
The Sangoma¹ and the MD: The clash of Western Medical Science and Traditional Medicine in South Africa

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Abstract

The clash between traditional methods of healing and Western medical science in places like South Africa requires that we ask questions like "What is health?" "What does healing mean?" and "What is science?" This paper will first outline the presuppositions contained in the approach of Western medical science towards health and healing, and contrast it with the radically different vision of human being that emerges from some traditional South African medical practices. The author contends that the contemporary move towards the recognition of alternative medicine is concurrent with a shift in Western thinking on the nature of science, healing and human being. Some ideas on how the sangoma and the MD can work together, rather than against each other, are explored.

Introduction

Coping with health problems forms a significant part of the lives of people in Africa, most especially in the light of the HIV/AIDS epidemic. Access to basic health services, as well as the related infrastructure, such as water supplies, sanitary works and roads remains one of the biggest problems on the continent. Western-based medical care is inefficiently designed to cope with the demands of the African environment (in all senses of the word); dependent on expensively trained personnel working in expensive hospitals; and is often of limited relevance to the conditions of people living in so-called "developing²" countries (Good, 1989). Yet, the problem in South Africa is even more complex than this:

Here in South Africa... we are confronted with the obscenity of a well-heeled, affluent (usually white) middle class being treated, at enormous cost, for complaints that frequently are themselves caused precisely by this affluence, while the greater part of the population is undernourished, badly housed and deprived of the most elementary hygiene. Basically, in South Africa... the problem is one of political economy³. (Hammond-Tooke, 1989, 13)

In South Africa, as well as in many other African countries⁴, the influence of traditional medicine⁵ and traditional medical practitioners is extensive⁶, and so it remains a question as to what role these practitioners can play in promoting the well-being of communities and individuals in South Africa. Western bias against traditional healing practices is strong, with many asserting that traditional forms of healing are suspect, scientifically unfounded, “dangerous relics of the past, clung to by the ‘backward’ populations out of ignorance and superstition” (Connor, 2001, 9).

This paper will therefore explore the relationship between traditional African methods of healing and Western medical science in South Africa, first by outlining the presuppositions contained in the traditional approach of Western medical science towards health and healing, and then contrasting it with the radically different vision of human being that emerges from some traditional South African medical practices. The author contends that the contemporary Western move towards the recognition of the value of so-called “alternative” as well as “traditional” medicine is concurrent with a shift in Western thinking on the nature of science, healing and human being. Some ideas on how the *sangoma* and the Western-trained medical practitioner can work together, rather than against each other, are then explored.

What is health? – A Western perspective

Modern Western medicine is a manifestation of a very distinctive worldview. In his *The Turning Point* (1982), Fritjof Capra discusses what he calls the “biomedical model”, which, he claims, is the underpinning of the Western approach to health and healing. Capra notes that the influence of the Cartesian paradigm on Western thinking has resulted in viewing the human body as a machine; and that by concentrating on smaller and smaller fragments of the body, modern Western medicine often loses sight of the patient as a human being (Capra, 1982, 118). Disease is seen as the breakdown of the machine, and the doctor’s task is reduced to the repair of that machine. Death is seen as failure – of both the patient and the medical practitioner.

Under the sway of the biomedical model, the sacred body of ancient times becomes the secular body (Kimbrell, 1993). The view that the human body was created by the gods/God gives way to the view of the body as machine. This “doctrine” of mechanism has flourished in the age of biotechnology in which we live, one that was born in the mechanistic view of nature that began during the Enlightenment. What is significant is that this vision of human being as machine has provided a philosophical basis for the commercialization and colonisation of the human body by technology. If

the human body is merely a machine (albeit a very complex one), why can it not be bought, sold and manipulated in the same way as other commodities?

In this context, La Mettrie's *Man a Machine* (1748) can be seen as one of the most important steps in the philosophical mechanisation of human being (La Mettrie, 1912). Whereas Descartes, in his *Discourse on Method* (1637), maintained the separateness of humans and non-human animals by positing that although the human body was machinelike (in the same way that the bodies of non-human animals were machines), humans were special because of their immaterial, immortal souls (Descartes, 1912). La Mettrie saw no need for this dualism, claiming that humans, like other animals, were soulless machines.

