since lost its significance. She quotes nurses who recount to her the experiences of Xhosa patients who accepted the diagnosis of tuberculosis after having witnessed people die following their consultation with a healer and others who, by contrast, survived after taking medication from the hospital (De Villiers 1993:156). The rapid effect of penicillin injections, which would work faster than the medicine of a healer, seems to be another success story that convinced some people of the merits of biomedicine (1993:164). Robert Pool writes similarly about Cameroonian people's ideas on health and healing: "people traditionally attribute all illness to personalistic causes" whereas naturalistic explanations in people's theories of disease causation were relatively recent (Pool 1994:184). Biomedicine would provide new explanations of illness that were free of traditional values and taboo obligations and also "an alternative health-care system which treats minor ailments effectively without asking any awkward questions" (ibid.).

It is difficult to make unambiguous statements about the historical development of the dual epistemology I am describing. As I discussed earlier, a division of labour between healers and herbalists has long been reported by social anthropologists working on South African health and healing. I would like to argue, however, that healers were well advised to come up with a concept which would guarantee them a legitimate and mutually exclusive realm of sicknesses only they were responsible for, especially given that biomedicine was a far more powerful and

[83] See also Jansen (1973:34), who makes the same point.

omnipresent agent (in the sense of a conglomerate of discourses and practices) compared to the individual herbalists. This realm is theoretically free of competition from biomedicine, although, the definition of a sickness as "natural" or "traditional" is not final. If patients are not satisfied with the course of therapy, they might consider re-defining it as the respective "other". This possibly leads to a whole different perspective on their ailment which then would be linked to various other forms of treatment. In fact, one could even speculate about the realm of Xhosa sicknesses having become smaller over time, that the more and more diseases turn out to be easily cured by biomedicine the less people are inclined to consider ancestors or witches to be the cause of their problems. However, the limits of biomedicine in providing a cure or an explanation for everything are well known which is why one can expect that a certain number of afflictions will continue to be interpreted as having an other-worldly dimension. And eventually the sicknesses indicating the ancestors' wish for their descendant to become a traditional healer can be described as constituting the main core of "traditional" sicknesses that will remain as long as there will be healers. [84]

Why Bother with Disease Causation?

At this juncture, I would like to address a few points of critique towards my undertaking. The aim is to pinpoint a scheme of disease causation, which is the basis for my argument of rationalisation. In Robert Pool's book on disease causation in Cameroon (1994), he asks: "Why so much trouble to prove that Africans traditionally explain most illness in naturalistic terms?" (Pool 1994:110). He refers to the beginning of the field of medical anthropology as having resulted in a "fundamental dichotomy" between biomedicine and all other forms of medicine. In contrast to biomedicine, these older accounts focused solely on the magic side of healing when studying health and healing in e.g. Africa (1994:110f.). The countermovement within medical anthropology, on the other hand, intended to "bridge the gap between traditional medicine and biomedicine by identifying indigenous medical systems" (1994:263). Pool, however, opposes the idea of proving some empirical or practical understanding of non-biomedical medicine, since the attempt to bridge the gap means to still adhere to it. A system,

[84] This more or less self-referential core group of religious specialists that the healers constitute shows some resemblance to the "peripheral healing cults" I.M. Lewis describes (1998[1971]). He distinguishes between "primary" and "secondary" phases in spirit possession and its treatment. First, women become ill, and later they become permanent members of the cult group themselves. Lewis argues that what begins "as an uncontrolled, unsolicited, involuntary possession illness readily develops into an increasingly controlled and voluntary religious exercise" (1998[1971]:83). As full shamans, the women can (as in the case of South African healing) treat and heal, i.e. train others. For a critique of Lewis's functionalist "sex-war aspect", see Boddy (1989).

rationale or, as in my case, an epistemology would not exist as such, Pool argues. Instead, social anthropologists, like myself, help to create the appearance of an identifiable logic. Due to their innate affinity for Western culture, Pool further contends, most anthropologists cannot help but focus on biomedically pre-determined ideas of how diseases and their causes ought to be explained. Moreover, to extrapolate a commonly shared model of disease causation from ethnographic material would be difficult. The process ultimately reveals an apparent lack of etiological knowledge on the side of the informants. This contention resembles Murray Last's argument in his famous article on "The importance of knowing about not knowing" (1992), which I mentioned in Chapter 2. Last shows that his informants cannot give a full account of their medical knowledge and, what's more, that they do not care about it. This attitude of not knowing, Last suggests, might constitute an adequate means for the people concerned to cope with illness (1992:402). This disposition further revealed itself the deeper he probed about certain ideas on illness as the anthropologist (1992:393). As knowledge proved to be increasingly uncertain, Last concludes, like Pool, that there is no coherent medical system that anthropologists can unveil. Pool concludes in evaluating his fieldwork that it would be "impossible… to generalise with any amount of certainty about what [his] informants 'believe'" (1994:246). "Local people actively appropriated biomedical … concepts and terms and altered them to suit their own purposes, thus creating new concepts, even as I spoke to them" (Pool 1994:260). Hence, to devise "explanatory models" in Kleinman's sense (1980) to explain what patients think in relation to a certain illness episode would not give enough credit to the "messiness" of people's beliefs. Because Pool does not see himself as a relativist who completely avoids generalisations, a few general conclusions could however be drawn, nevertheless, if not as a "seamless web" than certainly as "partially consistent themes" (Pool 1994:247). He states that there are interpretations and descriptions that are more or less adequate, but the criteria to judge this appropriateness would be "historically and culturally contingent" (ibid.).

Pool warns against the creation of coherent traditional cosmologies and not taking into account that people's ideas are fluid and varied. Researchers would moreover often forget to mention the role their own knowledge played in the creation of these cosmologies (Pool 1994:212). To avoid these pitfalls, Pool suggests a dialogical approach to make the "shared praxis" of ethnography – the common process of knowledge production through the act of communication between ethnographer and his or her counterpart – visible (1994:239).

What do eventually Pool's critical arguments mean for my study? Is my endeavour to describe a growing rationalisation which becomes explicit in an increasing tendency to divide sicknesses into "natural" and "traditional" categories evidence of Western, biomedical or scientific imprinting? Pool is right to point out one of the pitfalls in social anthropology, namely that our way of thinking predisposes us to construct categories or models in relation to a particular setting. Nonetheless, another inference can be drawn here that in fact lends support to my undertaking: differences should not be "discovered" too easily. Thus, the issue that Pool raises about the validity of categories argues in favour of taking a more empirical approach. My dissertation, accordingly, centres on the very interaction between healers and biomedical categories, concepts, and practices. This is the empirical core of my work where its interpretative significance resonates most strongly.

In this chapter, I do not want to suggest that all people relate to what I call dual epistemology in the same way all the time. For some people, it might be less relevant than for others. Some might even find this idea of a dual disease classification totally alien to their own understanding regarding health and healing. Nonetheless, I have demonstrated that for patients and healers, this epistemology – the way it plays out in practice and how it comes to the fore when the merits of biomedicine and traditional medicine are discussed – is important for negotiating meaning. Even if it may be argued that I have to some extent stimulated a form of reasoning here, the notion of a dual epistemology is nevertheless not simply reducible to some self-reflexive, Westernised abstraction. It is rather rooted in the empirical encounters between healers and biomedicine and the healers need to find a niche of exclusive competence in the face of direct competition with, and comparison to, biomedicine. The categories I am describing are informed by the healers' encounter with biomedicine. In Pool's words, they proved to be "partially consistent themes" (Pool 1994:247). At the same time their application might be site of controversy, and differs from case to case and setting to setting. Whereas the two realms of the dual epistemology are mutually exclusive, their application is obviously not uncontested. I have shown, however, how patients within their networks struggle to establish their interpretations of sickness, i.e. their definition of it as being either "natural" or "cultural".

Disenchanted Trajectories

I would now like to discuss Weber's terms "disenchantment" and "rationalisation", which are key aspects of his modernisation theory. When formulating his concepts at the beginning of the last century, Weber was convinced of the equalising power of rationalisation and predicted the decline of magic and religion – the disenchantment of the world. Time has shown, however, that he was not entirely correct. The belief in witchcraft or the power of religious faith; conviction about the godlike skills of biomedicine or the imposition of hands; the world-wide worship of the pope or the president of the United States; the followers of fundamentalist ideologies or merely strict fitness and beauty ideals: each of these is evidence of enchantment and its persistence in society. They accordingly raise doubts about the omnipotence of a process of disenchanting rationalisation. Despite this critique of Weber's work, the terms "enchantment" and "rationalisation" have important analytical value as they highlight actual tendencies and processes I observed during my research.

Disenchantment and Rationalisation

Weber suggests that disenchantment and rationalisation constitute the core of modernity. As I discussed earlier, rationalisation for Weber is a universal process. As Weber scholar Benjamin Nelson notes:

> … there is no aspect of activity or thought which is not in some way under the dominion of the outcomes and consequences of theoretical and practical rationalism alike. Rationalisation is to be found wherever there is action. But clearly not everywhere do we have the kinds of rationalisation that occurred so powerfully in the West and, surely, nowhere else has universal rationalisation set in. (Nelson 1981:7)

Disenchantment in this context represents one facet of rationalisation. Weber's concept of rationalisation is multidimensional and encompasses various forms and layers (Weiß 1981:47). Among its other aspects, rationalisation is synonymous with: the scientification, i.e. the disenchantment, of experience; intellectualisation; the control of natural instincts; ethical rationalisation; socialisation or universalisation; and the systematisation of knowledge, norms, ethics etc. according to certain principles (Weiß 1981:47f.). The common denominator of all these processes is that what is to be rationalised always reaches higher levels of reproducibility and can consequently be better socialised. The possibilities of communicating about the respective object can become more extensive or intensive (1981:48). The improvement of communicability about something and the attendant possibilities of interaction are facilitated through tendentially argumentative, discursive explanations and a

consequent use of rules and principles which guide people's actions (ibid.). More concretely: the way healers and also patients refer to different categories of disease allows for generalisations to be made about treatment options, causes for sickness and therapy paths. The differentiation between "natural" and "cultural" diseases, determined with the respective treatment specialist, institutes a certain pattern of rules about where to go and what to do in given situations It thereby guides patients' actions. In the case of patients, their actions also reach a certain level of predictability, which is another criterion for rationalisation according to Weber (Weiß 1981:49). I also laid out earlier how the creation of an own sphere of competence enabled healers to agree to a collaboration with biomedicine as well as to the scientific testing of their plants. Part of their knowledge thus became subject of scientisation with the aim of making it transferable and applicable to pharmaceutical use. Traditional healers' knowledge became social in a way, or at least some aspects of it, namely those that were transferable and could be communicated in the world of science. This "compatible" part of traditional healers' knowledge was the realm of "natural" sicknesses where empirical knowledge about plants, disease causation or infection as well as different therapy options (e.g. hospitalisation or herbal treatment) played a role.

As indicated, disenchantment is one aspect of Weber's rationalisation. Since the sphere of "natural" sicknesses will likely continue to shrink as more sicknesses are seen as being curable by biomedicine and more biomedicine becomes available, the concept of a withdrawal, a disenchantment, is particularly appealing. Weber primarily discusses the disenchantment of the world in two essays, namely in "Science as a vocation" (Gerth and Mills 2009[1948]:129-156) and in the introduction to "The social psychology of the world religions" (Gerth and Mills 2009[1948]:267-301). He moreover highlights two tendencies. The first one concerns the decline of magic. Science will one day be able to explain all the world's mysteries and, as a result, religious and magical interpretations of it will become less and less meaningful (2009[1948]:284). Equating the process of intellectualisation with disenchantment, Weber remarks:

> …one can, in principle, master all things by calculation. This means that the world is disenchanted. One need no longer have recourse to magical means in order to master or implore the spirits, as did the savage for whom such mysterious powers existed. Technical means and calculation perform the service. (Gerth and Mills 2009[1948]:139)

Elsewhere he writes: "The tension between religion and intellectual knowledge definitely comes to the fore wherever rational, empirical knowledge has consistently worked through to

the disenchantment of the world and its transformation into a causal mechanism." (2009[1948]:350). Even though people would not necessarily have more direct knowledge about their existence or the world, Weber stresses that a level of awareness exists whereby one could learn about it at any time (ibid.). The second tendency is the transference of morals and values from the public sphere into the transcendental realm or "the brotherliness of direct and personal human relations" (2009[1948]:155). Whereas in earlier times meaning was part of publically shared beliefs and understandings which constituted epistemic and moral communities, today this unity has been disrupted (ibid.).

Critique of Disenchantment and Rationalisation

There is of course a vast body of literature that critique's Weber which cannot be covered here in even a rudimentary way. One very illuminating account of Weber's notion of rationalisation and disenchantment can be found in Richard Jenkins' (2000) article "Disenchantment, enchantment and re-enchantment: Max Weber at the Millenium". For Jenkins, Weber's assertion about "the disenchantment of the world" was meant to be a "sociological – perhaps even an ethical or moral – provocation which continues to resonate today" (Jenkins 2000:11). What makes Weber challenging, in Jenkins' eyes, is that while he appreciated progress and emphasised "that history has some direction", "that things have improved", he was also aware of the Janus-faced character of modernity, its "Dark Side" (2000:11f.).

The disenchantment of the world was Weber's key concept for portraying the West's distinct difference when compared to the rest of the world. He described it as an historical process wherein humans increasingly experience and understand their world as less mysterious and more predictable, knowable and manageable due to science (Jenkins 2000:12). Jenkins differentiates between two aspects of disenchantment in Weber's work: one is the increasing secularisation of the world and the decline of magic; the other is the increasing power and scale of formal rationalities like bureaucracy, science and law. These processes developed unevenly and at different speeds (ibid.). Jenkins wants to demonstrate that whenever disenchantment and rationalisation occur they produce countermovements or what he calls "oppositional (re)enchantments" (ibid.). In terms of disenchantments and (re)enchantments, modern societies would be "an array of opposing tendencies, themes, and forces" (Jenkins 2000:13). Despite showing that the disenchantment Weber predicted did not materialise to such an extent, Jenkins nevertheless stresses that the whole notion of disenchantment should

not be abandoned. Rather, it can be used to sharpen our understanding of its conditions, limitations and peculiarities.

Regarding the critical literature on Weber's thesis of disenchantment and rationalisation, two main strands of critique can be distinguished. The first is to argue that formal rationality has its weaknesses, since it can be subverted by identity shaping attachments like ethnicity, sexuality, media or consumerism. The second strand confronts disenchantment with countermovements such as alternative or new-age beliefs, persisting witchcraft fears or the popularity of Chinese medicine. Many authors have tried to deconstruct the rationality of bureaucratic rule by emphasising the capacity of humans to subvert it in various ways (e.g. Douglas 1991; Harding and Jenkins 1989; Herzfeld 1993), which I will focus on in Chapter 6. One interesting example relating to the second group of critics is Ritzer's thesis of "The Mc-Donaldization of society" (1993), a form of highly rational "disenchanted enchantment" (Ritzer 1999) that can also be found in other forms of organised cultures like art galleries, entertainment industries or the Olympic Games (Jenkins 2000:13). The growing scepticism and uncertainty towards science and medicine, as well as a growing awareness of environmental issues could also be considered countermovements. Ulrich Beck coined the term "risk society" (1986) and "reflexive modernity" (1996) to describe these trends. Other distinctively modern (re)enchantments are all forms of religious fundamentalism, alternative life styles criticising consumerism and capitalism, various spiritual and healing traditions, but also "minor" (re)enchantments like tourism or the entertainment industry (Jenkins 2000:18). In sum: Jenkins strongly argues that the concept of disenchantment is valid although, but also because of its countermovements (2000:20). Although the impact of bureaucratic rationalisation has differed throughout the world, the fact that this model spread quite successfully should not be ignored. "This has been possible because it is a way of doing things – and a vast array of things at that – which, in important ways, *works*." (ibid.) Thus, Jenkins argues that a "disenchanted enchantment" is not such a paradox after all, but rather two sides of a coin and an integral part of modernity (2000:20, 22). The relationship between disenchantment and enchantment is "neither unidirectional nor straightforward" (2000:20). To acknowledge and explore the limits of the two tendencies, as well as the conditions and contingencies regarding their interrelatedness, seems nevertheless to be a worthwhile undertaking. Returning to the healers, it is interesting to investigate exactly which aspects of healers' life worlds can be described as becoming disenchanted, and where possible (re)enchantments take place. Also, what are the conditions for both processes and how persistent are they?

Jenkins concludes that enchantments as well as disenchantments "are anything but total in their impact or scope" (2000:28). The dimensions of space and time are also central to these processes. If disenchantment and rationalisation can be said to shape space and time into straight lines, (re)enchantment does the opposite (ibid.). In our study, it is worth noting how the debate surrounding the African Renaissance, which I will focus on in the coming chapter, draws heavily on the past – on African tradition and the "true" African identity. The aim was to create a distinctive "other" African modernity. As I will explain, a definite time (the historical past) and place (Africa) were privileged in order define something different from the West.

What does the discussion about rationalisation and disenchantment tell us? As I laid out in the introduction, I strongly favour holding on to a concept of modernity that would entail aspects of rationalisation. The realities and the effectiveness of rationalisation as well as its extensive scope cannot be denied (Jenkins 2000:28). Weber also would have hardly disputed the observation that rationalisation is not a uniform and all-encompassing project or that it has blind spots (Nelson 1981:1). It should further have become clear that disenchantment opened up "new vistas of possible (re)enchantments" (Jenkins 2000:28). Since tendencies relating to disenchantments might provoke resistance, the aim should be to better understand the connectedness of the two.

4.4. Summary

This chapter aimed to condense the dissertation's major findings so far before moving on to the professionalisation and legalisation of traditional healing. The overarching frame of the dissertation is the modernisation of traditional healing for which I identified three major processes – professionalisation, legalisation and standardisation – on the basis of which this development becomes most concrete. A key concept in this regard is one of Max Weber's most prominent themes, the rationalisation of all spheres of life. The chapter centred on the partial transformation of the dual epistemology, whereby, on the one hand, the two different spheres of competence were made more explicit and, on the other, the distinction between two different kinds of sicknesses had apparently always been made. This process of adaptation could be explained as a theoretical rationalisation. The establishment of two different spheres of competence for healers (who are able to communicate with ancestors and can thus deal with related disturbances) and biomedicine or herbalists (who treat so-called "natural" or

"normal" sicknesses without taking agents such as ancestors or witches into account) was fundamental to the realm of health and healing. Healers as well as patients refered to this distinction when they talked about being sick, explained different therapy options or shifted between them. In practice, this reasoning about the most probable cause of a sickness can become enacted within a patient's network in establishing a therapy path. I emphasised that a constant revaluation of this preliminary closure can occur. Depending on various associated healers, patients, their family members or friends, a certain affliction can be framed differently during the course of therapy or, in the case of Thabisa, divergences can occur within a family as to how to label a disease and hence how to treat it. Also, the issue of how to finance the respective therapy path might play a role, as well as the success of a treatment, of course. Symptoms can also obviously reappear over time, which might again lead people to reconsider a former disease classification. To sum up, the process of classifying diseases according to the dual epistemology, of dividing them into "traditional" or "Xhosa-" and "normal" or "natural" sicknesses, is to be regarded as fluid, and as a potentially highly contested site of negotiation between a variety of human and non-human actors: practitioners of any kind, patients and members of their network as well as the ancestors of everyone involved. The identification of an affliction as "traditional" or "natural" does not have to be permanent or provisional. Rather, it is a snapshot within a potentially longer course of therapy, a preliminary conclusion that allows and facilitates action towards the restoration of well-being. The significance of the dual epistemology appears to be in the role it played within the self-understanding of healers in that it created a sphere of competence free of competition with biomedicine. In the sphere of "natural" sicknesses healers could acknowledge progress, biomedical success, the validity of HIV and the possibility of getting their plants scientifically tested. The realm of "traditional" sicknesses, on the other hand, provided a field for exclusive healing competence which underlines healers' indispensable role in the changing South African therapeutic landscape.

