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From Ancestors to Herbs: Innovation According to the 'Protestant Re-formation' of African Medicine

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This paper argues that popular healthcare practice in urban South Africa bears little resemblance to the essentialized descriptions of 'Traditional African Medicine' (TAM) that abound in the literature. It defines several key transitions that have occurred in African medicine, outlining how it can be re-formed on another basis which better matches both the pluralistic-syncretistic logic of current medical practices and the less deferential 'spirit' of those enacting them. We present the search for 'embedded innovation' formulated with Procter & Gamble as a recommended approach for cross-cultural product development (in healthcare and more generally).

Prologue

For EPIC 2005 I wrote (in completely partisan fashion) that ethnographers working on commercial projects are in prime position to break new ground on emerging phenomena because they are often thrust into such areas before they register on academic radars. I then stated this held especially true for areas within "the socio-technical nexus" since new technology products are usually planned and launched before their wider social uses are apparent. (Jones, 2006) This attention to technology was consistent with the project I was writing about (a new media offering by the BBC) and a majority of that conference's case studies (not to mention its sponsors).

However, this paper indicates I may have tried to focus the positive halo effects of the applied ethnographic gaze too tightly. For here we discuss how research into a very different product area (over-the-counter medicine) for a global consumer goods company (Procter & Gamble) equally delivered unexpected insights into an emerging area of cultural change - the transitional nature of African medicine.

The Project and the Paper

This paper proceeds at a slight angle from the project that gave birth to it, since our research was not specifically concerned with theorizing a transition. Our mission for Procter & Gamble was to help guide new product development in over-the-counter (OTC) medicines for the Southern African region. As such, we were interested in learning about the fullest range of responses, beliefs, and current treatments comprising household healthcare (with special attention to colds & flu and gastro-intestinal issues). We took a practice-led or

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treatment-focused approach, so were initially agnostic regarding which medical tradition a treatment might be assigned to (if any). Nevertheless, when we discovered that 'Traditional African Medicine' (abbreviated TAM) in township South Africa was undergoing a process of transition akin to that which characterized the medical landscape as a whole; we took it as a positive case for believing the synthetic model for product innovation we were developing would resonate well in this context.

This paper is an account of current healthcare practice in urban South Africa. It details several overlapping transitions in the use of African medicine and its common logic (that we part-facetiously refer to as its 'protestant re-formation') and which we believe can form a new basis for understanding African medicine. We will then speculate on what macro-level determinants lay behind these transitions; and go on from there to ask, from a cultural perspective, if some Western allopathic and African medical practices have interpenetrated, what elements of TAM still remain that are in some sense 'traditional' and 'African' while not conforming to the definition above – or even remaining *within* a body of tradition. Finally we discuss how these insights contributed to the innovation strategy recommended to Procter & Gamble.

The project on which this paper is based was commissioned by an advanced research unit of Procter & Gamble in the UK charged with furthering methodological innovation. The method we inherited was designed to gain insights into 'personal healthcare' by making in-home visits; conducting 'audits' of medicine chests, as well as detailing any 'home remedies' they made for themselves. The understanding, as soon as Lodestar was hired for this project, was that we were going to do a 'deeper' version of the method. The anthropology-as-brand effect was clearly to the fore here (Suchman: 1998) as both consultants leading the project were former or current anthropologists (myself and the research manager who was fulltime in the field).

The ambition for Procter & Gamble was to go beyond the usual strategy of taking OTC medicines that had been successful in other countries and transplanting them to an emerging market aiming at whoever could afford them there. In contrast, they wanted to design new preparations specifically for Southern Africa (to fit Africans' tastes and habits) as well as target 'lower income consumers'. To achieve a mixed sample we made use of the largely-intact socio-spatial segregation characteristic of urban apartheid (Frescura, 2001) researching in (formerly official, yet still mostly) 'black townships' 'colored townships; and a couple other urban areas.

Plural Practices, Purist Model

The institutional view

In traditional African medicine healing is believed to follow from putting things right between an array of forces that go beyond the person of the sufferer. As a leading

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commentator on the field puts it, "One characteristic feature of traditional medicine - wherever in Africa it is practiced - is the belief that serious illness can be caused by a supernatural agency, for example, ancestor spirit anger." (Okpako, 2006: 239). In this view, bodily health is largely a by-product of an intermediary successfully attending to the wider metaphysical causes behind a person's illness on their behalf.

It was only after conducting research into personal healthcare practices in South Africa (at mainly township locations in Cape Town and Johannesburg) that we learned just how far many people's everyday health narratives diverge from this traditional model. If we as researchers went into the field sensitive to the cultural influence of specifically 'African' approaches to healing, we quickly learned that in urban South Africa there was little privileged status accorded to 'traditional African medicine' compared to other forms of available healthcare. But while it therefore had no hegemony, it remained one resource upon which people could draw.

As I said, we took a practice-led approach in our research focusing on the actions these households took (both preventatively and reactively) to safeguard their healthcare. This often began by with looking first at the medicines or treatments used. These tangible artifacts served as prompts for more detailed descriptions of their healthcare practices (as well as the institutions they interacted with). As these narratives unfolded we got access to any beliefs or ideologies concerning their healthcare situation or providers in the townships.

One of most striking things we learned was that most informants did not feel hard pressed in their health needs, but instead had whole repertoires for dealing with household health (involving medications, institutions, and practices). Within their considerable collections of medicines we usually found no less than four types: prescription drugs or remnants of these (often antibiotics or vitamins); western branded OTC medicines; Old Dutch patent medicines, and some kind of herbs or herbal-derived treatments (often located in another part of the house). This in turn gave insight into the institutions they were interacting with and what they felt about them.

