


Fall 2018

Exploring the Space Between Healers: A Narrative Approach to Understanding the Relationship Between Traditional Healers and Biomedical Practitioners in Kwazulu-natal

Marisa DelSignore
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EXPLORING THE SPACE BETWEEN HEALERS

EXPLORING THE SPACE BETWEEN HEALERS: A NARRATIVE APPROACH TO UNDERSTANDING THE RELATIONSHIP BETWEEN TRADITIONAL HEALERS AND BIOMEDICAL PRACTITIONERS IN KWAZULU-NATAL

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School for International Training

Fall 2018: Community Health and Social Policy

Acknowledgements

Foremost, I would like to thank my family in America for supporting my anthropology major and for giving me this opportunity to study in South Africa. It has made a world of difference in my academic interests.

Second, I would like to thank Zed, Clive, Thula, and Hlobi for all of their time, concern, mentorship, and seemingly endless patience. That take the time to get to know us on a personal level and seriously consider students' input has made this study abroad experience that much more enjoyable. They deserve every ounce of praise for all of the work that must occur behind-the-scenes to make this program as enriching, experiential, educational, and safe as possible.

Third, I would like to thank my two new families in Cato Manor and Nzinga for opening up their homes, hearts, and kitchens to me. This has been a trip of "firsts"—first time I've had little brothers, first time I milked a cow, and first (and probably last) time I cooked *phuthu* successfully under my mama's supervision. I could not be more grateful for these experiences and for the endless supply of warmth, humor, and motherly concern that seemed to exude from both my homestay mama and Mama Zuma. I would especially like to thank my little brother, Kitty Nana, for his unlimited enthusiasm in trying to teach me South African dance moves evening after evening.

Finally, I would like to thank Dr. Nceba Gqaleni, not only for his guidance on this research project and his profound knowledge on the subject, but also for his continued efforts to uplift traditional medicine through his work with the Interim Traditional Health Practitioners Council. He has been a role model for me throughout this whole process, and I couldn't be more grateful for his direction.

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Abstract

Despite playing essential and parallel roles in the lives of patients, there exists a frictional, imbalanced relationship between traditional healers and Western doctors in South Africa. While national policy encourages a seamless system rooted in both Western science and indigenous knowledge, biomedical institutions are hesitant to accept traditional medical practices, which are based on less tangible and more spiritually-oriented elements. This research project turns to these two ideologically different entities to assess their perspectives on the roles of themselves and the other within the context of the South African health system.

Responses from semi-structured interviews with seven health practitioners from KwaZulu-Natal – izangoma and doctors—were the primary sources used for the knowledge acquisition process. Given that I was the lens through which these participant stories were told, my own narrative and perspectives on the subject were interwoven throughout this report.

Participant narratives suggest that there is no consensus within either biomedical or traditional health domains about perceptions of the other, save for the agreement that the South African health system is disconnected with both modalities working in parallel. However, there are five overarching points of engagement throughout the practitioner-patient healing process through which the modalities directly or indirectly interact with one another and form cross-disciplinary opinions. These serve as points of discussion in this report. Elements keeping the domains separated include miscommunication, suspicion, and adherence to cultural paradigms. However, doctors and traditional healers alike expressed varying degrees of interest in facilitating a working relationship, since the South African public healthcare system relies extensively on both domains of healing. These findings have reinforced my personal sentiments about the importance of medical pluralism in systems operating under two distinct healing paradigms.

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Introduction

Coming from America where Western biomedicine is the only prevailing ideology, I hadn't—until beginning anthropology studies at University—questioned my assumptions about the legitimacy and absolutism of biology as the only explanatory model of disease. There was only ever one type of healing system available; I was never challenged to critically consider the parameters that define healing, curing, and wellness in the biomedical paradigm. Left out of our education is what might have been the cost of propelling biomedicine into the dominant doctrine of health, largely because any form of holistic health and wellness in the US that might have countered this ideology has been long since subverted from the public. The motivations underlying this research stem from my curiosity about the interactions that must occur between simultaneously-held, conflicting belief systems in a context where there are two prevailing domains of healing.

Even though I believed I was academically prepared to understand a health system defined by medical pluralism (most of my Anthropology classes include at least one unit about Paul Farmer, culture-bound syndromes, and cultural relativism), I still noticed my own surprise every time any time one of my the guest lecturers on my study abroad program in South Africa—most being respected Ph.D.'s—would speak openly about *izangoma* (Zulu diviners; the term has also been spelled as “sangomas”). These exposures have tuned me into my personal explanatory model of medicine and disease. Explanatory models of health are the ideologies by which people understand their bodies, sources of illness, and healing. They are uniquely constructed by the dominant ideologies—both explicit and latent—working in an individual's environment, and they may change throughout that individual's lifetime. Ultimately, different modalities that contribute to a person's explanatory model interact in the patient's health frameworks, often distorted from their purest forms, and shape that person's health-related decisions.

My first introduction to this topic came from a lecture delivered by Dr. Nceba Gqaleni, adjunct professor at the University of KwaZulu-Natal and member of the Traditional Health Practitioners Council of South Africa. He foremost discussed South African indigenous knowledge systems and Bantu cosmology, which form the foundation of African traditional medicine. It is based on a guiding principle that there are seven spheres that correspond to an

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African realm of existence and spirituality. It is within this framework that ancestors are understood to communicate directly with traditional healers and inform their actions. (Gqaleni, 2018).

In stark contrast to the ideological dominance of Western medicine in the US, in South Africa conflicting explanatory models manifest in a much more frictional and explicit dynamic between dominant modalities of healthcare delivery, which include biomedicine and traditional healing. Both systems have developed seemingly contradictory paradigms:

The sangoma...considers the human body as part of a cyclical structure, simultaneously social, spiritual, emotional, physical and non-material. Characterized by a reverence for ancestral authority established through ties of clan and kinship, treatment may involve addressing, and if need be, altering, relationships, both material and spiritual...Western medicine has increasingly inclined towards the separation of mind and spirit from the body. Thus, the treatment of illness has become a question of botched biochemistry. in which the human body is a 'thing' to be worked on, altered, adjusted, and...even rebuilt (Wreford, 2005, p. 4).

What fascinates me is how both traditional and Western ideologies have been adopted simultaneously by the majority of South Africans (Gqaleni, 2007). Mbatha *et al.* suggest that an estimated 70% to 80% of those living in South Africa use some form of traditional healing or medicine. (Mbatha, *et al.*, 2012 in Flint, 2015, p. 4326). These ideologies co-exist not without tradeoff, however. Over time, both disciplines have become adaptive and transformative. Traditional healers have had to “professionalize” their practices, collectively organizing themselves into national and provincial healing councils and developing pharmacopeia (Gqaleni, 2007). Western biomedicine has been more resistant to change, but the Department of Health—rooted in a Western biomedical belief system—currently partners with traditional healers in the prevention and education of HIV/AIDS and primary health care.

In this research, I ask the how personal experiences, perceptions of “the Other” (Tremlett, 2003), and constructions of legitimacy in the realm of medicine and health inform and ultimately shape the space between Western medical clinicians and traditional medical sangomas in KwaZulu-Natal. I also wanted to explore perceptions about cross-disciplinary referrals, and how healing paradigms interacts with power and positionality between the two forms of medical

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practice. Finally, I wanted to explore the nature of the compromises made by each discipline for the sake of providing the best health outcomes for patients and get a better grasp of what that “best” might constitute within each context.

Although I began this independent study project (ISP) thinking that I would be able to sum the cumulative experiences of doctors and izangoma into a space that they are all operating within and describe concrete patterns of exchanges between the two groups, I soon realized that the dynamics and relationships between doctors and healers—the “space” between them—is not a fixed “thing” that they are working inside. There is no overarching pattern, nor consensus by either group on what is the proper opinion to have about the other discipline. Not all participants fit into the same model—far from it. Rather, the very perceptions held by each practitioner actively shape their own “space,” and consequently the spaces of others with whom they engage. Conceptions of Self vs. Other, disease vs. illness, negotiations on what compromises are acceptable, purpose as a healer (in both paradigms)—these are as unique and personal to each individual as reasons for why he or she became a health practitioner in the first place.

What has emerged from the narratives, however, was a spectrum of practitioners’ affinity for medical pluralism: on one end lies integration, and on the other end separation. Each participant lies somewhere different on the spectrum, and exactly where they lay comes from years of past experiences, learned sentiments, culture, education, etc. As the narrator of their stories, and my own, I am not here to pinpoint practitioners at one place on the spectrum; however, through their narratives, I hoped to improve my own understanding of *why* doctors and traditional healers might hold their respective opinions, as variant as they are among individuals. The stories that they chose to share were in every way as important as their position on the spectrum. As Hendry writes, narrative research should strive to explore not only “what stories are told, but why we tell a particular story at a particular time” (Hendry, 2007, p. 490).

It is important to qualify my own positionality as the narrator. As a university student indoctrinated into a strictly biomedical paradigm, I can make limited knowledge claims about dynamics between healing modalities. However, through my interviews and engagement with primary sources, I was able to tune into my own meaning-making process regarding this topic. Throughout this ISP, I used participant narratives and journal entries to identify the themes that

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shaped my own perceptions of the space between doctors and izangoma in the current South African context.

Background and Literature

South African interaction is, in effect, the “education” of traditional healers into the biomedical perspective, rather than a “meeting of minds”. (Flint, 2015, p. 4332)

The South African medical arena has garnered much academic attention due to its part in the nation’s ongoing sociopolitical transformation in the face of post-Apartheid reconstruction. My ISP focus draws inspiration, direction, and knowledge from past discourses related to the nature of the relationship between izangoma and biomedical practitioners.

Current prevailing sentiments surrounding traditional healing and biomedicine in South Africa stem from the notorious and inadequate response to the HIV/AIDS pandemic during the Mbeki government (1999-2008). During this period, there was a major shortage of biomedical practitioners, with particular scarcity in the rural areas, encouraging government to seek solutions within the traditional healthcare sector. Adrian Flint discusses how the friction between healing modalities mirrored friction in the political realm, writing:

President Thabo Mbeki was “skeptical” about the links between HIV and AIDS, being persuaded by much of the denialist “science” on the subject. The result, driven by his determination to present his position as being one based on resistance to imperialist values, was an increased focus on traditional medicine as a potential “African solution to an African problem”. This message had traction because, as Dickinson points out, while South Africa is not a traditional society, “it still retains much traditional belief” [23] (p. 26). (Flint, 2015, p. 4332)

One lasting product of Mbeki’s formalization of traditional medicine was the 2008 Traditional Health Practitioner’s Act which attempted to legally recognize the authority of izangoma and inyangas (traditional herbalists). This Act would, among other things, grant traditional healers the right to “write legally-valid ‘sick notes’ for workers” and enable patients to “claim...traditional healing expenses on their medical insurance” (Mbatha, *et al.*, 2012 in

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Flint, 2015, p. 4332). Despite these formal policy changes, however, the sentiments between health practitioners remain imbalanced. In the HIV/AIDS context, for example, efforts have been made to mass-educate traditional healers on identifying the signs and symptoms of the disease, so that they might refer suspected HIV-positive patients to biomedical practitioners; the literature suggests that this has generally been met with compliance. However, surveyed biomedical practitioners have demonstrated resounding reluctance to refer patients to traditional healers. As Flint succinctly puts, “South African interaction is, in effect, the ‘education’ of traditional healers into the biomedical perspective, rather than a ‘meeting of minds’” (Flint, 2015, p. 4332).

Beyond the longstanding precedent of Western-imposed ideologies affecting the nation’s healthcare sentiments, South African biomedical doctors’ reluctance against adopting traditional healthcare also stems from traditional medicine’s unfortunate hand in exacerbating the HIV/AIDS pandemic during the Mbeki government. Traditional approaches currently do not have a concrete solution for significantly improving disease outcomes. This lies in contrast to biomedicine’s indisputably successful counterpart, antiretroviral therapy (ART or ARVs), which has dramatically improved the lifespan and quality of life for people living with HIV/AIDS (PLWHA) (Flint, 2015, p. 4433). In fact, research suggests that “the South African government’s failure to roll out ART between 2000 and 2005 [resulted in] ‘more than 330,000 lives or approximately 2.2 million person-years...lost’” (Chigwedere, *et al.*, 2008, in Flint, 2015, p. 4333). While traditional healing did—and continues to—play an important role in making meaning out of the disease for PLWHA, these historical events certainly drove a larger wedge between the modalities of healthcare in South Africa.

One important consideration, as mentioned earlier, is how simultaneous and conflicting explanatory models of health are implicated in patient health practices. Stoner writes that the division between “traditional” and “biomedical” are not as dichotomous as often portrayed in academic discourses—practitioners and patients both “dip into” the different forms of sickness and healing available to them, and “meaningful engagement can take place when the need arises” (Stoner, 2013 in Flint, 2015, p. 4326). Moreover, he writes that what people ultimately want are options regarding their healthcare, “irrespective of how these may be defined.”

Campbell-Hall et al. explore the interactions between the different health modalities in the realm of mental health; they find that “patient non-adherence to biomedical treatment regimens may...sometimes be the result of the lack of considerations of a patient’s explanatory

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model of illness...in the treatment regime.” (Campbell-Hall, *et al.*, 2010, p. 612) Contributing to this is the distrust on both sides: Western practitioners claim that traditional healers hold a lack of knowledge and willingness to cooperate, whereas traditional healers believe their methods would be exploited by Western clinicians (Campbell-Hall, *et al.*, 2010).

The idea that this hybridized system might have harmful consequences provides a valid counterpoint against medical pluralism. While in principle it is important to give acceptance and credibility to prevailing modalities of health—be it hegemonic or marginalized—that system must foremost focus on preserving patient health, even if at the cost of dismantling medical pluralism. These sources provided important context for my research by exemplifying why each side so firmly resists concession—the tradeoff extends far beyond the symbolic sharing of patients and the health system. Rather, the livelihood of the patient is at stake. Each modality stands for nothing less than its own system of truth; therefore, begrudging compromise (at best) and animosity (at worse) are natural outcomes of these negotiations.

Coming from the unique position of being both a healer and a social anthropologist, Wreford compels biomedical professionals to develop a working understanding of traditional healing. Biomedicine cannot claim hegemonic dominance, since it has failed to reach the “health for all” objectives that might have justified its ambitions (Wreford, 2005, p. 4). She also articulates specific “fundamental ideas of African healing and its spiritual evocations—the question of healing and cure, theories of pollution and cleansing, the functions of ritual, the purposes of witchcraft” as a baseline framework that might help to concretize traditional healing for biomedical doctors (Wreford, 2005, p. 5). This work provides an important cross-disciplinary perspective, since Wreford holds authority as both sangoma and social scientist to comment on the relationship and power imbalances between traditional and Western medicine; power is a central component of my ISP focus.

Important to this ISP is an understanding of the opinions of Western medical doctors and the belief systems that shape their perspectives. Nemitandani *et al.* provide insight into the current traditional versus Western medical relationship through the lens of allopathic health workers. Their research found consensus among participants in “concerns...with regard to [traditional healers’] standard of care; patient safety; medicine storage; overdose; false promises, especially that of a cure for HIV and/or AIDS; and unscrupulous practices and the lack of control measures” (Nemitandani, *et al.*, 2016, n.p.). This research is significant for my ISP because it

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pinpoints key points of friction that perpetuate the distrust between the different healing modalities, which I expect to come across during my interviews with doctors.

Nemutandani, et al. also provide recommendations for seaming together a working relationship between the disciplines, positing that “exposure [of students] to traditional practices and their sciences at the undergraduate level of study is the corner stone in developing trust and exchanging knowledge” (Nemutandani, *et al.*, 2016, n.p.). This suggests that compromises should be made within the arena of Western medicine; the onus is not only on traditional healers to become educated in Western science.

Design and Methods

This research aims to explore a highly interpersonal relationship between health practitioners. The space between two disciplines is not something explicit—it exists in power dynamics, self-concepts, assumptions, associations, successes, defeats, and compromises. For this reason, I used a narrative qualitative approach to piece together stories and perspectives of clinicians and izangoma in KwaZulu-Natal, including practitioners in urban and rural settings. Through this series of loosely-structured, one-on-one interviews with each type of health practitioner, greater themes pertaining to unspoken interactions and compromises between their domains emerged from lived experiences. Because my perception and subjectivity played a role in the construction of this ISP, I kept a journal throughout the process so that I could unpack themes and critically engage with participant narratives. I discuss this in more depth in the *Data Collection* section.

