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NEGOTIATING HEALING: THE POLITICS OF PROFESSIONALISATION AMONGST TRADITIONAL HEALERS IN KWAZULU-NATAL

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The Politics of Professionalisation amongst Traditional Healers in Kwazulu-Natal

Abstract

Traditional healing in South Africa is undergoing a process of change. Recognition of the role of traditional healers in health care, especially in the face of the HIV and AIDS pandemic, has led to government calls for professionalisation amongst this group. Traditional healers themselves have been increasingly experiencing a need to professionalise in order to gain more equal treatment in the public health sector and to secure access to state resources and support. In response to these developments, the government passed the Traditional Health Practitioners Act in 2004, which sets the parameters for official recognition of healers under the state. This paper focuses on the dynamics and politics amongst traditional health practitioners as they undergo this process of professionalisation, focusing on the KwaZulu-Natal Traditional Healers Council, the official body responsible for representing healers in the Province. It explores and analyses several key tensions amongst healers within and beyond the Council, showing how these tensions reveal particular power struggles over authority, as well as conflicting perspectives on the control and use of indigenous knowledge and the parameters of 'authentic' and 'appropriate' healing practice. The paper also looks at how the KwaZulu-Natal Council has attempted to mediate these tensions, emphasising that healers will have to find ways to resolve such conflicts in order for them to be able to come together and work on a common vision of professionalism.

Introduction

After a long history of marginalisation, the South African government has started to recognise traditional health practitioners (THPs) as a valuable health resource for the wellbeing of South Africa's people[1]. This growing recognition has emerged with the ascendance of the ANC government in 1994 and has been driven by both ideological and pragmatic reasons. The new government has promoted the concept of an African Renaissance, which supports finding African solutions to problems, and restoring the dignity and value of 'culture' and 'tradition'[2]. On a pragmatic level there is widespread recognition within government that the majority of South Africans frequent THPs and that they

therefore provide an important health service for those who use them[3]. Accordingly, in 2004, the South African government passed the Traditional Health Practitioners Act, which provides the policy framework to enable the professionalisation of traditional healers in South Africa. This paper focuses on the dynamics and politics amongst THPs as they undergo this process of professionalisation.

A traditional healer is somebody who engages in indigenous medical practice. Such practices are considered indigenous because a practitioner "invokes African conceptions of cosmology and cosmogony" to effect them (Xaba, 2002:24). In South Africa the blanket term THP refers to a number of different types of health practitioner. These include *izangoma*, who are diviners, *izinyanga*, who are herbalists, *abathandazi*, who are faith healers, traditional birth attendants (TBA), traditional surgeons as well as *muthi*[4] traders who are involved in the trade and sale of traditional medicines. I have included *muthi* traders in this category because although some do not have formal training as traditional healers, they generally have a significant amount of informal knowledge about traditional medicines and play a crucial role in the politics of traditional healing in KwaZulu-Natal[5]. (Xaba, 2002:24). Although there is a certain amount of overlapping in these roles, in South Africa the position of *izinyanga* tends to be filled by a man while the role of an *izangoma* tends to filled by a woman (Ngubane, 1981:361).

Support for the development of traditional medicine, and co-operation between traditional healers and the public health sector, was first promoted in the international health arena by the World Health Organisation in the late 1970s, with the Declaration of Alma Ata in 1978. This Declaration with its emphasis on a holistic definition of health that included the environmental, social and spiritual aspects of an individual was a significant event for traditional health practitioners whose healing system was based on precisely such a holistic understanding of health.

More recently with the growing crisis around HIV/AIDS in South Africa, researchers such as Green (1994, 1996) and Leclerc-Madlala (2002) have drawn renewed attention to the potential role THPs could play in prevention and treatment[6].

In a context where many South Africans do not have access to adequate health care services[7], and where HIV and AIDS is placing additional pressure on an already strained public health sector[8], traditional healers currently provide important health care that could be expanded and enhanced with greater government support. Many of the traditional healers interviewed for this paper felt that engaging in some process of professionalisation would enable them to be more effectively involved in health care provision. They viewed professionalisation as a means of recognising and legitimising their practice, but

also equally importantly as a means of gaining access to state resources, research and training, particularly resources and support relating to HIV treatment and prevention.

Within government there is a general agreement that in order for traditional healers to be engaged effectively as health care providers, they must be organised and regulated. This has prompted the promulgation of the Traditional Health Practitioners Act in 2004, which lays out the policy framework to enable the professionalisation of traditional healers in South Africa. The professionalisation of traditional healers raises a number of important questions: why should traditional healers professionalise? What is their role in contemporary society? How should traditional healers professionalise their practice? Is professionalisation the most suitable form of organisation for traditional healers? These questions intersect with a range of contemporary debates concerning the role of traditional healers in the health care system and the relationship between these health practitioners and the state.

Within the traditional healing community, there are a variety of different perspectives on, and responses to, these questions. These responses have been shaped by factors such as the type of healing work a practitioner is involved in (for example are they a diviner or a herbalist), their experience and attitude towards healers associations and structures of organisation, and their position within the value chain of the *muthi* trade. The diversity of these factors reflects the heterogeneity of traditional healers in South Africa, but also reveals conflicting tensions and interests within this community. It is these conflicting interests and tensions between different groups of traditional healers, which form the focus of this paper. Drawing on the KwaZulu-Natal Traditional Healers Council[9] as a case study, this paper attempts to explore and understand some of the dynamics and politics underlying these tensions, and how they are shaping debates around the professionalisation of traditional healers' practice and their role in contemporary South Africa.

The paper begins by situating the professionalisation of traditional healers within a broader literature on the professionalisation of biomedicine in the West. An understanding of the history of biomedicine is useful because it helps us to understand better some of the dynamics within the professionalisation of traditional healing today, and because it provides an historical contextualisation of the unequal relationship between biomedicine and traditional healing. The paper then goes on to outline the movement towards the professionalisation of THPs in Africa and South Africa, contextualising this process within the changing relationship between Africa and the West, and within evolving local and international attitudes towards health care needs and provision. The paper focuses specifically on the historical roots of professionalisation amongst traditional healers in KwaZulu-Natal, emphasising that current processes of

professionalisation are part of a deeper historical struggle, whereby healers have used organisation, and claims to a professional status, to try and gain formal recognition and to protect their rights as health professionals. These introductory sections provide a backdrop to the body of the paper, which outlines and explores some of the tensions emerging within the traditional healing community as healers engage with this process of professionalisation.

The Professionalisation of medicine in the West

> [I]n South Africa the right to health, and to define exactly what is meant by healing is contested. This is because there exist differentiated conceptions of health, and concomitantly differentiated systems of care and practice (Faure, 2002:2).

As the quote above suggests, healing practices are not 'given', rather, they are negotiated within a particular cultural and technological paradigm, and contested by alternative or competing practices. Health and healing practices are infused with power relationships as different systems of healing compete and interact with each other. In South Africa, as in most of the world, the professional structure of biomedicine has enabled this particular paradigm of healing to dominate over other healing practices.

Foucault's (1987) writing on the relationship between knowledge, discourse and power offers an insightful way of understanding how the professionalisation of biomedicine has enabled it to dominate over other systems of healing in Britain, Europe and the United States. The professionalisation of medicine in these regions was intricately linked to the development of an elitist body of medical knowledge and a particular set of discourses about the body, race, gender and medical technology. Western doctors' monopoly over this body of knowledge and their participation in shaping this particular set of discourses around health and the body, has enabled these doctors to establish themselves as a profession and has given biomedicine a considerable amount of power and authority within these societies. Twumasi and Warren offer the following definition of professionalisation:

> Theorists of the professions argue that professionalisation is a historical process whereby people who occupy certain role-positions within the societal division of labour…tend to struggle to achieve a certain degree of autonomy and continually struggle to maintain that power. They organise their work activities, cultivate a distinct body of knowledge, and develop norms of practice and codes of conduct for the training and socialisation of members of the group. They also

> establish rules of conduct between themselves and the larger society (1986:119).

Another feature of biomedicine, which is often neglected in formal definitions, is the gendered nature of this process of professionalisation. The influential position biomedicine has assumed as a professional discipline in the West has enabled it to marginalise other groups of healing that stood in competition to it, many of which were occupied by women. By excluding women from entering its practice, biomedicine reinforced the gendered power relationships of its day, a trend that has only been seriously challenged towards the end of the twentieth century[10].

Biomedicine's power and influence in society has been largely dependent on its ability to gain state support and protection, mainly in the form of legislation, for its privileged position within society. Any evaluation of the professionalisation of traditional healing therefore requires an understanding of the changing dynamics between traditional healers and the state.

The professionalisation of traditional healing in Africa

Under British colonial governments indigenous medicine was generally considered to have little or no value in African society. In fact it was portrayed as 'harmful', 'primitive' and based on 'superstition' and 'ignorance'. In most British colonies it was also outlawed by a series of Witchcraft Acts[11]. These attitudes were reinforced by biomedicine's monopoly over medicine, a monopoly that denied any recognition to indigenous systems of healing. The emerging acknowledgement and interest in indigenous medicine as a profession has only been made possible in a post-independence context, where there has been a fundamental change in the relationship between traditional healers and the African state.