The state of affairs described by much of the published commentary (Dunlop, 1975), (DeJong, 1991), (Hewson, 1998), (Gilbert and Gilbert, 2003) is one in which the majority of the non-white population have practically no access to Western-style physicians, or biomedicine, (and thus were said to depend on traditional African healers). By 2004 in township Cape Town and Johannesburg this was no longer the case. In fact "The Clinic" or free government health service emerged as the main healthcare institution that was not only within reach for our informants, but appeared to be (in marketing jargon) their 'first port of call'. Clinics had the virtues of being a "drop-in" service and of dispensing free prescriptions on the spot. However, the highest status was reserved for "Doctors" (meaning private doctors) who required an appointment and charged a hundred rand fee for a consultation (bundled with medicine). Doctors were preferred because believed to be more efficacious. One informant explained, clinic medicine is "weaker" whereas with Doctor's medicine "you notice an improvement in two days". An important backup to these institutions were

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"Pharmacies" where prescription refills, or OTC medicines could be obtained between clinic visits along with advice; and "Supermarkets" or street stalls, where these items could be purchased when advice wasn't needed.

Only four of the households described treatment by traditional healers: two giving favorable accounts; two rejecting any further such treatment. In contrast, almost all of the households had herbs in their medicine collections, yet there was usually no practitioner guidance or institutional support corresponding to these. It was this notional 'gap' which started us thinking about the transitional role of traditional African medicine.

Doing it for ourselves: DIY Pluralism

But to understand the South African healthcare landscape from this institutional perspective over-simplifies the situation. Because probably the most important healthcare 'resource' (outweighing even the primacy of the state clinic) was our informant's wide knowledge of ailments and treatments, of the practices of 'folk medicine', and of how to 'work' the different systems. [2] This was actually the household's first line of defense for their health. All of them, when faced with an illness, started not (as typical now in the West) by asking 'Where can I go'; but 'What do I know' and 'What can I do about this'. This is why at their relatively modest level of income these families had such large amounts of medicine – because to a large extent they were their own healthcare. But equally important to prepared medicines was the practice of making 'home remedies', an original focus of our research method which proved highly significant. These families kept ingredients such as ginger, garlic, aloe vera on hand; or collected special ones like gum leaves or alse herb to treat colds, fever, pain, diarrhea, cramps. One woman in Johannesburg made her own cough syrup by combining Dutch patent medicines and fresh ingredients. When symptoms presented themselves, the initial response was to check the medicines, mobilize these recipes, make and administer a preparation, then watch the response (all before any 'expert' is consulted). The most influential source for advice on illnesses, all maintained, was friends, family and drawing on their collected experience. Now all this may seem to quaintly reference old notions like 'peasant wisdom' or equally what Giddens calls the "knowledgability" (1984:281) that underlies all societies able to act for themselves [3]. But in this study these practices can not be overemphasized, because this tendency toward self-help or DIY treatment can, in effect, be considered both as a '4th tradition' in South African healthcare (to be added to Western scientific medicine, traditional African medicine, and old Dutch remedies) or as the crucial missing 'layer' in the institutional or 'systems' perspective from which most healthcare planning is done.

This DIY 'tradition' of course has its own characteristics or even 'spirit'. What animates this approach (and influences these township dwellers views on medicine overall) is a vigorously pragmatic orientation to healthcare that values only what works and whatever works without bias. [4] This almost 'empirical' attitude based on trial and error (and the accumulated experience of others) means that our informants took a non-ideological

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approach to medicine. Just as they would play one institution off against another; going to the clinic only if OTC or 'home remedies' failed; then escalating to a private doctor (or considering a healer) if relief was not forthcoming; so to they were also playing one 'tradition' off against another to get the most effective treatment (again showing little ideological or cultural preference relative to their own background). [5] This was results-driven healthcare with the main basis of 'preference' being outcomes (always really the perception of outcomes). Except, unlike what we may be used to in the West where health (or diet) choices are increasingly identity- (and thus ideology-) laden; preferences here were not generalized to a tradition, but specific correlations between an illness and a remedy. We never heard anyone say "Western medicine is best, so that's what I use." [6] Instead; one Colored informant quite representatively said "For some things (like chest infections) you *must* have antibiotics" (not linking these drugs to type of medication). But the same woman also advised that when picking the alse herb (to prevent diarrhea) you had to be very careful to do it before sundown. So we discovered the healthcare situation, in urban South Africa is one of overwhelming 'medical pluralism' (Dauskardt, 1990) (Gilbert and Gilbert, 2003), a term we were using even before we found it in the literature:

> *Many patients seek care from several different systems of care simultaneously or at different stages in an illness episode. These choices often represent highly rational responses to the constraints and opportunities people face.* (DeJong, 1991)

This statement perfectly matches a focus of our debrief document. And while I know that understanding behavior as "highly rational" is not considered sexy at present –when it is not *your* theoretical precept, but something immanent in the social action, you have to go with it. Consequently, we did hear about many rational 'strategies' being pursued. People would go to clinics for a free diagnosis then go to a pharmacy to get the "stronger" drugs if they knew they could buy them under the 100Rand charge for private doctors – thus getting the best drugs *and* saving money. (Over this cut-off point they might as well go to the "Doctor" and get the consultation and drugs together). A Colored mother switched treatments when she realized the psoriasis crèmes she traveled to get her daughter from the Red Cross Hospital (which they used for emergencies and trusted deeply) were not really improving the condition. Instead she started buying African herbs (comfrey and wild cannabis) from nearby Rastafarian street traders (achieving better results *while also* saving time and money)

A key point here is that this rational action went *across* medical traditions almost as if there were no boundaries between them (as if our township dwellers were healthcare nominalists for whom only the particular is real). I believe the spirit of pragmatism drove the pluralism, then the pluralism reinforced the pragmatism; having more options for treatment (balancing efficacy, time and money) means there was no sense in committing to one tradition to the exclusion of another – playing across borders can turn constraints into advantages.

