Introduction

There is nothing certain about life lived in Africa. Indeed it is the existence of uncertainty and the responses to it that shed light on the myriad understandings and practices that accompany attempts to avoid sickness and ensure healing and wellbeing. As in other parts of the world, in sub-Saharan Africa, a variety of pathways to health and healing are available for those who have fallen ill. However, not all pathways result in health or even a cure.

This chapter explores the practice of biomedicine in relation to ‘traditional healing,’ a term used to describe African vernacular healing traditions. It does so from two angles: those of the practitioners and providers of healing and healthcare, and those of the patients and clients that seek recovery and wellbeing. Combined, the two angles shed light on the structural factors that enable access to particular kinds of therapies (and not others) and the role of entrepreneurship in biomedical and traditional healing.

Using examples drawn from sub-Saharan Africa, the chapter begins with a discussion of the people who administer therapy to the afflicted, how they are trained, and the conditions under which they practise. This is followed by a discussion on how the afflicted and their kin navigate different healing traditions and make sense of the therapeutic options available to them. In doing so, the chapter discusses ‘medical pluralism,’ a term used to describe people’s pluralistic approach to dealing with illness and disability. The chapter concludes with a general discussion of some of the contours of postcolonial medicine in Africa.

The landscape of health and healing

In many societies in sub-Saharan Africa, people believe that a person is connected to other beings (living and dead) and the land. Good health is attributed to good relationships with the living and the dead (ancestors), and ill health and misfortune are a sign of disharmony in relationships, the social milieu, and the natural order. Illness can therefore result from the disapproval of ancestors, or it may be caused by a witch or sorcerer (Flint 2001: 203). Indigenous healing is thus orientated towards healing the social body and the body politic (Schepers-Hughes and Lock 1987) rather than just the biological body. Local healers commonly treat problems ranging from reproductive disorders to climate irregularities, and social and political tensions.
The treatment often involves others in order to be collective and public. In sub-Saharan Africa, ill health has always been (and remains) attended to by a variety of local healers who are part of established indigenous healing traditions and work in a diversity of contexts.

In Africa, south of the Sahara, biomedical ideas and therapies are a relatively recent phenomenon having been only introduced in the nineteenth century alongside colonization and Christianity. The foot soldiers of this endeavour, medical missionaries, often lived far away from the large colonial stations and since they possessed medical supplies and some knowledge of medical diagnosis and treatment, they treated Africans on a regular basis. Through this interaction, missionaries were introduced to local ideas of disease causation and treatment, and of salvation, and the afterlife (Landau 1996). Initially, attempts to convert Africans to Christianity were largely unsuccessful. Missionaries blamed this on ‘witchdoctors’—a term they used to describe African healers—for perpetuating superstition. While local populations, for various reasons, did not wholeheartedly accept biomedical therapies, the relationship between the two groups of healthcare providers—traditional healers and colonial doctors—was not necessarily nor always adversarial. Some colonial doctors sought advice from local healers about disease aetiology and treatment (Flint 2008: 200).

What distinguishes African and biomedical healing traditions is their particular conceptions of the body and disease aetiology, diagnosis, and treatment. When biomedicine was introduced to Africa, the dominant biomedical idea of disease causation at the time was germ theory—the idea that diseases are caused by pathogens and can be isolated and destroyed through the use of biomedical technologies. Converting people to Christianity and to accepting biomedical therapies thus required a cosmological shift from an understanding of people as connected to each other, the land, and the ancestors, to one of the individual and germs.

With regard to the perception and treatment of the colonized, the emergence of germ theory was an important milestone. During the imperial era, diseases were thought to have been caused by miasma which was linked to vapours and unclean air triggered by the climate and the environment. Biomedicine was therefore only used to treat the diseases of the settlers since the constitution of settlers and indigenous populations was seen to be different. The advent of germ theory led to the idea of ‘biological commensurability’ enabling biomedicine to be used to treat illness among the colonizers and the colonized alike (Lock and Nguyen 2010). Germ theory also coincided with a reorientation among colonizing powers to the value of a healthy labour force in building the colonies. Consequently, eradicating epidemics and keeping populations healthy became a priority.