Drawing upon Weber for support, this chapter aimed to show how the dual epistemology can be understood as an abstract concept that allows for the intellectual mastery of various developments and informs later courses of action. By means of older and more recent literature sources, I suggested that the dual epistemology consolidated over time. Concerning Weber's disenchantment thesis, I argued that one might indeed speak about certain afflictions being disenchanted as they become deprived of their potentially responsible "other-worldly" agent. Some sicknesses, such as tuberculosis (the example I used), might indeed have been turned into a "normal", treatable, labelled disease as soon as effective treatment became

available. However, consistent with various critics of Weber's notion of disenchantment, the practice of traditional healing does not become rationalised or disenchanted as a whole. One could say that the differentiation between "normal" and "traditional" sicknesses spares the latter from becoming disenchanted or biomedicalised as well. A niche is thereby secured for the continuity or survival of traditional medicine.

Along with other Weber recipients, I would argue that although the concept of disenchantment is valid, it is unthinkable without respective countermovements. This is a paradox or rather one peculiarity of modernity and its Janus-faced character. Following Jenkins's (2000) advice on exploring the conditions for possible disenchantments and simultaneous enchantments, in the following chapter I will focus on the valorisation of traditional healing within the context of nation-building and the African Renaissance, wherein traditional healing serves to epitomise the African heritage. Particular focus will be on the question of whether a growing loss of control due to state legislation and standardisation can be compensated for through an increase in symbolic capital.

5.

African Renaissance and the Legalisation of Traditional Healing

The legalisation of traditional healing can be described as one facet of a rationalising process. Whereas the last chapter focused on a growing theorisation within the traditional healer's practice very much in line with Weber's arguments on theoretical rationality, the current focus will be on the history of the legalisation process in connection with the nation-building discourse around the African Renaissance. The next chapter will focus more thoroughly on the state's logic and the primacy of bureaucratic rule as a prerequisite to ensure equality and the implementation of the rule of rational law.

The Traditional Health Practitioners' Act was enacted in 2007 and legalises traditional healing, providing the healers with an identical legal framework as biomedical doctors and pharmacists. Healers are now required to get registered and their training is standardised. In crucial points the bill stands in stark contrast to basic principles of traditional healing. At the same time the healers experienced a kind of acknowledgement they have always hoped for. In order to show how healers related to this dilemma, I will highlight the extensive interview material on this topic gathered during my fieldwork.

One of my main arguments of this chapter concerns the link between the legalisation of traditional healing and the rhetoric of the African Renaissance in South Africa. I will argue that the incorporation and legalisation of traditional medicine into the South African health system was part of a nation-building process aimed at integrating certain parts of society into the modern nation state that were formerly marginalised or illegal.

On a national level, two examples showed the increasing symbolic importance of traditional medicine within the political discourse. On the one hand, the process of incorporating and legalising traditional medicine demonstrated how the idea of an emancipated, "own", African way of healing was closely linked to the rhetoric of a (South)African Renaissance and the quest for a new identity. On the other hand, the AIDS debate about the pros and cons of introducing antiretrovirals on a national level showed how traditional medicine was depicted as being a symbol for African identity as well as a worthwhile alternative to simply adopting Western strategies in the fight against HIV/AIDS.

In this chapter, I will first focus on the content and history of the African Renaissance discourse in general before I come to the history of the legalisation process and the AIDS debate in connection with the African Renaissance discourse of ex-president Thabo Mbeki. I will then describe the stance healers took towards both the legalisation of their practice and its portrayal as a symbol of South African heritage and identity. In concluding, I will present examples of legalisation relating to traditional healing in other parts of the world and compare them with the legalisation process in South Africa. At the same time, these examples of other states that have legalised traditional healing provide a perspective on how traditional healing develops when it is standardised and incorporated into a federal health system.[85]

5.1. African Renaissance

The motto for an African Renaissance appeared in the political arena in president Thabo Mbeki's inauguration speech in 1999 and has acquired greater importance ever since. For many it seemed to be just a new slogan for enhancing Mbeki's profile as the successor of Nelson Mandela, a global icon (Ernst 2002:25). But the theme "has snowballed" (ibid.) so much, that the way it has played out in the political arena cannot be ignored. Various authors suggest that South Africa is a state currently in the making, characterised by a search for a new national identity (see e.g. Chipkin 2003; Oomen 2000). Barbara Oomen discusses the strong standing of traditional authorities and traditional law in present South Africa and, besides the obvious pragmatic reasons (such as a lack of alternative institutions and the competition for rural voters), she notes "the search for an authentically South African political ideology able to contribute to a post-apartheid identity" (Oomen 2000:74). In my fieldwork, I noticed that the same factors are involved in the political instrumentalisation of traditional medicine.

The concept of an "African Renaissance" became a dominant theme in South African politics. In his famous speech "I am an African" in front of the Constitutional Assembly on 8 May 1996, Thabo Mbeki inaugurated the concept as an awareness-raising process. In his vividly detailed speech he referred to certain historical moments in Africa's past. Being African for Mbeki meant having an awareness of African history and the fates of its different peoples, no matter their skin colour, gender or ancestry (Mbeki 1996). However, even if one prefers to

[85] I was not able to study the consequences of this new law, which was only enacted towards the end of my fieldwork. I am also not aware of any studies that have been published yet on this topic.

perceive Mbeki's thoughts on being African as essentialist, the notion of renaissance gained momentum not only in South Africa, but in Africa as a whole. Conferences were held on the topic and the African Renaissance Institute was founded in 1999 with a South African Chapter based in Johannesburg. At its launch in April 2000, then-deputy president Jacob Zuma's speech once more evoked the image of Africa as a continent being reborn and leaving behind decades of hunger, war, corruption and epidemics (Zuma 2000). Mongane Wally Serote, ANC veteran and vocal advocate of the African Renaissance justifies the concept's usefulness as follows:

> Because the concept says, Africans must build Africa. Africans must find a manner in which they locate the African continent to be equal to any other continent. But more important also, that Africa must be able to contribute to the human experience. That is what the Renaissance means. (Ernst 2002:158)

Predecessors

The idea of an African Renaissance has been powerfully present in the African struggle against colonialism, slavery and racism in general since well before the theme received so much attention in the 1990s in a South African context. Hence, it "cannot just be a single event or an identifiable object but should be seen as a process that is historically grounded" (Moore 2002:76). Although I cannot go into detail here, I would nevertheless like to mention the concept's most important touchstones. One was unquestionably the Harlem Renaissance, a cultural movement surrounding a booming Afro-American literature, music and theatre scene in the 1920s and 1930s in New York City (Huggins 1971). The founding fathers of the movement were the writer and philosopher Alain Locke (1997[1925]) as well as the novelist Langston Hughes (2001[1940]; 2008[1930]). The Harlem Renaissance fostered a new racial consciousness, which eventually gave rise to e.g. the Back to Africa movement lead by Marcus Garvey (1986[1923]), the early Pan-Africanism of American civil rights activist and historian W.E.B. Dubois (1994[1903]; 1998[1935]; 2010[1915]), and the Civil Rights movement of the 1950s and 1960s with its renowned leader Martin Luther King and Black Power icon Malcolm X (Haley and Malcolm X 2001[1964]). The ideas of the Harlem Renaissance were taken up in Paris by young black francophone writers who later established the Négritude intellectual movement. They fought against the prevailing racism in France and French domination in their respective home countries by valorising what they believed to be common African values, characteristics and aesthetics. Its main exponents are Martinican poet Aimé Césaire (2001[1939]; 2001[1950]), Guinan Léon Damas (1947) and Léopold Senghor

(1988; 1998), who later became Senegal's president. Mobuto's *Authenticité* campaign in Zaire, today's Congo, during the 1960s and 1970s and Julius Nyereres concept of *Ujamaa* in Tanzania reflected Senghor's ideas (albeit in rather extremist form) about Africa finding its own developmental path in a way that is based on distinct African customs and tradition (Meredith 2005).

Another concept that was somewhat of a forerunner to the African Renaissance is Pan-Africanism, which affirms the shared identity of African people worldwide. It grew as a cultural as well as political idea simultaneous to the Harlem Renaissance and the Négritude movement in the 1920s and 1930s (Young 2001:236). As an ethical system, it traced its origins from the past, and promoted values which were regarded as being the product of the African civilisation and the struggles against colonialism, racism and slavery. Many of Africa's first post-colonial presidents after independence are regarded as Pan-Africanists such as Ghana's Kwame Nkrumah, Kenya's Jomo Kenyatta, Tanzania's Julia Nyerere, and Congo's Patrice Lumumba as well as Guinea's Ahmed Sékou Touré.[86] The latter, along with Kwame Nkrumah and President William Tubman of neighbouring Liberia, was the driving force behind the creation of the Organization of African Unity (OAU), which was transformed into the African Union (AU) in 2002. The organisation today is comprised of all African states, except Morocco, and has its headquarters in Addis Ababa, Ethiopia. It aims to integrate Africa politically as well as socio-economically (ibid.). In South Africa, the Pan-Africanist Congress (PAC), a splinter group of the ANC, seized on ideas of Pan-Africanism and African Nationalism. Some members of the ANC felt that Black Power was not given its due in the Freedom Charter and so they left to form their own party in 1959. Together with the ANC, the PAC was unbanned in 1990 but does not play a major role in today's politics anymore (Ross 1999).

Another important point of reference, especially for South Africa, was the Black Consciousness Movement led by Steve Biko in the late 1960s (Gerhart 1979; Karis and Gerhart 1997). The movement not only called for resistance against the Apartheid regime, but also, along with Malcolm X's Black Power and the "black pride" movement in the US at the time, opposed the ANC's policy of non-racialism. Biko (1978) was also influenced by authors tied to the Négritude movement as well as by post-colonial writer Frantz Fanon (1963; 1967) (Turner and Alan 1999). For Jean-Paul Sartre, Fanon marks the beginning of a new generation

[86] For more on Nkrumah in particular and Pan-Africanism, see Young (2001:236-252).

of colonial writers. Not only does Fanon deduce why violence is a legitimate, and in fact the only effective, means to fight colonialism. Through violence and the consequent renunciation of the West, the colonised themselves become new and better human beings. "We were men at his expense, he makes himself man at ours..." (Sartre 1963:24). Fanon's ideas found fertile soil in South Africa, driving a wedge between the ANC and Biko's Black Consciousness Movement.

The ideas of Black Consciousness had a large impact on black literature and theatre at the time, but they were toned done after the end of Apartheid by Nelson Mandela's policy of a multi-racial South Africa. In Thabo Mbeki's rhetoric, however, Africanist motifs reappear. Interestingly, Mbeki's African-Renaissance discourse can be described as nativistic in the sense given by Mühlmann (1961), who defines nativism as constituting actions that are aimed at the reconstitution of a group sensibility that had been undermined by a dominant foreign culture. Here, what is important is the powerful demonstration of one's own contributions and the desire to offer something personal in response to the perceived dominant foreign culture (1961:11f.). Certain elements of culture can be revitalised, which is Mbeki's intent when he refers to Africa's values and traditions. For Mühlmann, however, the desire to create something of one's own is key. This aspect comes to the fore when Mbeki, for instance, speaks of "African solutions".[87]

One published work that strongly influenced Thabo Mbeki, according to his biographer Mark Gevisser (2007:728), was Martin Bernal's three-volume "Black Athena" (1991; 2006). The author overturns the accepted historical paradigm in which ancient Greece is the cradle of classical civilisation. Instead, Bernal argues, Greek civilisation was profoundly rooted in Egypt and in Africa in general. However, due to the racist assumptions of Eurocentrism, academic research remained blind to this evidence. Throughout the lengthy biography of Thabo Mbeki, one gets the sense that, for its subject, strongly advocating the idea of an African Renaissance was also an attempt for him to "reclaim his Africanness" after 28 years of exile, the first nine years of which were spent in Europe (Gevisser 2007:574). The author convincingly argues that, after his return to South Africa, Mbeki's politics were very much sparked by his attempts to reconcile two identities: Mbeki the black Englishman and Mbeki the African freedom fighter (ibid.). Gevisser also highlights the importance the Renaissance

[87] Whereas nativism in Mühlmann's sense can be regarded as a form of explicit resistance, other religious beliefs or cults have been extensively discussed in social anthropology as forms of hidden or implicit resistance. Examples of this include the Cargo cults of Melanesia (Worsley 1968), the continuity of magical beliefs in capitalist labour relations (Taussig 1977; 1980) or spirit possession in industrial factories (Ong 1987).

discourse had for building a "patriotic bourgeoisie" during the years of Mbeki's presidency (2007:588). Mbeki had managed to bring black professionals, executives, journalists, lawyers and academics "into the heart of the ANC" who might otherwise have become its most damaging critics. The challenge for Mbeki was to bring the growing black middle class into the ruling elite "and to hold it there with a set of politics (BEE)[88] and an ideological frame (Africanism) that resonated with its own aspirations" (Gevisser 2007:589). For Gevisser, Mbeki was driven by both a need to create a social world of loyal allies around him that supported the African Renaissance and to find a "home base" amidst the ambiguity of his life as a returned exile.

Postcolonialism

The issue of homecoming and the related creation of a discourse about an "authentic" and "true" homeland resonates with well-known debates within cultural theory and postcolonial studies in particular (Appiah 1992; Ashcroft, Griffiths et al. 1998). Topics in most of the so-called postcolonial literature included postcolonial identity formation (mostly marked in distinction from Western identity formation), cultures of diasporic Africans, resistance to Western colonialism and the debate about its consequences and the search for a country's "own", African ways of governance.[89] Robert Young defines postcolonialism as a "set of critical concepts, and oppositional political identities and objectives that have been developed out of the continuing reverberations of the political and cultural history of the struggle against colonialism and imperialism" (Young 2001:69). For Young, what is remarkable about postcolonialism as well as anti-colonialism is that both are:

> … a diasporic production, a revolutionary mixture of the indigenous and the cosmopolitan, a complex constellation of situated local knowledges combined with radical, universal political principles, constructed and facilitated through international networks of party cells and organizations, and widespread political contacts between different revolutionary organizations that generated common practical information and material support as well as spreading radical political and intellectual ideas. This decentred anti-colonial network, not just a Black Atlantic but a revolutionary Black, Asian and Hispanic globalization, with its own dynamic counter-modernity was constructed in order to fight global imperialism … (Young 2001:2)

The African Renaissance could be described similarly. Thabo Mbeki's theme may be read as the attempt to construct an own counter-modernity, very much in the sense of Eisenstadt's

[88] Black Economic Empowerment.
[89] For a comprehensive account of postcolonialism and its history, see Young (2001).

(2000) notion of "multiple modernities" that I laid out in the introduction. What Young also hints at here is the fact that within the notion of an African Renaissance universal ideas about autonomy, freedom, the nation state, resistance to colonialism and exploitation through transnational companies intersect with what Mbeki in this case perceives as African values, kinds of knowledge, practices and custom. As I have discussed, the roots of his Africanism are manifold and reach back at least a century. Paul Gilroy terms Pan-Africanism and Black Power global phenomena (2003:64). In his book about the "Black Atlantic" (1993) he provides a study of African intellectual history and its cultural construction. With his concept of the Black Atlantic as a zone of cultural contact he depicts a space of transnational cultural exchange, production and belonging. Very much like the diasporic biographies that Gilroy traces of black intellectuals like Dubois and C.L.R. James, Thabo Mbeki's life also can be described in these terms, as Gevisser's biography convincingly shows. Not least, Mbeki became acquainted with so-called AIDS dissidents' views via the Internet. This led him to announce the search for African solutions to an African problem, as I will show below in more detail.

Criticism

Critics stress that the concept of African Renaissance has never been clearly defined. This was not even done in the proceedings of the conference of 1998 published the following year by Malegapuru Makgoba, today Vice-chancellor of the University of KwaZulu-Natal. Instead, its accounts would draw upon "old-style pan-Africanism or a romanticised African history or philosophy" (Ernst 2002:26). Mahmood Mamdani states that a true African Renaissance would need an "Africa-focused intelligentsia" to drive it forward (1999:133). South Africa apparently lacked intellectuals who would be needed as a driving force of change who would challenge current processes of identity formation and who would take part in its debates (Mamdani 1999:130f.). South African literary scholar Michael Chapman criticises the dearth of new insights and insufficient level of complexity within the symbolic discourse on African Renaissance that was essential for providing new perspectives for the country so that it could "find its locality at the same time as its role in the world" (Ernst 2002:81)[90]. Nevertheless, it was thought that the debate could enhance discussions on how to position the continent in the world order and might further be a fruitful "way of trying to focus our minds on the

[90] Ulrike Ernst (2002) published a book featuring various interviews she had conducted with South African scholars, poets and artists on African Renaissance. The accounts I cite in the following stem from this book.

challenges of our locality in the 21st century" (2002:85). South African sociologist Ari Sitas suggests that the ANC's cultural policy after 1994 was mainly defined by the attempt to create a new identity and to build a nation. Whereas, before 1994, art was a tool for expressing resistance and mobilising people, it was utilised after the elections in the cause of nation-building. First of all, there was the artistic theme relating to the new emerging Rainbow Nation; then ideas emerged about reconciliation and forgiveness; and now the cultural emphasis was on African Renaissance. Most artists, however, remained rather cynical about these ideas and did not buy into the nation-building themes, as Sitas observes (Ernst 2002: 93). On the other hand, in her interview with Ulrike Ernst poet and trade unionist Nise Malange underlines the cause of nation-building as exactly her task. Due to Apartheid, she states, people were never patriotic. They also could never truly relate to their country. Art, however, could help people to reconnect to South Africa, which is why artists should support Mbeki's efforts to build the nation (Ernst 2002:125f.).

Vale and Maseko (1998) describe two distinct and conflicting interpretations of the African Renaissance discourse: one that is globalist, emphasising South Africa's economic interest in the rest of Africa[91], and one that is Africanist, underlining its social constructions around African identity (Vale&Maseko 1998:278f.). Depending on their interests, different actors would push either one of them. "Africanists call for a reinterpretation both of their history and culture, away from its colonial construction towards a consolidation of the wealth of knowledge that Africans are carrying around in their heads" (ibid). This Africanist interpretation of African Renaissance seems to have been evoked when Mbeki, for instance, spoke of the need to find "African solutions", instead of making ARVs readily available to treat HIV/AIDS, or when ex-Health Minister Tshabalala-Msimang similarly advocated the use of garlic and olive oil.[92] Vale and Maseko refer to the powerful appeal of the Black Consciousness movement around Steve Biko to point out the rich network of personal, social and political relationships that lie within the Africanist framing. Africanism, however, did not produce viable policy outcomes that would touch the lives of people (1998:281) – unlike the president's stance on the importance of traditional healing.[93] The legalisation of traditional medicine affected an important aspect of people's lives: health and its management.