It’s crucial to qualify that this research is in no way representative of the true nature of these institutions. My positionality as an undergraduate American college student limited by lack of experience, time, expertise—as well as by my own subjectivity and constructs—disqualifies my ability to produce research that can comprehensively evaluate such a dynamic relationship that forms one backbone of the South African health system. Regardless, I still wish to express the rich stories of these experts working within local paradigms; I hope to engage personally with their stories to depict to the best of my ability overarching themes that illustrate the experiences of my interviewees and their relation to “the Other.”

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Sampling Plan

Because clinicians and izangoma were not easily available for interviewing, given the busy nature of their careers, I used purposive sampling method to access these participants. Purposive sampling is a “non-probability sampling method [that] occurs when elements selected for the sample are chosen by judgement of the researcher” (Dudovskiy, 2012). In this case, Dr. Gqaleni and Dr. Stephen Knight, SIT program partners, connected me with Durban healers and clinicians whom they understood to be willing and available to participate. Similarly, Mama Zuma, our Nzinga community contact, connected me with available and willing rural village izangoma.

I spoke with a total of seven practitioners working within the KwaZulu-Natal province: four Western doctors and three izangoma. Recruited participants were older than 18 and had at least five years of practice in their respective fields. This province provided an ideal setting because it had a well-established Zulu community and a high concentration of traditional medicine practitioners and users (Gqaleni, 2007). All four doctors currently work in Durban, but each has had experience working in rural clinics and/or hospitals during their medical training. Doctor 1 is an epidemiologist, and Doctors 2, 3 and 4 are family medicine doctors. All of the doctors currently practice in Durban. Izangoma 1 and 2 are healers practicing in Nzinga, Impendle who have received formal training by other izangoma, and Sangoma 3 is a healer practicing in Chesterville (a suburb of Durban) who would be classified under a more lay definition of traditional healing. Although Sangoma 3 was not formally trained by another sangoma, she has been called and trained by her ancestors through her dreams (Sangoma 3, personal communication, 2018).

Although race, gender and education status are not the central focus of this ISP, they nonetheless contribute to the positionality of participants. Given that each interviewee was born during Apartheid, the perspectives of participants have been constructed, at least in part, along racial lines. Similarly, the intersection between race, gender, and education status positions viewpoints and contributes to experiences of authority and power. Therefore, I will disclose these attributes of participants in order to provide some context and background for their expressed opinions. Doctors 1, 2, and 3 are White, male doctors, and Doctor 4 is a Black African, male doctor—each has lived in South Africa for at least the duration of their medical

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careers, with the first three coming from cities and the latter coming from a rural area. All four of the doctors have received a college and medical education. All three izangoma are Black African and female, and each was born where they currently practice (Nzinga and Chesterville). None of the izangoma have received a college education, although two of the healers have been trained by other experts in their field. All three are recognized as izangoma by their respective municipalities.

As mentioned earlier, these individuals are products of their population but are not representative. They are storytellers. In no way can seven stories encapsulate the sheer magnitude of the South African health landscape. Their role in my ISP was not to answer the research questions, but to narrate stories that were deeply embedded in local systems and structures. It was from these narratives that I explored themes and congruencies, but by no means definitive truths. Ultimately, this ISP was written to reflect how their narratives shaped my perceptions. Although I am not a participant in the South African health landscape, I nonetheless wanted to explore this topic, hoping that narratives of health practitioners would shape my own understandings of medical pluralism and its shifting dynamics within the nation's context.

Data Collection

The data produced for this ISP was compiled from a series of semi-structured interviews. Although I prepared a list of questions, I merely used them as a framework for conversation. Thus, I used a two-pronged approach to knowledge acquisition and synthesis. First, I used a voice recorder to document and transcribe the full conversations. Second, I captured details and about my perceptions in the interview context by keeping a journal: qualities of the atmosphere, hesitations, body language, and tone of the participants, as well as my own engagements with their responses. Everything exists in relationship, and the doctor-sangoma relationship I am studying exists in relationship to my positionality of myself as the observer (Lincoln, 2010). It cannot be ignored that the construction of this ISP is grounded in my subjectivity. Therefore, I reflected on my own positionality coming from a fully Western context and used that as my baseline of conceptualizing the doctor-izangoma dynamic.

All of the interviews were conducted in English. However, because the three izangoma were of Zulu heritage and spoke virtually no English, I used personal connections as translators during my interviews with them. While I would prefer to spend equal amounts of time discussing

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the sentiments of both izangoma and doctors, my ability to hold lengthy conversations that appropriately conveyed research topics to the Zulu-speaking izangoma was limited by the translation barrier. Therefore, the following sections contain many more excerpts from my conversations with doctors, since I was able to have richer and more in-depth discussions with them; in no way do I intend to diminish the voices of the izangoma, nor misrepresent them.

Certain questions differed between clinicians and izangoma because of their contrasting positions. Moreover, my limited understanding of traditional medicine required that I ask more general, simplified questions to izangoma. This ISP refrains from “comparing and contrasting” their respective roles in the health system, since that is something that has been extensively documented in literature. Since Western medicine is more accepted as objective in the status quo, I found it necessary to ask clinicians questions that probe into topics surrounding legitimacy. Similarly, it was equally as important to explore topics of subordination with izangoma, whom I assume to have more relevant experiences with marginalization in the South African health context.

Data Analysis

To examine patient responses, I transcribed all of the interviews from recording to text, adhering to participant requests of privacy, anonymity, and confidentiality. I also transcribed all of my personal notes from the conversations, capturing details relating to tone, demeanor, visuals, etc. I engaged with my previous exposure to subject matter through lecture notes and journal entries as well as current literature on the subject. When writing my ISP, I had to use discretion over the components of interviews I chose to include and exclude, reflecting on why I included certain responses and not others.

I poured over the seven transcribed participant narratives and let their stories speak to me all at once. From their interviews, I explored which themes re-emerged and overlapped, comparing perspectives across domains. I focused especially on perceptions of “Self” and “Other,” constructions of legitimacy and norms, and culturally-contextual definitions.

The use of narratives as a method of data interpretation stems from the importance of expressing truths. Frank writes that “authenticity is created in the process of storytelling; it is not a precondition of the telling, and authenticity remains in process” (Frank, 2002, p. 109). People’s

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truths cannot be inferred from a questionnaire, or a structured interview—truths require context, body language, digressions. Narrative theory allows for researchers to “fill the gaps” left by storytelling (Baldwin, 2013, p. 101). I used narrative theory to enable my participants to depict their own realities and narrative environments, which are constructed uniquely and specifically within each individual. Since this research aims to study the space between representatives of two ideologies, only narratives can truly capture the lived experiences and perspectives of these participants.

In addition to engaging with participant narratives, I also interwove my own perspectives into these results, keeping in mind my positionality and lack of ability to draw significance or conclusions from this research project outside of my own personal understandings of the space between ideologies. Including a small version of my own narrative within this process was important for providing context for my research project and overall purpose.

Limitations

While I have touched on the limitations of this ISP throughout this section, they are important to reiterate. My perspective as an American university student born and raised in a Western context severely limited my ability to engage with this subject. I have partial understanding of biomedical terminology, but especially meagre knowledge of Zulu culture, cosmology, and traditional medicine paradigms. Similarly, I must acknowledge the power imbalance inherent in these interviews: my privilege as a university-educated, Asian-American student being able to interview health practitioners in South Africa might have led to some answer biases. For example, Mama Zuma encouraged me to pay the izangoma I interviewed in Nzinga, which might have compelled them to give responses they believed *I* wanted to hear, rather than give responses that might have reflected their full truths.

Second, the sample size of participants was extremely limited—so limited that the compiled narratives merely reflect the experiences of those individuals, not the greater whole of “doctors and izangoma in South Africa.” While I could not necessarily extrapolate the responses to the two populations of practitioners, I still gained invaluable insight from the seven unique worldviews of my participants, all of whom put incredible thought into their stories.

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Third, the translation barrier hindered my ability to engage with izangoma and their narratives. Although I reviewed questions with each of the translators before the interviews, opinions and narrative details were inevitably lost in translation. There were likely ideas that izangoma had on the subject matter that could not be expressed as easily in English as their native language of Zulu. I also found difficulties asking the “right questions” to be able to engage in extensive dialogue about cross-disciplinary perspectives on healing. Similarly, the translators that assisted me were not affiliated with medicine or healing, and therefore, they might have found difficulties relaying health-related topics. Because of these barriers, and perhaps because of cultural differences in privacy and disclosing information, the izangoma I spoke with did not provide as many stories compared to their Western doctor counterparts. While they certainly did share great insight that was incorporated into this ISP, the doctors were more represented in my discussions and explorations.

Finally, my biases as an anthropology, pre-medical student certainly factored into how this ISP was written. One of the reasons I decided on this topic was because I have always been academically interested in local systems of illness interpretation and healing—I am fascinated by the idea that healing institutions have developed in every known culture and that there exist many parallels between them cross-culturally. I also have always been interested in how Western hegemony has spread its spheres of influence across the globe, interacting with (and often suppressing) local paradigms. Given the nature of South African’s oppressive history rooted in colonialism, institutionalized racism, and nationalism against people of indigenous South African background, I believed that exploring the health care contexts and interactions would be an extremely interesting and invaluable research experience. That being said, I acknowledge I came into this research paper with a partiality towards indigenous health systems, often viewing them through a rose-colored glasses. While I myself have grown up in a Western sphere and use Western doctors exclusively for my own medical needs, I nonetheless came into this ISP partially believing that traditional healers in the South African context should have every authority and claim of legitimacy as biomedical doctors in this system. Their healing institution has been established for innumerable generations and has reliably served millions of South Africans. In my perspective, Western medicine and the culture of positivism was just as culturally-ingrained in the Western paradigm as traditional healing was in the traditional Zulu paradigm. While I have tried to withhold perspectives that essentialize Zulu culture or

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biomedical culture and place participants in boxes, these opinions might inevitably come across due to my own biases on this subject. However, I must note that I am not writing a neutral paper—I explore how the narratives provided by participants shaped my preconceived notions, including my previously held biases. I use my preconceptions as the starting points for discussion and analysis.

Ethical Considerations

Numerous ethical precautions were made to ensure that participants were safeguarded prior to and during the ISP process. The participants selected did not include any vulnerable populations, and the identities of all practitioners were kept private throughout this ISP. Personal identifiers for these participants were withheld except for pertinent details (such as age, ethnicity, gender, and place of work). The only individuals who know the participants' identities are Dr. Nceba Gqaleni, Dr. Stephen Knight, Mama Zuma, and my Cato Manor homestay mama; the first three connected me with the participants, and the latter two translated communications between myself and the Zulu-speaking izangoma. Pseudonyms were assigned to the participants; to keep things simple, I refer to them as Doctor 1, Doctor 2, Doctor 3, Doctor 4, Sangoma 1, Sangoma 2, and Sangoma 3. These names were assigned in the order that I interviewed them.

In order to not inconvenience participants, I arranged my travel to meet them at their places of work. For the doctors it was at their offices, and for the izangoma it was in their rondavels. I ensured that the meetings occurred in private, closed spaces, with the exception of translators being present for the interviews with Zulu-speaking participants. The izangoma I interviewed were compensated in payment for the time they allocated to the interview that they otherwise might have allocated to a patient. This amount was deemed appropriate by Mama Zuma, who connected me with these participants. Dr. Knight, who connected me with the doctors, said that I did not need to compensate them for their time. Each interview with the doctors lasted for approximately an hour, and those with the izangoma for about half-an-hour. The discussions were semi-structured, based the questions list provided in Appendix 3. However, due to the nature of narrative research, conversations did deviate from those specific questions.

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Before beginning each interview, I read participants their rights to anonymity, privacy, and confidentiality. These were relayed to the izangoma in Zulu by the translator. Participants were informed that they had control over which questions they chose to respond to—if any—and that they could withdraw their participation from this project at any point before noon on November 26, 2018; I gave patients my WhatsApp number if they should need to contact me at any point following the interview. Participants were also told that they could choose to have certain portions of the recording deleted or not included in the ISP. Additionally, they were informed that their identities would not be disclosed by myself, translators, or other related contributors.

After being informed of their rights, participants signed for two consent components: the first indicated their consent to be interviewed, and the second indicated their consent to be recorded. All interviews were recorded on my phone after receiving consent from the interviewee so that I could transcribe the interviews in-full. After submitting the ISP on November 27, 2018, I will delete all of the recordings from my phone, as well as journal entries that contain participant identifiers.

Participation in this study did not directly benefit participants, since this ISP will admittedly have no impact on pre-existing power differentials. That being said, I hoped that participants enjoyed being interviewed about their respective disciplines. Since none of my questions asked participants to divulge or recount traumatic personal stories, I don't believe participants risked any harm by participating in this research. Throughout the interviews, I would ask participants to qualify and clarify any statements they made that I was unsure about. After each interview, I would thank participants for their time, and I sent each doctor a follow-up email expressing gratitude for their participation and contributions to my research project. Since none of the izangoma had an email address, I requested from my community contacts that the izangoma be thanked again on my behalf.

Regarding the ethics of representing other individuals, I turn to Hendry, who suggests that researchers “construct lives by reducing them to a series of events, categories, or themes and then put them back together again to make up a whole called *narrative*” (Hendry, 2007, p. 491). He writes that this construction of people's stories inevitably erases components of lived experience and “[imposes] particular [ways] of thinking about experience” (Hendry, 2007, p.

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491). As a researcher and author of this ISP, I understand that it is my responsibility to represent participants appropriately and fully, rather than imposing my research agenda and preconceived notions on this topic. Throughout the writing process, I tried to avoid fitting participant responses to conform to my pre-existing sentiments and expectations (Hendry, 2007, p. 493); it is both ethical and crucial for this project that the participants and their stories speak for themselves. The only knowledge claims I make are those pertaining to my own narrative.

Findings and Analysis

“With rare exceptions, all of your most important achievements on this planet will come from working with others—or, in a word, partnership.” (Farmer, 2012)

Beginning this research project, I initially found difficulties with picking themes and asserting them to be the definitive components that make up the “space” between healers. While I did notice recurring examples of power, legitimacy, and compromise, these topics seemed far too broad to begin discussion. I sought a lens through which I could interpret my own findings and directly relate narratives to one another. Although practitioners spoke to their unique experiences and perspectives, one pattern emerged across both healing domains: the chronology practitioners’ engagements with patients.

In my research of relevant literature, I came across the work of Geest et al. in a piece titled, “The anthropology of pharmaceuticals: A biographical approach.” In it, the authors analyze the “biographical order” of pharmaceuticals, which begins at a drug’s conception and marketing by a pharmacist and ends at its consumption and consequent efficacy for the patient who used it (Geest, *et al.*, 1996, p. 156). While the article itself plays a bigger role in later discussion in this paper, I toyed with the idea of using the chronology of the **phases of healing** to frame my findings. This is because, explicitly, the space between the two forms of practitioners is observed through physical manifestations of the healing process, which can be broken down into five stages.

This begins with the **practitioner**, who holds conceptions relating to the identity of being a “legitimate” healer, sometimes in relation to the Other. Then, the process moves to the engagement with the **patient**—how the patient presents illness intersects with how the

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practitioner interprets illness. Next is the “**pill,**” or treatment method; this is the crucial act of healing: the action performed by the practitioner (not always biological) that both recognizes the illness and moves to resolve it or alleviate symptoms. After that comes the **process:** how the patient responds to the treatment, and what that might reveal about the modality of healing used. Finally, the **proof** is the last stage in the phases of healing—the evidence required, within a particular modality’s framework, to support that the treatment has indeed “cured” the patient. These terms are intentionally vague because how each phase occurs among and within domains of healing varies extensively across practitioners and settings; this chronology will be unpacked in depth in the following sections.

Each phase of this process is a place where practitioners critically examine themselves and evaluate their work. In these spaces, they are reinforcing or challenging the pre-existing paradigms surrounding their modality. Given the high frequency of multiple-modality patients—those which utilize both biomedical and traditional healing—practitioners also come into contact with the Other’s paradigms in these spaces. To frame my ISP, I decided that the most appropriate method to explore themes that emerged from the narratives was to segment my findings into the five stages of this healing chronology. At these points of critical reflection, participants’ narratives revealed the most about implicit dynamics between modalities, as well as current processes used to facilitate or hinder exchanges.