Today in many African countries, Christianity is widespread and biomedicine is an entrenched healing tradition that exists alongside indigenous healing practices. In South Africa, approximately 80 per cent of the population consults traditional healers (Flint 2008). The term ‘traditional healing’ can be somewhat of a misnomer if it is thought to imply that traditional healing practices adhere to long-established norms and are immune to changing socio-cultural, political, and economic environments. What counts as traditional healing today includes a variety of healing practices, some of which use ideas borrowed from world religions such as Christianity and Islam and/or from other medical traditions including biomedicine, Ayurvedic, and Chinese medicine. The category ‘traditional healers’ thus includes herbalists, diviners, faith healers, prophets, and spirit healers, but as can be seen in the burgeoning ‘market of wellbeing’ (van Dijk and Dekker 2010: 2), traditional healers are not just limited to these categories.

While some predicted that the efficacy of biomedicine would lead to people turning away from other healing traditions, vernacular healing practices persist and indigenous healers continue to be consulted to attend to affliction. Sometimes a healer is chosen because the
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Cosmology that underpins their healing practices is familiar to clients and/or patients. Other times it is because of the healers’ distance from the everyday world of the patient that gives them the power to heal. The mobility of healers is seen as one factor that increases their ability to heal. According to Thornton (2017), when people seek out healers and therapy, alongside trust and the quality of the relationship, belief is an important consideration—belief both in the ability of the practitioner and in the efficacy of the medicine.

Cosmology underpins many local healing traditions and practices. In Swahili-speaking East Africa, it is common for Muslim religious leaders to also become healers (Parkin 2007: 197). In Muslim dominated northern Nigeria, the reliance primarily on Islamic prophetic medicine and consulting malamai (Muslim scholars) since the fourteenth century continues even in the era of AIDS.

A tenet of Islamic prophetic medicine is that ‘with every disease, Allah has also sent its cure.’ Given the high prevalence of HIV in sub-Saharan Africa and since there is no cure for AIDS, this tenet puts malamai in a difficult position. However, so as not to falsify the doctrine and knowing that a claim to be able to cure AIDS can put people at risk, malamai have incorporated biomedical technologies in their diagnostic practices and they often insist that their clients also consult a biomedical doctor (Tocco 2014). Thus, rather than quell the use of Islamic prophetic medicine, the introduction and expansion of antiretroviral therapy (ART) has resulted in a resurgence of Islamic prophetic medicine. Furthermore, rather than perceiving the two healing traditions as adversarial, people experience them as complementary and easily navigate between biomedicine with its intervention in the body and Islamic prophetic medicine with its intervention on the body through emphasis on the curative properties of divination, prayer, and numerology.

Perceptions of the therapeutic landscape

People are often able to bring together a number of different beliefs to bear in the treatment of a condition. Alongside considerations of access, finances, pressures from kin, and so on, belief in the efficacy of the cure is an important factor in the choice of therapy even in the face of mounting evidence of inefficacy.

What happened in Tanzania in 2011 illustrates how people seek out a cure simply through belief, despite warnings that the cure might be fatal. The incident began when a retired Lutheran pastor claimed that God had given him the recipe for a herbal drink in a dream. He gave the drink to a few people who claimed that it cured them of HIV, cancer, diabetes, and hypertension. When the word spread, thousands of people flocked to the village of Samunge seeking ‘Babu’s cup,’ including government officials, high profile people, and the political elite. According to Mattes (2014), the popularity of the concoction was in being able to arouse the interest of both the proponents and critics of biomedicine and the healing power of religion, suggesting that people did not adhere only to biomedical logic but were also willing to believe that other healing traditions might provide a cure. He points out that for the ‘masses of pilgrims . . . scientific evidence was unimportant’(2014: 182). As a pandemic affecting millions of people in Africa, HIV/AIDS has opened up a market for entrepreneurial healers, particularly because it is known that there is as yet no biomedical cure and because the biomedical therapies that exist to prolong health are experienced as toxic to the body, underscoring a widespread perception that biomedicine and the pharmaceutical companies are intent on exploiting Africa and Africans (Masquelier 2012; Tocco 2014).