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Purist Model

Yet, set against these myriad practices, we have the discourse of 'Traditional African medicine' with a more unitary logic. We have already mentioned how Okpako (2006: 239) said traditional African medicine -wherever in Africa- ultimately has a metaphysical basis. If we are to believe further commentators TAM also has a common aim and ontology: "For traditional healers, healing involves an attempt to remove impurity or disequilibrium from the patient's mind and body" (Hewson, 1998) Hewson goes on to give an account of her research with six traditional healers in Southern Africa. This account is useful because it describes healer practices rather than purely the 'philosophy' of traditional African medicine where many writings focus. It is significant however, that while most of her informants lived in South Africa, she chooses as her paradigm case Julia, a Shona-speaking woman from outside Maputo, Mozambique:

> *Once, a man came to see me who suffered pains in his legs and many other places and could not walk. First, I talked to him and I asked about his life, what life had given to him and what he had given to life… I had to throw the bones many times, until I could make sense of this person and his problem. The bones did not want to talk to me at first, so I asked the man to come back another day…This didn't work either, so I took him to my own compound. Every day I got up before sunrise, washed with herbs, put on my ceremonial clothes, and beat the drums. I sometimes took muti (medicinal potions) so that I could talk to the ancestors. My patient participated in these ceremonies while he lived in my compound. Then I would go alone to the bush to hunt for herbs to make muti for him and other patients...This man stayed at my compound for 2 weeks.*

This account is also instructive because it links the two terms of the transition discussed in this essay (ancestor spirits and herbs) and reveals part of the traditional conceptual model behind their relationship. Going deeper on this, Hewson relates how "healers prepare and prescribe therapeutic medicines, believing that every disorder has a corresponding plant or animal product that neutralizes its effects" (1998). What Hewson neglects to describe is that these functions were not 'traditionally' preformed by the same person. There was a crucial division of labor between 'diviners' *(sangoma)* and 'herbalists' *(inyanga*) (Ngubane, 1981; (Hammond-Tooke 1989). The diviner, who acted as an oracle to the spirit world (as well as observing the afflicted body) came up with the fundamental metaphysical diagnosis, the herbalist then prepared the plant or animal treatments to redress the ailment. It is important for us to emphasize this distinction because it is precisely here that we believe the current fault line in African medicine lies. But again in the 'traditional' model there was a unifying overlap between these professions because the use of herbal medicine had its own metaphysical element, being accompanied by a ritual practice known as 'incantation'. "Incantation is medical poetry…a collection of carefully chosen words used to bring out the healing effect of the medicine." (Okpako, 2006:239). It appears in this purist model herbs really only work if 'activated' through the auspices of the traditional herbalist. So far, so tidy.

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Transitions from a Tradition

If the discipline of anthropology (and doing ethnographic research) teaches anything, it is that time, shifts in context, and different social actors play havoc with even the most solid institutions and representations. One of the great global transformations emerging from the European industrial revolution has been migration from rural hinterlands to urban centers. The history of South Africa has its own painful version of this story. The historian Robert Ross has even written that the whole rise and fall of apartheid hinged on its ability to deal with the issue of urbanization, or "attempts to control the numbers and behaviour of Africans within South Africa's cities, and by resistance to such control" (1999:116). As part of this attempt 'townships' emerged toward the end of the 19th century (becoming official policy after 1948). A township was an area on the outskirts of established cities where members of non-white groups were encouraged (or forced) to live in racially distinct zones. Since their formation townships have been the entry point absorbing most of the migration from rural areas, so even if racially prescribed, they remain extremely diverse environments composed of people and customs from across South Africa and beyond. Nine of the households we studied lived in townships, three in urban areas of equal diversity; and one of the questions their health practices helped us answer was: *what happened to 'traditional African medicine' once it moved to the city?* In our ethnographic research for Procter& Gamble we discerned four key transitions in the use of medications from the way it is 'traditionally' described for African medicine. We summarize these as *from ancestors to herbs*:

- *from the power of 'ancestor spirits' to that of the body-* People talked and understood their health in terms of bodily symptoms (pains, chills, aches, fevers) and furthermore described treatments as ways responding to the body. The cause or reason for sicknesses was blamed on; climate, heredity, diet, stress, unclean surroundings, or other people. Neither Black, nor Colored nor Indian seemed to have a supernatural disposition toward their health or ailments – even though many professed to have a religion. Even those who mentioned using traditional healers spoke of consulting them to address a problem of the body (in one case, a pain in the throat).

