Re-visiones # Seven

ISSN:2173-0040

DOSSIER

A Postcolonial Analysis Of The Status Of Epistemological Equality In South Africa's Medical Realm

Anna Hupperth

Goldsmiths, University of London

Abstract: The article begins with sketching out narratives around indigenous medicine in South Africa and around its ostensible counterpart 'modern', Western medicine. As the former was officially tried to be kept in check by limiting it to its traditional roots, the dissection of the concept of tradition is necessary in order to understand if 'tradition' is really as static as is often assumed. The results clarify that the difference between 'traditional' South African knowledge and 'scientific' Western knowledge is rather a question of narrative than of actual facts. Comparing the legal situation of healers during colonialism and apartheid in South Africa brings to light that the ostensible difference between Western and traditional medicine is of a constructed nature rooted in the different legal treatment of these ways of healing.

The second part of the essay assesses whether the prevailing epistemological superiority of Western medicine during colonialism and apartheid has vanished over time. Doing so requires taking a close look at who is able to produce knowledge, how it can be produced and secured. Knowledge production concepts such as hybridity and creolisation are closely examined, delineated and evaluated. This is necessary to critically discuss the ways in which 'traditional' knowledge is treated by the state and to what extent the existing forms of cooperation between the two medical approaches can be regarded as on eye-level.

Keywords: Postcolonial Theory, Knowledge Production, Epistemologies of the South, Hybridity, Creolisation.

Introduction

In 1940, Mafavukek Ngcobo was put on trial for mixing "traditional" medicine with substances normally available in Western-style pharmacies. He sold this mixture in several muthi-shops in South Africa. This was forbidden through the Natal Native Code regulating the practice of "traditional" healers by limiting them to using "traditional" ingredients only (Santos, 2007). Questions posed within the trial and their respective answers shows the difficulty of determining "what is 'traditional' about traditional medicine?". It reveals that the binary imaginary – with South African medicine (SAM) on the one side and Western medicine[1] on the other – is not as clearly divisible in practice as the imagery itself promises. The imagery serves not as a mirror of reality but as a construction thereof (Vaughan, 1991).

The following essay will examine the problems deriving from that imaginary as well as explaining the rationale behind establishing the binary in the first place. The second part of the essay will explore whether this epistemological superiority, constructed through the binary in the medical realm, vanished alongside the political superiority and to what extent knowledge production is possible outside of scientific boundaries.

The Binary Imaginary of Medicine

Walter Mignolo calls the assumed possibility of clear division the "modern/colonial imaginary" resulting from the assumed "colonial difference" on which basis the planet was classified in either belonging to the modern or the colonial (Mignolo, 2000). The former with the "imperial belief that the rest of the world shall submit to its cosmology, and the naive or perverse belief that the unfolding of history has been of one temporality and would, of necessity, lead to a present corresponding to Western civilisation" (Mignolo, 2000). This belief implies that the colonised did not know what was good for them and were therefore better off with modern world's domination (Said, 1978). The first belief was not self-evident but was forcefully established through "enacting coloniality of power, an energy and a machinery to transform differences into values" (Mignolo, 2000) – known as colonialism – and led to a profound domination of the political, economical and social sphere as well as of the cultural and epistemological – as we will see in the following analysis (Santos, Nunes, Meneses, 2007). The medical South African landscape showcases this epistemological domination well. This is mainly due to the transformation of European local histories into global designs meaning that European medical practices were regarded as having a universal validation no matter what context they are placed in. This transformation led to a clash with South Africa's fundamentally different medical culture (Mignolo, 2000).

The two medical cultures of relevance to this discourse will be introduced in the following. Western or European medicine is based on scientific, protocolled research and is believed to be logically cohesive and detached from culture and therefore believed to be universally applicable regardless of its context. The medical system is hierarchically organised with an invasive and symptomatic treatment and in need of a complex infrastructure to function.

In contrast, the medical culture in South Africa is based on ancestral knowledge that has been orally transmitted from generation to generation over centuries. There are two main types of healers; Inyangas, predominately male, use roots and herbs while Isangomas, predominately female, rely on spiritual insights in addition to Inyangas' knowledge (Ngubane, 1992). These practices need little to no infrastructure and are run in an egalitarian system with an non-invasive and – especially important – holistic approach to diseases (Xaba, 2007).