A shift in international attitudes towards traditional medicine

Serious research into the professionalisation of traditional medicine has been facilitated by a change in international health policy on traditional healers, which began to occur in the late 1970s. In 1977 a resolution was adopted by the Thirtieth World Health Assembly, which urged "*interested governments* to give adequate importance to the utilisation of their traditional systems of medicine *with appropriate regulations*", and requested the Director-General of WHO "*to*

assist member states in organising educational and research activities" around traditional healing (WHO, 1978:7).

The Declaration of Alma Ata in 1978, with its emphasis on a holistic definition of health, was a significant event for traditional health practitioners, whose healing system was based on precisely such a holistic understanding. The Declaration conferred "international sanction and a high level go-ahead" on the subject of indigenous healers, emphasising the important role traditional healers could play as a valuable health resource for local communities (Pillsbury, 1982: 1826).

The professionalisation of traditional healers in post-colonial Africa

Encouraged by the WHO's support for THPs, newly independent African states, who were grappling with the problem of poorly developed healthcare infrastructure, began to consider ways in which to professionalise traditional healers to enable them to collaborate effectively with national health care systems.

The Professionalisation of African Medicine, edited by Chavunduka and Last (1986), provides one of the most comprehensive accounts of this movement towards the professionalisation of indigenous medicine in a range of post-independent African countries. Key to this process of professionalisation was the development of a range of national and regional traditional healers' associations, which *The Professionalisation of African Medicine* traces and critically assesses. The trajectory of these associations provides a useful framework for understanding and comparing some of the dynamics amongst traditional healers in South Africa today, as they move towards professionalisation. Some of these associations achieved moderate success but many also faced numerous significant challenges and difficulties. These included the inability of associations to gain any real government influence and the failure to achieve broad-based representation. Many associations were also weakened by power struggles and "personal cultism and factionism" (Chavunduka and Last, 1986: 65; 233).

Contextualising the professionalisation of traditional healers in South Africa

In South Africa the entrenched association of traditional healers' practice with witchcraft has been the major obstacle preventing traditional healers from obtaining state recognition and support. With the exception of the Natal Code of Law (1891), traditional health practitioners have historically been criminalised

and prevented from practising. Repressive legislation, in particular the Witchcraft Suppression Act 3 of 1957 and the Amended Act 50 of 1970, made it an offence for "any person to exercise supernatural powers" or "to impute the cause of certain occurrences to another person" (Xaba, 2002:9). Legislation limiting black businesses has also prevented traditional healers from establishing formal practices. This restrictive environment has not stopped healers from practising; rather it has pushed traditional medicine into the informal economy where it has continued to operate in the invisible and unregulated spaces beyond the control of the state.

The context of traditional healers in the Colony of Natal however differed to a certain extent from that of healers in the rest of South Africa. As a result of the Natal Code of Law (1891), a limited number of *izinyanga* were legally permitted to practice. In the other areas of the country however all types of healers were completely outlawed (Flint, 2001: 205). The introduction of the Natal Code of Law was directly linked to the development of indirect rule, a dual legal order, which enforced a separate but subordinate state structure for natives based on customary African law (Mamdani, 1996:111). Although indirect rule only ceded superficial power to African chieftains and customs, it provided a space in which a limited number of *izinyanga* were able to practice. *Izangoma*, in contrast, by being completely outlawed from practising, were at a greater institutional disadvantage.

Early attempts to organise: The Natal Native Medical Association (1930)

Traditional healers have always responded actively to the colonial restrictions imposed on traditional medicine[12]. They have engaged with their changing environment, taking advantage of the new opportunities it offered, and have found ways to work around restrictions. The transformation taking place in traditional healing today as it moves towards professionalisation is part of this deeper historical legacy of dynamism and ingenuity within the traditional healing community. The formation of the Natal Native Medical Association during the 1930s provides an interesting case study of how *izinyanga* have attempted to use claims to professionalisation to protect their interests, and to gain recognition as health professionals, against the growing restrictions imposed on their practice[13].

By the end of the nineteenth century a flourishing trade in traditional medicines was beginning to develop in the city of Durban to service the growing black urban population (la Hausse, 1996: 39). Urbanisation gave *izinyanga* access to new sources of patronage, clients and income, but required the restructuring of medicinal trade and practice (Flint, 2002: 207-208). This restructuring resulted

in the large-scale harvesting of *muthi*, the processing and commodification of traditional medicines and the development of extensive mail order systems for medicines in the 1930s and 1940s[14].

Izinyanga were able to extend their client base by incorporating new forms of healing that they had learnt from other healers and from white chemists and doctors. "They appealed to modernity by borrowing the implements and language of biomedicine and science. Some *izinyanga* bottled herbs, and used preservatives, stethoscopes, thermometers, and other modern equipment." *Izinyanga* began to advertise in new ways by erecting signboards outside their practices and by distributing leaflets. They also began to expand their knowledge of medicines by adding Indian herbs to their pharmacopoeia (Flint, 2001:207-210).

The urbanisation and commercialisation of traditional medicine enabled *izinyanga* to exploit their new urban environment. Yet urban *izinyanga*'s success and dynamism also brought them into fierce conflict and competition with European doctors and pharmacists, particularly as it enabled traditional healers to extend their client base significantly.

Mobilised by these concerns, the white medical community formed themselves into the South African Medical Association in 1926 and began to lobby the government to end government licensing of African herbalists. These efforts "resulted in the passage of The Medical, Dental and Pharmacy Act of 1928, which eliminated all types of medical practitioners not acknowledged by the association" (Dauskardt, 1994 quoted in Nesvåg, 1999:79). Only currently licensed *izinyanga* in Natal were exempted. The 1928 Act was highly significant because it laid the foundation "for the official recognition of biomedicine alone in South Africa" (Dauskardt, 1994 quoted in Nesvåg, 1999:79)[15].

In response to this repressive legislation, *izinyanga* began to organise to protect their right to practice against the growing hostility of the biomedical community. In response to the 1928 Act, there was a rise of urban African herbalist associations. While the majority of these were short lived, the Natal Native Medical Association formed in 1930, was one organisation that did manage to achieve some degree of success (Nesvåg, 1999:82).

The Natal Native Medical Association constructed an identity for its members as health professionals, and called on this identity and the medical rights associated with it, to protest against discriminatory legislation affecting their practice. In an attempt to win government recognition for their organisation, "the association sought to 'professionalize' African medicine by using many of the same tactics as their White counterparts". They "organised themselves into an elite group that monopolised a distinct body of knowledge", they strived to enforce codes of conduct, establishing exams for *izinyanga*, issuing them with certificates and

they sought to convince the government of the value of their services to the black community at large. Finally, they set themselves up in contrast to *izangoma* arguing that their organisation sought to preserve traditional healing practices from the corruption of untrained 'charlatans' (Flint, 2001: 218).

The Natal Native Medical Association was able "to organise strong opposition to the Natal Pharmaceutical Society" and fought to have various sections of the 1928 Act amended, "which they claimed were in conflict with their legitimate profession." (Nesvåg, 1999:83). But the Association remained relatively powerless in the face of the growing influence and monopoly of biomedicine in South Africa during the 1930s. *Izinyanga* were unable to achieve any kind of state support, a key feature necessary for professionalisation. In fact, the South African government at that time refused to recognise any of the herbalist associations that had emerged in response to the 1928 Act, including the Natal Native Medical Association. Although the Association persevered, the disadvantaged position of its members as traditional healers and as black men in an increasingly segregated and unequal society, eventually forced the Association into silence (Nesvåg, 1999:82, 88)[16].

The failure of the Natal Native Medical Association must be understood in the context of the vastly unequal power relationship between traditional medicine and biomedicine during this period. Biomedicine used the powerful arguments of science, rationality and race to set itself up as the only legitimate healing system. It was also able to use its state support and influence to encourage the promulgation of discriminatory legislation against traditional healers and *muthi* traders to strengthen its own position. This ideological conflict between traditional and biomedical healing systems in Natal was deeply rooted in economic conflict and competition, as these two systems of healing competed for the growing urban health market. Consequently, traditional medicine was forced to retreat into the invisible and unregulated space of the informal economy in order to continue practising.

Understanding differences in organisational cultures

It is significant to note that it has been *izinyanga*, such as those in the Natal Native Medical Association, rather than *izangoma*, who have adopted various forms of organisation, and claims to a professional status, to fight for their rights as health professionals despite the fact that *izangoma* were affected earlier and more harshly by discriminatory legislation. One of the reasons for this is that *izinyanga* have more in common with biomedical doctors and can justify their healing practices using a scientific paradigm. *Izangoma* whose healing practices are more removed from the logic of biomedicine have less incentive to organise

themselves on a similar basis to *izinyanga*. In fact the secretive nature of certain aspects of healing practice among *izangoma* can make them weary of too much contact with their peers.

The concept of professionalisation developed by the Natal Native Medical Association brought *izinyanga* together in a common cause, but it was also built on entrenching divisions between *izinyanga* and *izangoma*. By setting *izangoma* up as 'witchdoctors' in opposition to the legitimacy of *izinyanga*, the Natal Native Medical Association excluded *izangoma*, who tended to be women. As a result of this, the Association promoted a male- dominated culture of professionalism.