- *from mediated 'treatment' by experts to direct treatment (by people of themselves and dependants)-* The traditional model of African healing emphasizes an intense personal engagement by the healer with and for the 'patient' (as in the example above). The healer crucially intervenes both in the spiritual and natural world on the part of the ill person until their health is restored. In our urban research however, the household were very active in their own treatment, seeing their health as mainly there own responsibility. They kept considerable armories of medications to hand. The women especially could describe a wide variety of symptoms and how they would treat them without outside help. Clinics and Doctors were reserved for problems they could not self-diagnose or treat, (or for children needing careful attention). There was some resentment and a feeling that the traditional healers would not allow one to take charge of your own health.

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- *from taking remedies composed of opaque mixtures to identifiable herbs*- In traditional African medicine herbal mixtures were specific to the person and the occasion and the way they were mixed or blended was kept secret. Often people who use herbs now know which ones work for what complaints and wish to be given them without going to a healer (possibly several times - if our account above is representative). They also seem to believe them 'effective' without being administered with an incantation.

- *from a reliance on healers for traditional medicines to use of pharmacies, street traders and other vendors lacking 'traditional authority'*- As many people know what they should use to treat particular symptoms, this opens up 'the market' to other suppliers who can supply herbal medicines simply as a product – often cheaper and conveniently free of ritual.

We had observed the results of such movements in their current-state but could only speculate about how and when these transitions occurred. Looking for background beyond our own research's scope, we found mainly timeless, ahistorical accounts like the expositors of TAM above. So we are indebted to a South African geographer Dauskardt (1990) who looked at the spatial flows of traditional medicine in South Africa over time. His most important contribution was the story of the growth of 'urban herbalism'; how the use of African plants (gained from sources other than traditional healers) spread during the last century in South African cites. [7] This provided some of the historical 'facts' needed to validate our analyses and help us realize these transitions had a trail into the past. We learned western OTC or 'patent' medicines became popular in the townships from the 1930's onwards at a time when access to actual western medical doctors was rare. So, combining these trends with the known lack of 'formal' healthcare in poor 'native' areas until recently (DeJong, 1991), (Gilbert and Gilbert, 2003) we arrived at the earlier impetus for the strong self-help tendency that we had observed. And given all these factors, we believe unlike the 'institutional' view would have it, the mass of urban dwellers had not simply resorted to the government's residual category of traditional African healing - but had been evolving their own DIY healthcare in a dialogue between TAM and western medicine, Dutch medicine and whatever knowledge of 'home remedies' they had brought from their native place or evolved there.

This self-care over time has given birth to a 'spirit' we discerned in the research; one of pluralism and pragmatic experimentation, as mentioned, but also a further attitude (that can be said to be a cumulative effect of the transitions above as well their encourager) of:
whatever increases my sense of personal power and control is desirable, whatever doesn't less so.
This combined with the specific transition towards people wanting to access herbs directly and not go through healer-intermediaries led us to proclaim "African medicine is undergoing a protestant reformation" in our original project document(Lodestar/P&G, 2004). And there are obvious conceptual echoes of that historical epoch. Certainly we mean it mainly as an ideal-typical analogy (following Weber (1930) but hold that this characterization matches

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the phenomenology of experience gained from listening to our informant's comparing different healthcare traditions.

Recent epochal events linking the personal and political (or macro and micro) in South Africa reinforce the analogy. Just as Schama (1987) has shown how the Calvinist Dutch of the Golden Age had their creative energies unleashed once they threw off their colonial masters the Spanish; so the average South African has seen a huge increase in their real and symbolic sense of agency since the transition to popular democratic rule in 1994 (Deegan, 1999). In one of the few works to deal with this subject in South Africa in a way not predominately structural, Naidoo and Van Wyk (2003) (who are community psychologists) cite Serrano-Garcia's (1984) description of empowerment as involving:

1. The enhancement of personal power
2. Creating awareness of alternative strategies to problem solving
3. Accessing resources in society

Naidoo and Van Wyk (2003:75)

It is possible to make a case on all three counts that a primary reliance on traditional African medicine (or traditional healers themselves) would represent a diminishment in South Africans' experience of empowerment. First, TAM in its purist mode is very healer-led and opaque in its treatment regime, representing less agency than the self-help of DIY practices (or the pluralistic mixing of different institutions where the patient *makes the choice* which to use and when). Reliance on traditional healing could also represent for many South Africans a throwback to when this was their only expected source of healthcare (and they had less alternatives), also, arguably, going to clinics or private doctors feels like the attainment of a wider involvement 'in society' especially since it was formerly withheld. So maybe it is not surprising - given wider social and political history - that newly enfranchised, non-white, urban South Africans are not embracing TAM in its wholly traditional form, preferring to cleave off its herbalism and mingle it with other types of medicine available to them.

Towards a Non-Essentialist African Medicine: The Protestant Re-Formation

Critique

But it is just this kind of failure - to acknowledge the separate destiny of 'herbalism', from the tradition of African healing - which is typical of the literature on TAM. In this paper we had to theorize these transitions because of a considerable lacuna between our research experience and what we encountered when we tried to reflect on it. Focusing on the prevailing forms of health and healthcare in township South Africa it appeared that 'divining', or conferring with the ancestors, was declining in frequency (at least as a 'healthcare' practice) while 'urban herbalism' appeared widespread and on the rise. [8] Yet