As mentioned before, given the very limited nature of this research, the only knowledge claims I can make within this project is how discussions with doctors and reflections have made meaning for me. Each stage of this healing chronology is represented as a chapter. Within each chapter I analyze recurring themes, interweaving participant stories, qualifying remarks, and other relevant primary or secondary sources; and at the end, I discuss my perceptions of the space between healers as it is explored and discerned through the responses.

Chapter 1: The Practitioner

Underlying all beliefs about others lies a person’s identity and beliefs about themselves. When trying to understand the positionality of practitioners in one domain in relation to the other, I had to first get a sense of the practitioners’ conceptions of themselves within their roles

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as doctors or izangoma. Doctors and traditional healers discussed their own roles as authorities, some of their working paradigms, and perceived responsibilities and objectives as health practitioners.

Calling vs. Choice

What was immediately apparent was a discrepancy between doctors' entry points into medicine compared to traditional healers'. Whereas all of the doctors had ended up in the medical field through culturally-sanctioned institutions—private primary schools, secondary schools, and university—the three izangoma discussed how the decision was not theirs to become healers. Rather, to become a healer was a fated responsibility. Sangoma 3 described a vivid dream she had when she was 15 that marked her first calling. She met her aunt in her dream, who told her that there were two izangoma at the gate outside her house waiting for her. Like this izangoma at the time, they were also about 15 years old. She said, “I knew where they were going, [even though] they never told me. Deep down I knew” (Sangoma 3, personal comm., 2018). They walked from her home in Chesterville to town, passing the markets on the way, and ended up on the beachfront. “We went inside the ocean,” she described, “and there was *impepho* burning (incense used to call the ancestors). A voice at the surface came down, [and] called my name. He told me this was my calling.” She began crying, but the voice told her that even though she was crying, she must answer. She responded, “*Angifuna!* I don't want to be a sangoma! I don't want!” She said that she was crying because she was still young—at this point she was only 15 years old—“you like it or not, you are going to be a sangoma” (Sangoma 3, personal comm., 2018)

Each sangoma revealed how they resisted the calling they received in their dreams, and each spoke to the subsequent sicknesses that befell them the longer they waited which could not be resolved by Western medicine. Sangoma 1 said that she had lost her vision before realizing her calling, yet doctors could not identify the source of her visual impairments (Sangoma 1, personal communication, 2018). In the same way that spiritual disconnect inflicted sicknesses upon the traditional healers, the strong connection with the spiritual world has provided them with health. Sangoma 2 said that “after practicing as a sangoma, [I] never got sick; but there [was] nothing wrong with going to the doctor” (Sangoma 2, personal communication, 2018).

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While the decision to enter healing was out of the hands of these izangoma, for the four doctors there was always the element of choice. Each expressed how it was not a question of whether to go into medicine; rather, it was in *which* discipline to enter. Doctors 2, 3 and 4 were family medicine doctors, which were described to me as, “specialist generalists,” working in “a discipline looking at providing excellence at district hospital level and below down into community” (Doctor 2, 2018, per comm.) In the South African medical context, Doctor 4 said that “[the country is] fluctuating between third world and trying-to-be first world, but [they] are purely third world if you’re speaking medicine...so, of the people who actually need care, the majority are living in the rural areas” (Doctor 4, 2018, per comm.) Doctor 4 continued to say that,

As family medicine, that’s really what it’s geared for: being in the community and being in the primary health care service delivery—and being a generalist, actually able to engage with community and health and see how that can link together to improve the overall well-being of an individual, and not just their disease. (Doctor 4, 2018, per comm.)

This was in contrast to the public health doctor, Doctor 1, who said that his role involves dealing with disease at the population level, and designing and implementing massive, cost-effective interventions. He said that he’s predominantly concerned with “[addressing] issues like vaccination, sanitation, water, TB control policy, [and] non-communicable diseases” (Doctor 1, 2018, per comm).

I thought it fortunate that I was able to interview doctors whose specialties were more likely to intersect with traditional healing. Family medicine and public health appeared to be some of the first lines of defense within the biomedical realm, and therefore these doctors could speak more pertinently to the referral process and working with patients who may have previously encountered izangoma.

What was also apparent to me was the seeming imbalance inherent to the gateways of each discipline: these biomedical doctors had the privilege of seeing the scope of the South African disease landscape and could pick and choose where and how to intervene. On the contrary, while izangoma play a very crucial role in this same landscape—as they are often the first point of contact with the healing process for patients in rural areas (Doctors 1; Doctor 2;

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Doctor 3; Doctor 4, 2018; per comm.)—each described how they had to make sacrifices in their personal lives (i.e. secondary school, previous employment, etc.) in order to answer their callings. To most people raised in a Western context, the idea that one can be called into a permanent discipline out of one’s control counters the very nature of the “American Dream” paradigm, through which we believe we can exact our will on the world through hard work and ambition. Therefore, for me, one qualifying factor in the space surrounding both modalities was the disconnect between entry points through which “healing” is entered, and the implications that might have in a medically plural context.

Perceptions of the Other

These implications about the entry points of healing were revealed to a greater degree in practitioners’ discussions of the Other. When I asked doctors and izangoma about the extent of their knowledge regarding the other modality, I was surprised both at the spectrum of responses and how participants chose to respond. All four Western doctors had in common that they worked for some time in rural hospitals during their medical training. I discerned two general positions from the four Western doctors: two generally believed that South Africa had “two separate medical systems working in parallel” (Doctor 2, personal comm., 2018); and two had more favorable dispositions towards integrated medical pluralism.

When asked about his extent of knowledge in traditional medicine, Doctor 1 responded, “it is a much more holistic approach in many ways, from a mental and traditional cultural belief; but you have to then exclude the germ theory and the biomedical model” (Doctor 1, personal communication, 2018). Similarly, Doctor 2 said that he knows very little about their worldview—only that medicines that make patients vomit and scarifications are indicative of visiting traditional healers (Doctor 2, personal comm., 2018). These two doctors also attributed the huge variety of healing remedies among izangoma to the lack of standardization and professionalization of healers, which might indicate a deficiency of qualifications. Doctor 1 noted that there is no standardization for what is meant by “sangoma,” in his understanding—this leads to “a range of people who may have psychiatric problems and hearing voices being called, to somebody else who says, ‘how can you make a living?’” (Doctor 1, personal comm., 2018). He says that for those who are unemployed and have some familiarity with traditional remedies, becoming a sangoma would “make [them] a reasonable living.”

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This is pertinent to the work of Devenish, who contextualizes the relationship between traditional and biomedical healing systems in Natal, arguing that the ideological conflict was underlain by “deeply rooted...economic conflict and competition” (Devenish, 2003, p. 41). Moreover, she sheds light on the historic and ongoing process of “professionalization” that traditional healers have subjugated themselves to in order to adapt to the dominant Western medical system; they suggest that not only does professionalization continue to exclude traditional healers from entry into training institutions, but it also “could lead to the imposition of the modern health sector’s curatively biased way of thinking...on to traditional healing” (Devenish, 2003, p. 98) These events indicate how present-day sentiments felt by subordinated traditional healers are situated in long-lived historic conflicts, not just over competing doctrines of Western science versus indigenous knowledge, but also socioeconomic opposition.

Conversely, Doctors 3 and 4 had strong knowledge of the traditional healers’ worldviews. Doctor 3 spoke richly of his regular meetings with izangoma at a small hospital in Drakensburg, KZN. He described the initial space between him and the izangoma as “difficult and uncomfortable,” since they were expected to ask questions, and he was expected to answer them. He told them that he would rather engage with them as equals to “see where [they were] coming from, so that [he] could then use their frameworks to explain where [he] was coming from” (Doctor 3, personal communication, 2018). His telling of it is quite extraordinary—he says that they decided to imagine a person who they called “Jabulani,” and track his experience with HIV over the course of his life. Jabulani’s story began with him contracting HIV, and they discussed how he got infected:

We talked about condom-use, we talked about safe sex, we talked about where the idea of safe sex comes from, and how that is culturally understood...then all sorts of really interesting stories came out. For instance, what is “faithfulness?” I mean, the way faithfulness is understood is *completely* different. So the whole...HIV prevention messaging was so, so interesting for me because it was so a-cultural. (Doctor 3, personal comm., 2018)

He said that they also gave Jabulani a girlfriend who contracted HIV before becoming pregnant. From there, they discussed mother-to-child transmission, with the izangoma being shocked that an HIV-positive mother could produce an HIV-negative baby. Towards the end of

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Jabulani's life, he died from cryptococcal meningitis. He described Jabulani's death as, "this amazing moment where, as this imaginary person just died, suddenly the whole group of us...we were just completely silent. It was as if a real person had died" (Doctor 3, personal comm., 2018). Then, one old sangoma stood up in front of the group and posed a question to everyone; she said, "why is our medicine not working?" Doctor 3 recounted being excited because he would be able to explain ARVs to them, "but clearly there was something else in the question" (Doctor 3, personal comm., 2018). Other izangoma were giving explanations such as their ancestors not knowing HIV since it was a new disease or believing that Americans conspired with the Apartheid state to "infect Blacks to kill them off" (Doctor 3, personal comm., 2018). When asked about what he thought, Doctor 3 said, "look...we've got the cleverest minds that we have sitting around New York and Geneva, and what do they ask? Why is our medicine not working?" (Doctor 3, personal comm., 2018). He spoke to being humbled in that moment—that question made him and the izangoma realize that they are all the same, that they have the same purpose.

While Doctor 3 came into medicine with a Western frame of reference and an open mind, Doctor 4 had the unique perspective of growing up in a context that subscribed to both healing modalities. His mother encouraged his education and guided him towards becoming a physician, and his grandmother was a local traditional healer in his rural village. Because of this, he was "integrally engaged with traditional healing" growing up, and he believed it to be unambiguously beneficial. He said, "as a child, [my grandmother] would send me as a kid to actually go to the...traditional healers' pharmacy to...buy certain ingredients to...mix for *muthi* (Zulu medicines). (Doctor 4, personal comm., 2018)

Compared to the first two doctors, Doctors 3 and 4 have a stronger understanding of the uncertainty implicit in the traditional healing process. Rather than attributing the variety of izangoma treatments to limited qualifications or financial incentives, these doctors believe that the domain of traditional medicine extends to a level beyond tangible perception, outside the realm of biomedicine. Doctor 4 says that his understanding of the paradigm is that "it's at the spiritual level...that engagement of giving medicine and helping, and [performing] certain prayers." However, he says that the paradigm is scary because "as soon as you're going into the spirituality of individuals, you're delving into quite a number of things...but they also feel that

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this has been something that ancestrally has been passed down” (Doctor 4, personal comm., 2018). He described the Western sphere of medicine as isolated, and that biomedicine “[hits] ceilings a lot of times, and we just don’t know how to go beyond those ceilings... we blame anything that is outside of that particular bubble that we’re within.”

For me, these sentiments revealed how biomedical practitioners’ perceptions of izangoma extend as far as their willingness to actually understand their worldviews. The practitioners who did not immediately dismiss traditional medicine, and the gray area that might appear to the untrained eye, seemed to have much more positive perceptions of the Other, the izangoma. They acknowledged that traditional healing certainly contains answers and interpretations of health beyond the scope of what makes sense in the Western context for them, but especially for the large majority of their rural patients. I interpret this to mean that, within the medically plural society, some doctors relinquish part of their authority as Western healers in the faith that traditional healers see and work in a paradigm that they are not necessarily working in, and certainly not one that they control. As I will go on to discuss in Chapter 5, Doctors 3 and 4—while they do believe that there does need to be some level of standardization to evaluate the potency of traditional healing—understand that the rules and metrics of this standardization will not necessarily be on their terms. In my understanding, this is a crucial difference between Westerners establishing the paradigm because it enables traditional practitioners to develop a metric that fits within their worldview and formalizes their authority.

These responses also surprised me because I came into this project believing that nearly all doctors would be skeptical about traditional medicine. That some doctors have positive experiences working with izangoma and take the time to understand their worldview exemplifies the variety of sentiments that exist in the South African health context.

Regarding the opinions of izangoma about biomedicine, they provided answers that initially surprised me. Sangoma 2 said TB, HIV and asthma fall exclusively within the domain of Western medicine, whereas “constipation, shingles, and stroke...are the things that clinics can’t help with” (Sangoma 2, personal comm., 2018). Similarly, Sangoma 1 said that traditional healers are better at remedying “backaches, stomach aches, knee problems, and headaches” compared to doctors (Sangoma 1, personal comm., 2018). Coming from my Western perspective, I was initially skeptical about these answers because as far as I am aware, doctors

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are very much able to treat the aforementioned illnesses. However, I realized that these answers were neither far-fetched, nor ignorant by any means. I discuss this in my journal entry:

November 9, 2018

When I spoke with the izangoma last week, they told me how they could cure shingles, stroke, and constipation, and body aches better than Western doctors, which I was initially confused about. I was quite sure that there were biomedical solutions for these. But I also thought back to when Annie and I waited for Mama and Baba Zuma at the empty clinic [near Nzinga] for well over an hour, and it dawned on me that izangoma are necessary to deal with the “every day illnesses” like constipations and backaches. Clinic trips take so long that they are impractical—Mama Zuma had to schedule her whole day around the visit. And the place was *empty*. (DelSignore, 2018)

Every doctor expressed how patients in rural areas typically visit traditional healers before coming to clinics. This is because rural clinics are largely inaccessible, crowded, inconvenient, and understaffed, whereas traditional healers are generally much more available—I discuss accessibility of clinics in depth in a subsequent chapter. Considering this, however, it entirely makes sense that the izangoma are the first lines of defense in the medically plural rural areas. Thus, for common illnesses, patients are visiting traditional healers for common problems like headaches, constipation, stomach aches, etc., and their remedies must be working for these patients, since they have no need to follow-up at clinics. This was significant to me because it demonstrated how, despite izangoma not necessarily being indoctrinated in Western education and formal biology training, their presence and remedies are essential to prevent saturation of the medical system.

What I learned from these narratives was doctors’ and izangoma’s perceived broad goals as healers. For the public health doctor, his discipline aims to change population statistics. The family medicine doctors aim to provide general medical care for their individual clients, and the izangoma provide personalized healing for whatever sicknesses patients might present to them, be they physical or spiritual. At the most basic level, these practitioners strive to meet the same

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goals—mitigate symptoms of illness. One question this brought up for me was—without conversation, how could both groups hope to align?

Regarding the practitioner phase of the healing chronology, then, the major contributing factor in the space between healers is the extent of open-mindedness practitioners have towards the other domain. In my view, I believe it to be extremely important that practitioners place trust into the other system. Without a clear line of communication between the two domains, doctors and izangoma might continue to hold perceptions of the other that are incorrect or based in untruths, such as Doctor 1 believing that many izangoma are in it for the financial benefit, and izangoma perceiving that Western doctors cannot remedy backaches and knee pains. And with most South Africans utilizing both systems of healing, I worry that patients might get lost trying to navigate the disconnected space between practitioners or might be influenced towards one healing system or the other without fully understanding their options. I believe that practitioners' willingness to be open-minded can only bring about positive communications that may facilitate respect and hopefully a working relationship between the domains.

Chapter 2: The Patient

“The common ground that we have is the person that is ill. So that is actually the space where we should be interacting, but we’re kind of interacting separately from each other.”
(Doctor 3, personal comm., 2018)

Equally as important as understanding practitioners' perceptions of themselves is understanding their perceptions of their patients. Ultimately, it is the patient that takes the first step towards getting healed; therefore, it is the patient who enters the space between biomedical physicians and traditional healers. The patient is the point of exchange—their motivations for choosing either modality rests upon sentiments that stem from broad factors (e.g. background knowledge, culture, worldview, access, socioeconomic status etc.) to the very personal factors (e.g. simply having a good relationship with your practitioner).

Exploring practitioners' perceptions of patients was crucial to my understanding because it shed light on how explanatory models for illness shape patient decisions and treatment. If patients do not understand the basis of germ theory, or if they accept multiple worldviews

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including germ theory, then what is the significance of that in terms of patients' decision-making process in entering the health care domain? How might patients' interpretations of their bodies and their understanding of biomedicine versus traditional medicine affect their health outcomes? Finally, what is expected out of the exchange between patients and practitioners? This all ties back into my research question about what lies in the space between different practitioners. Even if each modality prefers to remain separate, it is ultimately their patients who maneuver in the space between domains when their expectations to be healed are unmet.

