Reeds in the wind of change

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Zulu sangomas in transition

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Photo front cover: healing session in progress

In memory of

Bongani Ntshangase

Preface

This thesis investigates the changing healing practice of Zulu sangomas in KwaZulu Natal, South Africa. It seeks to detect where transformations in healing practices originate and why adaptations are implemented.

Several of my fields of interest converge in this study; (indigenous) religion, health, psychology and philosophy. Although not all these spheres surface equally, they are part of my mode of thought and my way of observing people and society. Since I was a teenager I have been fascinated by the phenomenon of religion. Not in the doctrinal ways but in the way people believe, in relation to their character and their attitudes towards social issues; the (discipline of) psychology of religion. In the 1990s during my theological studies, I was introduced to African indigenous religions and how these are intertwined in daily life; I was captivated. My major thesis however dealt with the views on illness and affliction in orthodox Christianity and of western 'holistic healers' (Hooghordel, 1996). In this research both those themes converge.

In Zulu landscape, reed is a frequently encountered phenomenon; near shores of lakes, in swamps etcetera. It is there, firmly rooted in the bottom of the river, whatever storm may pass. Reed is an important feature in Zulu culture as well. The Zulu Creation myth relates of Mvelinqangi creating people out of the reeds in a Northern valley (Knappert, 1977; Schipper, 1999). Makhosi Mbuyisa provided me with the thesis' title, by using the metaphor of 'reeds bending in the wind' for sangomas' lives. While they are exposed to all kinds of dynamics and influences, sangomas execute their practices in an experiential, pliable way. Their healing practice is firmly embedded in Zulu indigenous religion and well-rooted in society. Enduring the winds of change in contemporary South Africa.

As most Zulu sangomas are women, in general descriptions I refer to the sangoma with 'she' and, for clarity reasons, to the patient with 'he'. All pictures are taken and published with permission and are part of the author's private collection, unless otherwise indicated in the caption.

The bottlenecks that I describe in this study are genuine dilemmas for (associations of) indigenous healers, the choices they make will possibly have their effects for the next decades. I hope my analysis will be valuable in the light of the westernisation of South African legislation and society at large.

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Chapter 1

The origin. Introduction and Theory

1.1 Four snapshots

As a starting point for this thesis, below I present a few field work experiences.

In the rural area

On the floor of a rondavel built on the slopes of the hills surrounding Inanda Lake, north-west of Durban, an 80-year-old woman is sitting with one of her pupils beside her. She is dressed in a black beaded skirt, her head wrapped in a red scarf adorned with a beaded headband. On her wrists are dozens of bracelets made from goatskin. Her pupil, about 40 years of age, wears a T-shirt, a cloth around her waist, and a leopard print scarf around her head. Hanging from the ceiling of the rondavel, opposite the door, is a leopard print cloth and close to that cloth on the floor burns a white candle and a small calabash with smouldering twigs. The woman and her pupil sit on the right side of the rondavel, the visitors on the left side. She tells the audience about her life and about the time, more than fifty years ago, when she herself was an apprentice in her profession. She tells of how, as a child, she was sick but the doctors couldn't help her and that she had to leave school because she could barely see anything anymore. She remembers that her parents took her to an old woman who told them she was under the supervision of the ancestors who wanted her to become a sangoma. And she explains that, still a young girl, she refused, even ignored the message, until years later when she was so poorly that she had no choice but to give in. So, she went to a sangoma for training. And she tells how, at the moment when she started her training, she started to recover from her illnesses. The woman now reflects on more than five decades of working as a traditional healer, a period in which she learned to cooperate with Western doctors from the local clinic and trained many initiates, just like she was trained long ago.

While she tells us of her life and profession, she receives sporadic text messages on her cell phone, which she immediately answers. In the meantime, noises from outside enter the rondavel. These are the sounds of children playing around the small brick building on her homestead that is the preschool annex of the orphanage that she founded a few years earlier and that she now runs with a couple of women from the area.

Figure 1.1 Mks Bhengu (m), her pupil (l) and Bongani in front of the consulting room, 2012

Figure 1.2 Mks Bhengu in her pre-school/orphanage 2014

In a township south of Durban

In a spacious rondavel, just inside a stone wall that separates the extended compound with several brick buildings from the street, a woman in her thirties is sitting on her knees. A cloth covers her shoulders, a pink scarf is wrapped around her head to cover her hair. On the floor in front of her are several lit candles, carefully arranged on a white cloth with a blue cross in the middle. Beside the candles are fruits as well as children's food and clothes, drinks, and sweets. This woman has turned away from the leopard print cloth that hangs from the ceiling opposite the rondavel's door; she now faces a blue dress hanging on the right wall of the rondavel. Behind her people enter and leave, some sit down to stay and have a talk, others come in just to fetch something and leave

Figure 1.3 Offerings at display

again. The voices inside the rondavel mix with fragments of sounds emanating from a TV set, located in a room in the main house where patients wait for their consultation. Alongside the pink-scarfed woman is a young woman sitting on her knees, dressed in several blue cloths, with a blue headband and goatskin bracelets. She lights some twigs in a silver dish and then extinguishes the fire, leaving the twigs to smoulder. The women talk in soft voices, and when the other people in the rondavel start to sing a song, the women's conversation can only be heard by the two of them.

Where the river meets the sea

On a Saturday evening on the beach, where the river meets the sea, a group of people dressed in colourful cloths and wearing all kinds of beadwork, are singing and dancing in the dark around smouldering twigs in a small pit in the sand. The air is filled with the sounds of more than just singing: a fierce wind (which has blown out the flames of the candles beside the twigs), the waves of the sea, and the murmuring water of the river. A few bystanders occasionally glance at the dancers, but their focus is on a man standing calf-deep in the river. His attire is white with black lines; on his head is a white and blue beaded headband, around his shoulders a leopard skin, and he is holding a white bucket overflowing with foam. To his right is a woman, covered in white cloths, on her head a black hat with a leopard print headband. To his left stands a young man covered in green cloths and a green headband around his head. Sporadically, this young man calls out to the other side of the river, to the Xhosa area. Everybody sings while the dancers perform and the man pours some of the basket's contents into the river. Moments later, he gently lowers the basket to refill it. Some people around him illuminate his actions with their mobile telephones.

Figure 1.4 Healing session in the river

In a township north of Durban

Behind a house, the compound fenced with a stone wall, and an iron gate, two men are sitting in a small rondavel, one on his knees, the other one, wearing a leopard print headband and goatskin bracelets, on a small wooden stool. Outside, right beside the entrance is a heap of sticks and grass, a herons nest, to be ransacked for it might be hiding a secret. The rondavel's interior walls are painted black with numerous white dots everywhere; the room is filled with smoke coming from some smouldering twigs in a small calabash. From the ceiling hangs a leopard print cloth and on the floor are many small pots and bottles. The man on the stool mutters, holding a leather pouch above the calabash, then he throws dozens of small objects from the leather pouch onto a reed mat in front of him. Pointing to the objects and touching some of them, he tells the other man why he does not feel well and, after another throw of the objects, what has to be done in order for him to feel better.

Figure 1.5 Throwing bones

1.2 Research questions

These snapshots are scenes from traditional healers' practices I encountered during fieldwork in 2012 and 2014 in (the vicinity of) Durban, South Africa. More precisely, they are the healing practices of sangomas.[1] The scenes show various settings in which traditional healing sessions take place: a rural rondavel or one in a metropolitan suburb; or, in the case of the third snapshot, at the riverside, a location precisely selected for a specific patient's healing.

A number of similarities and differences can be detected across these scenes that are relevant to further understanding these healing practices in contemporary Africa. Moreover, they are relevant for understanding the ways in which such practices are living traditions that continue to play a role in modern South African society.

One similarity is found in aspects of professional dress, i.e. goatskin bracelets and a headband. Other elements common to the snapshots are the leopard print cloths (a reference to the ancestors) and the smouldering twigs that produce an essence that facilitates the connection and communication with the ancestors. Props
In addition to these parallels, we also encounter obvious differences in the healing practices, e.g. the way that diagnoses are made, the healing rituals, the presence of Christian symbols in the consultation room, traditional healers' attitudes to patients and ancestors, and the use of contemporary methods and objects.

For anyone unfamiliar with the subject of traditional healing, the scenes may seem somewhat strange, perhaps not belonging in modern times, or in a country as (relatively) highly developed as South Africa. One may be tempted to think these practices belong to another, historical era (and actually they do) and, at first sight, the use of mobile telephones during the healing sessions seems anachronistic.

One may also assume that with the arrival of missionaries (and, subsequently, Christianity) and Western healthcare, this indigenous view of health and healing would have lost most of its ground. Yet, the opposite is true. In contemporary South Africa, this kind of healing, often involving herbal medicine, various rituals, and communication with (the spirits of) ancestors, is increasingly important. According to Thornton (2009), about 80 per cent of the total population (also) visits a traditional health practitioner when feeling unwell. In fact, this branch of healthcare is flourishing, for some people it is even a booming business.

It is exactly these apparent incongruities that captivated me. I wondered what mechanisms contribute to or even effectuate this paradoxical image of traditional health practices today. For a better understanding of such (supposed) anachronisms and transformations in traditional healing I began to analyse various sources.

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[1] Sangomas call themselves 'traditional health practitioners' or 'traditional healers' and their profession 'traditional healing'. I adopt their lexicon for the moment.

In my exploration of the backgrounds of transformations in healing practices and traditional healthcare's present status, I analysed the collected data in the context of the existing academic literature on traditional healing in (South) Africa, both earlier studies (Callaway, 1884 (1870); Bryant, 1949; Bryant, 1966; Krige, 1965 (1936)) and more recent ones (Janzen, 1992; Erdtsieck, 2003; Van Binsbergen, 1991; Mlisa, 2010; Werbner, 2015). The older (ethnographical) studies paint fine pictures of, specifically, Zulu society in the second half of the nineteenth and the first half of the twentieth century. Both Callaway and Bryant were missionaries who lived and worked among the Zulu people for decades. They described Zulu culture, including the practices of diviners, or, as Bryant calls them, medicine men. Krige, a South African social anthropologist, documented the social system of the Zulu in detail. In her solid book, she pays ample attention to Zulu religion and the social position of the three kinds of doctors she distinguishes: medicine man; diviner; and heaven-herd, as well as their healing methods. These valuable descriptions helped me to understand the context and history of Zulu traditional healers and gave me an insight into longitudinal developments in Zulu identity, society, and healing.

More recently, apart from Janzen's extensive work on discourses of healing in Central and Southern Africa (1992), in which he describes and compares various elements (like drums) and meanings of 'cults of affliction', there are a few case studies in academic literature on indigenous[2] healing that are comparable to this present one. Erdtsieck's field study (2003) was about spirit healers in both rural and coastal Tanzania. A major focus of this work is the musical components (especially singing) of healing therapies. She also found that there was no standard procedure in healers' usage of plants as remedies; indeed, sometimes the healer would just take what was available. She thus distinguishes many individual aspects and adaptations in the course of treatment.

Werbner (2015) and Van Binsbergen (1991) make traditional healing in neighbouring Botswana the subject of their studies. Werbner's longitudinal research on divination highlights the poetic language used in healing sessions, because 'the focus is persuasive reasoning and argument' (2015, p. 117). He describes divination as a situational expression of the moral imagination. Van Binsbergen writes about his path to becoming a sangoma, despite his initial academic motives. A major topic addressed in this study is whether it is possible to become a practising sangoma (an insider) and also maintain academic (outsider) research standards.

In their, non-academic, ego-documents Arden (1996) and Hall (2009) narrate their unanticipated ancestral calling and the arduous path of a subsequent sangoma training.

Within South Africa, the study closest[3] to this one is Mlisa's (2010), which focuses on the training of Xhosa women as traditional healers (Xhosa: *amagqirha*). She emphasizes that the training (Zulu: *ukuthwasa*[4]) is dynamic and affected by time, circumstances, and

[2] Explanation on the use of the words 'traditional' and 'indigenous' follows in subsequent pages.

[3] Both geographically and chronologically.

[4] All Zulu words in the text are in *italics*, see also the list of Zulu words in Appendix A.

context. The curriculum is flexible and individually attuned; every trainee has her own (training) trajectory and must construct her own healing identity. How these dynamics and this distinctiveness emerge in the healing practice, Mlisa does not elaborate on.[5]

Erdtsieck (2003), Thornton (2009), and Van Beek (2010) also write about the transfer of indigenous healing knowledge in such trainings. These academics agree on how trainees learn from their teachers, namely like a pupil from a craftsman, by watching and experiencing what it is like to be an indigenous healer. However, there is no agreement on exactly what knowledge is transferred. While Mlisa states that the ancestors assess the amount of knowledge an apprentice (Z: *thwasa*, pl. *amathwasa*) gets to learn, Thornton defines various disciplines of indigenous healing that must be taught. Van Beek suggests that the content of the indigenous knowledge transferred is not a 'fixed parcel', handed down from one generation to the other, but varies per teacher and per apprentice. Rather, he found that discovery procedures are taught; that is to say, how to build personal knowledge about, for example, medicine and treatment.

As for the position of traditional healing in contemporary South Africa (the anachronism in the snapshots), the earlier mentioned ethnographical studies also helped me to determine longitudinal changes in various aspects. Moreover, with regard to the shifting relationship between indigenous healing and Christian churches, Oosthuizen (1989; 1992) described how indigenous healing is increasingly acknowledged in religious institutions, predominantly in African Independent Churches, but also in initially inimical mission churches. Medical doctor (and son of a traditional health practitioner) Gumede (1990) writes about the frictions and mistrust between Western healthcare and indigenous healing, as does Botha (2004). Both plead for better cooperation and state that a more flexible attitude on the side of Western healthcare workers is a prerequisite for this. More recently, Gqaleni (2010), Ndzimande (2014) and Zuma (2017) describe the collaboration – compelled by new healthcare legislation – of both healthcare systems in projects concerning the prevention and treatment of HIV/AIDS.

The effects of contemporary society and the institutionalisation of Traditional Medicine on sangomas' healing practices is a matter that exercises many minds. Mbatha (2017) and Ndzimande (2014) explore how indigenous healers cope with the challenges of this juncture. In addition to the advantages of the latest healthcare law for traditional healers, they notice many frustrations regarding the government's indifference to the legislation's enactment.

In sum, the image of traditional healing that emerges from recent literature is that it is a dynamic system. The *thwasa's* training is tailored to her individual situation (Mlisa, 2010; Van Beek, 2010). Every healer executes the healing practice in her own way (Erdtsieck 2003; Mlisa 2010) and adapts the healing procedures to the given context

[5] Which is just plain logic, while the subject of her book is specifically the *training* of *amagqirha.*

(Erdtsieck 2003; Werbner, 2015). However, I have uncovered a gap in this academic literature when it comes to the transformations in traditional healing, also in relation to the social context in which traditional healers practise. The shifting relationships between traditional healing, religious institutions, Western healthcare, and society in general has been described, but not how these phenomena affect the traditional healing practice.

In short, too little attention has been paid to what exactly transforms in traditional healing practices and what the underlying processes are. Given this, more research on the transformations and the dynamics involved was needed. This thesis is the culmination of my study on this subject.

Analysing the literature on sangomas' healing practices and the collected data revealed that traditional healing practices change due to internal dynamics (concerning the transfer of knowledge and sangomas' individual healing identity) as well as processes external to the traditional healing system (in the form of adaptations to other institutions and to contemporary society).

Moreover, I wondered how to relate these transformative and dynamic healing practices to the claim that such practices are 'traditional'. These considerations consequently led me to formulate the main research question as follows:

How do internal and external dynamics inform 'traditional' healing as an experiential system in contemporary South Africa?

With the term 'traditional healing system (TH system)', I refer to the sum of the elements like (the organisation and execution of) training, healing practice, and association that together form traditional healthcare. A further explication of the term traditional (or indigenous) healing follows below.

I use the term 'internal dynamics' for dynamics within the system of traditional healing. Examples include: (changing) processes of diagnoses and healing; how the training is given shape; discrepancies in training and performance; relations and referrals between traditional health practitioners; healers' opinions on the TH system; and their initiatives to improve traditional healthcare.

'External dynamics' is used for processes and forces external to the TH system that affect this system, e.g. cosmopolitan healthcare, religious and pharmaceutical institutions, different levels of government, and South Africa's changing society at large.

By designating traditional healing as an 'experiential system', I emphasize the importance of various experiences in traditional healing procedures. In his 'Modes of Religiosity' theory, Harvey Whitehouse (2004, p. 64) describes a way of knowledge transfer and execution of practice in which experience and interpretation are important. He calls this the 'imagistic' way of knowledge transfer, in contrast to the doctrinal way. I will elaborate on these concepts when I return to Whitehouse's theory.

I steer clear of any attempt to provide a comprehensive description of contemporary South Africa here. Any indication is a reference to '21st-century South Africa'. In the following chapters, I subsequently single out and describe various relevant elements of contemporary South African society.

Clearly, research such as this has its limits; so, while the working title says it is about traditional healing in South Africa, the actual research is done among female sangomas in the province of KwaZulu Natal, more precisely in (the vicinity of) Durban. An all-embracing study among approximately 350,000 (Ndzimande, Sibiya, & Gqaleni, 2014) traditional healers in South Africa is a mission impossible. Therefore, the field of research had to be narrowed down to a practicable size. 'Sangomas', the main figures in this study, are a specific group of traditional health practitioners, predominantly (about 75 to 80 %) women.[6] I am fascinated by their profession, which incorporates both religious and medical elements. KwaZulu Natal is the area where most Zulu people live and Durban, situated on the Indian Ocean's coast, is the largest city of the province. I will return later to the relevance of the obtained data for the situation of all traditional health practitioners nationwide.

For reasons of transparency, I will break up the matter into two evident domains, the internal and external dynamics. I address both domains separately in two sub-questions, which are dealt with in consecutive chapters. With regard to the internal dynamics, I will start by zooming in on the healing practice itself. Then, I will shift the focus to the sangomas' training and indigenous knowledge transfer.

1. Internal dynamics

1a. The first sub-question therefore is: How do processes of diagnosis and healing characterise the traditional healing practice?

1b. The second sub-question is: What dynamics and contradictions are in the curriculum and knowledge transfer of sangomas' training?

Then, the scope widens to external dynamics that affect traditional healing, first to fields that are adjacent, and finally to contemporary society in general.

2. External dynamics

2a. Sub-question three is: What dynamics are involved in the interrelationship between (cosmopolitan) healthcare, religion (indigenous and institutionalised), and indigenous healing?

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[6] I will return to this topic.

2b. And lastly, the fourth: How do historical, social, and political processes inform contemporary indigenous healing?

Up to now I have been speaking of traditional healing, following the general discourse in South Africa. This demands a clearer definition. What, then, is traditional healing? This is the subject I will explore in this chapter, followed by a description of the fieldwork method used to obtain significant data and the theories I applied to analyse and interpret those data.

1.2.1 Definition of terms and perspectives

'Traditional' healing

The World Health Organisation (WHO) defines traditional healing, also termed 'traditional medicine'[7] as follows:

> it is the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (Website WHO).

The WHO states that this kind of medicine has a long history. This is also reflected in the definition of 'traditional medicine' in the Collins English Dictionary: "systems of medicine developed before the era of modern medicine, based on cultural beliefs and practices handed down from generation to generation" (Website Collins Dictionary). Both descriptions refer to the long history of this kind of medicine and its connection with cultural beliefs and practices. That it is (or should be) used to maintain or improve health goes without saying as far as the Collins' dictionary is concerned.

Thus, traditional healing is generally agreed to be a mix of medicinal and religious elements, based on knowledge, skills, and experiences. South African legislation on traditional health practices, the Traditional Health Practitioners Act (THP Act),[8] mentions four categories of traditional health practitioners: herbalists; traditional birth attendants; traditional surgeons; and diviners. This research is not about the healing practice of traditional birth attendants or traditional surgeons or herbalists (*inyanga)*;[9] the focus is on 'diviners'.

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[7] 'Medicine' in the sense of 'healthcare'.

[8] Also called Act 22, 2007, assented by the President in January 2008.

[9] Marginally, the profession of *inyanga* is mentioned, for instance in opposition to the profession of sangoma or where the two professionals cooperate.

The diviner, a sangoma

In the healing practice of 'diviners', elements of both medicine and religion are obvious. Such practitioners, referred to in English as a 'diviner', are called *sangoma*s in Zulu language. The word diviner points exactly at the part of the sangomas' healing practice that distinguishes it from other traditional health practices: divination[10]. A sangoma uses divination, in this case the alleged ability to communicate with the spirits of deceased ancestors[11] (Zulu: *idlozi*, pl. *amadlozi*), in order to, for example, diagnose a patient's ailment. The ancestors also provide a solution for the patient's problems via the sangoma, the ancestors' intermediary. The cure may be in the form of offerings to the ancestors, the performance of specific rituals, the prescription of some sort of (biological) medication (Z: *muthi)*, or whatever the ancestors consider applicable.

This divination aspect to the healing practice and its effects have a clear cultural and religious background. Indeed, the sangomas' healing practice has its roots in indigenous religion; it presupposes a belief in (the power of) the spirits of deceased ancestors. People who do not believe that deceased persons become spirits in the spirit world and people who do not ascribe any power to the supernatural over the visible world are unlikely to take a sangoma's healing practice seriously. Hence, for some people, the snapshots detailed at the beginning of this chapter may seem weird, out of place in the 21st century and in a developed country such as South Africa.

African cosmology

In the context of South Africa, however, we must take into account that, for the majority of African people, religious belief is an integral part of daily life (Mbiti, 1969). Ter Haar (Website Platvoet)[12] mentions three characteristics of religious beliefs in Africa: the indivisibility of the visible and invisible spheres of life; the centrality of the spirit world; and the power that is ascribed to the spirit world. Bearing this in mind, it becomes clear that, in the African context, the sangomas' healing procedure is merely a consequence of the way people conceive of life in general. For them, the presence of the ancestral spirits and their ability to intervene in a person's life is something quite common, not out of the ordinary (Hammond-Tooke, 1975; 1986). Moreover, they anticipate that the spirits will protect them and take care of their well-being.

The people involved in this research, i.e. sangomas and their patients, see the ancestral spirits and their influence on daily life as facts. The sangomas communicate with their ancestors day and night, with this communication initiated by both the ancestors and the sangomas. The patients believe that ancestors look after them and,

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[10] I will go deeper into the subject of divination in Chapter 3.

[11] I use the term 'spirits' and 'ancestors' interchangeably.

[12] Speech at the Symposium "Jan Platvoet and the Study of Religion", Leiden, 8 June 2015 in honour of Jan Platvoet's 80th birthday.

if things are not going well (physically, mentally, or socially[13]), they conceive this lack of well-being to be a sign of an ancestor's discontent. By consulting a sangoma, the reason 'why things go wrong' will become clear; subsequently, a specific ritual or an offering will please the ancestors and the patient's well-being will be restored.

A number of academics have written specifically about the way Zulu people conceive of misfortune and illness, and the way these are handled. Berglund (1989) observes that, traditionally, the Zulu do not think in terms of chance, fortune, or fate. When evil shows its face, the Zulu believe there is always somebody responsible, whether it is a living person or a spirit of a deceased one. Subsequently, according to Krige (1965 (1936)), a diviner (*sangoma*) is consulted to discover what caused this bad luck and to hear what steps to take to resolve the situation. The significance of this procedure for Zulu people is captured in the following quote from Du Toit: "The diviner is of importance for the very fact that when man is faced with unknown and unpredictable situations then it is through consultation with the diviner that he receives the will of the ancestors and consequently his doubts are removed and his anxiety reduced" (1971, p. 55)

We can distinguish three characteristic elements in this explanation of the way Zulu people understand mishap and illness: a propensity to think in terms of causations regarding the things that happen in life; an inclination to consider the cause of negative experiences to be something outside themselves; and the reinstatement of the predictability of life and thereby of a just (or at least an explainable) world. This way of thinking has not been superseded, and nor is it a Zulu prerogative; that is attested in the many recent academic writings on the subject of 'evil' in Africa (Olsen & Van Beek, 2015; Ter Haar, 2007). The issue of 'why things go wrong' is an incentive and motivation for Zulu people to attend a sangoma; indeed, it is the main question in traditional healing processes. In fact, these processes can be interpreted as an instrument, a technique to answer this question. I will return to this subject later.

[13] The Zulu see health as a balance within and of these three spheres, see Chapter 3.

1.3 Methodology and Operationalisation

The main topic of this study, however, is indigenous healing; an exploration of how healing practices are transformative and what dynamics motivate these changes. As mentioned before, in order to gain a proper perspective on the subject, we must consider both the internal and external domains of the traditional healing system. Within the TH system, the focus will be on the healing practice and on the sangomas' training. Subsequently, I will zoom in on the external dynamics; firstly, the interrelation between indigenous religion, cosmopolitan healthcare, and traditional healing; and secondly, the historical, social, and political processes in South African society. It seems appropriate to start with a small excursion to the (gender) context of indigenous healers.

Women and men

While all inyangas are men, nowadays, sangomas are predominantly women.[14] Inyangas are respected (also by sangomas) for their extensive knowledge of medicinal herbs, minerals, etc. and their ability to communicate with the ancestors means sangomas are held in high esteem, also by inyangas.[15] However, in early writings about Zulu society (Callaway, 1884 (1870)) diviners, as sangomas were called, were referred to as men. During his research in the late 1950s and 1960s in the Nyushwa area, 50 kilometres north of Durban (close to the homestead of Makhosi[16] Bhengu, the oldest interviewee), Van Nieuwenhuijsen (1974) found that up to ninety per cent of sangomas were women. He suggested the reason for the predominance of women sangomas can be traced to the subordinate role of women in Zulu society. Answering the call of the ancestors, whose authority was beyond any doubt, and becoming a sangoma could have been one way to attain status or prestige in male-oriented Zulu society. He also found a socio-political reason: as a result of apartheid and the subsequent urbanisation,[17] the rural area was chiefly inhabited by women, since the men had gone to urban areas in search of work. It is no surprise, then, that most of the sangomas in the rural area were women. In fact, Van Nieuwenhuijsen's point of view had already been aired in the 1930s, by Gluckman (1935). He explained the subordinate role of Zulu women in the context of the history of the Zulu people as warriors, giving men a superior role. Being a sangoma (in Gluckman's observation 95 per cent of the sangomas were women) might have been a way for women to cast off their subordinate position. What is interesting here is the link this writer makes with the fertility rituals performed by girls and women for *Nomkhubulwane*,

[14] Makhosi Mbuyisa (the interviewee of the middle generation) told us that whilst she was still a child, she wanted to become an inyanga but she couldn't because she was a woman, so she settled for the ancestors' calling to become a sangoma.

[15] Baba Cele is a renowned inyanga who also cooperated in this research. His offspring precisely reflects this division, two of his sons are inyanga, one of his daughters is a sangoma.

[16] Makhosi is a respectful form for addressing a sangoma, abbreviated to Mks.

[17] I will elaborate on the topic of apartheid and the consequences for sangomas in Chapter 5.

the Heavenly Princess in indigenous Zulu religion.[18] He draws a parallel between the important role women play in these religious rituals and the high percentage of women sangomas, a key social position in Zulu society. Ngubane (1977), an anthropologist and Zulu herself, disagrees with Van Nieuwenhuijsen and Gluckman, however, and maintains that becoming a sangoma is not an outlet of social inequality or an escape from male dominance for women. According to her, in Zulu society, women are closely associated with life's transitions, i.e. pregnancy, birth and death, and therefore it is obvious that most sangomas, who communicate with the ancestors' spirits in the invisible world, are women. She argues that these women are merely playing a role that is set for them by society for the benefit of the society. In 2012, my key informant Bongani Ntshangase, based on his extended network of sangomas in KwaZulu Natal, judged the percentage of women to be about 75 per cent. He did not support any of Van Nieuwenhuijsen's or Gluckman's social scientific explanations; these days, he said, these figures just reflect the population statistics, i.e. there are more women than men in South Africa.

Clearly, there is no consensus on the reasons behind the historic and actual percentages of men and women sangomas. Were Van Nieuwenhuijsen and Gluckman wrong in their observations and analyses, preoccupied perhaps by their idea of alleged social inequality between men and women? Or did Ngubane and Ntshangase, both Zulu, take the social structures of Zulu society for granted, without considering another perspective? Perhaps the different analyses are not contrary, but rather complementary, a reflection of changes in society.

It would be interesting to monitor the future developments in South Africa regarding inyangas, sangomas, and gender. To find out whether the percentages of men and women sangomas in the rural areas correspond with those in the urban areas and to investigate if, indeed, the number of men sangomas is growing, perhaps because the profession of sangoma in post-apartheid South Africa is assumed to be more rewarding, thus more attractive for men.

Now, following this brief detour to the (gender)context, we return to the indigenous healing system and its practice.

1.3.1 Internal dynamics: The healing practice

Evidently, the starting point for an investigation on transformations of the TH system is the traditional healing practice itself. In order to find out what internal dynamics affect this practice, I investigated healing practices as they are executed. Both the diagnosis and the healing proved to be significant elements. The main question for this part of the research was:
How do processes of diagnosis and healing characterise the traditional healing practice?

[18] More about this ritual in Chapter 6.

I expected that interviewing sangomas, attending healing sessions, and comparison of the data would reveal differences and similarities. To judge whether changes and differences are longitudinal or related to the location of the healing practice and to assess what other internal dynamics are involved, I selected a specific fieldwork method.

The genealogical sampling method

Central to this method is the notion that the researcher can trace longitudinal changes by comparing data from subsequent generations, in our case of sangomas and their healing practices. To this concept, I added the element of 'location' to determine whether differences in healing practices occur in relation to the area where they are performed.

Initially, I planned to interview three generations of sangomas from one family, preferably a grandmother living in the rural area, a granddaughter in the city, and a mother in an in-between (semi-urban) area. By comparing the outcome of the interview in relation to the different areas where the sangomas live and the time they were trained, I expected to gain more insight into how differences in healing practices occur.

A strategic selection of sangomas was needed to accomplish a thorough analysis of research data and here my key informant Bongani Ntshangase's comprehensive knowledge of sangomas in the Durban region came in useful. But, although Bongani confirmed that becoming sangoma 'runs in the family' (Lee, 1969), he did not succeed in finding three generations of (living) women Zulu sangomas in one family in the various areas, despite his professional network. I then opted to let go of the 'one family' claim and hold on to the three generations in various areas. As it turned out, both with regard to the interviews and the healing sessions, we visited three generations of sangomas in diverse places and settings.

An extensive account of the fieldwork and all related matters can be found in Chapter 2. Chapter 3 provides an elaborate description of traditional healing practices.

1.3.2 Internal dynamics: Knowledge transfer during training

By using genealogical sampling, I aimed to gain a better understanding of the transmission processes of healing knowledge and thereby investigate the consistency of this knowledge transfer from teacher to apprentice, and onwards in the cycle, as this apprentice becomes a teacher to other apprentices. I wondered if a daughter with a healing practice in a semi-urban area, who had been trained by her mother in a rural area, would teach the same things and in the same way to her own daughter, the granddaughter.

A crucial part of this study thus focuses on the training to become a sangoma (Z: *ukuthwasa*). One aspect of sangoma training emerged clearly from the academic literature (Mlisa, 2010; Erdtsieck, 2003; Thornton, 2010; Janzen, 1992; Ngubane, 1977), namely, that it varies. Mlisa writes about her own experiences as an apprentice and

she states that "ukuthwasa is a unique and individual spiritual journey" (2010, p. 128). Another subject most academic writers agree on is that the exact knowledge that is passed on during *ukuthwasa* is secret, because it is considered sacred, as in Chidester's definition of the sacred: "that what is set apart, but set apart at the centre of personal subjectivities and social collectivities" (Chidester, 2012, p. 2). It is generally assumed that part of the knowledge that is being transferred during the initiation period is theoretical, for example, which plants are presumed to have medicinal powers and what kind or amount of medicine to mix in certain circumstances. Another part of the knowledge is practical, i.e. how to perform a specific ritual and how to treat patients. An important question with regard to this internal domain is:

What dynamics and contradictions are there in the curriculum and knowledge transfer of sangomas' training?

For this reason, ample attention was paid in the interviews with the sangomas to what they learned in the training period to become a sangoma and how they execute their own healing practice in relation to what they learned during their training. In this way, I wanted to clarify a few issues concerning the transfer of knowledge, in particular, where sangomas get their knowledge and if there are other sources of knowledge than the teachers that trained them. I also tried to find out whether there is a fixed training curriculum, or whether a sangoma's training and knowledge is idiosyncratic. I also wanted to discover whether sangomas are authorised to make changes to rituals and healing procedures.

The sangomas that I interviewed were adamant that they execute their healing practice in the way their teacher taught them to do. Moreover, they maintained that their current initiates get the same training that they themselves once had. Apparently, the training and the execution of the healing practice is constant. Thus, in 'emic' terms (from the sangomas' point of view), the training and healing practice is fixed. From my outsider's, scientific (etic) point of view, however, there seem to be a variety of contemporary elements used and incorporated into traditional healers' practices. For example, when we look closer at the snapshots at the start of this chapter (elements derived from sangomas' healing sessions), the contemporary elements soon catch our attention. In other words, it seems to me that there are longitudinal developments in sangomas' healing practices.

1.4 Interpretative Theories: Modes of Religiosity

1.4.1 An interpretative theory of religious knowledge transfer

To analyse the findings I will use a theory on (the results of) various kinds of knowledge transfer. Harvey Whitehouse (2004) explains in his theory 'Modes of Religiosity' that the manner and frequency in which religious and specialist (theoretical as well as practical) knowledge is transferred determines how well this knowledge will be remembered by the students. First and foremost, he argues that there are two elements conditional to students recollecting the newly presented knowledge: the theory and praxis must take a form that people can remember; and people must be motivated to pass on these practices and theory. When these conditions are fulfilled, Whitehouse states, there are two divergent ways of ritual knowledge transfer, the doctrinal and the imagistic, each with their corresponding mode of religiosity.[19]

The transfer of knowledge within the doctrinal mode is characterised by frequent repetition (often over a long period). Theory and praxis thus become highly routinized, which facilitates the storage of the (complex) teachings in the semantic memory, i.e. the part of our memory where, for instance, general knowledge about the world is stored. Frequent procedural repetition also leads to implicit memory of the gained knowledge[20] and this implicit memory enhances the survival potential of the authoritative teachings. When one has to repeat a specific ritual a dozen times a day for months in a row, after a while one executes this act without thinking and will not be inclined to change certain elements of the action. This last point is the major advantage of the doctrinal mode, students internalize the acquired knowledge and thus feel no need to alter it. The drawbacks of this method of transfer, however, are the risk of declining motivation and the need for the presence of a leader who checks the orthodoxy and suppresses any unauthorized innovation.

Within the imagistic mode, according to Whitehouse, the transfer of knowledge is typified by a low frequency or infrequent procedural repetition so there is far less routinization than in the doctrinal mode, but the knowledge is accompanied with high arousal. This activates the episodic memory, where we store the memory of our life's special events. Activation of the episodic memory triggers spontaneous exegetical reflection (SER) and this leads to a diversity of religious representations. In the same way as when, on an annual trip with friends the whole group is nearly swept away by an avalanche, everybody escapes the disaster thanks to well-tuned cooperation and everyone looking after each other. But no one will ever forget this experience. What

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[19] In describing Whitehouse's theory, I will adopt his terminology regarding 'modes of religiosity'. The theory, however, is about transfer of religious as well as any other kind of specialist knowledge.

[20] In the same way that one finds oneself singing along with every word of a frequently heard song, while not even being aware of knowing the lyrics.

exactly is remembered, however, and the explanation given for the events will differ from one person to another. Moreover, each and every person has learned from what happened, but what is learned and the way it affects individual lives will vary. In the long run, every member of the group will attribute his own meaning to the events, what Whitehouse calls representational re-description.

One consequence of the imagistic mode with regard to knowledge transfer could be a lack of centralization and orthodoxy. When going through a certain ritual, a student will remember what happened, not the meaning of the ritual and, over time, he will attribute his own meaning to it. The advantages of this experiential mode are the intense cohesion between students fostered by highly arousing events and the way in which this mode invites students to interpret and explain, independent of any authority.

Traditional healing is a construction of several kinds of specialist (religious, medical) elements. It is therefore interesting to apply Whitehouse's theory to the transfer of knowledge in the training of sangomas and the execution of their profession, particularly when it comes to possible transformations in the healing practices. It sheds a light on what was learned (and in what way) during the training in relation to the performance and execution of the healing practice later on.

It appears that sangomas do not (have to) do exactly what they learned according to the doctrinal mode, but rather they are (feel) free to make adaptations in rituals, to have their own exegetical reflection and interpretation, parallel to the imagistic mode. In other words, sangomas do not execute their profession according to a 'programme' learned during training, but they perform their healing processes departing from 'practice and experience', judging what is opportune at that moment. During *ukuthwasa*, a large part of the knowledge is acquired in a discovery procedure, by trial and error (Van Beek, 2010). After graduation, a sangoma continues to develop skills and knowledge, by consulting other THPs or through 'private revelations of the ancestors'. I will return to this topic in Chapter 4.

The results of the application of Whitehouse's theory show that sangomas are trained in an imagistic mode. Moreover, as the training mode affects the way sangomas execute their healing practice after graduation, we may say that the healing practice is executed in an experiential, imagistic mode. That, in fact, the entire TH system, training as well as practice, is an imagistic system. The differences in the healing sessions that we attended are strong indicators of this assumption. Consequently, this view led me to explore exactly what is 'traditional' in traditional healing and why sangomas hold on to the term 'traditional'.

1.4.2 An interpretative theory of tradition

To clarify the issue, we must first examine what we mean when we use the word

'tradition'. Tradition often has connotations of timelessness and consistency; we use the word to refer to matters that are old and valuable, worth preserving. As a consequence, 'traditional' used as an adjective suggests a noun's invariability and constancy. Traditional healing is thus easily associated with history, ancient knowledge, and practices carried out 'the way it has always been done'.

We use the word 'traditional' as a disjunctive to what we experience here and now, in our contemporary society. Basing myself on the views of Ferguson (1999) and Hobsbawm & Ranger (1992) I will argue that we actually classify habits and practices as tradition(al) due to our position in modern society. Tradition can be considered as a concept of modernity.[21] Hobsbawm & Ranger (1992) point out that 'traditions' that appear or are claimed to be old, are often quite recent in origin. Traditions have a history, but, by definition, they transform. Occasionally, we all use the word tradition in the context of an event to indicate that we think it valuable; for example, exclamations about an invitation for a family Christmas dinner like: 'We also had a family dinner last year and the year before, it is becoming a tradition!' We may assume the speaker had a good time and wants to hold on to the concept of the family dinner. But what exactly is meant by 'tradition' in this case is not clear. It could be about the people attending the dinner, the food presented, the way the table was set, the way people were dressed, the location, or the specific day of the dinner. Even if the food is different and people wear different clothes, the dinner will still be regarded as traditional. Moreover, in this case, the tradition is obviously not a matter of a long-established custom.

Hobsbawm & Ranger further explain that traditions are sometimes invented, especially in societies that change rapidly and when old social patterns are under pressure. They speak of 'invented tradition' in situations where ancient elements are used to construct a new type of tradition, for quite a new purpose. In a changing society, people sometimes fall back on the argument that the way things are is tradition and therefore they should not change, even if the things referred to are not long-standing or are from another context. In such cases, the concept of tradition is used as an argumentum ad autoritatum, i.e. defending a position by appealing (appropriately or not) to an authority. This is a well-known sophism.[22] Authority is attributed to 'tradition' on the basis of alleged value, history, and the context and circumstances of a particular case.

We frequently come across examples of this kind of (re)invention of tradition in daily life: like the older generation, which holds on to a particular way of managing a company, rejecting the initiatives of the younger managers, appealing to 'tradition' but

[21] I am aware of the extensive academic debate on the subject of modernity (in relation to tradition) and its significance for e.g. anthropology. However, I will only refer to this debate insofar it is relevant with regard to this thesis' part on tradition and glocalisation (Robertson, 1995), and therefore prefer using the word 'contemporary' to 'modern'. With regard to 'glocalisation' see § 6.3.2.

[22] A sophism is an invalid argument pattern; an argumentation that is not correct however reasonable it seems.

in fact defending their dominant position; or men in certain circumstances appealing to 'tradition' to ensure their dominance over women is not diminished. In such cases, the word tradition is used in a manipulative way in order to maintain the status quo, often because, in some way or another (in these cases it is about dominance and power), it is to their advantage to keep things as they are (Hobsbawm & Ranger, 1992).

It is interesting to apply this theory of Invention of Tradition to traditional healing. Sangomas call their healing practice 'traditional healing' and, at the same time, they acknowledge that they are standing (at least with one foot) in contemporary society and incorporate elements of that society in their healing practice. But do they also stick to the term traditional to set themselves apart from this society? Might it be beneficial for sangomas to position themselves, on the one hand, in today's society and, on the other, as belonging to tradition?

One consideration is that by referring to themselves as the ones that carry out the instructions of the (traditional) ancestors they endow those ancestors with authority: the authority of wisdom, historicity, and power over the visible world. What are the implications of this attributed authority for the position of sangomas, the ancestors' mediators, in present-day society?

Another fascinating element is trying to discover what sangomas refer to when they call their healing practice 'traditional'. What elements do they consider to be traditional and do they use old elements for new purposes. In other words, to what extent is the traditional healing practice an invented tradition?

In sum, it is now clear that the terms 'tradition' and 'traditional' are too ambiguous and misleading to use in this context. To avoid any confusion, I therefore distance myself from the healer's emic phraseology and, henceforth, I will call the sangomas' healing practice 'indigenous healing practice' and sangomas and inyangas 'indigenous healers', in accordance with the academic debate on the substitution of 'indigenous' for 'traditional', for example in theology and religious studies. I will further explore this theme in Chapters 4 and 6.

1.4.3 External dynamics: Mimetic Desire theory; medicine and religion

Besides dynamics internal to the TH system, we must also pay attention to processes external to this healthcare system. As indigenous healers and their patients are members of contemporary society, they will probably be influenced by all kinds of general and specific processes. Previously, we have established that indigenous healing is a mix of religious and medical elements, therefore I will start with these two domains that are closely related to our subject. The main question here is:

What dynamics are involved in the interrelationship between (cosmopolitan) healthcare, religion (indigenous and institutionalised) and indigenous healing?

For the majority of African people, religion is an integral part of their daily life, they expect the ancestors to protect their well-being, and, when 'things go wrong', they consult a sangoma to find out what has caused the ancestors' wrath. However, the involvement of cultural or religious beliefs in matters of healthcare is deemed inappropriate, e.g. by people who had their medical training in the Western Healthcare System (WHS).[23] They argue that sangomas' procedures are based on beliefs in the supernatural and are therefore unscientific. They even claim that these healing processes are dangerous for patients. In cosmopolitan healthcare, the diagnosis and the prescribed medication have to be scientifically based; it is inherent to the system that these issues can be checked and supervised. When feeling ill, they pose, a patient should go as soon as possible to a Western-trained doctor or to a local hospital in order to get a scientifically based diagnosis and the corresponding therapy. The application of Kuhn's 'Paradigm approach' casts some light on the discussion about whether indigenous healing is scientific. I will elaborate on this in Chapter 5.

In the meantime, I wondered why so many patients prefer to (also) attend indigenous healers for consultation. Moreover, the interviewed sangomas told me about their cooperation with medical doctors in the local clinics. What is the status of such collaboration? In addition, contemporary indigenous healing practices are increasingly organised like those of medical doctors. Do the latter conceive this as an overture and how do they react to this? In order to analyse the dynamics and contradictions in the relationship between CHS and indigenous healing I will use Girard's 'Mimetic Desire' theory on indigenous healers' imitation of CHS health practice organisation.

Anthropologist and philosopher René Girard classifies the process of imitating a specific 'model' as 'mimetic desire' (Girard, 1965). The imitation originates in a mutual desire for the same object. The model has (access to) an object, and anyone who really wants to have (access to) this object will imitate (elements of) the model. Initially, the model will not be unnerved, but as the imitator comes closer to reaching his goal, the model will try to hinder the imitator. Like a young boy who wants to be the best tennis player in a club, just like his idol is now. To achieve his aim, the boy will copy his idol's training methods and game tactics. Many people (probably even his idol) will encourage him to reach his goal. When, a few years later, the idol meets the boy in the finals of the club championship, the idol will fight to win the game, to maintain his revered position. The model has become an obstacle for the boy to get the desired object, the championship trophy. I will apply this theory with CHS as the model and indigenous healers as the imitators and recognition as the desired object.

Thus, within cosmopolitan healthcare the indigenous healers' practices are generally not approved of, due to 'supernatural elements'. Subsequently, we must examine the relationship between indigenous healing and religion.

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[23] I use this reference, 'cosmopolitan healthcare system (CHS)' and 'cosmopolitan medicine' interchangeably.

Interestingly, the vast majority of the contributors to this research (sangomas and patients) is a member of a Christian community as well as believers in the presence (and acting in accordance with the demands) of ancestors. They do not experience any contradiction in the two religious systems. On the contrary, for them, the two are neatly intertwined; in the same way that, in their indigenous religion, the ancestors 'inhabit' the space between the living people and uMvelinqange,[24] so the ancestors also dwell between the living and the Christian God.

Here we come to yet another institutional field where the sangomas' healing practice is looked at with the eyes of Argus: Christian churches. According to their doctrine, Christians believe in the Holy Trinity: God, the Father; Jesus, the Son; and the Holy Spirit. Christian churches state that believing in the power of the ancestral spirits deviates from this Christian doctrine and for the mission churches so does healing. An example of this is the Catholic Church's reaction to the healing ministry of Archbishop Milingo in Zambia, described in Ter Haar (1992). In African Indigenous Churches, however, we generally encounter a greater openness towards indigenous religious and healing elements. We see this especially in the Zionist Churches, where, besides the priest, there is often an important role for the so-called 'prophet', who heals members of the congregation in the name of the Holy Spirit. In Chapter 5, I will elaborate on the relation of indigenous healing and various Christian denominations in South Africa.

So, while we consider indigenous healing to be a mixture of medicinal and religious elements, the healing practices of sangomas are met with a strong aversion from both medical and religious institutions. Essentially, the objections from both fields originate in indigenous religious elements like (the powers of) the ancestors in the spiritual world, which are rejected by the mission churches and evangelical congregations as 'pagan' or 'occult' and by medical professionals within the CHS as 'unscientific' and as 'not belonging in today's South African society'. That said, there is individual cooperation between indigenous healers and Western-trained doctors and indigenous healers are members of Christian churches. This research aims to shed some light on these apparent paradoxes.