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most literature seemed not to acknowledge this divergence preferring to treat 'traditional healing' as a timeless unity (with the salutary exceptions of Ngubane (1981) and Hammond-Tooke (1989), cited by Dauskardt, (1990). This is an illusion I believe commentators on TAM have actually fostered by focusing on the 'purest' examples they can find. For example, Hewson also researched with a healer from the Eastern Cape of South Africa, "who practiced in a herbalist *store* that she co-owned with a white South African man" (1998: my emphasis) yet chose to highlight as her prime model of healer practice a woman who lived in a "traditional African compound" in Mozambique. There is only one word for this - essentialism - and it has had a prominent critique within anthropology and social theory for years. (Said, 1979), (Rosaldo, 1989) (Abu-Lughard, 1991) This tendency to treat certain chosen qualities of a cultural form as intrinsic, defining or unchanging (Sayers, 1997) has been seen as one of the weaknesses provoked by the 'culture concept' itself, leading Abu-Lughard to claim we should "write against culture" to uncover a more differentiated sense of the real (1991). We have already seen how (Okpako, 2006: 239) defined TAM as bound up with concepts of supernatural agency; and others (Hewson, 1998) (Gilbert and Gilbert, 2003) characterize traditional African medicine as a whole (from a cultural-ideological perspective) rather than as a set of practices that can be discretely deployed at different places and times by different actors.

Once we move beyond this essentialistic vision of TAM and place it back within history we realize its trajectory is typical of many traditions within 'a post-traditional society', (as described by Anthony Giddens in his notable essay on the topic (1994). He usefully connects the contextual nature of tradition with its ability to command authority, "The natural state of tradition, as it were, is *deference* .Traditions exist in so far as they are separated from other traditions, the ways of life of separate or alien communities" (1994:86) But a tradition becomes "disembedded" (1994:86) when it has shifted to a context "where pre-existing traditions cannot avoid contact not only with others but also with many alternative ways of life" (1994:96). Therefore, its sense of authority loosens, becoming something to be reflexively 'chosen' (among other alternatives) rather than simply adhered to. Township South Africa is such a post-traditional context, and in this setting you will remember our informants unanimously opted for a pluralist stance showing little *deference* to any of the medical 'traditions' they encountered; but much *deftness* in choosing to juggle them all. Taking Giddens' analysis further by adding the dimension of practice, we realize there is in fact a triple disembedding that a 'tradition' can undergo:

1. *A tradition can be disembedded from its context* (as traditional African medicine has been from its historically rural setting; as emphasized by Giddens when he speaks of time-space distanciation), but equally;
2. *A tradition's practices can be disembedded from its experts*, or traditional 'guardians' (e.g. for TAM, the growth of herbal stores and pharmacies, prepared herbs sold without input of healer), and;
3. *Practices can become disembedded from any tradition at all* (remedies and herbs as part of everyday life, little concern with origins or deeper explanatory principles)

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From our research it appears parts of TAM have undergone all three senses of disembedding (particularly in the transition to the newer practices of urban herbalism), but these can also be used as a heuristic to evaluate any current medical tradition.

The third disembedding is especially important since it illuminates a key aspect of the self-help (or DIY 'layer') of urban healthcare described earlier. At this level there are really no 'traditions'; just treatments, regimes and strategies that respond to particular conditions. In this 'view from practice' all medicines and remedies are pooled together into one great repertoire of *competence*: ginger, Dipirin, alse, Grandpa powder, aloe vera, antibiotics, comfrey, Vicks Vaporub, gum tree leaves, verstek druppels, axel grease, Med-Lemon, and camphor oil. What unites them is that they can all be *called on*, are all ready-to-hand within practical wisdom waiting to be mobilized, and are all seen as somehow effective if they are to remain within the repertoire.

If we have already referred to this as the 4th tradition in African medicine, it is really more like the master; or meta-tradition that contains the others, and in so doing cannot be said to be *within* any tradition at all (except the catch-all of 'folklore' or 'folk medicine'). I do also believe from our research that this folk practice is the most responsive and relevant form of healthcare in urban South Africa; (without it there would be many more people miserable or dead in the townships everyday) and that for the herbalism of TAM to join this repertoire does not entail that it *as a tradition* is 'dying', rather, it shows that TAM can be resilient and adaptable.

However, from this viewpoint some of the *writing* on TAM (DeJong, 1991), (Hewson, 1998) (Gilbert and Gilbert, 2003) (Okpako, 1999, 2006) seems to amount to scholarly re-construction; or a reification of practice extracted from current social process in order to isolate a strong and intact African tradition (that can stand alongside the indigenous medical 'great traditions' of China and India) for the purposes of policy-making or systematic integration into state health systems. Okpako is a particularly strong proponent of this cause, even lamenting the fact that being an oral tradition "has hindered emergence of a generally accepted theory and hence the systematic development of TAM as a self-regulating profession" (1999:482).

I am reminded at this point of a trope from the anthropologist and potent critic of essentialism, Renato Rosaldo, who suggested we would be better off thinking of culture and cultural forms as more like 'garage sales' than 'art museums' (1989) I feel like I have just sketched out how one such garage sale can work for the healthcare needs of urban South Africans, yet we are in no short supply of would-be curators.

Construction

A deeper consideration of DIY health practices makes the project they have in mind seem all the more unpromising. Namely, there is a final transition we observed but have not

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yet revealed: *from pluralism to syncretism***.** Our research and analysis suggests that in township South Africa the 'medical pluralism' we described (different traditions or systems separately applied for different ailments or phases of them) is tipping over into a state of 'syncretism':

> *The attempt to reconcile disparate, even opposing, beliefs and to meld practices of various schools of thought. It is especially associated with the attempt to merge and analogize several originally discrete traditions*…and thus assert an underlying unity (Wikipedia, my emphasis).