Historically, lay people in sub-Saharan Africa have not always received biomedicine with openness and confidence. Referring to Algeria during colonial times, Fanon described
Algerians as having an ‘ambivalent attitude’ towards biomedicine due to its entanglement with colonization and oppression. He explained that Algerians avoided going to hospitals ‘of the whites, of strangers, of the conqueror’ (Fanon 1994 [1959]: 125) because they did not trust that the doctors would not intentionally kill them. He described hostile encounters between doctors and patients, positing that they were based on mutual misunderstandings, misreadings, and mistrust. More recently, biomedical interventions, including the provision of free ART, have elicited suspicion. In Nigeria, for example, Muslims who have relied primarily on Islamic prophetic medicine were suspicious of the recent push for the use of ART in the north, an area where biomedical services were relatively recent and unevenly distributed (Tocco 2014). When biomedical services were introduced they rapidly became overcrowded, and as is now a common story across Africa, the facilities are under-staffed, and there were frequent drug shortages. Weak government response to HIV healthcare provision has resulted in massive intervention and funding from the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and the United Nation’s Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Although this has not been met with widespread opposition, the people and religious practitioners who have expressed misgivings point to profits and interest motives of pharmaceutical companies, the toxicity, and side effects, questioning the efficacy of ART as a therapy that treats but fails to cure (Tocco 2014: 125). Furthermore, the idea of providing free drugs to Muslim Nigerians against the backdrop of Western aggression towards the Muslim world made people question the motives and interests of global HIV/AIDS agencies and foreign donor bodies like PEPFAR and United Nation’s GFATM.

Perceptions of biomedical practitioners have also not always been positive. In the late nineteenth century, the local population in the kingdom of Buganda considered African hospital workers to be ‘defiled’ by their work and regarded them as being polluted because they failed to cleanse themselves after having been exposed to polluting substances such as blood during birth or dead bodies (Iliffe 2002: 21). Algerian perceptions of ‘the native doctor’ in the 1950s were ambiguous (Fanon 1994 [1959]: 131). On the one hand, the existence of African doctors proved that the colonized were as capable as the colonizers, on the other hand, African doctors were despised for having adopted the ways of the colonizers. Only through their involvement in the war of liberation did perceptions of local doctors change for the better. Beginning with the first medical students in East Africa, being a medical doctor set doctors apart from laymen because training required ‘an extraordinarily rigorous socialisation’ (Iliffe 2002: 73). Today being a medical doctor still requires extensive training and socialization and is regarded as a position of status. Indeed physicians and clinicians make up the elite of many sub-Saharan countries.

Negative perceptions of traditional healers arise from political and religious ideology rather than being a statement about their ability. It has often been the case that newly independent Marxists states will denounce traditional healers. In Zanzibar, for example, during the revolution of 1964, a number of traditional healers were denounced as fake and out to exploit people. Some were killed by self-appointed political agents of the new regime (Parkin 2007). In Mozambique, following independence, the ruling Frelimo party regarded traditional healers as primitive, superstitious, and as an obstacle to the progress of the country. In Maputo, traditional healers were made to stand before popular courts and, if found guilty, were banished from the city. In terms of religion, some Christian churches and strict Muslims regard some types of traditional healing as satanic (cf. Last 1986; Parkin 2007; van Wyk 2015).
Learning to heal: biomedical education in Africa

How healers are trained differs according to the particular healing tradition, and considering these differences offers an important background to the practice of medicine in postcolonial African states. The training of biomedical practitioners has been a site from which to gauge the enduring legacy of colonialism as well as resistance to it in Africa. Pentecost and colleagues made the point that in South Africa and other postcolonial states ‘modern biomedicine has been indelibly shaped by colonial histories, reflected in its infrastructures, bureaucracies and pedagogies’ (2018: 221). While it is no longer racialized, it remains hierarchical and gendered. Some attempts are being made to change this overwhelmingly male profession in new medical schools like the University of Global Health Equity in Rwanda, however the form of instruction remains largely male, white, and somewhat proselytizing, continuing the entanglement of medicine and religion.

The first medical school in Africa was in West Africa. Then known as the Ecole Africaine de Médecine et de Pharmacie de Dakar, it was established at the Cheikh Anta Diop University in Senegal in 1918 (Chen et al. 2012: 4). Although East African doctors, who at the time were mainly male, began practising biomedicine in the 1870s, their training was not formalized until the early twentieth century (Iliffe 2002: 7). Until the 1920s in East Africa, missionaries provided medical care and training to Africans in the form of apprenticeships. It was only in 1924 that formal medical training was provided for Africans at Makerere College in Uganda. While the first African medical practitioners came from poor families, the formalization of medical training attracted people from a more privileged background who would later become part of the educated African elite.

In the 1960s and 1970s, during the immediate post-independence era, there was a burgeoning of medical schools in sub-Saharan Africa. Governments of most newly independent states and their leaders saw health and education as important pillars of nation-building so in the early years of independence, education and health were prioritized.