Apart from these two domains closely related to indigenous healing, it is clear that indigenous healing is affected by its contemporary surroundings too. So, the next and final focus is on how South Africa's changing society affects the indigenous healing system.

1.4.4 Interpreting historical, social, and political developments

South African society is very dynamic. Firstly, both the people and the government are still struggling with the aftermath of apartheid. After more than twenty years of

[24] The First Being in Zulu indigenous religion.

democracy, Nelson Mandela's dream of a Rainbow Nation has not (yet) come true, despite all people being equal according to the law. The unemployment rates are high, especially among black people (over 25%) (Mail & Guardian, 2018), and the country's crime rates are also high. Secondly, the nation-wide developments and opportunities are multiple and, during my fieldwork, I witnessed many people, inspired and determined to collaborate in order to achieve prosperity for more of the South African population.

In the past few decades, the social and legal position of sangomas in society has also changed. From being illegal in the apartheid era, today the government acknowledges the sangomas' healing practice. The question arises, then, has the healing practice of those healers remains unaffected? It is tempting to think so when we look superficially at the 'snapshots' at the start of this chapter. However, that did not seem logical given that indigenous healers as well as their patients are living in and are part of this society in transfer. My hypothesis was therefore that the mentioned variations in healing practice cannot be attributed solely to the different teachings of various sangoma schools.

During the field study, both in the interviews and while attending healing sessions, I tried to discern (using the genealogical sampling method) what elements of the sangomas' healing practice have varied from one generation to next, and what elements have apparently remained constant. Moreover, I asked the sangomas what they believe to be the motives for transformations. The main question for this section, therefore, is:

How do historical, social, and political processes inform contemporary indigenous healing?

In the last decade, new healthcare legislation has been implemented in South Africa. The government intends to incorporate indigenous healing in the national healthcare system in order to improve healthcare for all citizens. To this end, the Traditional Health Practitioners Act (Act 22, 2007 or THP Act), was passed, which introduced a system of regulations for traditional health practitioners. According to this Act, all indigenous healers must register in order to be able to execute their profession legally. Moreover, the Traditional Health Practitioners Council) was established to manage the registration procedures.

For sangomas, Act 22 (2007) brings benefits such as the formal recognition of their profession. The obligatory registration is presented as a quality mark of their healing practice. Every sangoma I met during the research was registered as a traditional health practitioner at an association[25] and all of them were well informed about the current situation concerning the new legislation. In particular, the older sangomas, who often performed their healing practice underground in the decades of apartheid, feel that their profession has been acknowledged with the passing of this Act and, more importantly, the sangomas feel personally accepted and appreciated. To them, their profession is not

[25] The Traditional Healers Organisation for Africa (THO) or the Durban branch of NUPAATHPSA (National Unitary Professional Association for African Traditional Health Practitioners of South Africa).

a job, it is a way of life. It is because of their ancestors' calling that they have become a sangoma, certainly not by their own choice. Patients have also benefitted from the THP Act; for example, registered indigenous healers are allowed to write sick-leave notes and insurance companies will refund indigenous healers' invoices.

While the new legislation seems to be beneficial to all those concerned, the registration of indigenous healers is still struggling to get into its stride. At governmental level, the procedure is making only slow progress; in May 2014 the Traditional Health Practitioners Council, the institute responsible for the registration, was set up by Parliament, but in April 2015 there were still no indigenous healers registered under the Council. In November 2015, seven years after the Act received assent from President Zuma, Dr Aaron Motsoaledi (then Minister of Health) published the Traditional Health Practitioners Regulations 2015,[26] which announced how indigenous healers must register and which, finally, included various registration forms. In the meantime, rolling out the Act in the provinces has met with varying success: in KwaZulu Natal local associations have started to set up structures, in other provinces there seems to be less enthusiasm.

The sangomas' attitude towards the implementation of the THPAct and its corresponding registration can be described as reluctant. I wondered what causes the indigenous healers' hesitance and what motivates the national government, the provincial government, and individual indigenous healers to act so slowly when it comes to fully implementing the THPAct. There appears to be some kind of inconsistency between the higher programme of officialising the legislation and the daily practice at governmental as well as at associational and individual level. Sophie Oluwole's (2017) understandings of the different paradigms in Western and African thought offer an intriguing perspective on indigenous healing and the social and legislative processes it is involved in nowadays. I will investigate this issue further in Chapter 6.

[26] Government Gazette, 3 November 2015.

1.5 Relevance

Although the data for this research was gathered among a limited number of sangomas in a restricted area, the research itself is useful in its representation of the contemporary status of indigenous healing in South Africa. The obtained data were complemented and compared with ample academic literature on indigenous healing in (South) Africa, both older and more recent. In many ways, sangomas, as a professional group, are just like any other professional group of indigenous healers (such as inyangas). Where sangomas' attitudes, e.g. with regard to legislation, may differ from that of other indigenous healers, I specifically mention it.

This thesis should also be considered as a contribution to the academic debate on knowledge transfer in education. The way in which knowledge is transmitted during training influences the way graduates execute their practice. I will show that this is the case for indigenous healers in South Africa; training as well as practice are experiential. In future studies on indigenous knowledge transfer these data can be compared, complemented, and disputed.

The aforementioned makes clear that this study is an academic treatise about a topical subject with high social relevance in contemporary South Africa. The institutionalisation of Traditional Medicine affects not only the healing practices of medical doctors and indigenous healers, but also the lives of the 80 per cent of the population that attend those healers. It is for good reason that recently in South African academic studies too (of which some are written by sangomas) much attention is paid to indigenous healing and how sangomas deal with the challenges of the changing society (Mbatha & Gqaleni, 2017; Ndzimande, Sibiya, & Gqaleni, 2014). Such studies, often under Professor Gqaleni's supervision, offer an academic insider's view on the indigenous healers' practice in KwaZulu Natal.

The value of this research and its analysis is in the outsider's perspective; my attention may be drawn to elements of the healing practice and South African society at large that are so common for the insider to have become a blind spot. The reverse is obviously also imaginable. The insiders' and my outsider's view should therefore be regarded as complementary.

1.6 Trajectory

In the following chapters, I present this study on transformations in indigenous healing processes by female Zulu sangomas in the transition from a rural to an urban society. Subsequent to the next chapter (field study and method), I will focus on internal (Chapters 3 and 4), and external dynamics (Chapters 5 and 6) that inform contemporary indigenous healing. In addition to the description, I will focus on the subject from different angles. To get a better grip on the data and to bring underlying contrasts to the surface, I will use a set of antipodal concepts for each of the perspectives. Where applicable, each chapter provides a brief introduction to the main characters.

After an introduction to the subject of the research, the theoretical outline, and the research questions in this chapter, the next chapter is about the field study I did in (the vicinity of) the city of Durban, KwaZulu Natal, South Africa. I will account for the choices I made, prior to and throughout my stay in the field. Choices concerning finding a key informant, choosing sangomas to interview, what to ask those indigenous healers, and the selection of sangomas' practices for attending healing sessions will also be detailed. In Chapter 2, I will explain the method I used in order to gain thorough research data to help me answer the questions at hand and, finally, I will provide an account of the research ethics and present and future management and protection of the bulk of data and personal details that I obtained during fieldwork.

In Chapters 3 and 4, internal dynamics that inform the indigenous healing system are central. First, the focus is on processes of diagnosis and healing, therefore I will describe a healing procedure (Mr Mbele's healing) that includes several healing sessions at different places. This procedure shows the uniqueness of the patient's treatment and a constant interaction between sangoma, ancestors, and patient. On the basis of this case, I compare the findings of the 2012 interviews on several issues and elements with the fieldwork data from attended healing sessions in 2014 and with academic literature.

In Chapter 4, the emphasis is on the sangomas' training and elementary dynamics of knowledge transfer. I will highlight three important elements of *ukuthwasa*; (*muthi*)-knowledge, diagnosis, and healing identity. As an illustration I will describe Mks Gasa's sangoma school. Contemporary associations can be considered as professional networks in sequel to the training and therefore they are important in terms of advanced knowledge transmission. By applying Whitehouse's theory on the way knowledge is transferred and Foucault's theory on 'Power' (Lynch, 2011), I try to gain a better understanding of internal dynamics and their effects. This prompts the question whether to call indigenous healing 'traditional' or 'indigenous'. Using the concepts 'programme' and 'practice', I analyse the discrepancies between what is said and what is done on several levels within the indigenous healing system.

As the sangomas' healing practice is a mix of religious and medical elements, it seems appropriate to focus on (Western) medicine and (indigenous) religion in relation

to indigenous healing in a separate chapter. In Chapter 5, therefore, I investigate how external dynamics are involved in the interrelationship between these three fields. I try to accentuate the content of both the training and the practice of indigenous healing and its position in relation to (indigenous) religion and (Western) medicine. I also examine what insights Whitehouse's theory concerning the transfer of specialist knowledge brings us when applied to the training of sangomas, with regard to the frictions between indigenous healing and Western medicine and those between indigenous healing and Christianity? By applying Girard's Mimetic Desire theory, I analyse various underlying currents in the relationship between CHS and indigenous healing. The antipodal concepts 'medicine' and 'religion' help to clarify where frictions in the relationships originate.

In Chapter 6, the theme is indigenous healing in South African society. Historical, social, and political processes affect indigenous healing as a system, but also the individual healer's practice. The history of indigenous healing is one of extremes; sangomas were key figures in the centuries of the Zulu Kingdom, later, in the decades of apartheid, they were marginalised as their profession was made illegal. Now, there is legislation regarding traditional health practitioners implicating the government's acknowledgement of the profession. In South Africa's changing society, many elements of indigenous healing practices prove liable to longitudinal, local, or situational transformation. One may wonder, then, what exactly is 'traditional' in traditional healing and why do sangomas hang on to this terminology? Using Hobsbawm & Ranger's (1992) theory, I try to analyse whether indigenous healing is a re-invented tradition. Can we consider the use of contemporary elements as a form of what Robertson (1995), employing an anthropological term, calls 'glocalisation'; the cultural interpretation and adaptation of global modern phenomena?

Sangomas must register under the new law on indigenous healing (Act 22, 2007). Registration is supposed to be a quality mark. I will explore the consequences of the law's implementation for indigenous healers and the reactions of associations and individual healers to the obligations and restrictions this law brings. In this chapter, the life and work of Bongani Ntshangase, my key informant, provides an example of an indigenous healer in contemporary society. I will analyse the paradoxes on several levels, once again using the concepts 'programme' and 'practice', but now with regard to external dynamics.

To conclude, in the final chapter I will draw some general conclusions on the basis of this research data, I will further reflect on them in combination with the literature and I will formulate some anticipatory remarks with regard to the future of sangomas' healing practices in South Africa.

Chapter 2

Methodology. Field study and Method

The considerations on the subject of this research mentioned in the first chapter are evidently based on extensive study of academic literature on indigenous healing, sangomas, indigenous knowledge and the South African society.

Reading about sangomas' healing practices in academic writings (Bryant, 1966; Erdtsieck, 2003; Janzen, 1992; Mlisa, 2010; Van Binsbergen, 1991; Ngubane, 1992) revealed a general picture of such healing practices. A startling element that became clear to me is the variations and differences in a patient's treatment. When a patient comes to a sangoma because he is not feeling well, the cure the sangoma prescribes might be different from the cure another sangoma would prescribe. As a Western researcher, used to the standardisation of prescription in the Western healthcare system, this intrigued me. I wondered where such differences come from: is it (partly) due to divergent education in the various 'sangoma schools'? Are healing practices in the rural area different from those in the urban area? And is a sangoma's personal preference of any significance? My aim was to get an insight into these matters and (consequently) to develop a better understanding of what it is like for sangomas to execute their profession in contemporary South Africa. In order to achieve that goal, I first had to know more about sangomas, about why they took up this profession, about their training, and what happens in a healing process. The best way to find out seemed to be to go there and interview sangomas about these topics. A field study scheme was developed in which the first step was to get in touch with indigenous healers. In the build-up to the field study and throughout the whole process of this research, I made several more or less fundamental choices. In the course of this chapter, I will provide details of these choices and explain my considerations and decisions.

2.1 Method and design

2.1.1 Genealogical sampling

While investigating traditional healers' healing practices in contemporary South Africa it is not enough to simply study the academic literature. To try to comprehend and experience what it is like for traditional healers (especially sangomas) to execute their profession nowadays, I went to South Africa three times between February 2012 and June 2014. Because of my fascination for the Zulu, I went to the city of Durban, KwaZulu Natal.

Given that the number of traditional healers in KwaZulu Natal is an estimated 26,000 (nationwide roughly 350,000), it was within the reach of this study impossible to do an investigation that covered all THPs in this province. Instead of a quantitative approach, I opted for a qualitative approach by interviewing three female Zulu sangomas, using the method of genealogical sampling: participant observation of subsequent generations of healers.

My first goal, in February 2012, was to make contact with (people who knew) Zulu sangomas and to find people who were willing to collaborate in the research, so that on my return to Durban in July and August 2012 I would be able to interview Zulu sangomas about their healing practice, their training, and their life as a sangoma. Before this first trip, I had tried to get in contact with an association of traditional health practitioners (THO) through their website,[1] but did not receive a response.

In early March 2012, I was introduced to Bongani Ntshangase, a sangoma and a member of the executive committee of NUPAATHPSA, one of the traditional health practitioners' associations in Durban. After consulting his fellow committee members, he agreed to assist me in this research. With his inside knowledge of sangomas' healing practices and his extensive network of traditional health practitioners, he in fact became my key informant and hence his role in this research is important.

As previously mentioned, I initially planned to interview three sangoma generations within one family, living in rural, semi-urban, and urban areas. By comparing the data in relation to the different generations and areas, I hoped to get a better perception of where differences in healing practices originate. Moreover, by using genealogical sampling, I wanted to gain an insight into the transmission processes of healing knowledge and thereby investigate the consistency of this knowledge transfer from teacher to pupil, and further on in the cycle, when this pupil becomes a teacher to other pupils. Does a daughter with a healing practice in a semi-urban area who was trained by her mother in a rural area, teach the same things and in the same way to her own

[1] http://www.traditionalhealth.org.za/ last accessed 28 July 2016, inaccessible since January 2017, the Traditional Healers Association's Facebook page www.facebook.com/traditionalhealth/ however is still accessible, last accessed 26 May 2020.

daughter, the granddaughter? And when this granddaughter starts her own practice in the city and becomes a teacher, what is the content of her teaching?

When it became clear that, in spite of his extensive network among sangomas in the Durban region, Bongani[2] was not able to find a family with three generations of female Zulu sangomas, I decided to drop the one-family issue and instead focus on three generations in different areas. The three sangomas Bongani strategically selected for the interview met these conditions. They all lived in the wider Durban metro (*eThekwini*) district: the oldest, Mks Bhengu, aged 80, lived in the Valley of a Thousand Hills, a rural area some 50 kilometres west of Durban; the youngest, Mks Ngidi, 36, lived in Inanda, an urban neighbourhood north of Durban City centre; and Mks Mbuyisa is 63 years old and lived in the Phoenix Settlement, a sort of in-between district. All three were teachers (Z; *gobela*) of apprentices who are in training to become a sangoma.

Ultimately, the field study consisted of two main parts, the first of which can be split in two sub-parts. The interviews with the three sangomas are central to the first part; the second part is about healing processes in sangomas' healing practices. For this part Bongani made a new strategic selection.[3] The attended healing sessions were predominantly executed by trainees and sangomas from Mks Gasa's, where a mother and two of her daughters train amathwasa to become sangomas. One healing session we attended was performed at Mks Mkhize's, at another location. Mks Mkhize belongs to the generation between Mks Gasa and her sangoma daughters.

2.1.2 Interpretative research design

As indicated before, this research is a combination of the comprehensive study of (academic) literature and field study, a qualitative research in the shape of a case study. In Mr Mbele's healing sessions (a detailed description of my observations is in the next chapter), I found a case study that serves as a model of contemporary indigenous healing; internal dynamics in healing practice and knowledge transfer converge with external (institutional) processes that apparently influence present-day sangomas and their healing practices.

The research design is interpretative, characterised by continuous comparison of the field study data, both mutually and with academic literature. I use an analysis cycle of induction and deduction to assess whether the data obtained during fieldwork correspond with academic literature on the subject and, vice versa, and to deduce whether I recognise literary elements and claims in my field study observations. It is also a constant process of interpretation and (emic) checks in order to gain an in-depth understanding of contemporary indigenous healing in South Africa. In my opinion, this procedure was even intensified by the fact that the field study was done in three separate periods between February 2012 and May 2014.

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[2] Because he will be mentioned frequently, I sometimes refer to Bongani Ntshangase with only his first name.

[3] The arguments for this new selection are outlined below.

2.2 Field study, first part

Because I had not been able to get in touch with one of the associations of indigenous healers before my first trip to KwaZulu Natal, my intention in the preliminary part of the fieldwork (February and March 2012) was to get acquainted with the area and some customs as well as to get in touch with (people who knew) Zulu sangomas. Even after my arrival in Durban, my quest for sangomas proved a challenging and an interesting one, in which I learned a lot about South African society, including about the kindness of the people. All the people whom I asked for information were willing to answer my questions and to help me, often finding new people so that my quest could progress. However, I also learned about how different groups of the population are 'living-together-apart' as it were, and how apartheid's dividing lines between various population groups are still traceable. No member of the white community that I asked about sangomas, for example, was ever acquainted with that kind of indigenous healer. Moreover, they told me to "be careful, they practice witchcraft." If I approached a member of the black community on the subject, however, I was met with surprise and enthusiasm; bystanders joined me, phone calls were made, and people accompanied me to friends who might be able to assist. This seemed to me a striking example of the ignorance of and between the different communities that I encountered, for example at the Howard College Campus of the University of KwaZulu Natal.

In my search for people who knew sangomas, the owner of my accommodation, Louise, referred me to the Philosophy Department at Howard College, where she had a friend who was a senior lecturer that might be able to assist me. But neither he, nor anyone else on the staff there was able to help me out, until one of them thought of his gardener, Michael, who might know someone. He promised to ask him the next day. In the meantime, they referred me to the Anthropology Department, but there, too, my question was answered with blank looks from white employees. On my way back from Anthropology, I passed the IsiZulu Department. The first person I met in the hallway asked me if she could help me and I told her that I was looking for someone who knew a sangoma. She was immediately interested and enthusiastic and she told me there was a sangoma's practice on campus. This sangoma is part of the university's healthcare team; students who are feeling unwell have a choice between a Western-trained doctor, a psychologist, or a sangoma amongst others. Lecturers and staff of both the Philosophy and the Anthropology department were clearly not aware of the sangoma in the opposite building. Moreover, she invited me to return in a few days to see one of the professors, who would be able to put me in touch with a Traditional Healers' Association. In the weeks ahead, I visited the sangoma's office several times but she was not there; apparently she had not yet returned to the city from her residence in the rural area.

Perhaps it was just bad timing that I had not found anybody acquainted with indigenous healing at the Philosophy and the Anthropology departments. Someone

who had a personal interest in the subject used to work at the Philosophy Department, but she had recently moved to the United States. An assistant professor of the Anthropology Department who was familiar with indigenous healing happened to be on sick leave. Yet, it surprised me that knowledge about sangomas and indigenous healing was obviously not common among members of the white community.

At the end of February, with the help of the lecturer's gardener Michael and his son Emmanuel, I managed to visit a sangoma, Mks Mgadi, who lives near the small village of Mnamatha in the Valley of a Thousand Hills. She showed up for us in full sangoma attire, including cloths (Z: *ibhayi*, pl. *amabhayi*) around her shoulders, a white beaded wig, and an oxtail stick (Z: *ishoba*). Having gained the ancestors' consent, we talked for about an hour with Emmanuel as the appointed translator (from Zulu to English). Mks Mgadi was also very interested in my background (a teacher from Holland) and my motivation to study sangomas. She told me that the fact that I am interested in sangomas has a reason; my ancestors want me to become a sangoma too. She invited me to come back in a few months and start the training. Surprised, I kindly refused her offer.

After our conversation, Mks Mgadi showed us around her compound and allowed me to take some pictures. From the way Michael and Emmanuel behaved during the visit and talked about her in the car on our way back, I could sense that they really respected Mks Mgadi for her wisdom and because she is a sangoma.

The things Mks Mgadi told me about her calling, her training, and practice as a sangoma for decades were very useful for me as a background for this research and in composing the interview questionnaire.

Ultimately, a few days before my return to the Netherlands in March 2012, I met the IsiZulu's Department professor, who indeed referred me to the Durban branch of the association of Traditional Healers and Bongani Ntshangase. I called him and after consulting his fellow members of NUPAATHPSA's executive committee he agreed to assist me. He proposed a meeting as soon as I returned to Durban in July, to discuss my goals and intentions for this research.

While staying in Durban in 2012 and in 2014, I spent many hours at the Library of the University of KwaZulu Natal (Howard College Campus) and at the Killie Campbell Africana Library in search of literature and other data that were not available in libraries in the Netherlands. Especially the Africana Library of the Campbell Collections proved to be an inexhaustible source of information on the history, culture, and people of South East Africa. This comprehensive collection of books, manuscripts, and photographs, covers a broad sweep of information about the south-east African region, especially KwaZulu Natal, and its population (Website Killy Campbell Collections).[4] All this additional material proved invaluable as background for my research.

[4] The Campbell Collections are part of the University of KwaZulu Natal since 1965 and still accommodated in Muckleneuk, the home of the Campbell family until Killie Campbell's death in 1965. In this colonial house also paintings, drawings and furniture are presented. See http://campbell.ukzn.ac.za/ for a detailed description of the collection and the way it was established, accessed 26 May 2018.

2.2.1 Realisation

A few days after my arrival in Durban in July 2012, I met with Bongani Ntshangase to explain the goals and method of my research and to discuss the modus operandi. As it turned out, he also wanted to probe my motivation for the planned research and my mind set, position, and attitude towards indigenous healing. Apparently, I passed, for after a three-hour conversation, he agreed to continue his assistance. Next, Bongani made clear to me that he had already done some preliminary work but had not been able to find three generations of (living) sangomas in one family. I then decided to adjust my plan and continue to focus on three generations in the various areas, but they no longer had to be from the same family. Aware of my research intentions, Bongani made a careful and strategic selection of sangomas and, with my consent, asked them for their cooperation. Bongani suggested paying the sangomas the same fee as is usual in other projects the association asks them to cooperate in with universities or as part of the PEPFAR[5] program, for example (Website PEPFAR). I agreed to this as an expression of equivalence and appreciation. Moreover, it would compensate for the time the sangomas should schedule for the interview. Fortunately, they all agreed and appointments for the interviews were made. In this part of the field study and in 2014 my partner, Lilian van de Kraats accompanied me. She took care of the recordings on the voice recorder, the pictures, and, in 2014, the video recordings.

Topic list

In the period between March and July 2012 I had put together a topic list for the interviews, but at that time my starting point was that the interviewees would be members of one family, each one trained by the older generation. Now that the interviewees would not belong to one family, I decided to intensify the part of the interview focused on the transfer of knowledge during the training to become a sangoma.

The topic list consisted of three main parts: The first part included questions about becoming a sangoma, nine questions covering the 'calling', the initiation period, and the relationship with the ancestors. With these questions I hoped to be able to grasp the personal background of the sangomas. The second part was about the transfer of knowledge and healing processes, six questions about the way knowledge is transferred from trainer to pupil, the kind of transferred knowledge, and what happens (to the patient as well as to the sangoma) when a patient comes to a sangoma for healing. The focus in this part is on discovering similarities and differences between the sangomas' training and the way they teach their apprentices as well as on what happens during a healing process. I anticipated that this part would give me a better insight into the processes of knowledge transmission and the consistency of the transferred indigenous

[5] PEPFAR: The US President's Emergency Plan for AIDS Relief.

knowledge. An important issue if only because academic literature is not unambiguous about this, indigenous knowledge is not (and is allegedly not allowed to be, because it is believed to be sacred) written down. The third part of the topic list concerned sangomas and their position in society, six questions about their relationships with other indigenous health practitioners, medical clinics, the way sangomas are respected in post-apartheid society, and the way indigenous healers are associated. The intention of this part was to get a picture of the sangomas in their surroundings in post-apartheid South Africa.

Bongani Ntshangase translated the questionnaire into Zulu,[6] accompanied me to the interviews, posed the questions and translated the answers back into English for me. Although most sangomas speak English, it was obvious that the interviews, which took place in the consulting room,[7] would be in Zulu as a matter of respect for the ancestors. Before the start of every interview, the sangoma introduced us to the ancestors and, once their approval for the interview was gained, I was given the opportunity to 'pay the ancestors respect', by donating what was called 'cattle' (the agreed ZAR 500 plus a silver coin). The sangomas also gave their permission for the interviews to be recorded on a voice recorder. In the days after the interview, I transcribed these recordings and, if some passages were not quite clear, I asked Bongani for an explanation. On our way to and from the interviews he provided personal background information about the interviewees, their position in their social environment, and in the community of sangomas.[8] After every interview, we took some pictures and I also made a sketch of the room(s) where the interview took place.

The sangomas

The reason for using genealogical sampling as a method for this research was that by interviewing subsequent generations in a family of sangomas in different areas I expected to gain insight into longitudinal developments in knowledge transmission and the execution of healing practices as well as to be able to compare these practices in the rural and urban areas. Once it was clear that questioning three generations of one family would be impossible, it became more important to find three generations in the various areas in order to obtain thorough research data. Consequently, we interviewed three sangomas, carefully selected by Bongani, each representing their particular generation.

The eldest

Makhosi Bhengu was born in 1932 and represents the oldest generation of sangomas in

[6] See Appendix B for the topic list in English and in Zulu.

[7] The place where sangomas communicate with the ancestors.

[8] The many conversations with Bongani, in the car, in the park, in the city, at a sangoma's compound, were also recorded and transcribed.

the rural area. She lives some 50 kilometres west of Durban in the Valley of a Thousand Hills, in an area called KwaNgcolosi, near Inanda Lake. Her homestead is situated in a rolling landscape with houses scattered on the slopes of the hills, the gravel roads alive with children and animals. From her homestead, one can see the hill slopes ending in Inanda lake and, further to the East, Inanda Dam, magnificent scenery. In a small rectangular building on her homestead Mks Bhengu (together with her apprentice and some local women) runs a pre-school for the neighbourhood children. Many of them also spend their nights in this pre-school because their parents have died of HIV/AIDS or TB and, consequently, they no longer have a home. Mks Bhengu is highly respected by the people in her community and by other indigenous healers in the eThekwini area because of her age, her wisdom, and the extensive experience she has gained as a sangoma since 1965. Bongani kindly calls her "the sangomas' walking library." She was the first sangoma in the area to attend the Community Care Givers Cause (CCGC), a programme where methods of treatment for various illnesses were exchanged between Western-educated doctors and indigenous health practitioners. She was also involved in an information-sharing programme initiated by The Valley Trust Clinic[9] in cooperation with researchers from the United States. At the age of 80 she was still practising as a sangoma and a trainer for her apprentice (Z: *thwasa* pl. *amathwasa*). A book was written about her life and work (Sliep, 2013) and she proudly presented me with a copy in 2014.

When we arrived at her compound, Mks Bhengu gave us a hearty welcome. Our interview with her[10] was the most extensive one; we talked for about four hours and in the meantime her helpers served us what Bongani called a 'traditional African meal' of dumbe[11] and fresh lemon juice. Here, I witnessed a few Zulu customs; the *thwasa* took the first sip of the juice to prove the drink has not been messed with, before offering it to Bongani (he was given it first because he is a man), then to the female visitors, and finally to Mks Bhengu. Another traditional element, Bongani explained, was the way we were seated in the consulting room: Mks Bhengu and her *thwasa* in the middle of the rondavel on a reed mat on the floor, near a leopard-print cloth hanging from the ceiling, on the right side of the entrance was a chair for Bongani and we were seated on a reed mat on the left side of the rondavel. My impression was that Mks Bhengu is a very kind elderly woman who nevertheless is highly informed and knows exactly what she wants. The first 'snapshot' at the start of the previous chapter is from her interview.

The middle generation

Makhosi Mbuyisa was 63 at the time of our first meeting[12] and for this research she represents the middle generation. She lives in Phoenix settlement north of Durban City

[9] A clinic in a rather distant area of The Valley of a Thousand Hills.

[10] On 1 August 2012.

[11] Some kind of root crop.

[12] On 9 August 2012.

centre, the oldest settlement of South Africa (established in 1904) and known as the place where Mahatma Gandhi and his family lived for many years. The further we drive into the settlement towards Mks Mbuyisa's compound, the shabbier the houses look. Some are built of twigs, clay, and corrugated iron; the roofs of others are made from canvas and tyres. Tarred roads turn into gravel roads and gradually all colour seems to disappear; a grey-brownish veil of dust and sand covers everything and the place is crowded with people, so much so that Bongani says: "This place is packed!" The day of our interview is a national holiday and many people are milling about near their homes. Women are doing their laundry in tubs, hanging their clothes on lines, and pouring water from the tubs at the side of the gravel road where goats and fowl are walking around freely.

Mks Mbuyisa's home suggests that she is well-off: it is made of bricks and painted in a bright light blue. Against the house are stacks of building material, heaps of cement, bricks, and buckets full of gravel.[13] Mks Mbuyisa is the contact person between the local clinic and the indigenous healers in 'her' part of Phoenix settlement. She makes regular rounds in the clinic, seeing patients that were referred by indigenous healers. Furthermore, Mks Mbuyisa is the key NUPAATHPSA representative in Phoenix settlement and acts as an intermediary between the association and its members in the neighbourhood. In addition, Mks Mbuyisa, together with her helper Thembi, takes care of teenage girls, offering them a place in her house to prevent them from living on the streets after school. In order for these girls to become self-sufficient and live their life according to certain values, she teaches them Zulu customs and crafts like beadwork.

When we arrived at Mks Mbuyisa's, there were about 10 girls in their early teens outside the house. Thembi invited us in and told us Mks Mbuyisa would be there soon. It was no problem to wait for a while, there was enough to see in this sitting room. A table with at least eight chairs, cupboards packed with all kinds of things like medals, photos, cups, and certificates. After some time, a good-humoured, lively woman somewhat out of breath, entered the sitting room. Mks Mbuyisa apologised for being late; she had been called to accompany one of her patients to the local clinic, an emergency. We then followed her to her consulting room, an annex at the back of the house.[14] Thembi joined us and stayed during the interview, during which she (as she told us afterwards) heard a lot she didn't know about Mks Mbuyisa.

The interview at Mks Mbuyisa's took almost three hours, but then she didn't allow us to leave because the teenage girls had rehearsed a singing and dancing performance. In front of the house, the girls were lined up wearing home-made beadwork and, after Mks Mbuyisa took their cell phones, they started to sing and dance. The performance lasted about half an hour, some neighbours came to watch and joined in the singing

[13] When we returned in 2014 all of this was still standing exactly where it had been in 2012.

[14] Mks Mbuyisa's consulting room is the only one we saw in this field study that is not a rondavel.

and dancing. Just like Mks Bhengu, Mks Mbuyisa is well-informed about changing legislation, cooperation with the local clinic, and she was committed to fighting for the welfare of her patients and the teenage girls.

The youngest

Makhosi Ngidi, was born in 1975, and was 36 years of age at the time of the interview. She represents the youngest generation of sangomas. She lives in Inanda, a suburb north of the Durban City centre, an urban area with tarred roads, brick houses, stone walls around the compounds, and the house numbers painted near the locked gates. The houses are rather well-kept and neatly built alongside the roads, most are painted in bright colours. Mks Ngidi lives in a compound at the top of a hill on the corner of a steep road, her house is separated from the street by a solid, six-feet-high, yellow painted wall. Her compound is marked by a locked iron gate, which, together with the high wall, suggests fencing is needed for security. This impression is supported by the fact that Mks Ngidi locked the gates again immediately after we parked the car in her compound. There, a splendid view of the valleys and hill slopes of Durban North unfolded.

Before she was called to be a sangoma, Mks Ngidi was working at a centre for indigenous health practitioners. A computer, various books, and devices in her living room suggested that she is an educated woman.

As we got out of the car Mks Ngidi was there to welcome us. She talked in a low voice and kept her eyes downcast, giving the impression of being shy, or at least very modest. Her consulting room was in very small rondavel on her compound, the door so small we had to crouch down to enter. Inside the consulting room, Mks Ngidi asked the ancestors for their approval for the interview and I paid them respect in the way I had become used to. In this first part of our meeting Mks Ngidi seemed tense. After receiving the ancestors' consent we left the consulting room and proceeded to her 'prayer room'[15] where she relaxed somewhat. She did not seem to be uncertain in her profession and showed inner strength when telling us about her calling, her training, her healing practice and her *amathwasa*. Her shyness could have been because, unlike Mks Bhengu and Mks Mbuyisa, she was not used to being interviewed.[16] Our interview with Mks Ngidi was the shortest and took a little over two hours.

After the conversation[17] with Mks Ngidi, we were invited into her house for cold drinks and cookies. After pouring our drinks, she disappeared into the kitchen, leaving us to eat and drink in her living room. Bongani tried several times to get her to join us and when she eventually did she showed interest in my background, where I came from, and why I was doing this research. After we finished our drinks, she told me that it had been her long time secret wish to visit Amsterdam and the Netherlands.

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[15] Another annex on the compound.

[16] Our impression of Mks Ngidi was confirmed when we visited her in 2014, to see her and her son who was just a few months old. She was clearly a modest and amicable woman.

[17] On 9 August 2012.

I found the difference in these sangomas' attitude towards the ancestors striking. Prior to us entering Mks Ngidi's consulting room, I had to wrap a cloth around my trousers to prevent the ancestors from confusing me for a man. We had to enter the consulting room with our right leg first and all the actions had to be done very precisely and in a strict order. While she was communicating with the ancestors, Mks Ngidi was very humble and subservient. Mks Mbuyisa did not worry about me wearing trousers, and she paid no attention to how we entered her consulting room.[18] In her communication with the ancestors she was respectful but certainly not subservient. At Mks Bhengu's there was no mention of how to enter the consulting room but there was, as I indicated before, a special positioning inside the rondavel. Mks Bhengu was respectful in her communication with the ancestors, but there also was a tone of persuasiveness.[19] These differences might be due to the sangoma's relation with the ancestors, or perhaps with the character or the mood of the ancestors. In the second part of the field study I will return to this.

Mks Bhengu, Mks Mbuyisa, and Mks Ngidi were all trained by a gobela, but each of them in quite different circumstances and all three of them are now trainers of their own apprentices. This, together with the different areas where they live and practise as a sangoma, gave me a large amount of solid research data to mutually compare and to use as a basis for the second part of my field study in 2014. In the upcoming chapters, I will draw on the data from the interviews in relation to the subjects at hand, hence the names of these three sangomas will return frequently.

[18] Except for leaving our shoes outside, but that was common practice at the homes of all the sangomas we visited.

[19] In 2014, we saw a similar attitude from Mks Gasa, the senior sangoma of the Gasa compound.

2.3 Field study, second part

At home in the Netherlands, working out my notes and transcribing the voice recorder's data, I concluded that there was much information gathered but not enough on the healing process itself. Although the sangomas had told me about such processes, it remained too theoretical. To better understand what happens during a healing process I had to go back and attend healing sessions. That way I should be able to decide on whether there are differences and, if so, in which parts of the healing process. I would also be able to discern the causes and reasons for such transformations.

I returned to Durban in 2014 for the second part[20] of the fieldwork and in the hope of attending healing sessions. My key informant, Bongani Ntshangase, agreed to assist and accompany me again, despite of his busy schedule. As he had succeeded Baba Hlongwane as chairperson of the eThekwini branch of NUPAATHPSA in May 2013, he also had several meetings to attend during my stay in Durban. While in 2012 he was already a respected man in and outside the circle of indigenous healers, in 2014 his prestige had grown even more.

Initially, my intention in 2014 was to visit the same sangomas I had interviewed in 2012, but Bongani proposed going to different ones. The most important reason for this was that, in his position as chairman of NUPAATHPSA, he did not want to be seen selecting a few sangomas for research purposes. He explained that there is a lot of jealousy between indigenous healers and he did not want anyone to become the object of envy. Another (to me the most convincing) reason was that, at that time, Mks Bhengu had given up her healing practice because of her age and Mks Ngidi was temporarily not practising because she had given birth to her son a few months earlier (for purity reasons sangomas are not allowed to practise for six months after childbirth). I accepted Bongani's proposal and he approached Mks Mkhize and Mks Gasa and both kindly agreed to cooperate under the same conditions as the interviewees in 2012.

We did, however, also visit the interviewed sangomas to thank them once more for their cooperation in 2012 and to hand them some gifts. It was very special to meet them again after two years of thinking and writing about them at my desk in The Netherlands. The sangomas welcomed us as if we were old friends. They were surprised that I had returned with presents for Mks Ngidi's son, Mks Mbuyisa's teenage girls, and Mks Bhengu's orphanage. In turn, Mks Mbuyisa gave me beaded bracelets and necklaces and Mks Bhengu presented me with an autographed copy of the book about her life and work (Sliep, 2013). Bongani later told us that our second visit increased the credibility of this study in the eyes of the sangomas.

[20] In April and May 2014.

2.3.1 Healing sessions

During this second part of the field study I was allowed to attend a total of eight healing sessions at two different sangomas' compounds, as well as at external locations like the estuary of the Mtamvuna River and a patient's home in Pietermaritzburg.

The planning for this part of the research was more complicated, because healing sessions are often not scheduled. Patients just come to the sangoma's compound and the sangoma starts a healing session. Consequently, it was hard to decide when to be where. Bongani suggested visiting a compound with several sangomas as "there usually are many things happening over there." It turned out to be Mks Gasa's compound in KwaMakhutha, a Durban township about 15 kilometres south of the City Centre. Here, I witnessed the first healing session[21] and it seemed as if it was by coincidence.

Mks Gasa's

We visited this compound to see a sangoma's practice with several sangomas and apprentices: the sangomas Mks Gasa (about 60 years old) and her daughters Mks Dudu (in her early thirties) and Mks Zinhle (in her mid-twenties), run this healing practice and sangoma school with over twenty *amathwasa*. When we arrived, Bongani introduced us to Mks Gasa and we talked for a while; then, for more than an hour, Mks Zinhle and the apprentices performed several sangoma dances for us inside a rondavel, their consulting room. At one moment, Mks Gasa came to tell us that there was a patient coming for healing and she invited us to stay, hence we were in attendance when Mr Mbele entered the rondavel for his healing session. In the meantime, while we were waiting for the patient to arrive, one of the trainees provided us with food and drinks. Mr Mbele's healing sessions will be described extensively in Chapter 3.

Mks Mkhize

A few days later, Bongani said he also wanted to take us to Mks Mkhize, a male sangoma, to witness a specific way of diagnosing, namely 'throwing bones'.[22] Although Bongani was aware that this study is on female Zulu sangomas, he thought it would widen our scope if we also were to see a male sangoma executing a healing session, if only for the sake of comparison. I agreed and we headed to KwaMashu, a township northwest of Durban City Centre. In a small rondavel behind his home, we witnessed a healing session in which Mks Mkhize (about 35 years old) used 'the bones' as a means of communication with the ancestors; one of his trainees was the patient. After the healing session, he took us to a waterfall, a 20-minute drive by car, to show us where he sometimes took his patients for cleansing. Back in his rondavel, we talked for another hour. He showed

[21] On 26 April 2014.

[22] Explanation of this procedure is in Chapter 3.

us some of his 'regalia', explained the interior of the rondavel and everything in it, i.e. the various pots with medicinal herbs, with separate pots for the treatment of men and women. When we walked out of the rondavel, he pointed at a bundle of sticks on the floor near the entrance, a heron's nest, in which something valuable was supposed to be hidden. He was still unravelling it.

While working on this study (the data from) this visit to Mks Mkhize continued to feel somewhat awkward to me. On the one hand, it was nice to have seen such a comprehensive healing session where the sangoma uses 'the bones' for diagnosis and his explanation of the various medicinal herbs was interesting. On the other hand, with hindsight, I would have preferred to have seen this method of diagnosis performed by a female sangoma, especially when we later found out that 'the bones' is one of the areas in which Mks Dudu, Mks Gasa's eldest daughter, was specialised. In handling the data, I have constantly been aware of the fact that the data from Mks Mkhize did not strictly belong within the scope of this research about the healing practices of female sangomas. That said, I did use some of the data of Mks Mkhize's healing session in comparison with other healing sessions; however, when it came to deciding what elements might be liable to transformation, I left the data of his healing session out of my considerations.

Mks Gasa's again

Mks Zinhle invited us to return to Mks Gasa's exactly one week after our first visit. We arrived at noon and after a warm welcome we sat ourselves on the reed mats in the consulting room, waiting for the things to come. On this particular Saturday,[23] the healing practice was in full swing. Mks Gasa was supervising the proceedings and procedures in the rondavel, where advanced initiates performed healing sessions with successive patients, Mks Zinhle made preparations for later that afternoon, and Mks Dudu explained to us what was going on and what was about to happen. She also gave us a tour of the rest of the compound. In the rondavel, it was a coming and going of initiates and sangomas, they all had their own chores and were focussed on their actions. Fortunately, from the start, we were allowed to record on video and to take photos, or else we would not have known where to start looking. This afternoon, we witnessed the healing session of a family performed by a young male initiate, followed by that of a young man and, somewhat later, a woman in her thirties, both by a young female initiate. While one healing session was being completed on this side of the rondavel, on the other side the preparation for next session was already starting. Then, Mr Mbele entered for his healing session, executed by Mks Zinhle, who was assisted by her mother and her sister Dudu. With this last patient, we subsequently drove to a river about 130 kilometres south of Durban where another part of his healing process took place and, after that, we went to his home in Pietermaritzburg for the final part of the process.

[23] 3 May 2014.

Being present at eight different kinds of healing sessions, performed by at least five different (initiate) sangomas in various places and settings, provided me with rich material to compare, to unravel which elements are central or dominant in such sessions, and what elements seem to be liable to changes.

In the next chapter, I will compare different aspects of Mr Mbele's healing sessions with the others that I witnessed, so Mks Gasa, Mks Zinhle, Mks Dudu and Mr Mbele will be the main characters.

2.4 Reflection and basis for choices

2.4.1 Ethics and privacy

Obviously, many people are involved in a study such as this. Although some people characterise field study as a reciprocal process of exploitation, I prefer to see it as a process of mutual benefit. While I obtained data in conversations, interviews, and by attending healing sessions, the participating sangomas profited from this study in the form of improved status in the circle of indigenous healers and in the eyes of potential patients. As agreed, the sangomas also profited financially; I donated ZAR500 (the by the association fixed sum for cooperating in research) to each of them for the interview or my presence at healing sessions. The sangomas themselves define such sums as 'cattle', an offering for the ancestors, because the ancestors are the ones that allegedly allow the researcher to interview the sangoma and attend healing sessions. Even Bongani evidently profited from my presence, judging from the way he introduced me to many people as his Dutch friend. In my view, the field study thus was a win-win situation for all participants.

Personal data

The names of informants, cooperating sangomas, patients whose healing sessions I was allowed to attend, and many others who helped me in one way or other have already been mentioned in these first chapters. I explained my intentions and the way I would deal with the obtained data to every person I talked to in connection with this study.

All sangomas and inyangas that cooperated in the research (Mks Mgadi, Mks Bhengu, Mks Mbuyisa, Mks Ngidi, Baba Hlongwane, Mks Gasa, Mks Mkhize, Mks Zinhle, Mks Dudu, and Baba Cele) were aware of the fact that the data I gathered were to be used in an academic study that would ultimately be made public. In our discussions on how I should protect their personal data, they gave me their consent to use their real names. In fact, they said they felt proud to participate in this study and that they would feel offended if I used an alias. Bongani Ntshangase, my key informant was of the same opinion. That said, any indications in the text regarding the sangomas' places of residence remain deliberately vague.

A similar case of informed consent is Mr Mbele, one of the patients whose healing sessions we attended. Having been told that I was gathering data for a thesis, he told me that he felt honoured by the fact that I had witnessed several of his healing rituals. For all other patients whose healing sessions we attended, I use pseudonyms to protect their identity (indicated in a footnote).

Some healing sessions at Mks Gasa's were performed by advanced pupils. I have changed their names to protect their identity, and the names of two extra sangomas that were present at Mr Mbele's healing sessions on 3 May 2014 (indicated in footnotes).

Finally, there are numerous people that were more or less indirectly connected with this study. I confine myself to using their first names in the text, sometimes in combination with a paraphrase, e.g. Michael the gardener, or just a paraphrase.

Other data

During the three periods of field study, I made many recordings using a voice recorder, videos, and photographs. In each case, I asked and was given permission beforehand. The data were stored on my laptop, the voice recorder, and an external hard disk. All files were kept on two devices, to guarantee a copy in case that one of the devices should crash or be stolen. I made transcriptions of all audio recordings and these were also stored on a laptop and external hard disk.

All original data have been preserved and are stored securely on one of my external hard disks (only accessible with a password). This data is only for use by this researcher and not available to any other person. Whenever I decide these data no longer serve any useful purpose, I will delete them.

2.4.2 Key informant

I am aware of the influence that the choice of Bongani Ntshangase as my key informant has had on this research and also in accommodating his choices for the sangomas involved in this study. Moreover, I acknowledge the fact that I was dependent on him with regard to the translation of the questionnaire into Zulu, the translation of the interviews, and every bit of communication[24] inside a consulting room from Zulu into English and vice versa. During the field study, I was continuously aware of the vulnerability of the research data when it comes to these elements and I have tried to attain data as adequately as possible, for instance by posing the same questions to various sangomas and posing questions in a slightly different way.

One of the reasons that Bongani agreed to assist in this research was that, according to him, Western (academic) writings often portray sangomas and their practices incorrectly. He felt that it was his duty to try to reshape the Western image of sangomas from so-called witchdoctors to cultural and socially responsible traditional healers. He intended to show 'genuine sangomas' in the execution of their profession, the healing practice. I continuously kept his agenda in mind, double-checking issues in different settings, and trying to find out if things were represented in a biased way or too positively.

