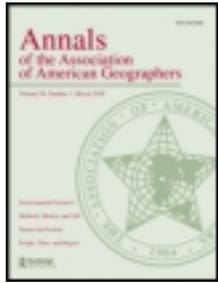


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“We Pray at the Church in the Day and Visit the Sangomas at Night”: Health Discourses and Traditional Medicine in Rural South Africa

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“We Pray at the Church in the Day and Visit the Sangomas at Night”: Health Discourses and Traditional Medicine in Rural South Africa

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Research within geography and cognate disciplines has worked to demonstrate the significant impacts of human disease on social and ecological systems. Although human disease fundamentally reshapes demographic patterns and regional and national economies, scholarly and policy research has tended to concentrate at the macroscale, thereby reducing attention to local-level dynamics that directly influence health decision making. This absence is notable given the invocation by various governmental agencies of the importance of traditional cultural practices, including the employ of traditional medicine, in responding to illness. South Africa's particular experience is representative of this, with national and provincial governmental agencies continuing to advocate traditional medicine in managing human health. Yet understandings of disease within South Africa remain deeply contested and expose underlying tensions about how health decision making is shaped by varied perceptions of illness and treatment options. This article draws on research that began in 2000 to analyze perceptions of health and the use of traditional medicine within rural areas. I work to uncover the divergent, and often conflicting, views on traditional medicine, and examine how they intersect with sociocultural systems that mediate health decision making. The article concludes that future geographic research on human health needs to engage with the social and cultural systems that contribute in shaping health perceptions and decision-making in various settings. *Key Words: health, political ecology, sangoma, South Africa, traditional medicine.*

地理和同源学科的研究曾经已证明人类疾病对社会和生态系统所产生的重大影响。虽然人类疾病从根本上重塑人口结构以及区域和国家经济，学术和政策研究往往集中在宏观尺度，从而减少对直接影响健康决策的地方一级的动态关注。这种缺乏是值得注意的，鉴于各政府机构所调用的传统文化习俗的重要性，包括使用传统医药应对疾病。南非的特别经验是其中一个代表，国家和省级政府机构继续在人类的健康管理中提倡传统医药。然而，在南非对疾病的认识，仍然有很深的争议，揭示出有关公共卫生决策的底层的紧张局势是如何由各种疾病和治疗方案的看法所塑造的。本文借鉴 2000 年开始的研究来分析健康的看法和传统医药在农村的使用。我努力发掘传统医学上的意见分歧和经常冲突，并研究它们如何与调解卫生决策的社会文化系统相交错。文章得出结论认为，未来人类健康的地理研究，需要考虑有助于塑造健康的看法，和考虑在不同环境中的社会和文化系统决策。*关键词：健康，政治生态，传统的精神医生，南非，传统医药。*

La investigación en geografía y disciplinas afines ha servido para demostrar los impactos significativos de la enfermedad humana sobre los sistemas sociales y ecológicos. Aunque la enfermedad humana fundamentalmente reconfigura los patrones demográficos y las economías regionales y nacionales, la investigación académica y de políticas ha tendido a concentrarse en la macroescala, reduciendo así la atención hacia la dinámica de nivel local que influye directamente en la toma de decisiones sobre salud. Tal ausencia es notable si se tiene en cuenta la invocación originada en varias agencias gubernamentales sobre la importancia de las prácticas culturales tradicionales, incluyendo el empleo de la medicina tradicional para responder a las dolencias humanas. Una experiencia particular representativa de esto es la de Sudáfrica, donde las agencias gubernamentales nacionales y provinciales siguen defendiendo el uso de la medicina tradicional para el manejo de la salud humana. Con todo, las maneras de entender la enfermedad en Sudáfrica siguen siendo profundamente debatidas y ponen de manifiesto tensiones ocultas sobre cómo la toma de decisiones sobre salud se configura a través de las variadas percepciones que existen sobre las enfermedades y las opciones de tratamiento. Este artículo se basa en una investigación que se inició en el año 2000 para analizar las percepciones de la salud y el uso de la medicina tradicional en áreas rurales. Mi trabajo se orienta a descubrir los puntos de vista divergentes y a veces en conflicto de la medicina tradicional, y a examinar la manera como aquellos se intersectan con los sistemas socioculturales que median la toma de decisiones sobre la salud. El artículo concluye que la futura investigación geográfica sobre salud humana

necesita involucrarse con los sistemas sociales y culturales que contribuyen a moldear las percepciones de la salud y la toma de decisiones en varios entornos. *Palabras clave: salud, ecología política, sangoma, Sudáfrica, medicina tradicional.*