The conviction of the colonisers that their medical approach is epistemologically superior due to its cultural independence led them to think of SAM as primitive, backward and a relict of the past in contrast to the progress embodied by Western medicine. It stood for everything the modern European was not (Flint, 2008). The holistic way of treatment using ancestral spirits contradicted the main Western value of rationality gained through the Enlightenment period and which had since become the guiding principle for not only governing and researching but also living one's life. The lack of systematisation and protocol in SAM has partially led to the westernised opinion that the spiritual take towards medicine does not have knowledge as a basis (Mignolo, 2000). Without a system as a foundation, understanding in the Western sense was regarded as impossible. This led to an oversimplification of SAM and thus equalisation with superstition (Last, Chavunduka, 1986). The created image of a binary medical realm served the purpose of reenacting the conviction of superior value (Flint, 2008). What strikes as ironic is that colonists abandoned the scientific principle of close investigation and neutrality when it came to understanding SAM and instead, as Said stated in the context of the relation from Occident to Orient, took "the sense of Western power over the Orient (…) for granted as having the status of scientific truth" (Said, 1978).

The rigorous separation between the two practices and the heavy legislation put forward to do so had not only the conviction of epistemological superiority as its basis, but also symbolised the political, social and economic threat that a healthy, striving medical culture on "traditional" grounds would constitute to European medical practitioners and political domination in South Africa (Xaba, 2007). The containment of SAM knowledge through "creative destruction" thus promised to guarantee political stability and success of the colonial mission (Santos, Nunes, Meneses, 2007).

Progress versus Tradition - Dichotomy or Two of a Kind?

Although the colonisers understood the intertwining of medical culture with other aspects of social, political and economical life, they regarded it as as something "that would eventually give way by degrees, as education and civilisation extended" as the judge in the Ngcobo trial stated (Flint, 2008). As a derivative of culture, they denied it the same validation as Western medicine that emancipates from a neutral, logical ground that is science and can therefore be deployed universally independent of the socio-cultural context.

The prediction by the judge reveals several possible assumptions about characteristics of SAM.

For one thing, the prediction of it to become extinct through growing civilisation and education could be interpreted as disbelief of its value to the emerging "new" society. Secondly, it could be understood as an expectation that SAM is unable to adapt to new circumstances. Either way he thereby characterises it as static and inflexible and eventually as a practice that won't prove itself to be of value as soon as society enjoys the advantages of Western epistemology. Thus, he completely dismissed the significant role South African healing played for its culture and the individuals well-being – an effect irreplaceable by Western medical procedures.

Another proof of these assumptions can be found in the introductory question "What is traditional about traditional medicine?". Cloaked under the claim to protect "African authenticity" (Flint, 2008), the underlying purpose of defining SAM practices can rather be seen in making it more controllable and governable. However, defining and thereby containing SAM proved to be impossible as documenting procedure or use cases of plants was not customary (Last, Chavunduka, 1086). Therefore, coming from an essentialist point of thinking and operating within it, legislators and politicians searched for a system and basic characteristics within SAM that would help them to better govern the "profession". The "system" they deemed useful to do so was tradition.

The answers given by various witnesses during the trail indicate how complicated the term tradition is to define. While some witnesses linked tradition to the ingredients used, they couldn't agree on the ingredients' origins or use cases thereof. Some plants defied classification as they were also used by Indian medical practitioners. Other plants were in frequent use despite them having arrived in South Africa only a decade ago. The question thus emerges if tradition really is a "system" feasible to define a living practice. In *Paths in the Rainforest*, Jan Vansina defines tradition as "a fundamental continuity of a concrete set of basic cognitive patterns and concepts" (Vansina, 1990). The basic cognitive patterns and concepts "act as a touchstone for proposed innovations (which) accepts, rejects, or moulds borrowings to fit. It transforms even its dominant institutions while leaving its principles unquestioned" (Vansina, 1990). Understanding tradition in Vansina's sense, helps making sense of the witnesses' answers. Additionally, one has to take into account that the image of a singular "traditional" medicine is too simplistic as "the history of healing is a history of multiple traditions, each one with its own distribution in time and space" (Last, 1992). Traditional medicine rather needs to be understood as pluralistic in regard to choice of remedy and practitioner, "so that a simple exchange between Western and indigenous medicine is likely to be too narrow" (Digby, Sweet, 2002).