The biomedical model is based on a worldview developed from the 17th century ideas of Isaac Newton. Newton's vision of the universe was one of a vast clockwork, functioning according to deterministic causal principles. The Newtonian observer is seen as independent of the phenomena observed, and reality is seen as "out-there", waiting to be discovered. Scientific objectivity is both an ideal and a reality, where unbiased observers obtain facts, and science is elevated to the status of being the only way to obtain "truth". This view can be called the "common sense" view of science (Chalmers, 1999).

With Newton, we see the further development of a process that began with Copernicus and Francis Bacon, with this process continuing into our own times. Science becomes the new religion in Western culture due to its profound intellectual effects on us, not only in terms of the extraordinary range of inventions which have transformed our lives, but also in terms of changing how we think about ourselves and our world. "If science has replaced religion... as the unifying focus of modern culture, then medicine is part of the central faith of our times" (Branson, 1987, 25).

In the biomedical approach, all authority and responsibility is given to the (usually male⁷) medical practitioner. This patriarchal tendency obviates the need for the patient to be seen as a responsible individual who plays a role in the healing process. It is also interesting to note the symbiosis between medical practitioners and the pharmaceutical industry, where profit and loss often overshadow the needs and humanity of the patient.

What is health? – A traditional African perspective

African traditional medicine can be defined as the:

... total body of knowledge, techniques for the preparation and use of substances, measures and practices in use, whether explicable or not, that are based on...personal experience and observations handed down from

generation to generation, either verbally or in writing, and are used for the diagnosis, prevention or elimination of imbalances in physical, mental or social well-being (Bannerman, Burton & Wen-Cheih, 1983, 25).

Traditional medicine, like its Western counterpart, is closely bound up with a people's worldview. A proper understanding of a culture's traditional healing practices thus also requires knowledge of the prevailing religion and cosmology. According to Kasenene (2000), two important ethical principles that underlie African life can be identified. Firstly, Kasenene (2000) asserts that African society is based on the recognition of a "vital force" that individuals seek to acquire⁸. Supreme happiness is to possess the greatest vital force; while the diminution of this force results in illness, depression, suffering and other social or physical evils.

Secondly, Kasenene (2000) asserts that African ontology is underpinned by the principle of communalism. The communalism principle can be expressed well by what Ramose (2002, 230) calls "...the root of African philosophy": *ubuntu*. *Ubuntu* (a Zulu word) is a worldview enshrined in the Zulu maxim *umuntu ngumuntu ngabantu*, i.e. "a person is a person through other persons" (Shutte 1993, 46). Individuals become real only in their relationships with others – in a community or group (Okolo, 2002: 213). It is the community that makes the individual – without the community the individual has no existence (Mbiti, 1969). The human being forms a link in the chain of vital forces and so the self is essentially a social person in relation to others.

In traditional African societies, healing is therefore all-inclusive, taking into account the whole person, as well as his/her social environment. "Shamanic therapy means the healing of an entire life, rather than just healing failing functions and disruptive pains. For shamans, healing involves philosophy, a view of life" (Kalweit, 1992, 3). Traditional medicine and its materials and practices do not simply deal with physical symptoms. Rather, they can be used to:

... supply personal strength and power, they provide protection against the malevolence of gods and spirits and the enmity of lose human rivals. They can also be used to influence the behaviour of others, to win a person's affection or induce them to do a favour. This demonstrates the all-embracing or holistic nature of traditional medicine (McLean, 1987, 10).

African traditional medicine is based on examining the causes of an illness, rather than the symptoms. The causes are oftentimes seen as social, in the sense that they relate to persecution by a third person in the form of witchcraft (Hours, 1987, 47). Hence, therapeutic strategy is also then a social strategy. The social and economic setting in which healing takes place is of great importance and the diviner's role is seen to be restoring a natural

balance and order (Ngubane, 1977, 27) by bringing the patient into a new way of being.

A shift in Western Thinking – Human being and Healing from a new perspective

With the advent of relativity theory and quantum mechanics⁹, the Western understanding of reality and a human being's place "in" that reality has undergone a major change. The observer now becomes an integral part of the process of observation, and the observable and observations can only be expressed as correlations, rather than simple, linear causes and effects. According to Zohar and Marshall:

Today's physics requires that we learn to see the physical world in different terms. The old Newtonian categories are inadequate for the new understanding... The familiar certitudes of classical physics – rigid categories of space and time, solid, impenetrable matter and strictly determined laws of motion – have given way to the strange world of modern physics, an indeterminate world whose almost eerie laws mock the boundaries of space, time and matter. A new kind of physical holism has replaced the classical emphasis on separate parts, and new patterns of dynamic relationship replace the old tension between isolation and collision. Where classical physics drew a sharp line between human beings and the material world, the creative dialogue between observer and observed in quantum physics suggest the possibility of an altogether more integrated relationship between ourselves and physical reality (1994, 11).