The expansion of human disease, including HIV/AIDS, in sub-Saharan Africa has had significant impacts on both social and ecological systems (Drimie 2003; Barnett and Whiteside 2006; International Union for Conservation of Nature and Natural Resources 2010). Although human disease fundamentally reshapes demographic patterns and regional and national economies, scholarly and policy research has tended to concentrate at the macroscale, thereby reducing attention to local-level dynamics that directly influence health decision making. In addition to the local, and contextually specific, impacts of human disease, less attention has been directed toward understanding how health and prevention programs are themselves shaped by sociopolitical and cultural systems that extend beyond the geographies of disease. This is particularly needed given that perceptions of disease, and hence the opportunities for healthy decision making, are themselves often deeply contested. South Africa's experience with HIV/AIDS is a clear example of this, with the country having endured years of deeply rooted conflicts over how the disease was understood and best managed. In fact, the national government received international condemnation for questioning the links between HIV and AIDS and the efficacy of antiretroviral medications (Jones 2005; Fassin 2007). Within the competing disease discourses at the time were regular invocations of traditional medicine as a viable strategy for managing illness. The previous Health Minister, Dr. Manto Tshabalala-Msimang, regularly asserted the value of diet and traditional medicine as preventatives for HIV/AIDS and also drafted the 2008 policy that proposed further integrating traditional medicine into the national health care scheme (Department of Health 2008).

The intention of this article is to demonstrate how geographic scholarship, particularly from within the fields of health geography and political ecology, can contribute to emerging understandings of health–environment interactions and health decision making. This article draws on long-term research in South Africa that began in 2000 focusing on changing livelihood patterns following the 1994 democratic elections, shifting institutional systems shaping resource access, and the impacts of conservation and development processes within rural areas. I concentrate here on the findings from a structured household survey and series of semistructured interviews that detail

community perceptions of medical options, including the use of traditional medicine and the collection and use of medicinal plants. Although rural residents have a range of options for medical treatment, health decision making is shaped not only by constraints to access, which have been well documented in the literature (McIntyre and Gilson 2002; Schneider et al. 2006), but also by historical processes and sociocultural factors that influence perceptions of illness and discourses of health. This article details how perceptions of health and traditional medicine are differentially understood and how these views intersect and are shaped by local context, cultural practices, and historical geographies. While rural populations utilize traditional medicine with some regularity, governmental agencies and other stakeholders have reified the use of traditional medicine in particular ways that do not neatly align with local views and practices. As such, this article works to uncover the “subaltern health narratives” that conflict with national discourses to identify policy failures that might stem from misunderstandings of local practices and knowledge systems (King 2010, 50).

In the first section of the article, I provide a review of the research and policy literatures on traditional medicine within South Africa. This is followed by an overview of the case study and methodology, which involves research completed in northeast South Africa that examines processes of livelihood change and political and spatial transitions following the 1994 democratic elections. The case study research reported in this article concentrates on the findings on the collection and use of medicinal plants and perceptions and decision making of medical treatment options. These findings are discussed in detail in two sections, which outline general patterns of medicinal plant collection by residents of the Mzinti community and the divergent views on the efficacy of traditional healers. The article concludes by discussing the benefits of this study for emerging research on human health from within geography, with particular emphasis on the subfields of political ecology and health geography.