On the other hand, there were a few, and in my opinion strong, reasons to maintain this set-up. Firstly, Bongani's network was very useful to me in a number of aspects. As a Western researcher and only spending short periods in KwaZulu Natal, I did not have

[24] Except for the conversations with Mks Dudu, who answered me in English outside and inside the consulting room.

the faintest idea who to approach for an interview. Bongani knew many sangomas and could therefore consider who would be best[25] (and willing) to be interviewed. Moreover, because Bongani introduced me and my research beforehand, the sangomas had prepared themselves for the interviews and healing sessions and had scheduled our appointments, so that our conversations were focused. Additionally, as the sangomas trusted Bongani, they consequently trusted me. Indeed, there was no trace in these meetings of the (quite obvious) suspicion towards me as a white, Western researcher, which I had encountered in the meeting with Mks Mgadi in 2012. Hence, there was no need for long introductions or ice-breaking talks before the interviews or healing sessions could start.

While inside the consulting room conversations were in Zulu, English was the main language outside. After the interviews or healing sessions, Bongani retreated into the background in order to offer me the possibility to talk and pose all kinds of circumstantial questions. He had the same attitude in our meetings with all those people we met in relation to this research; after he had introduced us, he left the conversation to us.

All cooperating sangomas, in 2012 and in 2014, seemed to be honoured to be chosen by Bongani and thus to be a part of this research. To what extent Bongani's presence influenced their behaviour remains hard to determine. The more senior sangomas seemed less impressed than the younger ones. Mks Bhengu, Mks Mbuyisa, and Mks Gasa treated Bongani amicably, while Mks Ngidi, Mks Mkhize, Mks Zinhle, and Mks Dudu clearly approached him with respect.

2.4.3 A polished reality?

To what extent the things I saw and heard at the sangomas' healing practices reflected reality and daily practice, or were modelled for the occasion, is also hard to say. In the case of the interviews, the sangomas' answers might have been influenced by what the sangomas thought that Bongani wanted to hear. Of course, it is possible that he instructed them on the questions and preferred answers beforehand, but I doubt that; the answers the three sangomas gave appear to be too divergent for that. Obviously, my role in the interviews was an active one and when something was not clear to me I questioned further until I understood what the sangoma meant. They might have modelled their answers so that I would appreciate them, so that they would fit my image of the indigenous healer's practice. After all, why would they feel obliged to tell me the truth? And yet, my impression is that the interviewees were honest and authentic in their answers; the way they told of their childhoods, their 'calling', and the patients who come to them for healing was pleasant and without hesitation; not at all as if they were constantly thinking of what was expected from them or what would be appropriate in that moment.

[25] Of course, this is in his opinion, with both our agendas in mind.

My presence as a Western researcher at the healing sessions may also have influenced the behaviour and doings of the sangomas. Mks Mkhize arranged the healing session of his thwasa especially for us and, during the procedure, he constantly explained to us what he was doing and the meaning of the results.[26]

During the healing sessions at Mks Gasa's, we were silent observers, sitting on the floor with our backs against the wall, filming and taking photographs. For a large part of the healing session, the patient and the sangoma or thwasa were seated with their backs towards us. At some moments, Bongani, whispering, explained what was happening, but only at the end of the session did we ask about what we saw and then he clarified. The apprentices that executed healing sessions paid no attention to us, they were completely focused on their patients and their tasks. I got the impression that they were far more aware of the woman sitting on the other side of the room, Mks Gasa, who now and then gave some additional instructions.

At some moments during Mr Mbele's healing process, however, the thought occurred to me that his sessions had been somewhat upgraded, made a bit more extraordinary. Especially in contrast to a very austere healing sessions at Mks Gasa's for a rather poor-looking young man. The thoughts about upgrading were nourished by the fact that parts of Mr Mbele's sessions were also recorded with tablets and cell phones by members of the Gasa company. The luxurious setting of his healing sessions may have been because of our presence; another possibility is that it had more to do with the fact that Mr Mbele was a very wealthy man. A third possibility is that they also recorded the healing sessions for Mr Mbele himself. At the end of his last healing session, Mr Mbele told us he was thrilled and honoured by the fact that we had attended his healing and, in his opinion, the ancestors' consent to our presence added value, importance, and meaning to the whole process.

2.4.4 Field study in three periods

On account of my job as a teacher, I was restricted to fixed holidays for the fieldwork, instead of having one longer period of time to do the research. If I had been able to conduct my field study in one longer period, I could have plunged deeper into Zulu society, culture, and indigenous healing, for instance by living in a sangoma's compound for some time. I would then have been able to describe the daily routines in an indigenous healer's practice from the inside. But I doubt whether I would have encountered such a diversity of sangomas and healing sessions as I have now.

By returning to Durban twice, a certain familiarity grew between me and, firstly, Bongani, and, secondly, the sangomas, their practice, and their environment. The mere fact that Bongani told sangomas that I had previously been there, added value

[26] See Chapter 3 for a description of this healing session.

and credibility to this research and to my reliability. Another advantage of returning to Durban with Bongani as my key informant was that we were accustomed to each other's way of working. Bongani knew of my eagerness to experience and witness everything involved in and about indigenous healing, so he took me to all kinds of places and people for days in a row.

In the months before I returned to Durban for the last time, I had worked intensely on my data from the previous visits. This allowed me to compare them with my new experiences and ask for clarifications where necessary, to get a better insight and deeper understanding of indigenous healing and a sangoma's healing practice. The interpretative design of the research emerges strongly here.

2.4.5 After field study

I am convinced that with Bongani as my key informant many doors opened that would have remained closed without him (I might not even have known there was a door at all). Furthermore, by taking me to all kinds of places, people, and events somehow related to indigenous healers,[27] and by constantly telling me about Zulu culture, tradition, and religion he showed me a colourful context of the sangomas' healing practice and thus gave me a wide perspective. Without his help this research would have been a different, more narrowly scoped one. As my informant and as a companion and guide I owe him a great deal. It grieved me deeply when his eldest daughter Thandeka informed me that Bongani Ntshangase had died in October 2014.

Following his untimely death, my dependency upon Bongani became even clearer. During my time in South Africa, all contacts with the sangomas had been through him and we had agreed that if I had questions or uncertainties while working out my data, I would get in touch with Bongani through e-mail. Now that he had passed away, it proved impossible for me to contact the main participants to ask for further information. My hopes rested on Thandeka Ntshangase, who offered to check on her late father's cell phone for the sangomas' numbers, but she could not find the names I mentioned, with one exception, Mks Ngidi, whom I interviewed in 2012. She kindly offered to help me out with questions concerning the sangomas' healing practice in general, the training, etc, an offer I took up on several occasions.

When NUPAATHPSA's website disappeared from the internet in February 2015, neither Thandeka, nor Mks Ngidi were able to find out why. I would have liked to ask one of the other sangomas or Baba Hlongwane (all members of NUPAATHPSA) what had happened, but I was unable to trace them. Mks Ngidi, as a member of the THO is not acquainted with the other sangomas, so she could not find out either. When the

[27] A meeting of NUPAATHPSA executive committee with members, the muthi market, the Interfaith Symposium with religious leaders of KwaZulu Natal, Sarvodaya, Mahatma Ghandi's home in the Phoenix settlement etc.

THO website also disappeared from the internet in January 2017, I again approached Mks Ngidi and asked her what was going on. She reported that THO still existed as an independent association and that the organisation currently prefers to communicate about their workshops and trainings on their (indeed very active) Facebook page (Facebook THO). In 2018, I finally discovered that NUPAATHPSA was still flourishing and that the organisation had simply launched a What's App group (in 2013) for mutual communication, as a substitute for the website.

As I wrote down the GPS coordinates of all the locations I had visited during the field study in 2014, it was my intention to return to the Durban area once more and visit the sangomas again, perhaps to settle any outstanding issues, or perhaps to continue this study in a longitudinal way.

2.5 Concluding remarks

In this chapter, I have sketched an outline of the field study I did for this research in two phases, as well as the method used, and the interpretative design of the research. The first phase was the preparation, getting acquainted with the area and (someone who knew) sangomas, and the interviews; in the second phase, I attended healing sessions. I have explained why I chose the method of genealogical sampling and how I expected this method to help me gain a better understanding of knowledge transmission processes and of consistency of knowledge transfer. I also showed how the interpretative design attributed to an analysis of the obtained data.

Throughout the chapter, the limitations of this study have been clear; it is restricted to a small number of interviewees and a small number of healing sessions in a limited area and a restricted time frame. The outcome may be used in addition to and in comparison with other (academic) writings, but it is never meant to be a truth in itself. The conclusions are tentative and provisional, to be overruled by future studies. In the last part of this chapter, I explained the ethics of my investigation, how I protect the identity of my informants, and how (long) obtained data are stored. I also recounted the dilemmas I encountered and the choices I made in and after my cooperation with Bongani Ntshangase.

In the next chapter, I will focus on the execution of the sangomas' healing practice, on what happens when a patient comes to a sangoma for healing. I will zoom in on the diagnosis, an important element of the healing procedures. Evidently, the whole context of a healing session must be taken into account; therefore, I will compare and describe various elements of a sangoma's healing practice, taking Mr Mbele's healing sessions as a connecting thread.

Chapter 3

Go with the ancestors' flow. Healing

After the introductory chapters, we will now dive into the actual world of indigenous healing and zoom in on what happens during a healing process. I will describe what structures can be distinguished in a healing session, what techniques are used; in short, the internal dynamics of the healing practice. I will also go into a few aspects of medicine, *muthi*.

The main question in this chapter is: How do processes of diagnosis and healing characterise the indigenous healing practice?

To provide an answer to this question and to give an impression of the sangomas' healing practice, I will examine the case of Mr Mbele's healing, one of the patients we met at the Gasa compound. I will describe four of the sessions in his healing procedure and compare them with other sessions we witnessed on Mks Gasa's compound in 2014,[1] where, on an average Saturday, about ten to twelve healing sessions are performed. I will distinguish and explain the various elements and the structure of a healing session in detail, as well as several parts of a sangoma's healing practice. When applicable, I will compare what we have seen on these days with academic literature on the subjects as well as with what the three sangomas in the 2012 interviews told us about their life and healing practice.

However, to understand what happens in healing sessions, it is essential to first describe the body of thought that is the foundation of Zulu indigenous healing: Zulu cosmology and the connected subjects of divination and aetiology.

Mr Mbele's healing process comprised at least five healing sessions. A healing process is indeed a process, it is not a one-off affair. For the greater part this is due to Zulu cosmology (Callaway, 1884 (1870); Bryant, 1949; Krige, 1965 (1936); Berglund, 1976), the indigenous Zulu belief system, in which the ancestors[2] play an important role and which encompasses a holistic view on mankind (physically and spiritually) and the environment he lives in (family, friends, neighbourhood, and physical surroundings). All of these parts are believed to influence each other. If someone is not feeling well, it is considered to be a manifestation of an imbalance in one (or more) of the three fields; body, mind, and (social) environment. To understand why someone is not feeling well,

[1] on 26 April and 3 May.

[2] The 'spirits of the ancestors' (Z: *amadlozi*) are believed to watch closely over the living and interfere in their daily life when necessary. These 'spirits' are referred to concisely as 'the ancestors'.

i.e. what the cause of this imbalance is, a specialist is needed, someone who is able to communicate with the ancestors. The ancestors are believed to protect the living and, in return, they allegedly demand certain offerings, such as respect or a specific ritual. If these offerings are not made, the ancestors supposedly get annoyed and may inflict bad luck or illnesses upon the living, thus disturbing the holistic tripartite balance.[3] Most of a sangoma's clients require healing in all three domains, in order to ensure that the balance will be restored, thus several healing sessions are needed to achieve this goal.

In (early) descriptions of Zulu society and Zulu cosmology, sangomas are referred to as 'diviners', because they are the indigenous health practitioners who are allegedly capable of connecting and communicating with the 'unseen world', specifically with the spirits of the ancestors. A sangoma uses this communication with the ancestors, i.e. divination to diagnose the patient.

Much has been written about 'divination' in academic literature. It is described e.g. as a globally practiced phenomenon used "to solve a problem of a client, by a technique to gain additional knowledge about the client's history and present situation in life" (Peek & Van Beek, 2013, p. 1). A consulted diviner uses divination techniques to retrieve the cause of the client's bad luck or affliction, an explanation for why things are not going well. When this cause is uncovered, the diviner prescribes a remedy in the form of some kind of herbal medicine, a specific ritual, or a special offering in order to restore relations with the ancestors, elicit their goodwill, and solve the patient's problem.

In addition to being a connection with the unseen world, divination is also about knowledge and about 'how things should be', reflecting the culture's core values that are often essential in rapidly changing societies to maintain some kind (or just a sense) of stability. Divination is practised globally and there is a wide variety of divination systems, each and every one of which reveals what is presumed to be important in that specific culture, what is valued, and what people worry about. Peek (1991) emphasises the importance of divination on the African continent; he refers to the key role divination has in African cultures as well as the crucial position diviners occupy in societies in transition because of their role as mediators between the visible and the invisible world. Stroeken argues that the meaning of divination "in the participants' frame of experience – a frame that […] is related to all other frames of experience" (2010, p. 182). That is what makes each divination process unique for everyone involved.

Within the scope of this research, the sangomas use divination techniques, they communicate with the ancestors, to find out what is causing the ancestors' anger and thereby the reason for the patient's problems. Basically, this is the reason why patients visit a sangoma: to discover why things are going wrong in his or her life. Divination is a technique for answering this question, it serves as an explanatory system.

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[3] More about Zulu cosmology, indigenous religion, and the aetiology of evil in Chapter 5.

It appears that the patient and the sangoma expect the world to be reasonable, consistent, and explainable and therefore they assume there must be a reason, a cause for any mishaps in life. Because 'everyone gets what he deserves in life,' the ancestors most likely have a reason for sending these afflictions, they assume. And this hypothesis makes them come to terms with these experiences, i.e. 'now it makes sense'.

Moreover, this assumption enables the patient to restore the ancestors' mood by performing a special ritual or by donating specific offerings. In doing so, the patient feels he is able to take control over his own life and health; as he makes an effort to please the ancestors, he again deserves the ancestors' protection from further mishap. In indigenous healing, the patient is an actor in the process of recovering health and well-being.

Let us now look at the indigenous healing practice and focus on the first healing session that was performed for Mr Mbele, a wealthy businessman in his early thirties. Although he lives in Pietermaritzburg and his business is in Mpumalanga, he came to Mks Gasa's practice in Durban for healing. The main characters in the following pages are Mr Mbele and the sangomas, Mks Gasa and her daughter Mks Zinhle. In the comparison of the observations with the interviews, Mks Bhengu (the oldest interviewee), Mks Mbuyisa (the middle one), and Mks Ngidi (the youngest) will be mentioned frequently.

3.1 Mr Mbele's healing, part one

3.1.1 In the rondavel

For[4] anyone entering the candle-lit rondavel on Mks Gasa's compound, it seems as if the man and three women inside are just chatting about daily routines; there is laughter, cell phones are ringing and being answered, and people are walking in and out. The setting might seem strange, however; the man sits on a mat in the centre of the hut, he faces a leopard print cloth that hangs from the ceiling opposite the door, and against the cloth is a big necklace in the form of a rosary. He sits, his legs in a V-shape, and between his feet is a silver dish from which smoke spirals up. A somewhat closer look reveals that his eyes are closed and that he is holding a burning candle in his left hand and in his right hand a staff, with the sign of a cross on top. Next to him, on his left side, is the youngest of the three women, Zinhle. On his right, with her back against the wall of the rondavel, is Dudu and on his left side, also with her back against the wall, is Mks Gasa.

Figure 3.1 Mks Gasa's consulting room, interior

On this Saturday evening at the end of April,[5] Mr Mbele has come for a healing session. He has been here before, so he is acquainted with the routine and knows that whatever procedure will be done, he will be guided gently by the youngest of the three women, Mks Zinhle. She is a sangoma, as are her older sister Mks Dudu and her mother, Mks Gasa. The daughters were trained by their mother, and now the three of them together train over twenty apprentices, including Mks Gasa's youngest daughter. All of them live jointly on Mks Gasa's compound, situated in KwaMakhutha, a Durban township approximately 15 kilometres south of the city centre. Even though she is the youngest

[4] The description of Mr Mbele's healing sessions is in a smaller font and indented.

[5] 26 April 2014.

in age, the ancestors' spirits have made clear that Mks Zinhle is the most important sangoma of this house and this is the reason why she is the one sitting next to Mr Mbele during this healing session.

When he arrived for this healing session, Mks Zinhle met Mr Mbele inside the gate of Mks Gasa's compound and together they walked the twenty metres to a rondavel; the consulting room (Z: *indluhlola*). There, Mr Mbele greeted Mks Gasa and gave her a paper bag filled with food, a bottle of Sprite, and a bottle of Coca Cola, offerings for the ancestors that Mks Gasa gratefully accepted and put beside her on the mat. Then, Mks Zinhle invited him to sit on the reed mat in the centre of the hut, which was covered with a leopard print cloth. Mks Zinhle talked to him softly while she took a printed cloth and draped it around his shoulders; next she fetched a fur crown (Z: *umnqwazi*), which she put on his head, and finally she put a lit candle and staff in his hands. After this, she sat down on her knees beside him and took a handful of twigs, which she put in the silver dish, she then lit these essence twigs (Z: *imphepo*[6]) and extinguished the flames, leaving the essence to smoulder in the dish. As soon as the smoke spiralled up towards the ceiling of the rondavel she started to invoke Mr Mbele's ancestors by reciting their praises. Next, she introduced all the people present in the consulting room and then asked the ancestors to be present, to unveil the cause of Mr Mbele's problem and for their assistance in healing him. After some moments of silence, Mks Zinhle yawned a few times (a sign of the presence of an ancestor) and asked Mr Mbele, who in the meantime had closed his eyes, to describe what he saw and heard. He said that he saw an old granny sitting on a chair with a white dress on her lap. The granny laughed at him and told him she wanted to make everything clear to him.

> This is the moment when her mother and sister join Mks Zinhle in asking questions to the patient. Intermittently, they pose questions to get additional information in order to form a complete image of what Mr Mbele is experiencing. In answering the sangoma's questions, in a soft trailing voice that sounds as if it is coming from afar, Mr Mbele describes in detail the things he sees and hears. Gradually, the picture unfolds.
>
> Mr Mbele speaks of the old woman he sees, she tells him his great grandfather was a king of a Xhosa[7] clan, but he has never been told about him. And he sees a soft chair in blue, red, and gold, with armrests. There are flowers on the chair's fabric. The granny gives Mr Mbele instructions to go and buy such a chair and bring it into his house. She also tells him she is unhappy with him driving the car he has at this moment. Next, he describes a specific kind of dress, a Xhosa dress with beads. The type of beads and the pattern are meticulously specified as is the colour, white and blue. A kind of leopard print apron completes the outfit.

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[6] Often a Helichrysum variety, *Helichrysum odoratissimum* (Everlasting), or *Helichrysum sutherlandia*, herbs with aromatic leaves.

[7] One of the neighbouring Nguni people, originally living to the south-west of the Zulu area.

> The old lady also tells him that there has to be a function, and this function must be performed in his house, but not in the first house because there is a family quarrel about that house. His mother wants him to give her that house, but he is not supposed to give it to anybody. He must tell the family that he sold the house and, in the meantime, find people to rent it. If he does this, the conflict will dissipate. The function should not be held in his second house either, but at the prayer place of a new house. In this prayer place must be a bottle with two colours, the upper part must be light blue and the lower part dark blue. Furthermore, an old 5 cent coin should be at the bottom of the bottle as well as in the *muthi* bucket that is going to be used for the ancestors. The bucket must be white, placed on a white cloth, and whenever he is going to use it, he must put white coins into it. Preparation for the function must begin next Tuesday, with the brewing of the Zulu beer that is needed for this function.

Mr Mbele answers the questions – at times only after a short silence, at times it seems with some reluctance, his expression set. The sangomas occasionally smile about the answers given[8] and a few times they even shake their heads,[9] but invariably they treat Mr Mbele with great respect. The last statement, about starting to brew Zulu beer, causes real amusement in the consulting room. Mks Gasa, not sure things are reflected correctly, verifies this remark once again, but to everyone's surprise it is repeated: the preparations should start next Tuesday.

Throughout this procedure, Mr Mbele is in an altered state of consciousness, he seems to be unaware of the things that are happening around him. What he tells the sangomas about are the images he sees with his eyes closed. While the session is in progress, amathwasa enter the consulting room, engage in a brief conversation with one of the women, or fetch something and leave again to resume their tasks elsewhere in the compound. One of the apprentices brings food and drinks for us, and while we eat and drink, the proceedings are explained to us. All this time, Mr Mbele sits there, his eyes closed, and reports what he sees and hears. The only visible changes in him are in his body; sometimes, he is bending a little to the front, as if he wants to get a closer look; at other moments, he leans slightly backwards, his body tightening, his eyebrows frowning, as if he doesn't like what he is experiencing.

After about an hour, Mks Zinhle closed the session by lighting the imphepo again and thanking the ancestors for their presence and their help. As this session comes to an end, the sangomas yawn and belch and Mr Mbele opens his eyes. For a moment, he remained in the centre of the hut, then he moved to sit beside Mks Gasa, he obviously had to recover from this experience for he brushed his hands over his face several times.

Sitting beside Mks Gasa, he is allowed to take time to recover. In the meantime, the sangomas will tell him what has happened in the past hour, because Mr Mbele himself

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[8] About the instructions Mr Mbele gets regarding the quarrel with his mother concerning the first house.

[9] When it becomes clear where the process has to be continued, i.e. not in Mr Mbele's first house, nor in his second.

doesn't remember anything; neither what he saw and heard, nor what he said. In doing so, they will also tell him the interpretation of what his ancestors have revealed during this part of the healing procedure and the implications for the rest of the process. Usually, recovery from such a session takes at least an hour, but it is only after a couple of days that a patient who has had such an experience will really begin to feel and understand what has happened to him. I learned about the interpretation and implications of this healing session exactly one week later when we attended Mr Mbele's next sessions. A description of those events is below in 'Healing Mr Mbele, part two'.

3.2 Healing process

Generally, healing sessions have a similar structure. The first step for the sangoma is to invoke the ancestors by praising them, and to ask for their help in the present situation. When a connection with the ancestors is established, it is of the utmost importance that the sangoma listens carefully to the message they give, i.e. the diagnosis. The sangoma then gives her interpretation of this message to the patient and, subsequently, she asks the patient if he recognises the ancestors' message; if necessary, she answers the patient's questions. Often, *muthis* are prescribed and the sangoma advises the patient, based on her experience, what to do in the situation at hand. In some cases, the patient is summoned to bring offerings for the ancestors to the next session. Both the sangoma and the patient are highly concentrated during all elements of the healing session, every element is executed with great intensity and dedication. Invariably, the session is closed by thanking the ancestors for their presence and help.

3.2.1 Communication with the ancestors[10]

When a person comes to a sangoma for healing for the first time, the sangoma is usually already aware of the reason for the visit and the problem(s) the patient has. Mks Bhengu[11] (the oldest interviewee) and other sangomas[12] told us that they often experience exactly the same pains that the patient feels, even before the patient has arrived at their premises. The moment the patient enters the consulting room the sangoma's pain vanishes, that way she knows this is the patient with those specific pains. The pains are one of the ancestors' ways of communicating with a sangoma (Callaway, 1884 (1870); Bryant, 1949; Berglund, 1976; Ngubane, 1992; Reis, 2000; Thornton, 2009) whose intention is to detect trace down the cause of the patient's problems in a healing session. In order to diagnose (Z: *uhlola*), the sangoma connects with the ancestors, usually by using some essence, *imphepo*, at the start and throughout the healing process. A handful of the small twigs are put in a dish or in a calabash and lit with a match; after a few moments, the flames are blown out, leaving the smouldering twigs to produce an aromatic smoke. The aroma is considered to please the ancestors and to encourage them to be present in the consulting room. By inhaling the smoke, the sangoma opens the pathways of communication with the ancestors; some sangomas

[10] I will use the terms 'divination', 'communicating with the ancestors', and 'connecting with the ancestors' interchangeably.

[11] Interview with Mks Bhengu, 1 August 2012.

[12] Mks Mbuyisa and Mks Ngidi interviewed 9 August 2012, Bongani Ntshangase referred to this phenomenon several times in 2012 and in 2014. More about this in the remainder of this chapter.

additionally use snuff[13] or a herb[14] to quickly connect with the ancestors or to intensify the communication.

Figure 3.2 Mks Mbuyisa burning essence

There are many other divination techniques for establishing a connection with the ancestors. A frequent method used by sangomas is 'stirring' a mixture of water and *muthis* in a bucket or a large calabash with a specially formed twig (Z: *iphahla*).[15] While stirring, she invokes the ancestors, praising them, and asking them to come and help. When foam starts to form on top of the mixture, it is seen as a sign of connection with the ancestors; the stirring will go on until the foam is spilling over the rim of the calabash. This foam may be used in various ways: the sangoma can eat the foam, spooning it with her hands from the calabash and bringing it to her mouth, or 'slurping' it directly from the calabash to open up for communication; or, she can smear it in her ears and nose to open specifically those channels, or put it on her head and the rest of her body as a sign of total dedication to the messages of the ancestors. In some cases, a patient is also instructed to eat the foam and to put it onto his body. We will encounter this application in the next section, on Mr Mbele's healing.

At Mks Gasa's compound, we also saw *muthi* stirred for another purpose: a sangoma carefully put the foam that was spilling over the rim on the lid of the bucket and went outside. While walking around in the compound, she strew foam on the ground all around her and asked the ancestors to guide people for healing to this compound.

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[13] In the form of powder inhaled through the nose, or in the liquid form sprinkled on the floor of the consulting room.

[14] E.g. 'Manono': the bark and wood from a branch of a special tree: Strychnos henningsii (Red Bitterberry). The sangoma bites a small piece of the bark/wood and chews it. After a few minutes he or she spits it out. In the case of Mks Mkhize, he spat it at the bones which he used for the diagnosis.

[15] A twig ending in a V form.

Eating the foam of stirred *muthis* is also known to be a frequent (if not daily) early morning practice for students as a part of their training to become sangomas. In that case it is used as an emetic, to purify the body, and, consequently, making the student more open to the ancestors' messages during the day to come. Mks Ngidi told us that there are at least three different sorts of *muthi*s for different kinds of ancestors: *indiki*; *indawe*; and *thumwe*.

Figure 3.3 Stirring the *muthi*

Whereas sangomas seeking to communicate must invoke the ancestors by praising them and asking them for their presence, the ancestors themselves are believed to be able to interfere in a sangoma's life at any given moment. They use many forms to communicate with a sangoma: dreams; pains; voices or other sounds the sangoma hears; images the sangoma sees; and even every element of the physical surrounding of the sangoma. All these methods of communication manifest all day, every day so that the ancestors can get across their messages, wishes, and demands. In fact, the ancestors are believed to manifest themselves this way to every living person, the sangoma however, as an intermediary, is supposed to be able to recognise these signs and to read them. A sangoma must therefore be open to everything that is happening to herself as well as to other persons; a sudden thought, an image flashing through her mind, a dream in the night, anything happening around her can be a sign from the ancestors and hence must be interpreted as such.

An important element of the sangomas' training is to learn to interpret these signs, starting with dreams. Early every morning, before sunrise, *amathwasa* gather with their trainer to listen to the *amathwasa*'s dreams, and to unveil the message that the ancestors want to deliver through those dreams. Be it about a person that is going to come for healing, about a specific way to harvest a special *muthi*, or about the clothes the

ancestors want the sangoma to wear, the *gobela* and her trainees take every message equally serious and they take them all into account.

As described above, a sangoma often feels the same pains, also with the same intensity, as the person that comes for a healing. However, the moment this patient gets near, the sangoma's pain vanishes. During the interview, Mks Ngidi told us a remarkable story about such an experience that happened in the time before she became a sangoma, when she was still a teacher in Eastern Cape. One day, while she was doing her administration her eye became red and painful. She asked an attendant sangoma to explain this pain and the sangoma told her it was not her pain but it was someone else's. So, Mks Ngidi went to her fellow teachers and asked: Who is the person with this eye ache? Then, one older lady said; "I am the one who has got this" and at that same moment Mks Ngidi felt her pain slip away.

In most cases, sangomas are wounded healers (Reis, 2000); they were ill before they accepted their ancestral calling, their *gobela* cured them, and then trained them to become a sangoma themselves. In turn, they use the knowledge transmitted during the training to be able to cure other ailing people (Thornton, 2009). Each of the sangomas we interviewed in 2012 had her own story of an illness getting worse and worse, to a point that she could no longer resist and subsequently had to give in to the calling of her ancestors. Mks Bhengu, for example, had been ill for many years. The doctors she consulted at the clinic said there was nothing wrong with her, but the moment she returned home her illness reappeared. The illness only started to disappear after she started her *ukuthwasa*. Mks Ngidi told a similar story; in her case, she was bothered so much by toothache that she had to stop working. When she ultimately gave in and went to her *gobela* to start *ukuthwasa*, her toothaches vanished instantly. Mks Mbuyisa (representing the middle generation) had an 'illness' in another form; she was often not able to concentrate or to read or write at school. Her attention was constantly drawn by all kinds of things she saw outside or voices she heard in her head. These stories were told not only as a part of the sangomas' lives, but also as an explanation for the respect people in the social environment have for sangomas. I will return to this topic in Chapter 6.

The ancestors are believed to use voices and other sounds to convey messages or demands in dreams as well as in other aspects of daily life. We experienced this a few times in our meetings with sangomas. When she was talking about her training to be a sangoma, Mks Bhengu came to the subject of the many strict rules regarding behaviour and purity that a *thwasa* must adhere to and how, as a young married woman, she did not always live up to those instructions. At the point that she was about to tell of her disobedience we heard a loud rattling noise in the top of the rondavel. Mks Bhengu looked up, smiled, and asked us to move on to another topic. After the interview, when the voice recorder was switched off, and in the absence of her *thwasa*, she explained the rattling was caused by one of her ancestors, warning her not to talk about the issue in front of her own *thwasa*, because it would undermine her status as a *gobela*.

At Mks Gasa's we heard another sound, believed to come from the ancestors, just a few minutes before Mr Mbele came into the consulting room for the healing session that I described at the beginning of this chapter. We were sitting in the rondavel and I inquired about all kinds of objects that were standing and hanging in the ancestors' place, behind the hanging leopard print cloth. Mks Gasa and Mks Dudu explained the symbolic meaning of the sculptures, buckets, knobkerries, and several musical instruments. All of a sudden, we heard a sound, like someone was strumming the guitar. Mks Gasa smiled and said to her daughters that one of the ancestors[16] had arrived, the sound of the guitar was the sign he was in.

A whistling noise at the top of the consulting room or behind the leopard print cloth is a common sound for some sangomas but not noticeable for everybody. After invocation, the ancestors sometimes insist on communicating this way and then it is up to the sangoma to interpret these sounds. This 'whistling' is also one of the ways to diagnose in the healing process, as will be discussed later in this chapter.

As we experienced in Mr Mbele's healing session, sometimes ancestors choose to make their messages clear through voices and images that are only audible and visible for one person. Mr Mbele heard and saw things, while the other people present in the rondavel remained ignorant. Mks Zinhle and the other sangomas had to ask Mr Mbele to describe what he saw and heard, in order to receive and understand the wishes of the ancestors. When we visited Mks Mbuyisa in 2012 this happened at some point in the interview, when Mks Mbuyisa closed her eyes and seemed somewhat distracted. After a moment, she opened her eyes again and asked to move on to the next interview question. She told us that she frequently hears somebody talking to her, telling her what is going to happen. In this case, she was instructed to cut off the current subject, for there were more important elements coming up in our conversation.

Like the above-mentioned guitar, ancestors may use objects to get the sangoma's attention. Therefore, the sangoma must be aware of all things and events in her surroundings. A candle that has to be lit twice, the flame of a candle that is not burning steady, the top of a bottle falling out of your hands, the spot where the top falls, all such minor incidents are noticed and interpreted as signs from the ancestors. Mks Mbuyisa described the life of a sangoma as "a special life for special people. Sangomas have to be able to bend like reeds in the wind"[17] Every day, the ancestors may, and indeed do, interfere with her plans for that day in whatever way they want to. A sangoma must go with the ancestors' flow.

[16] One grandfather from the mother's side used to play the guitar. Now when he is coming to them, when they invoke the ancestors, he says "I want my guitar".

[17] Interview with Mks Mbuyisa, 9 August 2012.

3.2.2 The diagnosis

After the invocation of the ancestors, there is often a sign of their presence, noticeable in the sangoma's yawning, belching, or producing of other loud noises. The next step in the healing session is the most important part, the diagnosis. Those ancestors who have been asked to help, indicate what the root cause of the patient's problem is and what is needed at this moment to heal the patient. It is only after the diagnosis is clear that the healing part of the process can begin. The indication of the problem's root cause can be given in at least three different ways. Which method of diagnosis a sangoma uses depends on the ancestors' preference, the training of the sangoma, and the relation between the sangoma and her ancestors. The three ways of diagnosing that we distinguished are: 'throwing bones'; 'using essence'; and interpreting 'whistles'. These procedures will be described below.

Throwing bones

The first diagnostic method to be described is 'throwing bones', which is also known as 'basket divination' in anthropological literature, referring to a basket in which the bones are kept, when they are not used for divination. Basket divination is a widespread technique for communicating with the unseen world. For the African continent alone there are countless descriptions of all kinds of varieties of this divination technique, e.g. Erdtsieck (2003) about Tanzania, Mlisa (2010) about the Xhosa in South Africa, and Granjo (2013) about Mozambique. In the Zulu context, I saw the bones stored in a small leather bag or in a bag woven from grass or reed. A collection of several small items is kept in this bag: all sorts of small animal bones, but also coins, stones, shells, erasers, dices, and pieces of wood, amounting to more than thirty items, each one of which has a special symbolic meaning. Together, these items are called 'the bones' and every sangoma composes her own individual collection.

At the beginning of the session, the sangoma lights *imphepo* in a calabash and invokes the ancestors. When the diagnosis part of the session starts, she fetches the bag with the bones and holds it in the smoke that swirls from the smouldering *imphepo*. The sangoma poses a question to the ancestors[18] while she shakes the bag above the *imphepo*, making the bones rattle. She then throws the bones on a mat or a piece of animal skin on the floor, in front of the leopard print cloth behind which the ancestors are believed to dwell. From the position of every individual item thrown and the total composition the sangoma 'reads' the ancestors' message, for they are believed to have arranged the objects in this specific order. Thus, from this display of bones, the sangoma distils the ancestors' answer to the posed question. By pointing out the individual objects and explaining the meaning of their position, the sangoma recounts what the

[18] E.g. what is the problem with this person?

ancestors are telling her through the bones. With every question she repeats this part of the ritual, although the bones are not necessarily replaced in the bag every time; the sangoma can also simply take the bones in her hands and shake them above the *imphepo* while asking the next question.[19] The position of the bones after throwing will give the answer to this question, again the sangoma will point out how to interpret this message. The patient is allowed, even encouraged, to keep asking questions.

The problems patients have when they come to a sangoma are more often than not on several levels, thus the diagnosis must also be multi-layered. The ancestors must be consulted on the physical level, as well as in the spiritual and environmental spheres. Because physical problems are frequently believed to be the result of spiritual or environmental causes, the sangoma must look for possible imbalances in every single domain during her consultation with the ancestors.

At a certain moment during the healing session, the sangoma will ask the ancestors what is needed to heal this patient at this moment. Another throw of the bones will make clear to the sangoma what the next step in the healing process will be. Sometimes, the ancestors indicate that the patient must make offerings to satisfy them: food, drinks, meat, or even live animals may be requested – not just a random chicken or goat; when the ancestors want an offering, it must be a special animal of a symbolic colour (Ngubane, 1977). The patient will bring those offerings when he comes for the next consultation. The slaughtering of the animal will be done by the sangoma or one of her assistants on the compound.

In order to heal their patients physically, sangomas prescribe medicine, which is often ingested straightaway and more is given to take at home, with precise orders on how to prepare it and when to take it. The medication (*muthi*) may be a mixture of diverse natural elements, such as roots, herbs, barks, minerals, fats, snake skin or other dried animal parts, and many other, often symbolic significant elements.

Example of basket divination

To his patient who had swallowing problems, Mks Mkhize (the male sangoma) gave some crocodile fat mixed with pieces of a crocodile's uvula to open up his oesophagus. The patient had been having recurring dreams about a crocodile, therefore the *muthis* that were needed to heal him had to be linked to that animal. During the last part of the healing session, he ingested small bits of the *muthi*, trying hard to swallow it, producing growling noises.

This patient, a young man called Zanimvula,[20] was in great trouble when he came to Mks Mkhize's compound for the first time. He didn't have any luck at all, there was "[…]

[19] E.g. what is the cause of this problem?

[20] Zanimvula (meaning: come with the rain) is not this man's real name. This name was given him when he came to Mks Mkhize's. He indeed arrived when it rained. Mks Mkhize renamed him to protect him from the forces of witchcraft that were after him. When he is outside the gate, he uses his own name, inside the gate he is called Zanimvula, so he cannot be reached by bad spirits. He is a frail, not very confident looking man, about 25 years old.

too much bad luck in him. The police was coming after him, people were opening a case on him, but he didn't know why."[21] The day before he came to Mks Mkhize's he was hurt in a shooting incident. A bullet went right through his foot so he couldn't walk anymore. Mks Mkhize treated his foot with special *muthis*; after a week, the wound was healed and Zanimvula could walk again.

Diagnosing this patient's problem, Mks Mkhize learned that Zanimvula was estranged from his ancestors. Pointing at a specific shell, Mks Mkhize revealed that Zanimvula's problem was that his grandfather was very distant.

To find out what the cause of this problem is, Mks Mkhize threw the bones another time. Now, the bones revealed that Zanimvula's great-grandfather had had a problem in the community. As a priest in a Christian church, he had chased every indigenous healer out of the church, saying it was a demon thing. All the ancestors of those who were chased from the church now come after Zanimvula and give him this bad luck. However, his "great-grandfather is like chained and can't help"[22] Zanimvula. First, the young man must help release his grandfather's spirit, so that, in return, he can help his grandson with his bad luck. This is the cause of the spiritual part of Zanimvula's problems.

Figure 3.4 Basket divination by Mks Mkhize for Zanimvula

The next throw of the bones was accompanied by a question about the cause of the physical part of Zanimvula's problems. Mks Mkhize read the position of the bones and deduced that the ancestors had deliberately made Zanimvula sick. They wanted him to go to an indigenous healer, and even to start the training to be a sangoma himself.

[21] According to Mks Mkhize, explanation of the healing session on 28 April 2014.

[22] Ibid.

Initially, Zanimvula didn't see the need to do that and he neglected the ancestors' wishes. To force him to go, they gave him have HIV-positive symptoms, including trouble with eating. When he eats, the food doesn't go down, it is like his oesophagus is closed. Even after an operation in hospital, his situation didn't improve. It was clear from the way that Zanimvula was sitting during the healing session that he had started his *ukuthwasa* at Mks Mkhize's: on his knees and resting on his hands, a position typical for a *thwasa*.

Mks Mkhize discovers how to heal Zanimvula spiritually after the next throw of the bones. Two white goats must be slaughtered. That offering is the first step, it will set the grandfather's spirit free. Secondly, Zanimvula's home must be sealed so the bad spirits that are after him are unable to enter. In due course, additional offerings will be requested in order for Zanimvula to finish his training and become a sangoma himself.

The topic of the last throw of this session is how to heal the physical problem. From the way the 'bones' are displayed after this toss, Mks Mkhize reads that Zanimvula must ingest some crocodile fat mixed with dried and ground parts of a crocodile's uvula to open his oesophagus. Expecting a better result from these *muthis* than from the operation in the clinic, Zanimvula doesn't hesitate and takes it immediately.

Sangomas use symbolism as an integral part of the healing rituals. An illustration is in the use of colours, some with various meanings in a different setting. Although in general colour symbolism is arbitrary (because it shifts), the meaning of the most used colours has been settled. Red, white, and black are the most important colours in African symbolism. Usually, red refers to danger and heat, white to purity, fertility, and health and black stands for evil and affliction (Turner, 1970; Jacobson-Widding, 1979; Ngubane, 1977). In Zulu healing rituals, green and yellow refer to, respectively, female and male ancestors. The colour blue represents the sky as well as water, but it also refers to elements relating to Christianity. I introduced these features in the 'snapshots' at the start of the first chapter. The lighting of candles at the start and during indigenous healing sessions can also be seen as a symbolic element. I will return to this in Chapter 5.

Muthi is believed to be more powerful and effective when it is used in combination with colours, for example coloured candles, clothes, beads, or strings. Besides the colour symbolism, minerals and specific parts of special animals are also symbolically applied to heal a patient in indigenous healing. This way, certain characteristics of the animal are allegedly transferred to the patient in need. In love potions, pieces of a dried python's skin are mixed with other elements to enable the client to secretly wiggle his way into the heart of the object of his love. Or, whenever a client needs power or speed, the indigenous healer may use parts of a lion in his *muthi* mixture. Crocodiles in general do not have swallowing problems, so when Zanimvula takes some ground parts of a crocodile's uvula it is supposed to solve his complaints.

Once the healing of a patient has started, a continuous diagnosis process is triggered. The sangoma diagnoses to see if the healing is on track and what is needed at that

moment to take the next step in the healing process. The desired offerings are made, *muthis* are prescribed and often actually provided. The next consultation will start again with a diagnosis, to search for remaining imbalances in the three domains: physical, spiritual, and (social) environmental.

Mks Mkhize frequently executes healing sessions with Zanimvula, who had been living at Mks Mkhize's compound for about half a year when we attended his healing session. The sangoma told us that, in the meantime, several of his problems had been solved; that the case against him had been dropped, and that the police were no longer looking for him. His bad luck had diminished and his physical condition had improved immensely, he was feeling much better. Zanimvula is convinced that coming to Mks Mkhize's and starting the training to be sangoma is the step his ancestors wanted him to make. He is determined to stay at Mks Mkhize's and finish his *ukuthwasa* in order to get healed and, more importantly, to comply with the wishes of his ancestors to become a sangoma.

Using essence

The second way of diagnosing is the use of essence, i.e. herbs, to establish a connection with the ancestors and to open up the sangoma's senses for all sorts of signs from the ancestors.[23] A sangoma's consulting session always starts with the burning of essence, *imphepo*, and the lighting of candles.[24] Additional herbs are often used in the diagnosis part of healing sessions. The way these are used depends on the invoked ancestors' preference and on their wishes in this specific situation. The sangoma conforms to the desires of the ancestors.

Many sangomas use snuff in one form or another: some sniff it as a powder or in a liquid form; others take snuff in their mouth or sprinkle it on the burning *imphepo*. At the end of our interview with Mks Ngidi, she fetched some tissues to take something out of her mouth. Bongani Ntshangase explained it was the remains of snuff she had chewed on to open up the communication with her ancestors. Mks Bhengu and Mks Mbuyisa threw some powder snuff on the burning *imphepo*, causing an incense odour in the consulting room. In his own healing practice, Bongani prefers snuff in liquid form, which he sprinkles on the floor. He wants his body to stay clean – he doesn't smoke or drink alcohol – therefore he doesn't take snuff either, because he considers it more or less mind-expanding. He admitted that he had spent some time negotiating this stance with his ancestors, but in the end they agreed.

At the start of the healing session, candles and *imphepo* are lit. As the flames get smaller, smoke spirals up from the smouldering *imphepo*. The sangoma invokes the

[23] This way of diagnosing is referred to in different ways, e.g. ecstatic divination, intuitive divination, and inspirational divination.

[24] White candles are always used, but, depending on the sort of consultation, yellow, green, red, and blue candles will be lit too.

ancestors by praising them and mentioning the names of many previous generations, ultimately asking them for their help with the patient. In the meantime, the above-mentioned special herbs are added to the *imphepo* or used in another way by the sangoma. After a short while, the ancestors signal their presence[25] and then they start to communicate with the sangoma.

Sometimes, this communication is through the patient, as we witnessed in Mr Mbele's healing session described at the start of this chapter. Typically, the patient is sitting on the floor with his legs in a V-shape in front of him, to be in a steady position.[26] The patient, his eyes closed, tells the sangoma what he sees and hears, as the sangoma (not experiencing the same things) asks the patient to tell her what is happening. She must understand the ancestors' message from his answers, in order to be able to interpret it correctly and to continue the healing process in the desired way. When she has received enough information, or when the ancestors decide to stop the communication, the sangoma will end the session by thanking the ancestors for their help. While the patient recovers from his altered state, she tells him what has happened in the preceding process. There is ample opportunity for the patient to ask the sangoma questions about the things he experienced.

Generally, however, the ancestors communicate directly with the sangoma, who is beside her patient. Both the sangoma and the patient sit on their knees, facing the leopard print cloth, behind which the ancestors allegedly dwell. The ancestors make clear to the sangoma what the cause of the patient's problem is and what is needed to heal the patient. Sangomas refer to this part of the session as 'listening to the ancestors', but the telling is not only in words, the ancestors also use symbols and images to clarify their message to the sangoma. It is therefore of the utmost importance for the sangoma to have an open attitude, be perceptive, and be receptive to the (whole) message. Patient and sangoma are sitting side by side, quietly and concentrated. When the message of the ancestors is clear to the sangoma, she must interpret it and explain to the patient what the cause of his problems is. In these cases, the patient is allowed, even encouraged, to ask questions about the message the sangoma has received. The sangoma will answer these questions and give the patient advice, partly based on what she has just experienced and partly based on her expertise. In their message, the ancestors include the cause of the patient's problems and the prescription of medication. The interpretation that the sangoma passes on to the patient is followed by the explanation of the rituals that he has to perform and the *muthi*s that he must take to be healed. Subsequently, the sangoma gives these *muthis* to the patient with a prescription for how to prepare and use them. A major part of the (many years of) sangomas' training

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[25] For instance, in the sangoma's belching, yawning, or snoring.

[26] Mks Zinhle told Mr Mbele to sit like this when he approached the mat in front of the leopard print curtain. Bongani explained the ancestors had told Mks Zinhle in advance they were to communicate through Mr Mbele in this session.

is concentrated on exactly this part of (healing) sessions, i.e. having a receptive mind for any communication from the ancestors, interpreting this communication correctly, having the necessary skills to perform rituals and the knowledge of (herbal and mineral) medicines to cure patients physically and mentally. Mlisa describes the training to become a sangoma (in Xhosa: *amagqirha*) extensively in her doctoral thesis (2010) and in non-academic literature like Arden's (1996) and Hall's (2009) autobiographical writings this part of *ukuthwasa* is portrayed in glowing terms.