Unfortunately for many states, the enormous investment in health and education was short-lived. In the 1980s, most countries were subjected to structural adjustment programmes from the West which resulted in budgetary cuts on essential services leading to the closure of some state hospitals. The state hospitals that remained open were under-resourced and under-staffed as a result and led to many local doctors and nurses leaving for countries of the North seeking better pay and working conditions.

Today, sub-Saharan Africa suffers a disproportionate share of the world’s burden of disease while having some of the world’s greatest healthcare workforce shortages (Chen et al. 2012: 1). There are not enough doctors, nurses, and other medical personnel. Sub-Saharan Africa lacks training facilities for the healthcare workforce. Sub-Saharan Africa has an estimated 145,000 physicians total, or eighteen physicians per 100,000 people. Some countries, such as Tanzania and Malawi, report as few as two physicians per 100,000 people (Chen et al. 2012: 2).

The training of medical doctors is a critical issue in sub-Saharan Africa. The sub-Saharan African Medical School study identified 168 medical schools in the region. In the twenty-first century there has been a concerted effort to increase the number of medical schools across the region. Consequently, in 1990s and 2000s, twenty-two new private medical schools were established. Of those private medical schools, six were faith-based and not-for-profit schools, nine were non-faith-based not-for-profit schools, and seven were private for-profit schools (Chen et al. 2012: 4).
Medical pedagogical and working environments present a challenge in terms of creating a cadre of dedicated doctors who are willing to work in public hospitals. The general atmosphere of austerity measures in hospitals, increasing populations, increasing disease burdens, and shortages of medical supplies has made working conditions in most African public hospitals difficult. Furthermore, the socio-economic and political situation of a country affects the conditions under which doctors practise biomedicine.

Let me draw briefly on the memoirs of two South African doctors to provide insight into three key challenges they face. First, I consider the intellectual and emotional process of training and practising as a physician. Second, these memoirs reveal the complexity of doctoring and healing particularly with respect to the personal and the political. Third, I reflect on the importance of ethics in achieving a humanized professional identity, an issue that has been of importance in discussions across Africa.

Regarding medical education and practise in South Africa, retired physician William Pick (2007) writes that studying medicine forcibly inscribed race on his body. As a medical student of colour during apartheid, certain opportunities were foreclosed to him that were not for white students. He gives an example of what he calls ‘Dermatological apartheid.’ He writes:

when the Dermatology lectures included white patients for demonstration, students of colour were excluded from the lecture theatre and shown black patients behind a curtain in the corridor outside the lecture room.

(2007: 91)

This exclusion resulted in white students and students of colour having qualitatively and quantitatively different knowledge despite being in the same course. The unequal access to knowledge remains for African doctors, especially those working in public hospitals.

A doctor practising in public hospitals in Africa will be exposed to high-risk situations and their chances of contracting a disease are very high. S/he is unlikely to have high tech equipment at her/his disposal, which means that one learns to adapt, and this leads to a different kind of knowledge than, for example, doctors practising in North America. Feierman has described the conditions under which doctors work in public hospitals in Africa as a ‘normal emergency’ (2011: 172). Medical staff often have to improvise by ‘making do, tinkering, and ad libbing’ (Livingston 2012: 12). In her account of an oncology ward in Botswana, Julie Livingston writes that ‘improvisation is a defining feature of biomedicine in Africa’ (2012: 6).

In her memoir, former physician Maria Phalime (2014) described her training at one of Africa’s top medical schools at the University of Cape as ‘brutal.’ She emphasized the overwhelming workload, the confusion, the continual sense of inadequacy and uncertainty, and the humiliation that junior doctors suffered at the hands of (mainly white) specialists and registrars. She also described the inadequacy of the approach to medical education in preparing junior doctors for the situations that they would inevitably encounter during their internships and community service, particularly with the added burden that HIV places on healthcare professionals.

I didn’t think to question the see one, do one, teach one approach to our training. I accepted it as the way things had always been done. It was only when I started practicing as a doctor that I came to appreciate how inadequate it was. What level of competence can be gained from observing a procedure once before being deemed fit
enough ot perform it and then in turn teach it? Not only was it nerve-racking for the inexperienced doctor, it was potentially dangerous for the patient.