Thus, defining SAM through the connecting factor of tradition is likely to be pointless as too many strands of tradition are operating simultaneously. Vansina further states that the "specific definition of a tradition is partly in the mind of the beholder" as there are "two realities people can be aware of: the cognitive reality, which predicts, and the physical reality, which then happens. When discrepancies between them become too great...the two realities have to be readjusted" (Vansina, 1990). Meaning: it is the people or the community that constantly redesign tradition. According to Vansina, this process is exactly what keeps traditions alive. Traditions have to change in order to stay relevant. Especially striking are the words process, continuity, innovations in this context as they depict a different picture than the one derived from the judge's statement as well as in the general perception of SAM. Indeed, these features are characteristic of SAM as the adaptability of it helped cater to different social environments and therefore contributed to the viability of the practice. Karen Flint in her book *Healing Traditions* extensively describes that "African or local medicine has maintained certain core beliefs over time, [but] it has also been dynamic and sometimes open to non-African beliefs, practices, practitioners and substances" (Flint, 2008). For example Indian medicine that was partially incorporated into SAM practices. Vansina calls this "a fundamental continuity of a concrete set of basic cognitive patterns and concepts" (Vansina, 1990). However, Vansina also states that traditions only become known as traditions in hindsight. Thus, tying the practice to tradition creates outdated boundaries while new traditions are already in the making but are however not yet defined as such. (Vansina, 1990). Naming SAM "traditional" medicine thus does it do no justice, as the "traditionalisation" of local knowledges was a constructed process - thus, the question emerges: if SAM is called "traditional", shouldn't all medical cultures be called traditional? (Meneses, 2007)

Considering Vansina's statement about the individual's role of defining tradition and adjusting it through social interaction over time, it becomes obvious that tradition and medicine are a result of social construction. Medicine is also "a subject to change from within and without. While certain values, practices and symbols may maintain, there is nothing authentic or essential about them as their importance shifts reflecting society's norms and values" (Flint, 2008).

While Karen Flint shows in what ways and due to which influences SAM has developed over time, Megan Vaughan tries to prove that Western medicine is as much a socially constructed knowledge as SAM is. She argues that the invention of scientific medicine was embedded in a particular social structure that consequently influenced medicine's role in society (Vaughan, 1991). In accordance with this is Murray's observation that "each ethnic community carries within itself not only its own specific illnesses but also its own cures. Thus European medicine was necessary originally only for Europeans, then later for those who have to operate in European society; now, finally, as 'modern medicine' it has the best cures for modern illnesses caught in modern society" (Last, 1992). The same is true for SAM which constantly developed new forms of treatment according to society's needs (Meneses, 2007). In contrast to what was portrayed as Western medicine, the book *Another knowledge is possible* states that "modern science is (…) just one form of particularism" (Santos, Nunes, Meneses, 2007). This explains the fact that Western medicine failed to satisfy the majority of African patients due to its non-holistic treatment. Consequently, a hybrid approach emerged with patients consulting different medical practitioners depending on their symptoms (Digby, Sweet 2002). This way of dealing with illnesses reflects that all knowledges are socially constructed, therefore adaptable and that none is complete but characterised through strengths and weaknesses. Obviously, this view would have undermined colonial superiority and would have admitted SAM too much room to prove the limitations of Western medical knowledge. Moreover, it posed threats to pharmaceutical competitors and therefore needed to be contained through the Coloniality of Power.

Enacting the Coloniality of Power – Creative Destruction

As mentioned in the beginning, the "[enactment of the] coloniality of power" is "an energy and a machinery to transform differences into values" (Mignolo, 2000) with the aim of "reducing the understandings of the world to the logic of Western epistemology" (Santos, Nunes, Meneses, 2007). According to Quijano, this reduction was partly constituted through "an institutional structure functional to articulate and manage such classification" (Mignolo, 2000). Tying medicine to "tradition" is indeed a classification able to destruct existing knowledges through hindering it from developing by caging it in an old-fashioned and too narrow definition. Vansina noted that "A tradition is harmed when it loses its ability to innovate efficiently. If the situation perdures, it will die" (Vansina, 1990).