Example of using essence

At Mks Gasa's we were allowed to also be present at healing sessions in which the ancestors communicated directly with the sangoma. In one case, a young family with their three-year-old son, let's call them the Dladla[27] family, came for healing. A male, almost-graduated *thwasa*, called Mngadi,[28] acted as the sangoma. On the left side of the rondavel, her back leaning against the wall, Mks Gasa sat on a reed mat, supervising Mngadi's work, interjecting every now and then to remind him of something, or to ask him about his actions. After the family entered the rondavel and sat down on the reed mat facing the leopard print cloth, the woman draped a shawl around her hair. She looked indifferent, depressed even, her facial expression and her movements were despondent . The man looked serious and worried. Mngadi, while gently explaining to the man and the woman what was going to happen, put *amabhayi* (cloths) around their shoulders. A white candle was lit, the *imphepo* set alight, and Mrs Dladla sniffed a bit of snuff.

At that moment, another *thwasa* came in with two white chickens. Both the man nd the woman took one in their hands. Because this was a couple, both the man's and the woman's ancestors had to be communicated with, hence there were two chickens, one for each ancestral side. It was decided Mrs Dladla would 'talk first' and that in today's healing session her ancestors were to be consulted. Mngadi started to invoke the ancestors, the woman joined him in praising the ancestors and asking them to connect with her family. Then Mngadi took the chickens, held them over the smoking *imphepo* one by one; in the meantime, he talked to the ancestors, dedicating the animals as offerings to them. He plucked a small feather from each chicken and placed it in the dish with the smouldering *imphepo*. The assisting *thwasa* entered again and took the chickens outside, where they would be slaughtered a few minutes later. Mngadi bent over the smoking *imphepo* and briefly communicated with the ancestors again.

[27] Not their real names.

[28] Not his real name.

Figure 3.5 Healing session Dladla family, notice the white chicken

Next, the family and Mngadi moved to a reed mat facing the right side of the rondavel, taking the burning candle and the *imphepo* dish with them. On the wall they now faced was a blue dress with a white cross and in front of the mat they sat on was another reed mat, covered with a white tablecloth with blue crosses stitched on it. On top of this tablecloth Mngadi had, before the start of the session, displayed all kinds of food and drinks in a systematic and attractive way: cakes; potato chips; sweets; fruit; raw meat; sweet potatoes; a bottle of Sprite; a bottle of Coca Cola; and a jar of Zulu beer. To complete the display on the table, Mngadi lit candles in different colours.[29]

Mngadi, the woman and the man alternated in saying prayers, in which the name of Jesus was often mentioned, and Mrs Dladla took another sniff. After a few minutes of silence, the *thwasa* started to explain what the message from the ancestors was; what was causing the family's present problems. Mrs Dladla and Mngadi got into a conversation that ended in a joint prayer. During the whole procedure, the small Dladla boy was walking in and out of the rondavel. The father took care of his son, his mother did not pay any attention to him at all.

The other *thwasa* brought a glass of water; Mngadi took it and sprinkled some water on the couple, their son, the offerings, and threw some drops over his shoulder. Then, he left the consulting room and the assisting *thwasa* entered with three plates; she seated herself next to the couple, in front of the offerings on display. On each plate she put a bit of the cakes, sweets, fruits etc., and she invited the woman, the man, and

[29] A yellow one for the male ancestors, a green one for the female ancestors, a blue one for the (Christian) spiritual ancestors. The last candle to light is a red one for danger, for fighting the evil spirits.

the child to eat of their offerings. This female *thwasa* took the sweet potatoes and the raw meat with her out of the rondavel. Mngadi then came back to the family and gave some *muthis* wrapped in paper, telling them the prescription, how to prepare and when to use it. While they ate of the offerings on their dishes, both the woman and the man sat in silence, contemplating, reflecting on the ancestors' message that Mngadi had conveyed. The father fed his son and the parents remained seated until all three plates were empty. In this period of silence, the family finalised the healing session and the connection with the ancestors.

This healing session was very interesting in more than one way. The Dladla couple came for healing to Mks Gasa's because they wanted to lift their level of happiness. Mr and Mrs Dladla were clearly not a happy couple and both of them were suffering in this regard.

In a previous healing session, the ancestors had made clear that the root cause of the problems was to be found in Mrs Dladla's history. Before her marriage, she had been called to become a sangoma and she had completed her *ukuthwasa*; she had graduated and had even started to practise as a sangoma. For whatever reason, she had decided to stop practising and ceased to live according to the strict rules[30] that are associated with being a sangoma. This meant that she had turned away from her ancestors; the ancestors were displeased and subsequently had stopped watching over her. The connection between her and her ancestors was broken. Mrs Dladla was aware of their disappointment and hence she felt unhappy and depressed. This depression is reflected on her husband, their son, and their family life. This was the diagnosis for the family.

To break through this miserable situation, the connection between Mrs Dladla and her ancestors had to be repaired. The ancestors asked for offerings, so to please and appease them the Dladla family brought things with them to their session that all ancestors like, including Zulu beer, sweets, and animals for slaughter.

[30] E.g. regarding purity and food requirements.

Figure 3.6 Offerings for the ancestors

At the end of the healing session, after finishing the food on her plate, Mrs Dladla looked somewhat uplifted; she paid attention to her husband and her son and when they left the consulting room she smiled and greeted all the people present.

The fact that Mrs Dladla has been a sangoma herself may explain her active role in the healing session. Though initially she seemed absent, when *thwasa* Mngadi started the healing session she quickly joined him in invoking and praising the ancestors, an action that we had not seen from any other patient during their healing process. The fact that she was a former sangoma may also explain Mrs Dladla's habit of taking snuff during the healing session, we also did not witness any other patient doing this.

For patients who are Christians, or whose ancestors were Christians, the healing session holds another chapter, as witnessed during this healing session and a few others that same afternoon at Mks Gasa's. These sessions all followed the same pattern; after the usual start (which includes invoking the ancestral spirits), while facing the leopard print cloth, the patients and the *thwasa* turned to another side of the rondavel, now facing a blue dress with a white cross stitched on it. On that spot, the Christian spirits were invoked much in the same way as the ancestral spirits were, although obviously the words were different. Whereas one of the keywords in the ancestral praises is '*makhosi makhulu*',[31] in the prayers to the Christian spirits the word 'Jesus' was frequently used and these prayers were invariably closed with the word 'Amen'. More about the syncretism between indigenous healing and religion in Chapter 5.

The couple's offerings (the chickens, cakes, drinks, etc.) were dedicated to the ancestors, both Christian and non-Christian. The patients themselves have to eat and drink from the food and the drinks, to show "this is what we offer and we can also eat it,

[31] A respectful form of addressing the ancestors.

it is not poisoned, it is safe."[32] As we saw with the Dladla family, the consumption of the offerings at the end of the healing session is a time for reflection and contemplation. They 'chew' on the ancestors' message, letting it sink in, digesting it together with the food. When patients have finished their plates, half of the offerings are put in bags and given to the patients to take home. The other half of the offerings are for the ancestors, personified by the sangomas, their *amathwasa*, and their staff. The offered animal is also cut into two halves, one for the patient to take home, the other half for the ancestors. The patients also take the candles that are used during the healing session, in order to burn them again at home, thus continuing the process. Only one white candle is left to burn in the consulting room, to secure the continuation of the healing process in this place as well.

The whistling sounds

The third method used by sangomas to diagnose is referred to as 'interpreting the whistles'. After the start of the session, when the ancestors are invoked and praised, sometimes the ancestors make clear to the sangoma that they want to "do the talking themselves," as Mks Mbuyisa described it in the interview. She explained that, in those cases, she can hear whistling and speaking behind the curtain in her consulting room. It is up to her to interpret these words to the patient. In Mks Bhengu's consulting room (Z: *indluhlola*), the whistling can be heard in the top of the hut on such occasions, but it is not always that the ancestors talk in whistles, sometimes they communicate through crackling noises in the roof. In those cases, Mks Bhengu knows how to interpret these sounds, because of her connection with the ancestors and because of what she learned from her *gobela*. At Mks Gasa's, the ancestors are believed to use various sounds to make their message clear, including whistling sounds in the top of the consulting room, the sound of someone strumming a guitar, and the sound of someone blowing a trumpet.[33] Mks Gasa and her daughters, Mks Zinhle and Mks Dudu, interpreted those sounds and explained their meaning to the patient involved. Similar to other methods of diagnosis, the patients were encouraged to ask questions and, at times, the sangoma gave her patients some advice and she usually gave them *muthis* to take home.

The kind of method for diagnosis that a sangoma uses in a consultation depends first and foremost on the preference of the sangoma's ancestors. As described above, the ancestors make clear to the sangoma the way in which they want to communicate. This is not just a matter of what mood the ancestors are in, there are other elements involved, e.g. which ancestors you have invoked. Mks Ngidi told us she is able to use two methods for diagnosis, 'throwing bones' and 'using essence'. She generally uses

[32] As Bongani explained to us. In Zulu culture, it is common use to take something yourself of the offerings (food and drinks) you give to others, e.g. visitors, as a sign of your good intentions, that it is safe to eat and drink.

[33] Some of these sounds were even audible for the innocent visitor.

the essence because the ancestors from her mother's side are Zulu and they prefer her to use this method. These ancestors are more important, more powerful to her. The ancestors from her father's side, however, are Swazi, they prefer her to use the bones for diagnosis.[34] So, although these ancestors are less powerful for her, she sometimes throws the bones to include them in her healing practice.

The different methods of diagnosis reflect successive stages in the competence of the sangoma. Mks Dudu (Mks Gasa's older daughter) explained that throwing bones is the first step in learning to diagnose during *ukuthwasa*. She is the one who teaches this part of the training to the *amathwasa* at Mks Gasa's compound. The second step in diagnosing is using the essence. This is sometimes part of the training but could also be an upgrade for a sangoma after her graduation. In the interviews in 2012, Mks Bhengu and Mks Mbuyisa suggested there are three stages in diagnosing for a sangoma. First, you learn to throw bones; secondly, you learn to use the essence and it may happen that the ancestors want you to develop to yet another level; thirdly, you will learn to interpret the whistles. In the transition from one level to the next, the very same illness the sangoma experienced at her calling, is involved. At the start of every consultation, the ancestors specify their preference within the limits of the sangoma's capability.

3.2.3 The closing

When everything is clear to the patient, the healing session comes to an end. The sangoma thanks the ancestors for their presence and their help on behalf of all people present, citing their names just like she did at the start of the healing session. One may notice the withdrawal of the ancestors in the sangoma's yawning or belching again. Generally, patients stay in the consulting room for a while after the healing session is closed, they take their time to recover from the deep concentration during the whole procedure. Often, the patient seats himself against the wall of the room, leaning against it, relaxing, talking with the sangoma about the things that he experienced. After a while he leaves, knowing what the next step in his healing process will be.

Having described these various parts of healing sessions, the picture is not yet complete. Up to this point, the description has focused on healing sessions executed in the consulting room in the sangoma's compound. But in order to heal a person, to establish a balance in the three domains,[35] it is sometimes necessary to perform healing sessions at other locations, in other settings. These are places connected with the ancestors of the patient or with the root cause of the patient's problems. We witnessed this in our second meeting with Mr Mbele.

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[34] As is more common among the Swazi, according to Mks Ngidi.

[35] Physical, spiritual, and environmental.

3.3 Mr Mbele's healing, part two

A week after we attended Mr Mbele's healing session, described above, we met him again at Mks Gasa's compound[36] when he came for a follow-up session. The previous day, Mks Zinhle had called to invite us to the compound again, so that we could attend a special healing procedure at a special location – where the river meets the sea. On that long sunny Saturday, I gradually became aware of the interpretation of the ancestors' message and the implications of the things Mr Mbele had experienced the week before.

3.3.1 At the compound

We arrive shortly before noon and enter the consulting room after taking off our shoes and tying an *ibhayi* (cloth) around our waists. In the consulting room, Mks Gasa warmly welcomes us and invites us to sit down. We seat ourselves on the same spot where we sat last week, on the right side of the door, our backs against the wall. To the left of the door, Mks Gasa sits on her mat, also with her back against the wall. There is a lot of activity at the compound this afternoon; new patients arrive all the time, they take their seats in a waiting room, where a TV is tuned to one of South Africa's popular channels. Patients enter the consulting room, some for a healing session led by an advanced *thwasa*, some just to greet Mks Gasa and to give her their offerings. There are constant sounds of mobile phones and the answering of calls. *Amathwasa* wander in and out of the consulting room, fetching things from behind the leopard print cloth, rearranging reed mats on the floor, or bringing drinks to us, the visitors. A young sangoma, let's call her Ntombi,[37] enters the consulting room frequently to stir *muthi* in a bucket, to take it outside, and to reappear after a short while to stir the *muthi* bucket again. Everyone seems to have their own chores and responsibilities and they all act accordingly. It gives me the impression of a well-oiled operation.[38]

When one of the healing sessions has come to an end, Mr Mbele enters the consulting room. He greets Mks Gasa, the ancestors (represented by the leopard print cloth), and the other people present. He takes his time to talk to a few of them until the moment Mks Zinhle calls him to come outside, then off he goes. In the meantime, a woman, who turned out to be Mrs Mbele, has seated herself next to Mks Gasa. The elder sangoma talks reassuringly to her, but Mrs Mbele shakes her head with tears in her eyes. After about half an hour, Mks Zinhle calls her to come outside as well. Some two hours later, we meet Mr Mbele at the back of the compound, when he comes out of another building, where he has been in a dressing room getting dressed for the coming

[36] 3 May 2014.

[37] Not her real name.

[38] For the way Mks Gasa runs the healing practice on her compound, see Chapters 4 and 6.

procedure, according to the desires of the ancestors he heard last week. His shirt and shorts have been exchanged for a 'traditional' Xhosa attire, a white robe with a few thin black stripes. On his head is a band of white and blue beads. He is holding a gold-coloured knobkerrie and one with white and blue beads.[39] Hanging around his neck is a long white and blue beaded necklace, across his shoulders is a real leopard skin, the claws still on the paws.

Figure 3.7 Mr Mbele greeting the ancestors

Figure 3.8 Mr Mbele dressed up for the session and Bongani

He walks proudly and barefoot to the *indluhlola*, followed by Mrs Mbele who has also changed her clothes. Her fashionable dress and high heels have been replaced by two brown-and-white chequered *amabhayi*, skilfully tied around her body, and flat sandals. Around her neck she wears a multi-coloured beaded necklace, a headband in the same print as the *amabhayi* completes her outfit.

Mr and Mrs Mbele are not the only ones that are dressed up for the occasion, Mks Gasa, Mks Dudu, Mks Zinhle, Mks Ntombi and several of the *amathwasa*, including the male *thwasa* Mngadi, have changed their clothes for freshly ironed *amabhayi* and colourful skirts. Mks Zinhle wears a white scarf around her hair; on top of it is a black hat, around the hat a fur crown with a 'tail' at the back reaching to her shoulders. Mks Dudu wears a single-layered beaded crown (Z: *umnqwazi*) on her head, Mks Gasa a red scarf. Judging by the way everybody has dressed up, we assume that the remaining sessions of today's healing procedure are a special occasion.

> In preparation for the process on location, a short function must be conducted in the consulting room. Mrs Mbele, still looking sad and worried, sits close to Mks Dudu while Mks Zinhle, who sits next to Mr Mbele on the mat in front of the leopard print cloth, takes the lead and puts a handful of *imphepo* in the silver dish.

[39] White and light blue are the colours of the Xhosa.

Figure 3.9 Mrs Mbele (centre) between Mks Ntombi and Mks Dudu (l)

In front of Mr Mbele is a white bucket, wrapped in a white cloth; on top of this bucket's lid are about fifteen silver coins. Mks Zinhle sticks five candles (blue, red, yellow, white, and green) to the floor and then she puts an *ibhayi* around her shoulders; she is ready to start this part of the session. She does so by lighting the yellow candle and the *imphepo*, then she invites Mks Dudu to light the green candle, Mks Gasa to light the blue one, and Mr Mbele himself to light the red and, ultimately, the white one. For each candle they use a separate match, which, after the candle is lit, is extinguished and thrown in the silver dish with the smouldering *imphepo*.

Figure 3.10 Start of the healing session

> Then, Mks Zinhle starts to invoke the ancestors by praising them. She introduces all people present and asks the ancestors for their guidance and help. In the meantime, many *amathwasa* have arrived in the *indluhlola* and everybody supports Mks Zinhle's praises by repeatedly saying "*Makhosi*". Mks Zinhle then takes the lid from the bucket and starts to stir the muthi inside until the foam spills over the rim, all the while continuing to praise the ancestors. The foam rises quickly, an indication of the connection with the ancestors. When Mks Zinhle stops stirring, Mr Mbele takes a few hands full of the foam and eats it, the last handful of foam he smears on his head. This part of the procedure is finalised after about twenty minutes with everyone in the consulting room praising and thanking the ancestors.

It is time to go to the cars. In a cheerful procession, everyone walks outside, singing, dancing, and ululating. Mks Zinhle walks ahead carrying the white bucket on a dish. Immediately behind her are Mr Mbele with the burning candles in his hands, Mrs Mbele, *thwasa* Mngadi, Mks Gasa, and Mks Dudu followed by the *amathwasa*.

Figure 3.11 In a procession to the car, Mks Zinhle leading

Mks Gasa, Mks Ntombi, Mngadi, and about eight *amathwasa* get into a minibus. Mr Mbele, his wife, Mks Zinhle, and Mks Dudu get into Mr Mbele's car. We also get into our car, eager to see where our destination is, where the next step in this healing process will take us. We become even more intrigued when our first stop is at the petrol station to fill up our fuel tanks, because, as Bongani explains, "we don't know where the ancestors take us."

Figure 3.12 *Amathwasa* dressed up for the occasion

3.3.2 At the beach

About three hours later, in complete darkness, we are walking on a beach, at a location where the river meets the sea. It is here, some 130 kilometres south of Durban at the Mtamvuna River estuary, under a star-strewn sky that the healing process will continue. Right here, because this river indicates the border between KwaZulu Natal and the Eastern Cape Province, the border between the land of the Zulu and the land of the Xhosa.

Figure 3.13 Map KwaZulu Natal, map by Yde Bouma.
Used with permission
©Gottmer Uitgevers Groep

This is an excellent place to invoke and connect with Zulu and Xhosa ancestors. Especially because the spirits of the ancestors are believed to dwell at the waterside at the end of the afternoon, around sunset. They supposedly bathe in the water every day, to be clean for when they visit (in dreams) the sangomas in the evening.

Water plays an important role in the sangomas' healing practice. Be it in the form of the sea, a lake, a river, or a waterfall, water is used to cleanse and to strengthen patients, *amathwasa*, and sangomas. Water is always connected with the spirits of the ancestors and therefore sangomas are often to be found near water. There is ample opportunity for the sangomas in the Durban Metro district, adjacent to the Indian Ocean. Occasionally, in this area NUPAATHPSA arranges trips to the beach for sangomas to empower them, to give them the opportunity to be close to the ancestral spirits and to be filled with spiritual power.

On many occasions during the 2012 interviews, we heard about recurring dreams of sangomas singing, drumming, and dancing near a river. Those dreams were the start of the calling to become a sangoma for Mks Bhengu, Mks Mbuyisa, and Mks Ngidi. Some sangomas, like Mks Mbuyisa and Mks Mgadi,[40] related an important event during their *ukuthwasa*. Both of them told of an old lady, calling them to come into the river. When they followed that lady and indeed went into the water they found there was "another world under the water, where they could breathe, eat, drink, sleep and learn."[41] Mks Mbuyisa and Mks Mgadi claim to have been in this world for several months, until they were told to go back to their family (Mks Mgadi) or to the *gobela* (Mks Mbuyisa).[42] They referred to this time as an important, valuable period in their training and talked about it with affection.

Having arrived at the Mtamvuna River estuary, south of the city of Port Edward, this location seems logical, but initially nobody knew exactly where this trip would take us. While driving from Durban to the south, the sangomas have constantly been communicating with the ancestors, asking for their guidance about where to go. Mks Dudu called it "the ancestral GPS." Especially in the last part of the trip we had to stop many times, turn around and get onto another bumpy (gravel) road. Now we have arrived, some 130 kilometres south of Durban, on the beach in the dark. In our left ear is the sound of the rolling waves of the Indian Ocean, in our right ear is the sound of the murmuring water of the river. It is a very special place. Even though this session that is about to start should be performed when the sun is setting, nobody minds the darkness. When light is needed, they use their mobile phones as torches.

Mks Zinhle carries the bucket on its dish and selects a spot near the riverside; the *amathwasa* lay several *amabhayi* on the sand for people to sit on. On the one with a

[40] I met with Mks Mgadi in March 2012 in the preliminary trip of the field study, see Chapter 2.

[41] Mks Mbuyisa, 9 August 2012.

[42] Bongani Ntshangase had a similar experience of going into the water, staying in that 'other world' for about a week before his gobela came to fetch him.

leopard print, Mks Zinhle, Mr Mbele, and his wife kneel down, like everybody else on the other *amabhayi*. Mks Zinhle digs a small pit in the sand and places *imphepo* in it, she puts the coloured candles in the sand and lights them. This lighting of the candles and, later, of the *imphepo* takes some ingenuity because of the wind. But with a little help from the other sangomas who try to block the wind with their bodies, Mks Zinhle succeeds and soon all is set to continue the procedure. Mks Gasa comes to Bongani and asks him to participate as a sangoma in this session and therefore to put an *ibhayi* around his shoulders as well. She expects there will be many ancestors, so the sangomas can use all the help they can get in carrying the weight of the ancestors in the next part of the process. Although Bongani initially joined this event as a bystander, Mks Gasa appeals to his professionalism and asks him to participate as a sangoma. He agrees and puts an *ibhayi* around his shoulders; from this moment on, to the end of the session on the beach, his plays an active role in the ritual, supporting Mks Zinhle.

Figure 3.14 Help to light the imphepo in spite of the fierce wind blowing

Mks Zinhle puts the bucket, with the silver coins on the top, and Mr Mbele's knobkerries in the sand, beside the burning candles. Mks Zinhle and Mks Gasa start the invocation by alternately praising the ancestors, introducing all the people present to them, and asking in a very persuasive way, urging them, to grant their presence and help. After closing the invocation, Mks Zinhle asks a few of us for a silver coin, to throw into the river as an offering for the ancestors. Then, she takes the lid off the bucket and starts to stir the *muthi*, praising the ancestors. Soon, the foam reaches the rim of the bucket and, moments later, it is tumbling over the rim. Mr Mbele again takes a few handfuls of foam to eat and one to smear on his head, just like he did back in Mks Gasa's consulting room.

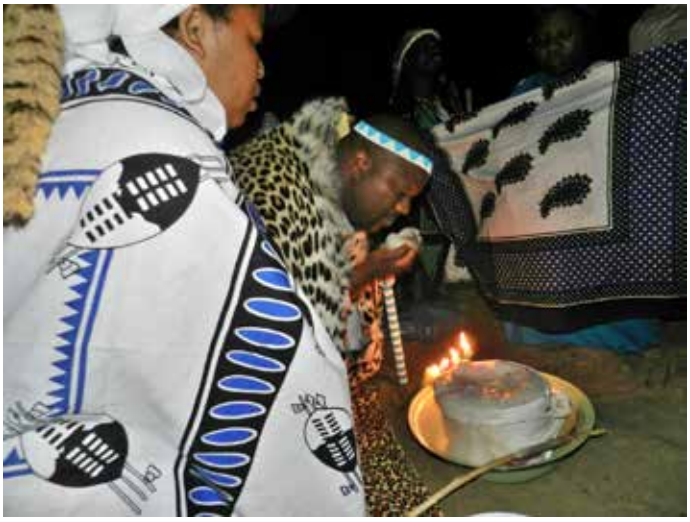

Figure 3.15 Mr Mbele eats the foam

From the moment Mks Zinhle selected the spot at the riverside, the *amathwasa* have been continuously singing and dancing, calling and praising the ancestors. Quite soon, there are signs of ancestral presence; a *thwasa* yells loudly, another one shouts, and the sangomas yawn, snore, and belch. The male *thwasa*, Mngadi, repeatedly shouts in the direction of the sea and towards the other side of the river. In the silence of the evening, the echoes come rolling back on the dark waves of the water; it sounds just like someone on the other side is answering.

The singing, shouting, and dancing continue. They intensify and are supplemented with blowing whistles and flutes as the healing session reaches its climax. Everyone is in high spirits as Mks Zinhle, Mr Mbele, Mks Ntombi, Bongani, and Mngadi rise and walk towards the river. Mks Ntombi (the extra sangoma) and Bongani stay near the water's edge, the other three enter the water and walk a few steps, up to a point that the water is well over their ankles. To go any further into the water, as is usually done, is too cold and too dangerous in the dark. Before entering the water, Mks Zinhle has asked the ancestors' permission to just go in with their feet. While standing in the river, Mks Zinhle again starts to invoke the ancestors and Mr Mbele takes the bucket to pour some of the contents into the water. Mks Ntombi and Bongani support the group in the water by giving them light with the torches on their mobile telephones. The rest of the group, including Mks Gasa, Mks Dudu, and Mrs Mbele, remain on the sand, near the *amabhayi* and the burning candles. Mks Dudu stays close to the still tense and worried-looking Mrs Mbele, to explain what is going on and support her if needed. The *amathwasa* continue their singing and dancing in the background.

A few moments later, on Mks Zinhle's signal, Mr Mbele holds the bucket in the water, to let some water slip into the bucket. Then, walking slowly as if bearing something on their shoulders, the small group returns to the beach, where they take their positions on the *amabhayi* and Mks Zinhle again starts to communicate with the ancestors while stirring the *muthi* in the bucket. When the foam has reached the rim once more, they slowly rise to walk into the river again. Now, Mr Mbele, holding his knobkerries in his hands, is shown

by *thwasa* Mngadi how to swipe them one by one through the water. When this is done, they walk back towards the rest of the group and sit down on the beach near the burning candles and join in the songs.

Figure 3.16 Again stirring the *muthi*

Coming to the end of this part of the procedure, Mks Zinhle again stirs the *muthi*, thanking the ancestors for their presence on behalf of all the people present (whose names she mentions again) and asking them to protect and guide Mr Mbele. Mks Zinhle gives the knobkerries, the white bucket, and the burning candles to Mr Mbele and together they lead the singing and dancing procession back across the beach to where the cars are parked. From the moment they first came out of the water, until much later that evening in Mr Mbele's house, the sangomas and Mr Mbele move like they are heavily laden, carrying (the weight of) the ancestors on their shoulders.

3.3.3 Like the granny said

Up to this point, we have encountered many elements that Mr Mbele saw last week during his previous session, when an old lady told him about his unknown Xhosa ancestors. The white striped dress Mr Mbele is wearing today was shown to him, including the colour and the pattern of the beads in the necklace, knobkerrie, and headband. The leopard skin Mr Mbele has wrapped around his shoulders looks like the apron he was told about.

The implications and the interpretation of last week's event become clearer in today's follow-up to Mr Mbele's healing process. Mr Mbele has been neglecting his Xhosa ancestors; he was even ignorant of the fact that his Xhosa great grandfather had been a Xhosa king. Consequently, the ancestors are disappointed, angry, and not looking after him. By fully dressing up in indigenous Xhosa attire and coming to the Mtamvuna

estuary at sunset, he has come to the place where his ancestors were assumed to be, dressed in clothes the ancestors will recognise. In doing so, and by bringing his offerings (silver, white coins) Mr Mbele shows he wants to make amends with his ancestors. He thus hopes and expects to please his Xhosa ancestors, to persuade them to connect with him and look after him.

The ultimate aim of this part of the process is to pick up the spirits of Mr Mbele's ancestors and to take them to his house. Therefore, in the procedure at the waterfront, the sangomas invoke the ancestors by stirring the *muthi*, praising and singing, dancing and whistling. Sometimes, when the ancestors are not responding fast enough[43] to the invocation, sangomas and *amathwasa* try to please and activate them by singing, dancing, whistling, and drumming.

At Mks Gasa's compound, Mks Zinhle had stirred the muthi in the white bucket to connect with the ancestors for the first time, here at the riverside she stirred the *muthi* again to strengthen the connection. At a certain moment, Mr Mbele, while standing in the river, pours a part of the stirred *muthi* into the water as an offering to the ancestral spirits. A few moments later, some river water is drawn into the bucket, to take to the next part of the healing procedure. The spirits of the ancestors are believed to be transported in the river water and hence join the patient on his journey.

The second time Mr Mbele went into the river, he carried his knobkerries. On the instructions of *thwasa* Mngadi, he bowed a few times and swiped the knobkerries through the water, first the beaded one, next the golden one. At this stage, the knobkerries are a symbol of a weapon. While bowing he asked the ancestors to protect him and to cleanse his weapons, thus, according to Bongani, by washing the knobkerries, he is actually performing a cleansing process.

We have not yet dealt with a number of issues that were raised in Mr Mbele's previous session. The ancestor that appeared in the session, the old lady, told him about a function that needed to be done in his house, involving a special chair and a prayer place with a two-coloured bottle. There was some confusion about in which house this was meant to take place because the old granny said she did not approve of any of Mr Mbele's houses. Mr Mbele and his mother were quarrelling about his first house and the ritual was not to be carried out in the other house. Reading between the lines, the sangomas interpreted this as meaning that a third house had to be bought and Mr Mbele has done exactly that in the past week. It had to be done quickly because the old lady also demanded Zulu beer at the ritual and, according to her instructions, the brewing of the beer had to be started last Tuesday. Zulu beer needs to ferment for three days before it is ready for consumption, which explains the timeline – this part of the healing session exactly one week after the last one.

[43] Some ancestors are 'too lazy', Bongani said.

3.3.4 At Mr Mbele's house

After a trip along dark and foggy roads, it is almost midnight when we arrive at today's final destination, a farmhouse on a hill outside Pietermaritzburg. This is where the last part of today's healing procedure will take place, the house Mr Mbele purchased only a few days ago. We park the cars behind the house and everybody gets out and lines up in a procession near the door. There is a stiff, cold wind blowing, the *amathwasa* (most of whom are scantily dressed) huddle together. On Mks Zinhle's signal, the *amathwasa* start to sing and immediately a group of young women, who were waiting for us inside the house, joins them in the praise songs. Mks Zinhle takes the lead, carrying the white bucket, Mr Mbele is behind her with the burning candles and his knobkerries. Singing loudly, everybody walks inside, through a corridor towards the main bedroom. Next to the bed is a prayer place. There is a white cloth on the floor and on it is a plate with silver coins, a feather, a few bottles with alcoholic drinks, a calabash with Zulu beer, and a chair covered with a leopard skin. There is another leopard skin on the floor and Mr Mbele and Mks Zinhle kneel down on it, in front of the prayer place. Mks Zinhle puts the burning candles and the dish with the *muthi*-filled bucket on the floor in the centre of the prayer place, then she lights some *imphepo*. The other sangomas and *amathwasa* kneel down in the bedroom and while Mks Zinhle and Mr Mbele talk softly, their singing goes on for several minutes.

Figure 3.17 In Mr Mbele's bedroom

The *amathwasa*'s singing is meant to do more than invoke the ancestors. Sometimes, singing is also used to prevent others from hearing what is said between patient and sangoma. It is a way of guaranteeing the privacy of the patient because the conversation between sangoma and patient is strictly confidential.

In a corner of the bedroom, Mr Mbele's mother is sitting on a pile of cushions. On our way to this farmhouse, our convoy stopped in one of Pietermaritzburg's well-off districts to pick her up. She is present because the aim of this part of the healing process is to resolve the family quarrels about Mr Mbele's houses. Initially, she looks on sternly, keeping herself aloof. In the course of the process at Mr Mbele's house her attitude changes, increasingly she seems to approve of the things occurring, so much so that, in the end, she looks like she is really enjoying the whole event.

Mr Mbele's mother is not the only person we picked up on our way here. At the start of our trip from the beach to Pietermaritzburg we stopped at a gas station, where a Xhosa sangoma, Mks Masingo,[44] was waiting for us. Mks Zinhle had arranged for her to join us on this last part of Mr Mbele's healing session, to emphasise his Xhosa roots and to please his Xhosa ancestors.

> While she talks softly with Mr Mbele, Mks Zinhle removes the lid from the bucket and she starts to stir the *muthi*, invoking and connecting with the ancestors, again. Soon, the foam spills over the rim of the bucket. Mr Mbele eats a few handfuls of the foam and gently rubs one handful on his head. Several praises and songs follow and during the songs Mr Mbele and Mks Zinhle continue to talk quietly. Then, for the first time in this process, Mr Mbele, talks aloud, saying a prayer,[45] encouraged and supported by the sangomas and *amathwasa*, who repeatedly say '*Makhosi*'. After mentioning all people present, he thanks the ancestors for coming to his house, asks for their long-lasting presence, protection, and guidance, and then he thanks the ancestors for having his mother here in this house at this moment. Mks Gasa continues the prayer, reiterating the gratitude for the ancestors' presence and the hope that they will stay with Mr Mbele and protect him and his house. To mark the end of this part of the healing session, a song is started again. Mr Mbele throws a bit of powdered snuff into the *muthi* bucket, on the burning candles, and around the prayer place as an offering for the ancestors. At the end of the song, Mr Mbele points at the ceiling, there is a green insect like a big grasshopper, a '*gogo*'.[46]

As soon as the singing is done, Mr Mbele's mother starts to talk; she thanks Mks Gasa, Mks Zinhle, and the others for their presence and for taking care of her son. She says she is glad she has witnessed this procedure and hopes her son will be blessed and wishes him well. Next, Mr Mbele invites us to the dining room where food and drinks will be served. Before we leave the bedroom, Bongani explains to us that the appearance of the '*gogo*' signals that the invoked ancestors (from the female side) have arrived in the house. Meanwhile, Mr Mbele's brother and his wife have arrived, too. This healing is indeed a social process (Van Beek & Blakely, 1994).

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[44] Not her real name.

[45] The process of sangomas talking to the (spirits of the) ancestors is also referred to as 'praying'.

[46] *'Gogo'* is the Zulu word for a maternal great-grandmother. To indicate the reference to the ancestors from the mother's side this grasshopper is thus called a *'gogo'*.

Figure 3.18 Mr Mbele and his mother in the bedroom

This is a big house; the curtains, the furniture, everything is big, new, and expensive. At first sight it seems to be a normal house occupied by a family, but a closer look reveals that this is not entirely the case: the cupboards are empty and price tags are still on decorations. In the kitchen, about five women are preparing food and drinks, they turn out to be *amathwasa* from Mks Gasa's compound. Because of the tight time schedule, Mr Mbele had not been able to arrange for pots, pans, and cooking utensils, so Mks Gasa offered her assistance and arranged for the catering.

When we arrive in the dining room, it becomes clear to us that there is yet another part in this healing procedure. The *amathwasa* have taken huge plastic bags from the car, out of which they get two drums and several anklets with tinkling metal pieces. Mks Zinhle and *thwasa* Mngadi beat the drums and the *amathwasa*, with the anklets on, start to dance in a line of four or five dancers, knobkerries in their hands. The other *amathwasa* sing, clap their hands, yell, and ululate in support and blow the whistle fiercely during all the dances. The sounds of the anklets, the singing, and the drums bounce off the tiles on the floor and the blank walls, it all adds up to an impressive, exuberant show. After a while, on Mks Gasa's signal, the sangomas get to dance; in turn, they step out of the line to the front to do a special part in the dance. Finally, Mks Masingo and a *thwasa* kneel on the floor and start to move as if they are walking like a lion, then they shake the upper half of their body like a snake, trembling.

Figure 3.19 Sangoma dance

Mr Mbele, his wife, and his mother watch the dancing intensely with approving smiles on their faces; eventually, the mother joins the *amathwasa* in singing and clapping her hands. From the moment the healing session in the bedroom is finished, Mr Mbele's wife looks more relaxed, she is obviously relieved this healing procedure has come to an end.

3.3.5 Back to the granny's words

In the last part of Mr Mbele's healing process today, in his recently purchased farmhouse, we recognise the ritual that the granny instructed him to do. The confusion about which house this ritual should take place in is solved. His mother still lives in his first house, the second house was not the right one, so Mr Mbele bought a third house last week. Now that the ritual has been carried out in this house, this has become his main house, his home, where the ancestors have been brought to and where they are watching over him. The Zulu beer Mks Gasa brewed last Tuesday was in a calabash in the prayer place as was a two-coloured bottle and, in the bottom of the white bucket with *muthi* was an old 5 cent coin. The chair beside the bed however was not yet the right one, because Mr Mbele had not been able to find a soft chair in red, blue, and gold. Therefore, today he used another chair instead and covered it with a leopard skin, he assured Mks Zinhle, however, that he would keep searching for the right chair.

Mr Mbele's healing procedure took at least five healing sessions, the last four of which are described in this part. He and his wife were gently guided through all the necessary procedures by Mks Zinhle, her mother, and sister. The sessions were performed at three different places: the consulting room at Mks Gasa's compound; the Mtamvuna estuary; and Mr Mbele's house. The three fields of healing are reflected in the sessions we witnessed. After the first described healing session, Mr Mbele was given *muthi*'s to take home, to heal his physical troubles, the spiritual and (social) environmental part were treated in the procedures at the river and finally in his house, where his mother

was present. There are two key moments in this process: Mr Mbele's contact with his ancestors when he got the instructions for the ritual that had to be done and the procedure at the river where he connected with his ancestors in order to take them to his new home.

In the week between these sessions, the sangomas were preparing all kinds of elements based on the granny's instructions. They bought the Xhosa attire, the beaded headband, knobkerrie, and necklace. They have brewed the Zulu beer, arranged for extra sangomas to join them at the river and at Mr Mbele's home and, ultimately, they provided extra help to feed everybody at Mr Mbele's after the last session that night.

3.4 Concluding remarks

After returning to Holland, it occurred to me to take Mr Mbele and his healing as a special case in this part of the research. However, as a consequence of Bongani's untimely death, and my dependency on his mediation, I no longer had any possibility of obtaining further information on Mr Mbele as a person, his business, his family, or on any results from his healing process. At the moment of writing, these matters unfortunately remain unanswered.

In this chapter, I have chiefly written, especially the indented parts, from an emic point of view, in order to give a reflection of what the sangomas and the patients believe to be true and real. Obviously, I respect their opinions on these matters, but that does not imply that, as a Western researcher, I fully agree with them.

I have given an impression of an indigenous healing practice by describing and zooming in on the healing processes of Mr Mbele, one of the patients we met on two consecutive Saturdays at the Gasa compound in KwaMakhutha, Durban. On the basis of Mr Mbele's healing sessions, I described and explained the various elements that comprise such a session: the burning of *imphepo*; invoking the ancestors; diagnosing the cause of the patient's problems and the remedy, be it in the form of performing a ritual or the prescription of *muthis*. It became clear that both the diagnosis and the healing itself are key elements in a healing session. Although we saw these elements presented in many different forms, they proved to be the characteristics of indigenous healing.

To sketch a picture of how these internal processes of diagnosis and healing characterise indigenous healing, I compared Mr Mbele's sessions with other healing sessions we attended. The information from the 2012 interviews and findings in academic literature served as a background for the description of this healing process. This led to an extensive explanation and account of what happens in an indigenous healing procedure, often a number of sequential sessions. Of particular note were the amount of time and effort that sangomas devote to the healing of their patients and the attention they give to the patients and their relatives.

I also found significant the notion that the ancestors' communication and the interpretation of the diagnosis is strictly the prerogative of the attending sangoma. This is both a strength and a weakness in indigenous healing; the sangoma has a powerful position but there is no way to check her claims. This led me to investigate the internal dynamics of the indigenous healing system, viz. the training of sangomas and the transfer of knowledge in that training. That is the subject of the next chapter.

Chapter 4

Indigenous knowledge transfer in sangomas' training

As a sequel to the dynamics of healing and diagnosis in healing processes, we switch our focus to another part of the indigenous healing system, viz. the sangomas' training and knowledge transfer in a wider perspective in order to distinguish other internal dynamics.

In the following pages the main question is: What dynamics and contradictions are there in the curriculum and knowledge transfer of sangomas' training?

A large part of the interviews in 2012 with the three female sangomas of different generations was about their training to become a sangoma (*ukuthwasa*) and the way knowledge is transferred. Questions were about what they learned in that period and if they, *gobelas* (sangoma trainers) at that time, taught exactly the same to their own apprentices and about the organisation of their healing practice in comparison to their own *gobela*'s practice. In other words: by using the genealogical sampling method, I tried to find out what transformations in training and knowledge transfer we can detect among these three generations.

Mks Bhengu represented the oldest generation and therefore her contribution was important in discovering longitudinal changes. She remembered the things she learned during her *ukuthwasa* in the early 1950s quite well. She talked vividly about the time when she had her training. Although initially it was hard for her (she was separated from her husband for the larger part of her two-year *ukuthwasa*), a certain nostalgia crept into the stories about that learning period. The comradery between the apprentices and the fact that Mks Bhengu gradually recuperated from her long illness (she is a so-called wounded healer[1]) may account for the positive feelings she still has when telling about those days. In her memory, all her fellow *amathwasa* got the same education from their *gobela*.

She also pointed out that variances exist between healing practices and knowledge of *muthis* and she explained that these are caused by the differences between the 'schools' of *gobelas*. Among gobelas, various ways of thought exist when it comes to the preparations of different sorts of *muthis* and the way to carry out the healing practice. Thus, the school where a sangoma is trained determines what knowledge is learned and the routine conducted in her healing practice. As Mks Bhengu witnessed, this particular practice is long-standing and has always been accepted and appreciated.

[1] Like Mks Mbuyisa and Mks Ngidi, see the previous chapter.

Furthermore, the interviewed sangomas were very straightforward about the fact that every sangoma has her own knowledge about *muthis* and, consequently about healing procedures. This endorsed Mlisa's (emic) statement that the curriculum for *ukuthwasa* training is "flexible and (that) it is led by the wisdom and blessings of the *iminyanya*[2] through dreams" (2010, p. 157). Additionally, they acknowledged the fact that the content of the training is different for every *thwasa*. They even implied that all sangomas apply their knowledge in their own specific way[3] and that, over years of experience in their healing practice, sangomas develop and increase their knowledge (as they are confronted with new illnesses or new complaints) even if it is by trial and error.

As an exemplary depiction of a contemporary sangoma school I take the one that I became most familiar with, Mks Gasa's. I will compare the data from the interviews with my findings of Mks Gasa's school and academic literature, thus resulting in a survey of (local and longitudinal) transformations in sangomas' training and transfer of (*muthi*) knowledge. Sangomas from Mks Gasa's school, Mks Gasa, Mks Zinhle, and Mks Dudu, will appear frequently in the description of the routines and organisation of their healing practice and school.

Subsequently, I will take the data to another level and analyse them by means of Whitehouse's theory on the transfer of specialist knowledge (Whitehouse, 2004). This will involve an examination of what elementary dynamics of knowledge transfer we can discover in the sangomas' training and what associated consequences for the execution of the healing practice there are.

I encountered discrepancies in what was said and what was done, between theory and daily routine, on several levels within the system of indigenous healing. To single out these paradoxes, I will use the antipodal concepts 'programme' and 'practice' on the level of individual sangomas' practices and concerning the transmission of knowledge during the training. I will again apply Whitehouse's 'Modes of Religiosity' theory to see what insights this brings us on the inconsistencies between programme and practice.

Given the differences in healing practice, training, and acquired knowledge, it is essential to investigate, with the help of Foucault's theory of 'power and knowledge', why indigenous healers continue to call their profession 'traditional' and hence to explain my preference for the term indigenous.

The final dynamics internal to the indigenous healing system that I will explore are to be found in the period after *ukuthwasa*. Even after a sangoma has graduated, she is constantly updating her knowledge, be it with the alleged instructions of the ancestors or through her contacts with fellow indigenous healers in various networks. Inyanga Baba Cele and my key informant Bongani Ntshangase are the main characters in this

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[2] *Iminyanya:* ancestors (Xhosa).

[3] Many sangomas are specialised in a certain kind of healing.

part of the chapter. The smaller networks of the past have rapidly been replaced by larger, well organised, associations. To show what internal processes are involved in a contemporary association, I take the example of NUPAATHPSA in the Durban district. I will start this expedition, however, with the transfer of knowledge in the sangomas' training, *ukuthwasa*.

During the interviews, I was told that two major categories are specific to *ukuthwasa*: the knowledge of *muthis* and learning to diagnose. However, Mlisa, an indigenous healer herself, writes in her thesis about the *ukuthwasa* initiation of Xhosa indigenous healers (2010) that the construction of a healing identity (marked by qualities like humbleness, total submission, and respect) is also an important part of the training to become a sangoma. In our conversations, Bongani Ntshangase often mentioned that a respectful attitude and skilful communication with both ancestors and patients were quintessential for life as a sangoma. Below, I will describe the daily routines at Mks Gasa's school and, subsequently, examine these three elements: I will first focus on the (transfer of) *muthi* knowledge and then we will come to the subject of the diagnosis. In doing so, I will get to the closely related aspect of the healing identity.

4.1 Mks Gasa: School, differences, and transformations[4]

Driving along a tarred road in KwaMakhutha township, almost 20 kilometres south of Durban City Centre, nothing suggests that we are approaching a sangoma's compound. The road is wide, most of the stone houses are well kept, some compounds are even surrounded by a stone wall. We stop at one such place, the iron gate is open to welcome all visitors, patients and researchers alike. We leave the car at the roadside and enter the gate. In front of us is a house but we turn to the right towards a rondavel. Mks Gasa welcomes us just outside this rondavel, which proves to be the consulting room. She asks us to park the car on her premises, just inside the gate and having done so, we again approach her consulting room. Before we enter, we take off our shoes and Mks Gasa wants me to wrap a cloth around my waist, so that the ancestors won't mistake me for a man because of the trousers I am wearing. Inside the consulting room, we are seated on a reed mat immediately on the right side of the door, our backs against the wall. In front of us, on the opposite wall, is a leopard print cloth hanging from the ceiling, against it a wooden necklace in the form of a rosary. Below the cloth, on the floor, are several reed mats standing in front of a multitude of items like white plastic buckets, Zulu war shields, a guitar, a trumpet, beaded necklaces, and a blue dress hanging on the wall. In front of the reed mats, on the right side, burn five white candles and a red one; in the centre is a silver coloured dish with essence. The interior of this spacious consulting room, with a diameter of at least 25 feet, is very neat and tidy and the floor shines like it is polished every day. Before entering this rondavel, everybody takes off his shoes or slippers and, once inside, *amathwasa* walk with a stoop or move on their knees out of respect for the ancestors.