Traditional Medicine in South Africa

The use of traditional medicine within South Africa, and other countries within sub-Saharan Africa, is relatively common, with individuals and families either

collecting medicinal plants themselves or visiting with traditional healers to receive treatment (Kale 1995; Flint 2008; Peltzer 2009). Bhat and Jacobs (1995) surveyed the use of traditional medicine in the Eastern Cape Province and find that traditional doctors, herbalists, herb sellers, tribal priests, and local people record medicinal benefits from twenty-six plants. In a later study from the same region, Dlisani and Bhat (1999) found twenty-seven plants identified at the species level that are used for the primary health care of mothers and children. Other work similarly details the significance of medicinal plant collection to household economy and livelihood production (Twine et al. 2003; Makhado et al. 2009). In addition to the collection of medicinal plants, there is a growing literature on the reliance on traditional healers in both urban and rural areas (Nattrass 2005; Peltzer and Mngqundaniso 2008; Peltzer 2009). South Africa has multiple types of traditional healers, including *sangomas*, *inyangas*, and *umthandazis* (faith healers). Within the study region *inyangas* and *sangomas* are two types of healers that are seen by local residents as generally equivalent, with the exception being that *sangomas* have the power of communing with ancestral spirits. Consequently, *sangomas* can receive additional training and are viewed as more powerful by some community members. *Umthandazis* might be affiliated with one of the African Christian churches and use the Bible, prayer sessions, and other approaches for treatment. In a widely cited piece, Kale (1995) reported as many as 200,000 traditional healers in the country on whom 80 percent of black South Africans depend for certain forms of treatment. Several studies indicated a preference for traditional medicine for specific purposes, such as improving personal well-being or spiritual needs (Cocks and Møller 2002; Ross 2008). Liverpool et al. (2004) argued that because traditional medicine tends to cost less than other medical care it is routinely sought out, reporting that 75 percent of inpatients at a hospital in Johannesburg and a health care center in Soweto have used traditional healers. Cook (2009, 264–65) noted that given the number of traditional healers, and presumption that many people seek them out as first caregivers, there is a “necessity to expedite registration, integration, and monitoring of traditional healers into the South African health care system.”

Numerous studies, including several of those already cited, indicate a limited understanding of the factors shaping the use of traditional medicine and assert the need for more research, particularly given the expansion of HIV/AIDS. Given that networks of exchange

exist between traditional healers in referring patients to one other, and also to local clinics or hospitals, the national government has pursued strategies to regulate traditional medicine. The South African Traditional Health Practitioners Act 35 was passed in 2004 prohibiting traditional healers from diagnosing or providing treatment to patients with HIV/AIDS, cancer, or other terminal illnesses. This was later found to be invalid by the Constitutional Court because of a lack of public hearings, but efforts continued, including those by the former Health Minister, Dr. Manto Tshabalala-Msimang, to formalize the role of traditional medicine within the national health care system. The Traditional Health Practitioners Act (No. 22 of 2007) established the Traditional Health Practitioners Council to provide oversight on traditional healers. This was followed by the Policy on African Traditional Medicine for South Africa that was drafted in 2008, stating that “the official recognition, empowerment, and institutionalization of African Traditional Medicine, and its incorporation and its utilisation within the National Health System, would be an important step towards delivery of cost effective and accessible clients based healthcare” (Department of Health 2008, 6). Building on previous efforts, the policy is designed to institutionalize and regulate traditional medicine, establish a pharmacopeia of medicinal products, and collaborate with other countries and the World Health Organization to exchange information intended to “harmonize policies and regulations according to international standards” (14). The Draft Policy is also notable for two reasons; first, for its advocacy of traditional medicine and stated assumptions about its widespread use within the country. Second, the language of the policy indicates a preference for an “evidence-based public health and epidemiological approach” (35) that, as noted by Bishop (2010), minimizes the importance of spirituality in how traditional medicine is understood and practiced. Given that the national government is advocating the use of traditional medicine, yet adhering to a formalized regulatory framework coupled with a specific discourse of traditional medicine, research on local perceptions and practices is much needed.