Although historically, *izangoma* have been less inclined to form associations, Green's work has shown that there is an organising culture among *izangoma* but that this is based on very different principles to that of the western styled healers associations that tend to dominate among *izinyanga*[17]. Among *izangoma* organisation has taken the form of *Impandes*, these are Zulu networks of spiritual kinship ties which link groups of *izangoma* together through a succession of initiators or trainers. In these *Impandes*, *izangoma* are also linked together by the particular medicines and the distinctive rituals and ceremonies used by those descended from the same trainer (Green, 1996:57-60).

The contrast in structure between the modern herbalist associations of *izinyanga* and the more spiritual kinship based *Impandes* of *izangoma* highlight the fact that *izinyanga* and *izangoma* have different reasons and motivations for organising. For *izinyanga* organisation is about claiming legitimacy and a professional status on a similar basis to that of biomedical professionals. For *izangoma* organisation is about belonging to a kinship network that connects one to the ancestors and guides ones treatment of patients. The differing structure of organisational patterns amongst *izangoma* helps to explain why this group is potentially at a disadvantage in the context of the KZN Traditional Healers Council, which is based on a western styled herbalist association.

The re-emergence of organisation among *izinyanga* in the 1970s

The 1970s marks the start of a shift in the Natal provincial government's policy towards *izinyanga*, from a repressive to a more regulatory approach. From this period onwards, various sectors within government called for the professionalisation of this group of healers. In the 1980s *izinyangas*' associations, both at provincial and national level, also began petitioning the South African government for formal recognition and the removal of discriminatory legislation regarding their practice. The motivations behind these

calls were both prescriptive and developmental, stemming from a concern that healing practices are potentially dangerous and need to be policed to protect the public, as well as the belief that *izinyanga* have an important role to play, and that their practice needs to be supported and developed to enable them to fulfil this role.

Over-harvesting of indigenous plants: Conservation authorities call for the regulation of *izinyanga* in the 1970s and 1980s

Concerned by the over harvesting of indigenous plants, conservation authorities tried to organise *izinyanga* in Natal and facilitate the registration and licensing of this group in the 1970s[18]. This attempt at registering, however, was largely unsuccessful and resulted in the formation of many weak and uncoordinated herbalist associations.

In the 1980s the provincial government decided to recognise the Inyangas' National Association (INA), one of the larger and better-established associations in Natal, as the only official body representing *izinyanga* in the province. But once again this attempt met with little success, as the recognition of the INA did little to discourage other associations from proliferating and operating (Cunningham, 1988:15). According to the KZN Council, more than a hundred herbalist associations were operating in KwaZulu-Natal in 2003 (Interview, 2003, Mr. Jamile, Deputy President KZN Traditional Healers Council, 22 January). There were also a large number of *izinyanga* who operated independently and who were not registered with any association (Freeman, 1992:2).

Although many of these associations remained fairly small in membership, the dynamics associated with their fractured nature continues to shape and impact the politics of professionalisation at present, by creating an environment conducive to power struggles. As a result, *izinyanga*'s associations have tended to petition government in isolation, rather than being able to come together under one representative structure, to liase around the process of professionalisation.

Witch killings and *muthi* murders: Calls for the prescription of THPs in the early 1990s

Operating in the unregulated space of the informal economy, the traditional healing community has been unable to develop the regulatory structures that

biomedicine has developed in order to monitor and prevent unscrupulous practice. Xaba (2002) documents a rise in political and social unrest and violence in South Africa during the 1980s, which contributed to the proliferation of individuals offering black South Africans medicines to help them cope in turbulent socio-economic and socio-political conditions. This rise in the number of what established *izinyanga* saw as 'charlatans', together with a number of witch killings and *muthi* murders in the early 1990s, "led to calls for the prescription of indigenous medical practice" (*ibid*:34). Once again it was predominantly *izinyanga* pointing fingers at what they saw as unscrupulous *izangoma*. In March 1995 a Commission of Inquiry was established into Witchcraft Violence. The Commission drew attention to the need to regulate *izinyanga* and *izangoma* in order to protect the general public (Public Hearings on Traditional Healers, 1997).

Indeed, amongst *izinyanga* in KwaZulu-Natal, anxiety over the number of 'charlatans' fronting as legitimate healers during this period was a key concern motivating this group of healers to push for the establishment of a formal body to regulate healers. These healers felt that such individuals were discrediting the reputation and status of traditional healing (Interview, 2003, Mr Jamile, Inyanga 22 January). However increased economic competition, as a result of this influx into the healing market, is likely to have also played a role in shaping *izinyanga*'s perception of newcomers as illegitimate. By concerning themselves with defining the boundaries of legitimate healing practice against what they considered illegitimate, *izinyanga* engaged in one of the fundamental features that has also marked the process of Western medical professionalisation.

Calls for the professionalisation of traditional healers in the face of South Africa's growing health crisis in the 1990s and 2000s

One of the strongest calls for professionalisation has come from segments within the state health sector, who have increasingly come to see healers, both *izinyanga* and *izangoma*, if regulated effectively, as an important resource, particularly in HIV and AIDS prevention and treatment.

In the 1990s the research of Green, which emphasised that traditional healers could play a major role in HIV prevention because of their efficacy in treating STIs, was instrumental in highlighting the role of THPs in prevention and management of HIV, and encouraged support for collaboration between the two sectors. Green argued that controlling the spread of HIV infection would be impossible without developing or expanding "collaborative programs involving traditional healers who already see and treat most STD cases" (1994:80).

Equally importantly, Green's research emphasises the significant role traditional healers' organisations[19] can play in facilitating collaboration between THPs and Western health care, and illustrates the general willingness of traditional healers to collaborate, and their receptiveness to biomedical training on HIV and AIDS and biomedical treatments and procedures (1994:39).

Although the concept of collaboration gained increasing prominence in South Africa during the 1990s, Wreford (2005) stresses that there has been a lack of progress in collaborative projects in Africa since Alma Ata. In South Africa such collaborative projects have tended to be small-scale and short term and have lacked national co-ordination (*ibid*:14,19,23). Consequently such collaborative projects have only had an impact on a small number of traditional healers, as their implementation has remained fragmented and small-scale.

During the 1990s *izinyanga* and *izangoma* were themselves increasingly experiencing a need to professionalise in order to be accepted as "more equal and effective partners" in health care delivery (Leclerc-Madlala, 2002:63).

By this time calls for professionalisation were coming from *izinyanga* as well *izangoma*. *Izangoma* were also joining traditional healers associations, although the leadership and interests of these associations continued to be dominated by *izinyanga*. The greater visibility of *izangoma* in these associations was driven partly by the AIDS crisis. *Izangoma* entered healers associations to be able to access AIDS education and training. In addition they began to incorporate such training and education into their *Impandes*. From this period onwards the push towards professionalisation was driven by both *izinyanga* and *izangoma*, although *izinyanga* continued to dominate this process.

Amongst healers in the KZN Council, calls for professionalisation were driven by concern over the lack of recognition and support for the work of THPs, particularly work around caring for AIDS patients and conducting HIV and AIDS education. The South African government's Community-Based Care (CBC) policy, which includes a focus on Home-Based Care (HBC), has been heavily criticised by social welfare and feminist scholars for the way it outsources the burden of care from state institutions onto primary care givers,[20] the majority of whom are poor black women. This policy can be equally heavily criticised for the way it outsources this burden of care onto *izinyanga* and *izangoma*, without enabling these healers to share adequately in the resources put aside for AIDS management. For example only a small proportion of healers have been trained in HIV and AIDS prevention and care, healers are disadvantaged in that they lack the most up-to-date information about AIDS, and healers do not have the same institutional networks that exist in the public sector to support them with the care of AIDS patients.

The government's CBC Policy, together with its lack of capacity in rolling out comprehensive treatment, has driven many AIDS patients to seek the assistance of traditional healers after discharge from hospital, or as an alternative to visiting hospital (Interview, 2003, Queen Ntuli, Secretary KZN Traditional Healers Council, 25 May). Patients frequently stay with a traditional healer for an initial period of their treatment so the healer has to provide food and accommodation for the patient (*ibid*). It is these healers who then assume sole responsibility for the care of such patients. Although healers generally receive fees for their treatment of patients, in a context of high levels of unemployment and poverty healers are likely to be forced to regulate their fees in order to ensure that they do not loose their clientele. This may lead healers to feel that as community-based carers, they are not adequately reimbursed for their care of AIDS patients (*ibid*). This is placing both a financial and a psychological burden on *izinyanga* and *izangoma*.

Chavunduka and Last emphasise that professionalisation can enable traditional healers to benefit from the distribution of state resources (1986:269). Amongst *izangoma* and *izinyanga* in the KZN Council access to financial support is one of the key motivations behind the drive towards professionalisation. These healers tend to frame their right to new resources and financial benefits in terms of their newly recognised status and contribution as traditional health practitioners. These THPs argue that they subsidise the state by taking on some of the costs involved in treating economically disadvantaged patients and by subsidising the training of new traditional healers (Interview, 2003, Queen Ntuli, Secretary KZN Traditional Healers Council, 25 May). The Council emphasises that access to financial support, as well as other kinds of medical resources, such as condoms and home-based care kits, will enable them to engage more effectively in health care, and in the care and treatment of HIV and AIDS patients.