(Phalime 2014: 143)

The majority of hospitals and clinics that newly trained doctors like Phalime are sent to for their community service in post-apartheid South Africa are under-resourced, over-stretched, under-staffed and over-subscribed. Shortages of medication, equipment, and qualified staff are common, resulting in the most junior of doctors working without supervision. Interns regularly perform procedures that they have never practised before. They work long hours, often twelve-hour shifts, four consecutive days a week. If the shifts fall on the weekend, they inevitably encounter gunshots, stabbings, car accidents, rape, beatings. If shifts fall over a holiday weekend, the trauma is relentless. This is true in other African countries as well.

Phalime describes how the sheer exhaustion after working long shifts put them at high risk for needle stick injuries while dealing with infected patients, or acquiring TB as a result of being run down combined with the overwhelming exposure to TB infected patients. Phalime practised medicine for four years before she left the profession. Similarly, Claire Wendland quotes a Malawian medical student who describes practising medicine as ‘hell’ because ‘[t]here are limited resources: manpower [sic], equipment, and drugs. Another thing is poor salaries (packages). HIV/AIDS is very high, making life really difficult in patient care because the picture and severity of disease has changed for the worse’ (2012: 113).

In an article written by twenty-seven-year-old Margaret Kirumbuyo, a former physician from Tanzania, she described an incident that occurred while she was a medical student posted in a rural hospital foothills of Mount Kilimanjaro. Kirumbuyo writes about the sense of hopelessness that she, her peers, and their instructors felt when a simple operation on an ectopic pregnancy turned into a nightmare. The medical equipment was faulty; the hospital had no blood store, the nearest referral hospital was two hours away along a bumpy road and during the operation, there was a power cut. Under these circumstances the measures they took including having one of the students hold a solar lamp over the patient so the surgeon could perform the surgery and using manual ventilation to help the patient to breathe highlight the lengths that many medical personnel will go to to ensure a positive outcome. In the article, Kirumbuyo (2019) questions the feasibility of universal health coverage which proposes good quality and affordable healthcare for all. She writes:

Despite the many efforts to train healthcare workers, the fact remains that if the spaces and systems do not support them to put into action the knowledge they have gained then improvement of health outcomes will continue to remain low in communities. This also causes a shift in the ratio of the health workforce in rural to urban areas due to failure of proper retention mechanisms. Most often people tend to think that the sole reason that stresses healthcare workers is the low wages (that is indeed an important one) but likewise, a lack of proper tools to practice further compounds the frustration, and I can personally say that the feeling of being rendered hopeless against your will is not one anyone finds pleasure in.

Practising as a doctor in the public health system in Africa is dangerous and over-whelming. The education medical students receive does not prepare them for the work they will do. Like Phalime and Kirumbuyo, who are both no longer practising, doctors often decide to leave the profession or seek better working conditions in other countries, resulting in the current
shortage of physicians in Africa. Many patients, especially those using public hospitals, often feel a similar kind of despondency.

Patients and clients: seeking out biomedical care

During my research on the experiences of teenage mothers in Nyanga East, a township thirty kilometres from the city of Cape Town, I became distinctly aware of the contradictions and complexities of navigating biomedical healthcare as a poor, young, African woman in South Africa through many of my interlocutors. However, it was my interaction with Fundiswa that indelibly stayed with me, underscoring how poor African women experience the under-qualified, under-staffed, and under-resourced public hospitals.

Fundiswa was twenty-one years old in 2001 when I first met her. She was unemployed and shared a three-room house with her two sisters. Since she knew that I was conducting research on teen-aged pregnancy, in our initial conversation Fundiswa told me about becoming pregnant at the age of fifteen. She told me how embarrassed she was to realize that she, like many young women in the township, was going to become a teen-aged mother. She also described the negative reactions that she received from her family, her teachers, and the nurses in the clinic.

Like most teen-aged mothers, Fundiswa said she was not aware that she was pregnant and only discovered that she was pregnant when she went to the clinic to renew the injectable contraceptive that she had allowed to lapse. When she arrived at the clinic and stated that she was there for ‘the injection,’ the nurse in charge asked her age and then demanded to know why she wanted a contraceptive, intimating that she was too young to be sexually active. Following protocol, the nurse tested her urine to make sure that she wasn’t pregnant, however the test came back positive for pregnancy. Fundiswa was by then six months pregnant. On finding out that she was pregnant, Fundiswa thought about terminating the pregnancy, at the time she was in grade ten and hoped to finish her schooling. She had heard about a woman in the neighbouring township of Langa who performed this service. However, she did not go through with the termination because she was afraid that God would punish her with infertility, a common belief in African communities where birth is valued for the status that it accrues for women in the family.