[91] On the question of how far not only cultural identity but also economic revival play a role in the discourse surrounding the African Renaissance, see also Liebenberg (1998).
[92] I will discuss the issue of HIV/AIDS in connection with the African Renaissance in greater detail below.
[93] This does not mean to suggest that Mbeki would solely ground his policy on Africanist notions of the African Renaissance. His speeches also reveal a strong commitment to the tenets of globalisation (Vale&Maseko

These accounts of African Renaissance constitute only a small number of the voices that responded to Mbeki's leitmotif. Nevertheless, they show different facets of the debate, while revealing both its weaknesses and its potential. What shall concern us here, however, is not so much the scope of the debate, its political background and its general significance. Rather, I want to explore the relationship between the African-Renaissance discourse and the legalisation of traditional healing. What role did the healers play in a discussion about "true" African identity, values and customs? And how did healers themselves relate to it? In the following I want to trace the beginnings of the legalisation process in connection with the evolution of the idea about an African Renaissance. Later, I will refer to the healers' accounts about this process that I collected during my fieldwork.

5.2. The Traditional Health Practitioners' Act

The History of the Legalisation of Traditional Healing

The professionalisation of traditional medicine has taken place throughout Africa since the late 1970s and there is a large body of literature that focuses on the issue (see Last & Chavunduka 1986). One of the most influential organisations in this area was the WHO, which put the integration and promotion of traditional medicine on its agenda (WHO 1978). Research on the medicinal plants used within traditional medicine has been common ever since, especially because of the original hope of finding new substances for treating illnesses like HIV/AIDS or cancer. The WHO, however, explicitly recommended for the promotion of traditional medicine compliance to scientific standards and the use of accepted instruments.[94] The WHO's effort can be seen as being embedded in a larger intellectual and political discourse in the aftermath of decolonisation in the 1970s. It was inspired by: the ecological movement's concern for sustainable environmental management; a general dissatisfaction with prevailing models of economic development in the Third World; and concerns with the cultural survival and rights of minority of indigenous peoples linked with the question of intellectual property rights and remuneration (Ashforth 2005:150).

1998:285). In my view, Mbeki is trying to strike a balance here between an Africanist and a globalist reading of the African Renaissance.

[94] The question of how to evaluate medicinal efficacy is highly contested both within and outside of biomedicine. In the case of traditional medicinal plants, especially in South Africa, this issue was instrumentalised in terms of identity politics. Ex-health minister Manto Tshabalala-Msimang argued for special criteria for the registration of traditional medicinal plants. A presidential task team on African medicine was established to work these out. Tshabalala-Msimang: „We cannot use Western models of protocols for research and development…some of the medicines have been used by traditional healers for thousands of years" (M&G 2008).

In South Africa, the legal status of traditional medicine had been discussed in relation to a reconstruction of the health system, one of the main aims of the new government since 1994. For the most part, the parliamentary Portfolio Committee on Arts, Culture, Science and Technology promoted systematic research on the efficacy of traditional medicine and fostered their integration as part of the project of the African Renaissance. The chairman of the committee, ANC veteran and poet Mongane Wally Serote spoke at a conference in 1998 at the World Intellectual Property Organization (WIPO) in Genf:

> Indigenous knowledge and technologies that were denied, destroyed and suppressed in the past will form the basis of our rebirth… indigenous knowledge, folklore and technologies have the potential to assist in the rebirth of our nation. A programme is currently under way to harness this potential and the very institutions that were created to maintain apartheid – the Science Councils and the black universities – have been brought into the process in a massive, visionary exercise of transformation whose outcome will be the economic empowerment of SA's rural poor. (Serote 1998:4)

He also pointed out that in South Africa a legal framework was being created for protecting and promoting "indigenous knowledge" and that this project was closely linked with (then) vice president Thabo Mbeki's African Renaissance program. According to Serote, responding to Apartheid and the oppression of an indigenous identity was the point of departure for the concept of African Renaissance. "The ideals expressed in the notion of 'African Renaissance' promote the rebirth of the African people and the forging of a new identity as South Africans emerge from the dark ages of colonialism and apartheid" (Serote 1998:3). Already at that time, the idea of legal regulation for traditional medicine revolved around the search for a new South African identity – the desire to discover hidden or lost knowledge, while establishing equal partnerships between industry, science and indigenous communities. Both of these were essential for the economic progress of South Africa and therefore closely linked to the government's GEAR plan (*Growth, Employment and Redistribution*). Formerly disadvantaged parts of the society could now return to their roots regarding medicine, arts, cultures, language and technology. For Serote herein lay the potential for local communities (1998:4, 6).

In 1998, the National Research Foundation was chartered to foster science and technology in general and traditional knowledge in particular (Ashforth 2005:151). The Medical Research Council (MRC) as well as various pharmacy departments in the country also started to conduct research on traditional medicine. One example of such research was the cooperation between the pharmacy department of the university in Port Elizabeth and several of the healers' organisations that I studied during my fieldwork. Another example is TRAMED, which I already referred to in Chapter 3, which was established in 1997 as a research project on

traditional medicine by the Universities of Cape Town and the Western Cape, with the support of the Medical Research Council, to create a database on traditional eastern and southern African medicines. The researchers involved were supposed to conduct the laboratory screening of traditional medicines for malaria and tuberculosis and to develop systems for scientific understanding of the action and uses of essential traditional medicines in the prevention and treatment of diseases.

Since 1994, parallel to the growing scientific interest in traditional medicine, the development of a legal framework for its integration into the health system started. During Apartheid practicing traditional medicine was illegal.[95] But since prosecutions rarely if ever took place, traditional healing was practiced nevertheless, although not as widely and openly as it is today. This, at least, was the information I received from some healers I talked to about their life during Apartheid. The first law that healers were (theoretically) subjected to in the new South Africa was the South African Medicines and Medical Devices Regulatory Authority Act of 1998, which requires all medicines, including traditional ones, to be registered with the Medicines Control Council. The law, again, was not implemented in practice, which allowed the healers to continue to use their medicine as always. Yet the act marks the beginning of the effort to come to terms with the legal recognition, regulation and incorporation of traditional healing the ANC envisaged already in its National Health Plan for South Africa in 1994. According to this plan, the new government promised to establish new mechanisms to integrate traditional medicine into the national health system (ANC 1994). It says:

> Traditional healing will become an integral and recognised part of health care in South Africa. Consumers will be allowed to choose whom to consult for their health care and legislation will be changed to facilitate controlled use of traditional practitioners. (ANC 1994:36f.)

The following tenets were formulated regarding the development of strategies for regulating traditional medicine:

- People have the right of access to traditional practitioners as part of their cultural heritage and belief system.
- There are numerous advantages in cooperation and liaison between allopathic and traditional health practitioners and interaction will thus be fostered.
- Traditional practitioners often have greater accessibility and acceptability than the modern health sector and this will be used to promote good health for all.
- Traditional practitioners will be controlled by a recognised and accepted body so that harmful practices can be eliminated and the profession promoted.

[95] The Suppression of Witchcraft Act from 1957 (first introduced in 1895) outlawed all forms of divination, which is the basis for traditional healing (Ashforth 2005:286).

- Mutual education between the two health systems will take place so that all practitioners can be enriched in their health practices. (ibid.)

It is interesting to note the connection that is made here between traditional medicine, "cultural heritage" and "belief system" as well as the empirically debatable assumption that healers would be more accepted by, and more easily accessible to, people. The last point suggests that actors of traditional and biomedicine can learn and profit from one another. This symmetrical view on both medical systems becomes characteristic for the later policies of Thabo Mbeki and his health minister in terms of health policy in general and for HIV/AIDS in particular.

Some time still had to pass before the respective bill was formulated. In 1996 representatives of the Interim Co-ordinating Committee for Traditional Medical Practitioners' Associations declared at a public hearing in the parliament that their dignity had been eroded by colonialism and Apartheid and asked the government to finally pass a law ensuring their legal standing (Ashforth 2005:291). A draft of the Traditional Health Practitioners Bill was eventually published in April 2003 and enacted one year later (Act No. 35, 2004). In August 2006, however, the Act was declared invalid by the Constitutional Court on the basis that the National Council of Provinces did not hold required public hearings. This order was suspended for a period of 18 months in order for the parliament to enact the bill again, this time according to the provisions of the Constitution (Mail & Guardian 2008). Hence, the very same Act was passed a second time in January 2007 (Act No. 22, 2007).

Content of the Act

The Act concerns not only those healers that were central to my study but also lists "diviners", "herbalists", "traditional birth attendants" and "traditional surgeons". These are all defined as practicing traditional health that is based on "traditional philosophy". The latter is defined as follows:

> "traditional philosophy" means 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; … . (RSA 2007:6)

It should not concern us here to comment on the limitation of these definitions from a social anthropological point of view. The purpose of the Traditional Health Practitioners Act is "to a) establish the Interim Traditional Health Practitioners Council of South Africa; b) provide for the registration, training and practices of traditional health practitioners in the Republic; and c) serve and protect the interests of members of the public who use the services of traditional health practitioners" (RSA 2007:8). The objectives of the Council are, amongst others, "to promote public health awareness", to "promote and develop interest in traditional health practice by encouraging research, education and training" and to "ensure that traditional health practice complies with universally accepted heath care norms and values" (ibid.). The final point is especially interesting in regard to the controversy surrounding the scientific testing of traditional medicine, as mentioned above. While the wording of the Act is kept general and neutral, I will discuss below how a draft policy from the year 2008 was crafted into a more explicit document.

Fig. 8: Bill discussion at UPE with various healers, a pharmacist, a lawyer and a medical doctor from UPE

Regarding the functions of the Council, the Act states that the Council may "make enquiries and conduct investigations into complaints and allegations concerning the conduct of registered traditional health practitioners", and, further, that it can "approve minimum requirements pertaining to the education and training of traditional health practitioners in consultation with relevant departments, quality assessment bodies or a body of traditional

health practitioners accredited by the Council for this specific purpose" (RSA 2007:10). An appointed officer may search the premises of a healer, except for a private dwelling, without an entry or search warrant (2007:28). These points in particular are especially critical to the healers I talked to about the bill. The premises of a healer, the consultation hut especially, are regarded as sacred places which no one may enter without the healer's consent. Furthermore, the training of a healer is a highly private issue, as it is guided solely by the ancestors of the healer-to-be, who communicate through dreams with their descendant. I will go into more detail later.

Another point looked at with scepticism was the issue of the constitution of the Council given that it was appointed by the Minister of Health. Besides traditional health practitioners from each province, the Council is supposed to contain an employee of the Health Department, a law specialist, a medical practitioner, a pharmacist as well as three community representatives (2007:12). The Health Minister can also "make regulations relating to...the courses of study and the training required for examinations" as well as to "the minimum requirements of the curricula and the minimum standards of education or examinations which must be maintained at every educational or training institution or by every traditional tutor offering training in traditional health practice" (2007:40). The minister can also, after having consulted the Council, determine the nature and the duration of the training healers must complete before registration (2007:42).

The most influential change healers are now subjected to concerns the obligation to be registered. Any practitioner mentioned in the Act who has not been registered or paid the annual fees is considered to be breaking the law and can be fined. Furthermore, healers can now legally issue sickness certificates and their treatment can be covered by health schemes. They are also taxed. The extent to which and especially when these fundamental innovations will be enforced, and what impact they might have, can only be speculated on at this point in time. When I visited South Africa to carry out my final fieldwork in August 2005, no further regulations or amendments regarding the Act of 2004 had been enacted.[96] Since then, a draft policy was published in 2008 by the Presidential Task Team of African Traditional Medicine, which was appointed in 2006 to make recommendations with regard to a national policy for

[96] This would seem to apply to the Act of 2007 as well. Normally, amendments to new legislation which regulate its enforcement are also published on the homepages of the respective government departments, in this case the Health Department. Regarding the Traditional Health Practitioners Act, nothing has been published yet except for a draft policy that I will now refer to. I also could not find any indication, either in online print media or on government websites, that an Interim Council of Traditional Health Practitioners has been established, as envisaged by the Act itself.

the institutionalisation of so-called traditional medicine. Funding for research on African Traditional Medicine has also been provided by the government (RSA 2008:2). The draft policy provides valuable insights into where the concrete policy regarding the regulation of traditional healing might lead. It would be difficult, however, to make any definite statements.

A Policy Draft with Links to Germany

The policy paper states that "African Traditional Medicine as a discipline has been suppressed and disempowered" and that the intention is to therefore foster it as a "distinct system within the formal health care sector in South Africa, equal in status to allopathic medicine..." (RSA 2008:8). It moreover states that "African Traditional Medicine is a body of knowledge that has been developed and accumulated by Africans over tens of thousands of years...", that it follows a holistic approach by taking the interaction between humans, both the living and the dead, as well as nature and the cosmos, into account (2008:5). Through the official recognition and incorporation of African Traditional Medicine (ATM), it is expected to deliver "cost effective and accessible clients based health care" (2008:6). The actions the paper recommends include the establishment of ATM health care facilities, the development of standards of safety and quality for ATM as well as the establishment of an ATM pharmaceutical industry to produce and process its medicine and "maximise economic benefits to the country" (2008:9f.). An institute for the research on ATM was supposed to be created, as well as a national pharmacopoeia of ATM to help maintain its existence through recording keeping and preservation (2008:4, 11).

The task force did research on comparable worldwide policies, paying special attention to the Chinese, Indian, and the German ways of regulating types healing that stray from biomedical standards. Regarding Germany, the paper states that the country "has arguably the most practical, comprehensive and detailed system of regulating traditional medicines..." (2008:18). The German *Heilpraktiker* is equated with a traditional practitioner in South Africa, and it is highlighted that *Heilpraktikers* are allowed to practice medicine if they are licensed, except in the case of specific restrictions of certain interventions like surgeries. The claims made in the policy paper could be confirmed by German legal text. According to the *Heilpraktikergesetz* from 1939 (see BRD 1939), a licensed *Heilpraktiker* can practice medicine (in the German legal text *Heilkunde*) without having the official medical license. The profession of a *Heilpraktiker* differs from a medical doctor insofar as its training is not

standardised and the parameters of its practice are limited. Prescription medication cannot be prescribed or distributed, midwifery cannot be practised and certain infectious diseases defined by the Infection Protection Act cannot be treated. But *Heilpraktikers* may carry out psychotherapy and physiotherapy without any limitations. To obtain a license, a *Heilpraktiker* has to undergo an oral and a written examination by a local public health officer (in German *Amtsarzt)* to ensure that he or she would not pose a threat to the public. The examination contains medical questions as well as questions about so-called natural medicine and its use and limits. The necessity of making referrals to medical doctors in case of serious diseases is also emphasised.

The policy draft refers to one specific legislation process in Germany in particular, namely the establishment of Commission E. This was a panel of experts appointed in 1978 to evaluate the safety and effectiveness of herbal medicines which had become pervasive on the market (RSA 2008:18). This process was supposed to take place within a period of 12 years. Traditional use (i.e. when a particular substance had proven to be effective over many years) was cited as one way to offer support of a medicine's efficacy. If manufacturers claimed that a medicine could cure or treat a disease, the product had to undergo the normal route of application followed for pharmaceuticals. Otherwise, labels of particular medicines would be limited to referring to minor conditions or making preventative statements (ibid.). Indeed, looking at the legal circumstances for accrediting an herbal medicine in the European Union, a simplified registration process for a traditional medicine is possible if the proof of efficacy is based on documented traditional experience. Thirty years of experience with the medication has to be documented, 15 of which need to have been in an EU state (see § 39b in German AMG). The Committee for Herbal Medicinal Products within the European Medicines Agency publishes a list of possible applications of traditionally used herbal medicines (see EMEA). Herbal medicine that is registered as traditional medicine has to be labelled as such.[97]

Also, the importance of the pharmacopoeia as an important mechanism to regulate medicine was stressed. It contains one or more official books describing medicines or other pharmacological substances, especially their use, preparation and regulation. Extensive research of herbal medicine was done at German universities. Commission E reviewed the reports, and published positive monographs that described the accepted uses of particular

[97] According to §10 of the German Medicines Law (*Arzneimittelgesetz*), the label must read: This is a traditional medication, which is exclusively registered because of its long and extensive usage for the particular area of application. (In the orginal German: "Das Arzneimittel ist ein traditionelles Arzneimittel, das ausschließlich auf Grund langjähriger Anwendung für das Anwendungsgebiet registriert ist." BRD 1976)

plants and negative monographs on those herbs deemed to be unacceptable either due to a lack of safety or evidence (RSA 2008:19)[98]. Besides Germany, a number of other countries and their policies regarding non-allopathic medicine were reviewed. Two main recommendations for the Department of Health came out of this comparison of the different countries. The paper suggests establishing "a system to develop, regulate and register traditional medicines to ensure safety, quality and efficacy, including scientific research and clinical studies" as well as creating "a national pharmacopoeia...as part of the regulatory system" (2008:25). With regard to the latter, Germany and China serve as primary examples (2008:43). Concerning the existing legislative framework for ATM in South Africa, the draft policy acknowledges that the Traditional Health Practitioners Act is "a valuable start" but needs to be supplemented with a more comprehensive and integrated legislative framework informed by the recommendations of the draft policy and its related strategies (2008:26). Apparently, there were difficulties with the registration of ATM due to delays in the process of formulating adequate regulations. A Ministerial Task Team was working on instituting a new Medicines Regulatory Authority as a single umbrella body that would regulate medical and veterinary products. This also includes pharmaceuticals, whether so-called complementary medicine (like Chinese or Ayurvedic medicine), prescription medicine or ATM (2008:27f.). As of 2011, no such legislation has been developed.

It may take years before just the registration of healers is enforced area-wide. Ashforth expects that "the most likely prospect for this sector is a continuation of the present unregulated market for healing services coupled with a smaller sector of healers who win control of state resources" (2005:300). As experiences in other countries with similar developments show, this is a very likely scenario. However, what I try to highlight (and what Ashforth pays only little attention to) is the increasing symbolic importance that is attributed to traditional healing within a growing discourse in South Africa that revolves around the African Renaissance, tradition and national identity. This is also evident in the controversy surrounding HIV/AIDS, which I will now turn to.

[98]See the following homepage for Commission E's complete and updated monographs: http://buecher.heilpflanzen-welt.de/BGA-Kommission-E-Monographien/

5.3. Traditional Medicine, "Black" Identity and HIV/AIDS

Since Apartheid ended in 1994, traditional healers have been playing an increasing role in the emerging discourse about health in general and HIV/AIDS in particular. The phenomenon of the healers' changing role in South Africa has been closely linked with the attempt of the government to develop its own policy towards AIDS and to therefore restructure the health system. The AIDS policy of the country has been widely criticised[99] and characterised as lacking a clear strategy. Its effectiveness has also been questioned with regard to both the speed of its response and the identification of measures that needed to be taken in order to bring the pandemic to a halt. The introduction of ARVs to treat HIV/AIDS has also been significantly delayed. Thabo Mbeki publicly questioned the causal link between HIV and AIDS, thereby justifying his reluctance to simply adopt Western strategies in the fight against HIV/AIDS.[100] Together with the health minister, he promoted "African solutions" instead. This set the stage for the subsequent efforts to integrate and research traditional medicine. Critics were blamed as being un-African (Posel 2008:13).