The lack of unity and coordination amongst THPs: A stumbling block in the way of professionalisation

The fractured nature of traditional healers'[21] representation in KwaZulu-Natal has impacted negatively on the ability of THPs to collaborate around important health care issues. Leclerc-Madlala argues that during the 1990s the potential role traditional healers could have played in the fight against HIV and AIDS was undermined because of the general lack of organisation and communication amongst *izinyanga*'s associations in the province (2002:4).

This lack of co-ordination has also had an impact on the ability of traditional healers to drive the process of professionalisation forward. During the 1980s and 1990s the traditional healers' associations involved in lobbying for recognition tended to approach government individually and in an uncoordinated and random capacity. The National Health Department stressed that there was "a great need for the Department to be able to liaise and negotiate with a national body", representing all groups of traditional healers in South Africa, before serious discussions on the recognition of traditional healers and their role in health care delivery could begin (Muller, 1992:31). Consequently the government called on traditional healers to organise themselves better and to "foster greater cohesion amongst themselves" before it could engage in discussions (Leclerc-Madlala, 2002:63).

The Traditional Health Practitioners Act 2004

The government has assisted traditional healers in this task by laying down a legislative framework which provides for a National Interim Council of Traditional Healers to guide the process of professionalisation. In 2004 the government passed the Traditional Health Practitioners Act, which represents a fundamental step towards the formal recognition of traditional healers in South Africa. The Act was presented to parliament as the Traditional Health Practitioners Bill in 2003, before being promulgated in September 2004. The Act provides for the establishment of a "regulatory framework to ensure the efficacy, safety and quality of traditional health care services" and "for control over the registration, training and conduct" of traditional health practitioners and students"[22].

The Act will exercise these provisions through the National Interim Traditional Health Practitioners Council. The main objectives and functions of the Council are to "promote public health awareness", to "ensure the quality of health services within traditional health practice", to "protect and serve" the interests of the public and to "maintain appropriate ethical and professional standards" [23].

The Council is also tasked with a broader set of responsibilities concerned with guiding the occupation of traditional health practice. These include promoting and developing traditional health practice by encouraging research, maintaining the dignity and integrity of traditional healing, determining policy on traditional healing and advising and consulting with the Health Department and other authorities[24].

By November 2005, however, the Traditional Health Practitioners Act had not yet been implemented. Traditional healers in the various provinces had elected their own council representatives but were still waiting for the government to initiate the Interim Council (see Moodley, 2005). This lack of action on the part

of the Department of Health has, in turn, created a delay in the process of professionalisation,[25] and raises concerns about the commitment of the Department towards the recognition of the health care services of healers, and their integration into the formal health care sector.

This delay highlights the gap that currently exists between policy and implementation with regard to the Traditional Health Practitioners Act. One of the major critiques made against the Act has been the fact this legislation has not included any concrete routes through which it could be implemented (Pefile, 2005). It is probable that the lack of a concrete strategy for implementation has further contributed to this delay. It also suggests that the professionalisation of traditional healers is going to be a difficult and complex process. It is quite likely that the timeframes set out in the Act were unrealistic. The current absence of adequate capacity within both the Department and provincial healers' Councils, is another factor which is likely to have further contributed to this delay.

The commitment of government to the recognition of traditional healers is also brought into question by the fact that neither the Witchcraft Suppression Act 3 of 1957 nor the Witchcraft Suppression Amendment Act of 1970 have been repealed. It must be stressed that both the old apartheid government and the ANC state have tended to turn a blind eye towards this legislation and that these Acts have rarely been enforced, even in cases of serious crime such as murder, the tendency has been to use common law instead (pers. comm. 2006, F. de Villiers, 10 February). Nevertheless the existence of this legislation places *izangoma* in a position of institutional weakness, as their practice and livelihood remains illegal according to government legislation. This legislation will have to be addressed in the future and may become a focal point of protest and organisation for *izangoma*.

The KwaZulu-Natal Traditional Healers' Council

In response to the Traditional Health Practitioners Act several provincial Traditional Healers' Councils have been formed to assist the National Interim Council in its responsibilities. *Izinyanga* and *izangoma* in KwaZulu-Natal, aware of the movement within government to develop and draft a Bill in the late 1990s, pre-empted the Act by being the first province to form such a provincial Council in 1999 (Mkhize, 1998:9). Amongst traditional healers in the province there are a range of responses to the provincial Council. Within the Council itself there are also several differing views on how it should function and the position it should assume on important issues such as the commercialisation of traditional medicine and collaboration between healers and doctors. These responses are part of an ongoing debate among traditional healers on the issues

around professionalisation and reflect particular power dynamics between *izinyanga* and *izangoma* in the Council, and between the Council and other herbalist's associations in the province, as well as divergent ideas about the future of traditional healing practice.

The support of *izinyanga* and *izangoma* for the KZN Council stems from a belief that the Council will be able to empower them to take advantage of the new opportunities available in post apartheid South Africa. Healers view the Council as a channel through which to achieve government recognition and a voice in policy decisions (Interview, 2005, Queen Ntuli, Secretary KZN Traditional Healers Council, 25 May). Support also stems from a belief that the Council will be able to assist them in obtaining access to training, resources and other opportunities.

Opposition to the Council has emerged from the *izinyanga* leadership of other herbalist associations in the province who feel that the Council is usurping the power and legitimacy of established traditional healers' associations.

Opposition to the Council has also been expressed by some *izangoma* who emphasise that professionalisation is unsuited to the nature of their practice. Some *izangoma* believe that organising in a group is untraditional and against the wishes of the ancestors (Interview, 2003, Ernest Gwala, Public Relations Officer, eThekweni Regional Committee, KwaZulu-Natal Council, 19 February). In South Africa the individualistic and personal nature of certain aspects of practice amongst *izangoma*, where ancestors visit them in their dreams, communicating to them the correct medicines to use for each patient, make some groups of *izangoma* cautious of organising. The relatively high level of competition and secrecy associated with traditional medicinal practice in KwaZulu-Natal furthermore makes these healers weary of having too much contact with other healers (Mander, 1998:50).

These two perspectives are part of a broader debate about whether professionalisation is an appropriate institution or structure for traditional healers. In *The Professionalisation of African Medicine*, Staugard (1986) argues against professionalisation and the integration of traditional medicine into the formal health care system, emphasising that such institutional changes would damage or destroy the unique character of traditional medicine. In addition, Staugard argues against professionalisation on the basis that it will disrupt traditional healers' socio-cultural position in their communities (*ibid*: 67).

These divergent views reflect a heterogeneity, which, according to Fassin and Fassin (1988), is characteristic of traditional healers. Fassin and Fassin argue that this "extraordinary heterogeneity" has developed because of indigenous medicine's non-institutionalised background. They go on to argue, like

Staugard, that the kind of institutionalisation demanded by professionalisation is incompatible with such heterogeneity (*ibid*:354).

In contrast to Fassin and Fassin, Chavunduka and Last (1986) argue that traditional healers will be forced to professionalise in order to preserve the unique character of traditional medicine. They argue that the politics of medicine requires "a degree of professionalisation among healers of all kinds", stressing that traditional healers need to professionalise paradoxically "so that they can survive as a relatively disorganised group in an increasingly bureaucratic society" (*ibid*:269).

These divergent views create an environment of dynamism and debate within the healing community but they also reveal some of the key tensions; between powerful *izinyanga* in the Council and other healers associations, between *izinyanga* and *izangoma* within the Council and between *izinyanga* within the Council and *izangoma* outside the Council. It is these key tensions that prevent traditional healers in the province from being able to come together and agree on various issues and policies. At present the Council is struggling to manage and mediate these divergent views. This absence of management is creating conflict. One area of particular concern is the conflict between the leadership of the KZN Council and other healers associations over the role of these associations, and their relationship with the Council. Finding a way to integrate and recognise these associations is one of the most critical challenges the Council currently faces.

Centralised or decentralised authority: the struggle for legitimacy and jurisdiction between the leadership in the KZN Council and other healers' associations in KZN

The historically fissured and uncoordinated context of *izinyanga*'s associations in the province has contributed to an environment conducive to power struggles amongst associations, and between associations and the KZN Council. These tensions were brought to the fore in 1999 when the president of the KZN Council called for the disbandment of all other healers' associations in the province. After concern was raised about this decision, another meeting was convened and it was agreed that these associations should not be disbanded but should co-exist with the Council (Interview, 2003, Mquansa Edward Makhathini, researcher for the KZN Council, 29 May). The initial decision to disband the associations caused conflict and confusion amongst healers in the province and has aggravated the power struggle between the leadership of other associations and the Council, creating a platform for resistance towards the

Council (Interview, 2003, Margaret Shangase, Assistant Director: Provincial KwaZulu-Natal HIV and AIDS Action Unit, 18 June).

The decision to disband the associations reflects a tendency in the Council towards an autocratic and top-down approach to leadership, rather than a negotiable and discursive approach. Such a top-down approach disregards the authority and legitimacy of other associations, and is likely to exacerbate the power struggle between the influential *izinyanga* leadership of the Council and important *izinyanga* and their followers in other herbalist associations.