As the cultural norm, her family had to declare the pregnancy to the family of the genitor (kubika sisu) and negotiate a settlement for the impregnation of a woman out of wedlock. When her family approached Sakhumzi’s family in order to negotiate for inhlawulo, Sakhumzi denied that they ever had a sexual relationship. Given the stalemate, Sakhumzi’s family decided that before they would consider paying inhlawulo, they would wait for the baby to be born ‘to see’ if the child bore a resemblance to Sakhumzi. On the day the schools closed for the holidays, Fundiswa gave birth to a boy she named Oluwethu.

After hearing the story of her conception and birth, I did not ask Fundiswa anything else about her child and hoped that as we got to know each other she might tell me more. A few months later I was at a workshop organized by Fundiswa and a number of young people who volunteered for the community-based youth organization, ‘We Are the Future.’ The workshop was specifically about teenage pregnancy and HIV. Fundiswa got up and told the captive audience about her experience of becoming pregnant, at the time she was in grade ten and hoped to finish her schooling. She described how she was taunted by the nurses when she attended prenatal appointments and during the birth. She also described how proud and happy she was of her son. I did not expect the story to end with her telling us that her son died from...
yellow jaundice at fifteen months. This unexpected turn of events left the room silent and stunned.

The following week when I visited Fundiswa, I asked her what happened. My memory of what unfolded remains very vivid. We were sitting side by side on a grass mat on the stoep (porch) outside, basking in the winter sun. I remember putting my hand on her shoulder and saying ‘You don’t have to tell me, if you don’t want to talk about it.’

She shifted from side to side and placed her hands on her lap. ‘It’s okay,’ she began.

I used to leave my son at Nkosinathi’s [a colleague’s] mother’s house. She had a crèche and I used to take him to that crèche. That Friday I didn’t go to school, he was in the crèche. Nkosinathi’s mother brought him to me and said he didn’t eat anything the whole day. She asked me to breastfeed him. But I could see that he was not the same.’ She paused. ‘He used to be an active child. He would come back from the crèche and then go and play with the other kids outside and come home later.’

‘Wasn’t he very young?’ I asked to confirm his age.

Fundiswa turned to look at me. ‘Yes, but the older children would come and fetch him, I didn’t mind. I would let him go and play with the other children. That day he was at home, crying and he was very weak. It was Friday and that evening he slept and at night he was screaming . . . like someone with a stomach ache.’

She looked down at her skirt tracing invisible patterns with her finger. ‘My grandmother said take him to the day hospital at KTC [a neighbouring township] in the morning, which is usually open 24 hours. The next morning I went there with my cousin and when I got there they just said to me “we don’t deal with young babies at this time, we only deal with emergencies.”’

I looked across at her bowed frame. ‘What did you do then?’

‘I had to come back home,’ she replied. ‘Luckily I had some money to take him to a [private] doctor but it was very early for the doctor. The doctor opens at ten [am]. When I got there it was nine [am]. I had to go and wait in the queue. It was a hot day and there were people outside.’ She paused and as an afterthought she added, ‘The lady next door, the one who used to babysit him when I went to workshops and others things, came with me to the doctor. She followed me to the doctor. I had him on my back.’

Fundiswa began picking at invisible crumbs, her eyes focused on the grass mat. ‘When we were there at the doctor’s, the lady told me “Hey . . . put a blanket over his head, it is very hot.” I put the blanket over his head. Then other people that were sitting around there all come around me and she took my baby from me.’

Her voice began to quiver. ‘When she took my baby, she was crying. They saw before me.’

Fundiswa paused to gather herself and in a whisper she added, ‘She took my baby.’

We sat in silence for a minute. I looked over at Fundiswa and she looked back at me. I could see the tears well up.

‘Then I saw the people; they were coming closer to me. They were trying to catch me. I was feeling dizzy. When I looked at my baby he was yellow . . . the feet and the eyes. And then they closed his eyes. That is when I fell down.’

‘I am so sorry,’ I said, not knowing if my words were of any comfort.

We sat in silence again. Her tears streamed down her face despite her attempts to wipe them away. ‘I wasn’t there anymore . . . I can’t remember how I got home. But I came back later. The doctor examined him and said he was three hours dead . . . which means when I went back to the clinic he was already dead.’