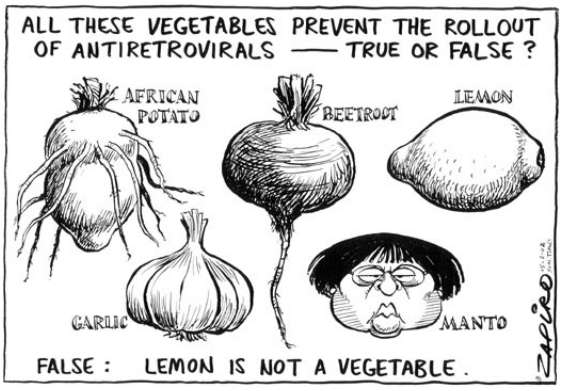

Fig. 9:
Zapiro cartoon on health minister Manto Tshabalala-Msimang who advocated for using vegetables to boost the immune system instead of ARVs.
(Zapiro 2008)

The AIDS debate in South Africa is best described by highlighting two contradictory dimensions: one that is systematic and one that is a historical. By "systematic" I mean focusing on the problem itself, whereas a "historical" approach takes the social context of the debate into account.[101] From a systematic perspective, then, there is a debate about how to tackle the AIDS epidemic and what premises such an effort should be based on. While in most of the rest of the world AIDS, its causes, effects and ways of treatment already have

[99] For more on the South African AIDS policy, see e.g. Crewe 2000, Epstein 2000, Fassin 2007, Natrass 2007, Robins and Lieres 2004, Robins 2006 and Schneider & Stein 2001. For the STS approach in regard to the AIDS-causation debate in general, see Epstein 1996, and especially for South Africa, see Weinel 2005 and 2007.
[100] Thabo Mbeki also claimed that the widely accepted mono-causal link between HIV/AIDS has been advocated by pharmaceutical companies that want to earn millions with the production of ARVs (Paton & Rickard 2000, Gevisser 2007:727). Together with the CIA, they were launching a campaign against him and even funding the Treatment Action Campaign, which is one of his major critics (M&G 2000).
[101] For more on the genesis of the antagonism between systematic and historical perspectives within the philosophy of science, see Seiffert & Radnitzky (1994[1989]:139ff.).

been biomedically established, these very "facts" were subject to the viewpoints of various actors in politics, science and civil society.

The historical dimension of the AIDS debate pertains to the asymmetrical power relations between the global North and South. The colonial heritage was also stressed as reflecting an ongoing exploitation of the South. Critical or even dismissive stances were assumed towards "Western things" like biomedicine, ARVs, HI-Virus and AIDS campaigns. This dimension was evoked by Thabo Mbeki when he talked about "African solutions for African problems". One example of a South African experiment in the fight against AIDS is the Virodene scandal of 1997, which marked the beginning of an "overt politicisation of science and scientific claims to truth" (Posel 2008:15). Researchers of the University of Pretoria claimed to have found an effective treatment that had been tested on HIV patients with governmental approval. The Medicines Control Council had thus been bypassed, a move that was backed by the Cabinet and then Deputy President Mbeki (ibid.). Later Virodene was proven to be in fact poisonous (Epstein 2000:53f.) and the miracle drug was totally discredited.[102] Quarraisha Karim, then director of the national AIDS programme explained the drama that ensued as follows:

> There was this sense that this drug would be the thing that offset the perception ... of Africans as substandard and less than capable. All eyes were upon [the ANC] and the expectations were very high and they were really trying to find their feet but they didn't want to exercise caution. This was driven by this need to show the world: 'Yes, Africans can do this. We can do this. Virodene became our redemption.' (Ndebele 2004:73)

Deborah Posel identifies two lines of argument in Mbeki's so-called AIDS denialism (2008:16). One is found in the denial of the causal link between HIV and AIDS. His quote "you cannot attribute immune deficiency solely and exclusively to a virus" (Time Magazine, 16 April 2004) became famous. It meant that all the treatment and prevention that followed from the standard theory was obsolete. Instead, Mbeki claimed, poverty and its ravaging effects caused AIDS. The other line of argument involved the view that AIDS in Africa was different from AIDS in the West (ibid.). Western theories would therefore not be applicable to the African struggle. The mainstream version of AIDS was an expression of Western scientific imperialism, which ensured vast profits for the medical establishment and pharmaceutical companies marketing ARVs. "So Mbeki cast his dissidence in a rhetoric of

[102]Another example is the support of the health ministry for the Matthias Rath Foundation. The Treatment Action Campaign (TAC) and the South African Medical Association (SAMA) filed a lawsuit against Matthias Rath and the government. Rath claimed that he can cure AIDS with the vitamins that he sells in the townships (see http://www.tac.org.za/rathwrongs.html; M&G 2005).

enlightened resistance to neo-colonial and racist tyranny" (Posel 2008:16) which he saw at work within scientific orthodoxy on AIDS. Mbeki even questioned the high mortality rates of 40% that the MRC stated in a report in 2001 as well as the high prevalence rates of AIDS in Africa which would "went hand in hand, for Mbeki, with assumptions about Africa's sexual promiscuity" (Posel 2008:16f.,23).

Returning to the theme of "African heritage", the restoration of "dignity", "identity and pride" after the end of Apartheid formed central themes in Mbeki's discourse (Mbeki 2002:43f.). In a speech held in Havanna in March 2001, he stressed the need for the country to develop ideas and strategies of its own that are different from the West:

> The critical matter however is that we have a duty to define ourselves. We speak about the need for the African Renaissance in part so that we ourselves, and not another, determine who we are, what we stand for, what our vision and hopes are, how we do things, what programmes we adopt to make our lives worth living, who we relate to and how. (Mbeki 2002:72)

For Thabo Mbeki, African Renaissance meant creating a discourse that ran counter to the widespread notion of Africa being "the hopeless continent" (Mbeki 2002:123ff.). Poverty and underdevelopment should remain in the past. It would be crucial to restore "our pride as human beings, with a culture and identity that define our personality" (Mbeki 2002:125).

According to Mbeki biographer Mark Gevisser, there are various explanations for Mbeki's standpoint on AIDS and his scepticism towards ARV treatment. The AIDS epidemic started in South Africa in the time of transition between Apartheid and ANC government. People returning from exile were denounced by the National Party as terrorists, who, due to their promiscuity, would bring home the deadly virus to their families (Gevisser 2007:731). Hence, the misrepresentation and the political instrumentalisation of AIDS had very real consequences for some. For Gevisser, the simultaneous appearance of AIDS and the end of Apartheid is a main factor that explains why the ANC leadership was so hesitant regarding the AIDS issue. He writes:

> … the AIDS epidemic presented a profound psychic quandary for South Africa's new leaders: even if they were not vectors of infection themselves, how was it possible that, at the very moment they assumed their victorious place as the leaders of a democracy they struggled for decades to bring about, they were presented with a dying populace, with a plague to which they had no answers? This was the era of birth of democracy, of the emergence of a life force out of the cadaver of apartheid, and yet here were portents that the fear of death – rather than the celebration of life – would drive the country into the future. (Gevisser 2007:732)

For Mbeki, moreover, as a declared advocate of the African Renaissance, the effects of AIDS seemed exaggerated, which, in turn, was further evidence of the so-called Afro-pessimism that he blamed the West for (2007:745). He alleged that the West was being racist in focussing so much on AIDS and launching campaigns in order to change the sex lives of people, especially when they could have been tackling treatable diseases like Tuberculosis and Malaria. This form of colonial, social control was possible because of the alleged link between AIDS and a typical African's sexuality (2007:748). In an on-line letter in 2002 in ANC Today, Mbeki wrote:

> …some in our society and elsewhere in the world, seem very determined to impose the view on all of us, that the only health matters that should concern especially the black people are HIV/AIDS, HIV, and complex anti-retroviral drugs, including nevirapine. (Mbeki 2002)

Jeremy Youde further points out that South Africa had numerous negative experiences with public health interventions, something that is also reflected in Thabo Mbeki's negative attitude towards international AIDS campaigns. The first law concerning racial segregation, for instance, was the Public Health Act of 1883, which aimed to prevent a possible outbreak of cholera and plague (Youde 2005:424).[103] Youde concludes that "Mbeki employs a discourse that employs narratives of political resistance to white domination and its global order, and relies on the tropes of the African Renaissance and rejecting domination by outsiders" (2005:430).

Deborah Posel also explains the controversy in similar terms. She additionally states that Mbeki's position cannot be understood without "embedding it in the symbolic politics of the 'new' South Africa in transition from the horrors of apartheid" (2008:18). He attached an enormous "metaphorical significance to the epidemic", against the backdrop of his "self-styling as President". Embracing the role of nation-builder, he established the African Renaissance as his principal rhetorical motif (2008:18f.). "Images of birth and new life constituted its symbolic core" (2008:19), whereas the devastating pandemic represented a threat to this symbolism. Posel argues that far more was at risk for Mbeki than the physical well-being of the country. Also at issue was the hope for a better future after the liberation struggle and preserving the integrity of the state. She concludes with a rather positive take on Mbeki's denialism, namely that it "displaced sex from the foreground of discussion" and that the scale of the epidemic became linked to the continent's economic decline rather than any judgement on African ways of life (2008:23).

[103] See also Swanson (1977) and Packard (1989).

Mark Gevisser sums up, not without pathos, that the AIDS debate started as a quest for scientific truth and turned into a call for self-determination: for the rights of the South and black people to be able to make their own decisions in escaping this new form of slavery (Gevisser 2007:750)[104]. This shift in emphasis also becomes clear in another quote from Mbeki's on-line letter:

> We will not be intimidated, terrorised, bludgeoned, manipulated, stampeded, or in any other way forced to adopt policies and programmes inimical to the health of our people. That we are poor and black does not mean that we cannot think for ourselves and determine what is good for us. Neither does it mean that we are available to be bought, whatever the price. (Mbeki 2002)

5.4. The Healers' Position on their Role in the African Renaissance

I now want to elaborate on how the healers central to my fieldwork related to both the legalisation of their profession as well as the African-Renaissance discourse.

As I laid out in Chapter 3, most healers were positively disposed towards the legislation and the idea of registration. Merci Manci, founder of the nationwide healers' organisation Nyangazezizwe, said she thinks "there has to be some form of control, upgrading and learning". In response to my question about whether she has a problem with the ancestors being put into a law, she promptly answered "No. Everybody follows laws." She also felt that it should be forbidden for healers to name certain people as having been allegedly responsible for an illness. That would only cause acrimony and stress. She prefers to keep such knowledge to herself, she said. On the other hand, she did see a problem with the training mentioned in the bill. Its nature was not further specified, and she feared that only herbalists with a diploma from a school would be registered, whereas the illiterate, less versed healers could be sidelined. In this regard, she hoped for further clarifications in the legislation (Notes, 2004-09-30).

For Linda, a healer from the Mkosi group, the main reason for the government to now support traditional healing was HIV/AIDS and the need to find a cure. She said she was suspicious of the government's true motives. Most probably, she remarked, they would just want their medicines in order to make money. Although she did not know much about the content of the

[104] Gevisser further argues that other policies of Mbeki were also based on or influenced by a "reconnection with African identity", such as his approach towards Zimbabwe, the establishment of Nepad and the African Union as well as his insistence that complaints about a crime epidemic in South Africa were motivated by racism (Gevisser 2007:793).

bill, she was hoping to be briefed soon by her chairperson, Mrs. Mkosi, who had just returned from a meeting at the health department in Bisho in order to learn more about the upcoming legislation (Notes, 2004-10-02).

Mr. Kota told me in an interview that he does not see many problems in the process of legalising traditional healers. Many members of parliament would themselves be healers or at least consult one. Healers, he noted, would be "custodians of customs and cultural values of the African people", which is why "there won't be a problem of recognition" (Notes, 2004-04-13). Similarly, Mr. Tekile characterised healers as custodians of *ubuntu*.[105] When I questioned him about his stance on registration and the legalisation of traditional healing he said: "Our government is performing what they promised, namely freedom. The healers that are afraid are just scared of something they don't know" (Int. A019, 2004-09-13). Our conversation about the pros and cons of the bill went on as follows:

> Q: But you are forced to register. What if your ancestors don't want you to get registered?
>
> A: You don't register your ancestors, you register yourself. They can't stop you. It is just like an ID-book or a driver's licence that you need in South Africa. So it is my concern [instead of the ancestors']. ...
>
> Q: Where do you see the traditional healers in future?
>
> A: We have a lot of enemies...But the government will upgrade us. In 10, 15 years we will be respected worldwide.
>
> Q: You don't fear that it's just about control?
>
> A: Take the example of cattle that is inside a kraal and you lock it to make it safe against thieves, but it's no control. Our government is just fencing the organisation. That's why I am not afraid. The government is securing traditional healing from anything. (Int. A019, 2004-09-13)

Previously Mr. Tekile had told me that the only thing he fears is that traditional medicine might be sold and exploited without the healers being compensated properly. Sivu indicated that the government supports traditional healing simply so that more people would use it. He trusts the government, he said, and as there is a new generation of young, educated healers, he was rather optimistic about the registration process of traditional healers. "It won't go down" in the course of the legalisation, he stated (Int. A028, 2004-10-29:2). Nomvumisa, on the other hand, was less positive about the upcoming changes. She was uncertain about the

[105] The term "*Ubuntu*" stems from the Bantu languages. It was "championed mainly by former Archbishop Tutu, (and) is an expression of community, representing a romanticized vision of 'the rural African community' based upon reciprocity, respect for human dignity, community cohesion and solidarity." It became a "key political and legal notion" in the time of transition after the end of Apartheid (Wilson 2001:9).

motives of the government but suspected that they aimed to turn the traditional herbs into pills that could be sold without the healers "getting anything out of it" in terms of profit. The AIDS crisis could have been a reason for legalising traditional healing, she pondered, "(b)ecause they want to join forces. Cause they can't cure it and now they want help". She also did not automatically trust them just because they are black. "They are not healers. They have not been through what we have been through", she proclaimed (Int. A029, 2004-10-14).

5.5. Traditional Healing and Nation-building

Since the 1970s, various countries worldwide have made efforts to professionalise traditional medicine and integrate it into their national health systems. In these post-colonial processes of nation-building, traditional healing and healers thereby seem to have functioned as symbols of authenticity and continuity with the past, very often in opposition to the West. In the following, I want to elaborate on some examples of post-colonial national-building. My intent will be to show that what happened in South Africa in the course of legalising traditional healing in the context of the African Renaissance seems to resemble a shared pattern for young post-colonial states. They, too, sought to develop their own modern identity in distinction to the West, which is associated with formerly oppressive power.

Governance Approaches

Numerous accounts have framed the regulation of traditional medicine in various states in terms of political power and governance. In the 1970s and 1980s, medical anthropologists observed a revival of traditional medicine that had been encouraged by nationalist movements throughout Asia (see e.g. Jeffery 1982; Khan 2006). Just as Mbeki attempted to redefine the South African identity after the trauma of Apartheid, countries like China, India, Japan, and Indonesia also used their medical traditions as distinct markers of a deeply rooted, commonly shared and valued history that is an important resource for the present. More recent studies have also established a similar link between state formation, identity politics and the revaluation of traditional medicine. Interestingly, whereas there are numerous related studies dealing with Asia, similar work on Africa is largely missing. Laurent Pordié's edited volume on Tibetan medicine (2008) in various countries incorporates several excellent studies on the topic. Janes and Hilliard, for example, compare post-socialist Mongolia and China and argue

that with the loss of their socialist foundations the countries in the 1990s sought to transform their national identities. In Mongolia, many traditions that were severely oppressed in the past have now been revived. Genghis Khan, for example, was declared as the nation's hero, Buddhism became the state religion, shamanism was rediscovered and Tibetan medicine was restored as a viable medical tradition. The rural countryside, formerly seen as backward and conservative, was now increasingly portrayed as "the wellspring of a nearly lost, authentic, Mongolian culture" (Janes and Hilliard 2008:42). As with Tibetan medicine, Mongolian traditional healing was thoroughly reconstructed and integrated into the contemporary health care system that was complementary to biomedicine. The authors argue that it was not only deployed as an inexpensive resource for a crumbling health care system (ibid.) but also mobilised as a symbol of cultural authenticity and a shared national heritage. They emphasise that although "the invention of Mongolian medicine may have begun as an overtly political...act, its creation has captivated the imagination, both local and global" (2008:52). In Tibet, the situation is somewhat reversed in the sense that certain aspects of traditional medicine were suppressed instead of revived. The state authorities aimed at a clear separation between Tibetan medical "science" and the "sacred" philosophical underpinnings of the Buddhist tradition, which are clearly ideologically and politically problematic for China. State control of the medical curriculum, bureaucracy and a recent health reform have produced a standardised, secular medical tradition in Tibet (Janes and Hilliard 2008:56).[106] Yet, what links the two cases of Mongolia and China is the respective states' concern about the relationship between medicine and identity – "championed in one context and feared in the other" (ibid.).

For Steve Ferzacca, traditional medicine is used as what he terms "veritable icon" of authentic culture to politically produce national identity (2002:41). Similar to the previous examples, in post-colonial Indonesia the Suharto regime sought to establish "things Javanese" as authentic cultural heritage in the new nation state of an ethnically diverse Indonesia (ibid.). While increasingly regulated and governed by the state traditional medicine has been deployed as a potent signifier in the cultural politics of the state's valorisation and appropriation of an authentic Javanese culture. Ferzacca argues that, as a result, medical pluralism has become part of the "rhetorical practices and discursive formations often originating from and supported by the state" (2002:50). Hence, for him, medicine can serve as a form of state rule and an instrument of governmentality since it "reproduce[d] the discursive and practical

[106] See also Vincanne Adams's work on Tibet (especially 2008 and 2002, but also 2001).

categories that were essential for state rule and governance during the Suharto Regime" (Ferzacca 2002:36).

Craig Janes (2002) describes in the case of the Autonomous Region of Tibet how the restructuring of Tibetan medicine against the backdrop of Chinese economic reforms for encouraging a market economy fundamentally reorganised traditional medical practices. Its role as an inexpensive and easily available form of primary health care in many areas is subverted because experienced Tibetan medical practitioners are drawn to private urban markets away from poor rural settings where health care is already scarce. Access to multiple forms of healing increasingly becomes a privilege for the urban elite (2002:271). One factor Janes emphasises is the globalisation of Tibetan medicine which has become increasingly popular in the West where people imagine the practice to be able to remedy afflictions biomedicine cannot. Amongst Asian medicines it is somewhat unique in the degree to which it has been able to address both interests amongst a Western middle and upper class in holistic healing and non-Western spirituality. It could thus detach itself from a "particular cultural 'boundedness'" and be linked to Western longings for wholeness and a balanced and healthy lifestyle (Janes 2002:282f.). It is doubtful that South African traditional medicine will reach a similar level of popularity on a global level and become commoditised in the same manner. Hence, it seems unlikely that a growing black middle class will use South African traditional medicine to such an extent that practitioners are diverted from other areas. On the contrary, what has been described as for "the" West elsewhere, such as Yoga and other Asian spiritualities, also appeared to have considerable appeal amongst friends of mine. Another difference I find even more striking, however, concerns the political situation in China, where Tibetan religiosity and philosophy certainly have a different status than so-called African values and traditions, especially in the wake of the African Renaissance discourse I have described.

Agency Approaches

Another take on the issue of regulating traditional healing as a form of nation-building is to focus more on practitioners themselves and how they use e.g. global discourses on traditional healing. The practitioners demonstrate how these discourses become localised and transform traditional healing practice, but, contrary to the political and economic changes I have just

discussed, not in a deterministic way. Rather, these discourses become appropriated, reinterpreted and shaped according to various local ideas, values and agendas.