Explanatory Models of Illness

One topic I discussed with participants was their idea of “sickness” and “healing.” Integral to this discussion is the idea of disease vs. illness vs. sickness. Boyd summarizes Marinker's in distinguishing between the “three modes of unhealth,” writing, “Disease then, is the pathological process, deviation from a biological norm. Illness is the patient's experience of ill health, sometimes when no disease can be found. Sickness is the role negotiated with society.” (Marinker, 1975 in Boyd, 2000, p. 10). During in my anthropology studies, these distinctions seemed straightforward enough at the time. However, after speaking with both forms of healers I found the lines to blur—definitions of what “illness” meant to each practitioner varied greatly among all participants. Boyd writes that some of this elusiveness comes from the “value judgements” we make “in determining what we mean;” she writes that in any given society, there is a “common core of ideas about what disease...or health is. But beyond that common core, judgements on whether a condition is a disease...begin to diverge” (Boyd, 2000, p. 12). While I did not ask participants to distinguish between the three modes of unhealth (and might have inadvertently used some of the terms interchangeably throughout the interviews), narratives nonetheless exemplified this concept, as ideas about “unhealth” varied among the groups of doctors and traditional healers alike.

At the most basic level, a patient will approach a healer if he or she is feeling unwell, in whatever capacity that means for that individual. The following sections contains practitioners' perceptions on the factors that create or exacerbate illness. I must first qualify that this list of factors perpetuating illnesses is not exhaustive in any way. It does not include discussion on social determinants of health, community health, mental health, or chronic diseases beyond HIV/AIDS. The greater focus is on acute illness, which are more likely to lie at the intersection of

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family medicine, traditional medicine, and public health. Therefore, the scope of this discussion is extremely narrow. This was significant for my meaning-making process, because it allowed me to hone in on a very specific aspect of illness—one in which the patient’s understanding of the illness process, and his subsequent health decisions, was pertinent to both traditional healers and Western doctors. Only then could I better understand the points of collaboration, negotiation, or friction.

Germ Theory

Perhaps the most unambiguous source of illness comes from the germ theory of disease; that people are sick because of abnormal biochemical markers inflicted by microbes or irregular biological processes. Doctor 1, who works in public health, believes that sickness is measurable and finite and insists that his role as a public health doctor is to make the most cost-effective impact. While he acknowledges that there is a mental-psychological component to health, he said, “in a country like ours where there’s a very high burden of disease and poor health literacy, the key thing is that you must address sickness...and the biomedical underlying issue” (Doctor 1, personal comm., 2018). He says that improving health education (in both patients and traditional healers), while ideal, is unlikely because “changing behavior is a very difficult thing to do.” Instead, he strongly supports the “systems approach to vaccinations...which [doesn’t] involve traditional healers” or cultural conceptions of sickness and healing; instead, “it involves biological markers of improving vaccine coverage and antibodies that children have.” In his first public health project, his team of physicians encouraged public primary schoolchildren across numerous districts to bring their family members in for measles vaccinations. In the area they worked in, he said that they observed “incredibly rapid results” and “a very high level of coverage [against measles] very fast”, even though their methods “completely bypassed traditional medicine” (Doctor 1, personal comm., 2018). For me, this story reinforced my own perceptions that biomedicine is, indeed, very powerful and effective, particularly in the far-reaching public health context.

Traditional Illness

Beyond physical disease is the traditional conception of illness. Participant narratives suggested that illnesses outside of the biomedical context exist, and these require traditional treatments. While each sangoma did acknowledge the existence of biological disease, none of

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them believed that a knowledge about germ theory was necessary to be able to treat or even identify the presence of disease. In my learned understanding of the traditional view, illness exists at the intersection between spiritual and physical. This ties in to the Mandala of Health model, in which human ecology results from the “interaction of culture and environment”, and an individual is the summation of his or her spirit, body, and mind (Dansereau, 1966 in Hancock, 1993, p. 42). Both biological illness and witchcraft are on the table as sources of illness—“some [patients] will tell you symptoms and you know that it’s TB or HIV; but sometimes I will pray and listen to the ancestors, and the ancestors will tell me that this is witchcraft, or this is something else” (Sangoma 3, personal comm., 2018). According to her, illnesses in the form of bewitchment may come from people or ancestors whom the patient might have upset. Similarly, Sangoma 2 said that certain sicknesses may manifest as a “sign that maybe the ancestors want to talk to you” (Sangoma 2, personal comm., 2018).

Working under an entirely different paradigm, their treatments and methods are not set in stone or guided by some rule book. Rather, treatments vary from person-to-person; scarification, vomit-inducing drugs, prayers, and herbal remedies were among the most common examples provided to me, but by no means compromise the exhaustive list of traditional treatments. Sangoma 3 said that her ancestors—typically her own grandfather—train her in her dreams and divulge remedies specific to the patients’ needs which they often know prior to the patient’s arrival (Sangoma 3, personal comm., 2018). Regarding patients coming to visit izangoma in their homes, Sangoma 1 said, “ancestors already know that the patient has come in with a headache, or [they] will be able to prescribe a sickness before the patient even gets sick” (Sangoma 1, personal communication, 2018). Similarly, Sangoma 3 said, “every time when someone is going to come see me – from anywhere around KZN—I will dream of that person before [they] come... I will see their car in my dream, the clothes they will be wearing that day...” (Sangoma 3, personal comm., 2018). For me, these stories demonstrated my lack of a grasp on the traditional worldview and humbled me. Additionally, it is surprising that such a huge proportion of this country relies on this form of healing, and yet it is excluded from academic curriculum in South Africa. Doesn’t a field of knowledge that has such a large impact on health deserve more credit for its successes? It demonstrates just how the power held by biomedicine ensures that its worldviews are maintained.

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Discerning between Biomedical vs. Traditional Illness

Doctor 2 conducted pertinent research about the decision-making process of patients at the rural clinic in which he trained in family medicine. He said that patients explanatory models for their illnesses often involved some classification of the diseases as more traditional or more Western (Doctor 2, personal comm., 2018). Regionally, there was a lot of malaria and TB. He said that patients with malaria would always first visit a Western doctor, whereas TB patients would always start with traditional healers. If patients didn't get better in one setting, then they would maybe "reinterpret those systems and look for another paradigm of healing" (Doctor 2, personal comm., 2018). His specific research qualitatively examined why TB patients don't take their medicines, and he found that patients only take their medications after first ruling out the presence of traditional illness (Doctor 2, personal comm., 2018). He said,

They would say, "we take our medicines because we *believe* we are not bewitched. We don't have *iglisio*." *Igliso* is a traditional illness that you get, and it manifests by vomiting and vomiting blood and losing weight. (He believed this to be the proper spelling of the illness, but I could not verify it with the Zulu speakers I consulted). And so if you *believe* that you have *iglisio*, you need to go to the traditional healer...You would never think of coming to hospital on the hill with the white doctor; they wouldn't understand it. So only when you've dealt with that...would you be willing to come to a hospital and consider a diagnosis of TB. (Doctor 2, personal comm., 2018)

Patients move between systems, but without a formal referral process between modalities for diseases beyond HIV and TB, the directionality of movement through the domains is entirely up to the patients' interpretations of symptoms and expectations from their practitioners. In my understanding, doctors and izangoma are only able to educate patients in their own specific perspectives, since they are only experts in their own fields. Without a necessary lifeline connecting the two worlds and paving the way for patients who are unsure about their illness attributes—be they traditional or biomedical—patients seem to be forced to navigate the space between domains alone.

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Friction

An unfortunate consequence of the rift between healing domains is that sick, vulnerable patients may fall victim to the friction between practitioners who don't relinquish responsibility over that patient. Doctor 4 emphasized the importance of communication between domains, recognizing that culture should influence healthcare delivery, especially since "very few of the doctors...are in the public sector serving a massive percentage of individuals" (Doctor 4, personal comm., 2018). His perspective maintains that South Africa is such a multi-cultural community, with 11 different cultures—each with their own language and knowledge systems. He says that "we see the effects of friction; there's a lot of people who die from that friction and the lack of communication between us and our cultural counterparts" (Doctor 4, personal comm., 2018).

He described a story to me, in which a 12-year-old boy came in to his practice with acute psychosis. His family first tried visiting a traditional healer, but to no avail. Biomedical doctors were equally perplexed; Doctor 4 recounts, "we went through all the lists as we were taught...but we couldn't find anything" (Doctor 4, personal communication, 2018). They decided to send the child for a CT scan to check for possible malignancies, but his parents were alarmed because the child had been in the hospital for a week and was still experiencing a prolonged psychotic episode despite being on medications.

The family decided to take the son back to the traditional healer because, in their eyes, the illness was clearly spiritual in nature. While the doctors tried to negotiate with the patient, insisting that the child would be able to go to a traditional healer after the CT scan, the father resisted. The doctors compromised on letting the family call the traditional healer to the hospital as long as they could still send the boy in for the scan—"we said 'let's have a discussion to see how we can work together to help this kid.' Because yes, we'd be happy for them to the rituals...they can even come and do the rituals here at the hospital" (Doctor 4, personal comm., 2018). The traditional healer came in soon afterwards, and the sangoma, parents, and doctors all discussed their thoughts on the matter, with the doctors still insisting upon booking the child for a CT scan.

Being in a rural environment, however, posed a challenge because the CT scan would not be able to take place for a few days. Doctor 4 said that the traditional healer acknowledged the

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doctors' concerns but insisted that the illness was traditional and demanded—along with the parents—that the child leave with them that afternoon; he would not be treating the child in the hospital. The doctors eventually had to force their hand and say that they were not willing to release the child until after the CT was given. The sangoma moved to leave, but before exiting, he turned around and threatened to send the weather on the doctors; Doctor 4 noted that, “culturally the weather is believed to be a part of witchcraft” (Doctor 4, personal comm., 2018). He proceeded to discuss how, almost comedically, the beautiful day the next morning turned into one of the most massive storms he had ever experienced.

The hospital is situated on top of a mountain, and everyone was now screaming and saying, “he did say he would send the weather!” And obviously dependent on your ideologies and your beliefs, you either believe that it truly happened, or you're sort of like...come on, let's do geography here...It was like the worst storm that we had in a while. But asking people the next day who [were] within the community, “so how was that storm yesterday?” People were saying, “what storm?” (Doctor 4, personal comm., 2018)

From the point of view of Doctor 4, that the storm may or may not have been the result of bewitching by the sangoma. He laughed describing the doctors' and nurses' shock at the situation, but he nonetheless insisted that the disagreements and stubbornness over that child's care likely aggravated his pre-existing illnesses. I certainly don't mean to exoticize traditional medicine in this ISP, nor diminish it in any way. Quite the contrary—I believe that its paradigms are compelling and valid and generally much more open to holding multiple belief systems than Western medicine.

That the disconnect between healing domains exacerbates illnesses that patients are already experiencing demonstrates the urgency of the matter. The mutual interest of the modalities should be enough of an incentive for them to coordinate. Participant narratives suggest that patient casualties caused by the “friction” drive the modalities farther apart, whereas they should be points for jointly evaluating what went awry.

Delay

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Just as there lies a causative element of illness—a germ, a parasite, an action of bewitching, etc. – there also lies a temporal element through which illness is propagated. For many diseases, the longer the delay in a patient getting sufficient treatment, the worse the illness experience (the exception to this being, naturally, short-lived diseases that just pass through one’s system, such as the common cold or a small stomach bug). In the South African health context, the problems of patients having to navigate the healing system—and reconstruct versions of health based what their practitioners were telling them—are exacerbated by the consequential time delay between accessing treatments.

Doctor 1 spoke to the consequences of late presentation by patients whose conditions were, in his experiences, worsened by their initial traditional medical remedies not working. He said that children that came to him appeared to be “worse-off because of the delay in getting to a hospital or formal medical situation,” or because of previous traditional remedies “like emetics, which [were] part of the traditional model of disease as opposed to germ theory” (Doctor 1, personal comm., 2018). These substances would exacerbate symptoms of illness, potentially causing increased toxicity, infection, and dehydration in patients. He describes being frustrated by late presentation of preventable diseases like measles, diarrheal disease, and TB, which he attributes to the mothers’ and patients’ misunderstandings about origins of sickness.

Western medicine similarly deserves blame for delay in treatment access. Specifically, regarding biomedical care, Harris, et al. report that the most common reason that South African patients delay seeking care from doctors comes from believing that their “illness was not serious enough to warrant immediate care (68.8 percent)” (Harris, *et al.*, 2011, p. S115). The report adds that other factors that contribute to the delay include “long queues (8.5 percent), perceived ineffective care (6.1 percent), and anticipated disrespectful treatment (2.9 percent).” At the heart of this is the fact that hospitals and clinics in South Africa are often oversaturated. A 2016-17 report released by the Office of Health Standards Compliance (OHSC) informed that only five of 696 inspected hospitals and clinics met the 80% “pass mark” standards of the Department of Health (Kahn, 2018). In response to this report, Health Minister Aaron Motsoaledi “[conceded] that the public health system was overloaded, with long waiting times and diminishing quality at some health facilities” (Kahn, 2018).

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In my own—albeit limited—observations of the public health care system in South Africa, I also noticed just how long the queues were, and how inconvenient trips to the doctor were for my homestay families. When my homestay mama was having teeth pains, she delayed her doctor’s visit by two weeks because she did not want to spend the whole day waiting in the clinic. In that time, her pains got increasingly more painful, until she decided she had to go (Moloi, personal communication, 2018).

October 11, 2018:

Today we visited the King Dinuzulu Hospital Complex, where we had the opportunity to observe different hospital wards...Immediately upon arriving, the place felt like a football stadium on game day. It was *packed*. The outpatient clinic had like 3 separate waiting rooms, and we were told that the wait time for patients was 6 hours. *6 hours*. Can you imagine being a doctor *or* a patient in this scenario? How doctors possibly establish a relationship with their patients when they are observing them by the hundreds per day? (DeISignore, 2018).

November 1, 2018:

Annie and I went with Mama and Baba Zuma to the Nxamalala Clinic in the morning, since they each needed to pick up medications. The clinic was very beautiful and spacious, and it wasn’t crowded at all. Mama Zuma said this was because it was the first day of the month, which meant people were spending their monthly paychecks in Impendle rather than visiting the clinic. Also, the doctors only come in one day per week, and today was not that day. Somehow, me and Annie still spent one-and-a-half hours in the waiting room.

While I my own examples are limited, these experiences still seem to reflect the sentiment that the public health care system is not the most accessible nor acceptable, especially for patients to establish a trusted doctor-patient relationship. At the present state, neither system appears to have the resources or capacity to provide full, unaided coverage to all South Africans in the public healthcare realm. Even if Western medicine did have ideological dominance—not even accounting for traditional, nonbiomedical illnesses—the system would be oversaturated.

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This further suggests the need for a collaborative relationship. The cost of these systems working in parallel are patients who lose time and health as a result of the medical system.

Syncretic Worldviews

One topic that re-emerged through participant narratives was how doctors and traditional healers primarily engage with one another through the patient—patients are perhaps the largest element in the space between practitioners. What I wanted to explore through this ISP was whether these interactions were working together or working apart from one another? As I have learned, the question is not so simple. Patients in the South African context need both forms for many reasons, as indicated throughout this chapter. Doctor 3 believes that practitioners should be interacting cooperatively, but given strict paradigms surrounding biomedicine in particular, “[practitioners] are kind of interacting separately from one another;” however, he believes that because their goals are so similar, that opens up the space for conversation (Doctor 3, personal comm., 2018).

As the chapter reveals, patient perspectives of illness vary tremendously, but one thing is certain: no one domain of medicine is capable of addressing all patients within the South African context—the variety of explanatory models of disease makes that impossible. Doctor 3 describes South African beliefs as “syncretic, [which] is when you have two seemingly opposing beliefs that you hold at the same time, and they’re not in conflict with each other” (Doctor 3, personal comm., 2018). He provided the example of someone who self-identifies as a Christian while simultaneously believing in biomedicine; he believes that every person is syncretic to some extent, because rarely would a person only have one belief system. Regarding the traditional worldview, he said that “traditional cosmology is much more holistic and interconnected...the history of the people, family, and clan are very much a part of what happens in the body. But it also doesn’t really clash with cellular, biochemical processes” (Doctor 3, personal comm., 2018). He believes understanding the dual worldviews of his patient improves his ability to see that they are properly cared for, because their cosmologies affect the way they talk about symptoms and their physical experience of illness (Doctor 3, personal comm., 2018).