Figure 4.1 Mks Zinhle in the consulting room

Mks Gasa is the oldest sangoma/*gobela* on the compound, the master trainer as Bongani calls her. She has trained both her daughters Dudu and Zinhle, the latter is now the most important sangoma of the house.[5] Together, the three of them are training more than twenty amathwasa. Each of them has a specific part of the training to take care of:

[4] These kind of descriptions are in a smaller font and indented

[5] See Chapter 3.

Mks Dudu teaches the *amathwasa* the first step in learning how to diagnose, which is how to use the bones. Mks Gasa herself teaches the use of essence and the Christian spirits (Z: *isithunywa*[6]), and Mks Zinhle teaches the apprentices to diagnose by means of the (whistling of the) ancestral spirits (Z: *amadlozi)*. At the time of our visits,[7] Mks Gasa's youngest daughter is also a *thwasa* at her mother's compound. Mks Dudu tells us it is common for sangomas to train their own children if they, too, are called by the ancestors to become a sangoma. In general, a sangoma's child does not go to another sangoma for *ukuthwasa*, she says.

Figure 4.2 Mks Zinhle (l), Mks Gasa (c), Mks Dudu (r)

Figure 4.3 Mks Zinhle, Bongani and *amathwasa*

Most of the twenty plus apprentices are staying at the Gasa compound during their *ukuthwasa*. In addition to the consulting room and the main house, at the back of the compound there are a few more buildings where *amathwasa* can sleep and do their daily work and activities. In one of those buildings, Mks Dudu has a room of her own where she lives with her son and prepares herself for sessions with patients or with *amathwasa*. In the main house, there is also a waiting room with plastic chairs along the walls and a TV-set, to entertain the waiting patients. At the rear side of the main building there is a spacious kitchen. There are also various cookers next to the main house and a stack of huge pots and pans beside the cookers reveal the bulk of food that must be prepared in this extended household. A shower, the cabin made of canvas nailed to wooden strips, has been constructed beside the house.

Life at the compound is a constant learning process for the *amathwasa*; every moment of the day and sometimes even of the night they watch carefully what the sangomas do and they listen to their explanations. This way they pick up what life as a sangoma is like, they also observe when to use what kind of *muthi*, how to prepare the *muthis*, and when and where to obtain the ingredients, by harvesting in the forest or by buying those ingredients at a pharmacy or *muthi* market. Another part of the education is the attitude

[6] God-sent messenger.

[7] In April and May 2014.

> towards patients: how to talk to them; how to treat them; how to be an intermediary between the patient and the ancestors; how to convey and interpret the ancestors' messages to the patient. Furthermore, they must learn to diagnose. Starting under the wings of Mks Dudu, the *amathwasa* learn how to use the bones to tell a patient what his problem is and what the remedy is. When this part of the training is finished, Mks Gasa or Mks Zinhle may proceed with their part, but only if indicated by the ancestors.

At Mks Gasa's compound, we attended several healing sessions, a number of the processes carried out by Mks Zinhle, others by nearly graduated *amathwasa*. In the final stages of their training, these soon-to-be graduates get the opportunity to show their competences on all parts of a sangoma's healing practice, one part of which is the healing session. Mngadi, an almost graduated male *thwasa*, performed one of the healing sessions autonomously. He took care of the preparations, like preparing the dish with *imphepo* and laying out the offerings that the patients brought, surrounded by candles of different colours on a special cloth on the floor. Mngadi was very focused while making these preparations; he arranged the offerings in a systematic way to make a beautiful display.

> While he prepared and carried out the healing session with a young couple and their little son,[8] Mks Gasa was sitting on the other side of the consulting room on a reed mat with her back against the wall, supervising Mngadi's activities. Now and then she made a remark, reminding him of an action to perform or something to say. In the course of the healing session, another less advanced *thwasa* brought some items, like a glass of water (to sprinkle on the offerings and the patients) and later some plates, for Mngadi to use.
>
> That same afternoon, Nomsa,[9] a female thwasa in the last stages of her training, prepared and performed two other healing sessions, also supervised by Mks Gasa. Nomsa also acted in a very concentrated way while she was preparing and performing the sessions. In the first one, the patient was a man aged about twenty-five; in the second one, the patient was a woman in her mid-thirties. Mks Gasa sometimes gave a few instructions to Nomsa in the same way she did to Mngadi. During both of her healing rituals, another *thwasa* supported Nomsa by bringing a glass of water and plates. This junior *thwasa* also assisted Nomsa in putting a little bit of all the offerings on the plate for every patient, so they could eat from the offerings they had brought. While they ate, the patients sat silently, as if they were not only chewing the food, but also digesting the things they had heard and experienced in this session.

Throughout the healing sessions, Nomsa and Mngadi acted in the same friendly and attentive way towards the patients. Because we saw three successive sessions, we were able to detect a professional attitude, the patients, however, must have experienced it as personal and particularly attentive. The three healing sessions covered all the usual

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[8] In Chapter 3, the healing session of the Dladla family is described more extensively.

[9] Not her real name.

stages described earlier: invocation of the ancestors; praising; the diagnosis (listening); interpretation of the diagnosis; and the closing the session. For the diagnosis, the soon-to-be graduated *amathwasa* used the essence, they burned *imphepo*, and invoked the ancestral spirits. They then turned towards another side of the rondavel facing the blue cloth on the wall to invoke the Christian spirits. The offerings[10] were displayed on a reed mat covered with a white cloth with a blue cross stitched on it. Half of the offerings on the cloth are for the ancestors (i.e. Mks Gasa's household), the other half is for the patient to take home in order to continue his reflection on the healing process.

On the whole, the sessions seem similar, both Mngadi and Nomsa prepared and carried out the healing ritual autonomously and in a very focused way. Yet, we have seen a number of distinctions, some of which may be due to a different kind of process. At the start of the healing sessions for the Dladla family and of the woman, a white chicken was held above the smoking *imphepo* to be slaughtered later as an offering for the ancestors. By contrast, the young man's healing session started without a sacrificial animal. At the end of his healing session, Nomsa handed the young man a small bag with *muthis* and explained when and how to use it. The Dladla couple and the woman, however, left without *muthis*, as far as we observed.

Other differences we encountered in the healing sessions are apparently based on the *thwasa*'s personal preferences or character. The different ways the offerings were displayed, e.g. the positioning of the candles, or the very orderly and precise way that Mngadi carried out his session and the somewhat more casual way Nomsa did hers. Given the fact that both Mngadi and Nomsa were trained in Mks Gasa's school and that the three healing rituals took place under the scrutiny of Mks Gasa herself, we may assume that (*amathwasa* and) sangomas are allowed to, and indeed do, have their own personal touch and expression in the performance of healing processes. Later that evening, when I asked Mks Dudu for the meaning of the differences in the way the offerings were presented on the cloth, she explained that a sangoma just tries to make a display as beautiful as possible, to please the ancestors.

Comparing these healing sessions to Mr Mbele's, which was carried out by Mks Zinhle,[11] at least one difference is notable. These patients were all Christians or had Christian ancestors, evidenced by the fact that, after invoking the ancestral spirits, they all went on to consult the Christian spirits. In all of Mr Mbele's healing sessions we attended, however, only the ancestral spirits were invoked. Yet, there were many similarities too, like the acting sangoma being assisted by a *thwasa* (Mks Zinhle was assisted by *thwasa* Mngadi), and all the patients bringing offerings (but in none of Mr

[10] The offerings the patients bring are often drinks (Coca Cola and Sprite), sweets, cakes, cookies, and sweet potatoes, because the ancestors like sweet things, and raw meat. Depending on the patient's problems other items can be added, like Zulu beer or, in the case of a stillborn child, baby clothes, baby food, etc. See also the pictures in Chapters 1 and 3.

[11] Described in Chapter 3.

Mbele's sessions that we attended was an animal sacrificed[12]) and, most significantly, the caring and comforting manner in which Mks Zinhle and the *amathwasa* acted towards their patients.

Another remarkable observation was the attention the sangomas and *amathwasa* paid to the patients' relatives. Mrs Mbele accompanied her husband to the Gasa compound for his healing session and during all parts of this extended session (in the consulting room, at the beach, and at their home in Pietermaritzburg) Mks Gasa or Mks Dudu remained close to her, explaining what the meaning and purpose of the various actions and rituals was. Initially, Mrs Mbele had been distraught, but as the evening proceeded she became less anxious and, in the end, she was even quite relaxed. We saw the same pattern, albeit less intensely, with the wife of Nomsa's patient, who sat beside Mks Gasa during the healing session. Mks Gasa was constantly telling her what Nomsa was doing and why it had to be done.

4.1.1 Method of knowledge transfer

In Mks Gasa's compound, the transfer of knowledge is embedded in the structure of daily life. The *amathwasa* are thus able to experience all aspects of the healing practice and of life as a sangoma in general; what it means to be a sangoma and this profession's impact on one's life from day to day. They are there when patients arrive, they watch how the diagnosis is done, they see the preparation of the *muthis*, they hear the instructions and recommendations for the patients, they join the *gobela* in the search for *muthis* in the forest, at the market or the pharmacy. The gobela constantly explains what she is doing, how it is done, and why, thus teaching the *amathwasa* unremittingly. We witnessed a fine example of such 'learning by being present' during the healing sessions of Mr Mbele. It struck me that on our way from Mks Gasa's compound to the river and, subsequently, to Mr Mbele's house in Pietermaritzburg, a large number of *amathwasa* accompanied the patient and the sangomas.[13] Apparently, this sort of healing session is not very common, so all *amathwasa* at an advanced stage of their *ukuthwasa* came to witness and learn from this event. The additional sangomas (including Bongani) , I was told, needed to carry the burden of the descending presence of the ancestors and to transport them to Mr Mbele's home.

The way sangomas teach *amathwasa* at Mks Gasa's is consistent with what the interviewees told us in 2012 and with academic literature such as Mlisa (2010) and Thornton (2009) who wrote about this practice in other South African regions (the Eastern Cape and the Lowveld, respectively), Van Binsbergen (1991) in Botswana, and Erdtsieck (2003) in Tanzania. While living and working together during *ukuthwasa*, the

[12] As far as I have been able to detect.

[13] Mks Gasa, her daughters Mks Dudu and Mks Zinhle, and Mks Ntombi. After the session at the river Mks Masingo, a Xhosa sangoma, also joined the company.

sangoma plays an exemplary role for her *thwasa*, like a craftsman does for a pupil.

The fact that Mks Gasa has trained her daughters and that the three of them now train *amathwasa* within one school might imply that they agree on the curriculum of the training on the various levels, be it skills or knowledge. But it is doubtful whether every *thwasa* learns the same within this school; indeed, there are indications that this is not the case. A *thwasa* learns how to diagnose, how to communicate with patients, how to make them feel at ease, and how to explain the diagnosis – in short, the skills – by closely watching the *gobela*'s doings. With regard to these skills, every *thwasa* will pick up during her training what is suitable for her, or, as the indigenous healers phrase it, what the ancestors want her to learn. Hence, I wondered if this is also the case when it comes to the transfer of knowledge, and specifically, the knowledge about *muthis*.

4.1.2 *Muthi* knowledge

Before dealing with the subject of *muthi* knowledge and its transfer, it is appropriate to be more specific about the terms. Although '*muthi*' is a somewhat problematic term, because it is used for various purposes with different connotations, here I would circumscribe *muthi* as 'a biological remedy' or 'natural substances'. I will return to other meanings and applications of the word (for instance in relation to witchcraft) later. At this point, I want to focus on *muthi* as a reference to the medicine an indigenous healer prescribes for his patients. These *muthis* are prepared from combinations of different (pieces of different) plants, fats, and/or minerals and handled in a certain process.

In 2014, Mks Mkhize showed us his *muthi* book; a Counter-book in which he had written all the names of the medicinal plants he had learned about during his *ukuthwasa*, two columns of names on dozens of pages, sorted by medicinal plants and which other *muthis* they can be mixed with for healing a specific sickness. I was surprised to see this information in writing because I assumed that all knowledge had to be learned by heart, so I asked if every sangoma has such a book. Mks Mkhize confirmed that while in training all apprentices write their own *muthi* book. Bongani Ntshangase told us he too had a similar book, but with different *muthis* in it, partly because he was trained by another *gobela*.

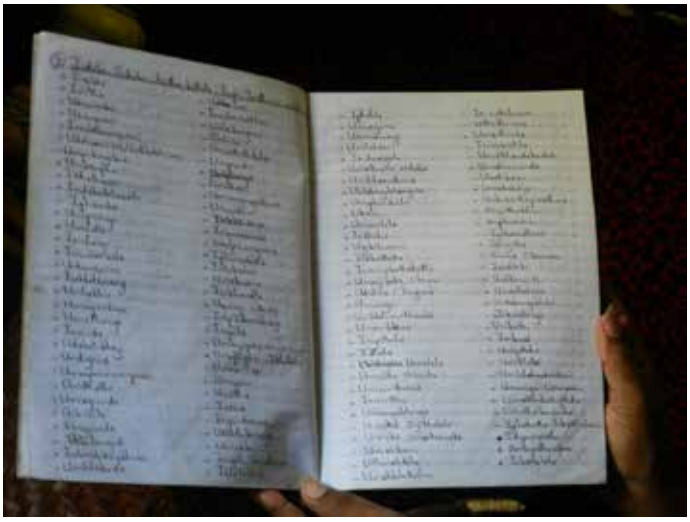

Figure 4.4 Mks Mkhize's *muthi* book

From the 2012 sangomas' interviews, I already understood that there does not seem to be a standard or canon in terms of what a *thwasa* learns about *muthis.* Every *gobela* has her own curriculum and her own thoughts concerning the preparations and applications of all sorts of *muthis*, obviously in the context of her healing practice location and the botanical environment. Thus, the content of the transferred *muthi* knowledge varies from school to school.

According to Mks Ngidi, a gobela teaches her *amathwasa* the basics during *ukuthwasa*. Subsequently, after graduation, a sangoma continues to develop and learn through the interventions of the ancestors or from other indigenous healers, like herbalists. Through years of practice, every sangoma develops her own range of (composite) muthis. Van Beek notices the same particulars in Kapsiki/Higi society in Northern Cameroon where, as he observed, blacksmiths/healers have three levels of specific non-shared knowledge at their disposal. This concerns additional knowledge with regard to the usual stock of medicinal plants, knowing which plants treat what specific disease, and the array of various plants and mixtures. Every healer has his specific prescriptions and they are often very secretive about them (Van Beek, 2010).

Secrecy

Which specific *muthi* links to specific problems is part of the (sometimes secret) knowledge indigenous healers obtain during their training, as is the mixture and preparation of that *muthi*. During the field study, for example, I twice encountered the healing capacities of porcupine needles. The first time was in 2012, in Baba Cele's uMlazi pharmacy, where we overheard a conversation about how to cure somebody's bleeding nose. The remedy was to grind a part of a porcupine's needle, to mix this powder with

another *muthi*, and then throw the mixture into an open fire. I was told that the patient's nose would stop bleeding after he has sniffed the smoke that comes from the burning powder. How much of which part of the needle has to be ground and what *muthi* to mix it with remained unanswered. The second time was in 2014, when we attended a healing where Mks Mkhize prescribed Zanimvula[14] crocodile fat mixed with pieces of a crocodile's uvula. He offered Zanimvula this mixture on the tip of a porcupine needle. Despite my questioning, neither the exact way to mix this *muthi*, nor the reason for offering it on the tip of the porcupine needle was revealed.

To some extent, indigenous healers themselves thus maintain and feed the (air of) secrecy with regard to the preparation and mixture of their *muthis*. They claim it is about the secret knowledge allegedly transferred during *ukuthwasa*, but we may also assume that more selfish motives are at stake here. For such secrecy is functional in the sense that it provides 'the exclusive rights' of a certain mixture to a specific healer and thereby it gives the healer a certain authority, power, and, consequently, income from the patients that come for that special *muthi* mixture. Mbatha designates the secretiveness regarding *muthi* knowledge "a survival strategy" (2017, p. 25) for individual healers.

The fact that the content of Mks Mkhize's *muthi* book was very different to that of Bongani Ntshangase's is an example of the existing differences and variations in *muthi* knowledge that is transferred during *ukuthwasa*. Inevitably, the execution of healing practices will also vary.

Differences in healing practices and training of sangomas have always (as far as I have been able to elicit) been indisputable; moreover, it is generally seen as a valued phenomenon. But these days (and as a consequence of the ratification of the sangoma's profession[15]), there is a need to formulate a kind of standard concerning the knowledge of *muthis* that all graduated sangomas have, regardless of the school where they were trained. In the *eThekwini* district, Baba Cele took the initiative to start a school for freshly graduated sangomas, where they can top-up their *muthi* knowledge to a standardised level.

***Muthi* school**

Baba Cele is a well-known *inyanga*[16] who owns a pharmacy in uMlazi, a township south of Durban City Centre. In the pharmacy, which he runs with two of his sons, who are also *inyangas*,[17] all kinds of medicinal herbs, roots, minerals, parts of animals, beads, cords etc. are on display. Sangomas and other clients come there to buy their *muthis* and to ask the *inyangas* for medical advice. When we visited him in 2012, Baba Cele

[14] See Chapter 3.

[15] More about recent legislation and its implications in Chapter 6.

[16] *Inyangas* are held in high esteem because of their extensive knowledge of medicinal herbs, minerals, and fats.

[17] One of his daughters is a sangoma, her consulting room is at the back of the pharmacy.

took us from there to his 'school', a building where he intended to start courses for recently graduated sangomas to increase their *muthi* knowledge. We also went to his *muthi* garden, Nkumba Nature Reserve, near his home, a large colonial farmhouse on the top of a hill. Down the slopes of the hill, all the way down to the river, is the *muthi* garden where he grows medicinal herbs, trees, and plants, and in particular those that are on the brink of extinction. There Baba Cele told us about his life,[18] his profession, and the urgency he felt to transmit his comprehensive knowledge in order to prevent it from getting lost for future generations, and that he had therefore also cooperated in a project that resulted in a book (Ahlefeldt, et al., 2003) on local medicinal plants. Baba Cele is a successful businessman; outside the pharmacy were three expensive cars, two new Mercedes Benzes and a BMW. One was his and the others belonged to his sons.

Figure 4.5 Baba Cele's school

In the compound of Baba Cele's school is a small garden for growing medicinal herbs as well as an annex where apprentices who come from far can stay during the week. A standard level of *muthi* knowledge has been established by the *inyanga* in collaboration with the *eThekwini* branch of NUPAATHPSA, to be sure about the knowledge level of graduated indigenous healers. One of the subjects Baba Cele teaches his apprentices is a rather practical one, viz. where to find, how to recognize, gather, and harvest the herbal parts of the *muthi* you want to prescribe to a patient. For that purpose, the *inyanga* founded the Nkumba Nature Reserve near his home where his apprentices can learn what the medicinal herbs look like, which parts of the plants to use for what purpose, and how to harvest them. According to Baba Cele, this kind of knowledge used to be a part of *ukuthwasa*, but, much to his regret, it is not anymore.

[18] When he was young, he used to be a professional tap dancer, but then his father summoned him to come home to take over the pharmacy. Baba Cele sounded as if he still regretted this.

Mks Bhengu told us the same in our interview: in the early 1960s, in the rural area, her *gobela* took the *amathwasa* to the forest to show them all about the medicinal plants and to learn about the various sorts of *muthis*. But she claimed that in the present South African society it is far too dangerous to make such a trip, even if you are travelling in a group. Mks Ngidi (of the younger generation) confirmed this. When she was a *thwasa* (in 2004, 2005) her female *gobela* could only harvest *muthis* that were growing close to the *gobela*'s compound. The effect of this is that knowledge about finding and harvesting specific plants, transferred from *gobela* to *thwasa* during *ukuthwasa*, is no longer comprehensive.

In 2014, the first group of twelve sangomas received their '*muthi* school' certificates after six months of training in healing herbs, plants, minerals, and fats. At the end of the training, Baba Cele gives his apprentices the opportunity to take some small commonly used plants (like Aloe) from the nursery to their homes so that they will have these *muthis* close at hand for their daily healing practice.

Thus, Baba Cele encourages sangomas in the rural area to grow the most-used medicinal trees and plants on their own homestead. Sangomas who have their healing practice in the urban area largely depend on pharmacies and *muthi* markets for obtaining their *muthis*. Mks Ngidi, for example, told that her *gobela* went to buy *muthis* at the *muthi* market and brought them home for explanation to her *amathwasa*. In the urban situation, it is evidently important to know what the *muthis* look, smell, and feel like after harvesting, and which *muthi* vendors are reliable and where you can buy the specific ingredients.

Figure 4.6 Baba Cele's pharmacy exterior,

Figure 4.7 and interior

Muthi **trade**

For his own pharmacy, Baba Cele employs harvesters and pays them to bring the *muthi* from the forest and to chop them behind his pharmacy. That indigenous healers make a point of teaching apprentices which vendor is trustworthy, implies that, in their eyes,

many are not. Bongani Ntshangase told us of a few vendors at the market who are *inyangas* or sangomas themselves, those are the ones he trusted and bought his *muthis* from.

Figure 4.8 Cubicle interior

The subject of the vendors on *muthi* markets[19] is a delicate one. The largest *muthi* market in Durban is right in the city centre, near Victoria Street market. At this location[20] more than a hundred vendors try to sell their, to many people seemingly useless, merchandise. Big sacks filled with stems, roots, barks of all sorts of trees, and herbs, chopped into small pieces, were displayed on the ground and brightly coloured minerals in plastic pots of all sizes were arranged on market stalls. Compared to this market, Baba Cele's pharmacy was a haven of neatness. In some of the market's areas there was a nauseating, hardly bearable stench. That is where parts of dead animals like skins, bones, tails, owl's wings, a python's skin and spine, and the fat of a puff-adder were exposed for sale. The vendors stood quite relaxed near their products, seemingly unnerved by the smell and rather amused by my apparent revulsion. Bongani knew some of the vendors and took his time to talk to them, which gave me the opportunity to look around. Walking in this market, we encountered very diverse reactions. Some vendors were friendly and cooperative, willing to explain about their merchandise. Most were indifferent, but others were openly hostile, shouting furiously and raising their fists when they discovered my photo camera. An angry woman almost came after me, but when I put the camera in the bag she decided not to. Evidently, these vendors were not

[19] There are two *muthi* markets in the eThekwini district. One, the Ezimbuzini *muthi* market, is on the boundary of uMlazi and Isipingo, about 25 km south of Durban city centre; the other, the Warwick market, is close to the city's central business district.

[20] We visited this *muthi* market in 2014.

eager to be photographed, maybe because, as Bongani assumed, they sold things that could not stand the light of day.

Figure 4.9 *Muthi* market in Durban City Centre

Figure 4.10 Animal parts for sale

The vendors rent a stone cubicle from Ministry of Health of the *eThekwini* Municipality,[21] or they pay the Ministry for about twelve square metres in the open air. Every vendor has his own numbered spot, sometimes with name and telephone number on display. In general, the vendors on the *muthi* market do not harvest the *muthis* themselves, they buy their wares from harvesters. For some *muthi* preparations, specific herbs, or parts of trees must be harvested in a certain season, or at a certain time of the day to have the right healing powers. In cases where a young and an old person have the same illness, the *muthi* may come from the same tree, but from different parts. To be sure of what one is buying, therefore, it is of the utmost importance that one can trust the salesperson.

Reliable (according to Bongani) or not, all those traders on the *muthi* market make a living by selling their stock to indigenous healers and pharmacists. At the *muthi* markets in the Durban area, some 4000 tonnes of (parts of) medicinal plants are sold annually, so the *muthi* trade is a business involving large sums of money (Ahlefeldt, et al., 2003).

"Zulu healing culture is dynamic, continually incorporating new elements in its expanding, shifting pharmacopoeia" is written in the introduction of the IPTRAD guide to market plants in Durban (Ahlefeldt, et al., 2003, p. 7). Crouch's research (1999) on indigenous Zulu healers' gardens showed that a considerable number of the medicinal plants that are grown in THPs' gardens were exotic to KwaZulu Natal. One of the reasons for these changes in the use of herbal plants may be the (local) distinction of some much used plants; when such herbs cease to be available in (more or less close) proximity of a sangoma's healing practice, the options left are to search for alternative herbs elsewhere or to consult fellow sangomas or *muthi* gatherers. Another reason for the shifting and expanding pharmacopoeia might also be the perpetual private revelation, the knowledge about *muthis* allegedly revealed to individual healers by the ancestors.

[21] The legal supervisor of the muthi market.

4.1.3 'Perpetual private revelation'

According to Mks Ngidi, the knowledge about *muthis* transferred during *ukuthwasa* is "only the basics". In some cases, this might be just a bit more than the folkloric knowledge[22] of herbs; in other cases it is more comprehensive. What exactly is learned in that period is allegedly instructed by the ancestors.

After graduation, every sangoma continues to develop her knowledge and skills by practising, by meeting and consulting with other sangomas, and by alleged revelations from the ancestors. Sometimes, "your ancestors will top up on what you know or else (reveal) something new."[23] This way, sangomas develop their own specialism; the ancestors show a sangoma a special *muthi* for a certain patient or a new way of preparing a specific *muthi*. Generally, these kinds of revelations are regarded as the sangoma's own knowledge, passed on as secret knowledge. "The ancestor will tell you: this is my *muthi*, don't tell it to anybody. It is only for this place, only the people that come here will be given this muthi."[24] Whether the sangoma shares this information is her personal decision. Mks Ngidi sometimes, with her ancestors' consent, chooses to share the new things she has seen or experienced with fellow sangomas she really trusts. A sangoma can thus turn her extended know-how to her advantage, call herself a specialist in a certain field of healing, and prescribe special *muthis* to her patients. Word of mouth will bring new patients to her healing practice.

Mks Mbuyisa (the middle generation) gave us several examples of how the ancestors showed her the use of medicinal herbs, sometimes long before she went for her training to become a sangoma. When she was a small girl in school she occasionally saw names of *muthis* on the blackboard, although the teacher had written maths on it. Sometimes, when she walked home, she saw herbs growing on the roadside and she recognised them as belonging to the words/names on the blackboard. In retrospect, she regarded these events as pre-emptive of her calling to be a sangoma. Later, when she went to live at her *gobela*'s compound, she was already acquainted with some *muthis* and ways of preparation that her *gobela* did not know, like the special Y-formed twig, *iphahla*, used for stirring *muthis*. Because the young Mks Mbuyisa knew where to find such twigs, her *gobela* sent her with a fellow *thwasa* to collect them. Mks Mbuyisa also told us that she spent a considerable part of her *ukuthwasa* in the river, underwater, where the grannies taught her about lots of *muthis*. When she returned to her *gobela*'s compound, she did not tell him of that knowledge because it was given to her by the ancestors. In fact, she did not like her gobela, so why share her secret knowledge with him? As a *gobela* herself, she has experienced this the other way round, too. Occasionally, one of her *amathwasa*

[22] Household remedies, passed on from (grand)mother to daughter, for example: drink cranberry tea when your bladder is infected, nettle tea if you need a cleansing effect, etc.

[23] Interview with Mks Ngidi, 9 August 2012.

[24] Ibid.

comes to her with a *muthi* recipe she does not know. Mks Mbuyisa then understands this is sent to her by the ancestors and she gratefully puts it to its proper use. According to Mks Mbuyisa, even when you are a qualified sangoma, you keep on developing and learning continuously, "your knowledge is never complete."

Mks Gasa, perpetual private revelation

Whilst Mks Zinhle is the most important sangoma of the house, Mks Gasa is the one who supervises the actions of the *amathwasa* in terms of their tasks and responsibilities at the compound as well as their communication and healing rituals with patients. Of course, this situation is mutually beneficial: Mks Gasa is able to run the household[25] and is, as the most experienced sangoma, in a position to judge the *amathwasa*'s progress; consequently, Mks Zinhle has the opportunity to focus on the relationship with the ancestors and the patients.

The constant interaction between Mks Gasa and her daughters creates a mutual and continuous learning environment for the three of them as well as for their *amathwasa*. My impression of the learning-attitude on the Gasa compound is that the sangomas and the *amathwasa* are aware of the fact that anybody might have special knowledge and that they want to use this for the benefit of all. In one of Mr Mbele's healing sessions, we went to the Mtamvuna estuary, the 'place where the river meets the see', to invoke Mr Mbele's Xhosa ancestors and to take them to Mr Mbele's home in Pietermaritzburg. During the this session, an extra sangoma, Mks Ntombi, accompanied us to help to execute the healing ritual in the river. On our way from the river to Pietermaritzburg, a Xhosa sangoma, Mks Masingo, also joined us, supposedly to persuade the Xhosa ancestors to travel with us to Mr Mbele's home. At the end of the session, in Mr Mbele's bedroom, Mks Masingo performed a special dance to show her gratitude and happiness to these specific ancestors.

Although the way indigenous knowledge is transferred during *ukuthwasa* is much the same nowadays as it was in the second part of the 20th century, it has become clear that the content of the knowledge is very different. After *ukuthwasa* is finished, a sangoma continues to develop and learn. New *muthi* concoctions are invented to cure (the symptoms of) new illnesses and afflictions that have emerged in the recent decennia. Later, in cases where a sangoma gets to train *amathwasa* herself, evidently the knowledge she passes on to the next generation will differ from what she learned in her training. We may regard this as one of the reasons why healing practices vary from one sangoma to another. On Mks Gasa's compound, there seems to be an open-minded attitude to any recondite, unfamiliar knowledge a sangoma or a *thwasa* may have, as long as this knowledge is claimed or believed to be ancestor-based. Mks Ngidi experienced a similar attitude at her *gobela*'s; there was a mutual exchange of (*muthi*) knowledge between trainer and *amathwasa*. Mks Mbuyisa's relationship with her *gobela* did not tempt her to share her private revelations with him. She does, however, share

[25] I will return to this later in Chapter 6.

them with her own apprentices, depending on the ancestor's instructions, as she told us.

Van Beek found similar results among the Kapsiki/Higi in Northern Cameroon and North Eastern Nigeria: the indigenous knowledge that is transmitted during an indigenous healer's training is not like a 'parcel with a fixed content' that is handed over from one generation to the other, rather each generation reconstructs the knowledge, at least partially. What is being transmitted in the training, Van Beek (2010) states from his etic point of view, are, for instance, tools for discovery procedures in order to compose one's personal knowledge, e.g. about medicine and treatment. To some extent, that is what I have encountered in this research too, a gobela sees to it that a thwasa learns the skills that are needed to autonomously execute the profession of sangoma. However, in my view, there is more that Zulu *amathwasa* learn during their training; from the observations in this research, I am inclined to conclude that it is imperative for *amathwasa* to acquire an appropriate healers' attitude, what Mlisa calls: the healing identity. In the Kapsiki context, Van Beek observed that among blacksmith/healers the healing identity is a hereditary quality. This required attitude, which for some *amathwasa* is a natural characteristic, is closely related to the performance of the diagnosis part in healing sessions.

4.1.4 Diagnosis and healing identity

A central part of the skills a *thwasa* must acquire in *ukuthwasa* is how to diagnose, viz. learning to communicate with the ancestors and interpreting dreams. In the actual diagnosis as well as in the execution of other skills a sangoma brings her own personal expression. Each sangoma, even if she has been trained together with several other *amathwasa* by the same *gobela*, will therefore carry out her healing practice in her own way. Other key factors for dissimilarities in the execution of healing practices are the range of assumed wishes and demands from the consulted ancestors and the sangomas' attitude towards superiors, ancestors, and patients.

What I found remarkable at Mks Gasa's was the subservient way the *amathwasa* acted towards the sangomas. All sangomas, and especially Mks Zinhle, were treated with the greatest respect, even though some *amathwasa* were twice Mks Zinhle's age. It was clear that the sangomas were the *amathwasa*'s superiors. There were also strict rules for the *amathwasa* on how to behave while eating (sitting on the floor on knees and hands[26]), while in the consulting room (crawling or 'walking' on their knees), or while waiting for the next thing to happen (sitting on their knees) and yet we did not hear anybody complain. Obviously, they were all accustomed to these practices and hierarchical power structures. The sangomas we interviewed in 2012 also told us that

[26] Eating in this position is best for the diaphragm and the stomach, I was told.

their *ukuthwasa* was a difficult period, also because of the characteristics they had to adopt before being allowed to graduate as a sangoma. Mks Ngidi and Mks Bhengu mentioned the struggle it had been for them to become a humble person. For Mks Mbuyisa, the most difficult part of her training was being subservient to her *gobela*. These are features of what Mlisa (2010) refers to as the "personal healing identity," which she says is a vital part of everyone's *ukuthwasa*.

Figure 4.11 Kneeling while singing

Figure 4.12 Kneeling while preparing the dance at Mr Mbele's

Mks Gasa, diagnosis and healing identity

At Mks Gasa's compound, educational tasks are shared between the three sangomas. When someone comes to this venue to train to become a sangoma, Mks Dudu is the one to teach the new *thwasa* the first 'chapter of the course'. Evidently, this task suits Mks Dudu very well; she has an easy way of communicating with people, she has the capacity to clearly explain what is at hand and why things are done in a specific manner. Mks Dudu was the only sangoma who talked to us in English in the consulting room. All other sangomas we met throughout the field study in 2012 and 2014 restricted themselves to the Zulu language and trusted Bongani to translate into English for us. Outside the consulting room, most sangomas spoke good English, but out of respect for the ancestors (who allegedly do not understand English) Zulu is the language that is used in the consulting room. The first stage for a *thwasa* is to start to learn what goes on in a sangoma's daily life. Mks Dudu teaches the new apprentice this, as well as using the bones to diagnose, in the first months of *ukuthwasa*. When this level is completed, the *thwasa* may proceed to the next level of diagnosing, i.e. using the essence, which is taught by Mks Gasa. In the final stage, Mks Zinhle teaches the *amathwasa* to diagnose with the whistles.[27] The three sangomas show their *amathwasa* what *muthis* to use in specific cases and how to prepare these. Although two patients with the same complaints may come to a sangoma, the diagnosis and hence the treatment might be entirely different. For an apprentice it is therefore considered very important to learn how to connect with the ancestors to get the patient's diagnosis clear by the way the bones are displayed or by other signals, and subsequently to interpret this message for the patient. The more ways of diagnosing a *thwasa* learns, the more methods she will be able to use in favour of the patient.

[27] Further explanation of these three ways of diagnosing is in Chapter 3.

Whether a *thwasa* goes through all three levels of the training depends on the ancestors' demands; indeed, sometimes ancestors indicate that a *thwasa* is to finish her *ukuthwasa* after the first or second level. Another more trivial, but also very significant reason to shortcut *ukuthwasa* is the financial resources of the *thwasa*'s family. *Ukuthwasa* is a very expensive undertaking that costs about half an annual salary (Mlisa, 2010; Thornton, 2009) for the complete training.

Communication with the ancestors can occur in very many ways[28] and there are understood to be many different types of ancestors, each with their own special demands, e.g. some are moody, others are very strict. Preceding the interview in 2012, when we were in Mks Ngidi's consulting room, she acted very subserviently towards her ancestors while invoking them. Her ancestors wanted her to carry out the rituals in a very precise manner; the actions, the words, everything had to be done in a specific way, she told us afterwards. Bongani Ntshangase's ancestors wanted him to wear sangomas' attire every day of the week, he related. But he did not think that would be convenient when he had to go to meetings e.g. with government representatives. Nor did he think that being dressed in 'traditional clothes' would be positive for the THPs' cause. So, he negotiated with his ancestors and in the end they allowed him to wear his ordinary clothes on week days; on the weekends, however, when he practised as a sangoma, he had to wear his professional sangoma clothes (Z: *ibheshu*).

At Mks Gasa's, we experienced that communication with ancestors is sometimes rather relaxed too. In the first of Mr Mbele's healing sessions[29] we attended, he received a message from his ancestors that another session was needed, the next Saturday in his house (but not one of the two houses he already possessed). The sangomas, reading between the lines, concluded that Mr Mbele had just one week to buy a new house. They kept smiling, joking, and shaking their heads in disbelief. The ancestors did not change their demands, however, and exactly one week from that Saturday evening, the sangomas performed a series of healing rituals for Mr Mbele, the last of which took place in the bedroom of his recently bought and by then completely decorated house in Pietermaritzburg.

In the case of Mr Mbele's first healing session, he himself was the one that received the messages from the ancestors while he was in an altered state of consciousness. The sangomas posed their questions to the ancestors through him and, like a medium, Mr Mbele passed on to the sangomas what the ancestors told and showed him. In all other healing sessions we attended, the sangoma was the one that received the messages from the ancestors, be it through the arrangement of the 'bones',[30] or through 'whistling in the roof' and other sounds,[31] or through an indication in the sangoma's mind.[32] In all

[28] As described in Chapter 3.

[29] In Chapter 3.

[30] At Mks Mkhize's.

[31] At Mks Gasa's, one of Mks Zinhle's sessions.

[32] At Mks Gasa's, the session executed by *thwasa* Mngadi.

instances, it was up to the sangoma to interpret these messages. Moreover, every daily-life occurrence, no matter how small, is understood as meaningful.

For any observer of such a ritual, it is hard to distinguish which part (if at all) of what the sangoma passes on to the patient is allegedly coming from the ancestors and which part is interpretation. Bongani (for whom communication with ancestors is a part of daily life) told us that the sangoma who executes the session is the only one that is able to receive the ancestors' messages. To someone who is not used to this kind of communication, it remains unclear whether (or to what extent) the patient's diagnosis comes from the ancestors or if the diagnosis is a compilation of the healer's intuition (Mlisa, 2013; Tedlock, 2006) and her impressions of the patient, completed with good judgement. After all, even fellow sangomas cannot listen in on the diagnosis or determine the sincerity of their colleagues.

4.2 Analysis: How to train a healer?

4.2.1 Programme and practice

On the level of individual sangomas, we come across contradictions between what, on the one hand, is claimed to be common practice and, on the other hand, what is actually done, for instance, with regard to the claim of consistency in the curriculum of transmitted knowledge during the training. The cooperating representatives of the generations of sangomas however also explained the ongoing development with regard to the use of *muthis* and their application for various afflictions. It is up to the sangoma to pass (some of) that personal knowledge on to her *amathwasa*. Based on the genealogical sampling method, this suggests that the knowledge transferred during *ukuthwasa* is variable. This assumption is supported by another sangoma's statement that, while in training, an initiate picks up what is suitable for her (or, as it was formulated: what the ancestors want her to learn) at that moment. A steady training curriculum therefore seems out of the question and, consequently, I conclude that *ukuthwasa* and the transferred knowledge is idiosyncratic, individually attuned.

4.2.2 Imagistic and 'tradition'

Hence, when we apply Whitehouse's 'Modes of Religiosity' theory (2004) to these findings of knowledge transmission in *ukuthwasa*, we understand that although the claim is that knowledge is transferred in the doctrinal mode through substantial repetition and routinisation, in fact the transmission is mainly through the experience of (high arousal) procedures and infrequent repetition of rituals. As previously mentioned, these kinds of experiences activate the episodic memory. *Amathwasa* and graduated sangomas are thus triggered to make an individual exegetical reflection on and application of what they learned in *ukuthwasa*. This means that *amathwasa* are trained to execute their healing practice in an experiential way and ultimately that indigenous healing is an experiential, imagistic system. Contrary to the doctrinal mode where convention is pivotal, there is no controlling authority that checks a standard of praxis, because, in the imagistic mode, the experienced and its exegesis are most important.

Up to this point, we have come across differences in various parts of the training and healing practice of indigenous healers, some (occurring in thoughts and practice) between sangomas, others general and longitudinal changes such as the conditions concerning obtaining *muthis*. Accordingly, indigenous or 'traditional' healing is, perhaps contrary to what one would derive from the term 'traditional', a dynamic and in some ways a versatile profession. In the first chapter I announced and introduced a discussion on the word 'traditional' in this context.

Sangomas call their profession 'traditional health practitioners', their healing practices are deliberately surrounded by an air of mystery and history. As we saw, the mystery is partly due to the secrecy with regard to *muthi* recipes, and in part the history can be explained by the way sangomas dress when executing their healing practice. I wondered why sangomas hang on to wearing goatskin bracelets, headbands, and leopard print cloths for, to put it mildly, these are not fashionable in the urban area nowadays. Their professional dress seems to belong to bygone days. The South African government also uses the term 'traditional health care' in healthcare legislation, and in doing so it joins the health practitioners in their emic terminology. From an etic point of view, however, the words 'tradition' and 'traditional' prove to be ambiguous to such an extent that I decided it inappropriate to use them and opted for the term 'indigenous healing'. Here, I will explain my preference for such terminology and, in this regard, it is obviously essential to investigate what we are referring to with the word 'tradition' and how this relates to indigenous healing.

In everyday life when we use the word 'tradition' (and the same applies for 'traditional'), we are usually referring to matters or customs we regard as old, historic, and valuable, that are worthy of preservation. Tradition and its derivatives thus carry the association of invariability, consistency, and constancy, and that is the way sangomas and *inyanga*s use these words too; suggesting that their knowledge is ancient and their profession is a 'traditional' one - an old profession - and that they invariably perform it 'the way it has always been done'. Their healing practice derives a large amount of authority from the assumption that it has not been recently thought up or invented by this specific healer, but rather that it has a long history and that such healing practices have been executed the same way by many healers for decades, maybe even centuries.

4.2.3 Power and knowledge

The French philosopher Michel Foucault has written extensively about the relationship between power and knowledge and how this manifests in society, e.g. in forms of social control. He states that between people there are always (and on every level) power relations that make people behave according to the prevailing standards. Power defines knowledge and power uses language as means of control and segregation. We thus should consider that language is a strategic (Meester, Meester & Kienstra, 2014) instrument in those social processes. Moreover, we have to be aware that knowledge is not a neutral word.

The power of sangomas is built on the ancestor discourse. By making an appeal to their privileged (only for 'called ones') status, its long-standing tradition and its accompanying access to ancestral (*muthi*) knowledge, sangomas adopt an attitude of authority. Since it is up to the sangomas to decide whom they share their knowledge with, they have authority and power over those who do not have (access to) this knowledge.

This is also the case in the *gobela-thwasa* relation during *ukuthwasa*; the *gobela* decides (allegedly instructed by the ancestors) whether a *thwasa* should continue the training to the next level. By wearing their professional, historic (or as they call it: traditional) clothes, sangomas emphasise their special status in society.

In my opinion, indigenous healers may truly feel they are carrying out a profession with a long-standing tradition that goes back to the times 'before the white man came,'[33] arguing it is the wisdom of the (old) ancestors that guides them in their healing work. The suggestion is that their profession is an important part of the, in the case of my interviewees, Zulu people's identity. That it is a bond between present-day people along the threads of a shared history by way of the connection with their ancestors and that this bond is facilitated by indigenous healers. We should be aware, however, that our discourse on 'tradition' is consequently a discourse on knowledge, authority, and power.

In light of the findings up to this point, the word 'traditional' proved too confusing to use within the context of the sangoma's healing practices. The term's connotation of power and authority strengthened me in my decision to search for a substitute and I was glad to be able to fall back on a similar dispute.

4.2.4 Indigenous

In recent decades, there has been an academic debate about the usage of the term 'traditional', for instance in relation to religion. What in academic discourse used to be referred to as 'traditional' religion proved to be flexible and dynamic. The ambiguity of the word traditional resulted in a consensus to replace it with 'indigenous' (Cox, 2007). Of course, this word needs clarification as, in a way, it is also problematic. However, by explaining that indigenous is meant to refer to the customs or beliefs of a certain group of people, often relating to a certain locality where those people live (or lived) and excluding connotations like 'autochthonous' and 'normativity', the term seems more feasible than 'traditional' because of the lack of notions like invariability, consistency, power, and authority.

Within anthropological circles, some scholars (Website Platvoet)[34] propose to use the term 'local' rather than traditional or indigenous with regard to religion, because 'local' is free of a historic connotation and it reflects the often local (or points to a former locality) community-based belief systems that these religions are. To describe the Zulu sangomas' healing practices as local seems to me to be pinching at least at two points. Firstly, the Zulu people are scattered throughout the country of South Africa and even beyond the nation's borders; and secondly, perhaps more importantly, the differences

[33] In reference to the title of A.T. Bryant's book (1949) on life and customs of the Zulu people before missionaries came to the area where they lived. In this book, the practice of 'diviners' is described, as is their role in Zulu society.

[34] Like Van Beek at the symposium in honour of the 80th birthday of Jan Platvoet in Leiden, 8 June 2015.

in healing practices are due precisely to the various localities of sangomas' practices. Some sangomas who were trained in the rural area found that when they started their own healing practice in an urban area they had to change some healing processes and *muthis* to accommodate to city regulations or lack of places to harvest herbs.

Following the general discourse in substituting 'traditional' for 'indigenous' in theology, religious studies and anthropology, I decided to do the same with regard to the sangoma's practice, as announced in the first chapter. By calling these healing practices 'indigenous healing', in my opinion, more justice is done to the flexibility and the transformations we witnessed in this research than offered by the word 'traditional'.

In sum, although it is probably beneficial for their status and the execution of the practices to hold on to their emic phraseology, from an outsiders', scientific point of view, one can see it is ambiguous, even misleading and in a way inappropriate; accordingly, I prefer the term indigenous.

After this clarification on the issue of terminology, I will switch to the final internal dynamics, which are closely connected to the training, namely, the transformations in indigenous healers' networks and associations. The developments in the province of KwaZulu Natal and the *eThekwini* district will serve as an example.

4.3 From networks to associations

For sangomas, it is common to take part in various kinds of networks. Most of the graduated sangomas stay in touch with their *gobela* and with their former fellow *amathwasa*. They thus create a network around the 'school' where they were trained and often they all are invited to each new sangoma's graduation festivities. When, after graduation, she starts her own healing practice, a sangoma expands her network by joining the group of sangomas in her neighbourhood. They meet on a regular basis to talk about their healing practice and the various sorts of *muthi*. In the interview, Mks Bhengu told us that if a patient does not react well to a treatment, it is common practice to consult other sangomas or *inyanga*s, or to refer the patient to the Western Healthcare Clinic. Such cases are discussed in these meetings, as are social developments and other subjects that are affecting their healing practices. Ngubane (1992) considers these meetings to be professional conferences insofar as the occasions are exclusive and give the attendants the opportunity for communication. The meetings also serve to maintain and emphasise Zulu cosmology. An important function of the sangomas' network, she claims, is to control and discipline the individual members.