An early example of such an approach is Charles Leslie's chapter on "The ambiguities of medical revivalism in modern India" from 1976. Leslie describes a revivalist ideology amongst Āyurvedic practitioners, focussing on the decreasing influence of Āyurvedic medicine due to influences of Western and Arabic Yunānī medicine. This, accordingly, made a revival appear necessary. What Leslie finds ambiguous is that "the revivalists have professionalised Āyurveda by adopting institutional forms, concepts, and medications from cosmopolitan medicine" (1976:357). He shows how, throughout its history, Āyurvedic medicine has always adopted new knowledge and that it would have in fact been syncretistic all along (ibid.). This theory of decline, however, provided the ground for professionalising reforms in both Āyurvedic and Yunānī medicine (1976:362). As a consequence, classical medical texts were published, regional associations of practitioners emerged and schools, colleges and hospitals for both Āyurvedic and Yunānī medicine were opened (1976:362f.). Medicine was manufactured, advertised and distributed regionally, but also nationally and internationally. Leslie concluded that Āyurvedic and Yunānī practitioners modernised the practice of traditional medicine during a time when Western medicine evolved in India: "they shaped careers for themselves, transformed the learned practice of traditional-culture medicine into a blend of popular culture and scientific medicine, and created within the pluralistic Indian medical system a dual structure of professional medical institutions" (Leslie 1976:364). Interestingly, Leslie also points out that in India, as probably elsewhere, the modernisation of traditional medicine has not been a "one-way process" in which one side takes over ideas from the other. Rather, Leslie argues, Western medicine also developed in a distinctive manner because of the presence of Āyurvedic and Yunānī institutions, and without which the health infrastructure of the country would crumble (1976:366f.).

Judith Farquhar writes about practitioners of traditional Chinese medicine (TCM) in China and the change of their practices due to the end of the state's role as the supplier for health and the privatisation of health care. This development encouraged the proliferation of private TCM practitioners who increasingly market themselves by advertising their uniqueness, effectiveness and experience (Farquhar 1996:245). Farquhar argues that a certain entrepreneurial ethic has emerged among TCM practitioners which associates profit with being a good practitioner. They would ostentatiously display their acquired wealth as an indicator for being successful and effective (1996:247). She makes out a growing

individualism that had been suppressed earlier. TCM seems to flourish under the new conditions of a market economy. She describes the practitioners as "alive and thriving, collecting their personal powers around themselves" (1996:252). Her perspective shows how determining forces on a macro level can play out in local contexts, unlike most accounts that foreground determinist structural forces of change.

Writing about Āyurvedic practitioners in India, Cecilia van Hollen sheds light on an important point, namely how healers perceive the changes in their profession. Van Hollen notes that the practitioners, in their struggle to gain official recognition of their HIV/AIDS treatment, are torn between condemning and accepting the impact of global economy. On the one hand, she found them clinging to nationalist discourses condemning imperialism, biomedicine and its industries to assert the distinctiveness of their practice; on the other hand, and simultaneously, they needed to demonstrate the value of their medicine by pointing out its degree of penetration in the global market and their resulting material success (van Hollen 2005:89,106). What Van Hollen's analysis makes clear is that within the context of traditional medicine's modernisation, in this case its inclusion into the global market, the changing practices of traditional medicine are neither just structurally determined nor freely contrived. The agency of single actors as well as complex socio-political and global forces come together in the production of what traditional healing is and means today.

Stephan Kloos argues (in press) similarly in his chapter on Tibetan medicine in a Buddhist village in India. He points out, that "information on the social mechanisms determining the impact of ... structural factors at the local level, as well as the practitioners' options dealing with them, remain scarce" (in press:38). For this reason, he focuses on one healer in particular, describing in detail how the healer acquired medical as well as social power. The healer accomplished this despite, and even with the help of, the tremendous socio-political changes taking place in the Ladakh region where his village is situated. Kloos shows how former reciprocal relationships between healers and patients were shattered when the government introduced an *amchi* scheme which paid a monthly salary to those healers (*amchis*) who passed a state exam. This system, together with the introduction of a local hospital, led to a significant decrease of income for *amchis*. One healer, however, managed to accumulate a substantial amount of wealth. His involvement with healer' organisations and NGOs brought him benefits such as further education, an exchange of experiences with other healers as well as access to cheaper medicinal plants. He passed the state exam to become a government *amchi* and invested part of his income in subsidising his medical practice, noting

that nowadays "patients cost money" since the reciprocal patterns of exchange had broken down (in press:47, 49). With his increase in wealth, he became a kind of local representative of the village with relations to government officials and local politicians. This, in turn, only further fostered his prosperity. Other *amchis*, however, became increasingly marginalised. The acquisition of wealth by the *amchi* just discussed caused resentment among some villagers, which undermined his status and the public's trust in the efficacy of his medicines. Kloos indicates that while still powerful and respected for the time being, the *amchi* he centres on is not very much liked and his social power starts to decline (in press:54). The author concludes that social tensions "arising from a combination of regional, structural changes and local factors, are the reason for the currently experienced decline of *amchi* medicine" in the village (ibid.).

Kloos' account is remarkable because it shows the considerable extent to which individuals can shape the medical landscape of a community as well as the impact of unforeseen consequences. It reminded me of some of the healers I encountered who managed to establish relations with local and international NGOs, politicians and businesses through their work in their healers' organisations and the partnership with the university. Similar to the *amchi* Kloos describes, they were fluent in English, well-educated, eloquent and impressive personalities who managed to develop a network of diverse contacts which increased their social power and opened up new possibilities for generating income. Some acquired the role of a gatekeeper, where access for healers to courses, conferences or rituals was channelled. NGOs or local pharmacy researchers, moreover, also had to have the gatekeeper's approval to get access to other healers. Hence, what becomes clear is that the impact of supra-local changes can be shaped tremendously by particular individuals on the ground, which challenges approaches that only focus on the governing aspect of states' attempts to regulate and incorporate traditional medicine.

In his study about the appropriation of intellectual property rights (IPR) discourses by practitioners of Tibetan medicine in India, Laurent Pordié (2008) shows how distant knowledge systems can become useful in local settings.[107] Similar to van Hollen's case, the interest of globally operating pharmaceutical companies is perceived as both a threat to their practice as well as proof of its value and effectiveness. Pordié argues that through affirming

[107] His case is discussed in Chapter 3. Another example is the study of Aumeeruddy and Lama (2008) that I also mentioned already in Chapter 3. In their account, healers make use of discourses offered by a conservation project to spearhead their interests.

their ethnicity and by adapting their medical identity, practitioners can limit a foreign power's ascendency over their world (2008:152). Despite the use of foreign discourses in accordance with their own interests and needs, however, Pordié highlights another very important point. He writes about the "chameleon-like medical identity" practitioners exhibit "which assumes different shades according to the support on which it rests" (2008:148).

> This identity is certainly homogeneous in a given context, but it differs from context to context. The *amchi* draw elements of otherness from various medical systems and then include them in their own medical discourse. Medical identity is thus transformed according to the conjunction of circumstances by a partial and selective shift in the foreign paradigms (ibid.).

As with my discussion in the last chapter, which drew upon Richard Rottenburg's metacode (2005) to show that actors, depending on their social field or setting, can adopt certain codes that appear to be more suitable or promising, the healers in Pordié's study shift their "medical identity" (as he calls it) according to the given context. Whereas I find the use of the notion of identity not quite appropriate Pordié describes the same phenomenon as I tried to. New elements, whether embedded in discourses, concepts, practices or symbols (e.g. as evidenced in the instances of the African Renaissance, IPR, and the use of gloves or stethoscopes) may be used according to their perceived impact in a certain setting. This, however, does not also necessarily mean that healers lose touch with their religious domains, are corrupted by Western promises of profit and power or are victimised by the state or Big Pharma. The notion that identities and the practice of traditional healing change seems rather exaggerated in view of the code-switching model. Healers, like most everyone else, make use of existing discourses when they find them appropriate and helpful, and, what's more, they are aware of it. The term "identity" thus appears misleading. The empirically observable behaviour of actors applying certain codes, i.e. discourses or practices, does not necessarily indicate the degree to which the actors feel obliged to use them or, in fact, identify with them (see Goffman's model of role distance I outline in Chapter 3). These two levels of utilising a code should not be confused with their relative closeness to the individual speaker or "realness" of it.

This does not mean that "anything goes". Issues of power and the degree to which different actors are forced to apply certain discourses and to interact with certain codes constitute the structural frame in which code switching takes place. Here, the structure-agency problem addressed in Chapter 2 arises once again, whereby the challenge of a study as such is to portray the actors, their practices and discourses, in their various interactions with others and

in different arenas. This further requires considering the structural constraints they are subjected to, but also their capacity to master them and reposition themselves in a changing socio-political landscape. Applied to the issue of ethnic revivalism, what can be concluded from both the different case studies I presented and the accounts I collected during fieldwork is that healers relate to efforts concerning the instrumentalisation of their practice in the context of identity politics in various ways and to varying degrees.
The fact that seemingly prescriptive socio-political changes and global discourses manifest themselves locally in diverse ways shows how the object of traditional medicine has been constantly produced and negotiated instead of constituting a fixed body of practices and knowledge. It shapes and it is shaped by a particular South African modernity.

It is difficult to draw conclusions from these examples relating to the legislation of traditional medicine outside of South Africa about how traditional medicine will evolve in future. The political, social, historical and cultural conditions of the different countries seem to be too dissimilar. After discussing some of the results from the legalisation of traditional medicine and its integration into the health systems in different other countries, and further pointing out the differences I see with regard to South Africa, it is clear that the avenues traditional healing can take are diverse and difficult to predict. What is nevertheless evident in all these different accounts is that all practitioners, unsurprisingly, try to relate to and negotiate the socio-political changes that impact their practice. New ways of practicing, new forms of power and social relations, emerge that cannot be predetermined.

5.5. Summary

In this chapter, I have shown how the search for an independent, South African way in terms of traditional medicine and HIV/AIDS is linked to the concept of the African Renaissance and thereby part of a nation-building process focussed on the creation of a post-Apartheid identity. Through legalising traditional medicine and its integration into the public health system healers experience a totally new form of public recognition in South Africa. As a result of this revaluation as well as the scepticism toward biomedical concepts of AIDS treatment expressed by the president and his health minister, the concept of an African Renaissance translated into real political consequences. The formative process of the Traditional Health Practitioners Bill showed how traditional medicine was depicted as embodying African identity. The AIDS debate revealed what role a distinct South African AIDS policy –

specifically "African solutions" – plays against the backdrop of Apartheid and the establishment of a national identity distinct from the West. The essentialising discourse surrounding traditional medicine in South African health politics coincides with the self-description of healers as experts in African, "cultural" diseases, as laid out in the previous chapter. Thus the label "tradition" provides the healers with a legitimate and, thanks to the law and African-Renaissance rhetoric, promising position in today's new South Africa.

In assessing various accounts from other countries about how attempts to institutionalise, legalise or integrate traditional medicine into the state's health care system played out, it became clear that generalisations or conclusions about where South African traditional healing might be headed are difficult to make. One point that should not be forgotten is the shift in South African health policy after Thabo Mbeki resigned and health minister Tshabalala-Msimang left office in September 2008. The subsequent health minister Barbara Hogan, a well-known AIDS activist whose appointment was greeted with great pleasure by TAC, promised to attend to the shortcomings of her predecessor with regard to the countrywide AIDS crisis (TAC 2008). Today, Aaron Motsoaledi is South Africa's minister for health under President Jacob Zuma. Now that Thabo Mbeki has left the political stage, it could very well be that the era of the African-Renaissance discourse is over. The Traditional Health Practitioners' Act is still in place, though it is difficult to anticipate its further development and effects.

Despite the changes in the political landscape, my main arguments are still relevant today. With this chapter, I wanted to show what role healers played in Thabo Mbeki's nation-building, African- Renaissance discourse. The legalisation of traditional healing (whose consequences are still being realised) as well as the AIDS controversy translated this rhetoric around African tradition and values into concrete political action. By integrating formerly marginalised and illegal practices into the nation's legal framework, Mbeki also accommodated the principle of equal treatment. In the next chapter, I will show how this particular action may be interpreted as one form of rationalisation in Weber's sense. I will argue that to ensure equality, accountability and safety the state has no other available means than to subject traditional healing to a legal framework.

6.

The Logic of the Modern State

This chapter deals with the principles and logic of rational-legal rule in a modern state. The last chapter showed how the legalisation of traditional medicine and its incorporation into the South African health system can be regarded as part of a nation-building process aiming at integrating certain parts of its society into the modern nation state that were formerly marginalised or illegal. The principle of equal treatment was thereby taken into account. I will argue that to ensure equality, accountability and safety, the state has no other means at hand than to subject traditional healing to a legal framework and thereby to bureaucratic logic.

In a first step, I will elaborate on Weber's understanding of bureaucracy, and its systemic operation, as a defining characteristic of a modern state. He argues that there is no alternative to bureaucracy, which is the most rational form of political rule. A central element of Weber's work, however, is his ambivalence towards a society which is purely bureaucratically organised. This ambivalence is indicated by his famous description of the "iron cage" that traps people when officialdom comes to dominate their lives. Most of Weber's critics, and critics of bureaucracy and rationalisation in general, also emphasise this aspect of bureaucratic rule, and its omnipresence in the modern state. Yet, other scholars foreground Weber's ambivalence in their work and demonstrate the usefulness of some of his concepts in evaluating present-day societies. The discussion, however, of both Weberian theories and their critique leads to the conclusion that in a modern state which is guided by the rule of law and the principle of equality before the law must subject the profession of healing to juridification. This means standardising some aspects of it according to bureaucratic logic. In order to be able to show this, I will elaborate on the logic of the state, especially on the issues of legibility, knowledge of the state and standardisation.

In order to convey my arguments about the presence of a specific logic that only makes certain objects legible and processable in a particular form, I will conceive of the state as a single "black box", as one actor. Of course, the state can be disassembled into smaller units. However, one perspective is not necessarily more accurate than the other. As the process of disassembling black boxes can represent an infinite endeavour, it is more productive for analytical purposes to either close or unpack only certain black boxes (Latour 1999:70, 191).

6.1. Weber's Bureaucracy

Characteristics

Max Weber defines three pure types of legitimate domination. Legitimacy can be based on 1) legal, 2) traditional and 3) charismatic authority. In the case of legal authority, people believe in the legality of enacted rules and the right of those in power under these rules to issue commands. Traditional authority rests "on an established belief in the sanctity of immemorial traditions and the legitimacy of those exercising authority under them". Charismatic authority is finally based "on devotion to the exceptional sanctity, heroism or exemplary character of an individual person, and of the normative patterns or order revealed or ordained by him" (Weber 1978[1922]:215). Whereas in the case of the last two, obedience is owed to persons (e.g. the chief or the charismatic leader), in the case of legal authority, people obey the legally established order as well as the officials "exercising the authority of office under it by virtue of the formal legality of their commands and only within the scope of authority of the office" (1978[1922]:215f.). It is this type of legitimate domination, also called the "rational type", which concerns this chapter. According to Weber, the purest type of exercising legal authority is that which employs a bureaucratic administration (1978[1922]:220). A bureaucratic administration converts politically made laws into concrete decisions which concern people directly (Münch 1984:447). Again, in a modern state bureaucratic administration constitutes the centre of political rule. Weber states that actual political rule affects the everyday life of people through the workings of administration. Hence, power lies in the hands of civil servants who are employed by and receive pensions and salaries from the state. They are specially trained, they document their work, and their duties are based on a division of tasks, fixed responsibilities and a hierarchical order. This kind of officialdom for Weber is a defining criterion for the modernisation of a state (Weber 2009[1922]:196-198). The reason for the expansion of bureaucratic rule, in comparison to other forms of organisation, lies primarily in its technical superiority. Precision, discretion, continuity, knowledge of filing, speed, unambiguity, unity, strict subordination and the reduction of material and personal costs reach their optimal level in a bureaucratic organisation (2009[1922]:214).

The continuous growth of essential tasks in the modern state made it necessary to increasingly concentrate expertise and know-how within the administration. Weber speaks of an "ever-increasing 'indispensability' of the officialdom, swollen to millions" (2009[1922]:232). Richard Münch stresses that there is an increase of complexity regarding the requirements and tasks for the state which lead to an increase in planning within the administration. He

moreover divides the tasks of the administration into those related to planning or implementing (Münch 1984:449).

The state's strict orientation toward laws and regulations allows the executive administration to come to binding decisions in individual cases, which may also run counter to the preferences and expectations of citizens. Only those expectations which comply with legal and administrative regulations can be accounted for. Everything else lies outside of the reality that can be perceived by the administration (Münch 1984:452). This point is also particularly relevant to the process of legalising traditional healing. In order for things to become visible, manageable and litigable for the state's administration, traditional healing has to be standardised and put into legal form. This is a fundamental feature of bureaucratic logic. Only those cases can be handled where administrative regulations can be accounted for (i.e., recorded, named and clearly defined); only then do they become legal and "real" in the eyes of the state.

Bureaucracy for Weber constitutes the most rational form of political rule. It is important to note that he understands his ideal type of bureaucracy as an analytical construct which is only rational according to its limited function, namely to ensure the predictability of the implementation of political decisions (Münch 1984:453). According to Münch, Weber has often been misunderstood as regarding its problems bureaucratic structures can turn out as inadequate and irrational. He stresses (just as Weber implied) that bureaucracy can only be called rational in terms of the predictability it ensures for the implementation of orders. An action can only be regarded as rational in relation to a specific purpose.[108] Critique of Weber's ideal type of rational bureaucracy which focuses on something other than pure predictability thus misses the mark (1984:454).

Weber's Ambivalence towards Bureaucracy

Weber regards bureaucratisation as modern society's inescapable fate. Every large scale administration can only function as a rationally organised bureaucracy (Münch 1984:454f.). Whereas rational socialism would be a possible alternative to modern capitalism, there is no alternative to the bureaucratic form of administration. Weber, however, is far from seeing a purely bureaucratically organised society in an entirely positive light. To the contrary, with

[108] See also Lepsius (1986:59), who stresses that criteria for rational action are not abstractly valid as such, but only in a delimited context.

regard to the bureaucracy that dominates people's lives, he describes people as being locked in a cage. Where spheres of social life are regulated, individual freedom is undermined. In his famous treatise, "The Protestant Ethic", Weber writes:

> No one knows who will live in this cage in the future, or whether at the end of this tremendous development entirely new prophets will arise, or there will be a great rebirth of old ideas and ideal, or, if neither, mechanized petrification, embellished with a sort of convulsive self-importance. For of the last stage of this cultural development, it might be truly said: 'Specialists without spirit, sensualists without heart; this nullity imagines that it has attained a level of civilization never before achieved. (1992[1904/5]:182)

In this quote, the dialectic of disenchantment and a possible re-enchantment (which would later be further developed by Adorno and Horkheimer) again come to the fore. Weber reflects on a competition of incommensurable values in a modern, disenchanted society and remarks that a lack of value-creating institutions, such as religion, have lost their ability to convey meaning (2009[1919]:149). Science, on the other hand, cannot substitute for this loss. Weber regards science as meaningless as its processes "never come to an end" (2009[1919]:138).

The mass of bureaucratic regulations are impenetrable for the ordinary citizen who is patronised by officials who possess secret knowledge about the inner workings of the administration (Münch 1984:457, Weber 2009[1922]:228-230). Weber describes the official as being "chained to his activity by his entire material and ideal existence" and who mostly "is only a single cog in an ever-moving mechanism which prescribes to him an essentially fixed route of march" (Weber 2009[1922]:228). Modern society cannot dispense with its "bureaucratic apparatus of authority", which rests on highly specialised knowledge and expert training. Increasingly, people's material fates depend on the steady and correct functioning of the bureaucratic system and the idea of its elimination "becomes more and more utopian" (2009[1922]:229). Weber foresees society developing in this way if a technically well organised rational administration is the only purpose or value of a state as a whole. He expands upon his bleak predictions even further in the following passage, which reads like a warning:

> The objective indispensability of the once-existing apparatus, with its peculiar 'impersonal' character means that the mechanism ... is easily made to work for anybody who knows how to gain control over it. A rationally ordered system of officials continues to function smoothly after the enemy has occupied the area; he merely needs to change the top officials. This body of officials continues to operate because it is to the vital interest of everybody concerned, including the enemy. (ibid.)