Drawing on the work of Kleinman and Benson, the latter of whom is my global health professor at my American university, Doctor 3 discussed how there are certain guiding questions that doctors can use to recognize how patients conceptualize their sickness: “what is your

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understanding of this illness? What do you call it? What do you need to do to mitigate it? How do you make sense of it?" (Kleinman & Benson, 2006 in Doctor 3, personal comm., 2018) These questions prevent doctors from "essentializing" their patients and assuming that they hold concrete, "cultural" viewpoints; rather, it lets patients layer their complex paradigms and conceptions (Doctor 3, personal comm., 2018). He holds himself to the standard of understanding a patient's worldviews as much as he can—only in that way can he provide (or refer) a patient to the most appropriate treatment.

Whereas practitioners seem to hold conflicting beliefs (mostly coming from the biomedical side, but certainly not excluding some izangoma), many patients live with both worldviews. In my understanding of the space between practitioners, the mutual concern for the patient makes up a large portion of that space and the sentiments about the Other. It seems as though both systems are necessary to provide reliable and accessible health for the vast majority of South Africans. Since healing and illness are so complex that they requires multiple layers of explanatory models, both traditional medicine and biomedicine are necessary to uphold all aspects of health in the South African context. Thus, despite frustrations and conflicting worldviews, I hope and believe that future concessions between the two healing domains will be oriented around the patients' syncretic belief systems.

Chapter 3: The Pill

The next point of interaction in the doctor-patient exchange that contains important meaning for me is the treatment process. Implicit in the action of a doctor prescribing treatments is the expectation of healing. Yes, a patient might be sick or be "unwell" in some way, and that sickness and its cause might be identified. But what next? What is expected from the practitioner by the patient in his or her car? On a similar note, how have practitioners been constructed to treat patients? These ideas are explored through participant narratives.

My previous perceptions on this topic was that seeking medical treatment in any domain was a one-stop shop: once you are diagnosed, the practitioner determines the best course of treatments (if any) for your illness, and you take their word for it because they are the expert, and you are the patient. But these views were based in a biomedical paradigm where *of course* you

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took the doctor's word for it—unless, of course, you were to get a second opinion from another doctor. Through participant narratives, my ideas about the doctor-patient process have reformed: there seem to exist multiple exchange points at which the patient may diverge from the practitioner's recommendations. Accepting the diagnosis and accepting the treatment are two separate steps. Once a patient is diagnosed, for example, a patient may accept the diagnosis, and choose to go to another healer for treatment.

The act of treatment pertains to the space between doctors and traditional healers because it parameterizes what constitutes solvency or adequate care for illness in each domain. Moreover, it positions the practitioner within the healer-client relationship—exactly how much say does a patient have in his treatment? As evident in the earlier example with the doctors who held custody of the boy while he awaited his CT scan, there are certainly gray ethical areas when it comes to patient medical autonomy.

Meaning of the Pill

One of the most interesting articles I have come across in my readings pertains to the meanings biomedical doctors and patients assign to pharmaceuticals, written by Geest et al. I referenced it in the introductory chapter because it provided a unique lens for analyzing the processual “biography” of pharmaceuticals and their cultural implications. The authors write that medicines are used largely for their “thinginess”— “[they] are tangible, usable in a concrete way: They can be swallowed, smeared on to the skin, or inserted into orifices—activities that hold the promise of a physical effect” (Geest, *et al.*, 1996, p. 154). I, only ever having been a patient, never questioned this process. Patients don't have the background knowledge to accept anything else; yet what is “correct” when a patient is given two conflicting prescriptions? I am curious to understand how uncertainty might play a role in the healing process from a patient perspective in the South African context, but that is a question for another ISP.

Geest et al. analyze the importance of the implicit cultural meanings within the prescription process, which they deem a social act. They write, “through prescriptions, doctors show their patients that they recognize their complaints and are trying to help them... Where medication is seen as the essence of medical practice, prescribing is the main thing expected from a physician.” (Geest, *et al.*, 1996, p. 160) Even in circumstances where not prescribing might be the better option, the literature suggests that doctors are more likely to prescribe than

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not (Geest, *et al.*, 1996, p. 160). Just as a doctor is expected to act on his or her role as the expert, the patient plays into the cultural role as the recipient in the doctor-patient exchange. The authors note that “a prescription...functions as a legitimation of sickness, [and] ...entitles him to the privileges and roles reserved for the sick” (Geest, *et al.*, 1996, p. 161). I continue to draw upon Geest et al. in this chapter, because they provide important parallels and considerations for thinking about the role of the healer in a biomedical context compared to the traditional context.

In my experiences with biomedicine, I have given very little thought to the deliberation with which pills and treatments are prescribed. I have always assumed that there were one or two pharmaceuticals to treat any given malady which doctors and chemists have determined to have the highest efficacy and safety. Never would I have considered any alternative beyond what my doctor prescribed to me, but that’s because my healing system doesn’t normatively offer alternatives. While I wouldn’t call my faith in biomedicine “blind,” discussing the idea of alternatives with practitioners in a semi-medically plural system did allow me to reconsider my previous perceptions.

Physical vs. Non-physical Treatments

What much of biomedicine and traditional medicine have in common is the use of physical treatments to cure illness. The izangoma I spoke with did not place a defining line on which treatments were included or excluded from its domain. Whereas Izangoma 2 and 3 spoke to going out into nature to collect natural ingredients for their *muthi*, Sangoma 1 said that she “sometimes prescribes PhytoMed herbal pharmaceuticals to [her] patients” (Sangoma 1, personal communication, 2018). Sangoma 3 said that she sees no difference between traditional medicine and Western medicine, because “they’re using the same plants to make those pills and everything else...they complement each other” (Sangoma 3, personal comm., 2018). While I previously believed that there was a fine line between the domains—traditional medicine must have X qualities and biomedicine must have Y qualities—I have come to understand that the distinction is much less clear.

While I cannot speak to the chemical potency of traditional medicines compared to Western medicine, I do know that biomedicine often touts their pharmaceuticals as proof that their science is more refined. And certainly, that may be true: biopharmaceuticals are backed by measured efficacy. Doctor 3, who considers himself a proponent of medical pluralism and a

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strong supporter of traditional healing, said that “Western medicine is...amazingly powerful. And it is much more powerful on the biomedical level than traditional medicine...both in knowledge, but also in its knowledge production process” (Doctor 3, personal comm., 2018). He notes that the science and resources that underlay biomedicine enable it to respond much more rapidly to diseases like HIV, turning it from a “universally fatal disease” to a “chronic disease” in the span of a few years; traditional medicine, he continues, is limited because “it is bound within a cultural context” that does not adjust as rapidly to the changing circumstances (Doctor 3, personal comm., 2018). Western medicine may be able to respond faster to the South African disease landscape, but Geest, et al. suggest that other factors contributed to the perceived efficacy of Western pharmaceuticals:

To most, the “miracles” of pharmaceuticals prove that natural science is the right “religion.” To others, who have integrated pharmaceuticals into their own explanatory models, those miracles are taken as proofs of the correctness of their model. The therapeutic efficacy of pharmaceuticals establishes belief in beings that have never been seen, like bacteria, and dogmas that are unintelligible, such as theories of infection and immunity (Geest, *et al.*, 1996, p. 169)

The self-proclaimed immaculacy and standardization of biomedicine, however, is not something that is necessarily missing within traditional medicine. Rather, traditional medicine finds its own version of perfection within imperfection. Sangoma 3 discussed this in one of her dreams with involving her grandfather. She said that she was preparing *muthi*, and she was told by her grandfather to put grass inside— “I couldn’t believe that thing was going to work because there were now ants in that *muthi*” (Sangoma 3, personal comm., 2018). She began removing the ants and the dirt, but her grandfather asked her what she was doing. She said to him, “no *umkhulu*, how are they going to drink this? This thing is dirty, and I’ve got to clean it.” He told her, “no...leave it like this. Have you seen the ants when they’re collecting food? Those ants, they go to the tree and take pieces of the roots and put it together, and it becomes *muthi*—the ants, they’re helping this *muthi* to grow. Taste it and you will see that it’s not bad.” She prepared this medicine for her patient as she had in her dream, and he was so pleased with the medicine that he referred many of his friends and family to this healer (Sangoma 3, personal comm., 2018).

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This beautiful story really made me rethink my understandings about healing paradigms. I have naively thought about traditional medicine as having flaws and imperfections – imprecise measurements, little emphasis on sanitation, ambiguous and ill-defined rules —that were outweighed by its benefits for patients that use it. I believed that, as long as traditional medicine reached its objectives and healed patients while doing as little harm as possible, then that must be why it has lasted so long in an increasingly Westernized world. I understand that this previous conception was misconstrued—part of the potency of traditional medications comes from its preparation vis-à-vis the sangoma. Naturally, that came from my being constructed in a Western system. Besides reinforcing that I understand very little about the traditional healing worldview, this story taught me that the precision that biomedicine holds itself to is just as culturally ingrained as the idea that American doctors should wear white coats.

Participant narratives also challenged my worldview that potency of treatment comes entirely from a physical element, that the practitioner is only the vector of healing. Geest et al. counter this, writing that “often...medicines derive their power from what the healer puts into them” (Geest, *et al.*, 1996, p. 167). And indeed, even within the Western biomedical context, there is something ritualistic and inherently cultural about the method of treatment delivery. In my own patient experiences, I always expect a clean waiting room with magazines, a kind nurse—usually female—in a patterned uniform, and a doctor in a white coat.

Doctor 4 discussed how even the absence of physical medication leads to healing in the traditional healing context. “Traditional faith-based healers,” he said, “might not necessarily be using...medication, but them coming in and doing prayers...[patients] say it helps” (Doctor 4, personal comm., 2018). He knew of many cases where his medical colleagues would give patients medications that were not healing them, but then faith-based healers would come through the wards and pray for patients. And the patients would get healed (Doctor 4, personal comm., 2018). Similarly, Doctor 3 speaks to the line drawn between what is recognized as “healing” and what is recognized as “religion.” At one of his meetings with izangoma, there was a man who was also a faith healer, which is a discipline excluded from the Western categorization of “traditional healers” because they sometimes identify as prophets. Since prophets operate within religious paradigms, the Department of Health excludes them from “counting” as healers (Doctor 3, personal comm., 2018). Whereas this distinction seems clearly

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defined by legislation, he says that izangoma and faith healers laugh at the arbitrariness of these categories. “For them, there is no line” (Doctor 3, personal comm., 2018). For me, this begs the question—what counts as a “health practitioner?” In the space between practitioners, then, are lines, drawn by those with authority and power. Sangoma 3 also spoke about how she always gives prayers from Biblical passages with her medicines, saying “first the Bible, then *muthi*” (Sangoma 3, personal comm., 2018).

Even in the Western context, I know of friends who have gone to religious leaders or spiritual guides as a way of seeking mental health, but I would never have considered those as “healing.” I explored these ideas in my journal:

November 11, 2018:

I’ve always understood how mental health has been medicalized: SSRIs, psychologists, therapists, medications, etc. That aspect of healing is very evident in my life and the lives of those around me, especially in college. While theoretically spiritual health makes sense, I guess I have not truly considered the *health* impact of spirituality. I always assumed that it was through people finding peace through prayers and medication; but the idea of faith healers is a whole different ballpark. It’s quite interesting to think about my pastors at home as “health practitioners.” And the parallel isn’t exact—it’s not as if all of the religious healers here are automatically “faith healers.” But just the idea that spirituality affects bodily health is something unfamiliar to me. (DeISignore, 2018)

A potential for this space, however, is harmony. Doctor 4 believes that if the medical realms were willing to cooperate, they would be able to achieve congruence. To him, the combined efforts would “bring about a whole lot more healing and less fighting” (Doctor 4, personal comm., 2018), tapping into patients belief systems on both sides. As Geest et al. write, “Efficacy is brought about in a context of belief and expectation through social communication and interaction...the therapeutic effect of a medicine cannot be reduced to its chemical substance” (Geest, *et al.*, 1996, p.167-168). The acts of validating the patient illness experience and reassuring them of their eventual recovery—or providing other emotional support if the condition is severe—substantially contribute to the healing process. In my perspective, the idea that treatments exists in a vacuum is reductionist.

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Negotiations

If the two domains of healing were to present patients with different explanatory models and treatments for their illness, how do patients decide the next step? What negotiations occur at this stage? Discussing this topic with my advisor, Dr. Gqaleni said that sometimes patients want to get a biomedical diagnosis but still want to receive herbal remedies from their sangoma rather than adhering to the doctor's prescription (N. Gqaleni, personal communication, 2018). He remarked that, "what Western medicine needs to respect are patients' rights—it's about the choices patients make [because] the patients know what works for them" (N. Gqaleni, personal comm., 2018). Similarly, he said that doctors will not check to see whether their patients are taking herbal remedies, but they will blame traditional healers when their pharmaceuticals interfere with izangoma's *muthi*; he noted how this does not occur so much with izangoma, who generally support the patients' choices regarding their treatment (N. Gqaleni, personal comm., 2018). This relates back to the earlier discussion with Doctor 3 about patients holding syncretic worldviews; how patients ascribe meaning to their belief systems is based on their lived experience. When the patients hold syncretic views, what jurisdiction do doctors have in telling them to prioritize one worldview over the other? In my perspective, doctors operating under one set of beliefs aren't able to validate or invalidate those which they don't understand.

Sangoma 1 and Doctor 3 shared similar perspectives as Doctor Gqaleni. Sangoma 1 said that doctors are too strict in their thinking and prevent patients from seeking alternative treatments. She said that she practices it differently— "when patients come in with a headache, the ancestors will already know whether the patient has a sickness. [A sangoma] will allow patients to ask [the] ancestors for treatment or refer them to the doctor" if the patient believes that would be better (Sangoma 1, personal communication, 2018). Similarly, Doctor 3 described a story involving one of his HIV-positive child patients. He said that clinicians are expected to tell patients to stop taking all traditional medicines when beginning ARV treatment. After two consultations, however, this child's mother told him that she did not stop using *muthi* on her child. Rather than reprimanding her for this, he encouraged her to bring all of her traditional medicines to him so that he could try to find a compromise. He said, "she brought these packets of stuff the next time, and she explained what everything was and why she was giving the different things" (Doctor 3, personal comm., 2018). He said that they reached a "wonderful

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negotiation,” where the mother could still provide some of the traditional medications and herbal cleansing remedies for her child as long as she staggered the doses she was giving to line up appropriately with the ARV treatment (Doctor 3, personal comm., 2018). While this cooperative solution may not work for all illnesses, it nonetheless shows that intention creates innovative solutions. Rather than giving the patient and his mother stress over picking the “correct” treatment, Doctor 3 and the patient’s sangoma treated the patient in all understandings of his illness.

Looking Beyond Biological Illness

Perhaps one of the biggest paradigm-shifting realizations I had was thinking about illness and healing as something not directly implicating the body. Izangoma not only treat a person on the basis of their physical ills, but also their safety. This challenged my preconceived notions that safety was separate from health and that “healing” should be constrained only to treatments that have a biological effect on a person. Sangoma 3 spoke about one of her patients who brought her car to be blessed and protected by the sangoma, as she had an upcoming long-distance road trip to her village in which she would be travelling alone. The sangoma described how she put the *muthi* in the car and performed prayers for her client. After a few weeks, her client came back and described how the sangoma’s healing and blessings worked on her car—she said that as she was driving, one lady stopped her car to ask for a lift. However, when the client stopped her vehicle, many people appeared by the lady outside who they tried to steal the car from the driver. However, because it was a rainy day and the windows were partially obscured, the people believed there were actually many people in the car, rather than just the lone driver; “they said, ‘no we can’t rob this one...she’s not alone’” (Sangoma 3, personal comm., 2018). And so her client drove off safely. Sangoma 3 said that her client believes it was the *muthi* that protected her car and obscured the vision of the potential thieves. Sangoma 1 brought up a similar story, explaining that patients will come in if they suspect their neighbors to have stolen some of their belongings. She says that, after she performs some a ritual and consults the ancestors, then those neighbors will return the stolen goods to her client (Sangoma 1, personal communication, 2018).

Concluding this chapter, it’s important to qualify that the idea of the “pill” is intentionally vague and not necessarily literal—the term is designed to encapsulate the sheer range of treatment modalities available throughout different healing domains. What the “pill” is *not* is the

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singular cause of health improvement; even in biomedicine, the entire process of healing stems from the exchange between patient and doctor, from beginning of illness presentation to its final form in the patient.