Case Study and Methodology

The majority of this research was completed from 2001 to 2002, employing a mix of qualitative and quantitative methods, including a structured household survey, participant observation within the community of

Mzinti, and semistructured interviews with residents and representatives from national and provincial conservation and development agencies. The Mzinti community is situated within Mpumalanga Province in northeast South Africa, in a region that comprised the KaNgwane bantustan during apartheid.¹ Follow-up fieldwork was completed in 2004 and 2006 with additional interviews completed in the Mzinti community and also with health care providers in Schoemansdal and the provincial capital of Nelspruit. This article relies primarily on data derived from fifty semistructured interviews that were completed with male and female household heads to analyze livelihood production systems, dependence on natural resources, collection of medicinal plants, and perceptions of health options within the region. These interviews focused on the use of traditional medicine and whether family members visited with *sangomas* for health treatment. Given the diversity of traditional healers in the area, this research specifically asked whether people visit with *sangomas*, as opposed to *inyangas* or *umthandazis*, for treatment. In some cases, however, people responded by discussing their views of *inyangas*, affirming Bishop's (2010) contention that there is fluidity within these categories. Interviews with community residents also provided insight into the varied options pursued for health care, including decision making regarding visiting the local clinic or nearby hospital and the sequence in which these particular options were pursued.

In addition to the semistructured interviews, this article reports on the findings from a structured survey of 478 randomly selected households that collected information on livelihood production patterns and reliance on economic and natural resources. The surveys were designed to collect data on household histories and demographic characteristics, household assets, natural resource collection strategies, and the collection and use of medicinal plants. I concentrate here on the reported reliance on traditional medicine as a source of treatment, in addition to the collection of medicinal plants from communal areas surrounding the community. Although the qualitative semistructured interviews provide insight into how Mzinti residents view traditional medicine, these interviews are limited in understanding generalized patterns within the community. As a result, this article works to integrate the findings from both qualitative and quantitative methods of data collection to generate a contextually rich understanding of health discourses and decision making. The following two sections outline the major findings, first discussing the collection and use of medicinal plants by Mzinti

residents. This is followed by an analysis of the varied perceptions of traditional medicine within the region and how these views are shaped by social, political, and cultural processes unfolding throughout contemporary South Africa.

Medicinal Plant Collection and Use in Mzinti

According to the structured surveys, 6 percent of households report collecting medicinal plants and 26 percent indicate that a family member had visited a *sangoma* for treatment. It is worth noting that the structured surveys and semistructured interviews generated different percentages of reportage for collecting medicinal plants or visiting a traditional healer. As evidence of this, the semistructured interviews generated higher numbers, with roughly 18 percent of households collecting medicinal plants and 45 percent having a family member visiting with a *sangoma* at some point in time. These discrepancies are not surprising, because as I discuss in the next section, there are multiple social pressures to underreport the use of traditional medicine. As one of my research assistants explained after the completion of the household surveys, people were uncomfortable stating they visited traditional healers because "we pray at the church in the day and visit the *sangomas* at night." Given these circumstances, it should be clearly stated that the intention of this article is not to report the use of traditional medicine with precision; rather, I find the inconsistencies in reportage to be a valuable entry point into the varied ways in which health is understood within the Mzinti community, as well as the ways that health decision-making is shaped by social, political, and cultural factors.²

The collection of medicinal plants occurs at a number of points surrounding the community, although changing patterns of land cover are impacting the ability of collectors to locate plants. Additionally, communal areas in rural South Africa, which remain vital locations for the collection of a number of natural resources for livelihood production, exist at the intersection between overlapping and sometimes conflicting rules shaping access (King 2005, 2011). Following the 1994 democratic elections, new pieces of legislation and empowered national and provincial governmental agencies have been working to reshape land use patterns and resource access in rural South Africa. Within the Mzinti community, this includes the Mpumalanga Tourism and Parks Agency, which has jurisdiction in enforcing the 1998 Mpumalanga