Although Weber at this point refers to Bismarck and then to France, the rationally organised Holocaust of the Third Reich comes to mind immediately. Indeed, as I will discuss below in more detail, numerous scholars have contemplated the extent to which modernisation and rationalisation laid the foundation for the state-run genocide of six million Jews.

Despite the possible negative developments of a fully bureaucratised society, Weber stresses that it remains unclear whether the actual power of bureaucracy within a society is increasing as such. The fact that it is "technically the most highly developed means of power in the hands of the man who controls it does not determine the weight that bureaucracy as such is capable of having in a particular social structure" (2009[1922]:232). In fact, Weber presents some countermeasures for preventing bureaucracy from gaining too much power. He suggests incorporating economic interest groups, occupational associations or other non-expert lay representatives as well as the establishment of local, inter-local or central parliamentary bodies. These "*seem* to run directly against the bureaucratic tendency" (ibid.).

Bureaucracy and a Growing Juridification

The trend of increasing bureaucratisation becomes even more likely the more people are accorded democratic rights. Contrary to earlier times when bureaucracy served only a property-owning minority, today the whole population is interested in the predictability of bureaucratic administration (Münch 1984:458) so that people can plan their lives in a similarly predictable way. One aspect seems even more crucial: the fact that the same regulations are applied to many cases is not only a prerequisite for a functioning administration. It is, more importantly, also a requirement of legal certainty as well as of the preservation of equality. The equal treatment of comparable cases (according to the general regulations) realises the postulate of egalitarianism. The application of the same regulations for the same cases, as well as the legal consistency of administration, are themselves elements of legal certainty. They protect the citizen from state despotism, and state action becomes calculable. This predictability is a requirement for the possibility of individual freedom, for only then can personal actions be permanently planned (Münch 1984:458f.).

Bureaucracy can, therefore, be both a limit to individual freedom and equality and a guarantee for it. For instance, a law can treat two cases equally, even though they are not equal at all in certain aspects. The regulation of all spheres of life increases legal certainty and in this sense also personal freedom, but only at the cost of ever increasing limits of individual freedom.

When groups of people, problems or actions which were formerly unregulated become subject to law, they are guaranteed equal treatment, legal certainty and predictability. This comes at the expense, however, of the consideration of concrete individual cases, i.e. of the possible individual freedom of a particular individual (Münch 1984:560). This however, is a result of bureaucratic logic which necessarily reduces the high complexity of cases and associated expectations to very specific and binding actions (ibid.).

Münch argues quite convincingly that collectively binding decisions by definition cannot leave any margin for individual adjustments to be made to regulations on the part of an official, who may want to give credit to the specificity of some cases. The principles of legal certainty and equal treatment must have first priority. If an official were to deviate from the regulations which are supposed to be implemented, he or she would consequently infringe upon equality (Münch 1984:461).

The more certain areas of society are included into state legislation, the more social relations are subject to juridification. Social spaces that were previously outside of the state's jurisdiction are turned into objects of administrative action.[109] Münch argues that this tendency is the result of a growing interdependency of actions across long-running chains of actions (1984:461). This requires broader control of these actions, which is only possible by means of collectively binding regulation. Controlling actions by relying on common sense or commonly shared ideas and values does not work anymore, as the actors involved in such a social structure are not communitised enough (ibid.). Hence, the modern state suffers from the following dilemma: on the one hand, it has to grant rights of freedom and equality as well as to account for e.g. new scientific findings that demand new policies; on the other hand, the process of juridification is thereby extended, which may lead to concrete inequalities and injustice (1984:462).

The ARV-rollout as an Example

One example which might elucidate this dilemma is the countrywide distribution of antiretroviral drugs (ARVs) in South Africa – a case where a number of challenges for the state became apparent. Before an actual policy was devised on how to handle the roll-out as a

[109] John and Jean Comaroff (2004) coined the term „fetishization of law" to account for the trend of a growing juridification of society. They claim that especially in culturally diverse societies, such as South Africa, people somewhat inflationary use legal means to solve conflicts and to claim rights.

practical matter, a number of issues had to be clarified.[110] First, the well-known and lengthy debate began about the drugs, touching on the following issues: whether they would be effective and not poisonous; if they would be applicable in South Africa, in urban as well as in rural areas; if people would comply with the strict regimen of the drugs or have enough food to eat with the medication as necessary; and finally, if the state could ensure the constant supply with ARVs in different combinations for decades to come. Patients have to take the drugs regularly without interruption in order to not provoke resistance to the HI virus. If they develop side effects, they then need to change the combination of ARVs. Hence, from the state's point of view these questions of effectiveness, practicability and safety are crucial, since the state can and likely will be held accountable for anything that goes wrong. The ARV issue also shows the importance science has for decision-making in politics and the concrete creation and implementation of policies and laws.[111] In 2004, the national roll-out of ARVs finally began. In accredited clinics, patients with a CD4 count below 200 could qualify for free ARV treatment (TAC 2004). Long waiting lists and life-threatening shortages of drugs indeed soon became a problem (TAC 2008). According to UNAIDS in 2009, slightly over 50% of HIV patients with a CD4 count below 200 were receiving treatment. In total, nearly six million people are infected with HIV, which is nearly 20% of the adult population. From this total amount of HIV infected people, 971,600 receive ARV treatment (UNAIDS 2009). The inequalities and injustices linked to South Africa's ARV policy are therefore obvious. By definition, those who are excluded from the right to treatment are all those with a CD4 count above 200. Due to drug shortages, limited roll-out facilities and long waiting lists, nearly half of the patients who would have qualified (CD4 count <200) also did not receive treatment. Short term solutions for shortages in certain provinces included granting treatment at least to pregnant women (TAC 2008). This, on the other hand, left everyone else to deal with the life threatening consequences of not being able to continue with their ARV treatments. Of course, the precarious situation represented by the AIDS epidemic and its treatment is a very special case and would thus has posed a challenge to any state. What I wanted to show, however, was how new scientific findings about e.g. the benefits of ARVs, creates new demands amongst

[110] The content and critique of the ARV debate in South Africa, together with the rightly criticised AIDS policy of Thabo Mbeki, shall not be of interest here (see esp. Fassin 2007; Nattrass 2004). My aim, rather, is to focus on the logic of the state.

[111] For more on the interrelations between science and policymaking, see Sheila Jasanoff's work (1991; 1995; 2004). Among other things, she shows how scientific and policy considerations are blended, which leads to scientific evidence being differently interpreted and legislated in various countries (1991).

the population towards the state, which must accommodate them.[112] With their eventual implementation, certain rights that are granted to a specific part of the population can potentially discriminate against others.

6.2. Seeing and Knowing like a State

Legibility

Weber describes the ideal type of a modern state under rational-legal rule as the highest form of legal formalism in terms of five postulates:

> First, that every concrete legal decision be the 'application' of an abstract legal proposition to a concrete 'fact situation'; second, that it must be possible in every concrete case to derive the decision from abstract legal propositions by means of legal logic; third, that the law must actually or virtually constitute a "gapless" system of legal propositions, or must, at least, be treated as if it were such a gapless system; fourth, that whatever cannot be 'construed' rationally in legal terms is also legally irrelevant; and fifth, that every social action of human beings must always be visualized as either an 'application' or 'execution' of legal propositions, or as an 'infringement' thereof, since the 'gaplessness' of the legal system must result in a gapless 'legal ordering' of all social conduct. (1978[1922]:657f.)

Here, Weber hints at the state's underlying logic: in order to make a condition legible, processable and workable for the legal system, it needs to be formulated in legal terms. If it is not "put into law form", it is legally irrelevant and thus virtually invisible for the state.

Legibility is also a central theme in James Scott's "Seeing like a state" (1998), where he describes how large high-modernist utopian state projects of change fail. He describes how in a premodern state knowledge about the state's subjects and their lives was lacking. The state was then "partially blind" (1998:2). "It lacked, for the most part, a measure, a metric, that would allow it to 'translate' what it knew into a common standard necessary for a synoptic view" (ibid.). The modern state had to "get a handle on its subjects and their environment", had to make them concrete in order to be able to design large-scale interventions. Weights and measures were standardised, population registers established, transport systems were centralised and cities designed. "In each case", Scott writes, "officials took exceptionally complex, illegible, and local social practices…and created a standard grid whereby it could be centrally recorded and monitored" (ibid.). In the context of these failed large national projects,

[112] In our example, the South African government was pressured internationally and internally by various patient support groups and NGOs and finally sued by the Treatment Action Campaign (TAC), which claimed that access to life-prolonging drugs was a human right.

such as the collectivisation of farms in the former Soviet Union, Scott identifies the presence of four common factors in the respective intervening states. Firstly, the state's administration is not capable of capturing the complexities of human life. The second factor is what Scott terms a "high-modernist ideology" – the optimistic faith in the ability of science and technological progress "to master nature" and structure the social order accordingly (1998:4). The third factor is an authoritarian state which is willing "to use the full weight of its coercive power to bring these high-modernist designs into being" (1998:5). A weak, crisis-torn civil society that is not capable of resisting these plans constitutes the fourth contributing factor to the development of the disasters Scott describes. He argues for "the indispensable role of practical knowledge, informal processes, and improvisation in the face of unpredictability" (1998:6). He also makes clear that he is not criticising the state *per se* as he views the state as the "vexed institution that is the ground for both our freedoms and or unfreedoms". Rather, he is against authoritarian states which ignore the values and desires of their subjects in order to realise their ambitious plans (1998:7).

What Scott calls "the logic of the grid" – a geometric order in human settlement (1998:57) – is primary to large-scale planning. This order, he writes, which is most apparent from a bird's eye view, has no necessary relationship to its residents and yet proves to be convenient for the market economy. Space is divided into abstract units, which can more easily be operationalised by bureaucratic and commercial logic (1998:57f.). The introduction of permanent personal surnames was necessary for the administration of large numbers of people who had to be individually identified. This, in turn, facilitated a uniform taxation system, censuses, land records and other official record keeping. People were made "officially legible" (1998:64-71).

For Scott, to "see like a state" means to assess social life by a "series of typifications" that are always some distance away from the full reality these abstractions are meant to capture. The result is to see "human activity … largely through the simplified approximations of documents and statistics" (1998:76). He further makes the important point that these simplifications are indispensable to statecraft. Complex reality must be reduced to schematic categories that make comparisons, summary descriptions and aggregations possible (1998:77). Scott points out five characteristics of state simplifications. Firstly, only those aspects of social life are collected which are of official interest. Hence, they are "interested facts". They are also mostly written, i.e. "documentary facts", as well as "static" and

"aggregate" facts. Finally, citizens need to be grouped by officials in order to permit a collective assessment. They thus become "standardized facts" (1998:80).

Johannes Weiß offers another reading of Weber's concept of rationality, which points in a direction similar to Scott's argument about legibility. According to Weiß, rationalisation always implies that its subject reaches higher degrees of comprehensibility and reproducibility. In other words, the sociality and sociability of these subjects increases. Hence, processes of rationalisation have a socialising sense. As a result, communication about certain issues or objects can be developed with regard to extent and intensity (Weiß 1981:48). Applied to the legalisation of traditional healing in South Africa, this means that in defining traditional healing in terms of the law, certain aspects of it become standardised, enabling its translatability into new arenas. Healing becomes communicable and legible: for bureaucracies such as insurance, jurisdiction, revenue offices; for science, drug monitoring, testing and registration; and for exporting South African traditional healing as a certified commodity. Healing can thus "travel" between different settings.

When speaking about the modern nation state, Ernest Gellner highlights the importance of having a common language code as well as a standardised educational system that provides literacy as a basic skill shared by the general public (Gellner 1983:142; 1999[1997]:54-56). So that it can be evaluated, compared, accounted for and talked about – in short, handled – traditional healing has to be subjected to a legal language code like biomedicine. What Gellner finds remarkable when characterising industrial society is that "the conception of the world as homogeneous, subject to systematic, indiscriminate laws, and as open to interminable exploration, offered endless possibilities of new combinations of means with no firm prior expectations and limits…" (Gellner 1983:22).

Knowledge of the State

For the state, knowledge provides the basis for any processes of planning, ordering, auditing, and legislating. It is foundation of the state's agency and ability to act. Knowledge shall therefore not be simply understood as a stored commodity. Instead, it is a resource that relates to a specific demand for action; it can set things in motion. It is also processual and reflexive since it is continually subjected to new contextualisations and revisions (Collin and Horstmann 2004:10-13). As Collin and Horstmann point out, it is important to keep in mind the various forms of knowledge that are relevant for the state. These not only include

scientific expert knowledge, but also administrative knowledge, the so-called local or practical knowledge which is related to individual local contexts, experiences and routines[113], as well as institutional knowledge. The latter refers to state institutions, whose stored knowledge and facts according to standardised norms and proceedings provide the basis for their operation (2004:13).

Linked to the topic of knowledge is the debate about a scientisation of politics. With the state's areas of competence expanding, new sciences like statistics, demography and economy evolved. Abstract and objectifiable knowledge came to determine politics since the early 19th century. According to Collin and Horstmann, one can only speak of a broad process of scientisation since the end of the last century (2004:21). Experts from the fields of economics, legal studies, medicine, engineering, sociology and psychology profoundly shaped the state's knowledge production. The aim was to improve the state's efficiency and productivity, along with its ability to make decisions. One downside of this development was the permanent pressure to come to a decision and act upon it. This remains a defining characteristic of the modern state today. Experts acquired more and more influence in the political realm, however, the impact and authority of their respective areas of knowledge has diminished as each scientific position has been opposed by a critical counter position (ibid.).

But not only an increase in the number of experts and scientific contention led to an hardly assessable amount of diverging scientific positions. Also the public won influence regarding certain fields of scientific research and its course as well as the assessment of risks linked to certain sciences and technologies. In the science and technology studies' (STS) literature this process is referred to as the "democratisation of science", which highlights the public's greater degree of participation in the sciences and especially medicine (Balogh 1991; Blume, Bunders et al. 1987; Brown 1992; Cozzens and Woodhouse 1995; Irwin and Wynne 1996; Kleinman 1995; Nelkin 1975; Peterson 1984; Wynne 1992). There has been debate about citizens' growing concerns about inherent risks in the proliferation of global environmental and health hazards (Beck 1992[1986]; Callon, Lascoumes et al. 2001; Giddens 1991). Related discussions focus on issues such as "reflexive modernity" (Beck 1992[1986]) and how citizens can more directly participate in public deliberations over scientific and public health

[113] James Scott calls this form of knowledge *metis* (1998:309ff.) and argues that it is sidelined in the context of the high-modernist projects he describes.

policies (Leach, Scoone et al. 2005; Robins and Lieres 2004).[114] Along with numerous accounts on how different publics influence science and "how users matter" (Oudshoorn and Pinch 2003) when it comes to the design of technology and social movements, especially in the field of health, HIV/AIDS has received special scholarly attention (Altman 1994; Epstein 1995; Epstein 1996; Epstein 2000; Kroll-Smith and Floyd 2002; Parthasarathi 2003; Treichler 1999). These forms of medical activism have been described as projects of "self-fashioning" and empowerment and are thought to constitute new forms of "responsibilised citizenship" (Comaroff 2007; Nguyen 2005; Rose and Novas 2005).

Within the context of a "reflexive modernity", issues such as uncertainty, complexity and ignorance reveal the limits of knowledge and science in politics. When decisions have to be made, the state is often confronted with a variety of possibilities before acting. Conflicting perspectives have to be reconciled and transformed into something practicable. The state here is not only held accountable by the various actors involved, but it has to protect the interests of those non-personifiable actors, like the environment or posterity (Collin and Horstmann 2004:23f.). These complex structures of conflicting interests and deficits of knowledge result in uncertainty that can have serious consequences, e.g. when dealing with technologies like nuclear power or genetic engineering. These new challenges to state planning and action, which are linked to the question of how to deal with uncertainty, require a new knowledge-based "management of complexity" that takes into account people's economic, social and mental concerns (Hofinger 2004). Peter Wehling (2004) argues for systematically generating and making available expertise on how to deal with non-knowledge. For him, the days of ruling through knowledge are over, especially in the area of environmental politics. He states that "the explosion of knowledge" goes together with an "explosion of non-knowledge" (2004:315). It would be indefinitely impossible to account for some gaps of knowledge or to estimate the consequences thereof. Hence, new strategies and methods are needed that consciously account for the state of not-knowing.

Standardisation

The state's knowledge empowers it to categorise and classify social reality. These categories are enforced by the state and profoundly shape its citizens' life worlds. Knowledge that is

[114] Matthias Kaufmann (2007) argues that the "emancipatory project of modernity" cannot be regarded as a failure as long as science as well as modernity as a whole are understood as „autopoietic", self-correcting processes driven not only by states but increasingly also by civil society and supra-national organisations.

categorised in this way has the power to determine how the world is perceived and also to legitimately define society (Landwehr 2004), such as in the realm of demographic policy. Alexander Pinwinkler (2004) shows how Western Europe statistics between 1850 and 1950 provided a pool of data for helping states to realise their policies. In 1850, for the first time, statisticians were able to conduct a census of the whole population. It provided the basis for the creation of the categories "race" and "family". Scientific constructions of populations were later used by totalitarian regimes to mould populations according to their particular aims.

Ian Hacking (1982) has also done research on statistics in Western Europe in the 19th century. He remarks on the great "enthusiasm" and "fetishism" about numbers and counting, which led to an "avalanche of numbers" between 1820 and 1840. This, in turn, contributed to "a moraine of new concepts" about which numbers mattered most and new ways of how to perceive individuals (1982:292). Categories such as professions and diseases were documented and counted for the first time (1982:293). Social changes also led to the invention of new categories into which people "spontaneously fit" (Hacking 1986:223). Hacking, nevertheless, addresses the question about whether categories are given by nature or human beings. He rejects the facile claim that categories are strictly man made. Instead, he proposes a "dynamic nominalism", claiming that categories and the people or things in them emerge simultaneously. Also, some categories are more natural than others ("It would be preposterous to suggest that the only things horses have in common is that we call them horses."). For an individual, however, categorisation might limit the range of options for how they lead their lives (1986:228f.). But Hacking also draws attention here to the fact that not everything humans do depends on how they are described (Was it not possible "to be a heterosexual kind of person before the nineteenth century, for that kind of person was not there to choose"?) (1982:229). He further makes a distinction between people and things, given that "what camels, mountains, and microbes are doing does not depend on our words" (1986:230). Yet, he argues that the idea of "making up people" affects how we should think about the individual self. "We are not only what we are but what we might have been, and the possibilities for what we might have been are transformed" (1986:233). He sums up that by adhering to "dynamic nominalism" and by paying attention to the fact that each category has its own story (meaning that generalisations about categorisation and "making up people" should be avoided), we have the chance to get closer to and give justice to the "intricacies of real life" (1986:236).