Fundiswa fumbled in her pockets. She found a small used tissue which she placed gently on each eye to stem the tears. ‘They told Sakhumzi the next day as he was working late on Saturday. They went to his family’s home and told him on Sunday. I wasn’t there but they said
he didn’t say anything. He just got up and went out to his room. He came here the next day with his uncle. He wanted to hear it from me because he thought they were lying. There was a funeral for Oluwethu on Wednesday.’

Barely audible, she added, ‘Oluwethu died on Saturday. Maybe I shouldn’t have waited for the doctor. I should have taken him to a *sangoma* [diviner]. My grandmother said they [Sakhumzi’s family] had bewitched him because they did not want to pay *inhlawulo*.’

**Issues of access**

This vignette allows me to make two points about how people experience healthcare in sub-Saharan Africa. Firstly, access to adequate healthcare is by and large not available for the majority of African people despite concerted efforts by governments to ensure equity and accessibility. To impress this point, I shall use South Africa as an example and take a few steps back in history to describe the actions taken by the government. The second point is hinted at in Fundiswa’s final statement that she should have consulted a local diviner, suggesting that her grandmother may have been correct in thinking Oluwethu had been bewitched. Such a statement points to how beliefs in causality and treatment are never rigid.

During apartheid, South Africa had a two-tiered healthcare system. White people had access to services equal to those of the developed world and had higher levels of ‘lifestyle diseases.’ African people, by contrast, had access to basic health services and suffered more from infectious and transmittable diseases and from diseases of poverty. Each racial group had its own health department and the South African government controlled the health departments and determined their budget allocations. Since resources were allocated unequally based on race, black health departments were severely under-funded, under-resourced, and under-staffed (Coovadia et al. 2009; Hassim et al. 2007).

The health system that the African National Congress (ANC) government inherited in 1994 was centralized, undemocratic, and highly fragmented. Since its intention was to serve the needs of the white population, the health system was biased towards curative and higher level services. It was not yet geared to meet the needs of the majority (cf. Mkhwanazi 2015).

In seeking to make health services available, affordable, and accessible to all, the ANC made healthcare in the public sector free for pregnant and breastfeeding women and for children under the age of six years. The previously racially divided health services were integrated. Sufficient and adequately skilled health workers were sent to rural and poor areas. In terms of education, more health sciences students were enrolled, teaching was moved from tertiary-level academic hospitals to primary healthcare settings and two-year compulsory community service was introduced. Despite these changes, the health profession remains skewed in terms of its urban basis both in the training of students and in service delivery. While the inclusion of women and students of colour has risen, students from rural and working-class backgrounds face challenges in accessing health science education (Pentecost et al. 2018: 222). Moreover, the two-tier healthcare system still exists; rather than being racially based, it is now divided between those who can afford private healthcare through medical insurance and those who only have access to public hospitals.

Addressing the second point, Thornton cautions against treating ethno-medical systems as if they have ‘internally coherent structures of meaning within definable boundaries of the community of practice’ and instead advocates for treating healing as a market where there are ‘options and risks, gains and losses and outcomes are not guaranteed’ (2017: 147). When people move between healers and different healing systems, their beliefs often change to fit the therapy.
Methods of healing are not entirely independent of each other; rather, many therapies implicate or entail one another. People use different therapies concurrently, often as assurance in case one practice proves unsuccessful. For example, a drink from a herbalist is often used to fortify the immune system against ‘the poison’ of antiretrovirals (ARVs). Furthermore, the choice of healer or healing options is also importantly circumscribed by the local context.

Daria Trentini (2016) provides a compelling account of how a series of social, religious, and economic changes in the lives of Makhuwa speaking residents of Nampula in Northern Mozambique has enabled practices in the healing of children who have fallen ill. The precariousness and uncertainty that permeates people’s lives in the city has resulted in mothers being suspicious that their jealous neighbours are trying to harm or kill their children. When children fall ill, parents often consult biomedical practitioners but they also consult spirit healers who are almost exclusively women and who are known to specialize in child medicine.

The domain of child medicine among healers is deeply gendered. Trentini writes that ‘because a large number of male healers have turned their backs on the “spiritual” side of their healing in favour of Islam, spirit possession and ancestral worship have become almost an exclusively female domain’ (2016: 534). Mothers also turn to spirit healers because they are more affordable and because they do not have any other options since other healing practices like Islamic medicine and those used in African evangelical churches do not specialize in child medicine. They are also most likely to choose spirit healers from their own region, and those who speak the same language because they share a similar worldview and are familiar with their traditions. Van Dijk and Dekker make a similar point when they write that ‘transactions in markers for health and healing are not anonymous and the actors are not interchangeable. Transaction in markets for health and healing, and thus health-seeking behaviour are personalised and relational, and in many cases involve trust’ (2010: 2).