Many of these local communities of indigenous healers gradually transformed into small associations, some of which worked closely together with local clinics. One example of this is the cooperation of sangomas with the doctors of the Valley Trust Clinic in the Valley of a Thousand Hills, which I will describe in the next chapter.

4.3.1 In KwaZulu Natal

In 2002,[35] KwaZulu Natal's Minister of Health, Zweli Mkhize,[36] convened all the local associations of Traditional Health Practitioners (THPs) in his province and persuaded them to form one organisation, which would be able to represent all kinds of indigenous healers. So that in case Western Healthcare workers or the government wanted to communicate with the indigenous healers, they could address one organisation, instead of talking to many individuals or local networks.

Not every THP was convinced, however, of the government's good intentions; there was a widespread belief that the government was primarily interested in saving on healthcare expenses[37] and collecting the THPs' taxes. Moreover, as a result of their experiences of suppression and illegality in the apartheid era, many THPs felt a strong

[35] A few years before, the national government passed the first Traditional Health Practitioners Act (Act. 35 of 2004).

[36] Zweli Mkhize is a doctor, legislator, and politician. He served as KZN Minister of Health from 1994 to 2004. In 2004, he was elected premier of KwaZulu Natal. In 2012, he entered national politics and, after a few other positions, was appointed by President Cyril Ramaphosa as Minister of Health in 2019.

[37] The costs of expansion of cosmopolitan healthcare are much higher than legalising indigenous healthcare.

aversion to cooperating with the government. The notion that the original plan for registration came from the national (at that time, still white) government, aroused all the more suspicion. I will return to these topics in Chapter 6. Nevertheless, in the province of KwaZulu Natal, a number of indigenous healers interpreted the formation of such a national association as a possible means to improve the image of their profession and, consequently, their social position. For them to set up an association was also a quest for legal and formal recognition of the indigenous healers' profession.

Bongani Ntshangase was closely involved with the founding of the association in KwaZulu Natal. He told us it was not an easy process: "It was a demanding period for both founders and participants. Some even called it a mission." After several years of negotiations, the association was officially launched in 2005 with the name NUPAATHPSA and under the theme "Ensuring quality of Health Care in the 21st Century through Traditional Health Practices. […] The Unitary inaugural historic conference of NUPAATHPSA marked an important culmination of a long history of evolution (Website NUPAATHPSA)."[38] The aim of the association was laid down in the Constitution as: "To be a National Unitary Professional Association for African Traditional Health Practitioners of South Africa which strives for promoting total health of communities."[39]

NUPAATHPSA substituted the smaller associations, functioning as an umbrella organisation for at least two other THP associations, Kwa Nyanga Yezizwe (organisation of herbalists) and the Traditional Healers Organisation (THO, originally from Swaziland[40]). NUPAATHPSA tried to persuade all THPs to register, with the aim to be able to negotiate with governments on behalf of all indigenous healers. In addition, the association wanted to have an overview of who the THPs were, where they practised, and what they were specialised in, in order to incorporate these data in a referral system so that THPs could easily refer to each other and to medical doctors from the CHS and vice versa. By launching such a referral system, the association expected that indigenous healers would be more widely acknowledged as a 'medical equal party'. More about that in Chapters 5 and 6.

In 2012 and 2014, I got to know *eThekwini* NUPAATHPSA as a very active organisation and the members of its executive committee were dedicated to the well-being of the THPs and of the district's inhabitants. The executive committee consisted of seven members: a chairman; a secretary; a treasurer; and four members with special portfolios, such as HIV/AIDS, training, the public relations, and the checking/screening/monitoring portfolio. The latter implied checking whether new applicants were indeed qualified THPs and monitoring the quality of THPs' practices. In the *eThekwini* district, mainly an urban area where many immigrants are settling, this screening portfolio was a very demanding one.

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[38] www.nupaathpsa.org website of NUPAATHPSA, inaccessible from February 2015.

[39] Ibid.

[40] Source: www.traditionalhealth.org.za website of THO, inaccessible from January 2017.

In terms of the acknowledgement of the profession of indigenous healer[41] it seemed of the utmost importance to be certain that people who are admitted as member of the association are indeed qualified THPs. That is why not every indigenous healer that applied for membership of NUPAATHPSA was allowed to join the organisation. The screening portfolio executive visited and interviewed the candidate, checked their credentials, education, and healing practice, and judged if he was a qualified indigenous healer and thus permitted to register.

In the *eThekwini* district, NUPAATHPSA was successful in convincing THPs to join the association. Over 3000 THPs, an estimated 75 per cent of the qualified THPs, have registered to date and this number is still growing.[42] Such high percentages were achieved largely because the executive committee showed indigenous healers that they could profit from the association's membership.

Another cause for the high percentages in Durban, however, may have been the strong connections felt between KwaZulu Natal and the then national government, especially since 2009 when Jacob Zuma (ANC leader and a Zulu) became the elected president of South Africa. Respect for the elders and people in high positions is a key value in Zulu culture. The provincial and municipal governments in KwaZulu Natal complied with measures and enactments of the national government with seemingly less criticism than those in the rest of the country.

In present-day South Africa, the city of Durban can be perceived as the home base of the ANC. During the campaign for the (national and provincial) elections in May 2014, the city of Durban was a sea of yellow, green, and black, the ANC colours. In the build-up to the elections there were many disturbances in other parts of the country, particularly in cities like Cape Town and Johannesburg, in Durban, however, there was excitement in the streets. When, on 10 May, the results of the elections were announced, this was done in Durban. In anticipation of the ANC victory, the celebrations had already started in Durban days before. Because many people wanted to be there for the announcement of the official results, the city was packed, and there were traffic jams on all highways and major streets in the city. On Saturday, 10 May, the election results were announced in the Elangeni Hotel at the beach in Durban, with a live connection to the Moses Mabhida stadium, where tens of thousands of ANC supporters were gathered. After the declaration of the election results, the stadium roared with the singing and dancing of those ANC followers, time and again their cheering rolled like waves over the city.

Notwithstanding the efforts by the NUPAATHPSA and individual THPs to promote membership and registration in the Durban metro district, roughly 25 per cent of the

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[41] The mission of NUPAATHPSA as stated on the website: NUPAATHPSA seeks to achieve unity, recognition and regulation of our profession and its indigenous practices so as to ensure that we remain the champions – not only as an organization but also in the development of our profession and its practices beyond recognition.

[42] These numbers are the records of August 2012, according to Bongani.

qualified THPs still does not want to join the association. And in cases where these THPs have *amathwasa*, they advise them not to register either. One argument I heard for not joining the association is that some indigenous healers (in this case, sangomas) are convinced that their calling is for themselves and does not belong to society or the government. They believe the ancestors want them to execute their healing practice in their private consulting room, without having to account for their education or work to the government or having to take part in associative structures.

4.3.2 Organisation

Durban NUPAATHPSA comprised five regional branches. Every week the executive committee met in turn with the THPs of one of the branches. These meetings gave THPs a fine opportunity to keep in touch with each other and exchange their opinions on various issues. The meetings were often held in the City Hall, a building in the centre of Durban, but not necessarily so. When we were at Mks Bhengu's homestead for the interview she asked the executive committee to come and meet the THPs in the Valley of a Thousand Hills, so that the rural sangomas wouldn't have to travel to town so often. For some of them, especially the older ones, it is a long and tiring journey from the rural area to the city centre. As a member of the board, Bongani promised to arrange the next meeting in the countryside.

In these meetings, indigenous healers were encouraged to give their contribution and the committee used this input to develop a policy on the discussed topics. Furthermore, the THPs were updated about governmental plans and projects (such as legal, social, or medical matters in their area) that would affect their lives and those of the people around them.

In 2012, I was invited to attend part of such a meeting on a Thursday morning in August in the City Hall, in Durban CBD (Central Banking District), where the executive committee, chaired by Baba Hlongwane, and indigenous healers were gathered. The meeting was held in this municipality building's large hall, the front wall of which is painted in a bright yellow and covered with several (aerial) photographs of the city of Durban. After the opening of the meeting with an invocation of the ancestors (asking for their presence and guidance) and a few songs, one of the board members read the minutes of the last meeting. More indigenous healers arrived in the hall after the opening and throughout the meeting. Some of the attending indigenous healers asked questions, a few came to the front of the room to make elaborate remarks on the topics at hand. The board members made notes of the comments and these were later discussed extensively.

Figure 4.13 The executive committee (right) listens to one of the members' contribution

One of the topics in this meeting was my research; the executive committee thought it was important for the THPs to know that a study was being done amongst them. The chairman, Baba Hlongwane, asked Bongani Ntshangase to introduce me and, subsequently, he asked me to explain the research, my motivations, and the findings to that point. After my explanation, translated into Zulu by Bongani, a few questions were asked about the research, but also about my life at home in Holland and my job as a teacher in a secondary school. In general, the outline of the research was warmly embraced by the THPs, especially when members of the executive committee emphasised that they trusted me to write about the healing practice of THPs in a way worthy of their profession. Many of the attending THPs expressed their approval to the executive committee and their endorsement of this research. Some indigenous healers we had not visited even asked if they could also cooperate in the research and sangomas who had already been interviewed smiled proudly and told the people next to them about their experiences. When we left the City Hall, a little short of two hours after the start of the meeting, there were some sixty indigenous healers in attendance, with others still arriving.

Figure 4.14 Bongani explains the committee's endorsement of this research

It became clear to me in this meeting that NUPAATHPSA expects members to forward the meetings' information to all people in their communities. In this way, indigenous healers become key figures in their surroundings and they are frequently the first to know of upcoming developments. In addition to this elevated position of communication, THPs are important for the social cohesion of their neighbourhood in other ways. Like Mks Bhengu (the oldest interviewee), she takes care of orphaned children in a small building on her homestead. Living near a primary school she often saw many small children on the streets during the daytime. These children had walked to school with their siblings but were not old enough to be in classes, so Mks Bhengu decided to start a preschool for these very young ones. When she found out that some of these children's parents had died, she consulted social workers from the municipality and arranged that the children could stay with her, so that at least they would have a home and food. As a sangoma, she also acts as a village health worker: she visits people who have been diagnosed with TB or HIV/AIDS in a Western healthcare clinic. After the diagnosis and the first treatment, these patients are sent home with medication they have to take every day at a specific time. But in their own surroundings, people are sometimes not used to keeping time, or they tend to stop taking the medicine when they feel somewhat better again. Mks Bhengu reminds them not to stop taking the pills once they feel good, as the symptoms may then return. For some patients, she even provides a checklist to tick off every time they take their medicine, just to make sure. Because of all these things, Mks Bhengu is well known by people in the wide surroundings and highly respected by all.

Mks Mbuyisa's is a similar case. She is the spokesperson for the indigenous healers of her area in the Phoenix settlement, a township north of Durban. She passes on the information she gets in NUPAATHPSA meetings to her fellow THPs and the inhabitants of her district and, furthermore, she is consulted by people and THPs about problems concerning all kinds of topics in her area. She forwards these worries to the authorities in charge, be it the local clinic, the association or (via the association), the municipality. In her area, she also visits the patients infected with HIV or TB to make them persevere in taking their medicine and she has initiated a project for teenage girls from her neighbourhood. Mks Mbuyisa offers them the opportunity to come to her place after school, where she teaches them to make beadwork and other 'traditional crafts'. Her intention is to keep these girls off the streets, to prevent them from early sexual behaviour and the related danger of HIV infection. She hopes that with these acquired skills the girls will one day be able to earn their own living.

Figure 4.15 Mks Mbuyisa and the teenagers wearing beadwork

The social status of indigenous healers is enhanced by doing this kind of work and by being an intermediary; they thus occupy an important position in their social environment. The responsibility they take is met with great community esteem and it shows their social engagement and professionalism as indigenous healers.

The most important reason for indigenous healers to join an association is the recognition, the legitimisation, and the confirmation of their professionalism. When we met her in 2012, Mks Ngidi proudly showed us her THO membership booklet and the shirt provided by her association. If a sangoma is allowed to be a member of the association, she is generally assumed to be a qualified indigenous healer. Mks Ngidi, perceived her membership as an official quality mark.

Figure 4.16 Membership booklet THO

My impression is that in the urban area comparatively more THPs feel the need to join the association. In the rural areas, people tend to know which THPs to trust and which

not. Membership of an association as a quality mark is less needed in these regions, whereas in the urban area the situation is rather the opposite. Here, a quality mark may convince people to come for healing to a specific THP precisely because they are registered.

In a way, NUPAATHPSA combines the old networks of indigenous healers (neighbouring sangomas, *gobela* networks) and a new organisation of the association (corresponding with the Western model of an executive board, districts, etc.), thus gaining respect from sangomas and acceptance from all governmental levels. In Chapter 6, I will elaborate on the importance of this for indigenous healers and the political processes in contemporary South Africa.

4.4 Concluding remarks

A central topic in this chapter, following the healing and diagnosis in the previous chapter, was the internal dynamics and contradictions in the curriculum and knowledge transfer in sangomas' training. Transfer of (*muthi*) knowledge, the diagnosis, and the healing identity emerged as the most important elements in *ukuthwasa*. The data in this research indicate that there is no steady curriculum for any of these three elements.

The type and amount of (*muthi*) knowledge transmitted during *ukuthwasa* turns out to vary per *gobela* and per *thwasa*. In the interviews we held in 2012, several remarks hinted at this and the observations of fieldwork in 2014 underline this thesis. As the curriculum of each *thwasa*'s *muthi* knowledge training is both influenced by the availability and the changing array of *muthis* as well as motivated by the assumed wishes of the ancestors, I state that the transfer of *muthi* knowledge in *ukuthwasa* is individually attuned.

Besides the *muthi* knowledge, an apprentice has to acquire a proper attitude to communicate with the ancestors and patients in a suitable way and thus be able to diagnose the patients' affliction. These two important elements of *ukuthwasa*, the performance of the diagnosis, and the healing identity, are heavily influenced by (if not completely based on) the sangoma's personal expression and the presumed demands of the ancestors. Hence, I conclude that the training of sangomas and the *muthi* knowledge that is transferred are idiosyncratic and experiential.

After the training, every sangoma continues to develop and expand her know-how in knowledge exchange with other indigenous healers (and) allegedly inspired by the ancestors, something I called 'perpetual private revelation'. She applies this new knowledge in her healing practice and in the training of her *amathwasa*. Thus, every sangoma has her own range of *muthis*.

Moreover, on the basis of the dynamics in healing practice (see the previous chapter), I found many transformations in healing processes, elements that seem to be tailored to the individual sangoma's circumstances and the patient concerned. It seems to me, therefore, obvious that (new generations of) healers design their healing practice to their own preferences and possibilities.

Consequently, in reference to Whitehouse's theory, I come to the conclusion that both the sangomas' training and the execution of the indigenous healing practice are executed in an imagistic mode, that indigenous healing is an experiential, imagistic system.

Within the training and practice of indigenous healers, we encountered discrepancies on various levels between what is claimed and what is actually done, between 'programme' and 'practice'. The training is generally claimed to be identical for all pupils from one generation to the other, yet individual stories confirm an ancestors' instructed idiosyncratic teaching. A possible explanation seems to be in 'similarity': sangomas train

their *amathwasa* in a way similar to the way they were trained themselves, not precisely but roughly the same. However, they experience it as the same.

The connotations of power and authority of the word traditional convinced me not to follow this emic wording but to prefer the word indigenous instead.

Within the indigenous healing system, but outside the healing practice, I observed dynamics in the developments and organisation of THP associations. The old community-based networks are replaced by larger scale associations that are organised after the Western model, with executive committees and regional meetings. These are transformations with the aim of being acknowledged by the government and thus to dovetail with the Western healthcare system.

In the next chapter, we cross the indigenous healing system's threshold and proceed to dynamics outside this system, starting with two domains closely related to indigenous healing, viz. medicine and religion.

Chapter 5

A treatment one believes in

However interesting the sangomas' healing practice and the training described in the previous chapters are, these phenomena obviously do not stand alone. Indigenous healing is an integral part of South African society. Therefore it needs to be studied from a wider perspective, viz. the social context that it is embedded in. Consequently, we widen our view to various processes and dynamics, external to the indigenous healing system, which inform and affect contemporary indigenous healing. We set off close to the healing practice. In the attended healing sessions we encountered both religious and medicinal elements, which immediately interested me. As these elements are essential to indigenous healing, what is the relation between the respective domains? Therefore, before the exploration of other external dynamics, I would like to focus here on the following matter:

What dynamics are involved in the interrelationship between (cosmopolitan) health care, religion (indigenous and institutionalised) and indigenous healing?

I will describe the relation between indigenous healing and cosmopolitan healthcare from the patients' point of view as well as from the healthcare workers' perspective. To analyse the involved processes, I use Thomas Kuhn's scientific paradigm approach (Kuhn, 1962) and René Girard's theory of 'Mimetic Desire' (Girard, 1965). With what we learned from the application of Harvey Whitehouse's theory on the transfer of specialist knowledge (Whitehouse, 2004), I try to shed some light on cosmopolitan healthcare workers' approach towards indigenous healers.

With regard to the religious elements in indigenous healing, I will investigate longitudinal dynamics in the interrelationship between religion (both indigenous and institutionalised) and indigenous healing, in the second part of this chapter. My key informant Bongani Ntshangase and particularly his views on institutionalised religion serve as an illustrative example for this part.

In this chapter, I will further apply the concepts of 'medicine' and 'religion' to accentuate the content of the training, the practice, and the indigenous healers' position in contrast to Western medicine and indigenous and Christian religion.

Main characters in this chapter are the interviewed sangomas, Mks Bhengu (the oldest one), Mks Mbuyisa (the middle generation), and Mks Ngidi (the youngest one).

5.1 Health and illness

In present-day South Africa, the number of medical doctors is estimated to be 40,000 and cosmopolitan healthcare clinics, which are set up in both the urban and the rural areas, are easily accessible and within reach of everyone. Yet, when people are not feeling well, the majority[1] (Thornton, 2009) of South Africans (also) visit an indigenous healer. Apparently, indigenous healing is a serious option alongside cosmopolitan medicine. It seemed interesting to find out why these people attend an indigenous healer rather than a Western-trained doctor, who, in most cases, is also close at hand. In other words, I wanted to discover more about the patients' perspectives on both healthcare systems. Furthermore, I was interested in the attitude of the workers in both medical systems towards the other system, as well as the potential forms of cooperation between the two healthcare systems.

To gain an insight into the patients' perspective on South Africa's healthcare systems, we need to understand why people (also) go to indigenous healers and when. While I am aware of the fact that this is a very personal decision, one that may even vary at different moments in one's life, certain tendencies in relation to this choice can be discerned, some of which are based on the comprehension of health and illness. A clarification of the terms health and illness is therefore needed.

As previously mentioned, well-being is a holistic concept in Zulu thought patterns, a balance between the physical, mental, and social domain. This is reflected[2] in the World Health Organization's definition (not amended since 1948), which describes health as "[…] a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Website WHO)[3]. According to the Zulu worldview, illness and misfortune are signs of imbalance in one or more of these three domains and are believed to have a cause and a reason. It is essential to find out what the cause was, so that in the future similar negative experiences can be avoided. I will return to this later in this chapter.

In Zulu indigenous healing it is therefore important to restore the harmony, the equilibrium within and between the three domains. An indigenous healer treats the patient physically and mentally in the context of his life; consequently, the healing may take several healing sessions and often includes medicines, therapies, and rituals (Emebo, 2006).

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[1] About 80 per cent of the national population.

[2] Although one could argue it is the other way around, the WHO definition reflecting the African conception of health, for the latter has a longer history.

[3] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

5.1.1 Patients' perspective

While he lived in Pietermaritzburg and had his business domiciled in Mpumalanga, Mr Mbele[4] came to Mks Gasa in Durban for healing. Why did he go to a sangoma who lived more than a hundred kilometres away instead of to a Western healthcare clinic near his homestead? A wealthy man like him could easily afford any treatment by medical doctors.

In recent decades, research has been carried out on *why* people go to indigenous healers in addition to or instead of going to medical trained doctors. Ngubane (1992) indicates a number of aspects that contrast in the practitioner-patient relationship, from the patients' point of view. In the aspects she highlights, we find that the patients' choice for an indigenous healer is (also) based on cultural differences. Firstly, Ngubane argues that communication problems with Western-trained doctors might occur, especially in the case of older patients who are not proficient in English; the patient must arrange for an interpreter, which (even when it is a relative) is often a lot of fuss. In general, indigenous healers speak the patients' mother tongue. Secondly, at a clinic the patient must tell the history and development of his ailment, after which the doctor examines the patient and often gives the diagnosis in a few medical terms with little additional information. This diagnosis concentrates on the patient's specific symptoms at that moment. When a patient arrives at a sangoma's practice, however, the sangoma already knows the pains he is experiencing. Thirdly, while diagnosing, a sangoma constantly checks whether the patient recognises what the ancestors are revealing. In this process, the patient feels more acknowledged as a complete person because of the holistic character of both the diagnosis and healing, as Bongani affirmed.

Mks Mbuyisa told us in our interview that, in clinics, nurses and doctors see their patients on a tight schedule; patients who do not arrive on time (e.g. because of travelling problems) get reprimanded and often have to reschedule their appointment. This hurts the patients' pride and they consequently hesitate to return to the clinic for another appointment. Sangomas are usually at their homestead[5] so patients do not have to make appointments, they can go there whenever it suits them. A sangoma's healing session often takes about an hour, whereas in a clinic most consultations are much shorter, which, in turn, is interpreted by some patients as a lack of attention and respect.

Of course, there is also the matter of money. In the clinic, consultation fees are fixed and, for some patients, these costs are a problem because they simply don't have sufficient financial means. By contrast, most sangomas leave their fee up to the patients - they tell them to give whatever they can afford: be it a few South African Rand, a chicken, or something else.

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[4] See Chapter 3.

[5] In the urban area, the sangoma's practice also seems to shift to schedules.

Finally, there is the fact that indigenous healers practise within the same worldview as these patients; the conviction that the spirits of deceased ancestors have the power to communicate with and intervene in the world of the living, for example by inflicting misfortune in somebody's life.

Besides these patients' arguments for choosing *why* to go to an indigenous healer instead of a clinic or vice versa, another important element is the kind of infirmity the patient is suffering from. This bring us to the issue of *when* people actually go to indigenous healers and when they visit a local clinic or hospital.

Several academic writers on health in an African context distinguish between various sorts of afflictions. This differentiation is based on the alleged cause of the illness and the meaning that is attributed to it. On the one hand there is 'disease', which is caused by the malfunctioning of biological or psychological processes that can often be cured by some kind of medicine. According to his preferences, the patient may use herbal (prescribed by an *inyanga*) or allopathic (prescribed by a medical doctor) medicine, until, ultimately, health is restored. On the other hand, there are 'illnesses' that are believed to be caused by spiritual forces emanating from angered ancestral spirits, evil spirits, or the effect of witchcraft (Erdtsieck, 2003). In general, the last category is referred to as African diseases[6] or disorders (Ngubane, 1977) and for this kind of spiritual occurrences cosmopolitan health care is not expected to have a cure. Patients with these illnesses sense they need a holistic healing to restore their feeling of well-being, and they would rather go to a sangoma than attend a medical doctor in a clinic. In our interviews with sangomas, we heard of several patients who went to a clinic but found the doctors were not able to diagnose what was the matter with them. When these patients subsequently were treated by a sangoma, they were cured, or at least, felt cured.

In sum, for many patients, indigenous healing has some important advantages over the cosmopolitan healthcare system; it is accessible, affordable, culturally appropriate, and acceptable (Green, 1986).

5.1.2 Professionals' perspectives on the systems

The last aspect of contrast between the CHS and indigenous healers that Ngubane mentions is the attitude of the workers in both settings towards the other system. A frequently heard grievance of health workers in clinics is that patients that come for consultation are beyond curing due to a delay in seeking clinical treatments. They blame patients for initially consulting indigenous healers and they blame indigenous healers for just muddling on while they are aware that they cannot cure the patient. Nevertheless, the indigenous healers' attitude we encountered during this research was

[6] Disease of African people, Z: *ukufa kwabantu*.

one of openness towards the CHS. All indigenous healers told us that they frequently refer patients to fellow healers as well as to clinics and that they consult medical doctors themselves. *Inyanga* Baba Cele repeatedly visits the local clinic on account of his diabetes, asthma, and high blood pressure; Bongani Ntshangase had eye surgery and, in 2014, Mks Bhengu was waiting for an appointment for hip surgery.

When confronted with the clinic workers' criticisms, both Mks Mbuyisa and Mks Bhengu told us they were familiar with this way of thinking. Mks Bhengu, with healing experience of over sixty years, told us that the sangomas' practice has become more complicated and it has expanded in recent decades. The number of patients she diagnoses with (as she calls it) 'extended illnesses' like TB, HIV/AIDS, high blood pressure, and diabetes have multiplied in the period she has practised as a sangoma. These are illnesses that she cannot cure although, she says, she is able to give a complementary treatment for the symptoms that come with these afflictions. As apparently is common practice among many THPs (Zuma & et al, 2017), she refers those patients for medical treatment to the local clinic. But she often has to convince the patients of the necessity to go to a medical doctor. Mks Mbuyisa also mentioned the conversations with her patients in which she has to explain why they should attend the clinic. Both sangomas emphasise that patients do not go randomly to an indigenous healer; they believe their ancestors deliberately send them to this specific sangoma. By talking to the patient and negotiating with the ancestors, Mks Mbuyisa tries to change the patient's mindset so that he will follow her advice and go to the clinic for treatment.

A major point of criticism on sangomas' practices is the involvement of cultural or religious beliefs in matters of healthcare. This is deemed inappropriate, for example, by persons who had their medical training within the Western healthcare system. They argue that the sangomas' procedures are not based on evidence, but rather on beliefs in the supernatural, 'intangible forces' (Website Doctors for Life), and, therefore, these procedures are not scientific. Moreover, they claim that indigenous healing is even dangerous for patients; indigenous healers use various parts of medicinal herbs, minerals, and parts of dead animals and a sangoma's healing practice is constructed on various kinds of superstition; consequently, the indigenous healing practice does not belong in contemporary society.[7] An often ventilated opinion among Western healthcare workers is that somewhat backward and illiterate people may agree with the sangomas' views, but nowadays educated people should know better and be wiser than to go there (Website Doctors for Life).

The arguments used to outline indigenous healing as unscientific, are basically the same arguments that are used in the global discussion on cosmopolitan and alternative medicine and these arguments are typically applied by persons from within CHS. They use this argumentation to oppose alternative medicine, (in this case indigenous healing)

[7] More about this in the next chapter.

against cosmopolitan medicine. For many people, however, (indigenous healers and people working in alternative medicine included) this opposition or exclusion is artificial. When not feeling well, they claim, people go to see a professional, one who is expected to be able to heal them (Feierman, 2000), often regardless of what kind of healing this professional practises. When people feel better after a consultation it is not important to them whether the treatment was scientific or not. It is not important whether medicine works, it is the effect that counts.

5.2 Analysis: Why (not) cooperate?

The academic debate on what is proper science and what is pseudoscience has been going on for over a century. In the philosophy of science, the question of how to distinguish between these two is called the problem of demarcation. According to the American philosopher Thomas Kuhn (Kuhn, 1962; Geerlings, 2007), every scientific theory is imbedded in a certain paradigm, i.e. a frame of references that is generally accepted within a circle of scientists and it determines what facts are relevant and what demands a theory (or in medical science a treatment) must comply with. To distinguish science from pseudoscience, Kuhn states, we should consider the paradigm's problem-solving ability. As characteristics of proper science, he mentions the making of headway and the receptiveness to criticism, whereas pseudoscience often refers to authorities and customs, uses vague and ambiguous strategies, and actually leads to nothing (Boudry, 2014).

Many views on whether indigenous healing is a science or not have been given within and outside academic literature. According to Janzen, divination is "mystical art, not an empirical science" (1992, p. 123). Thornton, however, explains that healers see "themselves as belonging to an intellectual tradition of which healing is just a part. They believe it to be a kind of science that possesses its own standards of empirical evaluation and criticism" (2009, p. 23). Indigenous healing as a different kind of empirical science. The findings in this research underline his explanation to a certain extent.

The paradigms of the CHS and indigenous healing are not the same. In fact, they can be seen as competing and irreconcilable accounts of healthcare's reality. Kuhn states that one of the results of opposing paradigms is that scientists are talking past each other, confused about terms and consequences. This might explain the permanent situation of misunderstanding and non-cooperation between workers in the WHS and the THPs in South Africa.

In cosmopolitan healthcare, the diagnosis and the prescribed medication have to be scientifically based; within this system, it is highly valued that these issues can be checked and supervised. When feeling ill, Western physicians posit, a patient should come to a medical doctor or to a local clinic as soon as possible in order to get a scientifically based diagnosis and the corresponding therapy. From my conversations with indigenous healers (sangomas as well as *inyanga*s), I understood that many healthcare workers in the CHS look down on indigenous healing, and they presume a position of power in which they can afford a superior attitude towards THPs. The CHS appears to be regarded as the dominant (white) healthcare model to which each health practitioner, in whatever healthcare system, is supposed to conform.

Not only the health practitioners, but also the patients have to adjust to the CHS model. The patients' objections to the working method and communication in clinics and by Western-trained doctors that Ngubane (1992) writes about are not taken

seriously; many clinics and doctors still stick to their time schedules and excluding attitude, I was told.

In this seemingly diametrical stance there are, of course, also cases of more balanced judgement, often coming from people who are familiar with both healthcare systems. One example is Victor Gumede, a medical doctor whose father was an *inyanga*. In his book *Traditional Healers*: *A Medical Doctor's Perspective* (1990), Gumede mentions 14 differences between indigenous and modern healing in South Africa, ranging from allegedly "rational vs irrational" to "treating the disease vs treating the patient (physical, spiritual and emotional)" and "'what' vs 'who' caused the illness." Where Western medicine is based on "the germ theory"[8] (p. 40), in indigenous healing, disease and bad luck are an ancestral "punishment for failure to fulfil certain obligatory customary rites due to the departed" (p. 41). According to Gumede, both systems have the same goal, i.e. to help the sick and those who feel uncomfortable, and they do so from their different backgrounds, both succeeding frequently but not always. In his view, the modern and indigenous healthcare system are complementary, rather than contradictory.

A section of South Africa's (educated) black population has adopted Western views on healthcare, including the tendency to regard indigenous healing[9] as inferior to the Western healthcare model. At least, that is what they proclaim. Even among this section of the population, however, there are many who attend sangomas' healing practices when they are not feeling well. Their unannounced visits are often in the evening after sunset, so that their consultation is hidden from the (social) environment, according to what Mks Bhengu told us in our interview. Social control, directions from the ancestors and secrecy may also have been reasons for Mr Mbele, the wealthy businessman from Pietermaritzburg, to come to Mks Gasa's healing practice in Durban for healing.

Health for all,[10] Gumede argues (1990, p. iii), cannot be accomplished by Western healthcare alone and since the character of the diagnosis is holistic, alternatives like indigenous healing have to be mobilized. Therefore, changes and modifications are needed in both systems, but, as he concludes, with a quote from Chavunduka[11]: "it is modern medicine which must widen its analytical framework and conceptions and learn from the holistic approach of traditional medicine" (p. 236). In medical anthropological circles, Scherz recommends not only having a critical eye for biomedicine, but also to look at "these vernacular systems as places to learn *from*" (2018, p. 12). Mbatha, an indigenous healer herself, agrees with them. She notes that "the contemporary medical practice, in general, can be defined within a narrow technical-scientific frame of reference" (2017, p. 14) and that in diagnosing patients, the social-psychological aspects of health are neglected.

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[8] The theory that there is a causal organism for every disease.

[9] For the parts where the belief in ancestors is involved, like the 'African diseases' and sangoma's healing practices.

[10] 'Health for all by the year 2000' was a popular slogan adopted by the World Health Organization 1978.

[11] Professor Gordon Chavunduka, a Zimbabwean sociologist and indigenous healer.

5.2.1 Cooperation

In order to reach the goal 'health for all,'[12] in the new healthcare legislation (Act 22 of 2007)[13] the basic principal is for both healthcare systems to collaborate as equals. The indigenous health practitioners that take part in this research have an open attitude towards the CHS; previously I mentioned that sangomas and *inyanga*s go to the hospital themselves to get treated for their ailments and that they refer their patients to Western-trained doctors. Medical doctors, however, rarely refer patients to indigenous healers (Ndzimande, Sibiya, & Gqaleni, 2014) because they do not seem to regard indigenous healthcare as a similar (let alone equal) system to the CHS.

Despite the alienated positions of the two healthcare systems, there are (and have been) cases of cooperation between sangomas and doctors in clinics and, in the scope of this research, we learned about a few. Mks Bhengu told us of an example of a long-term collaboration: the Valley Trust Clinic in the Valley of a Thousand Hills worked together with indigenous healers in the area, for instance by planting medicinal trees near the sangomas' compounds, to have certain *muthis* close to their homesteads, and also by sending Western-trained doctors to the villages to share their knowledge with indigenous health practitioners in meetings about the two health care systems and how to improve the collaboration. The medical doctors also informed the sangomas about 'extended illnesses'[14] like diabetes, TB, and HIV/AIDS and their symptoms, the treatments, and medicines for these illnesses. Mks Bhengu was still cooperating with the local clinic when we visited her in 2014; she showed us the building next to her orphanage that is at the local clinic's disposal. Doctors and nurses came twice a week to this rural homestead to see patients.

[12] This goal had not been reached in 2000, so the 'crusade' continued.

[13] In the next chapter is an extended description of this law and its impact on indigenous healing.

[14] An expression used by Mks Bhengu, interview 1 August 2012. She was one of the first sangomas to work together with this local hospital.

Figure 5.1 Cooperation THPs and Edendale hospital in 2004, poster at Mks Bhengu's

Figure 5.2 Room at Mks Bhengu's where medical doctors can see patients, 2014

Another example of collaboration is the middle generation's interviewee, Mks Mbuyisa, who is the THPs' representative in the local clinic in the Phoenix settlement. This involves her doing her rounds in the clinic's wards on a regular basis, visiting THPs' patients who were admitted in the hospital. Sometimes, while she is in the clinic, she is consulted by the doctors or nurses about matters concerning one of the patients.

Kuhn calls deviations in the paradigm's approach anomalies. When, over a long period of time, many anomalies occur, he predicts that scientists will try to formulate a new theory to incorporate these anomalies. When we apply Kuhn's theory to the situation of the two healthcare systems in South Africa, we may assume that real cooperation between the systems is not likely to be achieved in the near future. If many individual Western-trained doctors and individual indigenous healers cooperate and come to appreciate each other's knowledge and ways of treatment, some progress in collaboration of the systems may be made. In agreement with Botha (2004), I doubt whether collaboration will be possible on the integrational level that the government proposes. Mlisa (2010) is convinced that the present situation of co-existence is the most feasible option.

However, after a long period of condemnation, some Western medical professionals apparently acknowledge the therapeutic potential of indigenous healing (Chidester, 1992) and the benefits of cooperation (Ndzimande, Sibiya, & Gqaleni, 2014). But these still seem to be more or less isolated cases based on personal efforts and know-how

instead of common practice, or due to special projects that were initiated by the (provincial) government.

THP associations have made efforts to improve the collaboration of both healthcare systems (thereby contributing to a decrease in national healthcare expenditure as well). In close consultation with the Minister of Health, NUPAATHPSA took the initiative to design a referral form to ease the referral procedure. Together with several partners like the CDC (Centre for Disease Control and Prevention), the University of KwaZulu Natal, KwaZulu Natal Department of Health, and the eThekwini Municipality, a form (with the text in Zulu and in English) was created and distributed among the members of the association. Mks Mbuyisa showed us the stack of those forms that she kept in her consulting room, ready to be used to refer her patients to the clinic if needed. The lower part of the form is a slip to be filled in by the doctor or nurse in the clinic and then returned to the THP, although the slips rarely come back to her. Consequently, she is not properly informed about whether her patient has indeed attended the clinic, or about the situation of the patient after referral, or whether her diagnosis was confirmed. It is clear that while indigenous healers do refer their patients to Western-trained doctors, referrals the other way round are rare.

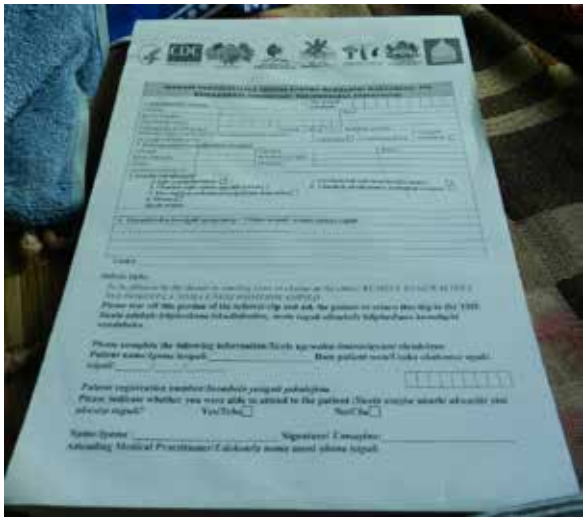

Figure 5.3 Referral form

Recently, in KwaZulu Natal, more projects have been set up to support the new healthcare legislation (Act 22 of 2007, passed in 2014) with regard to collaboration and integration of both healthcare systems. It is the intention that successful projects will be sustained and spread to other areas (Gqaleni, Hlongwane, & Khondo, 2010). For some time now, the Durban University of Technology and the KwaZulu Natal Health Department cooperate in a special project to train THPs in diagnosing patients with illnesses such as TB and HIV/AIDS, and in mutual referral with local clinics (Gqaleni,

Hlongwane, & Khondo, 2010). In July 2014, over 500 indigenous health practitioners graduated within the scope of this project (Website Durban University of Technology). Other university departments (e.g. medical sciences) and institutes like the Africa Health Institute and the Medical Research Council initiated and facilitated research on the role of THPs in the treatment of and care for HIV/AIDS patients. In such a research, Zuma found that THPs are key players in this field and pleaded for improvement of the "understanding between traditional and biomedical health systems" (2017, p. 9). In June 2018, "traditional and conventional health practitioners" gathered in Durban at an event initiated by the municipality to discuss ways of collaboration. The then *eThekwini* Mayor, Zandile Gumede, stated that "training and development, support and knowledge sharing between academics, healers and the current health system was vital to bridge the gap between the various health approaches" (Website SABC News).

5.2.2 Training

In spite of all these governmental and institutional efforts, structural cooperation with the CHS still appears to be granted mainly to a few senior indigenous healers. The appreciation of these sangomas in particular may have to do with another major point on which the CHS is critical of indigenous health practitioners: there is no fixed curriculum or supervised institution for the training of indigenous healers. In the previous chapter, I concluded that every indigenous healer has her own level of knowledge, acquired in an apprenticeship that is a practical training by a random experienced healer. What exactly is taught during this training depends on the trainer and the individual apprentice; the training is idiosyncratic. It is in sharp contrast with the educational methods used in the CHS where everyone wanting to become a doctor must attend university and pass through series of high standard exams. It is possible that the healing knowledge of those sangomas that the CHS cooperates with is deemed satisfactory by CHS standards.

When we apply Harvey Whitehouse's theory on the transfer of knowledge, we learn that knowledge in the cosmopolitan healthcare system is transferred in what Whitehouse calls, a doctrinal mode, which is characterised by frequent repetition over a long period. The students internalise the acquired knowledge and see no need to alter it or think beyond what they learned. The effect of this is a more or less fixed mindset and, consequently, different doctors give similar treatments to their patients. Within the CHS, health inspectors check medical doctors' competences and, in that process, knowledge and treatment are the most important parameters.

In the indigenous healthcare system, the transfer of knowledge to apprentices is in line with Whitehouse's imagistic mode, an infrequent repetition of knowledge that is accompanied with high arousal. Apprentices may not remember exactly what they learned, but they do recall the attributed meaning to what they experienced during their training. A vast diversity in patients' curing and treatment by the various healers is

the result. For indigenous healers, the autonomy of the healer is paramount since the only authority a sangoma feels she has to answer to are the ancestors.

While both conventional health practitioners' and indigenous healers' purpose is to cure their patients, the modus operandi is different. The views on health and illness vary as well as the communication with the patients and, furthermore, their cosmologies differ. In other words, they are working in separate systems, from within distinct paradigms; the CHS in a scientific paradigm with checks, proofs and evidence, the indigenous healers in an experiential, causal paradigm where the cause of and the reason for the felt lack of well-being is the central focus.

In my view, cooperation between individuals of both systems, based on mutual personal respect, is realistic for now and eventually may turn out to be the maximum, despite the efforts of various authorities like the Provincial Health Department and THP associations to integrate the two systems. Although Kuhn predicts that when many anomalies occur scientists will try to formulate a new theory that may lead to a change of paradigm, with regard to the two medical systems in South Africa, I have serious doubts about an imminent paradigm shift. The CHS is a hegemonic system, unlikely to change. Consequently, the pressure is on the THS to adapt.

We saw signs of this process in the interviews and healing practices; elements in the THP's practice that are familiar in the scope of Western healthcare practice. Whether such adaptations will lead to improved collaboration between the two systems is unlikely according to René Girard's Mimetic Desire theory.

5.2.3 Model and mimesis

At various levels of indigenous healthcare we see efforts to copy (elements of) the Western (healthcare) system: at the governmental level in the form of registration and keeping records, at the associational level with regard to its organisation and the establishing of *muthi* knowledge standards and a referral system between THP and CHS; and at the level of the individual healer with the planning of appointments and the organisation of the healing practice.

This is a process of imitation of a specific 'model' that the anthropologist and philosopher René Girard (1965) classifies as 'mimesis'. Such imitation originates in a mutual desire for the same object. The desired object in this case is recognition; indigenous healers strive to gain the same recognition as the Western healthcare system, from patients, professional workers in the medical field, and from various governmental levels. In order to achieve this recognition, elements of the Western (healthcare) system are copied in the individual healers' healing practices and by the association in terms of procedures of registration and organisation.

We may conclude that many South Africans already acknowledge indigenous healing from the fact that a large majority of the population (also) attends indigenous

healers. In the latest healthcare legislation, the national government recognises indigenous healthcare as an equivalent to cosmopolitan healthcare; individual THPs are acknowledged on condition of registration. Acknowledgement of indigenous healing is not common, however, at the level of Western healthcare professionals, the 'model' that already receives recognition (the THPs' desired object). Many Western healthcare professionals consider their medical system to be superior to indigenous healing, as I described previously, and that is not likely to change in the near future. According to Girard's Mimetic Desire theory, the closer the subject (indigenous healing) comes to the model (Western healthcare) with regard to the desired object (recognition), the more the model will consider the subject as a rival. I therefore expect that Western healthcare resistance towards indigenous healing is unlikely to decrease in the short term, with the exception of small-scale collaboration based on individual esteem. For indigenous healthcare, the western healthcare system might even convert from being the model to an obstacle that ultimately hinders the THPs from gaining their desired recognition.

5.3 Religion and healing

Besides the medical aspects of in indigenous healing, we also see numerous religious elements. Earlier I defined the terms 'health' and 'medicine'; now, before exploring this juxtaposition, it is necessary to outline what we mean when we use the word 'religion'. In the scope of this research, a working definition of religion is useful, i.e. a tool to analyse data and that is appropriate for the task at hand, namely, to discover contrasts and analogies between indigenous healing and religion. In my view, Ellis & Ter Haar's definition of religion is appropriate here: "[…] religion refers to a belief in the existence of an invisible world, distinct but not separate from the visible one, that is home to spiritual beings with effective powers over the material world" (2004, p. 14). This, as they call it, anthropology-based[15] definition is appropriate for the African context, for Christianity as well as for indigenous religion.

According to Janzen (1992), the distinction between religion and medicine is also effected by the point (and background) from which you observe it, be it indigenous terms and institutions or Western analytical models. From my (etic) point of view, as a Western academic outsider, I would argue that indigenous healing is rooted in (within the scope of this research) Zulu indigenous religion. The sangomas cooperating in this study would probably disagree with me on this, because they see indigenous healing from their indigenous worldview and background (the emic point of view), in which the ancestors are real. They would not deny, however, that there are religious elements in their healing practice.

When we look somewhat closer at the procedures during a patient's consultation at a sangoma's healing practice, we come across elements that, as a Western researcher, I would call religious rather than medical, namely: starting the consult by lighting *imphepo* and praising and invoking the ancestors; diagnosing by 'listening' to the message of the ancestors; thanking the ancestors at the end of the session and patients bringing offerings for the ancestors. Moreover, the burning of multiple candles in various colours can be interpreted as a religious symbol. An interesting feature with regard to the sangomas' use of candles is that pictures and paintings of indigenous healing sessions in the late nineteenth and early twentieth century do not feature candles.[16] The presence of candles in sangomas' healing process may be due to Christian influences on the indigenous healers' practice.

In the preceding pages, I have explained that exactly these elements are a major reason why the CHS considers indigenous healing to be neither scientific, nor medical. Is indigenous healing to be regarded as a more religious phenomenon than a medical one?

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[15] Ellis and Ter Haar's definition refers to the nineteenth-century anthropologist E.B. Tylor. He briefly described religion as 'belief in Spiritual Beings'.

[16] E.g. drawings by Gerard Bhengu, Simon Mnguni, and Barbara Tyrrell and early photographs in Killie Campbell Africana Library, Durban.

Considering the way the sangomas' healing practice is intertwined with (communication with) the ancestors, from a Western academic point of view the CHS' arguments are understandable. Their claim is that the ancestors belong to an indigenous religious domain and therefore the sangomas' practice has little to do with healthcare.[17] In the first chapter, however, I have already clarified that, in the South African context, for a majority of people the presence of the ancestors and their ability to interfere in a person's daily life is an integral part of their worldview. This worldview is not a separate part of their life as religion is for many (religious) people in the Western world. In the African context, the power of the ancestors is not something people believe in, it simply exists, just like a mountain or a river. They experience the influence of the ancestors in their daily life, since they consider, for example, good luck, bad luck, health, and illness to be brought about by these ancestors; they do not, however, label it as a religious phenomenon.