Don Handelman (1995) looked at taxonomies as the basis for bureaucratic logic. Those who are in possession of the "bureaucratic means of production" have the power to define and control this taxonomy, which is constantly reinvented and implemented, helping to create and change phenomenal realities (1995:264). Handelman analyses the taxonomies of the "Book of Lord Shang", an ancient Chinese legal reform from the fourth century B.C., which aimed at forming and re-forming people and the state through new laws. "Integral to this formation was to make the people totally unified and consistent in their perception and thought, so that they would behave utterly according to the law, but ultimately without recognising that this was a human construction" (1995:281). The state laws ought to be conceived as the natural way of life. Although Handelman is not particularly explicit on this point, his later discussion of the issue makes clear that he understands the extreme views Lord Shang articulates in the book as being consistent with the aims of today's bureaucratic logic: namely the production of submissive individuals who are easily taxonomised. Handelman argues that categories in the form of laws shape their subjects like a mould would shape its content. "Form is also form-ation." Taxonomies bring forms into being (1995:275). He summarises the logical mechanism of Western bureaucracy as follows:

> [It] has the capacity to fragment any organic relationship into the smallest, most singular of units - the individual. Modern bureaucracy individuates persons, and aggregates individuals in categorical terms, in accordance with taxonomic instructions. Modern bureaucracy works most efficiently with a particulated cosmos, in which individuals are sorted and re-sorted without any principled reference to social or organic relationships. Modern bureaucracy and the 'mass society' of individuated beings go hand in hand, each helping to constitute the other. (1995:285)

Bureaucratic organisation – the "machine of individuation" – is an "ideological power" which creates the impression of autonomy and freedom for the individual, whereas its true purpose is the separation, aggregation, and alienation of humans. It "weakens them as beings in the world", and "prepares them to be taxonomized and hegemonized as massed aggregates" (1995:286). Handelman's views come across as somewhat extreme. Despite the fact that the link between totalitarian Lord Shang from 400 B.C. and today's bureaucracies is not sufficiently established, the author is obviously not in favour of relating each category's own story to avoid generalisations, as Ian Hacking proposed.

Theodore Porter (1995) studies the process of quantification as one form of standardisation. He regards numbers, graphs, and formulas as strategies of communication which can conveniently summarise a variety of complex transactions. Quantification, a "technology of distance", helps to produce knowledge which is independent from the people who produced it.

Such knowledge can be easily communicated beyond local boundaries (1995:viiif.). Porter examines and recounts the history of statistics in Europe and America in great detail and shows that effective quantification is never simply a matter of discovery, but always also of administration and, hence, social and technological power (1995:15). Quantitative objectivity is the use of rules to confine and tame the personal and the subjective. Porter's main thesis is that science has not always adhered to this mechanical form of objectivity, but has come to do so in adapting to modern political and administrative cultures –the very structures it helped to shape. Especially impressive is Porter's balancing act between pointing out the emancipatory effects of quantitative objectivity as well as the dangers inherent in oversimplifications that sacrifice substance and authenticity. (1995:84ff.). According to Porter, quantitative measurements and formal procedures were of great value to those who had to deal with the complexities of the new societal arrangements in the 19th and early 20th centuries, when trust in the traditional elites had decreased. Instead, public accountability was promoted as a new ideal. This process of quantification ultimately facilitated the emergence of new professions as well as the rationalising of state bureaucracies (1995:90-98).

To summarise: within a modern state's administration, objects, relationships and knowledge have to be standardised in order to be legible, processable, storable and applicable. Only then, legally speaking, can it be determined whether they belong to one category or another and can given due process according to the rule of law. This is the basis for rational-legal authority, and things are not practicable within a state's logic in any other form. Unless they are standardised in this way, they cannot be accounted for or processed. Standards can be defined as "abstract specifications of the necessary features of a component that make it compatible with the rest of the system – they ensure its 'fit'" (Schmidt and Werle 1998:3). In order to allow traditional healers, for instance, to be paid by health insurance providers, abstract regulations have to be created. Payments, in this case, may be influenced by the length of a session or the healer's level of experience. Also, in order to make healers accountable for their actions, further determinations must be made about what practices they may conduct, what fees they can charge for performing certain rituals and whether the latter are in fact legal. Above all, the conditions have to be defined for when a person can claim to be a healer and thus practice as one. Obviously, certain aspects "go by the board" during standardisation simply because they cannot be standardised: they do not fit and cannot be processed in terms of the state's logic. Ancestral guidance or witchcraft may be examples of this. John and Jean Comaroff (2004) attend to an analogous case about how cultural specificities cannot be standardised or made legible by the state. As they show concerning the phenomenon of witch

killings in South Africa (see also Ralushai, Masingi et al. 1996), cultural justice is difficult to integrate with criminal justice. The latter does not provide for a generalised, standardised and broadly accepted procedure, with the Witchcraft Suppression Act of 1957 still technically running, while being questioned by various interest groups as unconstitutional and hence existing somewhat in limbo. The only way that the South African judiciary can thus currently process for such cases is to take "culture" into account as a mitigating factor on a case to case basis (2004:194f.), in a way somewhat familiar to recent western jurisprudence as "cultural defence" (Renteln 2004).

Regarding the problem of certain aspects being incommensurable with the state's logic, a key aspect of Luhmann's "system theory" (1995[1984]) can be illuminating: social systems operate by a "binary code" which establishes a boundary between a processable interior and an unintelligible outside – the so-called "environment". Although Luhmann's reified notion of static, self-referential systems is not entirely convincing, his theory is still instructive in regard to the logic of the state. But this logic, under whose influence actors only operate in some contexts and not in others, must not be confused with actual "states at work" (Bierschenk 2010). As I will argue below, there is a need to distinguish between real existing states and the logic of the state, the latter referring to the "formal organisation" or "image" of the state, whereas the former refers to states in practice, combining "formal" and "informal elements of organisation"(Migdal and Schlichte 2005; Rottenburg 1995).

I would like to stress again that, as Handelman and Scott argue, it is possible that within the process of standardisation, of making the world legible, the world changes. Objects that are put into a particular form are moulded, i.e. standardised. Scott shows how the state forms the world by making it legible in reference to the transformation of landscapes and cities, or the introduction of permanent surnames for citizens etc. It should be recognised, however, that the extent to which standards shape the world is, first of all, an empirical question. In the case of traditional healing in South Africa, the effects of its legalisation largely remain to be seen. However, as I discussed in Chapter 4, the dual logic within the realm of "natural sicknesses" already offers one aspect of traditional healing which is perfectly intelligible and legible according to the state's logic and which provides a common ground for its interaction with biomedicine (see Chapter 3). By contrast, cultural sicknesses are incommensurable with the state's logic.

6.3. Critical Engagements with the Modern State

The number of works dealing with rationality, modernisation or Weber's concepts alone is vast. I will therefore limit my reflections to only a few which appear to be the most important. In the introduction, I referred to Horkheimer, Adorno and Benjamin and their concern with the destructive elements of modernity and enlightenment: a fact they experienced painfully during the Third Reich and the state-controlled Holocaust. Another author who also deserves to be mentioned in this respect is Zygmunt Baumann, who wrote "Modernity and the Holocaust" (1989). Like his predecessors from the 1940s, Baumann states that the Holocaust was only possible in the modern era due to the combination of bureaucratic culture, the logic of industrialisation and an unleashed instrumental rationality void of ethics or goals on its own (1989:12f.). Here, Weber's apprehension about a formally rationalised bureaucracy which functions without ethics, morals and values and, what's more, can be appropriated by anyone proved to be true. The disenchantment of the world left an empty space waiting to be filled with substantive rationality. The sense and meaning of Hitler's ideology, instrumentalised to realise his endeavour, are well known.

Baumann points out that modernity is not by definition totalitarian. Although the Holocaust was modern, it does not follow that modernity is a holocaust (1989:93). Rather, the traumatic event brought something to the surface that had already been present in the people themselves, which was waiting to happen, namely "anti-modernist phobias" about Jewish people, who would signify modernity and mobility. These phobias were "uploaded trough channels and forms which only modernity could develop" (1989:45f.). The genocide also occurred because political power gained supremacy over economic and social power (1989:112). For Baumann, however, the fate of modernity is contingent and open: there is no iron cage. What is needed is a strong civic society as a moral instance for defining consensus and fighting conformism (1989:179).

In connection with state logic and modernity, Michel Foucault deserves to be mentioned. His entire corpus can be regarded as a critical history of modernity. He developed the concept of "governmentality", which means "the art to govern". He further defines the term as follows:

> 1. The ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security.

2. The tendency which, over a long period and throughout the West, has steadily led towards the pre-eminence over all other forms (sovereignty, discipline, etc) of this type of power which may be termed government, resulting, on the one hand, in formation of a whole series of specific governmental apparatuses, and, on the other, in the development of a whole complex of *savoirs*.
3. The process, or rather the result of the process, through which the state of justice of the Middle Ages, transformed into the administrative state during the fifteenth and sixteenth centuries, gradually becomes 'governmentalized'.

(Foucault 1991[1978]:102f.)

A more subtle form of power emerged that he calls "discipline". Discipline here means managing the population of a state, forming its people to "fit" (ibid.). Central to this process is the collection of knowledge about people through systematic observation and evaluation. Knowledge for Foucault is tantamount to power. Medicine and psychiatry have proven to be essential, as Foucault (1965) shows, in the study, categorisation, and sorting of people, in defining who is deviant from the norm so that they can be excluded from society. Closely linked to the issue of medicine as a definatory power in the service of the state is Foucault's concept of biopower. Here he refers to "an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" (1998[1976]:140). Foucault contrasts traditional forms of power based on the "sovereign's right to death" with the modern state, whose power is directed towards the protection and regulation of life. The primacy to protect life, the "body" of the state and its population as a whole justifies the use of any means (genocide being one conceivable option) (1998[1976]:137).

The metaphor of Jeremy Bentham's "Panopticon" aptly summarises Foucault's look on modern society. The panopticon is an architectural form designed for a prison, where a single guard stands watch in the middle without being seen by the prisoners. They fear being watched, unconsciously internalise rules and laws and forget that they are under surveillance (Foucault 1979[1975]:204ff.). In modern society, people have similarly internalised disciplinary forms to become docile citizens. Power and control are invisible and therefore do not have to be directly exercised. Instead, they are instilled in each individual, who unconsciously become norm-compliant.

Apart from these critiques of modernity as a whole, the issue of bureaucratisation has been widely discussed. The weaknesses and the irregularities that have been detected were often used to claim that rationalisation has generally not been successful. Probably the most famous critique of bureaucratisation has been made by Michael Herzfeld in his book "The Social

production of indifference" (1993).[115] The question he seeks to answer with is: "How and why can political entities that celebrate the rights of individuals and small groups so often seem cruelly selective in applying these rights?" (1993:1). For him, bureaucracy's indifference towards the needs of individuals contradicts democratic and egalitarian ideals. With some pathos, he remarks that "Indifference is the rejection of common humanity. It is the denial of identity, of selfhood" (ibid.). Missing from the book, however, is a thorough reflection on the dialectic that is intrinsic to bureaucratic logic, which, on the one hand, treats people objectively and equally, while, on the other, being unable to account for exceptions to the rule or unique needs and situations. Herzfeld cites anecdotal examples about state officials, mainly in Greece, but also in other European countries, whose practices are more informed by considerations of status, custom and patronage than by noble ideals such as impartiality, neutrality and accountability. In the encounters he describes, clerks are corrupt, incompetent and arrogant and abuse their power. Herzfeld claims that fatalistic thinking explains why people would become "accustomed to obedience" (1993:127). Drawing on Weber, he introduces the concept of "secular theodicy" (1993:7), connoting a pragmatic means for people to deal with disappointment. People view bureaucratic decisions as having been reached in mysterious ways, and the outcome of dealing with an official is viewed as a matter of fate or luck.

All in all, the picture Herzfeld paints is one of exclusively negative confrontations between state officials and the public, which ultimately makes his book appear rather one-sided. Furthermore, he seems to equate bureaucracy with state administration only, whereas the actual bureaucratic organisation of most fields in today's society is not even mentioned.[116] Also Mouzelis proposes focusing on the bureaucrat as a "human being with emotion, beliefs and goals…which would not always coincide with the general goals of the organizations" instead of perceiving him or her as a "mere administrative tool" (1969:57). There would then be an identifiable ongoing tension between rules which are supposed to control the behaviour of officials and the "recalcitrance" of the latter which defies complete control and develops unpredictably (Mouzelis 1969:60).

Weiß convincingly argues that it is crucial to be precise about the domains of social action which are subject to processes of rationalisation. Otherwise, one misunderstands Weber's ideas on rationalisation. Also, it must be determined what the ultimate points of view are and

[115] See also e.g. Crozier (1971), Downs (1994), Hilbert (1987), and Britain & Cohen (1980).
[116] See also Beidelman (1995), who makes the same point in his review of Herzfeld's book.

in what direction domains or spheres are being rationalised (Levine 1981:12). A business relationship which is characterised through a high degree of calculability and rationality according to this specific standard can also be ethically irrational, since personal relationships or individual desires are foreign to the logic of business relationships. Moreover, it would not be a contradiction if the processes of rationalisation and societal differentiation were to also bring along with them an increasing number of irrationalities (Weiß 1981:55). Much of the criticism against Weber, therefore, seems misguided.

A variety of authors explore the applicability of Weber's ideas to actual circumstances today. George Ritzer, for instance, has developed a concept of hyperrationality as a logical extension of Weber's concept of rationality (Ritzer 1991:93). The basis for this new theoretical concept is, according to Ritzer, the unique characteristics in Japanese industry, which has rationalised in a different manner when compared to the West (1991:94). He describes Japanese manufacturing as even more bureaucratic and formal than Western manufacturing. Interestingly, however, the importation of formal rationality in Japan did not lead to the demise of substantive rationality, a development Weber feared. On the contrary, formal rationality was forced to accommodate itself to the already strong substantive form of rationality. Ritzer argues that precisely because Japanese industry is formally rationalised to such a high degree, it can allow for greater flexibility in other realms (1991:104f.). There would thus be greater experimentation and openness to new ideas in Japanese bureaucracies. Also, Japan was able to stick with a consistent set of values, like groupism, harmony, unity, debt, cooperation and obligation. Hence, substantive rationality in this instance "helps to counter the excesses of formal rationality" (1991:106). Ritzer calls the resulting synergy due to all types of rationality interacting and flourishing to a high degree hyperrationality (1991:113). His example demonstrates how a co-existence of values, ethics and a highly rationalised society is possible. In the case of South Africa, the discourse about the African Renaissance with its associated values might present a similar counterbalance to the legalisation of traditional healing. Weber, at least, had some hope regarding passionate politicians, who regard their duty as a "vocation" and could act to restrict the effects of routinised bureaucracy (Weber 2009[1919]). With his theme of an African Renaissance, Thabo Mbeki could very well be such an example.

Lawrence Scaff contemplates where we stand today in regard to Weber's prophecy about the iron cage. Have we been able to make use of the "alternatives left by his legacy" or are people today spiritless captives of a dehumanised, rationalised world (1989:232)? He states that

Weber's *Zweckrationalität* (instrumental rationality) has become even more dominant nowadays as the primary mode of action and thinking. Instrumental rationality pervades every sphere of life, even those where it might be least expected or wanted, e.g. love, childrearing or art. Those things are successful that are easily applicable and translatable into other contexts. Knowledge is reduced to know-how and becomes "an informational commodity", art becomes conceptual and science needs to be practicable by serving economic and political needs (1989:233). Scaff, however, expects critical input from the "aesthetic culture of the avant-garde", which would establish culture as a meaningful instance in the fields of morals, values and politics (1989:235). Scaff here refers to Jürgen Habermas, who endorses the idea of modernity and enlightenment. Habermas seeks to remedy modernity's discontents by countering them with "the communicative practice of everyday life" (Scaff 1989:238). Contrary to subjectivists for whom rationality is the problem and who claim that fleeing the iron cage would not be possible, Habermas depicts a "model of unconstrained consensus formation in a communication community standing under cooperative constraints" (Habermas 1990[1985]:295). According to this model, a thorough critique of the negative excesses of rationality and a "reconciliation of the life-orders of ethics, aesthetics, and science according to an ideal of unified experience" would be possible (Scaff 1989:238). Habermas thus does not criticise rationality per se. Instead, he holds on to a form of communicative rationality which facilitates communication with others. Its premise is that rationality inheres to language (Habermas 1981:30). Thus, when communication is free of power and hierarchy its results are rational. In an ideal situation, in other words, the best argument wins (1981:47, 70).

Alan Sica (1988) also presents a more positive understanding of the "iron cage" of rationalisation. He finds that dark visions about "the merciless coercion of behaviour and thought into desiccated rationality and bureaucratic regulation" have not in fact played out in present day societies (1988:263). Rather, people "cope" in the undramatic, unheroic sense of being more concerned with the "privatization of consciousness" in a Marxist sense. Sica argues (ibid.) that if people were truly frustrated by the irrationalities typical for advanced industrial societies, they would just turn away from them. Besides, humans are "meaning-seeking animals" who "gravitate" to places where meaning can be found or created (1988:264). Hence, the realms of the "supernatural, aesthetic, [and] recreational" do not vanish in times of highly rationalised, modern and bureaucratised societies, as Weber presumed. Instead, once again, people have their arenas where they can find meaningful experiences (ibid.).

This synopsis of various critics and their concerns with rationalisation, modernity or Weber in particular can only be partial. My intention, nonetheless, was to outline different strands of accounts dealing with these issues in order to give an idea of where contemporary responses to Weber have been heading. Returning to the focus of this chapter, I would like to again emphasise my point about the difference between the state's logic and its practice. No matter how actors relate to certain laws, orders or regulations of the state, its logic remains unaffected. This point seems, moreover, to be in line with Foucault's argument of governmentality. For Foucault, governmentality refers to the logic of the state that has been internalised, creating docile citizens. When officials adhere to the state's governmentality, their practices correspond to its logic. However, officials might also deviate from this official line, engaging in different practices at the backstage of the state. Hence, some critiques of the rationality of bureaucratisation as such, which suggest that informal relationships are paramount for an official's action, miss the point because they fail to distinguish between a state's logic and its practice.

6.4. Giving Substance to the Formal Logic of the Modern State

Wolfgang Schluchter identifies one shortcoming in Max Weber's work which can possibly help reconcile the two conflicting aspects of, on the one hand, the legal authority to subject all realms of society to juridification in order to grant everyone the same rights and, on the other, possibly limiting and restricting individuals' personal freedoms. Weber equates formal rationality with legality and depicts substantive rationality as its opposing principle. Substantive rationality refers to rational action that is guided by ethical norms, morals or political maxims, which Weber regards as disabling the "rational machine" of the legal and administrative apparatus (Schluchter 1981:108). The result would be a lack of calculability. Schluchter argues that substantive and formal aspects together have to constitute the basis of a rule of law. Substantive aspects include e.g. "the freedom of self-determination of the people", whereas formal aspects refer to legal stability, the division of powers and the constitutional constraint of legislation (1981:109). Indeed, when exploring the history of the rule of law, a combination of the two is exactly what many countries today, including South Africa, adhere to.

In his overview of the history, politics and theory of the rule of law, Brian Tamanaha (2004:1ff.) starts with the observation that "the rule of law" constitutes the most important

political ideal today: it represents an orthodoxy in the liberal West, and has been upheld by the World Bank and IMF as a condition for financial assistance to "the Rest". By now, it seems "adherence to the rule of law is an accepted measure worldwide of government legitimacy" (2004:3). Various authors distinguish between a "thinner" definition of the rule of law, the "formal" one, and a "thicker" definition of the rule of law, the "substantive" one (Tamanaha 2009:4). "Formal rule of law" is crucially defined, on the one hand, by the fact that the government itself is limited by law, typically by a sufficiently independent judiciary. On the other hand, this variant of the rule of law also entails the related concept of "formal legality", i.e. the minimal requirements that "law must be set forth in advance (be prospective), be made public, be general, be clear, be stable and certain, and be applied to everyone according to its terms" (2009:3).