Chapter 4: The Process

The next point of discussion is the process through which the treatment heals, as understood by both types of practitioners. In this section, I hope to explore what is expected to occur after the treatment is given, during the healing process. How much of the patient's health is on the onus of the practitioner to resolve? A major theme within the treatment process, as I understood, was the idea of side effects of treatments, particularly ones that negatively impact a patient's health—I discuss this idea in depth later on. With regard to this ISP topic, the healing process was an important consideration because it reveals much about the expectations and roles of healers in each context.

Levels of Involvement

My first consideration regarding the patient healing process was the perceived purpose of the practitioner as the deliverer of treatment. How they think about their own objectives necessarily implicates what they expect for and from their patients after prescribing treatment. Through participant narratives, I discerned that there were different levels of involvement practitioners had with their patients, and different considerations for patients at each level. I spoke to practitioners about their perspectives on the patient healing process.

One of the first questions that I thought about was, what elements do practitioners consider when thinking about their patients when they have a low level of engagement with them? Naturally, the best perspective on this topic came from Doctor 1 who, as a public health doctor, believed that his role as a physician involves improving population health in the most efficient, large-scale, and cost-effective ways. While he did work as a generalist during his training in a rural area, he currently works at a population-level, which I inferred to mean that he was no longer seeing patients individually. In his view, since the country has such limited resources, he believed that the most important aspects of healthcare should be the options that are “cheaper and easier in the long run.” He suggested the most effective methods would be “to do

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proper basic symptoms screening for every patient who comes in to a primary health care facility” (Doctor 1, personal comm., 2018). The example that he provided was that if a patient were to come in for a sore toe, they should also be given a GeneXpert sputum screening to detect early symptom TB; he insisted that this was the “best way to move the epidemic to the left” (Doctor 1, personal comm., 2018). In his worldview, the most cost-effective and harm-reducing way excludes traditional healers because they might delay patients by 2 or 3 weeks, potentially giving them their own remedy to try out first (Doctor 1, personal comm., 2018). I understand this to mean that the healing process at low levels of patient involvement is symptoms-oriented. The illness symptoms shown explicitly (or as measured by tests) are the focus points for health practitioners in that context.

I was curious about the sentiments of izangoma, who generally have a much deeper involvement with their patients. Each of the izangoma expressed that they generally prescribed treatments on a per-individual basis, considering the input of the patient and the ancestral authorities. Narratives with Sangoma 2 demonstrated a parallel logic with the ideas expressed by Doctor 1, with one important distinction: she expressed that izangoma “only give you medications for the sicknesses you have at that time—if they see that you have other sicknesses, they send you to the clinic” (Sangoma 2, personal communication, 2018). She spoke about that in the context of chronic illnesses, saying, “it’s only the doctors who can tell you, ‘you must take *this* or do *this* for the rest of your life.’” Similarly, Sangoma 3 said that she will treat many things, but if she suspects her patients to have HIV or TB, she will send them to the clinic before she helps them further (Sangoma 3, personal comm., 2018). To me, these responses spoke to the power dynamics and understandings between izangoma and doctors. Unlike much of biomedicine, which claims to have solutions to most illnesses, the izangoma I spoke with seemed to convey that they understand their own position within the South African health landscape. This is not to say that the izangoma were diminishing themselves, or that they exist at a lower level. As I understand, the perceived roles of Izangoma 1 and 2 was to heal illnesses that could be healed within a finite timeframe. Their narratives suggest that chronic illnesses seem to be in the domain of Western medicine, along with TB and HIV. Again however, given the very limited sample size of this ISP, I cannot represent any sentiments of izangoma or doctors beyond my participants.

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Doctor 3 also spoke to the sentiments of izangoma based on his exposure. He discussed how the University of KwaZulu-Natal Howard Campus recreated a hut on campus grounds, where izangoma can consult patients and grow herbs, as a step towards professionalizing their discipline. This relates to the healing process, because he says that the environment and mode of delivery is quintessential to that domain's efficacy. He said, "in traditional medicine it's not only the substance that cures you; it's the process and the ritual that cures you as well" (Doctor 3, personal comm., 2018). He juxtaposes this with his experiences in biomedicine, claiming that there truly exists a parallel— describing a visit to a doctor's office, he claims that "there's a whole lot of social and cultural things that happen when you consult...that make you better or worse. It's not the antibiotic usually that cures you; it's the context of taking that antibiotic within a much larger process" (Doctor 3, personal comm., 2018). This is important to me because it reinforces my sentiments about Western medicine being very much a cultural product.

Doctors 2, 3, and 4 spoke to their considerations of the treatment process and their own roles as physicians, coming from a discipline of medicine that focuses on more underlying aspects of health than ostensible illness. Doctor 3 critiqued Western medicine for generally only focusing on the biomedical, calling it "reductionist in its thinking and approach" (Doctor 3, personal comm., 2018). He said that the human experienced is so nuanced that focusing only on symptoms and measurements cannot reflect reality.

Doctor 2 discussed the multiple roles of practitioners regarding chronic or layered illnesses. While defining sickness from a physical perspective was simple enough, his idea of the purpose of treatment in chronic diseases, such as HIV, was to stabilize patients (Doctor 2, personal comm., 2018). He said, "in HIV you're never cured," and that patients are stable when they "have viral suppression and [are] no longer getting symptoms suggestive of opportunistic infections" (Doctor 2, personal comm., 2018). In diabetes and hypertension, he added, patients "aren't ever cured, but [doctors] want to...make sure that their blood pressures...and sugars are controlled". To this, he added that there exists even broader level of consideration—"is the diabetic patient struggling at home, and does he have the psychosocial supports that he needs?" He says, in general, Western medicine neglects holistic health and deeper lifestyle-related issues; "[doctors] focus too much on, 'take your tablets and lose weight'" (Doctor 2, personal comm., 2018).

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Similarly, Doctor 4 speaks to his perspective coming from a rural environment. He thinks “that no illness is isolated—he considers it important to ask a patient, “so how did you get here?” and “how can I help? (Doctor 4, personal comm., 2018). Using the example of a toe ache (which was completely coincidental, given the previous example of a toe ache used by Doctor 1), he said “Yes, you may come to me with a toe ache...and yes, I can treat that toe ache. But have I really treated you?” (Doctor 4, personal comm., 2018). He deems it necessary to inquire into other aspects of the patient’s story—family life, home life, work life, sleep quality, etc. Asking how a patient ended up at the doctor’s office “answers a whole lot of things, because it tells [him] exactly the difficulties that this individual has experienced to be able to get [there]” (Doctor 4, personal comm., 2018). Like Doctor 3, he said “healing” involves so much more than, “I’m going to give you a tablet, and this is going to do the miracle work. And outside that, sorry I can’t help you. I’m just a doctor—I’m only trained to give you medication” (Doctor 4, personal comm., 2018).

My discussions with family medicine doctors suggest that their discipline and practice of healing does look at health more holistically; however, these doctors all suggested how much of biomedicine ignores these aspects. They expressed how the a treatment’s effects don’t occur in a vacuum for a patient—lifestyle factors influence its manifestation within individuals. Healing, as I understand it, is a process that needs to give full attention to all of the circumstances occurring in a patient’s life that might affect their health.

Side Effects

With treatment inevitably comes tradeoff. In my exposure to pharmaceuticals in the Western context—through advertisements, doctor warnings, personal experience—without fail there is always the possibility of side effects. They vary tremendously in severity across different pharmaceuticals and individuals: at the very least they may involve headaches, nausea, fatigue; at the very worst they might involve blindness, psychosis, or even death. While side effects are not always expected to show up, they *can* occur in some measured probability, as that is what pharmaceutical companies determine in precise laboratory settings. This begs many questions—what is the tradeoff patients are willing to make during treatment? Doesn’t this mean that biopharmaceuticals are technically making patients sicker to some extent? And what is the cost of healing in each domain? Of course, these questions are largely hypothetical. But considering

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side effects was certainly a pivotal focus for me, since traditional healing too must produce its own variations of side effects in patients, as that is the nature of active chemicals interacting with human biology. Who deems which side effects are appropriate for healing, and which aren't?

“Side effects” are defined as “a result of drug or other therapy in addition to or in extension of the desired therapeutic effect” (Etkin, 1992, p. 100). Nina Etkin sheds light on this subject, writing in depth about the cultural construction of Western pharmaceuticals. She writes that, within the biomedical paradigm, “not only is a notion of ‘general medical treatment’ (such as placebo)... anathema, but also...there must be a “primary” effect to which all others are subordinated;” moreover, if patients experience effects not anticipated based on experimental trials, these effects are considered to be “psychosomatic” (Etkin, 1992, p.100). This, she continues, displays lack of attention to cultural context and social dynamics within which a drug's effects occur in a patient. However, she points out that despite the intentions of biomedicine to utilize drugs without considering any cultural dimension, this is impossible given the very nature of pharmaceuticals. She writes, “the primacy or subordination of effects depends on why a medicine is administered, the intentions of the user and prescriber, and the anticipated outcome—in short, it's cultural context” (Etkin, 1992, p. 101).

What is interesting to me about this topic is the idea that Western pharmaceuticals are expected to give side effects that may make a patient feel worse. However, traditional medicines may induce their own array of side effects. Products that contain similar active ingredients might be prescribed in different doses, depending on the healing domain, practitioner, illness, setting, and patient. How these effects are then interpreted is entirely a matter of cultural perspective. Etkin writes about how for some non-biomedical therapeutic paradigms (not specifically South African traditional medicine), “the desired effects are signs that a disease or its agent is expelled from the body via some portal...these effects represent a symptom set explicitly primary to the functional effectiveness of a medicine” (Etkin, 1992, p. 102). She says that effects are not necessarily desired in a Western paradigm; doctors or pharmacologists might deem these as side effects, or secondary effects. This ties into a response given by Doctor 3, who suggested that doctors have these negative sentiments that traditional healing is dangerous and nephrotoxic, without really delving into the subject. He added that most doctors also believe that 80% of South Africans use traditional medicine. He reasoned that their logic was counterintuitive: “you

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can't have it both ways—why is it that 80% of the population then isn't dying of kidney disease?" (Doctor 3, personal comm., 2018).

Doctor 4 said that the difference between Western and traditional medicines is that, while both have side effects, biomedical doctors predict and recognize their own and not those of traditional medicine. He says, "because we're in a different sphere and a different paradigm, as soon as [their side effects] come into our paradigm, we blame them, [saying] 'they don't know what they're doing! They're not scientists!'" (Doctor 4, personal comm., 2018). Tying this in to Etkin, she writes,

The interpretation of signs or symptoms is deeply embedded in cultural meanings or therapeutics and outcome, and patients and healers in the same society do not necessarily agree on what is primary and what is secondary to effective therapy. In some cases, what is deemed a side effect in biomedicine is embraced by another biomedical paradigm as a requisite part of a process in which the early outcomes indicate that therapy is underway." (Etkin, 1992, p. 102)

The thresholds evaluating the primary and secondary effects of a medication are culturally defined, and these distinctions are not always apparent cross-culturally. This ambiguity about healing signs and symptoms is certainly something occurring in the space between practitioners since it contributes to the Otherness associated with the other domain. For example, Western doctors may prescribe a much smaller amount of an active substance than a traditional healer for the same illness. Whereas the traditional healers may be searching for overt side effects as evidence of the medication running its course, doctors may associate too many side effects with the drug being too neurotoxic for the patient. These limits are culturally specific.

Doctor 4 describes how hospitals generally only see the "bad side of things" because many of the patients they receive from izangoma are the cases where traditional healing did not work, and the patient needed additional medical attention (Doctor 4, personal comm., 2018). They rarely see the positive aspects because, if initial traditional healing worked, then the patient wouldn't need to follow-up with the clinic. He says, "in the community, we've seen a lot of patients coming in sick, and we're thinking that it's herbal intoxication [from traditional medicines]. We're blaming it all on that, but we're not understanding" (Doctor 4, personal comm., 2018). He thinks it's necessary that the practitioners discuss the effects of medication,

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such as comparing biomedical ARVs to traditional remedies that suppress viral loads (Doctor 4, personal comm., 2018). Sangoma 2 shared this viewpoint, saying that doctors came to Impendle (the larger town where Nzinga Village is located) and told izangoma not to give this medication that they give to pregnant women— “these doctors said babies were dying from it. But if you look around all of Impendle, there was not one baby that died” (Sangoma 2, personal communication, 2018). While I cannot verify the claims of either the practitioner or sangoma in this scenario, Sangoma 2 expressed that ultimately it comes down to lack of respect from the doctors, who will make assertions without asking questions. She said the meetings they hold for izangoma at the regional hospital used to be one-way: the doctors would do the talking and the teaching, and the izangoma would be expected to learn. However, she said that “it is better now” (Sangoma 2, personal communication, 2018), indicating that the dynamic has improved.

An important aspect of the treatment process is how practitioners engage with patients who use both domains of medicine. As Doctor 4 understands it, izangoma are less likely to openly discuss side-effects of their remedies with their patients, which means many patients coming from traditional healers appear to be sicker due to traditional medicines (Doctor 4, personal comm., 2018). Unfortunately, I did not address this topic as much during my conversations with izangoma, which means I cannot represent them beyond the perspectives of Doctor 4.

In the biomedical context, Doctor 4 says that doctors dealing with traditional medicine patients are looking for an excuse. He says that the difference lays in the question: “we ask parents, ‘have you given this child herbal medication?’ instead of, ‘when last did you use traditional medication?’ we’re finding something to blame, and now we’re blaming the traditional healer” (Doctor 4, personal comm., 2018). He said that they blame the izangoma for worsening the illness, forgetting that the child was sick and malnourished before visiting them. He believed that practitioners need to work together with parents to help the child.

This reminded me of an earlier discussion I had with Dr. Gqaleni in which he spoke about how traditional healers have been forced to “professionalize” by establishing a pharmacopeia of their herbal remedies. In my understanding, linking the bridge between traditional medicine and biomedicine would require practitioners on both ends to extend themselves further—more than just establishing the pharmacopeia, health practitioners must also

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try to learn about how the prescriptions are made, evaluated, and interpreted in the other modality. The stakes for developing a baseline understanding of the other domain are high since such a huge proportion of the population uses traditional medicine. It also requires taking blame away from the patients, whose limited resources may force their hand just as much as their syncretic worldviews.

Biomedical Iatrogenesis

A recurring theme within this paper is the idea that biomedicine is not inherently flawless process. Through my exposure to the literature on the subject, I have begun to understand how even when the doctor has the best of intentions, there are still systematic flaws underlying the Western medical culture. Biomedicine is just as much a product of Western culture, beliefs, mores, and paradigms as traditional medicine and izangoma are shaped by Zulu culture. Illich provides a scathing critique of what he calls the “epidemics of modern medicine,” citing doctor-inflicted injuries— “iatrogenic disease”—as the result of “professional callousness, negligence, and sheer incompetence” (Illich, 1976). He attributes clinical iatrogenesis to the culture of depersonalization that is propagated in the Western medical sphere and claims that it affects one in five patients of a research hospital. While this polemic assumes an extreme and controversial take, it nonetheless highlights fundamental flaws that are promulgated, overlooked flaws of the Western medical culture. It begs the question: is Western medicine so resistant to change that it is willing to turn a blind eye to its embedded flaws?

Within the South African context, iatrogenesis does indeed have a significant hand in the nation’s disease landscape. While the advent and mass dissemination of ARVs is credited as the best solution to HIV/AIDS, biomedical malpractice has affected a fair share of patients in its domain. Brody et al. discuss the effects of iatrogenic HIV transmission in South Africa, writing that there is growing evidence that “rapid HIV transmission is fueled by parenteral exposures in health care settings, especially medical injections...[and] transfusions of untested blood” (Brody *et al.*, 2003, n.p.). Studies in multiple non-African countries have revealed that unsafe medical injections (i.e. with non-sterilized or reused needles) are “efficient vectors of HIV transmission” (Brody *et al.*, 2003, n.p.). In African adults, as much as 20% to 40% of HIV infections are associated with injections (Brody *et al.*, 2003, n.p.).