In the following we will see what measures were taken to erase SAM. Contrasting the judges prediction mentioned earlier, SAM was not to become extinct through education and the extension of civilisation but by forcefully enacting the Coloniality of Power.

After Inyangas and Isangomas were both legally prohibited from practising and thus criminalised for years, Inyangas were surprisingly freed from this prohibition in 1891. However, this was not without limitations. They were only allowed to treat patients living in "African" areas (Mignolo, 2000). Moreover, they were prohibited from promoting their practices and from forming a lobby for their interests. These measures were hoped to limit the professionalisation of Inyangas in urban areas where they began to operate dangerously similarly to Western medical practitioners thus posing a serious competitive threat (Flint, 2008). Appropriately, they were restricted further by not being allowed to label themselves as 'doctors' or 'chemists' (Mignolo, 2000).

Another competitive advantage of SAM was the affordability of "traditional" healers. Being based on an egalitarian system, payment was oftentimes only due after a successful treatment and could be payed in some cases in kin. To limit this advantage, practitioners were burdened with acquiring a license fee. In 1912 alone these were raised 3 times. They were also forced to charge consultation fees which made it difficult for the majority of patients to get treatment as they were lower-income citizens in the majority. The consequences were not only disastrous for the medical practitioners themselves, but also for the supply of medical service to the vast majority of the population. To satisfy the demand a growing underground business of healers emerged. Out of legal supervision charlatans emerged which damaged "traditional" medicine's reputation further.

The former undifferentiated criminalisation towards all forms of healing, this created an oversimplified picture of the "profession" which labelled all forms of treatment as superstitious or witchcraft. This could be interpreted as an "othering" in a Saidian sense with the purpose of "reducing the understandings of the world to the logic of Western epistemology" (Santos, Nunes, Meneses, 2007) (Last, Chavunduka, 1986). This public "othering" helped to "articulate and manage those classifications" (Meneses, 2007). While it is undeniable that there is a difference between Western and SAM practices, this condemnation "deepened and even hardened the distinction" (Said, 1978) which eventually became to be understood as an incompatibility of the practices.

All of these measures against SAM practitioners were supported by missionaries, the white medical establishment and the pharmaceutical industry.[2] Whilst the marginalisation of SAM was of advantage to reducing competition and increasing further racial segregation, it also served for the purpose of hindering the emergence of a hybrid system in which SAM's knowledge would make sense. Its attempted erasure was of interest to the aforementioned parties on the one side, but also to confirm what Western scholars deemed as truth: the epistemological superiority of European medicine. However, the truth is rather that Western epistemology was constructed to appear as superior by preferring it economically, politically, financially and socially than actually representing reality.

How to break out of the Epistemological Cage?

The question is how to get out of this epistemological cage that colonialism implemented in many countries, one of them being South Africa and in particular its medical realm. Mignolo, whose analysis we used in the beginning to dissect the epistemological status of medicine, suggests the concept of creolisation as a new form of knowledge production. As creolisation is a term used by many writers, it is necessary to firstly state how it is understood and then secondly, as Mignolo uses creolisation in reference to languages, examine whether the concept is transferable to the medical realm.