The new vision of human being and her world has set the scene for renewed interest in what have been called "alternative" or "complementary" therapies in medicine. Barrett (1998), for example, notes that the "alternative movement" in medicine can be seen as part of a general societal trend towards the rejection of science as a method of determining truths. According to Barrett (1998), this movement embraces the postmodernist doctrine that science is not necessarily more valid than pseudoscience and that scientific medicine is but one of a vast array of health-care options. This does not mean that we are becalmed on the waters of relativism, but rather that we need to change our rigid ways of thinking about "truth". Adopting a pragmatist stance, in other words, working with what "works", can be a very fruitful way of thinking about the "truths" of science in general, and medical science in particular¹⁰.

Our bureaucratized and materialistic medicine – this mechanical model with an active therapist and a passive patient that reduces the patient to an object and relegates healing to the long corridors of the hospital – has failed. This kind of healing belongs to the mechanical age. Today, however, we are already daring to make the transition to 'organic'

medicine, 'spiritual healing' through personal transformation, though the transformation of consciousness on all levels (Kalweit, 1992, 2).

Kalweit (1992, 244) claims that a number of the world models of contemporary physics (most especially quantum theory), when compared to the shamanic worldview, show that contemporary Western science and shamanist concepts converge. This controversial idea, which has attracted a faddish and almost cultlike following in terms of the supposed convergence between Eastern mysticism and quantum theory, can be called the convergence theory (Pine, 1989). The philosophical consistency between the results of contemporary science and shamanism does not "... prove much by itself" (Pine, 1989, 246). There have been many historical instances of a philosophy/religious view being consistent with the science of a time, and the resultant rush to claim that the new science validates that philosophy/religion. What is more interesting, and meaningful, in my opinion, is that the so-called convergence of these ways of thinking opens up to us a space in which new ways of thinking about health and healing can be accommodated.

In the 1978 Alma Ata resolution, the World Health Organisation suggested that African governments might make use of "traditional practitioners" in primary health care (McLean, 1986, 8). This suggestion, however, revealed a number of problems in practice:

Most African healing systems have not been formalized in print so that their principles could be open to outside scrutiny. Part of the ethics of many African healing systems is secrecy: this protects the society against the indiscriminate use of such medicine by certain individuals. Such secrecy also reflects the fact that the knowledge of indigenous medicines can be an index of one's power and influence in society. Just as Western practitioners of medicine guard their professions through tedious methods of registration and induction, so does the African traditional medical class obtain the same protection through secrecy. Unfortunately the success of that secrecy has resulted in a serious blow to the credibility of the entire system. (Ademuwagun, Ayoda, Harrison & Warren, 1979, p. vii)

Additionally, in trying to force an integration of traditional medicine with its Western counterpart, a number of factors that preclude this integration can be identified (McLean, 1986):

1. Modern medicine is based upon an entirely different set of concepts from traditional medicine.
2. The spiritual, psychotherapeutic and social dimensions of traditional medicine are ignored, since it is easier to focus on studying herbs, an aspect of traditional healing which is visible, tangible, measurable and manageable¹¹.
3. In some countries like Ethiopia for example, the existence of severely separate forms of traditional medicine makes integration complicated.

4. Western trained professionals are mostly those who occupy positions at the national level of health care, and their bias towards traditional healers as 'quacks' could hinder integration.
5. Traditional practitioners may not be effectively organized to act as a pressure group, and so be less powerful in this respect than members of the Western medical tradition.
6. Political instability in African countries could hinder integration, since a programme of integrating traditional medicine requires political commitment.
7. Limited economic resources in African countries could hinder integration, since instituting such programmes is very costly.
8. Practical problems, such as the selection of traditional practitioners for integration, systems of sorting, registration and licensing, payment, responsibility, as well as training and evaluation of the integration programmes, could hinder the process.