Religious ideas "provide a framework for understanding causes of events" Ellis & Ter Haar (2004, p. 24) observe and they point out that religion is, among other things, a system that aims to explain events, to be able to predict and control such events in future settings. In a way, it is a 'theory of causation'. When things go wrong in life, when we encounter evil, we want to know what the cause of that evil is. In anthropological terms, we search for the aetiology of evil (Olsen & Van Beek, 2015) with a view to being able to avoid it in the future.

Where does this evil, bad luck, disease or misery come from? Why do things go wrong? In search for the answers to these questions Zulu people turn to a sangoma, for this is her expertise. The goal of sangomas' communication with the ancestors is for them to find out what caused the ancestors' intervention in the patient's life. All this, together with religious symbols like candles and praising the ancestors, are arguments to claim that the sangomas' healing practice leans towards a (indigenous) religious phenomenon.

What processes, then, characterise the relation between indigenous healing and (institutionalised) religion?[18] The attitude of the churches towards indigenous healing and vice versa is a significant element in this matter, as is the position of the individual patient. I shall briefly examine the patients' perspective and then move on to various denominations of Christian institutions and their approach to health and indigenous healing.

In the healing sessions at Mks Gasa's compound that I described, we saw that patients with different (religious) backgrounds came to her healing practice to find solace. For Christian patients or patients whose ancestors were Christians, the healing session

[17] Judging from a narrow definition of healthcare.

[18] When I use the term (institutionalised) religion in the remaining of this chapter I am referring to Christian religion. I do not have sufficient data about the relations between indigenous healing and the Muslim or Hindu community (both significant communities in the Durban Metropole).

apparently involved an extra chapter. Their sessions also started in front of the leopard print cloth and included the invocation of the ancestors, but then these patients shifted their position 90 degrees to the right, to where a blue dress with a white cross stitched on it was hanging on the wall. The session then continued in this vein with Christian spirits invoked in much the same way as the ancestors' spirits, although obviously the use of words differed. Evidently for these patients and sangomas both religious systems blend together, they co-exist. It seems that from the patients' point of view, there is no hindrance to going to a sangoma for healing, whether they are Christians or not, or whether their ancestors were Christians or not.

At the Gasa compound, I got the impression that the communication with the Christian ancestors is also a special field of expertise. Mks Gasa herself is specialised in these spirits, she teaches the *amathwasa* this part of the training. When a patient's problems allegedly have to do with his Christian ancestors, Mks Gasa is the one that takes the lead in the healing.

In a nutshell: for the sangomas and the patients I met during this research, indigenous healing and Christian faith are not conflicting, they may even go hand in hand. Before we explore the Christian churches' attitude towards indigenous healing, a small note on the efforts sangomas make to be of service to their (potential) patients.

Because their patients come from different countries, and all kinds of religious and cultural backgrounds, sangomas have to gain in depth-knowledge of religions and cultures, and some of them do. Bongani told us that, for example, every few years, the Durban metro branch of NUPAATHPSA arranged study trips to India for small groups of sangomas, with the aim of becoming familiar with the culture and religious habits of the country, in order to improve the sangomas' ability to communicate with and understand a patients' Indian ancestors. After the trip, these sangomas are more or less specialised in the treatment of patients who (might) have Indian ancestors.

5.3.1 Christian churches and healing

Writing about the relations between indigenous healing and the Christian churches is a perilous undertaking. There are many denominations and the differences between various denominations are huge. Moreover, within denominations, local communities are allowed to more or less develop their own policies (Chidester, 1992), which are liable to constant changes. A general image of the churches' attitude towards indigenous healing therefore is hard to sketch.

Nevertheless, on the basis of some contrasts, I will try to give a rough overview of the way churches look at and engage with indigenous healing and indigenous health practitioners. First, I will give a (very) limited historical context of Christianity in South Africa, followed by the differences between so-called 'mainline' churches and African Indigenous Churches (AIC) and their respective attitudes towards healing in general

and indigenous healing specifically. For the present situation, I rely on the data of my fieldwork, which are the products of a restricted area and a limited time.

Christianity came to South Africa initially as a white man's religion. Initiated by frontier missionaries in the 19th and 20th century, churches were built wherever groups of white people settled. African people were converted to the new religion and joined the churches, but their position was kept marginal. The mainline Christian churches remained dominated by white people, men habitually, which reflected the social structure in South African society (Ray, 1976). Some of these churches even supported the government in the realisation of apartheid laws by justifying racial inequality and oppression, through biblical stories and pericopes.

In the second half of the 20th century, black people felt less and less at home in these 'white controlled' churches with their Western cultural patterns and structures. Many felt sorely offended by the way their custom, culture, and worldview was ignored and rejected. An example is the Christian churches' attitude to the subject of healing. As I have described, black people use(d) to relate the healing of diseases to their African cosmology; for them, healing has a 'religious' connotation. In the mainline Christian churches, however, there was little serious attention paid to the views of African people; healing was simply kept outside the walls of the church. Matters of health and illness were referred to medical doctors and Western-oriented hospitals (Griffiths & Cheetham, 1989).

During these decades, numerous black people left the church and found a shelter and a home in African Independent Churches (AIC), Christian communities led and supported by black people (Oosthuizen, 1992). In these churches, which are often founded by a 'prophet', they found a religious environment where healing, which conforms with their cosmology, is understood to be a mainly religious concept (Emebo, 2006). Within AICs, the 'healing ministry' has become a central feature and is performed by prayer-healers (Z: *abathandazi*) who heal parishioners in the name of Jesus or the Holy Spirit, and prophets (Z: *abaprofeti)* who heal by means of visions. Various methods are used for these healings, like prayers, faith-healing, laying on hands, singing, and beating of drums. Currently, thousands of denominations with millions of adherents form the body of AICs. According to Oosthuizen, the ongoing growth is due primarily to the fact that African Independent Churches "take the negative forces of the African cosmology seriously" (1989, p. 77).

There are often two hierarchical lines in the organisation of an AIC, one with the bishop or minister at the top and the other with the prophet or healer as the most important person. The priest or minister is seen as the protector of the cult, doctrine, and religious tradition, while the prophet often takes a more critical stance towards those institutional religious expressions.

5.3.2 Churches and indigenous healing

Mainline churches

Within some mainline Protestant Christian churches, the attitude towards indigenous healing can be described as aloof, even disapproving. These Protestant churches are still primarily white men's churches, with little room for black people or appreciation for their customs. The biases we encountered among many white people regarding indigenous healing are also vivid in some of these communities. Healing (and health in general) is seen as a medical phenomenon that belongs to the medical doctors' practice. Moreover, indigenous healing (because of the ancestors' part) is not in line with their Christian doctrine.

Other mainline Christian denominations like the Roman Catholic Church, the Anglican Church, and the Lutheran Church, have been more welcoming towards black people and parts of their culture. These congregations are often mixed communities where (similar to the Protestant churches) the teachings and doctrines are delivered top-down to the parishioners. Although people from all kinds of backgrounds are equal and are able to become priests and ministers, the organisation and structure within these churches remain those of the Western-oriented churches they used to be.

In Zanimvula's healing session at Mks Mkhize's compound, we encountered an example of the hostility of an official in a Christian church towards indigenous healing. As a priest, Zanimvula's great-grandfather (so Mks Mkhize concluded from the position of 'the bones') chased every indigenous healer out of the church with the argument that it was demonic. It turned out that Zanimvula's bad luck was the bitter fruit from his great-grandfather's behaviour.

African Independent Churches

In African Independent Churches, influences of custom and indigenous religion have come from bottom-up. Between the various denominations of AICs, however, there are many differences regarding the degree to which black people's customs are common in Sunday services and, for instance, in meetings throughout the week. With regard to indigenous healing and the belief in ancestors, the policies may vary for each denomination.

For example, within most of the Ethiopian Churches, which pursue pan-African unity (Chidester, 1992), there is a more or less negative attitude towards the belief in ancestors and indigenous healing, just like in Pentecostal-Charismatic Churches and Evangelical Churches where the born-again congregation often displays an aversion to sangomas. In recent decades, these Pentecostal Churches have become increasingly popular in Africa (Meyer, 2007).

In the Zionist Churches, however, spiritual healing is an important feature; Zionist healer-prophets heal members of the congregation in the name of the Holy Spirit.

Oosthuizen (1992) observed that for the prophet in AICs the emphasis is generally on the physical and social healing of parishioners, which implies opening the way to self-fulfilment and restoring disturbed relations. Here we see a parallel with the sangomas' healing practice (Sundkler, 1961; Schoffeleers, 1989; Van Dijk, 2000).

In his book about African Independent Churches, Oosthuizen writes about the differences between diviners (sangoma) and the prophets in AICs. One of the differences he indicates is that prophets go to church whereas sangomas do not. Another one is that while sangomas work under the power of the ancestors, prophets work under the power of the Holy Spirit. In a way, he argues, these prophets can be seen as institutional substitutes for indigenous healers such as sangomas and *inyangas* (1992).

Both West (1975) and Oosthuizen notice a movement from sangoma to prophet. People who were called to be a sangoma bend their calling (by an offering to the ancestors) towards becoming a healer-prophet in an independent church, which is a legal and respected position. West also suggests this development might be caused by a lack of money for financing *ukuthwasa*.

These last observations may partly have been a result of the apartheid rules and regulations, including the illegality of the healing practice of sangomas.[19] Both cited books were published during and shortly after South Africa's apartheid era. Recently, we see an increasing blending of those former separate worlds: Christianity and indigenous healing. Where the churches' attitude towards indigenous healing used to be sceptical, during the field study for this research we encountered an open and self-confident attitude among sangomas towards the churches. And while Oosthuizen states that Christian diviners occasionally can be found, for the majority of the sangomas that we met, Christianity and indigenous healing obviously go hand in hand these days. Therefore, it no longer seems necessary for them to bend their calling to become a sangoma to the profession of healer-prophet.

From the interviews in 2012, it became clear that the relationship between Christian churches and indigenous healing has not always been an easy one. However, the kind of hostility we heard of in Zanimvula's healing session did not emerge there. Rather, we were told of more moderate, understanding attitudes and reactions by church professionals, even during the period of apartheid when the sangomas' healing practices were prohibited.

Mks Mbuyisa told us that when she was called to become a sangoma in the 1960s, her grandfather, who did not want her to become a sangoma, took her to a prophet of a Christian church to stop the calling. But when the prophet comprehended what was happening to Mks Mbuyisa, he said to her family "I can't stop this thing. This child is like this. She came out with this from her mother's womb. It is a God's gift."[20] He sent them

[19] More about this in the next chapter.

[20] Interview with Mks Mbuyisa, 9 August 2012.

away. Her grandfather then understood there was no other option for his granddaughter and gave her his consent to start her *ukuthwasa*.

In the story of Mks Bhengu's life (the eldest interviewee) the shifting positions of the church and indigenous healing are clear. As a young girl, Mks Bhengu had recurring dreams in which old people told her not to go to church anymore because she should come to them and become a sangoma. Mks Bhengu first denied this calling exactly because she was brought up in a family who were members of the Lutheran church. When she married she joined her husband in attending the Zionist church. Only after she gave birth to her first child, in the 1950s, did she accept her calling to become a sangoma. After her *ukuthwasa*, her ancestors wanted her to return to the Lutheran church and, with her husband's approval, she did. In 2012, she was still a practising sangoma and an active member of the Lutheran church.

Mks Ngidi's calling (the younger generation) came at the start of the 21st century, when she was a member of a Zionist church. First, she denied the calling and when the drums were played in her church, for example in a healing by the healer-prophet, it got on her nerves. The sounds were hurting her and she started to tremble all over. She explained during the interview that her ancestors did not want her to go to church at that time, but instead they wanted her to become a sangoma. Finally, a few years later, she gave in to her ancestors' calling and went to her *gobela* for training. During her *ukuthwasa*, sangomas played the same sort of drums, and then she enjoyed it. Now, as a sangoma, when she goes to church the drums do not bother her anymore; she is able to enjoy this music inside the church as well.

Phiri (2006) observed that sangomas are both Christian (often members of AICs) and followers of indigenous religion, or only adherents to their indigenous religion. Less than ten years later, this still applies to sangomas in the *eThekwini* district.

Apart from above described examples of sangomas who attend services in Christian churches, some sangomas actively combine their indigenous healing practice with (elements of) Christianity. Like Mks Mgadi, who I visited in March 2012, and who has started her own church. In a white rectangular building on her homestead she conducts services for the people in her neighbourhood every Sunday, during which the drums are used frequently. And in Mks Gasa's consulting room, prayers and songs are directed towards the ancestors as well as to Jesus and the Holy Spirit, depending on the patient's beliefs and background.

Figure 5.4 Mks Mgadi's church

Recent developments

More recently, new developments have emerged in mainline churches. They show interest in indigenous healing and they approach indigenous healers to come and tell about their healing practice to the congregation. Bongani Ntshangase explained that, as a member of the NUPAATHPSA executive committee, he had recently received several invitations from Christian churches to give a presentation to its members about the sangomas' healing practice.

5.3.3 Bongani Ntshangase, churches

For Bongani Ntshangase, one of the things that came with the calling to be a sangoma was the task of building bridges and raising people up, ultimately to improve people's lives and society at large. One special area he was very passionate about is removing, what he called, misunderstandings and prejudices about indigenous healing. He wanted to show what the sangomas' healing practice is like, that there is no evil in the work that sangomas do. On request, he gave lectures to students at universities and medical high schools and also in Christian churches and to other religious communities. He liked to go to churches to set up a dialogue with the church leaders and parishioners about indigenous healing.

That his efforts in building bridges were noticed is evidence, for instance, in invitations for meetings with religious leaders of the eThekwini district or even the province of KwaZulu Natal. In May 2014, for example, he was invited to the Interfaith Symposium in the Legislature of Pietermaritzburg[21] as the representative of Traditional Religion. Almost six hundred people attended this symposium with delegations from all religious denominations in KwaZulu Natal (among them representatives of the Muslim community,

[21] A central topic in this three-day meeting was the contribution of religious leaders and their communities to building the nation and improving South Africa.

the Jewish community, the Jains, the Hindus, the Rastafarians and the various Christian Churches). Since Bongani represented a considerable, but religiously diffuse group of people, his contribution to the discussion was highly appreciated.

Figure 5.5 Interfaith Symposium in The Legislature in Pietermaritzburg

Bongani was not the only one who was invited to Christian communities, we discovered. One day, when we were at Mks Gasa's compound, Mks Zinhle got a telephone call from the minister of the Methodist Church in KwaMakhutha, the township where the Gasa family lives. He asked her to come and give a presentation about 'traditional medicine and the sangomas' healing practice', especially in relation to Christianity. It seems that in the churches there is a need for knowledge about these subjects nowadays. To obtain first-hand information they directly approach a reputable sangoma in their neighbourhood.

This current situation, that mainline Christian churches and other religions are making approaches to indigenous healers and showing interest in indigenous religion, is a dynamic typical for the post-apartheid era. It is a result of the new awareness of culture and religion and goes along with the pride and growing self-confidence of sangomas with regard to their profession.

5.4 Concluding remarks

In this chapter, I have explored and described what dynamics are involved in the interrelationship between (cosmopolitan) healthcare, religion (indigenous and institutionalised) and indigenous healing. Indigenous healing has both medical and religious elements; nevertheless, the relationship with CHS as well as with (institutionalised) religion can be difficult.

The relationship between CHS and indigenous healing is characterised by dynamics that originate from the different paradigms that the two healthcare systems are imbedded in; one is an evidence-based scientific paradigm and the other an experience-based paradigm. In the previous chapter, we encountered a similar difference in the training. To put it in Whitehouse's terms: a doctrinal training in CHS and an imagistic, experiential training in indigenous healing.

Although, according to healthcare legislation, both healthcare systems are (to be regarded as) equal, the cosmopolitan healthcare system is hegemonic. And as power defines knowledge, Western (healthcare) discourse determines not only if, but in what way and under what circumstances acknowledgement of and cooperation with indigenous healers will take place. In reference to Kuhn's paradigm approach, the CHS will recognise (and collaborate with) the indigenous healthcare system provided that the latter conforms to the scientific paradigm. There are signs of indigenous healing's conforming with the CHS in, for instance, the organisation of the healing practice and association, and in the attempt to standardise *muthi* knowledge and the creation of a referral form.

Nevertheless, it is unlikely that the CHS will ever accept indigenous healing. Girard's Mimetic Desire theory shows that the more the indigenous healing system approaches the CHS model with regard to the desired general recognition, the stronger the CHS's rejection of indigenous healing will get.

Equal to the law or not, a majority of CHS staff considers the cosmopolitan system superior to the indigenous one. I do not expect this to change easily for the matter reaches deeper than only healthcare; the whole Western paradigm is apparently hegemonic, superior to whatever other paradigm there is.

Overall collaboration between the two healthcare systems is therefore only conceivable if indigenous healing discards its distinct individuality. For the time being, cooperation is confined to individual cases and special projects. The conceptual analysis of 'medicine' and 'religion' showed that whereas the discourse on indigenous healing is in medical terms, in my view the sangoma's healing practice consists predominantly of religious elements. To sangomas, their profession is first and foremost a matter of healing, a term that in this context proves to have a much wider definition than merely medical. Furthermore, for numerous sangomas and many of their patients who are members of mainline Christian churches or of AICs, (institutionalised) religion and indigenous healing are not oppositional, but easily go hand in hand.

Indigenous healing's relation with institutionalised religion seems to have improved in the decades after apartheid. Many Christian churches are now showing interest in indigenous healing and there is an exchange of knowledge and practices. This mutual interest might be an effect of the influence of the African Independent Churches, in which African custom and culture is combined with Christian doctrine.

An example of Christian influences on indigenous healing is the prevalence of candles in sangomas' healing practices, which may be considered a form of syncretism between Christianity and indigenous healing in general.

Now that dynamics between indigenous healing, cosmopolitan healthcare, and the various kinds of Christian churches have been examined, we can proceed to other external dynamics that inform indigenous healing in contemporary South African society.

Chapter 6

Indigenous healing in contemporary society

In the past century, the status of indigenous healers' practice in South Africa has been subject to radical changes. Originally, in Zulu society, as is other societies (Beattie & Middleton, 1969), both *inyanga*s and sangomas were held in great esteem and (as counsellors) their social position was close to the king. Later, in the apartheid period, the sangomas' practices were declared illegal (Flint & Parle, 2008). In the decades after apartheid, however, (the social status of) their profession has transformed to one that is accepted and respected by many people. For a few years, their healing practice has been officially legalised and indigenous healers are getting organised and registered. With an estimated 350,000 THPs nationwide, 26,000 of whom are registered in the province of KwaZulu Natal,[1] indigenous healing is for a majority of South Africans today an obvious and legal option next to the Western healthcare system.

In this chapter, I will look at indigenous healing in the wider context of South African society. Its position is partly defined by the relationship with the CHS and its liaisons with religion, which I have sketched in the previous chapter. Evidently, there are more processes external to the indigenous healing system that have an effect on this system, the sangomas' healing practice, and the training. In her book on the training of Xhosa women as indigenous healers, Mlisa states that "ukuthwasa is a dynamic practice that is affected by time, circumstances and context. It becomes affected by global changes" (2010, p. 3). And if the training is affected, it seems clear to me that the indigenous healing practice is also influenced. According to Thornton, healers perceive their profession as part of a dynamic "intellectual tradition of which healing is just a part" (2009, p. 23).

The main question here is therefore: How do historical, social and political dynamics inform contemporary indigenous healing? Obviously, these processes are connected in multiple ways.

I wondered to what extent the sangomas' healing practice is prone to changes due to external processes. To find out, I analysed the data of the fieldwork, comparing the interview texts and the various healing sessions that I attended, internally and mutually. Despite the limited scope of this research, I found many longitudinal transformations, in the interviews as well as in the execution of the sangomas' healing practice and between the interviews and the practice.

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[1] In *eThekwini* district there are 3,000 traditional health practitioners registered.

In connection with the external dynamics, I encountered (as with the internal dynamics) discrepancies on several levels in terms of what was said and what was done. Therefore, I will once again use the antipodal concepts 'programme' and 'practice' to single out these paradoxes, but this time at the level of the national government with regard to the implementation of the national healthcare legislation and at the level of the indigenous healers' association and their claim to be able to distinguish 'real' sangomas from 'fake' ones. This leads us to the topic of whether such a contrast is useful or possible at all.

Part of the dynamics in a sangoma's healing practice were illustrated in the description of Mks Gasa's practice and school in the sections on healing and training. This led to my decision not to follow the THPs in calling their profession 'traditional healing', but instead to use the term 'indigenous healing'. When we look in this chapter at indigenous healing practices in changing society we must also examine why THPs hang on to the term 'traditional'. I return to this topic because it is an important issue; my analysis of the indigenous healer's practice is not similar to the sangomas', it may even be an unwelcome deconstruction of their claim. In addition to the concept of power, I explore what other connotations are connected with that term and what the implications are in view of this research. Using Hobsbawm & Ranger's theory on invented tradition, I try to comprehend to what extent indigenous healing is traditional or rather a re-invented tradition.

The concept of 'tradition' is often used as an indication of something, e.g. a custom, that supposedly has its origin in a time different from the one we live in. A 'tradition' is not of our days, it maybe even slightly out-of-date. As I argued before[2], when we use the word 'traditional' we do so as a disjunctive to what we experience here and now, in our contemporary society. It is actually owing to our position in present society that we classify habits and practices as tradition(al). But what aspects of present-day life mean that we experience it as something so different from life in the past? To assess whether or to what extent indigenous healing is 'traditional' it is necessary to also circumscribe what it is compared to, therefore I will concisely sketch 'contemporary society'. Additionally, by applying the antipodal concepts of 'tradition' and 'changing society', I intend to cast some light on the ways in which sangomas' healing practices relate to these concepts.

In contrast to tradition's connotations of ancientness, continuity and invariability our contemporary society is characterised by concepts such as fluidity, rapid change, technology, and globalisation. In his book on cultural dimensions of globalisation, Appadurai (2010) describes how, until the start of the twentieth century, sustained cultural interaction came about either by warfare or by religions of conversion. The technological explosion in the last century, e.g. increased mobility and the (use of social) media, has resulted in, among other things, new conditions of neighbourliness,

[2] In § 1.4.2.

de-territorialisation, and the assimilation of new elements in cultures. Nowadays, we are able to travel and settle wherever we want to, we can keep in touch by cell phone or email with people everywhere and buy products that have their origins on the other side of the globe. In recent decades, the developments in several fields like mobility, communication, and technology are overwhelming; "our modern world is an interactive system in a sense that is strikingly new" (p. 27). Indigenous healers are residents of this rapidly changing world, they utilize it and seize the opportunities it brings them. At the same time, they claim to deal with entities from another era in the execution of their profession. Indigenous healers experience standing with one foot in tradition and another in contemporary changing society.

Changes in South African society obviously have repercussions on the indigenous healers' practices. To demonstrate the ways that indigenous healing is influenced by various external dynamics, I draw from the data from the interviews and the attended healing sessions and, also significant, my endless conversations with Bongani Ntshangase. Besides being a valuable source, he was also a fine example of a sangoma in contemporary society.

Other main characters in the first part of this chapter are the interviewees (Mks Bhengu for the older generation, Mks Mbuyisa for the middle generation, and Mks Ngidi for the younger ones) and *inyanga* Baba Cele. In the second part, Mks Gasa (familiar from Mr Mbele's healing in Chapter 3) will appear again as exemplary of contemporary urban healing practices.

Bongani Ntshangase, a present-day sangoma

When we first met in 2012 Bongani Ntshangase was in his mid-forties and had been practising as a sangoma for more than fifteen years. Before he was called to be a sangoma, he had jobs at multinational companies such as Unilever and SA Breweries. Even after he graduated as a sangoma and had given up his "Western job", his former employers kept asking him to help them out. His skills in solving problems were highly appreciated as were his capacities as a qualified assessor. So, he was frequently invited to come back to work on specific projects. He combined these projects with his healing practice at home in the Inanda area, a township north of Durban city centre.

He practiced in the evenings and at weekends. For him, this was convenient with regard to the projects he did for his former employers and his commitments to the association of indigenous healers. As a member of the executive committee, he often had to address administrators and ministers from the municipality or the province. In addition, his schedule proved to be comfortable for his patients too, because most of them were well-educated and worked during daytime. In his healing practice, the patients came for consultation by appointment. He booked one hour per patient in order to be able to explain all details of the diagnoses and prescribed cure. He was convinced that when his patients were told why they were prescribed certain *muthis*, they would value the *muthis* more. He saw a maximum of five patients a day, the only exception he made on this point

was for a consultation for a child. That could be his sixth appointment, because as he said "children are always emergencies". Sometimes, Bongani also visited patients at home, for example when a patient had just been discharged from hospital or when the patient was too ill to come to his healing practice.

Bongani was respected among the indigenous healers as well as by the multinationals' managers and governmental administrators. With his extensive network, he could bring people together and build bridges between these generally separate domains. What he pursued was a better mutual understanding, which he believed was, ultimately, in everybody's interest.

"If you are respected by the community partly depends on your behaviour. Being a sangoma, you have to be a humble and trustworthy person. That has to show in day to day life. Respect is there for those who respect themselves first." Mks Bhengu[3] is clear about how a sangoma has to act. For more than 60 years, she practised as a sangoma in the rural area, where people know each other. When you are not feeling well, for healing you go to somebody who you respect as a person, or to somebody who is recommended to you; preferably you do not go to a total stranger. The way a sangoma behaves from day to day reflects whether she can be trusted.

People also respect you, Mks Ngidi[4] confirms, for the work that you do; they know that sometimes things are revealed to sangomas. As an example she tells of the day when she was on the bus and a man came to sit beside her. The moment he sat down, Mks Ngidi had an experience about this man, and when she told him of this experience and explained the meaning of it, the man was amazed but grateful to her for sharing with him. He was not an exception; most people are surprised but appreciate it when a sangoma tells them what is revealed, whether it is something about their history, about their behaviour, or about a decision they have to take. This kind of respect is due to the work sangomas do and the things they allegedly learned during *ukuthwasa*.

Not everyone holds sangomas and their practices in such high regard. In the present South African society, there is also a lot of (what sangomas refer to as) ignorance and misunderstanding concerning the healing practices of indigenous healers. In the periods I was in Durban to do my field study, I encountered many - mostly white, but also some Zulu - people who actually warned me about sangomas and their practices. I repeatedly heard phrases such as "Look out for them, don't go there! They are witches, they use witchcraft! They really are dangerous!" There are, however, also white people who look at sangomas in a more unbiased way and who are interested in their profession; some white people also attend sangomas for healing and there is a small number of initiated white sangomas.[5]

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[3] Interview, 1 August 2012.

[4] Interview, 9 August 2012.

[5] Mks Bhengu trained one herself.

A few issues are crucial to the way the profession of sangoma is regarded in South Africa today. One, which is inherent in the history of this country, is the point that 'traditional healer', '*inyanga*' and 'sangoma' are unprotected titles. Anyone could decide to call himself a traditional healer and give whatever treatment to whoever comes to him for healing. The second is the rapidly changing South African society, which brings opportunities but also feelings of discomfort for many people. And the last one is the recent healthcare legislation, its implementation, the involvement of THP associations and individual sangomas. I will examine each of these connected historical, social, and political processes in turn.

6.1 Historical dynamics

Zulu ethnography and social history have been well documented (Ngubane, 1977). Travellers and missionaries like Callaway (1884 (1870)) and Bryant (1949; 1964) and anthropologists like Krige Jensen (1965 (1936)) have written extensively about daily life of Zulus. Both Callaway and Bryant lived among the Zulu for decades and learned the Zulu language (isiZulu). Berglund (1975), who grew up among the Zulu as a missionary's son, describes the Zulu cosmology and belief-system comprehensively.

The pictures they sketch of rural Zulu society and the position of medicine men (*inyanga*'s) and diviners (sangomas) have many similarities. These healers were held in high regard because of their knowledge and the fact that their social position was close to the elders and even to the Zulu king. High-ranking people often consulted them before taking decisions concerning important matters. *Inyangas*' knowledge about herbs, roots, and minerals was essential in curing illnesses and keeping people healthy. Sangomas were revered as the protectors of society, for they were considered to be the link between the ancestors and the living, the visible and the invisible world. Many sangomas combined being diviner with knowledge of medicinal powers of herbs, which made them all-round healers.

Since the writings of these scientists and missionaries, South African society has changed a lot, and so has the social position of indigenous healers. It is beyond the scope of this chapter to describe extensively the social and political history of South Africa in the last century. To outline the dynamics that most affected indigenous healers and their practices (Janzen, 1992), I will focus on three major, closely connected topics: apartheid; availability of means; and urbanisation.

6.1.1 Apartheid era: Health, rich and poor

In the time of apartheid (1948 to 1990), the white government made an effort to minimise or even destroy indigenous healers' practices, especially those of sangomas. The divining part of their practice was seen as pagan and heathen; furthermore, the sangomas' healing practice was referred to in terms such as witchcraft and sorcery. By declaring their practices unlawful, the national government politically and socially marginalised sangomas and they were forbidden from executing their profession. In his research among Nyuswa sangomas in 1959, Van Nieuwenhuijsen (1974) encountered the consequences of this policy: some sangomas refused to take part in his research in fear of prosecution, based on the Medical, Dental and Pharmacy Act (1928) and the Witchcraft Suppression Act 1957. These laws, however, did not stop patients from going to sangomas for healing. On the contrary, the emotional distress caused by the apartheid system made many black people turn to sangomas, who were appreciated as rays of hope in those dark times. The demand for their services increased and therefore

those sangomas that considered their profession not just a job but rather a calling, secretly continued their healing practices. Many of them went underground. Officially, their practices stopped, but the patients came after sunset and the healing processes were executed at night.

Mks Mbuyisa[6] told us how the oppression during the apartheid regime marked her life, then and even now. Her calling, her training, and her initiation as a sangoma were in the days of the apartheid laws. "In those days sangomas were looked down upon, we were called witch-doctors. We couldn't do our practices in the open, had to work underground out of fear for being prosecuted. These circumstances caused me a lot of pain and hurt." For a woman like Mks Mbuyisa, who is proud of her calling and her profession, the restrictions in those days must have been very frustrating. As soon as it was not illegal anymore to practise as a sangoma, she decided to become a member of a THP association. She wanted to leave the pain and hurt behind her. "I could feel this thing in my heart, in the bloodstream: I am a sangoma, I am going to live this life, it is my life for now and for ever. So now I must go and show them that I want to be seen as this, today, tomorrow and the next day."[7] But even twenty years later, when she told us about those dark days, I could still see the pain and grief in her eyes.

Throughout those apartheid decades, Western healthcare developed rapidly, globally as well as in South Africa; hospitals and clinics with Western-trained doctors and nurses were built in all provinces of the country. Most black people were not able to go to these places because of apartheid's restricting travel laws and the prohibitive costs of treatment. Apart from the social dividing lines on skin colour, the split between rich and poor deepened in terms of healthcare issues. Wealthy people who could afford the costs attended Western healthcare clinics, those who could not afford such costs went to indigenous healers. Many indigenous healers did not charge any money, but asked patients to pay in whatever means they could, including food or drinks or nothing at all. Indigenous healing thus became associated with the poor, uneducated (black) part of the population.

This image still exists in the minds of some of the South African population, many white people think of sangomas as dangerous witchdoctors, quacks, and charlatans. For many educated black people, Western culture has repressed their indigenous cultural roots and they regard indigenous healing as inferior to Western healthcare. Especially sangomas and their patients are regarded as uneducated even backward people, because of the role the ancestors are believed to have in their healing processes. "There is a certain level of people in the (black) community, mostly the learned people, that look down upon traditional healers. During the daytime they say no to traditional healing practices, however often these people do come to sangomas for consultation at night.

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[6] Interview, 9 August 2012.

[7] Ibid.

At face value they don't respect sangomas, but actually they do. They only don't want it to transpire."[8] Mks Bhengu told us of these double moral standards, drawing from her comprehensive experience as a sangoma in the rural area. There are things that the doctors in the clinic cannot cure, she said, referring to the difference between 'Western' illnesses and African diseases[9] and remembering the afflictions that marked her youth while, according to the doctors, there was nothing wrong with her. Then, these people come to a sangoma and they choose a moment when their visit won't be noticed. At Mks Gasa's compound, in the urban area, we saw patients from all walks of life, most of them were rather well-to-do, middle class, only a few looked to be more badly off. Some, like Mr Mbele, even turned out to be quite wealthy. In Mks Mbuyisa's and Mks Ngidi's healing practice, patients come from all levels of society too.

Whether it is appropriate to associate indigenous healing with the poor and uneducated in modern South African society is questionable. In any case, sangomas do not see themselves as the poor man's doctor, they compare themselves with other professionals, like medical practitioners. This observation by Thornton (2009), in his research in the Lowveld (Mpumalanga, Gauteng), is confirmed by the findings of this research in the Durban metro district; we saw people from all social classes in the sangomas' consulting room. The educational remark might be true for the older generation of indigenous healers, who often did not finish their schooling because of the calling to become a sangoma. Nevertheless, it does not seem to be the case for the patients, as people with all educational levels come to indigenous healers for consultation nowadays. Moreover, many sangomas we met (especially the younger ones) were modern and educated themselves; Mks Ngidi has worked as school teacher, Mks Mkhize had toured the world as a musician. They are both now full-time sangomas; other sangomas practise their healing profession part-time. While working in a 'normal' job from Monday to Friday (Trouw, 2014), they practise as sangomas at weekends and in the evening hours, as described in the case of Bongani Ntshangase.

Bongani Ntshangase, education

Bongani is also an illustration of a well-educated sangoma. He was born in uMlazi, B-section, one of the oldest parts of this township south of Durban,[10] one of his parents' seven children. After primary school in uMlazi, his ambitious parents sent him to boarding school, to be in an isolated place where nothing would distract him from his studies. They judged that there would be too much to take his mind off his studies in the township. As he was ambitious himself he continued his education after boarding school at a Technical High School. After graduation, his working career involved teaching at Technical High School and management jobs at multinational companies. He gave up his 'Western' job

[8] Interview, 1 August 2012.

[9] See also Chapter 5.

[10] After Soweto, the second biggest township of South Africa.

and accompanying privileges (lease car, high wages, bonuses, high social status) when he eventually became a sangoma. Although he earned far less money as a sangoma, he chose to send his three daughters to (expensive) boarding schools, because, just like his parents, he was convinced of the importance of education, preferably in a place without any distractions. In these boarding schools, the pupils stay on campus for the whole term, they are only permitted to go home during the holidays. Visitors are allowed at weekends, and even then the pupils must stay near the school's compound.

The apartheid period has left its marks on sangomas more than on other indigenous healers. One of the consequences of the declared illegality of their healing practices is that even twenty years after the end of apartheid there are still large gaps in lifestyle as well as in terms of respect for sangomas between the white population, on one side, and the rest of the population on the other side. Every indigenous healer we talked to was aware of these enduring (as they called it) misconceptions and for some of them this situation is a thorn in the side, others resign themselves to it. Nonetheless, sangomas seem to carry out their healing practice with even more pride and passion; all sangomas we met were self-confident about their profession and the accompanying way of life.

6.1.2 Apartheid era: Health, rural and urban

The apartheid policy as a comprehensive discrimination strategy ranging from the racial segregation of public facilities and social events to prescribed housing and employment rules, led to dramatic structural changes in South African society. When, at the end of the nineteenth century, diamonds (1867) and gold (1886) were discovered, the mining and accompanying industries flourished and, in the following decades, thousands of men left the rural areas to go to the mines and the cities to try to earn a living. Some took their families with them, but most of the women and children stayed in the rural area, where they continued their pastoral life. The migrant men were under the impression that they would earn a lot of money in a short time and then return to their families (Rounds, 1982). In the meantime, they had to limit their expenses to be able to send money to their families. These men's living conditions were dreadful; they had to share shabby rooms in barracks with several other men. Isolated from their families and daily affairs at home they were often socially deprived and miserable. While they were used to living on a small scale in the rural area, now they had to live rather anonymously in rapidly expanding urban centres. Experiencing feelings of discomfort, being uprooted, and longing for their families caused tensions for many of these men. The women and children at home often felt the same way. With an uncertain income, the women had to take care of their own chores as well as those of the men (Ngubane, 1977). Often, they lived on the homestead with the husband's extended family, where mounting tensions (caused by e.g. rivalry with other wives or between their children) could easily get out of hand (Nieuwenhuijsen, 1974).

The pastoral society that had been in existence for centuries, fragmented in only a few decades. Migration to the cities and colonial oppression during the apartheid period made many people feel lost, homeless, even hopeless too. The implementation of the Group Areas Act 1950 resulted in a policy of 'resettlement' and until the early 1980s, millions of people were forced to move to their designated 'group areas'. These removals to specific areas for black, coloured, Asian, and white people had an enormous impact on everybody's daily life. Black people, for example, were not permitted to run a business or a professional practice in areas labelled as 'white'; instead, they had to move their business to a black region. In those days, Zulu *inyanga* Baba Cele[11] owned a pharmacy and shop in the centre of Durban City. Because of the Group Areas Act he had to close this shop (as the city centre was declared a white man's area) and move it to uMlazi, a black township about 15 kilometres south of Durban city centre. These drastic governmental laws and far-reaching measures caused a lot of distress among black and coloured people.

In circumstances that things are going wrong for them or when feeling discomfort, the Zulu believe their ancestors to be the cause of their misery. In such cases they are used to calling on the sangomas' intermediary abilities to find out why the ancestors have stopped protecting them or have inflicted this misery upon them. Although ancestors are sometimes malicious and annoying, they are believed to have the power and authority to influence people's daily life and therefore one must take their wishes and demands into account. The women and children who stayed in the rural areas would go to local, familiar sangomas for consultation, but the situation was much harder for the migrants in the urban areas. In need of advice or treatment for their misery, they turned to unfamiliar indigenous healers who practiced in the cities.

As so many people in the urban areas were feeling miserable, the demand for sangomas increased rapidly. When and wherever demand is higher than supply, a gap in the market is soon discovered. And so, as Baba Cele told me, it happened in the urban areas; the number of sangomas in the cities rose exponentially. Not all of them were trained as a sangoma. Those who were not saw a sangoma's healing practice as a chance to earn easy money. In the anonymity of city life, the patients were unaware of the competences of individual indigenous healers. And in good faith many patients went for consultation to someone whose advertisement they had seen, on a lamppost in the street or in a local bar, for instance. Posters advertising love potions and penis enlargement creams for people who are not happy in their love life, posters promising a cheap and painless abortion, fortune tellers to brighten the dark future or a 'wizard' who has a remedy for everything; symptoms of what Comaroff and Comaroff call 'the occult economy' (1999).[12]

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[11] Conversation with Baba Cele, 13 August 2012.

[12] These authors describe a parallel, occult, economy in South Africa, characterised by e.g. "the constant pursuit of new, magical means for otherwise unattainable ends" (1999, p. 284).

Figure 6.1 Palm reader advertising

Figure 6.2 Advertising enlargement cream and pills

Figure 6.3 Gandalf has a remedy for everything

After the end of the apartheid regime in the early 1990s, the new government (led by Nelson Mandela) strived to make South Africa a 'Rainbow Nation', a country where all people are respected and have equal rights and opportunities, not just legally but particularly in daily life. Especially the black and coloured people's lives and prospects improved significantly and the standard of living increased (more or less) for many. These developments were noticed worldwide and caught the attention of people in neighbouring countries as well.

As a result, in recent decades, immigrants from countries like Zimbabwe, Swaziland, and Mozambique have come to South Africa to escape from the lower living standards at home; most settle in the urban areas. Some of them are trained as indigenous healers in their home country and start a healing practice again in their new residence. It is particularly attractive for other immigrants from the same country to go to these indigenous healers for consultation because of the presumed familiarity with the patients' backgrounds and cultural and religious ways. Others, even those not initiated as indigenous healers, also started healing practices in this new and unfamiliar environment, where nobody knows of their education, competencies, or experience. For them indigenous healing is a chance to earn their money.

Contrary to their experiences at home (or) in the rural area, urban patients were often disappointed in the healing abilities of the (self-proclaimed?) sangomas. Love potions did not put a spell on the desired one, the cream for penis enlargement did not do the trick, and time did not bring the promised fortune, despite the money the patient spent on the potion, cream, or fortune teller. Gradually, the respect for sangomas in the urban areas diminished. Not because the education of urban sangomas was necessarily of a lower standard, but because some people had taken advantage of the fact that the profession of sangoma is not a protected one. Anyone can call himself a sangoma and start a healing practice. Baba Cele[13] expressed it as follows: "Sangomas, some get a calling and some are taking chance." The major implications of the fact that sangoma is not a protected title will be discussed later in this chapter.

The 'taking a chance phenomenon' occurred especially in the urban areas. In the villages and in the rural area people tend to know each other, and it is common knowledge for those living in these regions who is a sangoma, who had a calling to become a sangoma, and who has finished her *ukuthwasa*, not least because the whole community is invited for the initiation celebrations at the end of *ukuthwasa*, the moment the apprentice graduates as a sangoma. In daily conversation and through the grapevine one hears which sangoma is trustworthy and in what kind of afflictions a sangoma is specialised.

One important contrasting element between urban and rural healing practices relates to the kind of questions and expectations the patient has when he attends a sangoma, I noticed in the conversations with indigenous healers. In the rural area, a patient goes to the sangoma to learn from the sangoma what the cause of his affliction is, by way of the diagnosis that is supposedly communicated by the ancestors. He merely gets a vague notion of what the actual result of the treatment will be. He puts his well-being in the healer's hands. In the urban area, however, the problems and the setting are different. Here, for example, sangomas use leaflets and posters to advertise their skills, thus patients often come to a sangoma with more specific requests (Zuma & et al, 2016) and, as a result, it is easier for the patient to decide whether his cure has been successful or not. The contemporary urban patient may have determined himself that his feelings of distress were caused by the lack of a loved one and, consequently, he comes to the sangoma with a specific request for a love potion. He has exactly in mind what the result of the potion should be. Then, if the desired person does not react in the anticipated way or the feelings of distress continue, the patient's conclusion might be that the sangoma is a fake. The patient comes to the sangoma with the outcome of the remedy in mind, the sangoma has to give a treatment that will have the desired effect, and the (treatment's) outcomes are measured along the lines of the Western (medical) model. Whereas rural patients used to come to a sangoma with (psychosomatic) afflictions, in the urban areas

[13] 13 August 2012.

the patients' requests are of another kind, frequently concerning (material) prosperity. Baba Cele explained that the practices of self-proclaimed indigenous healers in the cities appeared to strengthen people's opinions of sangomas as being charlatans.

In the media the idea of sangomas as witchdoctors has also popped up again, for instance in stories of sangomas allegedly being involved in the trafficking of body parts (IOL News, 2015)[14] and reports of witch hunts (Mail & Guardian, 2015).[15] The belief in witchcraft as "a manifestation of evil, believed to come from a human source" (Kgatla & Ter Haar, 2003, p. 3) is common on the African continent. In South African society (in some provinces more than in others), witchcraft has become an explosive issue, due to elements in the changing society like urbanisation (Niehaus, Mohlala & Shokane, 2001; Ter Haar, 2007). When your neighbours are not your family anymore but often total strangers, it may lead to feelings of unsafety. Insecurity, discomfort, and bad luck are genuine, intense emotions that are perceived as evil and caused by witchcraft (Berglund, 1976; Ashforth, 2000). So (the belief in) witchcraft is not just a relic from colonial times, it is a contemporary phenomenon (Geschiere, 1997). Witches and sorcerers supposedly use the same kind of *muthis* that sangomas use, but for negative purposes: to cause evil, destroy well-being, and health. Remarkably, during this study's fieldwork I did not encounter witchcraft as an aetiological system. In none of the attended healing sessions I heard a witchcraft-related diagnosis, every patient's complaint was said to be caused by discontented ancestors.

All the sangomas we met during this research confirmed (belief in) the existence of witchcraft but persistently emphasised that they only use their *muthis* in a positive way, to do good, and to heal their patients. The sangomas did admit, however, that they suffered from these kind of negative images and stories and that this influenced their social position and their healing practices (Gqaleni, Hlongwane, & Khondo, 2010). While they had been sangomas for decades sometimes, respect for their practices and way of life could no longer be taken for granted. I will return to this subject and the support THP associations offer their members in cases of accusations.

6.1.3 After apartheid, attempt to legislate

After the apartheid regime ended, the government's[16] attitude towards Traditional Health Practitioners changed diametrically; their healing practices were no longer judged illegal (Mlisa, 2010). To improve healthcare for all inhabitants of the country and to simultaneously control expenses, collaboration was sought between Traditional

[14] Parts of dead bodies are believed to be used in witchcraft.

[15] See also Comaroff & Comaroff (1999).

[16] In the 1994 national elections, for the first time in South African history all adults regardless of (skin) colour, had a right to vote. The African National Congress won the elections and Nelson Mandela, released from imprisonment in 1991, became the first black president of South Africa.

Healthcare and Western Healthcare. This modification of policy can be seen as an obvious next step and interpreted as a reaction to the previous regimes. The government started a process to acknowledge indigenous healers and include them in the national healthcare system.[17] One part of this process was the initiation of the forming of a national THP association. The purpose of founding such an organisation was to have all indigenous healers registered and licensed, so that provincial and national governments would get an overview of the number of the various kinds of indigenous healers, their training, and their income. In Chapter 4, I described the founding process of such an organisation (NUPAATHPSA) in KwaZulu Natal.

In 2007, the government passed the Traditional Health Practitioners Act (THPAct or Act 22, 2007). Earlier, the Parliament had passed the Traditional Health Practitioners Act of 2004 (Act. 35 of 2004), giving indigenous healers a license to practise for the first time in South African history. However, this act was ruled unconstitutional after Doctors for Life International[18] challenged it, mentioning the insufficient public participation at provincial level in the drafting of the act. Mlisa (2010) confirms the lack of public consultation at that time, at least in the Eastern Cape province. There was a lot of mistrust towards the government among Xhosa indigenous healers, especially those in the rural areas. The way procedures were executed and the indistinctness of the real governmental goals made indigenous healers sceptical and reluctant to cooperate. Thornton (2009) describes the same ambivalence about the government's regulatory attempts among sangomas in Mpumalanga. In the province of KwaZulu Natal, the formation of an association and the implementation of registration seems to have encountered less opposition than in the Eastern Cape and northern provinces. New rounds of public consultation were started and these resulted in Act 22, 2007. Similar legislation to acknowledge indigenous healers had already been passed in other African countries like Zimbabwe[19] and Botswana.[20]

The THP Act (assented in January 2008) intends to "provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for the management and control over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners profession; and to provide for matters connected therewith."[21]

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[17] See for the global policies: WHO traditional medicine strategy 2014-2023: http://www.who.int/medicines/publications/traditional/trm_strategy14_23/en/ last accessed 13 November 2017.