It is, in fact, essential that the Council learns to work with these associations if it is to be able to fulfil its functions as a professionalising body successfully. At present the Council lacks the capacity and grassroots institutional networks to reach it's constituency, and it's membership base is still relatively weak, representing only a fraction of healers in the province. In January 2003 the Council had 1200 members (Interview, 2003, Jerry Mhlongo, 28 January). According to the Food and Agriculture Organisation (FAO), however, in 1998 there were estimated to be between 7 600 and 15 600 traditional healers operating in KwaZulu-Natal (Mander, 1998:76). This is likely to be a significant underestimate as current calculations of the number of traditional healers in South Africa as a whole range from 200 000 to 300 000 (see Kahn, 2003 and Moodley, 2005). Because THPs currently operate in the informal economy on a part-time basis, it is extremely difficult to collate accurate numbers as their practice is generally invisible and unregulated. The Council will have to start looking at ways to address this current lack of conclusive figures in order to begin registering healers.

It will take a number of years for the Council to regain the trust of these associations, and to develop a partnership with these associations. If the Council fails to integrate and recognise the leadership of these associations, it could be an indication that the organisational structure established by the KZN Council is incompatible with the dispersed and decentralised forms of authority existent among other *izinyanga*'s associations in KwaZulu-Natal.

Public versus private knowledge: Conflict between *izinyanga* and *izangoma* over the ownership and use of Indigenous Knowledge Systems (IKS)

The leadership position of the KZN Council on the ownership and use of indigenous knowledge systems reveals another key tension between *izinyanga* and *izangoma*. The *izinyanga* dominated leadership of the Council supports the

development and commercialisation of traditional medicines provided that the Council is able to direct and control this process[26]. *Izinyanga* have a greater vested interest in research into the pharmacological properties of traditional medicines and their commercial development, both in terms of financial benefits and in terms of professional credibility.

The entrepreneurial nature of *izangoma* would also make this group interested in the financial possibilities to be gained through research and development. However as the pharmacological potency of medicines is only part of a broader healing spectrum for *izangoma*, which includes other important ritual and spiritual treatments, and because of the secretive and very individualistic nature of certain aspects of their healing practice, *izangoma* as a group are more likely to oppose the research and commercial development of traditional medicines. According to a sangoma interviewed, if traditional medicine is made into a tablet, some of the potency of the medicine is lost along the way. This is because the medicine works not only through its chemical composition but also because it is accompanied by supernatural powers from the ancestors. In order to ensure these supernatural healing powers, traditional medicines must be harvested and prepared in accordance with specific rules and rituals. This is not to assume that all *izangoma* would oppose commercialisation, it is likely that there are number who do in fact support this process. However *izangoma* as a collective group seem to have less to gain from such processes and have expressed greater concern over the implications of commercialisation on their practice. It is on this basis that this paper suggests that a key tension may emerge between this group of *izangoma*, and the *izinyanga* leadership of the Council who support commercialisation.

A study by the FAO in 1998 emphasises that there is "a large and growing local and international demand for medicinal plants", and that this demand is unlikely to decrease with a rise in levels of education and formal health care (Mander, 1998: 4). The extensive market potential for traditional medicines has expanded further with many HIV positive South Africans turning to traditional health practitioners for treatment. The most recent UNAIDS Report released in November 2005 confirms escalating levels of HIV infection in South Africa, while Statistics South Africa has reported a significant increase in adult mortality between 1997 and 2002 (see Beresford, 2005). As traditional healers are frequented by a large percentage of the population in South Africa, the increase in these statistics indicates that there is a growing market for traditional medicines.

These trends have been accompanied by an increasing concern amongst traditional healers in the Council around scientists and pharmaceutical companies 'exploiting' and 'plundering' traditional medicines and traditional healers' knowledge of how to mix and use these medicines (Interview, 2003,

Ernest Gwala, 19 May). There are several homeopathic treatments containing the African potato on the South African market at present. These products are manufactured by local companies and sold in health shops and on the Internet. Prices range from R25 for to R576 for capsule and tincture products[27].

The *izinyanga* leadership of the Council view professionalisation as a way to protect, and to assert rights over, indigenous knowledge. Pharmacological research, however, is an area where traditional healers are considerably disadvantaged by the unequal power relationship between traditional healing and Western biomedicine. The traditional healing community lacks the resources, institutions and technologies to develop and protect IKS. A survey conducted by the FAO in 1998 on the medicinal trade in KwaZulu-Natal confirms that there is an "an imbalance in support for indigenous medicine" with research and development into traditional medicines "directed at bio-prospecting and pharmacological investigations", and that very little effort has been made to develop "the current markets, their associated products, infrastructure and market players" (Mander,1998:4).

The KZN Council leadership believes that the most effective way to protect traditional medicine from exploitation is through giving the Interim National Council exclusive rights to register and patent traditional medicines (Interview, 2003, Ernest Gwala, 19 May). Currently the Council lacks the capacity and financial resources to undertake the necessary research on traditional medicines to be able to apply for patents. This is an area where an equal partnership between the Council and various formal research institutes could benefit traditional healers considerably. Chavunduka and Last emphasise that professionalisation can benefit traditional healers by giving them greater institutional recognition, and by placing healers in a stronger position to fight for entry into medical institutions and to participate in the funding, teaching and research taking place in these institutions (1986:268).

At present there are several developing partnerships between healers and other institutions in South Africa. In 2003 the Department of Health launched the National Reference Centre for African Traditional Medicines. The Centre will work towards establishing a network of experts and facilities, and will build up a database of information on traditional remedies, encouraging the public to bring medicines for testing (Hahn, 2003). The DOH has also given the Medical Research Council of South Africa a grant of several million Rand to test traditional medicines[28]. In 2005 a collaborative project between the US Department of Health, the KwaZulu-Natal Traditional Healers Council and the Universities of KwaZulu-Natal, Western Cape and Cape Town was launched to test the healing properties of indigenous South African plants (Horner, 2005).

However as Wreford emphasises, because such projects focus on research into the biomedical properties of traditional medicine they are likely to favour the

work of *izinyanga* over *izangoma* (2005:35). By incorporating traditional medicines into their research institutions, the state endows traditional healing practice with a legitimacy and power that it did not have before. Such developments are beginning to allow *izinyanga* to enter into and participate in the knowledge making around traditional medicines taking place in these institutions. However the current focus on the pharmacological components of traditional medicines contributes to the continued exclusion of *izangoma* from these knowledge making structures. If research and development into traditional medicines continues to be promoted by *izinyanga* in the Council as a necessary part of the process of professionalisation, while *izangoma* both inside or outside the Council continue to remain excluded from this knowledge making process, or continue to view such processes as a threat to appropriate and authentic healing practice, this could create a rift preventing healers in the Council, and more broadly in the province, from being able to work together towards a common vision of professionalism.

The registering and patenting traditional medicines also raises several other complex questions. Firstly, does this knowledge belong to healers exclusively or rather to the broader communities in which this knowledge is maintained? Following on from this, how are the profits from the commercial use of traditional knowledge to be distributed? A community trust would be one option as a suitable form of distribution, but again such a system would not be able to encompass communities in their entirety. Although this paper is unable to address these questions in detail, it is important that they are raised, as they constitute part of the broader debate around professionalisation.

The processing of traditional medicines: the differing perspectives of muthi traders and izangoma

Izangoma's general opposition to any form of commercialisation or processing of traditional medicine also positions this group in opposition to a significant constituent of *muthi* traders at the Durban *muthi* market who support the processing of traditional medicines. Support for the processing of *muthi* among traders is evident in the establishment of a small *muthi* processing business, *Isinthu imithi yesizulu*[29], at the Durban market. *Isinthu imithi yesizulu* reveals a more flexible and market orientated approach to trade in traditional medicines and traditional medicinal practice. These traders established *Isinthu* because they wanted to change the appearance and presentation of *muthi*. Unprocessed *muthi* is exposed to the elements at healers' stalls, expiring easily and causing wastage of stock and a loss of revenue. The partners also felt that processed *muthi* would be more acceptable and convenient for a younger generation of patients (Interview, 2003, Ms Ngcobo, Sangoma and *Isinthu imithi yesizulu* business

partner, 13 February). For those situated at the lower end of the value chain in the *muthi* trade, processing offers an important means of increasing the economic value of their goods. When I asked one of the traders whether she thought the processing of medicines was unAfrican she responded that times are changing and that ultimately it is important for people to be able to adapt (Interview, 2003, Ms Ngcobo, 13 February).

These debates around the processing of *muthi* reveal the divergent concerns of *izangoma*, who are opposed to commercialisation, and *muthi* traders who support this initiative. *Muthi* traders are more likely to support processing because it offers them new economic opportunities. Their livelihoods require them to be flexible, innovative and increasingly open to change, as their economic position is more precarious than that of well-established *izangoma*. In contrast *izangoma* who are opposed to collaboration are concerned with maintaining control and 'authenticity' over the context in which healing therapies are administered. *Muthi* traders are not doubt an economic threat to both established *izinyanga* and *izangoma*, however this economic threat tends to be couched in terms of fear of over 'corruption' of 'authentic' practice for *izangoma*.

A clash of paradigms: Tension between *izinyanga* and *izangoma* over developing a framework for examining Indigenous Knowledge Systems

Tension between *izangoma* and *izinyanga* is also evident in other areas concerned with the use and control of indigenous knowledge, such as the establishment of a formal training programme and qualifications for traditional healers.[30] According to the KZN Council's constitution, only duly qualified *izinyanga*, *izangoma* and *abathandazi* are permitted to become members of the Council. The Council's constitution defines a duly qualified inyanga as having undergone no less than five years training under a qualified inyanga, and a sangoma as having undergone no less than one year of training under a qualified sangoma. The Council's constitution also requires applicants to undergo a written or partially written examination[31].