Originally, Creole was a language that came into being in the Caribbean where slaves used European grammar and African vocabulary and thus created a new language symbolising their identity as relocated citizens. Creolisation then developed as a counter movement to Negritude. The latter was criticised for falsely portraying an "us" versus "them" binary. In contrast, creolisation symbolised a community not bound by borders, race or skin colour. Creolisation is also a concept "[proposing] the possibility and the necessity of producing knowledge without maintaining disciplinary principles" (Mignolo, 2000) that was mainly coined by the Martiniquan writer Edouard Glissant. Mignolo describes creolisation as a particular form of border thinking which works towards re-establishing differences formerly erased by colonial rule (Mignolo, 2000). It is thought "from the perspective of "the underside of modernity", which is the perspective of those formerly excluded from the universalist consciousness of European philosophy" (Parham, Drabinski, 2015). The produced knowledge is new and never finite - in contrast to hybridisation the outcome is neither planned nor fixed: creolisation does not reproduce its sums, it creates the unexpected and unprecedented (Parham, Drabinski, 2015). Thus, creolisation does not lead to homogenisation but is a "process of creative evolution" (Headley, 2015) that transcends the known. Creolisation breaks free from constructed binaries and produces knowledge that is neither local nor universal. This knowledge – rather than emphasising on differences – uses its in-between position to work with dominant knowledge features. The benefits of these knowledge features are appropriated. Creolisation "thus [encroaches] a mode of being into a dominant one but from the perspective of the subaltern" (Mignolo, 2000).

As Glissant and Mignolo mostly refer to language when talking about creolisation, it needs to be examined whether creolisation is applicable to medical knowledge. Although the medical case is not comparable to the brutality of slavery in whose context the language Creole came into existence, it still holds a similar core: suppression of indigenous knowledge from a hegemonic centre especially aimed at the periphery. Mignolo himself posed the question where to act and answers promptly:"In education, in the media, in all possible spaces where and when 'culture' becomes a question of power, domination and liberation" (Mignolo, 2000). As developed in the essay's first part, SAM qualifies as a cultural characteristic and has been used for demonstrating power. Moreover, language and medical treatments in this case have shared qualities with the latter having intensive ties to communities well-being and identity. Glissant himself views creolisation as inherent to all cultures. Headley fittingly concludes that "there are no pure cultures, all cultures are composites" (Headley, 2015) – also the medical culture in South Africa as well as the European.

The concept of creolisation can be used to analyse the status of epistemological superiority in South Africa. Therefore, it needs to be questioned as to how knowledge can be produced and by whom? How is the medical realm structured? Rather than asking whether creolisation is happening, this essay is trying to examine whether the structural circumstances are given to make creolisation theoretically possible. For this reason, the term creolisation has to be applied in a narrow manner. What this means can be illustrated quite well in the term's demarcation to hybridity. A broad definition of creolisation makes it more complicated to differentiate it from hybridity. In fact, some writers use both terms interchangeably, whilst others say that hybridity is the overarching term and creolisation one particular type of it (Headley, 2015). Mignolo and Glissant, however, explicitly distinguish between the two. Mignolo grasps the outcome of creolisation not as a hybrid result of cross-breeding of cultures but "as a rearticulation of global designs from the perspective of local histories" (Mignolo, 2000). Cross-breeding, a characteristic of hybridity, "[thinks] from the colonial difference (…) [and] is the visible outcome that does not reveal the coloniality of power inscribed in the modern/colonial world imaginary" (Mignolo, 2000). It rather blends together two differences into a new outcome (Headley, 2015). If one does not pay attention to the structural inequalities constructing the locus of enunciation of knowledges, hybridity can easily be mistaken for creolisation (Ahmed, Castaneda, Fortier, 2003). Thus, creolisation can be performed by anybody while hybridity needs prepared and calculated information to come to a conclusion.

In order to analyse whether creolisation in the medical realm is theoretically possible, the structural set-up of the sector needs to be inspected.

The status of Epistemological Superiority in South Africa's Medical Realm

One can say that fortunately the colonists' ambitions to erase traditional medicine in South Africa were greater than their actual means at hand to enforce them. According to estimations, around 80% of South Africans consult South African medical practitioners. This ongoing consultation of South African practitioners had manifold reasons. The main reason being a strong connection between South African cultural identity and SAM. Furthermore SAM's adaptability to new circumstances can be seen as an important factors of its surival, next to economical reasons and infrastructural insufficiency of Western medicine in rural areas (Flint, 2008; Meneses, 2007, Last, Chavunduka, 1986). According to Flint, laws could structure the public but not determine how citizens act and think in private (Flint, 2008).