Among the matrilineal Makhuwa, children belong to the maternal clan and it is mothers and their kin who care for children. Children, especially infants, are regarded as being close to the spirit world and so are particularly vulnerable to being victims of witchcraft or vehicles through which ancestors show their displeasure to the living (Trentini 2016).

While parents make a distinction between which disease should be treated in hospitals and which ones should be treated by a spirit healer, changing socio-economic environments have influenced which healing system mothers turn to. Decisions about healing should not be seen purely as a rational response towards ensuring optimal health; they also entail social considerations. In one of the three cases studies in her article, Trentini tells the story of Anastasia, an infant whose father was rumoured to have died of AIDS while her unemployed mother, Lucia, was pregnant with her and her brother, Matteus. At two months old, Matteus fell gravely ill and passed away. Months later, Anastasia also became ill, her belly was distended and she refused to eat. When Lucia took her child to the hospital, they prescribed some vitamins and antibiotics. When they consulted the spiritual healer, she prescribed a herbal drink three times a day and a week’s stay at the healer’s house so she could monitor the effect of the treatment. After a week with no effect, the healer told Lucia and her mother, that the condition was caused by her deceased husband and son who wanted their sister to join them. To heal Anastasia they needed to undertake a ritual in their homeland to release the child who was carrying ‘water to clean the body of the dead’ in her stomach. Returning home with the child, Lucia and her mother decided to ignore the healer’s advice and take the baby back to the hospital. Unfortunately, Anastasia died a week later.
Postcolonial medicine in sub-Saharan Africa—concluding remarks

In the third decade of the 21st century, governments of sub-Saharan African countries continue to struggle with providing adequate healthcare for the majority of their populations. This has opened up a space for transnational organizations, religious organizations, and enterprising individuals to come to the fore. It has also allowed for a proliferation of therapeutics, health technologies, and a variety of health experts, not all of whom have undergone training.

What is evident, more so than ever, is the futility of borders in containing illness, health-seeking behaviour, and health interventions. Diseases travel rapidly due to increased mobility. At the same time, mobility has enabled wider access to healing technologies. While this creates a greater measure of choice in how to avoid ill health, it also perpetuates inequalities where a wealthy minority have the access and resources to mobilize the best medical services and the vast majority make pragmatic decisions based on location, finances, and other structural constraints. Nevertheless, technological advances in communication (including, but not only limited to the internet) and travel have enabled the movement of technologies and ideas at an unprecedented scale that have helped to challenge any aspiration of biomedical hegemony.

Such landscapes of healing, which are now part and parcel of everyday life in the twenty-first century, highlight the diversification of medicine and the rise of entrepreneurial health experts to replace the biomedical professionals who left for greener pastures due to stringent structural adjustment reforms or untenable working environments. Mobility is central to contemporary healing and therapeutics in Africa—the movement of people, medicines, and experts. These connections are at the heart of postcolonial medicine. While this is not a new phenomenon, the scale at which diverse healers and their services are accessible is indeed new.

Historically, there has been a tendency to perceive peoples’ experiences of affliction and recovery in terms of discrete regional illnesses and medical systems ignoring other forces at play. The global is implicated in the local and vice versa. At every turn, the broader social, political, and historical considerations simmer under the surface.

Notes

1 This chapter is about healing practices specifically in sub-Saharan Africa. The term African is shorthand for people living in this area.
2 Although termination of pregnancy is legal in South Africa, there remains a stigma that surrounds both those who choose this procedure and those who perform the procedure. Very few women will openly go to a biomedical facility for terminations and, instead, many terminations in African communities are conducted in secret by unqualified people who operate illegally.
3 The birth of a child often allows a woman to acquire a higher status. A girl becomes a mother and a girl’s mother becomes a grandmother, thus a respected woman.
4 Inhlawulo is commonly referred to as ‘the payment of damages.’ When a girl becomes pregnant out of wedlock, her family has recourse to approach the genitor’s kin and ask for reparations. This payment does not mean the beginning of marriage negotiations. It enables the child to be acknowledged by the patriline.
5 When young girls begin menstruating, their mothers or guardians often watch over them carefully and try to control their movements as a way to guard against them becoming sexually active.

Bibliography