These regulations will, however, disadvantage illiterate and informally trained *muthi* traders and traditional healers. Firstly, there are many traders operating at the *muthi* market in Durban city do not have formal training as traditional healers, although most have a wealth of informal knowledge and training. Secondly, even if these traders were formally trained they would still face the obstacle of a written exam. A survey conducted in 1995 by the City Health

Department revealed that 36 percent of traders in the informal market area were illiterate (Mkhize, 1998:4). If no provision is made for oral examinations, illiterate healers and traders will be impeded from registering with the Council. As most *muthi* traders at the market are women, and as women generally have higher levels of illiteracy and lower levels of education, it is women traders and also women traditional healers, who will be disproportionately effected.

Deciding on a standardised syllabus and set of qualifications could become another issue of contestation and disagreement within the Council, leading to *izangoma* feeling misrepresented or marginalised. In the concluding chapter of their book, Chavunuka and Last warn against the pattern of professionalisation that has happened in many of the African countries documented in their work, in which 'technical herbal expertise' has tended to dominate over other forms of indigenous knowledge:

> there is an inherent danger that traditional medical knowledge will be defined simply in terms of its technical herbal expertise, that this expertise will in turn be recognised only for its empirical pharmacognosy, without reference to the symbolic and ritual matrix within which it is used-still less, the social matrix in which those rituals and symbols have meaning at any particular time or place (1986:267).

Chavunduka and Last stress that one of the characteristics of professional traditional healer associations in Africa is the tendency for these associations to be "more strictly herbalist in background", with founders or leaders who tend to be herbalist (1986: 262-3). This pattern of organisation seems to be repeated within the KwaZulu-Natal Traditional Healers Council where male *izinyanga* constitute the majority of the Council's top leadership. In fact both the President and Deputy President of the Council have come from prominent leadership positions in the Inyangas' National Association. Because there appears to be a gender division amongst healers in South Africa, with men being more inclined to become herbalists (*izinyanga*) while women dominate as diviners (*izangoma*), the predominance of *izinyanga* in the Council leadership raises concerns about male dominated leadership within this institution, and holds potential ramifications for *izangoma* who are generally female and form the majority of the Council's membership.

Analysing his research on healers associations in Africa, Green also notes that regional or national association presidents tend to be men, and that one of the common complaints made against these associations by women is the fact that they feel they are bossed around and denied the respect they deserve (1996:46). The dominance of *izinyanga* in the Council's leadership also raises concerns about the outcome of the Councils framework for testing and qualification. If the predominantly *izinyanga* leadership is directing and controlling the

development of this set of qualifications, there is likely to be a bias towards an alignment with biomedical practice.

Historically, the organisation of traditional healers in KwaZulu-Natal suggests a pattern of discrimination against *izangoma*, the majority of whom tend to be women. This can be traced back to the implementation of the Natal Native Code (1891), that allowed for the licensing of a limited number of *izinyanga*, but outlawed *izangoma* completely. The Natal Native Medical Association reinforced this discriminatory division by constructing an identity for male *izinyanga* as health professionals in opposition to *izangoma* who were represented as 'witchdoctors'. More recently this pattern is also evident in the province's official recognition of the Inyangas' National Association in the 1980s.

Yet there is also evidence that the Council is simultaneously challenging entrenched patterns of discrimination between *izinyanga* and *izangoma* in the Council, and between the informal practice of *muthi* traders and more formally established *izinyanga* and *izangoma*. Despite the fact that *izangoma* are not equally represented in the KZN Council leadership, they have made important progress in gaining some representation in leadership positions. In 2003 twenty percent of the Council's executive leadership consisted of female *izangoma*. Women were also represented on the Council's regional structures in the province. Though the representation of women does not automatically guarantee the development and protection of their interests, it does increase the opportunities for greater gender equality.

The Council's decision to adopt a more flexible and inclusive examination and qualification structure is another example of how the Council is attempting to accommodate both the informal oral knowledge of *muthi* traders and the community and kinship legitimacy of *izangoma*. Although the KZN Council's constitution states that traditional healers will have to undergo a written or partially written examination, the Council has decided that it will test healers orally as an alternative to a written exam (Interview, 2003, Margaret Shangase, 18 June). This will be a significant benefit for *muthi* traders and traditional healers who are illiterate. In addition, the Council has decided on a community and trainer review system for *izangoma*. What this means is that an initiate's trainer will decide when a healer is ready to qualify and confer legitimacy. In order for a healer to qualify that healer will also have to be known in their community have some kind of reputation and interaction with local residents. Although such a method presents other difficulties, for example how does one establish the qualifications and legitimacy of trainers, it shows that the Council is able to think beyond the boundaries of rational legal frameworks of legitimacy, to include a more flexible and less exclusive approach in order to successfully bring the traditional healing community in the province together.

Furthermore because women in the traditional healing community historically tend to have lower levels of formal training and literacy, and because *izangoma* are generally female, these changes can be seen to directly benefit women.

Negotiating the terms of collaboration: The Council's relationship with the government and the Department of Health

Although the formal health care system in South Africa is increasingly coming to realise that traditional healers have an important role to play in health care provision, that role is still being debated and contested. Traditional healers engaging in these debates are concerned that the unequal relationship between traditional healing and biomedicine will subordinate them to Western medicine. One of the key questions for healers is how they can use professionalisation to engage in health care as equal partners with doctors. For doctors and medical staff the question of whether traditional healers offer care of adequate quality, and the question of how efficacious traditional healing practices and treatments are, remain key concerns (Freeman, 1992:2).

According to the KwaZulu-Natal Provincial Deputy Director of the Traditional Healers Portfolio, both the Provincial and National Departments of Health accept and support traditional healers as partners who work at grassroots level. They emphasise that if they are able to empower traditional healers, that they will be able to draw on them as partners in health education and service provision (Interview, 2003, Margaret Shangase, 18 June). But this developing partnership has also created new sources of tension and disagreement, mainly around the way the Department and healers themselves understand their role in health care services. The question of whether the formal health system should refer patients to traditional healers is one of these areas of potential conflict.

Although the Department supports a system of collaboration on Primary Health Care and HIV and AIDS prevention and education, at present the Department does not support referrals from the formal health system to traditional healers[32], principally because of a lack of research and regulation around the dosage and efficacy of traditional treatments (Interview, 2003, Margaret Shangase, 18 June).

The KZN Council leadership, however, would like a mutual referral system to be established between traditional healers and doctors (*ibid*). The work of Ngubane emphasises the complementary perspective of African healers who accept "Western-type agencies of cure as additional to their own" or even as "alternative in certain instances" (1981:362). Traditional healers' complementary perspective on treatment helps us to understand why some healers view a mutual referral system as something that can benefit and enrich

Western medicine as well as African healing practice. Equally importantly, these healers view the establishment of such a system as part of a broader set of demands for formal recognition, contact, and exchange of resources,[33] between healers and the formal health care system.

Traditional healers in the Council who support collaboration understand their role and responsibility as being distinct from that of Western doctors. They acknowledge that the Western health system is better equipped to treat and cure certain diseases but emphasise that THPs have a number of advantages over biomedicine. These healers stressed that the in-depth and personal relationship between practitioner and patient enabled them to give a better quality of care in terms of patient doctor relationships and enabled them to play a very important role in counselling patients. In addition they felt that healers could play an important role in increasing the life span and health of HIV positive patients by using traditional immune boosting treatments and by educating the patient to eat traditional foods high in nutritional value. (Interview, 2003, Ernest Gwala, 19 May).

At present there are a number of important barriers obstructing doctors from feeling equipped to refer patients to traditional healers. These obstacles stem from the largely informal and unregulated way in which traditional healers currently operate[34]. Traditional healers' position within the politics of HIV and AIDS treatment, particularly the use of anti-retrovirals, has further increased doctors' concern and opposition to referrals and collaboration with this sector. Some traditional healers have come out in support of the government's initial resistance towards anti-retrovirals, ostensibly on the basis of concerns around toxicity, and the government's emphasis on the use of traditional immune boosters, such as the African potato and nutritional supplements, as effective alternative treatments[35]. This stance has placed the traditional healing community, together with the National Minister of Health, in conflict with the biomedical fraternity. This could have serious long-term implications for building trust and a sense of common purpose between doctors and traditional healers.

The successful implementation of the Traditional Health Practitioners Act could play a pivotal role in enabling a mutual referral system to be established between the two sectors. The Act will make it possible to draw up a list of registered and properly qualified traditional healers[36] for every region or district in the country. This could serve as a guideline for doctors and clinic staff when a patient needs to be referred. By providing for the establishment of a body to regulate the efficacy, safety and quality of traditional health care services, the Act also offers the possibility of some kind of control over the standards and quality of traditional healing. This will open up new possibilities for the establishment of a mutual referral system over a long-term period. However if

the framework for qualification focuses mainly on biomedical elements it is likely to benefit *izinyanga* over *izangoma*. Even if legitimacy is also conferred though kinship and community, it is uncertain whether biomedical practitioners would recognise such forms of legitimacy and be prepared to establish a referral system on such a basis.