This means that in practice 'Traditional African Medicine' is all the more inseparable (and functionally fused) with other practices and traditions**.** We noticed such syncretism on three different levels:

1. *Home remedies***:** There was significant frequency of homemade remedies, made by our informants that literally combined Western over-the-counter medicines with fresh ingredients or traditional herbs to make new hybrid preparations. Examples - Boiling Dispirin, a soluble aspirin, together with fresh ginger (or ginger beer) to make a fever-reducing hot drink; another made the same mixture adding tea from gum leaves. This is syncretism at its purest and most literal, like the Christian Saints in Condomblé who are venerated after the fashion of Yoruba gods.

2. *Treatment regimes:* Often the manner in which something was used demonstrated a local cultural '*appropriation*' (Miller, 1991) of a product and a melding of logics. Examples - Vicks Vaporub (from P&G) was not merely used alone as soothing relief but as one crucial element in a whole regime (with other components) for "sweating out" a fever. In another example a popular headache powder was mixed with Vaseline and applied directly to the body as a poultice to soothe painful joints more (explained as more powerful relief than taken internally).

3. *Medical theory*: There were also signs of 'conceptual unification' typical of syncretism. Examples - The mother of our only known informant who was HIV+ spoke of using a traditional herbalist to get her son *muti* not in order "to remove impurity or disequilibrium" as in TAM (Hewson, 1998;), but, as she said, "to boost his immune system" - expecting the potency of a substance from one medical ontology to have an effect on an entity within another. In a non-syncretistic system these ontologies would be incommensurable, but is here illuminated by knowing her son was also taking the full complement of anti-retroviral for the same reason. This is how traditions of practice conflate; as different means toward the same aim - thereby pluralism begats syncretism. In other words, syncretism seems to be a kind of 'strategy' born out of an overwhelmingly practical orientation, rather than a confused or mystified one as commonly believed. Similarly, other informants said they used traditional remedies to combat "stress" and "psychosomatic" ailments – because that was what they had on hand.

The syncretistic mechanisms were put in place when western OTC or 'patent medicines were disseminated widely through the culture (at a time when there was little

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access to western doctors in 'native' urban areas) and the only 'institutions' were traditional healers. But then as now domestic DIY healthcare was probably the mainstay and people began experimenting with the 'new' and the 'old' medicines at their disposal. From the 1930's onwards Grandpa headache powder and Vicks Vaporub have been pluralistically used alongside traditional 'African' medicines and 'home remedies; gradually interpenetrating into the hybridized 'folk medicine' that predominates in the townships today.

So rest assured, dear reader, if worried that nothing of 'local' or 'African' culture remained in township health practice; syncretism is not 'westernization', and both sides of such a pairing 'bleed' into one another. The strongest evidence for this is what our informants felt they needed to *add to* or *take alongside* the 'western' medicines they used. There was a systematic pattern here that we shared with our client; in Southern Africa medicines needed to be more experiential. It was good to know something would work (empirical criteria), but better to also *feel* it working (cultural criteria *cum* empirical evidence). And the form that the 'evidence' should take was highly shaped by South African culture and preferences. Soluble aspirin alone may work, but taking it as a hot drink along with the burning taste of ginger is believed to make it work much better (and therefore preferred).

Consequently, Dauskardt goes too far in speculating that Western pharmaceuticals have conquered "the consciousness of medicine" (1990:282) in urban South Africa. What they *have* done (in line with this paper's focus on practice over ideology) is capture a large share of medicine's *modus operandi*. Some practices of 'Traditional 'African Medicine', especially its herbalism, may seem to have been re-configured in the image of Western over-the-counter medicine. (But you could equally say herbalism had 'grafted' onto it after it was unloosed from traditional healers by 'internal market forces'). Whatever your choice of metaphor (military or botanical – though which has serious implications) herbs, like OTC remedies, are now something you can recognize a symptom for, conveniently buy, then administer yourself. In this one can also say that certain characteristics of western medicine dovetail with the spirit of the times and the more 'protestant' character of township dwelling 'consumers' - who in a shocking parallel to ourselves are indeed concerned with time and money. Which is not surprising given they all live in a big city, work 8, 10 ,12 or longer hours a day, commute some distance to work, and can afford little time off to be sick.

Given the current nature of urban healthcare that I have been describing throughout this paper, and the fact South Africa is now 57% urbanized and due to continue at 2.9% a year, (Unicef, 2004) we believe the 'disembedding' of TAM will continue. We would furthermore argue that the essentialistic construction of 'Traditional 'African Medicine', in leaning heavily on its metaphysical basis and the ministrations of healers (my title-transition could almost equally have been 'from healers to herbs'), fails to acknowledge the reality of everyday healthcare for a growing majority of the population, tying its practices to an imagined place in the rural past. Consequently, I believe TAM as a concept should be displaced in favor of an African medicine drawing more loosely on the following characteristics:

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- *We treat ourselves whenever we can* (self-help/DIY medicine, OTC drugs, home remedies)
- We use whatever works – old or new; homemade or commercial; and mix them together (despite source or 'tradition' in a way characteristic of pluralism-syncretism)
- *We use local ingredients for remedies whenever we can*; especially. herbs "from the African soil" (as Rastas might say) or simply "things from the neighbors garden" (as one Colored family put it)
- *We want treatments in which we feel the healing* (other formats in addition to pills, such as; rubs, hot drinks, poultices – manifesting culturally favored sensations, e.g. burning taste, sweating out fevers)
- *We draw on treatments and recipes handed down informally*; from 'the elders', family, friends, and 'folk knowledge'; not only 'experts' (healers or doctors). (The sense of authority of our medicines can thereby be said to feel 'traditional' – even if not located within a specific 'tradition').