In 1998 the World Health Organisation released a paper on the *Legal Status of Traditional Medicine and Complementary Medicine* which was "intended to facilitate the development of legal frameworks and the sharing of experiences between countries" (World Health Organisation). The paper stated that "traditional and complementary/alternative medicine provides an important health care service to persons both with and without geographic or financial access to allopathic medicine" (World Health Organisation) and advised to further develop legal frameworks to facilitate the practice of traditional medicine. Simultaneously, the first democratically elected government of South Africa called for an "African renaissance" including the promotion of Indigenous Knowledge Systems (Flint, 2008). Through both circumstances SAM gained international attention as well as governmental recognition (Flint, 2008). Two things need to be questioned however. Firstly, whether the epistemological superiority of "scientific" medical knowledge over SAM vanished? And if so, is the medical diversity in South Africa allowed to develop and flourish freely beyond the systematic limits of Western science?

Maria Paula G. Meneses (2007) negates this freedom in respect to medicine as "(…)in the present as in the past, the delimitation of what is knowledge and magic, of the official and the non-official, is done according to normalised practices that the state itself controls". According to Sousa Santos (2007), this normality is constructed through the epistemological monoculture that – despite the criticism of the colonial suppression of knowledge diversity – "is still accepted nowadays as a symbol of development and modernity".

In order to come to a conclusion whether Meneses' and Sousa Santo's statements are valid for the South African medical realm, it needs to be examined to what extent the good will of the South African government translated intro reality and manifested itself legally. Interestingly, Isangomas and Inyangas are treated differently by law. Despite the governments call for an "African renaissance" in the 1990s, Isangomas were continuously criminalised until 2007, however, the lift was only constituted legally in 2011. In contrast, Inyangas' practice is legal but faces constant endeavours of systematisation of knowledge. Isangomas still play a crucial role in the populations healing process due to their holistic treatment encompassing social and psychological aspects. They are often first responders for AIDS/HIV infected patients and are able to alleviate for example psychological side-effects of the virus. Legally, however, they are prohibited from treating HIV/AIDS patients and obliged to refer them to hospitals. A creolised treatment process would combine both medical cultures and make use of strengths and weaknesses especially in these particularly difficult and significant cases. Instead, the process is pervaded by mistrust that results in the negligence of consultation altogether. In turn, this is often blamed on Isangomas as European medical practitioners suspect the referral system to be not working (Wreford, 2008). In *Shaming and Blaming,* Jo Wreford (2008) describes that patients with HIV/AIDS are not only experiencing an othering socially when diagnosed but also an othering by hospital staff for seeing Isangomas beforehand. Additionally, they are being firmly told not to do so in the future (Ngubane, 1992).

This results in a feeling of having to chose one medical culture. Projects that should have led to closer cooperation were, according to Wreford, often one-directional and of an educative nature with the expectation that Isangomas learn from European medical practitioners (Wreford, 2005). Executing the state led initiatives one-directionally leads to the conclusion that European medical practitioners have not yet realised the advantages of cooperation and their own incapability of "curing" diseases fully. Therefore, creolisation is unlikely to happen as the "principle of incompleteness of knowledges [has to be accepted in order to make an] epistemological dialogue and debate among knowledges [possible]" (Santos, Nunes, Meneses, 2007).

The motivation behind the legal recognition of Isangomas is questionable. Did it materialise due to acknowledging their epistemological importance in the healing process or due to their position as first responders? The ongoing prohibition of treating HIV/AIDS patients can be interpreted as a continuous denial of SAM's capability of contributing to the treatment process. Although the prohibition might seem legitimate, the healing capability is still debated in the healer's community. While some argue that HIV/AIDS is a new disease and therefore not curable with ancestral spirits as "(…)[the ancestors] they died earlier before! It's a new illness! They knew only about other illnesses" (Wreford, 2005), others are convinced that a cure for HIV/AIDS could be found as new remedies often develop over time. Some think the power to cure is dependent on the ancestral spirits of the healer (Wreford, 2005).

Despite state led initiatives for further cooperation, mistrust from both sides - newly created but also remnant from Colonialism and Apartheid - hinders an effective creolised treatment process for patients (Wreford, 2005). This mistrust still rules the medical realm. Through this, the binary view, which was prevalent in the 20th century, is maintained to the present day and with it the conviction of epistemological superiority. These circumstances foster a competitive rather than a cooperative attitude between the practices despite cases where South African healers have alleviated for example psychological pain stemming from HIV/AIDS. The disregard of these contributions also stems from a second problematic area.