In addition the current delay in the implementation of the Act has negative implications for such a positive outcome. The government will need to show real political will, leadership and commitment in order to ensure the effective implementation of the Act. This commitment will have to be reinforced with resources and institutional support. Even if the regulatory structures set out in the Traditional Health Practitioners Act are effectively implemented, this will take a number of years. In the short- and medium-term a gap will continue to exist in the active structures required to monitor and ensure good practice and standards within traditional healing.

The question of reciprocity and common understanding: Izangoma who oppose collaboration

Although Green's work has shown the general willingness of both *izinyanga izangoma* to collaborate in AIDS training and education programmes there remains a constituent of healers who continue to oppose collaboration. Arguments against collaboration tend to be stronger for *izangoma* whose system of healing is more removed from that biomedicine. This could lead to the development of another key tension, where *izinyanga* and *izangoma* in the Council are united together in support of collaboration against *izangoma* both within and beyond the Council who oppose collaboration.

Among such *izangoma* there are also concerns that collaboration between the two systems will create an unequal relationship that will subordinate traditional healing to biomedicine. Staugard argues that professionalisation and collaboration could lead to the risk of "imposing some of the analytical, biomedical concepts of modern medicine" onto traditional healers (1986:68).

Wreford has stressed that where collaborative programmes exist that they are educative and unidirectional, and that they are defined by the absence of a reciprocal relationship of exchange were medical staff are able and willing to learn about the healing principles of *izangoma* (Wreford, 2005: 22). MacCormack emphasises furthermore that the professionalisation of traditional medicine, which is often called for as a requirement for collaborative programmes, also runs the risk of subordinating traditional healers as 'junior partners' to the medical profession (in Wreford, 2005:16).

This reflects the fact that doctors continue to hold a position of undisputed authority within state health care structures and consequently a monopoly over defining appropriate healing practice. Although sectors of the biomedical profession may be prepared to engage with healers through collaboration, that they continue to dominate the shaping of knowledge in this collaborative relationship, with a distinct bias towards focusing on biomedical and pharmacological paradigms.

In addition, there are some traditional healers in the Council, both *izinyanga* and *izangoma*, who support Chavunduka and Last's argument that professionalisation through a statutory body can give the government too much control over the activities of traditional healers through laws and regulations (1992:13). These traditional healers want the Council to stand as an independent body and to have the authority to be able to make its own decisions (Interview, Margaret Shangase, 18 June).

Although the relationship between the Department of Health and traditional healers has changed, it is still an unequal relationship and the balance of power is in favour of the Department. The Department of Health continues to maintain control over defining the relationship between itself and traditional healers, as well as the terms of collaboration between the two sectors. This is clearly illustrated by the fact that the Traditional Health Practitioners Act places the Interim Council, as well as the Provincial Councils under the jurisdiction of the Department of Health. In addition the Act gives the National Minister of Health the discretion to choose all seats on the National Interim Council of Traditional Healers, including that of the chairperson[37].

The Traditional Health Practitioners Act and the possibilities for collaboration that it offers not only create a potential tension between healers in support of collaboration and a constituent of mainly *izangoma* opposed to collaboration, they could also position healers in the KZN Council in general against the government in a struggle for autonomy and control over decision-making around traditional healers, their practice, and the terms of their recognition by government.

Concluding remarks

The diverging responses and tensions of THPs as they engage and negotiate with professionalisation reflect a broader process unfolding in South Africa, which has come to be known as the 'African Renaissance'. At the heart of the African Renaissance is the endeavour to reassert the value of indigenous traditions, histories and philosophies, and to draw on elements within these, to find solutions to contemporary problems and to renegotiate South Africa's identity and future in a global context.

The African Renaissance offers an alternative view of Africa's future, which envisions positive change. The immense potential that the professionalisation of traditional healers holds to contribute significantly towards healthcare is part of this positive vision. But the new identity that the African Renaissance offers is very much still in the making; it is an identity that is currently being negotiated and contested. The tensions and divergent responses of the traditional healing community towards professionalisation can be interpreted as part of this larger dialogue around constructing a new South African, and African identity. These diverse and evolving responses reflect the historically dynamic and resilient nature of traditional healing in this country, yet they are also highly problematic, as they can lead to conflict and contribute to a lack of cohesion within the traditional healing community.

These conflicts have coalesced around several key tensions between different constituents of healers and are driven by conflicting interests within these different groups of healers. The first key tension at a provincial level is between the powerful male *izinyanga* leadership of the KZN Council and the *izinyanga* leadership of other prominent healers associations in the province. This tension over organisational authority has limited the Council's reach over traditional healers in the province. By refusing to acknowledge the legitimacy of other associations, the Council's autocratic approach has prevented it from being able to tap into the capacity and institutional structures of these organisations, a valuable institutional network which it will need in order to be able to organise and regulate healers effectively. Equally importantly, a continuing lack of co-ordination between traditional healers' associations, as Green (1994, 1996), Leclerc-Madlala (2002) and Chavunduka and Last (1986) have shown, impacts negatively on the ability of THPs to be effectively involved in collaboration with the health care system.

The second key tension that exists is between healers who support the current processes of professionalisation and collaboration pushed forward by the KZN Council, and those that oppose these processes arguing that they are destructive and disruptive to 'authentic' healing practices. This second tension tends to position the leadership of the KZN Council against certain constituents of *izangoma* both inside and outside the Council, and is played out over the debate around the use and control of indigenous knowledge systems as well as the question of collaboration with the formal health care system. A third key tension within the Council exists between *izinyanga* and *izangoma* over leadership and the strategic direction of the Council. This tension is not always present but tends to emerge when female members feel that issues concerning them are not adequately addressed, or when they feel excluded from decision making processes. This tension also seems to play itself out over the debate around the use and control of indigenous knowledge systems as well as the question of collaboration with the formal health care system.

Professionalisation calls for a high degree of co-ordination and cohesion amongst traditional healers in order to establish standards and regulations for practice and to represent and promote their interests. The challenge is to find ways to accommodate and mediate these diverse constituents within a professional framework.

If the KZN Council is unable to bring into accord these different constituents, and the diverging viewpoints and interests they hold, it could be an indication, as Fassin and Fassin (1988) and Staugard (1986) have argued, that professionalisation is incompatible with the heterogeneous character of traditional healing. The historically adaptable nature of the traditional healing community and the success the Council has had so far in accommodating and mediating different groups, however, is a positive indication that the Council may well be able to negotiate this process of professionalisation successfully.

The Council, which brings together a diverse range of traditional health practitioners with a large range and level of skills, has shown innovation in developing a more flexible approach to testing and qualifying THPs to accommodate this diverse constituency. This is seen in the Council's suggestion of a kinship and community framework to qualify *izangoma* and its use of oral examinations. In addition, the inclusion of women in the Council's leadership structures, even though they are not represented equally with men, is a positive indication of the potential for a gender sensitive change in the Council's leadership.

Yet, in order for professionalisation to have a positive impact on health care provision, as well as the enhancement and development of traditional healing practice, the commitment of traditional healers will have to be met equally by real commitment and political will from the state and the biomedical fraternity, who will also have to be prepared to accommodate greater diversity of healing practices in South Africa.

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Notes

[1] In 1997 the Portfolio Committee on Health recommended the legal recognition of traditional healers as a health resource. In February 1998 hearings were conducted for national stakeholders on this matter and a year later, in

June 1999, a traditional healers stakeholders workshop was held where traditional healers from all the nine provinces were represented (Portfolio Committee on Arts, Culture, Science and Technology, 2001).

[2] Mbeki's conception of an African Renaissance is discussed in more detail in chapter five by Vale and Maseko (2002).

[3] The rationale for the government's recognition of THPs is expressed clearly in a speech by the Minister of Health during the signing of a memorandum of understanding between THPs in Kwazulu-Natal and the Nelson R Mandela School of Medicine in October 2003. In this speech, the Minster emphasised that 'Traditional medicine has sustained the health of millions of Africans over hundreds of years' and that ' part of our emancipation as Africans', requires the need to begin to 'recognise traditional medicine as critical in improving the health of our people.' She also stressed that traditional medicines are widely available and that up to '80% of our people in the south use traditional or complementary medicine as part of primary health care.'

[4] *Muthi* or *Imithi* refers to the medicinal plants and animal parts used in traditional healing such as herbs, bark, bulbs, fat of animals and other animal body parts.

[5] All the above types of healers clearly disassociate themselves from what they refer to as '*charlatans'* and '*abathakathi'* (witchdoctors who prepare medicines to produce destructive and harmful results) (Xaba, 2002:24).

[6] In the 1990s the research of Green (1994), which emphasised that traditional healers could play a major role in HIV prevention because of their efficacy in treating STIs, was instrumental in highlighting the preventative role of traditional healers in HIV management, and encouraged support for collaboration between the two sectors.

[7] The lack of adequate health care services in South Africa is emphasised by Magasela (2006:46) in the 2005-2006 *State of the Nation* publication.

[8] Barnett and Whiteside emphasise that the additional demand created by AIDS patients on the public health sector will reduce the resources available for other health care needs (2002: 308).

[9] The KwaZulu-Natal Traditional Healers Council, also referred to in this paper as the KZN Council, is one of the official provincial bodies formed in response to the Traditional Health Practitioners Act to represent traditional healers in the province.