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Similar research points to iatrogenesis in the HIV/AIDS epidemic—Simosen et al. write that "the average person in the developing world received 1.5 injections per year...in the majority of studies reviewed, the proportion of injections that were unsafe was greater than 50%." (Simosen, *et al.*, 1999 in Gisselquist, *et al.*, 2002, p. 662) Lastly, Kane et al. attribute 80,000 to 160,000 HIV infections that occur each year, with two-thirds of these coming from Africa (Kane et al., 1999 in Gisselquist, *et al.*, 2002, p. 662). Among the most at-risk groups (i.e. those receiving injections) include STD patients, pregnant women, and commercial sex workers (Gisselquist, *et al.*, 2002, p. 662), and settings with high HIV prevalence. These results indicate that the culture of Western medicine, particularly in under-resourced settings, is not without its failings.

This research was meaningful to me because it demonstrated the extent of the embedded flaws within the biomedical domain in South Africa. Now of course, this is not to undermine the incredible work being done with Western medicine in this country, specifically regarding its rapid mobilization in response to the HIV epidemic with ART development and dissemination. However, it was for my meaning-making process to critically consider biomedicine through the lens of its culture, which is something I believed to be often ignored.

Doctor 4 also discussed the ethics of Western pharmaceuticals and what that implicates about the biomedical paradigm. He said that the original HIV medication that doctors used to prescribe was "causing patients to have the most unbelievable toxicity. It was killing patients—we knew it was because of this drug, yet we continued to use it" (Doctor 4, personal comm., 2018). He says that this speaks to the somewhat uncompromising nature of biomedicine. Doctors knew the effects of that particular medication and would tell patients, "if you start having the effects [of this medication], sorry...we're probably not going to put you in our ICU's because chances are that you're going to die" (Doctor 4, personal comm., 2018). He says that it's fortunate that there is a new HIV medication in use that no longer causes these effects, but nonetheless, that does reflect poorly on biomedicine and its parameters of acceptability within healing (Doctor 4, personal comm., 2018).

Within the treatment process lies a sizable amount of ethical considerations for health practitioners. The space between healers in my understanding holds these culturally-embedded standards about ethics and treatment evaluations, and they draw upon these standards to justify the consequences of their methods. Without dialogue between healing modalities, there appears

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to be miscommunication regarding the boundaries of these standards, which contributes to the confusion about how patients respond to treatments prescribed by the Other. This justifies my own views about the importance of dialogue and transparency within a medically plural context.

Chapter 5: The Proof

The last stage of engagement within the P process between practitioner and patient is the proof of healing; that is, when the patient no longer demonstrates symptoms of illness, and thus no longer requires care. If the patient didn't heal in a manner he or she deems suitable, then this stage cycles back to the beginning, starting with the patient returning to another practitioner of sorts. Many crucial considerations occur at this stage, such as how much of a say a practitioner has in deeming that a patient is healed and what happens when the illness persists or manifests differently. For me, this is significant to the space between healers because it lends perspective to the end goals and evaluations of each healing domain. Just how healers interpret when their work is "finished" speaks to the differing worldviews. Moreover, this chapter explores cross-modal dynamics, thinking about what happens if a patient's sickness was treated in the incorrect domain. Participant narratives discuss viewpoints about the referral process, as well as their own constructions of legitimacy.

Evidence

When thinking about "proof" of healing, I first explored cultural considerations for what counts as evidence. My previous conceptions from my Western paradigm are that healing is completed at the physical level when the symptoms of the illness are gone, and at the emotional level when the patient has recovered enough that they no longer partake in the sick role. Doctor 1 reaffirmed these beliefs, saying that in his view, "there are biological indicators when [patients] are free of disease—when the markers [of disease] are gone" (Doctor 1, personal comm., 2018). However, he further suggests that just because two people might have similar biological markers, it does not necessarily mean that they have the same amount of "sickness."

Doctor 4 speaks to the element of proof that resides within the patient's mindset. In his perspective, evidence for healing comes from "seeing a mindset change in our patients...even if they're not getting better" (Doctor 4, personal comm., 2018). He describes how this is

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particularly true with his pediatric patients: he said that, “the first sign to see this kid is really getting better was that smile that you get after about a week or two weeks of actually treating them.” As a doctor, he prioritizes healing in a holistic way, saying, “it’s not just the medication, but it’s the interaction. It’s the way that I greet them every day...it’s the way I try to bring play into that environment...and they start to feel better” (Doctor 4, personal comm., 2018). Doctor 4 believes that helping people goes beyond just prescribing tablets to patients. Even just being a listening ear brings a form of healing (Doctor 4, personal comm., 2018).

For the izangoma proof of healing comes from the close relationship healers have with patients. When asked how they know when a patient is cured, they each said that their patients call them or come in to thank them for their services. Sangoma 1 added that the ancestors will sometimes let her know when a patient no longer needs treatment (Sangoma 1, personal communication, 2018). What I noticed reading through participant narratives was the way they each described this to me—each sangoma made the note of saying that their patients expressed gratitude and warmth towards the izangoma. Sangoma 3 said, “whenever she helps anyone, they always come back and say, ‘Mama, there’s no one like you!’” (Sangoma 3, personal comm., 2018). For me, this shed light into an interesting cultural aspect of traditional healing—the interpersonal dimension that seems integral to the practice of traditional medicine.

Despite doctors being uncertain about the methods and process of traditional healers though, each admitted to observing seemingly miraculous proof of it working in some instances. While Doctor 1 largely attributed the workings of traditional medicine to the placebo effect (Doctor 1, personal comm., 2018), Doctor 4 says that doctors simply “haven’t explored [it] enough” (Doctor 4, personal comm., 2018). He provided an example of seeing a child come in with a complex and large abdominal cyst. Despite the doctors recommending surgery to remove this cyst, since there was the threat of it rupturing and causing complications, the parents were adamant about visiting a traditional healer first. Three months later, the child returned to the hospital and the cyst was completely gone, without any evidence of scarification. He said that the doctors were shocked— “there was not a trace of the cyst...it was clear, clear, clear” (Doctor 4, personal comm., 2018). This was evidence for Doctor 4 that practitioners not only have mutual intentions, but that there are elements to be learned in both domains.

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This story made me understand how proof of healing factors into conceptions of legitimacy between domains. Doctor 4 described being more willing to delve deeper into the workings of traditional medicine after this successful encounter with traditional medicine. In the health domain, the ends seem to justify the means—a healthy patient is a universal language.

Limitations

What I have come to understand about biomedicine throughout this ISP process is that it is conspicuously limited when it comes to making meaning out of illness. While major focus is placed on discerning the biological cause of disease, there is little to no discourse within the biomedical framework to help patients interpret their illness experiences. This seems to be because it is not within the Western model to think about diseases as anything beyond biological abnormalities. Even in mental health, for example, environment and traumatic events may induce stress, which may in turn trigger a neurochemical imbalance leading to anxiety or depression; but ultimately this is still very much a biological perspective. As Doctor 2 says, “often people want to understand ‘So why did *I* get cancer? Why do these things happen to me?’ And we have no real explanation for those kinds of things” (Doctor 2, personal comm., 2018). He says that some of traditional healing’s value comes from its holistic worldview. In their approach, meaning and cause of sickness can be drawn from “the ancestors and higher beings; there’s meanings beyond the here and now” (Doctor 2, personal comm., 2018).

Similarly, Doctor 4 perceived Western medicine to be limited in its lack of engagement or desire to even understand the paradigms surrounding traditional healing, particularly in a rural context (Doctor 4, personal comm., 2018). He said that this is a limitation because the traditional model is essentially how patients conceptualize their health. However, because doctors are dismissive of it and are not willing to change their training to accommodate for this majority paradigm, that handicaps doctors to not be able to address community health problems beyond diseases. He continued, saying that this limitation could potentially be resolved through Department of Health-facilitated meetings and conversations between practitioners. However, he says that there’s reservations about this on both sides: doctors remain resistant to engaging in these conversations, and izangoma “don’t see the need to be registered,” since the community already knows them to be traditional healers. (Doctor 4, personal comm., 2018).

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Doctor 1 said that one of the biggest limitations of biomedicine is that it operates largely under the pretenses of knowing everything about disease, but despite years of science and knowledge production, the domain's knowledge and understanding is still very limited. Providing an example, he said, "we don't actually know the best way to treat hypertension in Africa...and that's frightening...when 40-50% of people over 45 have [it], and...we don't even know the biomedical way to manage those people in 2018" (Doctor 1, personal comm., 2018).

Before this ISP process, I have always separated the notions of "medicine" and "meaning." While I did consider Western medicine to have cultural dimensions (e.g. white coats, rapid knowledge production, etc.), I never thought about my health practitioners as people who could assign meaning to a sickness, or who could deduce *why* a sickness happened to a patient. To me, that always seemed like a job for people more in touch with the spiritual realm, such as religious leaders or fortune-tellers. However, perceiving that there must be a distinction between the two—that physical healing and spiritual healing must necessarily be separated—speaks to how I have been constructed as an individual within the Western paradigm.

The limitations of traditional medicine in my understanding come from Sangoma 2, who says that sometimes, traditional healers are only able to address symptoms of disease and not resolve entire problems. While ancestors may shed light into possible causes of sickness (such as witchcraft or familial problems) and can provide remedies, their hands seem to be tied when it comes to healing deeply rooted biological issues. She provided the example of a woman who came to her who had been menstruating for a long time. In that scenario, she said, "doctors are the only ones who can take a pap smear and discern the cause to be womb cancer;" as a sangoma, her medicines are "only able to stop the bleeding" (Sangoma 2, personal communication, 2018). She said that cures for TB, HIV, cancer, and asthma are not within the domain of traditional healing.

Sangoma 3 expressed a different take on the limitations of traditional healing, saying that much of doctors' negative perceptions of izangoma come from "those who are fake." Both she and Sangoma 1 admitted that they were not aware of true izangoma making any mistakes. When they both told this to me, I was surprised and taken aback. It seemed bizarre that izangoma—even the most experienced ones—would believe their practices to be flawless. Naturally, this led to other considerations, such as what parameterizes "mistakes" within their understandings?

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This also shed light on the exposure izangoma have to the practices of one another. Sangoma 3 says that since she is trained in her dreams, she does not formally engage with other izangoma; however, Sangoma 2 attends meetings regularly with the other izangoma in her village, where they collaborate and share ideas. While it seems unnatural to me that such a huge institution utilized by most South Africans lacks consensus, exposure, and formality, I have begun to understand just how strict and unyielding the rules and standards are within my Western paradigm; this sentiment needs not be shared by those operating within separate paradigms, especially those that have been working for generations.

Power, Suspicion, and the Other

Another element that re-emerges in the proof of healing is the notion of power and legitimization. Although greater strides are being made towards a more cooperative system, the doctors noted how the system is maintained by longstanding sentiments felt on either side. Doctor 3 said that, despite traditional being outlawed during Apartheid, it continues to survive “because that is how people make meaning...the issue of legitimacy is *only* a power issue of how people’s beliefs are legitimized by the state or by Western medicine.” Referring to the Foucault’s discussions of power and the “biomedical gaze,” he said that “biomedicine is very powerful, and...not by accident. It’s a collusion between capitalism and the state that actually maintains this” (Foucault, ? in Doctor 3). He noted how the Department of Health tends to underfund the process of setting up the legislated Interim Traditional Health Practitioners Council, despite the legislation being very clear about how it should be funded (Doctor 3, personal comm., 2018).

When I spoke with the izangoma about their sentiments, they expressed that the relationship between doctors and traditional healers was largely “imbalanced” (Sangoma 3, personal comm., 2018). Sangoma 2 spoke to how izangoma were under-resourced, and that despite being required to attend trainings at the hospital, the izangoma are not provided with any useful healing resources, such as gloves for touching wounds (Sangoma 2, personal comm., 2018). Speaking to the role of traditional medicine in the changing world, each sangoma said that they don’t believe traditional medicine can change too drastically. Sangoma 3 said, “traditional medicine will never change, because even her grandparents...used the same medicines that [sangoma] are treating with now,” adding that doctors don’t regard this element of traditional medicine because of their education (Sangoma 3, personal comm., 2018).

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Doctor 4 spoke to the inherently disconnected models, saying that the people who lead medicine are not willing to subvert their “positivist mentality,” and traditional healers, “don’t want to be ‘believed’ anyways—they’re...happy practicing where they practice in their communities, isolated” (Doctor 4, personal comm., 2018). Doctor 2 also brought up izangoma’s fear about exploitation, saying, “there’s certainly some suspicion that big pharmaceutical companies will take [their] herbal medicines and will understand the ingredients of them. They’ll market them, and [izangoma] won’t benefit” (Doctor 4, personal comm., 2018). This made me think about past vs future knowledge—why is so much emphasis placed on the future? Who gets that final decision? It also challenges the Western paradigm that there is a one-size-fits-all approach to the production of pharmaceuticals, that there *must* be a standard remedy. Given that every person’s human biology is different, it’s perplexing that we just assume that health will manifest similarly in everyone with the same prescriptions and treatments. While I believe that health practitioners don’t truly believe health manifests equally in everyone, biomedicine still generally upholds standardization and mass-production of knowledge over variability. That traditional healing’s domain is criticized for adapting remedies to the individual, however, reveals much about who holds the authority in the dynamic. Adrian Flint writes about the positive aspect of this individualized attention given to patients, saying, “traditional forms of healing in South Africa are unhurried and deeply personalized, with treatment being specifically tailored to each individual...including counseling for both...patients and their families” (Flint, 2015, p. 4329)

This reveals yet another tradeoff between biomedicine as it is delivered in the public health realm and traditional medicine. For me, health is such a sacred aspect of the human experience that it warrants full attention and commitment by health practitioners. In the South African context, where public health institutions are quite saturated in regions like KwaZulu-Natal, patients still deserve an interpersonal relationship with their healer who can provide important insight into the patient’s understanding of themselves and their bodies. This again reinforces my belief of medical pluralism in this region—both traditional healers and Western doctors each contribute different essential roles for South Africans in the public health realm.

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Referral vs. Consulting

One of the final elements that I consider in this ISP is what happens when one domain fails to heal a patient, or cannot meet their needs? Beginning this ISP, one of my biggest curiosities was about the referral process. We were taught in lecture that izangoma were trained to refer patients to clinics for issues they cannot resolve, such as TB and HIV. And this made sense to me—TB and HIV have biomedical remedies with proven effectiveness that have enabled hundreds of thousands of people to live healthily in spite of those diseases. However, what my previous exposure did not answer, was why the formal referral process was one-way. It certainly suggested that biomedicine believed it could solve all illnesses. But I wanted to gauge the perspectives of clinicians and izangoma about their experiences with the referral process.

I asked doctors about their hesitations—or lack thereof—in sending their clients to traditional healers. Doctor 2 said he finds it particularly challenging because doctors “see the mistakes” of izangoma; working in the rural environment, he would receive patients who are dehydrated or in renal failure after taking traditional remedies, and it was difficult *not* to assign blame to those practitioners. He says that doctors are unwilling to compromise uniformity and standard output, because that is the standard that doctors themselves are held to—if you visit a doctor in Durban, you should expect the same prescription and treatment from a doctor in Cape Town (Doctor 2, personal comm., 2018). In traditional medicine, he argues, there is too much uncertainty even across traditional healers.

Doctor 3 adds to the idea of “seeing” izangoma but holds an entirely different perspective. In rural areas clinicians are exposed to countless opportunities to observe and engage with traditional medicine, even within their own clinics (Doctor 3, personal comm., 2018). However, he holds that doctors “edit out all of the things that [they] don’t understand...they don’t *see*.” He provided an example of working in a TB ward with another doctor in 2007. He said in this particular TB ward, there was tremendously high mortality rate of about 50%. During his ward rounds, he smelled *impepho* burning, which he said was common in rural wards because patients “have come to call the spirit home” (Doctor 3, personal comm., 2018). When he asked his colleague if she could also smell the burning, she said that she couldn’t smell anything. He was shocked—“how is it possible that she has worked in this ward for months [and] has never smelled *impepho*? Every day people come and collect their

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spirits...and are burning *impepho* in that ward” (Doctor 3, personal comm., 2018). His colleague was apparently just as surprised that he knew so much about traditional medicine; he reasoned that “[doctors] just don’t see it because this is something ‘other.’ And I think that is how...biomedicine works—that we only see what we want to see” (Doctor 3, personal comm., 2018).