While adherence to the formal rule of law prevents completely arbitrary decision-making by the state, this variant ultimately remains silent about the actual content of the law. In the absence of any separate criteria of what constitutes good or just law, the formal rule of law is still quite compatible with ruthless, authoritarian regimes, such as Apartheid in South Africa, as long as they fulfil its formal requirements. It is with regard to this problem that a thicker version of the rule of law can be defined: "the substantive rule of 'good' law" which adds various substantive content specifications. These usually include fundamental, individual rights, democracy and/or other criteria of justice such as substantive equality. The obvious, yet unsolvable, problem with such substantive approaches consists in the fact that there is no way to determine the content of "good" laws that is free of controversy (Tamanaha 2009:4). Historically, states have solved this issue as a practical matter by enshrining in their constitutions certain human rights, which are themselves a matter of age-old debates. South Africa underwent a stage of development from being a state that was governed by means of formal laws only – Apartheid, in fact, was facilitated completely through legislation – to a state under the substantive rule of "good" law with a strong constitution.

Hence, Weber's fear of an unleashed formal rationalisation void of any values and morals was not borne out. Instead, the legal history, not least of South Africa itself, exemplified what a combination of formal and substantive rationalities could look like in a state: the right of freedom of religion and belief is enshrined, customary law is recognised, and "diversity" is at least ostensibly protected (RSA 1996). On another level, the substantive rationality of the African Renaissance can be regarded as having served as a counterweight to the process of the juridification of traditional healing, a kind of a symbolic re-evaluation.

6.5. Summary

In this chapter, I explored the principles and the logic of rational legal rule in a modern state. Above all, I elaborated on Weber's understanding of bureaucracy and its operations as the principal characteristic of a modern state. He is convinced that there is no other alternative to bureaucracy in contemporary society, which is the most rational form of political rule. I outlined the underlying ambivalence in his work towards a society which is purely bureaucratically organised, a facet Weber described as an "iron cage". I also exemplified the relation between a growing bureaucratisation and juridification: the former facilitates and enacts the latter. The more people are granted democratic rights, the more they are subjected to official administration. Life becomes more predictable and designable. Hence, bureaucracy can be both a limit to individual freedom and equality and a guarantee for it. I discussed accounts of various responses to Weber's primary ideas. Regarding more recent critics, one main weakness could be identified: the authors failed to distinguish between the logic of a state and its actual practice. Due to this shortcoming, I showed how some of the critics miss Weber's main point. The state can only process things that are legible, i.e. standardised. Otherwise they remain incommensurate with its frame of reference and effectively invisible. During this process, however, it is possible that the creation of standards and categories also form a world according to their own image. Regarding the legalisation of traditional healing, it still remains to be seen how it will change. But, as I emphasised, in terms of the dual epistemology elaborated on in the previous chapter, the natural realm of sicknesses is already sufficiently legible according to the logic of the state.

My main argument of this chapter is that a modern state which is guided by the rule of law and the principle of equity before the law necessarily subjects the profession of healing to juridification, thereby standardising some aspects of it according to bureaucratic logic. Due to the enactment of the Traditional Health Practitioners Bill, equal treatment before the law of both traditional and biomedicine has been ensured. How this will be translated in practice is an empirical question that does not affect my overall argument, namely that making such a law is the only mechanism a state has available to it for preserving and enforcing equality – for making legible and "known" a form of healing that was previously illegal and excluded from the realm of the state.

7.

Conclusion

My dissertation has dealt with the modernisation of traditional healing in South Africa. I explored how traditional healers perceive and negotiate their relations with a changing social world and how they actively position themselves in the arena of South African health policy.

In my view, the use of Weber's concept of rationalisation is a new approach which most effectively addresses one particular point that is central this project: namely, the inevitability that the practice of traditional healing would be subject to legislation that gives credit to the principle of equal treatment before the law, ensures certain rights and enforces accountability. Linked to the process of legalisation is the unavoidable standardisation of elements of traditional healing, which makes them legible to both the sciences and the state.

In the introduction, I discussed dominant theories on modernisation in order to develop the analytic framework and key arguments of my thesis. I demonstrated why a certain concept of modernisation is a useful tool for trying to comprehend and theorise the dynamics at play in the ongoing changes in South African traditional healing practices. My interpretation of what I call the modernisation of traditional healing is primarily based on two concepts from Max Weber: the leitmotif of rationalisation and the notion of bureaucratic rule as a prerequisite of rule of law.

I briefly elaborated on critics of rationalisation and the principle of enlightenment, such as Horkheimer, Adorno, Benjamin and Foucault. All these authors share a concern about the dialectic of modernity and its Janus-faced character, which was already a focus of Weber's writings. More recent critical engagements with the processes of modernisation, particularly in social anthropology, have emphasised the production of local modernities by taking greater account of the specificities of different settings and the various perceptions and practices of people depending on their socio-cultural background. However, most authors fail to provide (or perhaps avoid doing so) a definition of what it is that makes practices and ideas, even if they differ locally, modern. I also argue that when authors attempt to characterise modernity, people's imaginations of modernity are foregrounded to the detriment of examining given structural conditions. Eisenstadt's concept of "multiple modernities" (2000) constitutes an exception in this regard and has guided my own interpretive approach. He defines a common

core of modernity and acknowledges a "multiplicity of cultural programs" which are constantly in the making.

I concluded that holding on to a minimal definition of modernisation as a process which leads to certain kinds of institutions (see also Zapf 1996:32) – in my study, to the professionalisation, standardisation and legalisation of traditional healing – would be especially instructive. I regard my study to be a reflection on another "multiple modernity", a portrait of traditional healers in a South African city striving to become modern. Healers are part of a modernising process that is both imagined and practiced. It is also limited, determined and facilitated by a modern new South African nation state.

The remaining chapters dealt in detail with the practice and ideas of traditional healing and its transformation in the course of its modernisation. Chapter 2 focused on the arena of health seeking and laid out the therapeutic options patients had in PE when they were sick or felt the need to have their well-being restored. I analysed the different narratives of my interlocutors on their illness experiences as well as relevant literature from the field of medical anthropology. I showed that being sick is a relative state that can mean different things to different people at distinct points in time. The perception of an affliction as well as the mode and order of therapy depends on a range of factors such as beliefs and former experiences with illness, but also on a treatment's effectiveness, the therapy management group and options available to the patient. It became clear that health and healing are complex sites of negotiation, compromise and change. They also can be crucial in the negotiation of identity and moral standing. Sickness is an existential experience that can challenge one's sense of social order and/or the capacity of one's social network. Hence, each episode of sickness has the potential to transform one's explanations, practices and perceptions about causes and strategies of resort and healing. Understandings of medical practices are therefore fluid and can be regarded as being both the outcome of objective, determining structures like infrastructure or prevalent discourses on health, on the one hand, and of subjective, internal definitions about health and well-being, on the other.

Chapter 3 explored the arena of encounters between healers and a variety of actors. Starting off with historical accounts of encounters between traditional healers, settlers, missionaries and doctors, followed by an overview of the various interactions healers were involved in during my research, I analysed the respective actors' motives, perceptions, and problems. I showed how healers negotiate opposing priorities: when taking part in various workshops and scientific testing, they strive for knowledge, prestige and resources but they also have to guard

their secrets. They aspired to become part of the health system, yet wanted to keep their autonomy. Finally, they underlined the importance of using and promoting biomedicine, especially in a time of AIDS, while, at the same time, aiming to remain important agents themselves in the field of health and healing.

In medical anthropology, a fundamental debate concerns the issue of whether elements of traditional healing are lost in encounters between healers and biomedicine – a process referred to as "biomedicalisation". As I demonstrated, however, this is not necessarily the case, even if there is evidence of healers not utilising certain concepts during the encounters with biomedicine. My observations showed, instead, that healers shift their discursive practices by using a "metacode" (Rottenburg 2005). During their collaboration, they effectively exclude certain explanations considered not translatable or not relatable in order to facilitate communication. Their "normal" lives as healers, however, were still very much characterised by referring to ancestors or witchcraft as causes of sickness. Hence, claims about fundamental epistemological changes through the healers' interactions with biomedicine are not necessarily valid. I concluded that in order to prove the occurrence of an overarching process of biomedicalisation, wherein essential elements of traditional healing systematically disappear, it would be necessary to take note of epistemological changes, not only during collaborations under the situational regime of the metacode, but in other arenas as well.

Chapter 4 summarised and interpreted the findings of Chapters 2 and 3 in order to relate them to the thesis's broader theme of rationalisation. I elaborated on the partial transformation of the dual epistemology. Here, healers as well as patients made a distinction between "normal" and "cultural" sicknesses when they talked about being sick or explain different therapy options and also shift between them. I argue that these two different spheres of competence were gradually being made more explicit, whereas the distinction between two different kinds of sicknesses has apparently always been made and that this adaptation could be explained as a process of theoretical rationalisation. Showing how they were central to the realm of health and healing, I explored the creation of the two different spheres of competence: one for healers, who are able to communicate with ancestors and can thus deal with disturbances of this type, and one for biomedicine or herbalists, who treat so-called "natural" or "normal" sicknesses without taking agents such as ancestors or witches into account. However, the line of reasoning about what might be the most probable cause of a particular sickness was typically the product of complex negotiations between a variety of human and non-human actors that could become enacted within a patient's network. A constant revaluation of this

preliminary diagnosis that depends on various concomitant factors could occur which lead to different framings of an affliction at different times. The significance of the dual epistemology is found in the role it played within the self-understanding of healers, for it created a sphere of competence that was free of competition with biomedicine. In the sphere of "natural" sicknesses, healers could acknowledge progress, biomedical success, the validity of HIV and the possibility of getting their plants scientifically tested. The realm of "traditional" sicknesses, on the other hand, provided a field for exclusive healing competence which underlined healers' indispensability in the changing South African therapeutic landscape.

In line with Weber's ideas on theoretical rationality, the dual epistemology can be understood as an abstract concept that allows for intellectual mastery over various developments and informs later courses of action. Drawing upon both older and more recent literature sources for support, I suggested that the dual epistemology consolidated over time. I elaborated on Weber's thesis about the disenchantment of the world as well as its various critics and concluded that the practice of traditional healing does not become rationalised or disenchanted as a whole. I further hypothesised that the differentiation between "normal" and "traditional" sicknesses saves the latter from becoming disenchanted or biomedicalised and that a niche is thereby secured for the continuity or survival of traditional medicine.

Chapter 5 focused on the legalisation of traditional healing, paying special attention to its history, content and the discourses surrounding it on a local as well as national level. The Traditional Health Practitioners' Bill was enacted in 2007. Healers are now required to become registered and parts of their training are standardised. I described how the bill stands in stark contrast in crucial points to the basic principles of traditional healing. At the same time, the healers have experienced the kind of acknowledgement they always hoped for and achieved a totally new level of public recognition. I have shown how the process of legalising traditional healing can be depicted as part of a search for an independent, South African way of healing which is linked to the concept of the African Renaissance and thereby part of a nation-building process focussed on the creation of a post-Apartheid identity. I argued that through this valorisation, which also involved the scepticism toward biomedical concepts of AIDS treatment that had been expressed by the president and his health minister, the concept of an African Renaissance had been translated into real political consequences. Against the backdrop of Apartheid and the aim to establish a national identity distinct from the West, I deduced how the notion of having "African solutions" played out in both the formative

process of the Traditional Health Practitioners Bill as well as the AIDS debate. The essentialising discourse surrounding traditional medicine in South African health politics, whereby its practice was depicted as embodying African identity, coincided with the self-description of healers as experts in African, "cultural" diseases, as discussed in Chapter 4. I concluded that the label "tradition" provided the healers with a legitimate and, in their eyes, promising position in present South Africa, thanks to the law and African-Renaissance rhetoric.

Chapter 6 explored the principles and the logic of the modern state, which are based on rational-legal rule. Paramount here were Weber's thoughts on the workings of bureaucracy as a defining characteristic of a modern state. I also described how a growing bureaucratisation and juridification are intertwined, since the former facilitates and implements the latter. I elaborated on Weber's ambivalence towards a society which is purely bureaucratically organised, where granting democratic rights to more people leads to greater juridification, which is also to say to more rules and control. Bureaucracy, hence, can be both a limit to individual freedom and equality and a guarantee for it. I discussed various critical engagements with Weber's theories. More recent critics, in particular, fail to distinguish between a logic of the state and its actual practice, thus missing the point. I argued that it is necessary to acknowledge the fact that a state can only process things that are legible, i.e. standardised. They otherwise remain invisible, as they are incommensurable with its frame of reference. Various authors point out that during this process, it is likely that the creation of standards and categories form the world in a way that corresponds to their specific image. I emphasised that this is an empirical question. Furthermore, with regard to the legalisation of traditional healing, it is not possible at this point in time to draw any conclusions about the influence of standardisation. In terms of the dual epistemology, however, one realm of sicknesses – the "natural" one – is already legible according to the logic of the state.

The last chapter, finally, consolidates the main argument of my thesis, namely that a modern state which is guided by the rule of law and the principle of equality before the law has no alternative but to subject the profession of healing to juridification and thereby standardise some of its aspects according to bureaucratic logic. The equal treatment of both traditional healing and biomedicine is now ensured before the law. How this will be translated in practice remains to be seen. My main claim, at any rate, is not affected by this consideration. Subjecting traditional healing to a law is the only mechanism a state has at hand to give justice to the principle of equality before the law. Only in the standardised form of law can

traditional healing, which was formerly illegal and excluded from the realm of the (Apartheid) state, be made legible and "known" for its final transference into the arena of the new democratic state.

With my thesis, I have explored how healers in various social arenas negotiated their identities, practices, tenets and values – where and how they lived and imagined their modernity. I followed healers in Port Elizabeth, tracing how the three rationalising trajectories constituting their modernisation – professionalisation, standardisation and legalisation – impacted their practice and ultimately defined their experience of modernisation. In doing so, I was able to show how traditional healers managed to become modern and part of the new South African state without having to give up their "tradition".

Appendix

Interview guide – healers:

- **Biography**

  → When did it start? When did you realised that you had to become a healer? How old were you?

  → Where did you grow up? Language? Rural/ urban? Parents' profession? School?

  → Profession? Jobs? When? Where? How long?

  → Life under Apartheid? Ancestors' rituals? Many healers around? Health infrastructure any different?

  → When did it start? When did you realise that you had to become a healer? How old were you?

- **Training**

  → How did you find your teacher? Was it here in PE?

  → How long was/is your training? From what does that depend on? Support from family/ husband? Finance?

  → What does the training consist of? What do you learn? How? You write it down? Exams? Herbs? Did you know about herbs before?

  → Different stages, names of stages

- **Practice**

  → How do you treat patients? How does it work?/ When a patients comes to you, what happens then?

  →Do you always talk to the ancestors when you treat a patient?

- **attitude towards so-called Western medicine**

  → What do you do when you are sick? Your family? Can you treat your family?

→ What do you go to hospital for? Or: What do other people go to hospital for? What are your experiences? Differences? Pros and cons? Examples?

→ What can they do at hospital what you cannot do? What can you do what they cannot do? Do you refer patients to hospital? When? Other way around?

→ Do you use different words for different medicines? Traditional/hospital others? In Xhosa?

→How do you know which problem you should go to the hospital for?

- **AIDS**

→ Your experiences with HIV/AIDS? What is different with AIDS?

→ Patients with AIDS? How do you know when it is HIV or AIDS? How do treat it? What do you treat?

→ How do you know about it? When? Training? Workshops? What do you think of the workshops? Important? Useful?

- **attitude towards being organised**

→ Are you member of an organisation? Which one? Why/ Why not? Since when? What changed for you with membership? Pros and Cons?

→ Why do you think it is important? Why not? What it is good for? Why necessary?

→ What changed after Apartheid for healers?

- **attitude towards the Bill**

→ You know about the Bill? What? From whom? When?

→ What do you think about it?

→ Why is it necessary?/ Is it necessary?

→ Will something change for healers? What?

→ Ancestors and Bill – not a problem/ conflict?

→ Trust in government? Motives of the government? Why do they do it?

Interview guide – patients:

- **Personal**

  →Profession/income?

  → married? Children? Age?

  → Who else lives in the household?

  → place of origin? Where grown up?

- **Health and healing?**

  → What do you do when you or one of your family is sick? From what does it depend on? Finances?

  → When was the last time that you or one of your family got sick? What did you do and why? Are you satisfied with the result? Is everything ok now?

  → Do you have a health insurance?

  → Did you ever go to a healer? When? Why? Your family members? Anyone you know? What do you think of it?

  → What are your experiences with hospitals or clinics? How treated? Long waited? What about the bad rumours? Is there anything to it?

  → When you were a child, what was it like? Where did your parents take you to when you were sick? Where there any hospitals around? Did they take you to a healer?

  → Did and does your family perform all those ceremonies for the ancestors? Do you believe in ancestors? Witchcraft?

  → How do you refer to medicine of healers/ hospitals/ doctors/ clinics? In Xhosa? What are the differences?

  → Are there some sicknesses you rather go to the hospital with and others that are better treated with traditional medicine? Can you give examples? → AIDS?

Interview guide – Health officials:

health department of PE; Head of AIDS-council of PE

- **Correct position and name?**
- **Scheme of organisations/ administrations that are important in the health sector**

  → How are they linked to each other? What is the hierarchy? Who decides what?

  →estimations, figures, statistics, figures on patients' behaviour and amount of healers

  →health infrastructure and its development within the last few years:

  → options; Where can patients go to?

  → finance; What ways of finances/ insurances do they have?

  → behaviour; What are they doing regarding their options?

- **ARV-rollout**

  → Did it begin already in the Eastern Cape? How does it go? What are the plans?

  → How does it work to get the grant as an HIV-infected person? How can I qualify for the grant and from what does the amount of money I get depend on?

- **motivation for involving healers; government policy towards it**

  → Is involvement of healers important? Why? Is there a certain policy given out by the government that you have to follow and how does it look like?

- **description of involvement and results**

  → How does involvement look like? How did it start and develop? How did it go so far, what are your impressions? What are the results?

  → Are there special fundings for involving the healers, if so from where? Does the government provide money?

- **How far is the law on traditional healing?**

  → How will it be implemented and when? Any ideas?

→Who will be responsible for the implementation? What's the standard procedure?

→ Any ideas on how the standardised training will look like?

→ Were you involved in any way in the making of the law? Do you know who was consulted? How did you learn about it?

→ Own opinion on the law?

- **personal behaviour towards health and healing**

  → What do you do when you are sick? Do you go to a healer when you are sick? Did you ever go? With what kind of problems would you go to a healer?

  → Do you perform traditional ceremonies for the ancestors where healers are involved?

Interview guide – People working with healers:

NGOs; Pharmacy Department

- **Correct position and name?**

  →Name and type of organisation? How linked to municipality? Status, funding etc.?

- **History of the cooperation**

  →How does cooperation look like? What do you do? Since when? How did it develop?

  → How did the idea develop? Links to other NGOs or organisations? Exchange of ideas?

  → Are there special fundings for involving the healers, if so from where? Does the government provide money?

  → How do you contact the healers? How do they learn about workshops?

- **Evaluation**

  → How did it go so far, what are your impressions? What are the results?

  → What goes well? Where do you see difficulties?

  → How do you think do the healers like your workshops? Any feedback?

- **motivation for working with healers**

  → Why do you do what you do? Is involvement of healers important?

- **personal behaviour towards health and healing**

  → What do you do when you are sick? Do you go to a healer when you are sick? Did you ever go? With what kind of problems would you go to a healer?

  → Do you perform traditional ceremonies for the ancestors where healers are involved?

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