[10] The number and proportion of women students entering medical schools in the United Kingdom has risen significantly in the final decades of the twentieth century. In 1970, 27 percent of new students entering medical schools were female. In 1980 this figure had risen to 38 percent and by 1989 it had increased again to 49 percent. The proportion of active female practitioners increased as well, although less significantly, from just under one-fifth in 1970 to more than one quarter in 1990 (Elston, 1993:27). Female doctors in the United States have also made important gains. By the early 1990s they constituted a substantial minority of about 30 percent of all active physicians. A similar increase has been found in other western countries (Lorber, 1993: 62).

[11] The mutual curiosity and interaction that had marked the early years of colonial contact between African healers and settlers in Southern Africa gave way to growing hostility in the second half of the nineteenth century as African healers increasingly began to be perceived as a political threat to the colonial government. (Gordon, 2003:42 and Andrews and Sutphen, 2003:7). This resulted in the introduction of legislation outlawing traditional healing practice in the colony of Natal in the 1860s (Flint, 2001). Similar legislation was introduced in other British colonies as well. This political threat however was couched cultural metaphor. The representation of traditional medicine as 'superstition' and 'ignorance' was part of a colonial discourse that positioned Africa as the 'dark continent', a place of 'savagery', 'superstition' and 'ignorance', in complementary opposition with Britain, a nation of 'rationality' and 'civilization' (Comaroff and Comaroff, 1991:88). This discourse was used to justify colonial authority, and has been noted in other British colonies also (Turshen, 1984: 62).

[12] The active resistance and engagement of subjects against colonial domination is emphasised by a number of historical writers. In his book *Citizen and Subject* (1996), Mamdani explores the way in which colonial subjects have subverted some of the ideological tools of colonial oppression, such as ethnicity, turning them into weapons of resistance against colonial domination. Flint's thesis on African healers in South-Eastern Africa (2001), focuses on the shared authority between chiefs and healers in South-eastern Africa and shows how both these groups have actively engaged and challenged the restrictions placed on their authority through colonial rule.

[13] In her doctoral thesis, Flint argues that the competition that developed between the biomedical community and African healers in the early part of the twentieth century played an important role in the development of African ideas of medical authority and contributed to the professionalisation of both African and Western medical practitioners (2001: 167).

[14] Dauskardt's research on the history of the traditional medicine trade as part of the informal economy illustrates how the growth of commercialism and competition in Johannesburg's traditional medicinal industry, together with restrictive legislation during the first half of the twentieth century, led to the restructuring of this industry (1990: 94). Similar restructuring occurred in the Durban traditional medicinal industry during this same period, resulting in the development of a commercial trade in muthi (Flint, 2001:207).

[15] During the same period Durban chemists also successfully lobbied for legislation outlawing the use of European medicines and the use of the European title of doctor or chemist by licensed izinyanga. In addition, legislation was passed restricting the advertising of black medicines (Flint, 2001:216; Nesvåg, 1999:87).

[16] Despite the fact that the Association was unsuccessful in it's attempts to change discriminatory legislation, Nesvåg notes that it did manage to lobby "authorities at all levels in Durban, Pietermaritzburg and Cape Town" and that its "efficiency and professionalism" must have impressed a number of authorities within government (1999:88).

[17] In his work on indigenous healers and the African state Green identifies Impandes as a form of organisation specific to izangoma in South Africa (1996:56). Through their research on healer's organisations in Africa, Chavunduka and Last have found that modern forms of traditional healer associations based on western models, tend to be dominated by herbalists or izinyanga (1986:262-3). The top leadership of the KZN Traditional Healers Council, consisting mainly izinyanga, seems to confirm this gendered pattern of organisation in South Africa. In fact both the president and deputy president of the KZN Council held leadership positions in the Inyangas' National Association, the only healers association recognised by the provincial government in the 1980s.This is not to say that izangoma do not join these associations but rather that the leadership and interests of these associations tend to be driven by izinyanga.

[18] Cunningham's research on the traditional medicinal trade in KwaZulu-Natal argues that legislation aimed at preventing the exploitation and sale of indigenous plant species, the hawking of traditional medicines and the practising of unlicensed herbalists, has failed to prevent the exploitation of traditional medicinal plants. Cunningham recommends instead the professionalisation of traditional practitioners as a way of controlling the exploitation and wastage of plant species and of standardising and regulating the toxicity and dosage of traditional medicines (1988: 85, 72). In 1998 the Food and Agriculture Organisation released a report on the "Marketing of Indigenous Medicinal Plants in South Africa", which explored the commercial development of muthi as a way of combating the exploitation of wild medicinal plants. Focusing on the Durban muthi market as a case study, the report concludes that the muthi market is at present under-developed and that development will only be possible if traditional healers move towards professionalisation through developing a common vision to lobby for government support (Mander, 1998: 100, 102). The FAO report contributed to a significant shift in the Durban municipality's understanding of the muthi trade, from a management and health problem to an asset and an important tool of economic development.

[19] Green focuses on the associations of both izinyanga and izangoma, interestingly he supports working with the organic structures of Impandes in favour of some western- modelled organisations of healers (1996:59).

[20] Barnett and Whiteside stress that one of the challenges regarding AIDS management is to ensure that the burden is managed within the public health sector, 'without shifting an unsustainable burden on to individuals, families and communities' (2002:308). Uys and Cameron emphasise that home based care is an emotionally and physically demanding job and that community care workers are likely to experience burnout unless they are given adequate support (2003: 9,28). A similar trend in which the burden of care is shifted onto voluntary care workers has also been identified in the context of the United Kingdom. Bennet and Ferlie stress that if effective collaboration does not exist between agencies in the context of inter-organisational networks of care for AIDS patients that this can lead to cost shunting with different agencies trying to off load responsibilities onto each other (1994: 116-117).

[21] By the 1990s both izangoma and izinyanga were represented in healers associations, although izinyanga continued to dominate the drive towards professionalisation. The term traditional healer therefore refers from now onwards to both izinyanga and izangoma.

[22] Traditional Health Practitioners Act, 2004, Preface.

[23] Traditional Health Practitioners Act, 2004, Chapter II Clause 5.

[24] Traditional Health Practitioners Act, 2004, Chapter II Clause 5.

[25] Jerry Mhlongo, President of the KZN Traditional Healers Council, and the Traditional Healers Association of SA, reported that traditional healers in the various provinces were struggling without the support of the government to collate statistics on the number of traditional healers, to enable successful registration. It has also been predicted that the lack of implementation will lead to a delay in incorporating traditional healers into medical aid benefit schemes (Moodley, 2005).

[26] However, the Council is not currently working towards securing intellectual property rights, as its attention has been focused on more grassroots needs such as establishing the organisation, building capacity and securing funding.

[27] African potato products available in Health shops include African Potato capsules and liquid manufactured by Conjan Pty Ltd, and Africa's Solution Forte liquid manufactured by Bermins. The following companies sell African potato products on the internet: The health shop, found at http://www.the-health-shop.net/house-of-health/products/african-potato-plus.html, the Guardian Angel Herbal and Natural Products, http://www.cure.co.za/hypoxis.htm, and Health Bells located at http://www.healthsbells.co.za/AFPotProducts.htm.

[28] International scientists support traditional medicines. 14 January 2005, http://www.doh.gov.za/

[29] *Isinthu imithi yesizulu* was started in 2002 by six muthi traders operating from the Durban muthi market with assistance from the Institute of Natural Resources.

[30] Chavunduka and Last emphasise that one of the greatest challenges facing the professionalisation of traditional healers will lie in deciding on the particular content of a formal training programme and qualifications for THPs (1986: 267).

[31] The Constitution of the KZN Traditional Healers Council, 2001, Chapter 3, Clauses 1-3 and Clause 1, Chapter 7.

[32] The Department stresses that it is up to the patient to decide whether they wish to consult a traditional healer after their treatment in the formal health system

[33] The THPs within the KZN Council emphasised that they wanted to access resources particularly those needed for AIDS education and home based care, such as condoms, gloves, plastic bed sheets and cream for bedsores (Interview: Queen Ntuli, 25-05-2003).

[34] The lack of scientific testing regarding the efficacy of traditional medicines and healing practices is the primary cause of concern for doctors. This is compounded by the fact that certain traditional treatments can undermine the effectiveness of ARV treatment if the two therapies are combined.

[35] This conflict is highlighted by the Traditional Healers' Organisation's (THO) recent public support for Dr Matthias Rath, a controversial AIDS dissident, in a dispute with the Treatment Action Campaign (Smetherham, 2004). Rath has been aggressively campaigning against the government's anti-retroviral treatment programme in townships in Cape Town, warning that anti-retrovirals are toxic and encouraging patients to take up his vitamin regiment instead. (Thom and Minyi, 2005) Doctors have for some time now been calling on the government to take action against the Rath Health Foundation. In September 2005, 199 health Professionals in the Western Cape sent a "strongly worded letter" to the MEC for health, requesting the Department to take action against Rath. (Thom, 2005).

[36] Healers will be considered properly qualified once they have registered with the National Traditional Healers Council and passed the exam or requirements established by the Council. The contents of the exam or requirements are still in the process of being formulated.

[37] The Traditional Health Practitioners Act. 2004, Chapter 2, Clause 8.