But Doctor 3 did see the benefits of a cross-disciplinary referral process, saying that he frequently refers patients to izangoma for illnesses he believe to be traditional in nature. He told this story of a young woman who had been admitted to the hospital because she was “apparently psychotic and had attacked her family with an axe” (Doctor 3, personal comm., 2018). When he did his ward round that day though, her demeanor was completely sane, helping out other patients and speaking in a collected manner. He also noticed that she was an izangoma from the traditional garments she was wearing. He probed to see why she was in the ward and discerned from her story that she suffered from a disconnect with her own ancestors—the ancestors that called her to become a sangoma were her husband’s ancestors. He said that she was deeply suffering from this, exacerbated by the fact that her family would not accept her as a sangoma. When she tried approaching them in a follow-up visit, a fight broke out, leading to her bout of violence. Because Doctor 3 understood that this problem was far outside of the domain of biomedicine, he suggested that they find another traditional healer to potentially mediate between the ancestors of her family and her husband’s family. She said to him, “I cannot believe this, that is exactly 100% correct,” and after connecting her with another sangoma he was familiar with, he discharged her that same day (Doctor 3, personal comm., 2018).

Despite recognizing the importance and massive influence of traditional medicine, Doctor 4 still had reservations about doctors referring patients to izangoma. He said that the first crucial step in getting doctors on board would be to integrate medical school curriculum with traditional medicine. However, he does not imagine that doctors could buy into the idea of witchcraft, saying, “if someone comes in and they’re psychotic, no it could never be because there’s a neighbor who [did] something to them...it’s outside our belief system [and] our training” (Doctor 4, personal comm., 2018).

When I spoke to the izangoma about their experiences referring patients, or receiving patients for the clinics, they each expressed how they had been trained to refer patients to clinics

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for TB and HIV. Sangoma 2 said that nurses will bring babies to her in secret, because she is able to heal sicknesses causing them pain in their bellybuttons, and she can tell when they are experiencing this pain” (Sangoma 2, personal comm, 2018). Sangoma 3 said that “doctors and nurses respect [izangoma], attributing this to their upbringing—“that is how they were raised” (Sangoma 3, personal comm., 2018). Based on the context of the answer, I inferred this to mean specifically doctors growing up in rural or traditional settings.

One consideration that I did not think about before this ISP was that a working relationship could be established between traditional healers by means of consulting together. The doctors I spoke with seemed to regard this option much more favorably than referring patients to izangoma; as Doctor 2 describes it, “[doctors] don’t feel comfortable sending patients into a system that [they] don’t know anything about” (Doctor 2, personal comm., 2018). Because mutual consulting takes away the element of uncertainty, it seems like something even skeptical doctors might support if it was shown to improve patient outcomes.

Regarding a consulting relationship with izangoma, Doctor 4 talked about how one of the board members of his hospital was a traditional healer who mediated between clinicians and the local traditional healer’s council. He said that this link between both modalities was extremely useful—he would tell other izangoma, “yes...we do our healing side of things, but let’s also send these patients to make sure that they are getting their blood tests [and] medication” (Doctor 4, personal comm., 2018). Moreover, he saw the usefulness of monitoring patients who are openly using both modalities. In his view, there doesn’t have to be a trade-off or ultimatum: patients don’t have to choose between traditional or biomedical healing. In his dealings with these patients who were using both *muthi* and ARVs, he said, “my role was just to monitor to see how they were faring” (Doctor 4, personal comm., 2018). He monitored their viral load, drug-to-drug interactions, and ensured that patients were still taking their ARVs. He suggested that an even more formalized cooperative setting involving the Department of Health would be even more beneficial, saying that some of the doctors from his rural hospital were considering adding a consulting room for traditional healers to practice. (Doctor 4, personal comm., 2018) Doctor 4 believes the close proximity of healers would facilitate conversations and discussions about the medicines each use. Moreover, it would expedite patient treatment, because patients could be referred to doctors immediately after consulting with their sangoma.

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Sangoma 2 shared this sentiment, saying that “if doctors don’t believe that [traditional] medicines are working, why don’t they bring someone who is sick to the izangoma to do the practical and diagnosis, so that they can see that these things are healing? (Sangoma 2, personal comm., 2018). This seemed like an excellent and valid question—in the space between practitioners, there seems to be a gaping hole of denialism. Tying it back to Doctor 3, biomedical practitioners don’t see, nor do they want to even verify, the strong potential of traditional medicine.

That being said, Doctor 4 still predicts a power imbalance with the consulting—he says that monitoring their dealings with patients and treatments would still subvert their authority. He explained that it might come across as doctors thinking that they’re better and taking over aspects of their control (Doctor 4, personal comm., 2018). He questioned where the balancing point lies in their dynamic. His concerns made sense to me. Any element of trying to modify or professionalize traditional healing does subjugate izangoma to the discretion of biomedical authorities. I imagine too that the opinions of izangoma vary greatly on the matter, which begs yet another question: who decides on behalf of traditional healers to professionalize their institution or maintain it? Who is the authority of traditional healers, if any? I question whether the idea of a central traditional healing authority would even fit within their paradigm of power and healing.

Offering izangoma consulting positions would benefit patients and doctors alike, since it may lessen the delay in receiving biomedical and traditional treatment. Patients could be screened, diagnosed, and treated all in one trip, and their treatments could include both biological and spiritual elements. However, I can anticipate problems with this in the event of conflicting explanatory models. Which healers would be excluded from the selection process for “traditional consultants” who might otherwise be recognized as izangoma within their communities?

Regarding the proof of healing, the space between practitioners contains conceptions of legitimacy—a patient showing physical signs of improvement is a sign in both domains that treatment has successfully run its course. However, the space also contains open-ended questions surrounding the referral process and authority. What is the cost of subjugating traditional healing to standardization and professionalization, and who is excluded from this process? This section was meaningful to me because it did reveal much about the current efforts being made to include

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izangoma into the formal health sector. In my understanding, there is no simple answer—even those with the best of intentions are still uncertain about what a true medically plural system would entail for practitioners and patients alike.

Concluding Remarks

I have two recommendations for further research on this topic. First, I believe that it would be valuable to explore the narratives of patients who utilize both systems of healing. How patients assign meaning to health and their bodies, and in turn use that meaning to select their healers, would shed more light on the dynamics between modalities. What I am curious about after writing this ISP is how patients negotiate their syncretic worldviews given their options. Second, I believe further research should be done on the meaning-making processes of izangoma throughout the healing process using a Zulu-speaking researcher and/or user of traditional medicine. I was not adequately able to learn from izangoma narratives, given my limited understanding of their worldview and the translation barrier. However, I believe they hold crucial insights into traditional explanatory models of disease, and they might be able to relay this information to someone operating within their paradigm as opposed to outside of it.

While they interact in policy via the provincial Traditional Healers Council of KwaZulu-Natal, there is often little personal interface between traditional healers and doctors in KwaZulu-Natal, despite their playing integral and intensely interwoven roles in their patients' lives. Thus, an instrumental relationship exists in the space between these two entities; one where each modality believes in its core principles but is forced to make compromises in the mutual interest of the patient. This research project used participant narratives and researcher journaling to paint a picture of the negotiations, collaborations, and dynamics between these fundamentally distinct ideologies that underlie healthcare delivery in the province's pluralistic medical system.

What I have learned from this research was that there were five key points of intersection with which I could explore the “space” between practitioners. These phases aligned with the chronology of the healing process of patients, and in each stage, participants reflected on their own positionality as health practitioners. I could not draw definitive conclusions from participant narratives; all stories and engagements were unique to each individual, and perceptions made

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about the Other varied tremendously based on previous experiences and paradigms. However, I could conclude that there were a spectrum of affinities for medical pluralism across domains—participants on both ends demonstrated a range of mixed feelings about collaborative efforts, but they all acknowledged the cultural importance of the other. That being said, these findings were meaningful for me because they reinforced my appreciation for the efforts being made to solidify medical pluralism in South Africa. Participant narratives also highlighted key differences and points of miscommunication and ambiguity between the paradigms. Medical pluralism would require facilitated communications between practitioners on both ends, as well as open-mindedness and the willingness to place trust in the expertise of the Other.

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Appendix 1: Local Review Board Approval



**Human Subjects Review
LRB/IRB ACTION FORM**

<p>Name of Student: Mairisa DeSignore</p> <p>ISP/Internship Title: What lies in the space between doctors and traditional healers in Kwa-Zulu-Natal?</p> <p>Date Submitted: 12 October 2018</p> <p>Program: SFH Durban Community Health</p> <p>Type of review:</p> <p>Exempt <input type="checkbox"/></p> <p>Expedited <input checked="" type="checkbox"/></p> <p>Full <input type="checkbox"/></p>	<p>Institution: World Learning Inc. IRB organization number: IORG0004408 IRB registration number: IRB00005219 Expires: 5 January 2021</p> <p>LRB members (print names): John McGladdery Clive Bruzas Robin Joubert</p> <hr/> <p>LRB REVIEW BOARD ACTION:</p> <p><input checked="" type="checkbox"/> Approved as submitted <input type="checkbox"/> Approved pending changes <input type="checkbox"/> Requires full IRB review in Vermont <input type="checkbox"/> Disapproved</p> <p>LRB Chair Signature: <i>[Signature]</i></p> <p>Date: 22 October 2018</p>
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Form below for IRB Vermont use only:

Research requiring full IRB review. ACTION TAKEN:

__ approved as submitted __ approved pending submission or revisions __ disapproved

IRB Chairperson's Signature

Date

Appendix 2a: Consent Form for Izangoma

SIT Study Abroad

a program of World Learning



CONSENT FORM

1. Brief description of the purpose of this project

This project aims to study the relationship between traditional healers and Western doctors. Research questions will be centered on the referral process between doctors and sangomas, how each profession is treated by the other, and different beliefs about healing. Your interview responses will be what I will think about when writing my research paper. The research will include the stories of interview participants that show the themes that make up the relationship between healers and doctors.

2. Rights Notice

In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview. Please take some time to carefully read the statements provided below.

- a. **Privacy** - all information you present in this interview may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer know.
- b. **Anonymity** - all names in this study will be kept anonymous unless you choose otherwise.
- c. **Confidentiality** - all names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to you.

I understand that I will receive **no gift** or direct benefit for participating in the study.

I confirm that the learner has given me the address of the nearest School for International Training Study Abroad Office should I wish to go there for information. (404 Cowey Park, Cowey Rd, Durban).

I know that if I have any questions or complaints about this study that I can contact anonymously, if I wish, the Director/s of the SIT South Africa Community Health Program (Zed McGladdery 0846834982)

Participant's name printed

Your signature and date

Marisa DelSignore

Interviewer's name printed

Interviewer's signature and date

I can read English. If the participant cannot read, the onus is on the project author to ensure that the quality of consent is nonetheless without reproach.

3. Consent for Recording

I also give my consent to be recorded during this interview. I understand that the recordings will be deletion upon completion of the ISP

Participant's name printed

Your signature and date

Marisa DelSignore

Interviewer's name printed

Interviewer's signature and date

Appendix 2b: Consent Form for Doctors

SIT Study Abroad

a program of World Learning



CONSENT FORM

4. Brief description of the purpose of this project

The purpose of this project is to explore the relationship and existing dynamics between traditional healers and Western doctors. Research questions will be centered around perceptions about cross-disciplinary referrals between traditional doctors and sangomas, power dynamics, and constructions of legitimacy. Data will be collected in the form of interview responses and journal entries written throughout the ISP process by the researcher. The research will be written as a narrative that showcases the major themes relating to components—if any – that make up the space between healers and doctors as expressed during the interviews.

5. Rights Notice

In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview. Please take some time to carefully read the statements provided below.

- d. **Privacy** - all information you present in this interview may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer know.
- e. **Anonymity** - all names in this study will be kept anonymous unless you choose otherwise.
- f. **Confidentiality** - all names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to you.

I understand that I will receive **no gift** or direct benefit for participating in the study.

I confirm that the learner has given me the address of the nearest School for International Training Study Abroad Office should I wish to go there for information. (404 Cowey Park, Cowey Rd, Durban).

I know that if I have any questions or complaints about this study that I can contact anonymously, if I wish, the Director/s of the SIT South Africa Community Health Program (Zed McGladdery 0846834982)

Participant's name printed

Your signature and date

Marisa DelSignore

Interviewer's name printed

Interviewer's signature and date

I can read English. If the participant cannot read, the onus is on the project author to ensure that the quality of consent is nonetheless without reproach.

6. Consent for Recording

I also give my consent to be recorded during this interview. I understand that the recordings will be deletion upon completion of the ISP

Participant's name printed

Your signature and date

Marisa DelSignore

Interviewer's name printed

Interviewer's signature and date

Appendix 3: Loosely-Structured Interview Guide

For Izangoma:

- I. Can you tell me about how you became a traditional healer?
 - a. Do you have a specialty?
- II. What do you know about Western medicine?
 - a. Who informs you about this?
- III. Do you visit a doctor?
 - a. What issues do you believe to require only Western medicine?
 - b. What about traditional healing?
 - c. Do Western doctors or nurses ever come to you for spiritual healing?
- IV. What does “sickness” mean to you?
- V. What does “healing” mean to you?
 - a. How do you know when a patient is cured?
- VI. Do you believe a cooperative system between Western and traditional medicine can work in the South African context?
 - a. Do you think sangomas have enough say?
 - b. (if no) what more can sangomas contribute to health in South Africa?
- VII. Have you referred patients to doctors?
 - a. Do patients from doctors ever come to you when they are uncured?
- VIII. Do you foresee doctors being able to refer patients to traditional healers in the future?
- IX. What do you believe to be the limitations of Western medicine?
 - a. Can you give me any stories or examples of failures of Western medicine as it is practiced in South Africa?
 - b. What about traditional healing?
- X. Can you give me five words or ideas that best explain the relationship between traditional healing and biomedicine in South Africa? These can be Zulu words.
 - a. Would you like to elaborate on these?
- XI. What does traditional medicine have to give up to meet the needs of people who rely on both forms of healing?

EXPLORING THE SPACE BETWEEN HEALERS

For Doctors:

- I. Can you tell me about how you decided to become a doctor?
 - a. Where did you study?
 - b. What is your specialty?
- II. What do you know about traditional healing?
 - a. Who informs you about this?
- III. Did you have any exposure or relationship to traditional healing prior to your entry into biomedicine?
- IV. What does “sickness” mean to you?
- V. What does “healing” mean to you?
 - a. What is the purpose of medicine?
 - b. How do you know when a patient is cured?
- VI. Do you believe medical pluralism (cooperative system between biomedicine and traditional medicine) can work in the South African context?
- VII. Have any patients been referred to you from traditional healers?
 - a. How were they referred to you?
- VIII. Do you foresee doctors being able to refer patients to traditional healers in the future?
 - a. What issues could you refer to traditional healers?
- IX. What do you believe to be the limitations of Western medicine?
 - a. Can you give me any stories or examples of failures of Western medicine as it is practiced in South Africa?
 - b. What about traditional healing?
- X. Can you give me five words or ideas that best explain the relationship between traditional healing and biomedicine in South Africa?
 - a. Would you like to elaborate on these?
- XI. What does Western medicine have to give up in the South African context to fit the needs of people who rely on both forms of healing?
- XII. What would be required for traditional medicine to gain legitimacy and recognition by the Department of Health?

Appendix 4: Consent for Use of ISP by SIT

	MY ISP MAY NOT BE PUBLISHED OR QUOTED IN ANY WAY – STRICTLY CONFIDENTIAL- VIEWED BY OTHER DURBAN SIT HEALTH STUDENTS ONLY
X	I HEREBY GRANT PERMISSION FOR WORLD LEARNING TO INCLUDE MY ISP IN ITS PERMANENT LIBRARY COLLECTION
X	I HEREBY GRANT PERMISSION FOR WORLD LEARNING TO RELEASE MY ISP IN ANY FORMAT TO INDIVIDUALS, ORGANIZATIONS, OR LIBRARIES IN THE HOST COUNTRY FOR EDUCATIONAL PURPOSES AS DETERMINED BY SIT
X	I HEREBY GRANT PERMISSION FOR WORLD LEARNING TO PUBLISH MY ISP ON ITS WEBSITES AND IN ANY OF ITS DIGITAL/ ELECTRONIC COLLECTIONS, AND TO REPRODUCE AND TRANSMIT MY ISP ELECTRONICALLY. I UNDERSTAND THAT WORLD LEARNING’S WEBSITES AND DIGITAL COLLECTIONS ARE AVAILABLE VIA THE INTERNET. I AGREE THAT WORLD LEARNING IS NOT RESPONSIBLE FOR ANY UNAUTHORIZED USE OF MY ISP BY ANY THIRD PARTY WHO MIGHT ACCESS IT ON THE INTERNET OR OTHERWISE