The epistemological dialogue that *is* conducted was officially started through the call for an "African renaissance" that entailed a plan for "normalisation" of "traditional" medicine. However, this was motivated by recognising that stopping HIV/AIDS is impossible without SAM practitioners, more precisely without Inyangas (Flint, 2008). Ever since, Inyangas face endeavours of systematisation of their knowledge by institutions and corporations. The reason for non-recognition lies also within the difficulty of systematisation. We have come full circle here with the judges attempt to find a defining concept for SAM. Concluding, de Sousa Santos is right when claiming that the epistemological mono-culture is still prevalent.

Although it is a question in itself whether SAM is even classifiable, there are voices in the healer community that view systematisation as beneficial (Last, 1992). However, the counter-argument reveals one of the main problems with systematisation. The call for systematisation holds, at least on the existing legal grounds, a danger for the cultural good that is SAM. Assuming that SAM remedies were to be fully recorded and the information thus broadly accessible, existing patent law would not protect this knowledge the same way as it protects scientific knowledge. "Traditional" knowledge is either viewed as belonging to communities or for some even to ancestors. Patent law, however, stipulates one-person ownership. Thus, a deadlock situation is created as communities regard multiple people to be "originators" of medical knowledge. By still tying recognition to systematisation and not providing the appropriate legal and infrastructural frame, SAM practitioners either risk losing cultural goods to pharmaceutical companies without further compensation or they live with being unappreciated by the government (Wreford, 2005). Moreover, the existence of infrastructural inequality between epistemologies can be confirmed. This pressure of systematisation is described as "the oppressive gaze of transparency" by Headley (2015). Additional dependence on laboratory testing leads to further "inequities of this system, which privilege those with capital and laboratories over those who are knowledge rich but 'research' poor" (Flint, 2008). Murray further claims that knowledge could be lost through systematisation if parts are not being classifiable (Flint, 2008). The danger prevails that only those parts of "'local' knowledge (…) are regarded as valid [that](…)serve the projects of capitalist modernity" (Santos, Nunes, Meneses, 2007).

Despite a theoretical possibility of creolising SAM and Western medical practices, we have to come to the conclusion that the practices remind more of hybridity than of creolisation – let alone of the fact that the locus of enunciation is not in the indigenous sphere.

Moreover, knowledge and discoveries are not only of ideological and influential value but also and probably mainly of monetary interest. Thus, the question arises to what extent the non-recognition is also a competitive calculation. In his essay on "Translating the Japanese Culture", Noaki Sakai speaks of the reality of translation: a procedure where two systems are confronting each other, while never being of the same power - a state that can be affirmed for the South African medical realm (Sakai, 1997). What can be learned from this Sakai example is a recognition that there will never exist a completely correct translation. Sakai says that the translation in itself is nothing more than a new translation, never reality. According to him, the accuracy of a translation can only ever be judged after its enunciation (Sakai, 1997). Despite the fact that the result of the "translation"/creolisation of SAM and Western medical practices needing to be awaited, what cannot be denied is the impression that the remedies of SAM are worshipped while the originators are not. Concluding, I tend to agree with de Sousa Santos claiming that the epistemological monoculture of Colonialism is still prevailing and even regarded as modern as can be seen in the attempt to systematise SAM. Despite agreeing with Sakai on the other hand, what needs to be understood is that epistemological and social suppression are closely intertwined and that social justice won't be possible without epistemological justice.

Conclusion

Despite the obstacles we have seen, there is still hope for a further co-operation and creolisation in South Africa's medical realm. Ultimately, it seems that an effective cooperation between practices is the only way to tackle health issues sustainably. The positive effects of a closer cooperation and creolisation of knowledge can be witnessed in other African countries. Despite the good will of the South African government, further action needs to be taken in order to overcome the obstacles listed above. Mistrust between the cultures, structural inequalities in the legal sector and in accessibility of research facilities were identified as the main problems hindering the effective battle against HIV/AIDS.