The above notwithstanding, the question we need to ask is "Why official *integration*?" Integration could imply great danger for traditional medicine and its practitioners, since from the point of view of modern Western medicine it means incorporation into a national health system dominated mostly by Western-trained professionals. This is not necessarily bad in itself, but when one considers the possibly significant negative bias against "traditional" healers, integration might turn into assimilation, and the contribution of "traditional" healers being lost in the process. It is also my contention that forced integration is another example of the patriarchal, colonising tendency of the West, in attempting to impose a superficial order on Africa. Scientific, "modern" technologies, based on a knowledge system deemed superior to the pre-existing knowledge system that will hopefully be supplanted, is, in my opinion, merely colonialism and imperialism in disguise.

The concept of medical pluralism is, in my opinion, the better option. Medical pluralism can be defined as the politics of therapeutic practices, i.e. "...how relationships of power and meaning are played out between diverse practices in a given context, and how they change over time" (White, 2001, 172). Differing models of healing should be respected – inclusion, rather than integration will aid us in avoiding doing violence to both systems. Exposing the relationships of meaning and power inherent in our conceptions of health and healing, rather than forcing one system to fit into another, could yield much more to us in terms of therapeutic practice. The peaceful co-existence of the traditional healer and the MD could represent a realistic vision for the future of a new type of health care. Institutionally independent, they could work together where necessary without laying claim to the supervision of the health activities of the other.

Surely, the aim of any healing system is to promote the health and flourishing of the patient and community? If this is so, then methods to ensure the safety of the patient should be considered to be of primary

importance, whichever medical tradition is being used. The practice of traditional healing practice should be standardized, regulated and have a code of practice to ensure that any harmful practices can be controlled. Instead of a forced integration, the establishment of an independent body to monitor and evaluate the practices of both systems, as well as foster dialogue between them, would be valuable.

Conclusions

Health care attitudes and methods have to take into account a people's philosophical and cultural concepts of disease and health (Kaseneke 2000, 350), but "The work of the African healer complements that of the hospital – it is not a substitute for it. Each system functions side by side in its own distinct sphere" (Fyfe, 1986, 4).

...Even though it is desirable to keep both systems going, and ensure intercommunication between them, it is inopportune to integrate traditional practitioners into the hospital services, as some experts have proposed...African medicine does not permit governments to save money by neglecting to provide health services and a coherent public health policy. Nor can it cope with epidemics. Its place is elsewhere. What it does, is to take care of most social pathology...It declares (and declares because it knows) that sick people live in society, that sickness is also social, and therefore that no therapeutic system should ignore this dimension – neglect of which is the great weakness of so-called scientific medicine (Hours, 1987, 57)

Traditional medicine relies on the resources of the past, but to remain valuable to contemporary society, it must remain open to the future and in dialogue with the total culture of which it forms part¹². A new paradigm of healthcare delivery is required, not to integrate African medicine and Western approaches, but rather one that ensures access to and dialogue between both treatment modalities. With Capra, I admit that the biomedical approach to health will remain extremely useful, as long as its limitations are recognized (1982, 164). The reductionist analysis of the body-machine has not and will not provide us with a complete understanding of illness. Biomedical research should be integrated into a broader system of patient-centered health care where human illness is seen as resulting from an interplay of human being and environment.

Unfortunately, South Africa is lagging behind other African countries in recognizing traditional medicine and establishing structures for traditional healers and medicine. A number of problems need to be addressed in this context, such as the problem of intellectual property rights, negative and sensationalist articles in the popular media and unethical behaviour of healers relating to the treatment of patients. Yet, the role that ethical and

well-educated traditional healers can play in South Africa's response to the HIV/AIDS crisis, as well as to contribute to improving the efficacy of its health system is great¹³. In line with the "Traditional Health Practitioners Bill" of 2003, a regulatory framework that ensures the efficacy, safety and quality of traditional health care services can provide a means to allow the Sangoma and the MD to work together as partners, without suspicion. A respectful attitude of open exchange and information is essential. What should be remembered, however, is that the new emphasis on collaboration should not serve as a substitute for the West's failure to provide the world's poor with adequate medical care (Farmer, 1992).