This is what we analogize as the 'protestant re-formation of African medicine'. It is revolutionary in breaking the misleading conceptual entailment between something being 'African' and therefore necessarily 'traditional'; it accounts for one of TAM's most vibrant constituent parts 'urban herbalism' where TAM cannot; it encourages an increased sense of personal power and agency in its users, making it in tune with macro forces in the culture and a good descriptive model of personal healthcare in South Africa today. Therefore, we believe this 'protestant re-formation' should be an effective reference for the development of over-the-counter medicines in the region.

Innovation According to the Protestant Re-Formation

What we uncovered in this project was a fascinating example of cultural change; when different traditions and practices rub up against one another altering each other in the process. If it appears that 'Traditional 'African Medicine' has been discarded, and then in part re-made by thousands of township residents along the lines of allopathic medicine, this picture would be overstated. Some of its metaphysical basis - at least for healthcare - *has* been marginalized, but herbs of African origin have also become more appealing and accessible to audiences (such as Coloreds, Indians or Whites) who have no background in African 'ancestor' theories, as well for many Black South Africans who would not believe they had the time or money to spend on traditional healers. [9] This arguably extends the reach of African medicine even while going beyond its 'traditional' basis. Purists might say it is the death of TAM, others that it's merely a transformation – a scholastic and irresolvable debate. On the other hand, we must add that most proponents of TAM want to reconstruct a more explicit model of 'Traditional 'African Medicine' from out of its oral culture in order to give even its 'diviners' *(sangomas)* something like the full treatment of Weberian rationalization (regulatability, calculability , predictability) (Ritzer, 1993). This is so that that it may serve as an alternative state health system standing alongside (yet integrated with) the western biomedical one. Arguably, turning TAM into such an 'art museum' (Rosaldo, 1989) would

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wreck a more profound change on this historically local and situated practice than any of the bottom-up adaptations we have observed.

While officializing TAM may do something for the cultural pride of elite Africans, Africanizing political parties, or Western academics wishing to take "progressive" stances within their own fields, the only study I can find on the subject, looking from a community (not policy) perspective, suggests many at that level do not think their primary healthcare will improve if traditional healers are officially integrated into it (Van der Geest S.; Geest S; 1997). Our evidence would tend to agree that such a move would be unlikely to better serve its urban audience at least. This is because I believe the pluralistic-syncretistic amalgam of practices we have been describing already amounts to an integration between the Western and African traditions - and one that works like a kind of 'customized solution' for its 'users' who have in fact been adapting and appropriating it for generations (as historical agents effecting their own cultural change).

Thankfully however, our task was to inform P&G's OTC product strategy, not advise on healthcare policy to the South African government. And for this we realized our conception of a re-formed African medicine was a powerful guide. Unlike a strategy based on a scholarly view of different medical 'traditions' that are becoming increasingly 'disembedded' from the context that gave birth to them; we realized the principles we had observed at work within the transition from medical pluralism to syncretism amounted to a kind of "embedded innovation" framework that was still vital and emergent. Instead of innovating from the outside (say at P&G's headquarters in Ohio) then trying to "understand the local culture" and sell the product using knowledge of what they find 'appealing' (and hoping it will connect with actual product properties), we were turning this process on its head. Our method was in effect innovating from within the culture by borrowing its own principles of health practice innovation (as well as some of its recipes and formulations).

What we had stumbled across in this reversal was the contrast between two very different conceptions of innovation. For new product development the standard corporate model draws on Roger's 'Diffusion of innovations' theory (1962) which basically erects a 'black box' around the *emergence* of innovation (singular events from heroic inventors or companies) to focus on its main problem of how to spread new products through a process of persuading first adventurous 'innovators', then 'early adopters' etc. to buy and use. Opposed to this is a much less well-known tradition, inspired by the economist Joseph Schumpeter's (1971) writings on entrepreneurship and the anthropologist H G Barnett (1953) who sees innovation and diffusion as two stages of the same process; based not on persuasion, but on the rational fit of an innovation to meet actors wants and needs once they have encountered it – by imitation or accident. On this view, innovation is socially embedded, akin to anthropologist Stephen Gudeman's "peasant innovation" (1986, 1991) which relies "upon using existing materials, seeing them in a new way, drawing upon and adding to the store of cultural knowledge" (1991:147). This is an apt framework for understanding the dynamics of the 'folk medicine' we believe to be the core repertoire in urban South Africa. It describes both why it is so mixed across traditions; why it does not

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have or need formalized experts; as well as how some of its syncretistic combinations came about. Reconstructing one case study, we imagine that after P&G introduced Vicks Vaporub into South Africa about 70 years ago, some found it was not merely a soothing topical decongestant (as the company intended); but that used in combination with other measures (hot drinks, being wrapped in blankets and going to bed) it was an effective catalyst for the 'sweating out' of a fever - the usual local treatment for flu. Word spread; it caught on, and joined the dominant 'cultural knowledge' as a treatment for *this* purpose. By the time of research, Vaporub was a well-loved mainstay in most of the households, provoking rhapsodies of appreciation. It is always encouraging when a framework can work in reverse to explain success (in this case the product also just happened to hit all the culturally desired experiential buttons, being both a rub and having a burning sensation). But since as Gudeman allows "such innovatory processes occur continually" (1992:147), we knew we could work these principles forward to generate new product ideas as well (inspired by the possibly newer and equally widespread practice of boiling soluble aspirin with some kind of ginger). By following the characteristics of African medicine's 'protestant re-formation' as our 'principles of combination', we came up with palettes of options for mating sensations and active ingredients; tastes and formats that referenced the cultural cues for healing with other medicines that delivered results; mixing the traditions of Western medicine with African herbs just as we had seen our informants do in their kitchens.