Table 1. Select medicinal plant use within Mzinti

Medicinal plant (Western or local name)	Usage
Marula	Chest problems and headache
Guava	Coughing
Peaches	Stomach
<i>Inyokane</i>	Newborn child
<i>Nunankulu</i>	Stomach
Mixture of trees	Work problem and wounds
<i>Rosaline</i>	Luck, vomiting, and all diseases
<i>Shongi</i>	Knees, shivering, and muscles
<i>Sihlangu</i>	Stomach
<i>Limphambo</i>	Stomach
<i>Matema</i>	Stomach

Nature Conservation Act that placed new restrictions on natural resource collection, including the collection of medicinal plants from within communal areas. The Act obligates provincial governmental agencies to enforce these restrictions on resource access, challenging the historical power held by the Matsamo Tribal Authority, which has jurisdiction over Mzinti and other communities in the region. One of the semistructured interviews was completed with a *sangoma* who discussed at length the constraints in accessing medicinal plants within the area. As he explained:

[The tribal authority] has a problem with us being *sangomas*. They are asking for a rule that you may not come from Mahlalela Tribal Authority to Matsamo Tribal Authority for the herbs. That is why I am here because I think I have the privilege when I go to the back of my place I just go to the bush to dig. You see this is Nkomazi West and the left side is Nkomazi East, so it differs in the soil. This one is sandy soil and that one there is clay so the red and black soil is more fertile. There are more medicines on that side than this side and the medicines that are on that side are not here and also the ones here are not on the other side.

Although 10 percent of households that collect traditional medicine report gathering plants monthly, the remainder collects only when necessary for treating specific illnesses. Plants are used for a number of purposes, and Table 1 reports on some of the more common uses by Mzinti residents.

The lack of medicine within the Mzinti clinic and nearby hospitals is also a factor contributing to the use of traditional medicine within the community. Household members noted that the clinic would recommend guava leaves and other traditional remedies for treating specific symptoms, particularly if there was an absence of medicine at the clinic. Although the percentage

of households collecting medicinal plants is relatively small, an additional 7 percent of households report purchasing traditional medicine in markets either in Mzinti or in nearby villages. The average amount that households spend purchasing traditional medicine is roughly \$4, although as discussed in the next section, the cost of visiting with traditional healers was noted as a barrier by some community members.

Health Discourses and Decision Making in Mzinti

In addition to collecting medicinal plants and purchasing traditional medicine at the market, many community members visit traditional healers. Twenty-six percent of surveyed households report having a family member visiting a *sangoma* for a variety of purposes, including headache, cancer, stroke, tuberculosis, stomach problems, and foot problems. One of the benefits of the semistructured interviews is that they assist in revealing several understudied elements shaping health decision making. First, Mzinti residents explained that some illnesses are “traditional” illnesses that require visiting *sangomas* for treatment. By comparison, it is believed that other illnesses do not fall into this category and hence the sick individuals decided to visit the clinic or hospital. As one resident explained, “Some diseases are better healed by the *sangoma*. We look at the sickness to know whether it is better to treat with the *sangoma* or by the doctor.” Another community member indicated that he would go see a *sangoma* for a “traditional problem, like maybe if you are bewitched by a spirit.” One resident explained that *muti* (traditional medicine³) can be used to be released from prison, “even if you are found guilty by the court.” In a number of the semistructured interviews, community members indicated that *sangomas* would be approached to remedy a traditional problem that in some cases could not be resolved by visiting the clinic or hospital. These interviews also help detail the order in which residents make specific decisions about their potential treatment options. Although traditional medicine has been invoked by various governmental stakeholders as an invaluable component of the national health care scheme, many residents explained that they visit traditional healers only *after* seeking out assistance from clinics and hospitals. As one man explained, “When someone is sick there are those diseases that the doctors cannot cure and those that they can cure, so if they fail to cure, we go to the *sangoma*.” Based on the semistructured interviews, it seems that