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Endnotes

1. The terms *isangoma* (traditional diviner) and *inyanga* (traditional doctor) should not be confused. In South Africa, in most groups, there are two clearly distinguishable types of healers – the diviner and the herbalist. The diviner is called to her vocation by the ancestors, and identifies the cause/s of illness and misfortune if they are the result of supernatural forces (*Isangomas* are predominantly women, whereas *inyangas* are usually male (Faure, 2002)). The herbalist, on the other hand, is not mystically called. Herbalists are masters of medicine and have knowledge of the medicinal value of roots, plants and other substances. They could be compared to Western-trained pharmacists; whilst sangomas can be compared to Western-trained medical doctors. In this paper, reference will be made to both sangomas, and inyangas, since it is recognised that both play an equally important and complementary role in traditional African systems of healing.
2. The use of the words “developed” and “developing” is itself problematic, since it is indicative of the continued hegemony of the West in terms of deciding what development should mean and be.
3. Even though this quotation was written pre-1994, I assert that the problem it outlines is still of great relevance in South African society today. The ostensible “end of apartheid” with the first truly democratic elections in 1994 did not magically erase racism, inequality or strife in South African society, although it was a first step in this direction.
4. See for example Good (1987, 2).
5. The use of the word ‘traditional’ is problematic, since as Hours (1987) points out, it implies that the tradition is an abstract, unchanging corpus of practices and knowledge. Instead, these practices and knowledge are evolving in a dialectical relationship of adaptation and competition with what is called ‘modern’ (i.e. ‘western’) medicine. It is also a confusing term, since it has also been used to refer to Western-based ‘scientific’ medicine (Barrett, 1998, 4). The WHO (Traditional Medicine Strategy 2002-2005, 2002) draws a distinction between ‘traditional medicines’ and ‘complementary and alternative medicines’, where the latter refers to a broad set of health practices that are not part of a country’s own tradition, such as acupuncture or homeopathy.
6. The WHO estimates that up to 80% of the population in Africa makes use of traditional medicine (Traditional Medicine Strategy 2002-2005, 2002, 1). It is, however, difficult to estimate how many South Africans make use of traditional healers and how many traditional healers practice their trade. Possible reasons for this include the fact that the South African government has only recently embarked on the process of formally recognising traditional healers and setting up traditional healer organisations (For example, the “Traditional Health Practitioners Bill” was only published on 11 April 2003); as well as that the majority of studies focussing on traditional healing in South Africa have focused on black African traditional healers. Very few studies have focused on other groups within the South African tapestry of cultures.
7. The position of women in postcolonial Africa in relation to the values, policies and practices of Western-based medicine is important to mention here. Women, as patients, and more specifically as child-bearers, have been subjected to invasive forms of surveillance and control by state health systems. In the drive to subject all to the superior

capacities of Western-based medicine, women's expertise as healers has often been rendered valueless.

8. This concept of universal energy has been conceived in many ways, for example, the Sotho call it *moya*, the Masai speak of *ngai*. The same is also meant by the Chinese *ch'i*, the Hebrew *ruach* and the Indian *prana*.

9. These theories will not be discussed in detail in this paper. See Pine (1998) for an excellent introductory look at these theories and their philosophical implications.

10. Pragmatism is, in my opinion, compatible with realism (i.e. the idea that a real physical does exist). Similar to Chalmers, I assert that even though we must concede that the common sense view of science is fraught with difficulty, we can, however, still maintain that there is a real world that human beings can investigate (Chalmers, 1999: 9). The problematisation of the common sense view is summarized well by Thomas Nagel when he points out, "...there is no view from nowhere" – we "can't get outside of ourselves completely" (Nagel, 1986: 6)

In "Unended Quest" (1976) Karl Popper claims that the evolution of physics will be one of never-ending correction and approximation. Even if one day we should reach a stage where our theories are no longer open to correction, they would still not be complete. For Popper (1976), this realisation does not prove that the objective physical world is incomplete, or undermined, but rather only reveals the essential incompleteness of our efforts as human beings. For Popper, science is distinguished by its critical approach, and not because of its "habit of appealing to empirical evidence in support of its dogmas" (Popper 1979: 27).

11. See, for example, Chavunduka (1987, 70).

12. Traditional healers are undergoing a process of change as Africa modernizes. Colonial powers and structures have played an important role in changing the cultural landscape in which traditional healers practice, such as the Witchcraft Suppression Act of 1957, as well as the Witchcraft Suppression Amendment Act of 1970 (Jolles, F. & Jolles, S., 2000).

13. See for example Green (1994) for details of studies focusing on bridging the gap between traditional healing and modern medicine in Africa, with a special focus on HIV/AIDS and STDs.