One of the advantages of ethnography is that it can powerfully connect you to this kind of embedded innovation if you follow the cultural transitions on the ground (over merely listening to the 'experts' or 'guardians' of traditions). We argue seeking these embedded frameworks of innovation will be particularly appropriate and successful for companies doing new product design in the developing world. For here, even though a practice may be 'proven' by intensive social use (people already doing it at home) often no provider will have yet brought out a product filling this 'market' gap – because no one else is close enough to its daily context to spot it.

If we had accepted much of the standard knowledge on medicine in Africa, the proposed OTC medicines would have more closely resembled those of the past. P&G would have felt less comfortable to draw on local culture and create hybridized products believing it had little authority to do so. Knowing how saliently Vicks Vaporub had inadvertently fed into the folk-medical culture of South Africa, instilled confidence and a spirit of innovation (as well as its process) that we could do even better by design. With the aid of our embedded innovation framework, by following the same principles of creation as our intended audience, a healing, burning-tasting, syncretistic (recognizably 'African') product was put into development at project's end.

Notes

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recruiting and language assistance (Zulu, Sotho and Xhosa) in Johannesburg and Cape Town. For reviewing the paper further thanks goes to: Yvonne Sanders-Hamilton, Nick Harrington, Melissa Cefkin; and Nina Wakeford.

[1] Coloreds are a mixed race 'ethnic group' in South Africa descending in part from former slaves imported (initially to Cape Town) by Dutch colonial authorities from areas of present day Malaysia, Indonesia, India and other parts of Africa and South East Asia. Most speak Afrikaans as a first language and many in Cape Town follow Islam. 'Colored' was an official racial category in apartheid South Africa; and although now a contested term persists as the designation for a variegated assortment of historical communities. For more on the history of this 'name', those it refers to, and their current status see (Martin, 2001)

[2] Uncovering these deep layers of knowledge was an important realization we brought to our client: that although this new target market was 'lower income' and often not formally educated, they were extremely sophisticated healthcare 'consumers' who would critically evaluate any new products by making wide comparisons.

[3] 'Knowledability' or reflectiveness is a key foundation for Giddens theory of 'structuration'; as it is almost a pre-condition for the exercise of agency, "all social actors know a great deal about the conditions and consequences of what they do in their day-to-day lives" (Giddens, 1984: 281). Most of our informant's sense of mastery and competence over their healthcare was something that struck us profoundly in this research.

[4] 'Pragmatic' is to be understood here not in the colloquial sense of making compromises, but in the sense of the American school of philosophy known as Pragmatism, in which "the meaning of an idea or (in this case, treatment) lies in its observable practical consequences". *American Heritage Dictionary*

[5] In a noted exception which proved the rule, the single informant (a Black Rastafarian in Johannesburg) who did make overt ideological statements about healthcare preference showed more complexity in practice than in his verbal testimony. After stating "We need to get back to using what was here (in Africa) before Western Man brought his gripe water…" and describing remedies he made from local herbs; he went on to enthuse about his affection for Dutch patent medicine, how he had grown up with it in Lesotho, and then show us a wall chart from the leading company 'Lennons' which he frequently used to diagnose and administer these medicines to his children. (Lodestar/P&G, 2004).

[6] Rather we heard just the opposite from a Black female informant in Gugulethu Township, Cape Town: "You can't say what kind of medicine is best, everyone has their own beliefs about what works for them." (Lodestar/P&G, 2004).

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[7] Dauskardt succinctly explains this change in supply, "The emergence of herbalist stores and of herbal pharmacies constitutes the major transformations within the organisation and structure of traditional herbalism in an urban area." (Dauskardt, 1990:281) However, he addresses the herbal side of the equation without analyzing its relationship to TAM as a whole.

[8] No one can estimate with much precision how many (or how often) South Africans consult 'diviners'; but as Hewson acknowledges most healers' work actually comes from "protecting" clients by offering "propitiation for real or possible offenses" (Hewson, 1998) e.g. by offering charms to ward off evil or bring love or success. This is a matter we might say is more concerned with 'fate' than their 'health', akin to what Ashforth has referred to as the "witchcraft paradigm" (2001). It is my contention that this paradigm is undergoing the transition of being subdivided off from a more physically-grounded understanding of 'health'. But neither here nor anywhere in this paper do I imply a teleology in which Africans are inevitably moving toward a rational-secular view of the world. I only note where these differing mentalités impinge on one another, overlap, or give ground.

[9] There was eloquent testimony from one household which embodied this theme as well as the transition focus of this entire paper. A Black woman in her 20's, after telling how she often treated flu and headaches with nearby herbs "Not quickly running off to the Doctor", responded thus to a question about traditional healers: "No, I wouldn't (see a healer) ever. I don't believe in them." On pressing for reasons why, her mother offered "They are very expensive, and they can tell lies sometimes."

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