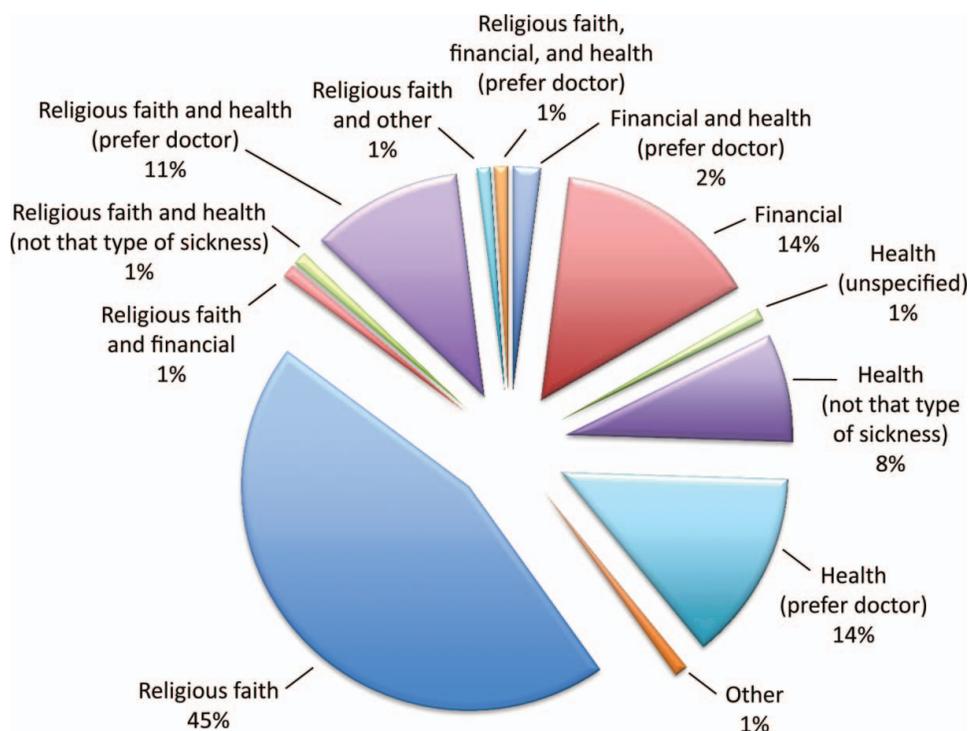


Figure 1. Reasons for not visiting traditional healers. (Color figure available online.)

the majority of residents approach traditional healers after first visiting the clinic or hospital for treatment.

Second, the research collected detailed information on the varied reasons for why traditional healers are not approached by certain community members. Figure 1 reports the percentages from the structured survey of 478 households. The different categories assigned to explain health decision making regarding traditional healers were religion, financial, other, and health, which was disaggregated to indicate “prefer doctor” and “not that type of sickness.” The financial costs of visiting traditional healers were described as a constraint by some residents. One person indicated that he never visits a *sangoma* “because the *sangoma* needs money and we do not have money since I am not working, so it is better at the clinic because it is free.” Another respondent discussed his anxiety about visiting a traditional healer and becoming sick, explaining that “the *sangomas* use a razor to cut you and they use the same razor with different people and therefore I am trying to avoid some diseases because AIDS can be transmitted in that way. In the hospital they use a new razor. That is why I prefer the hospital.” The invocation of biomedicine in explaining health decision-making was notable in a number of the comments provided by community members. As an example of this, in discussing why she goes to the doctor before seeing a

traditional healer, one resident indicated, “The doctors have drips for a shortage of blood or water, and they are able to cure types of diseases that the *inyanga* cannot. So it is important to go to the doctors first.” Yet another Mzinti resident indicated that she does not see a *sangoma* because “they are not professionals. Now we have professional doctors who are able to heal us well, even if there is something in your body. The problem with the *sangomas* is that they cannot see that.” These statements reflect the acceptance by some residents that clinical medicine is preferable for treating disease and its symptoms. It is also notable the ways that biomedicine is infused with local discourses of health decision making, which seemed to predispose these individuals against seeking out traditional healers.