Although it might be ironic to end this essay with an idea from Kant, one of enlightenment's masterminds, the idea is, in my opinion, of great value when looking at a concept such as creolisation. It would be wise to view creolisation as a Kantian regulative principle: as an ideal that guides thoughts and thus hopefully actions (Pomerleau). I close my argument with the advice to regard the creolisation of medicine as a project rather than as a status; a project that requires continuous care, adjustment and attention.

Bibliography

Digby, A., Sweet, H. (2002). Nurses as culture brokers in twentieth-century South Africa. In W. Ernst (Ed.), Plural Medicine, Tradition and Modernity, 1800-2000, London: Routledge.

Flint, K. (2008). Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820–1948. Athens: Ohio University Press.

Headley, C. (2015). Glissant's Existential Ontology of Difference. In M. Parham, J. Drabinski (Ed.). Theorising Glissant: Sites and Citations. London: Rowman & Littlefield International.

Last, M., Chavunduka, G. L. (1986). The Professionalisation of Medicine. Manchester: Manchester University Press.

Last, M. (1992). Observations from Hausaland. In S. Feierman, J. Janzen (Ed.). The Social Basis of Healing in Africa. Berkeley: University of California Press.

Meneses, M. (2007). When there are no problems, we are healthy, no bad luck, nothing: Towards an Emancipatory Understanding of Health and Medicine. In B. Santos (Ed.). *A*nother Knowledge is possible: Beyond Norther Epistemologies. London: Verso.

Mignolo, W. (2000). Local Histories/Global Designs: Coloniality, Subaltern Knowledges, and Border Thinking.Princeton: Princeton University Press.

Ngubane, H. (1992). Clinical Practice and Organisation of Indigenous Healers in South Africa. In S. Feierman, J. Janzen (Ed.). The Social Basis of Health and Healing in Africa. Berkeley: University of California Press.

Parham, M., Drabinski, J. (2015). Introduction: Glissant, Creolizing Philosophy. In M. Parham, J. Drabinski (Ed.). Theorising Glissant: Sites and Citations. London: Rowman & Littlefield International.

http://www.iep.utm.edu/kant-rel/ [08.01. 2017.]

Said, E. (1978) Orientalism. London: Routledge & Kegan Paul.

Santos, B, Nunes, J., Meneses, M. (2007). Introduction: Opening Up the Canon of Knowledge and Recognition of Difference. In B. Santos (Ed.). Another Knowledge is possible: Beyond Norther Epistemologies. London: Verso.

Sakai, N. (1997). Translation and Subjectivity: On "Japan" and Cultural Nationalism. Minneapolis: University of Minnesota Press.

http://bit.ly/2i4m1Os [07 January 2017]

Ahmed, S., Castaneda, C., Fortier, A., Sheller, M. (Ed.) (2003). Uprootings/Regroundings. Questions of home and migration. Oxford: Berg.

Vansina, J. (1990). Paths in the Rainforests: Toward a History of Political Tradition in Equatorial Africa. Madison: The University of Wisconsin Press.

Vaughan, M. (1991). Curing their Ills: Colonial Power and African Illness. Stanford: Stanford University Press.

http://bit.ly/2i4qkJy, [07.01.2017]

Wreford, J. (2005). Missing Each Other: Problems and Potential for Collaborative Efforts between Biomedicine and Traditional Healers in South Africa in the Time of AIDS. Social Dynamics, 31:2, 55-89.

Wreford, J. (2008). Shaming and blaming: Medical myths, traditional health practitioners and HIV/AIDS in South Africa. CSSR Working Paper No. 211. Centre for Social Science Research University of Cape Town.

Xaba, T. (2007). Marginalized Medical Practices: The Marginalisation and Transformation of Indigenous Medicines in South Africa. In B. Santos (Ed.). *A*nother Knowledge is possible: Beyond Norther Epistemologies. London: Verso.

References

[1] Western medicine refers to the medical practices developed in Europe. Other names are biomedicine, allopathy or cosmopolitan medicine. I will refer to it as Western or European medicine as I would prefer to refer to the place of origin. In the same manner I will refer to what others call "traditional" medicine with SAM, as the use of the former would undermine the point I am trying to make.

[2] Enumeration and more detailed interests of different groups in Last, Chavunduka, p. 13.