In addition to the financial constraints and negative perceptions on the efficacy of traditional medicine, there are sociocultural beliefs that are quite pervasive in shaping health decision making. Specifically, it was common for respondents to explain that their decision to not visit the *sangoma* was determined by their religious views. This is evidenced in Figure 1, which reports that 45 percent of respondents identify religious faith as the sole reason for not visiting a *sangoma*. Numerous respondents are conflicted about admitting visiting traditional healers, sharing that they are Christian and expected to believe in the power of prayer and Western

science. One Mzinti resident indicated the decision to not visit with traditional healers because “we are a religious family. We believe in prayers and the divine.” Another woman explained:

I am a Christian and we do not believe in that. We believe in God. I have seen that some of my family members where I am married believe too much in *sangomas*. They sometimes go to *sangomas* and I still remember after the death of my husband they brought most of the *sangomas* and then I was very, very sick. Then my sister came here and called the Christians and they came and held prayers and after that I was well. That is why I never turn my face towards the *sangomas*.

The number of households that report purchasing traditional medicine, taken together with the number that visit *sangomas* for treatment, suggests that a segment of the population relies on traditional medicine for a variety of purposes. This clearly places a demand on the natural resource base and requires ongoing negotiations between various systems to determine the institutions of access in the rural areas. Yet the collection and use of medicinal plants, in addition to visiting traditional healers for treatment, are specific decisions shaped at least in part by sociocultural factors that are deeply rooted and contested within rural communities such as Mzinti.

Conclusions

The central objective of this article was to draw on the findings on medicinal plant collection and reliance on traditional healers in Mzinti to show how perceptions of health and decision making are shaped by multiple processes unfolding within contemporary South Africa. Whereas external actors, including the national government, remain insistent on the value of traditional medicine in attending to disease, local actors have specific views on the types of illnesses warranting treatment from particular sources. The research informing this article suggests that many community members visit with a *sangoma* only after going to the clinic or hospital, which does not fit with some governmental representations of traditional medicine use. Additionally, people visit with traditional healers for a variety of purposes, including spiritual reasons or good luck, which suggests that the national government's policies on traditional medicine, and insistence on an epidemiological approach, do not fully engage with the diversity of health decision making in rural areas. This demonstrates that health decisions, which are deeply

rooted and mediated by divergent perceptions of disease and health, are varied and do not align neatly with discourses generated by public health and governmental officials. Health decision making is fluid, pluralistic, and dynamic, and intersects with sociocultural processes in addition to individual biases and spiritual belief systems.

Although the findings from this work are specific to South Africa, I believe that the larger argument has value for geographic research on human health in two specific ways. First, this article shows that perceptions of disease, and by extension human health, are often multifaceted, historically and spatially situated, and conflicted. Research within health geography and political ecology has explored the intersections between health care and cultural and social geography (Gesler and Kearns 2002; Andrews and Evans 2008; King 2010) and challenged the hegemony of the biomedical model (Mansfield 2008). This article contributes to these studies by demonstrating the specific ways that sociocultural systems shape health perceptions and decision making. Second, this article shows the importance of engaging with subaltern health narratives that conflict with state discourses and policies that might be based on misunderstandings of local practices and knowledge systems. Although this article focuses on traditional medicine in South Africa, I believe it demonstrates the need for geographic scholarship to more critically engage with the ways that health perceptions and decision making are shaped by sociocultural systems in various settings.

Acknowledgments

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Notes

1. KaNgwane was one of ten territories that were constructed by the apartheid government to enforce its ideology of separate development. The bantustans expanded on existing systems of segregation established under colonialism.
2. As further evidence of this, the structured surveys probed whether anyone in the household was sick or had died from HIV/AIDS. At the time of the survey in 2002, only one respondent indicated a household death from AIDS. Obviously, this was not an indication of the prevalence of the disease at that time but of its significant social and cultural stigmas, which have been documented in the literature (Campbell 2003; Posel, Kahn, and Walker 2007).
3. *Muti* (also *muthi*) can also include potions that can be used to inflict harm on another person. Much of the power of *muti* is ascribed to the belief in its effectiveness (Ashforth 2005).

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