[18] Doctors For Life International is a non-governmental and registered Non-Profit making Organisation (NPO) established in 1991, among other principles upholding "Sound science in the medical profession". http://www.doctorsforlife.co.za, last accessed 11 May 2018.

[19] 1981.

[20] The first reference to the official acceptance of traditional medicine practitioners in Botswana appears in Section 14.86 of the National Development Plan of 1976–1981.

[21] The text of Act 22 as published in the Government Gazette, 10 January 2008, volume 511 Cape Town, No. 30660.

Hereby, the government recognises and acknowledges the practices of indigenous health practitioners, sangomas, *inyanga*'s, indigenous birth attendants, and indigenous surgeons, in South Africa and the medicine they dispense. In order to regulate them, the Act says, the indigenous healers need to register as a THP. Instrumental to this registration is a (to be established) national THP Council. The minister instructed the provinces to implement the bill and to get all indigenous healers to register. Five years after the president's assent of the THP Act, in February 2013, the Minister of Health inaugurated an interim Council for Traditional Health Practitioners. Several sections of the Act, dealing with the governance of the national council and the registration of practitioners, came into effect on 1 May 2014 (twenty years after apartheid[22]) and, in the same month, the Traditional Health Practitioners Council was set up by Parliament. In April 2015, however, no indigenous healers were registered so far, allegedly because of the Council's inability to select "credible THPs from bogus ones" (Mail & Guardian, 2015). Apparently, the government had not yet successfully formulated adequate conditions for registration and implementation. This left the THPs back at square one. At the governmental level, the process evolved agonizingly slowly and every new delay fed the indigenous healers' feelings of discomfort and frustration.

Here we see some discrepancies at the governmental level between 'programme' and 'practice'. Firstly, the government passes a law to regulate the practices of indigenous healers by registration and association, but the implementation of the law, i.e. setting up an authorised register and a framework for a national association and THP Council is long overdue. Secondly, the government wants THPs to register, but the communication with indigenous healers and supply of information to them is poor, especially in the rural areas. Thirdly, the government suggests that registration is attractive, however some registration consequences conflict with indigenous healer's basic principles and are possibly detrimental for their patients, which makes THPs hesitant to register. One may well wonder what the aim of the legislation ultimately is: recognition; legitimation; control; or merely a symbolic?

The implications of the THP Act on indigenous healers' practices as well as the reactions of individual sangomas and the association will be discussed later in this chapter. Now, however, let us focus on the way social processes and dynamics affect contemporary sangomas' healing practices.

[22] Obviously, this legislation was not the democratic government's first priority.

6.2 Social dynamics

Although they claim that there is still a lot of misapprehension about their practice, in general the indigenous healers' social position, specifically the sangomas', has improved a lot in the last twenty years. Since the end of the apartheid era, sangomas are gradually taking back their active role in society with pride and zest.

Along with the changing South African society, indigenous healers' practice is constantly transforming. In the interviews and the healing sessions we attended (most of which were in the urban area) we came across many examples of transformations in the practical execution of healing practices, e.g. how to carry out specific rituals, the use of contemporary elements (such as cell phones), and expanded mobility. By using the genealogical sampling method we could trace down and identify those longitudinal changes, due to social dynamics. A number of transformations in healing practices will be presented below. Other adaptations in the healing practice, for example with regard to *muthi* and allegations of witchcraft, can be related to the social acceptance of indigenous healers' practice.

6.2.1 Accommodations to a changing society

The way a sangoma carries out healing processes for her patients is partly dependent on the location of the healing practice. Hardly any adaptations are needed if this location is similar to the place where she did her *ukuthwasa*, which means that the learned procedures can be performed the same way in her own healing practice. But when a sangoma settles in a location very different from her *gobela*'s surroundings, healing processes may need to be tailored. Mks Ngidi told us, for example, about "raw fire". During her *ukuthwasa*, she learned several healing processes in which an open fire is needed. In the rural area where her *gobela* lived, lighting a raw fire is very common. However, now that Mks Ngidi is practising in the urban area, she is restricted in laying fires in the open. To be able to carry out these specific procedures she uses a gas stove and adapts the healing procedure to it. In such circumstances, it is up to the sangoma to consider all important and vital elements in a healing process and to decide on how to execute it in the actual situation.

Figure 6.4 Mks Ngidi's consulting room

Other adaptations have to do with practical issues of the healing practice, for example in the availability of sangomas for their patients. Sangomas used to stay at home as much as possible in case a patient arrived for a consultation. Mks Bhengu even told us that being at home (and thus available for patients) was one of the points on which respect for a sangoma was founded. These days, there is less need to stay home because everybody can be reached by cell phones; when a patient arrives unannounced, the sangoma can easily be notified. In the urban area, some patients do come to a sangoma without a message beforehand, but here it is more usual that appointments are made.

Bongani Ntshangase, changing society

Bongani executed (as I mentioned before) his healing practice at the end of the afternoon and in the early evening in his home in the Inanda area (Durban North) because of his daytime activities on projects for his former multinational employers and for NUPAATHPSA. For this association he participated in meetings with other indigenous healers, the eThekwini Mayor, the provincial Ministry of Health and other official bodies. He wanted people of all backgrounds and social classes to become (more) familiar with indigenous healing, to remove biases and to show what indigenous healing involves. His aim was to improve the total healthcare for all people by collaboration between indigenous health practitioners and the Western Healthcare clinics.

He kept in touch with his wide-ranging network within South Africa by mobile telephone; with his (inter)national connections he communicated through email, Facebook, and his LinkedIn account. No matter when or where he went, he always carried his cell phone close at hand as well as his emergency bag with *muthis* (amongst which powder snuff and a small bottle of fluid essence as the most important items to quickly open up the communication channels with the ancestors) around his shoulder. It was

imperative for him to be within reach for his patients and his fellow indigenous healers and to be prepared to help in case of trouble.

Figure 6.5 Bongani always carried his muthi bag

The way Mks Bhengu ran her healing practice (staying home to be there in case a patient arrives) is quite the opposite of how Bongani Ntshangase ran his. And at Mks Gasa's we saw a combination of the way it used to be and a more modern way. For the first consultation patients often come to her compound without an appointment. For a follow-up healing session Mks Gasa makes an appointment with the patient, she plans several of the same sort of healing sessions in one shift. The way Mks Gasa has structured her healing practice looks a lot like the way doctors in Western clinics organise their office hours.[23]

Another element that has entered the sangomas' daily life and healing practices in the last decade is the cell phone. These days everybody in South Africa has one, which means that sangomas need not stay home, they can always be reached. During our interview with Mks Bhengu, she frequently received and sent text messages and inside Mks Gasa's consulting room, even while healing sessions were performed, cell phones were ringing constantly – everybody's phones, except those of the sangoma and the patient who were involved in the healing session at that moment. Having a phone at hand is also convenient for a sangoma in case a problem occurs with a patient during a healing ritual. When a patient doesn't respond fast enough or in an unexpected way to certain *muthis*, a quick consultation call to another indigenous healer saves the sangoma travelling time and the patient's healing process can be continued immediately.

But not every sangoma thinks similarly about these things. Mks Ngidi didn't want any phones or devices in her consulting room, because of the negative energy they

[23] See Chapter 4.

allegedly bring. When we came to interview her we first went into her consulting room to ask the ancestors' consent and then, for the actual interview, we entered another room, her prayer room where all devices were allowed. Bongani told us of a sangoma who fainted after answering her phone in the consulting room and that it took two very experienced sangomas and a long extensive healing session to get her conscious again. During this healing session, it became clear to Bongani (who performed this healing together with Baba Hlongwane) that she had fainted as a result of the negative energy that was transmitted by the cell phone. Mks Bhengu only answered text messages and Mks Mbuyisa didn't bring her phone into the consulting room. How to handle phones in the healing practice seems to be a matter of personal preference, prompted by the demands of the ancestors.

An important element affecting the healing practice is the increased mobility, a development that brings new possibilities for both patients and indigenous healers. Returning to Mr Mbele's case: because of the increase in mobility in recent decades Mr Mbele's healing sessions could be started in uMlazi district, with a sequel at the Mtamvuna River estuary (130 kilometres south of uMlazi), and finalised in his house in Pietermaritzburg. All sessions were performed in one day. I was told that in former days some patients walked a long way to get to the indigenous healer their ancestors wanted them to attend. Nowadays, even larger distances are covered allegedly in response to the ancestors' desires.

Furthermore, these days, a patients' lineage is often more complex than it used to be. While in the apartheid period sexual relationships between people of different ethnic groups were forbidden, in contemporary democratic South Africa this ban has been abolished, so more children are born to parents with different backgrounds. When those children (even as adults) come for healing, the indigenous healer is confronted with their ancestors. So, to be able to adequately interpret the message of these ancestors, sangomas have to be aware of tradition, special habits, and customs of patients from all sections of the population. Being informed and keeping abreast of Zulu culture and usage is not sufficient anymore. For example, in the eThekwini district, where over twenty per cent of the population is Indian, sangomas have to delve into the subject of Indian culture and indigenous healing. As I mentioned earlier, NUPAATHPSA anticipates this need by facilitating trips to India; for registered indigenous healers a trip to that country is arranged once every six to eight years. In India, they meet their Indian colleagues and visit universities. This way they are able to expand their knowledge of Indian custom, medicinal plants and herbs, and indigenous healing. A few members of the executive committee accompany the invited indigenous healers on this trip. NUPAATHPSA pays a part of the travel expenses and, in exchange, the organisation expects the indigenous healers to act as intermediaries, to pass on their knowledge to indigenous healers in their surroundings. Arranged like this, more indigenous healers are able to interpret the illnesses of patients with Indian ancestors and treat them accordingly (Flint & Parle, 2008).

At least, that is the idea. In practice, indigenous healers who made the trip confirmed they enjoyed being in another culture, being among 'all those people' in South India and undergoing new experiences. And, yes, it was interesting to see what kind of plants and herbs are used in indigenous medicine in India. At the same time, in their stories about the most recent trip to India[24] there was a certain disappointment about the way they were treated by their hosts, who refused to tell them why they had to participate in specific processes and rituals. The indigenous healers were eager to get some explanations of the things they were asked to do (like walking around a fire for seven times or meditating in front of a specific rock) but their questions were not answered.

The visiting healers were confronted with many differences between the Indian customs and their own and did not understand the rituals or the symbolism. They actually experienced that (the action of) a ritual in itself is empty and seems irrational to outsiders (Kyriakidis, 2007). Because the Indian hosts refrained from giving them the desired explanation or interpretation, the THPs were unable to understand the meaning and sense of the ritual actions. This course of events left the India-goers feeling as if they were not taken seriously, unsatisfied, and disappointed. Then, the question remains to what extent these trips really help indigenous healers to have a better understanding of Indian culture and ailments of patients with Indian ancestors.

Even though the sangomas are so familiar with the use of symbols and rituals in their own healing practice, apparently they felt a need for explanation of the rituals that they were part of in India, to be able to understand, interpret, and eventually apply these and similar ones to patients with an Indian lineage.

So far, the examples of adaptations in healing practices are contemporary elements that sangomas incorporate in their practice. Other transformations can be characterised as reactions on social dynamics in the changing contemporary society; (associations of) indigenous healers defend their profession and knowledge against outsiders' allegations and nosiness. I will give a few examples that are related, albeit in different ways, to '*muthi*'.

6.2.2 Stand against a changing society

Lately, the value and use of medicinal herbs as well as the expertise on this subject has become a source of concern. In the course of this study, we have already come across the general use of the word '*muthi*', referring to medicinal plants, fats, minerals, and all other natural substances that are believed to have healing capacities or powers. Used in this sense, *muthi* is a very clear word. Information about the healing powers of trees, plants, and herbs is transferred during *ukuthwasa* too. Unfortunately, this *muthi* knowledge is threatened with fading away, something inherent to the oral transmission

[24] In August 2013.

in *ukuthwasa*, but also as a side effect of contemporary society. In the past, many people used to live and work in the rural areas, close to natural sources. Nowadays, however, with the great majority of people living in urban areas and the forests having become unsafe places, the knowledge and know-how of medicinal plants seems to be left in the hands of herbalists and *muthi* gatherers. To keep this information vital, to prevent it from disappearing altogether, Baba Cele and NUPAATHPSA cooperate in a top-up course for indigenous healers. The *inyanga* also started the Nature Reserve (his 'nursery') near his home, growing all the medicinal plants that he knows, and a small one near the school (see Chapter 4).

The fact that the THP association feels the need to participate in standardisation of the *amathwasa*'s *muthi* knowledge indicates a certain internal discontent about the level that is achieved during the training. Baba Cele's school, however, is still in the starting phase; it will take years and years to establish a solid institute. He was the first to acknowledge this problem and, given his advanced age (born in 1931) and delicate health,[25] he worried about it: "Who will have the knowledge and who will take the lead when I am going on my long holiday'?" Baba Cele asked us rhetorically. Initiatives like his are endorsed by Mbatha; in her opinion institutionalisation will "provide an opportunity for the retrieval, archiving and standardisation of indigenous […] knowledge." (2017, p. 26)

This kind of *muthi* knowledge regulation seems to be a significant reaction to processes in contemporary society and the ratification of the profession of sangoma. Standardisation is in line with the government's requests concerning the training, certification, and registration of THPs. Such procedures are parallel to those in the Western medical model, the model that is (after all) perceived as the supreme example. The attempt at knowledge standardisation can therefore, in my opinion, be interpreted as a way for the association to shows its good will (by imitation of Girard's 'model') and an effort to find the government's and CHS's favour. More fundamental is the question whether it is possible at all to formulate a generally accepted standard of required *muthi* knowledge for THPs.

Besides his personal missions, Baba Cele also participated in an IPTRAD project (Indigenous Plant Trade Research Associates of Durban) that resulted in a book, a guide to muthi market plants (Ahlefeldt, et al., 2003). By cooperating in the publishing of this book, Baba Cele hoped to preserve his *muthi* knowledge, to help future generations learning about medicinal plants. Together with a team of scientists and researchers from the University of Natal in Durban, officers from the Municipality's Parks Department, and KwaZulu Natal Wildlife, he has made an extensive survey of all the medicinal plants that are traded on the *muthi* markets in Durban. The authors' aim is to help readers relate the *muthis* on the market to equivalent plants in the wild. Because the medicinal plants

[25] Baba Cele suffered from asthma, high blood pressure, and diabetes.

are usually presented and sold as parts, various chapters of the book are on specific parts like barks, roots, fruits and seeds, and leaves. Pictures of the medicinal plants, the Latin names, vernacular names, the growth form, habitat, Red Data List[26] status, and finding places, are listed, among other things. Several times in our conversations, Baba Cele expressed his concerns about the state of many medicinal herbs and trees and he told us that this was one of the main reasons for starting his own Nature Reserve and cooperate in the IPTRAD project on the *muthi* market guide. In fact, there seems to be a renewed interest in research about local medicinal plants (Flint & Parle, 2008; Jones, 2018).

Since the vast majority of people in South Africa consult an indigenous healer when not feeling well, there is a huge demand for *muthis*. Around 2002, the national trade in muthi plants was worth approximately ZAR270 million a year (Ahlefeldt, et al., 2003). To meet this demand, *muthi* gatherers tend to over-harvest certain medicinal plants, especially in the places relatively close to the markets, and, consequently, (regional) extinction is imminent for some of the species. This does not seem to bother the harvesters or the traders very much, however; for them, plants and trees are *muthi*, and trading *muthi* is simply big business.

One member of the IPTRAD team, ethnobotanist Professor Neil Crouch, is currently (in a sequel to the *muthi*-market book) involved in the complex regulatory processes that are needed to ensure that the commercialisation of components of the particular (medicinal) species will benefit the holders of the indigenous knowledge that informed the research and development process (Website Kloof Conservacy). The follow-up to the IPTRAD project is thus supportive of *inyanga*s and sangomas and their efforts to preserve their comprehensive indigenous knowledge for future generations.

On the one hand, there are projects to share and standardise *muthi* knowledge; on the other hand, there is a reverse motion, i.e. to protect *muthi* knowledge from various kinds of misuse. The interviewees told us e.g. about the secretiveness concerning specific *muthi* preparations. As reasons for this concealment they mentioned professional confidentiality and 'exclusive rights' for individual indigenous healers.

More recently, in the last two or three decades, yet another element has been involved in this matter. Indigenous healers try to guard their *muthi* recipes against the scrutinising eyes of the multinational pharmaceutical industry. They want to protect this indigenous knowledge in order to avoid the *muthis* becoming available in shops all over the world and exploited by Western companies without crediting the African indigenous healers' ownership (Masango, 2010). With regard to the subject of intellectual property rights of traditional medicines, Timmermans recommends preparing policies and strategies that "address and balance the various objectives and interests" (2003, p. 745). These should include issues such as "access regulation" and "differential treatment

[26] The Red Data List contains an indication on the degree of threat to a plant in the wild habitat, for example 'vulnerable', 'critically endangered', or 'extinct in the wild'.

of various categories of knowledge", furthermore she called "the involvement of all stakeholders" crucial.

Bongani Ntshangase told us about research on medicinal herbs executed by the pharmaceutical department of an American university. The researchers tried to find a remedy for a certain, frequently occurring, complication of HIV/AIDS. *Inyanga*s and sangomas from the *eThekwini* district showed the researchers a healing herb with the vernacular name of '*unwele*', *Lycopodiella cernua* (Ahlefeldt, et al., 2003, p. 52) and the way they prepare it to treat that complication. The researchers left and, after some time, a medicine with exactly the same mixture was on the market, produced by an American pharmaceutical company. The researchers had sold the recipe to the company, the company had patented it, not using the vernacular name '*unwele*' but 'Sutherlandia', another (botanic) name for the same medicinal plant. The indigenous healers that shared their indigenous knowledge did not get a penny of the profits that the company would gain by selling the medicine. They regarded this as unfair and theft of their specialist knowledge and, with support of the Zulu king, Goodwill Zwelithini, a lawyer raised the matter within the scope of indigenous knowledge ownership and intellectual property protection with the pharmaceutical company. Confronted with the threat of a lawsuit concerning the indigenous knowledge property rights, the company agreed to set up a pilot project to compare the effectiveness of the Western and the indigenous herbal medicine at several stages. In 2014, after four years of research,[27] two stages of this project were completed and the results, published in Pietermaritzburg, were interpreted positively by the indigenous healers. The results of the rest of the project should be published in the near future. In general, however, acknowledgement of a herbal medicine is rare. Lack of funding to carry out very expensive clinical trials is one reason, another important one is the fact that pharmaceutical assessment is in accordance with the Western, hegemonic model, which is unfavourably disposed to anything other than chemical medication.

As a consequence of such cases, indigenous healers have become aware of the value of their knowledge and the necessity to protect it as their indigenous property. Therefore, indigenous healers have resolved not to disclose the mixtures and the preparations of *muthis* to anybody (apart from their own inner THP circle) anymore. A side effect of secretiveness about a specific mixture's exact recipe is that there is no possibility to check its effectiveness, or to refute the healing claims of the prescriber. This strategy may thus arouse suspicion.

Sometimes, an awkward notion surrounds the term *muthi* because it is also used as an indication of or a synonym for witchcraft.[28] Therefore, and as a result of the apartheid era,

[27] As a part of the PEPFAR project.

[28] More about 'witchcraft' in the next pages.

muthi has a negative connotation for a part of the South African population. Moreover, this sceptical undertone resounds in the national press' attitude[29] towards indigenous healers. To cope with such negative coverage is a huge challenge for individual healers as well as for associations (Gqaleni, Hlongwane, & Khondo, 2010). I encountered an example of a more or less ambiguous attitude towards indigenous healing in one of the newspapers during the field study in 2012.

A few days after the police shot 34 strikers (the largest number of casualties since the end of the apartheid regime) at the Marikana mines in 2012 an article in the *Sunday Times*[30] showed ambivalence towards *muthi* and indigenous healers. The article headed: *"Muti[31] 'protected' miners. Sangoma's hilltop rituals made protesters fearless in the face of police gunfire."*, and proceeded as follows:

> A mystery sangoma is believed to be behind the foolish courage displayed by striking miners during Thursday's deadly standoff. Undeterred by water cannons and teargas the miners crept through the bushes towards the police and charged straight into a heavy line of fire. The surviving miners are not talking, but Union officials, residents of Marikana and the police confirmed the presence of an unidentified sangoma who carried out rituals on the hill and dished out muti where workers had gathered throughout the week. It is said the man, who is from Eastern Cape, had provided muti to the protesters, and made them believe it would make them invincible. … Several of the strikers the Sunday Times spoke to yesterday were reluctant to talk about the sangoma, and some even denied his existence. 'I heard about that, but I don't want to talk about it.' Said one before walking away. […] A senior policeman who was in one of the police helicopters told the Sunday Times they had recorded the muti rituals on camera. […] While some argue that it was stupid to brave automatic gunfire in the manner in which the workers did on Thursday, some locals believe that, if it hadn't been for the muti rituals, many more would have been killed. […] Amcu[32] national organiser Dumisani Nkalitshana denied that their members used muti. 'We haven't heard any of our members telling us about that. We don't know anything about muti. We are Christians and we believe in God.' (*Sunday Times*, 2012)

The country was in shock after these events and the presidency announced a national week of mourning. Newspapers showed pictures of then President Jacob Zuma visiting wounded mineworkers in hospital. Policemen killing so many demonstrators raised questions like 'How come we are living in this kind of society?' and 'Is our country on the edge of a precipice?' Many South Africans felt as if the country's clocks had been wound back, memories of the apartheid period returning. Zapiro, a well-known South African cartoonist, articulated these feelings in a cartoon in the same paper.

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[29] At least in the Anglophone papers there is an ambivalent, but often explicit negative attitude towards indigenous healers and *muthi*.

[30] 19 August 2012.

[31] '*muti*': anglicised spelling of '*muthi*'.

[32] Association of Mineworkers and Construction Union, a South African trade union.

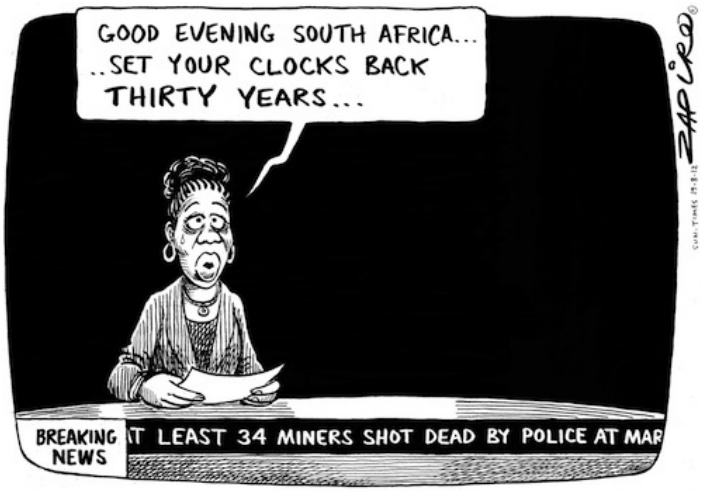

Figure 6.6 Marikana © 2012 - 2018 Zapiro (All Rights Reserved)
Originally published in the Sunday Times in 2012.
Used with permission. More Zapiro cartoons at www.zapiro.com

In looking for possible causes, the nation's eyes were not only set on the violence used by the police force and the accountable police officers (Mail & Guardian, 2017), many questions were also raised (maybe as diversionary tactics to hide the extreme amount of violence that was used) about the alleged reckless behaviour of the strikers. Why did the strikers seem unafraid of the police gunfire? What was the influence of the sangoma's rituals that were performed on the hilltop?[33]

Several passages in the article show an ambiguous attitude towards indigenous healers and *muthi*. The miners' behaviour is ridiculed by the journalist, several times in the article a '*muti* ritual' is mentioned and the reluctance to talk about the sangoma, all these elements add to the shroud of mystery hanging over this event that has become known as the Marikana massacre. Another thing that struck me in this article is the supposed contrast between indigenous healing and Christianity, as if the two are mutually exclusive. For many people, however, as I have shown, there is no contradiction between the two.

As emerged in the article about the Marikana massacre, indigenous healing is associated with secret rituals and mystery, reflecting suspicion and the widespread

[33] To find out what really happened on that disastrous Thursday and the preceding week of strikes, President Jacob Zuma appointed a commission of inquiry, chaired by retired judge Ian Farlam, which sat in public for 293 days, hearing evidence from miners, their bosses and the police, and reviewing all available recordings of the shooting and the days before. At the end of March 2015, the commission delivered its report to President Zuma but the conclusions were not published until the end of June 2015. Its conclusion: more inquiries are needed to find out what really took place on that day near the Lonmin mines. In August 2019, seven years after the incident, no one has been held accountable. The sangoma concerned was murdered before he could testify in court, no suspects have been arrested in this case.

belief in (and fear for) witchcraft. In 2013, the Pietermaritzburg High Court sentenced three men to 20 years in prison for the murders of two women. The men said that they suspected the women to be witches: "They said that the *muti* they would dig from the ground would ensure we would not be alive in three days' time […] We got scared […] that is when we got our weapons and started to hit them." The judge stated: "We live in a modern society where superstition and belief in witchcraft should not be viewed as a justification for murder." (IOL News, 2013) Newspaper articles with accusations of witchcraft, alleged body part trafficking (eNCA, 2017; IOL News, 2015),[34] cannibalism, and illegal and cheap abortions (eNCA, 2017) affect the general image of indigenous healing. In KwaZulu Natal, the belief in witchcraft does not seem to have a huge impact on social life, but in other provinces, like Gauteng, Mpumalanga, and Limpopo, every now and then cases of witch hunts are reported.

For an individual sangoma it is no use contradicting such allegations or defending themselves against these kinds of media reports. In such cases, Bongani told us, the THPs' association can take up the task of a trade union and be an advocate for its members. The organisation can do so because of its maxim that all members are qualified and registered indigenous healers. By issuing a communiqué, the association can refute certain ideas about indigenous healers (eNCA, 2017),[35] if needed nationwide.

[34] Trading parts of human bodies allegedly to be used as ingredients for *muthis*.

[35] Like in the case of body part trafficking, NUPAATHPSA explained in a communiqué that sangomas are not allowed to touch dead bodies, because of the strict purity rules they have to abide to.

6.3 Analysis: Why (not) accommodate?

Up to this point we have seen that the indigenous healing practice is informed by various kinds of external dynamics and processes. With the help of the genealogical sampling method, I have sketched an impression of longitudinal developments in sangomas' healing practices. Modifications that are applied by individual sangomas to conform to (the demands of) changing society; adaptations in attempt to increase the acceptability of the healing practice and strategic protection of the profession in general.

When we add these findings to those in the previous chapters on transformations in healing practice and *ukuthwasa* due to internal dynamics, it becomes clear that sangomas' training as well as practice can be characterised as flexible and experiential, in correspondence with Whitehouse's imagistic mode.

Indigenous healers fully acknowledge and endorse their profession's flexibility and variety, but even so they refer to their profession as 'traditional healing' in contemporary society. Moreover, the characterisation of sangomas' training and healing practice that emerge from this research data is quite the opposite of the connotations of 'tradition' (in common parlance) like stability, invariability, and constancy. It is a significant discrepancy, in my opinion, therefore, as previously mentioned, I once more zoom in on the subject of tradition. In light of the preceding, it seemed obvious to me that indigenous healers have ponderous arguments for hanging on to the term 'traditional'. With Foucault's theory on Power[36] in mind, I revisited Hobsbawm & Ranger's theories on 'tradition' to find out what other elements are involved in the dynamics of 'tradition' in a changing contemporary society.

6.3.1 Revaluation and re-invention

After the apartheid regime, which suppressed their cultural identity, black people in South Africa seized the opportunity to revalue their alleged tradition and culture. Although, following decennia of apartheid, it was not clear in all instances what exactly belonged to the cultures and customs of the various black peoples. Some customs were still known, others had passed into oblivion. Other aspects were left where they were because they were not regarded as useful or valuable anymore. Yet other customs or practices from the past were picked up and executed again, but now in a new setting. "People pick and choose from their culture those things which suit their present circumstances," Bourdillon observes (1993, p. 14), and in doing so they create new patterns that, in due course, might result in a new 'tradition'.

We saw an example of revalued tradition in a contemporary setting after Nelson Mandela's death,[37] when his grandson Mandla Mandela, as the oldest male descendant

[36] See Chapter 4.

[37] Nelson Mandela died on 5 December 2013, he was buried on 15 December in Qunu, Eastern Cape.

of the family, accompanied his grandfather's body on the several stages of his journey to the grave. Parts of this journey and the funeral (service) were broadcast live on television and, all around the globe, people were able to see the grandson explaining sotto voce to his grandfather where they were going and why, even when Mandela's body was transported by plane. This old Xhosa custom is called 'guiding the spirit home' and it was performed to ensure that Mandela's spirit would 'not wander' (IOL News, 2013).[38]

Another case in point occurred in recent years in the form of the performance of a so-called 'praise poet', heralding the arrival of then President Jacob Zuma, for the deliverance of his State of the Union in Parliament (Mail & Guardian, 2015).[39] The official role of the praise poet reaches back to times before the arrival of Christian missionaries in South Africa. In those days, the praise poet travelled with the king (or queen) and praised him wherever he went. Anyone who wanted to speak to the king had to speak to the praise poet first. One part of this poet's official role was the right to criticise the leader without fear of punishment. The praise singer that preluded the former President's State of the Union was selected annually taking into consideration a fair representation of the many cultures and languages in the country. A critical notion regarding the holders of power, however, was not appreciated in this situation. By resurrecting the praise poets, former President Jacob Zuma appealed to a certain part of the country's population, namely the people who value 'traditional ceremonies' and identify with old customs.

Within this motion of, what Thornton (2010) calls, 're-traditionalisation'[40] new possibilities presented themselves for sangomas; they were allowed to exercise their profession in a generally more visible way. Furthermore, the renewed interest in their healing skills led to an increasing demand for the services of these THPs, who consequently profited financially from these developments. The growing number of 'chancers' (Mail & Guardian, 2015),[41] especially in the urban areas might be interpreted as collateral damage in this process.

Hobsbawm & Ranger (1992) argue that what we assume to be traditional, for example a ritual which appears (or is claimed) to be old, has often been quite recently reshaped or re-invented and that this frequently occurs in rapidly changing societies. We pick and choose old elements to use in the construction of a new tradition, for a new purpose. The new (concept of the) ritual is seen as traditional because of an assumed 'old' element. In addition to the above-mentioned examples, I would like to give an illustration of re-invented tradition; the revival of *Nomdede* ceremonies in the province of KwaZulu Natal.

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[38] To prevent it from troubling some of the relatives after some time.

[39] In 2015, for the first time in history a female praise poet was selected.

[40] Revaluing cultural and 'traditional' roots of a specific group of people.

[41] People who were not called by the ancestors but nevertheless pretend to be a sangoma, taking a chance.

According to Krige (1965 (1936); 1968), the *Nomdede* ceremony used to be an agricultural fertility ceremony. In the mists of early spring, *Nomkhubulwane*, the Heavenly Princess, was believed to come to the fields. Early on one agreed morning, the young teenage girls would go to those fields, dressed in their brothers' clothes to herd the cattle.[42] They would bring calabashes with freshly brewed Zulu-beer to sprinkle on the soil where the crops were sowed. A small part of the fields was dedicated to *Nomkhubulwane*; it was a 'Garden for the Princess'. In the following weeks and months, the girls returned (with Zulu beer) to the fields a few times. While walking through the fields they sang songs for *Nomkhubulwane* and asked her to make the crops grow well. When it was almost time to harvest, the girls and their mothers walked through the fields once more, plucking some cobs and ears. Then they continued their way to the river where they buried the ears, roasted the cobs, and bathed, after which the girls and their mothers sang and danced and consumed the cobs (Hooghordel, 1999).[43]

The Zulu women and girls performed these rituals to appease and honour their Heavenly Princess. This annual ceremony was executed by the group of girls that were going to marry within the next year. They believed and expected *Nomkhubulwane* to take care of her people by applying her fertility influences (Berglund, 1990) not only on the crops, but also on the (young) women. Krige observed that the ceremonies were different in every region and that this ritual was still only rarely performed in the 1930s.

Kendall's (1999) investigation on rituals by Zulu sangomas in the 1990s revealed that *Nomkhubulwane's* rituals and *Nomdede* ceremonies were re-invented and revalued. In the new setting, the rituals and ceremonies did not necessarily take place in the crops fields, any location seemed suitable. Whereas the ritual used to be a preparation on a young girl's marriage, in the 1990s it was performed for the large groups of young girls (and their families) that have been the victims and survivors of rape. The position of these girls in their society was often problematic as they were ashamed, sometimes even blamed by and excluded from the community for what was done to them. Sangomas, in their role as keepers of the community, acknowledged these rape survivors' fate and performed rituals like *Nomkhubulwane's* and the *Nomdede* ceremony to cleanse them, so that after the ceremonies the girls could be included in their communities again, according to Kendall.

In the re-invented ritual, some elements (like the young girls and the notion of sexuality) have remained, others have vanished (the harvest and herding the cattle). The general idea that *Nomkhubulwane* takes care of her people is still clear in the 1990s performance of the rituals but in a way far beyond this idea in times past.

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[42] In the normal course of events, the boys herd the cattle, but on this specific day the girls sneak out before the boys notice.

[43] See also Hooghordel, 1999 for a further description of these rituals, the differences in literature and remaining questions.

These examples show ways that cultural elements are taken and given a new meaning and how 'tradition' can be reshaped or re-invented. "Traditions grow and change to suit the people who live by them", Bourdillon argues in his book on changing culture in Zimbabwe, and that "is particularly obvious in a rapid changing society, such as we find in African cities" (1993, p. 12).

Without reviewing all transformations in the training and healing procedure here, in my opinion the only element of the indigenous healing practice that remains unaffected is the 'diagnosis-ritual'; the invocation of the ancestors and the supposed ancestors' communication of the diagnosis. Therefore, in light of my research data, the indigenous healing practice with one old core element and many transformations could be considered as a reinvented tradition, even stronger: the indigenous healing practice is subject to continuous reinvention. Be it in the form of an application for an individual patient or as an adaptation to environment or time, sangomas' healing practices are constantly modified. The sole constant element is the sangomas' supposed intermediary role between the patient and the ancestors; the sangoma as contact and communicator with the ancestors.

6.3.2 Glocalisation

It is interesting to analyse why or, as Hobsbawm puts it, to what purpose the new elements are combined with precisely this old element of intermediary between the patient and the ancestors. Let me start with the most obvious reasons for the use of new elements in the healing practice; both sangoma and patient are part of contemporary society and therefore accustomed to the comforts, the technology and the communication of these days. It would be inconsistent for sangomas to abandon the available means from their healing practice (why not light a healing ritual in the dark river with your cell phone?). What is more, the sangoma would be less convincing for patients if she would exclude new elements from her practice. Then it would be as if she stands outside contemporary society altogether. Rather, it is exactly by the incorporation of such new elements that the indigenous healer gains the patients' credibility and authority.[44]

New elements that are tailored for the use in one's own setting, is what Robertson (1995) calls 'glocalisation'. The extraordinary thing about these dynamics is that especially by using new elements and adjusting them to one's indigenous setting, the identity is not affected but, on the contrary, confirmed. As if it proves that the identity is so strong that it can easily incorporate global phenomena, and yet stay 'the same'. With regard to sangomas' healing practices this is an important issue, for it shows that while indigenous healers use contemporary elements the prestige of the profession increases, exactly due to those elements. Thus, sangomas as well as their patients take advantage of the opportunities that are at hand.

[44] See also Ferguson, 1999.

At the same time, it is crucial for sangomas to also hold on to old elements; firstly, the supposedly intermediary role in the diagnosis, because that is their raison d'être. If it was not for this part of the healing practice the profession of sangoma (diviner in older texts) would not exist at all. And, secondly, and more peripherally, the professional clothes sangomas wear, like goatskin bracelets and leopard print cloths, because wearing those can be interpreted as a statement with which the sangoma sets herself apart from the community. Such clothes distinguish the sangoma from ordinary people, in fact they are a sign of status (Bourdillon, 1993), authority and therefore also an expression of power.

The combination of 'new' elements with the old elements makes indigenous healing special and interesting; it is performed by contemporary people who use up-to-date means, yet it is surrounded by an air of history and mystery. In their healing practice, sangomas unite the seemingly antipodal concepts of 'tradition' and 'changing society'; they stand with one foot in today's world, the other in history. They pose as a bridge between the present and bygone days, between the inhabitants of present-day South Africa's unbalanced society, and the (knowledge of the) ancestors who lived in times that are understood as steady and stable.

Besides, in the claim that they are 'called', able to communicate with and carry out the instructions of the ancestors, sangomas attribute authority, wisdom, and power to those ancestors over their own lives and that of their patients. It is beneficial for indigenous healers to emphasise their relationship with the ancestors belonging to the cultural cosmology and the concept of alleged tradition, it underlines their unchanging, powerful social position as long-standing mediators. The ancestors' authority and power also reflect on the mediating sangomas, whose status in society increases consequently.

However, the ancestors' authority is a phenomenon that is not acknowledged by people who do not share the African cosmology. People, like Western academics, who do not believe in possible intervention in this visible world by entities from an invisible world. For them, the discourse on 'tradition' and ancestors is based on an invalid argument pattern, an argument 'ad verecundiam' or 'argumentum ad autoritatum'. The authority that is appealed to is considered inappropriate.

A remarkable element in this is that the 'argumentum ad verecundiam', the appeal to an authoritative person or source, was originally not seen as an invalid argument but as a sign of modesty.[45] Currently, however, the element of modesty has vanished from this invalid argument pattern, it just expresses the defence of a stance by the, justified or not, appeal to an authority (Geerlings, 2007). In that case, the term 'argumentum ad autoritatum' is more in style. The used phraseology of course also reflects whether one's approach of the matter is emic or etic. In my opinion, the sangomas' appeal to the ancestors' authority (emic) might be based on such modesty, originating from their cosmology.

[45] The Latin word 'verecundia': modesty, respect.

One of Thornton's conclusions in his research in the Lowveld (2009, p. 32) is: "While [sangomas] are distinctively African, they are also part of modern South African society and cannot be relegated to the past." In the previous pages, I have exposed that this statement is valid for sangomas in the Durban district in 2014 as well; although embedded in Zulu ancestral beliefs, sangomas accommodate the execution of their healing practices to the demands of contemporary society and integrate new elements in their practices.

6.4 Political dynamics

Above I described that, in the apartheid era, sangomas' healing practices were illegal. One could be tempted to assume that in contemporary democratic South Africa the legalised indigenous healing practices are in smooth waters, but that is far from the truth. Now that indigenous healing has become more visible in society, it is consequently expected to meet current requirements.

It was the national government's goal to acknowledge indigenous healing via Act 22, 2007 and make it an integral part of the national healthcare system. One vital aim of this THP Act is to regulate the indigenous healing sector with a registration system; registration should be regarded as a quality mark. This way, the law anticipated what is, according to Mbatha, one of the major challenges of contemporary indigenous healing; the increase of malpractice. (2017).

NUPAATHPSA cooperated with various levels of government to achieve this (quality standard) goal, for example in stimulating THPs to register and in collaborating with Baba Cele in his *muthi* school, in an attempt to standardise *muthi* knowledge. Although the association's cooperative strategy may turn out to be beneficial for the indigenous healing system, it is questionable whether it will be favourable for the individual indigenous healer too.

Many individual sangomas are sceptical with regard to the obligations and other implications the new healthcare legislation imposes on their healing practice. Implementation of the THP Act will have a positive impact as well as negative consequences for indigenous healing as a system and the healer's practice. Eventually, one of the results of the Act will be that all registered indigenous healers will be allowed to issue legitimate sick leave notes for employees. Another positive turn is that, in time, health insurance companies will refund patients' bills from registered indigenous healers' consults.

But a consequence of the new legislation is that the government wants indigenous healers to use fixed prices for consultations and healing sessions, just like in the WHS. While the THP association uses a standard fee for (Western) researchers in favour of the cooperating sangomas,[46] among individual THPs there is a lot of resistance towards what they call "treating indigenous healing like a business." With an appeal to the cultural ("we don't have the fee-structure in our culture") and religious connotation ("this is not a job, we had a calling") they reject this part of the Act, as Bongani told me. Indigenous healers fear that their services will become inaccessible for the poorer part of the population. In their opinion, patients should be able to pay with whatever they have. Moreover, the obligatory need to account for income and the accompanying tax payment encounter resistance among indigenous healers. Furthermore, the new law requires THPs to

[46] As described in Chapter 2.

keep a logbook in which they write their patients' names, their afflictions, and the prescribed medicine. This, too, incites opposition among the indigenous healers who want to protect their (patients') data. Obviously, their (full) cooperation with the law's implementation is in doubt.

In this last part of the chapter, I will explore what effects political dynamics have on contemporary indigenous healing. First, I will focus on the involvement of associations (typified by NUPAATHPSA) in the (forthcoming) implementation of the THP Act and next on how individual sangomas deal with the (possible) implications of this Act. Many earlier mentioned elements come together in this part.

The internal and external processes and dynamics and the way they are intertwined will be exemplified by descriptions of Mks Gasa's healing practice and Bongani's intellectual legacy.

Bongani Ntshangase, association

His grandfather, who was an *inyanga*, taught Bongani from childhood about the healing qualities of herbs, minerals, and fats. When the ancestors called him to be a sangoma, he felt he had to give up his 'Western' job to start his *ukuthwasa*. For this, in his case a top-up training to become a sangoma, he lived at a *gobela*'s compound in Mozambique. After his initiation, he left Mozambique and went back to Durban, where he set up his own healing practice that flourished. While he was practising as a sangoma in this urban area he grew more and more convinced of the importance for indigenous healers of being organised, if only to be united in discussions and negotiations with the (local, provincial, and national) government. Another reason is that he thought an organisation could offer many services to indigenous healers, like legal help in case of false accusations. Bongani dedicated himself to that cause and got involved in the merging of about thirty small networks to one provincial association and the foundation of NUPAATHPSA in KwaZulu Natal. In 2012, he was a member of the executive committee of the Durban metro branch of NUPAATHPSA with the portfolio of Public Relations; contacts with the Mayor, the Provincial Minister of Health and the press and supporting the chairman of the association at important meetings. In 2013, Bongani Ntshangase with his eloquence, humbleness, and charisma, was chosen to take the Chair from Baba Hlongwane. He was asked by the executive boards of the other NUPAATHPSA districts in KwaZulu Natal to collaborate, to help to bring them to the same (high) level of registration and organisation as in the eThekwini district. According to Bongani, the best way to achieve this was to show indigenous healers that being a member of the association would be favourable for them. He understood, however, the reluctance of a considerable part of the THP community towards registration. He knew that for some indigenous healers it is like they have to look at their healing practice in an entirely different way. He put it aptly: "When we are talking to learned people they say; 'treat it as a business'. But in our culture we don't have the fee-structure. When you have got a chicken, you pay with a chicken. Others have a goat or cattle and pay with that. This is a God's thing. Yet they want us to treat it as a business. It is like we are changing the whole system right now, shifting our focus."[47]

[47] Conversation with Bongani Ntshangase, Botanic Garden Durban, 30 July 2012.

6.4.1 Legislation and association

Bongani was convinced that the association could play an important role in increasing the acceptance of indigenous healing. In our conversations he gave multiple examples of the way NUPAATHPSA was in discussion with all kinds of (municipal and national) governmental departments about relevant issues. Within the association's executive board there was a division of tasks. Communication with external authorities like the municipal and provincial administrations was part of the assignment of the chairperson and the PR officer. The association wanted to validate the acknowledgement of indigenous health practitioners by being a conversation partner for the government. Some other goals were to promote the well-being of all Durban's inhabitants and to create a platform for the (re)presentation of cultural heritage of the Zulu people. On a regular basis there were meetings with the Mayor of Durban, the Minister of Health, and the Minister of Traffic.

Especially this latter one may be surprising, so I will provide two examples of how the association was engaged in this regard. Firstly, they were involved in the issue of safety on the roads in and around the city of Durban. In the past, many accidents happened near primary schools. The children were not careful enough when playing near and crossing the road where cars, especially minibuses, were driving far too fast. In 2012, at the association's suggestion, the municipality constructed four speed bumps in the roads near every primary school, to lower the traffic's speed as well as to ensure the children's safety. The second issue on which the association and the municipality were cooperating is what Bongani called 'hotspot cleansing'; sangomas performed certain rituals at sites where traffic accidents happened frequently. If somebody died at a specific location, according to Bongani's explanation, his spirit kept dwelling on that spot and attracted other spirits, so more accidents were prone to occur there. After consultations between municipality and association, sangomas were informed with regard to where these hotspots were and they went there to perform a ritual to guide away the spirits of the deceased motorists. Through the special ritual, the location was cleansed and less accidents were expected to happen there. Meetings with the Minister of Health were often about the THP Act, its implementation, and THP registration. NUPAATHPSA was successful in convincing the THPs (about 75%) to join the association. Among the association's persuasive arguments for registration were access to legal advice and representation at a governmental level. All members of the association were automatically registered as THP at the Municipal Department of Health.

Registration, a quality mark?

This implies that 25% of the qualified THPs were not registered (elsewhere in the country the percentage of not-registered THPs is considerably higher). Those not registered are either THPs that did not meet the association's criteria or they are self-appointed healers

(also called quacks, chancers) or initiated THPs who, for various reasons, do not want to register. I wondered how to differentiate between a graduated THP and a quack. I asked several people, including some indigenous healers, if there is something that may serve as a criterion for determining if a THP is 'real' or not. They all told me it is hard to find out if somebody is a quack. Bongani Ntshangase and Mks Mbuyisa stated that you have to ask the right questions, for example about the '*inyamazane*'[48]. If someone who calls herself a sangoma does not know what your question is about, you may assume she is a quack. Mks Mbuyisa's *inyamazane* is a tiger,[49] Mks Ngidi's (the youngest interviewee) and Bongani's is a python, they both hunted and killed these animals at the end of their *ukuthwasa*. But Mks Bhengu, whom everybody admired as the 'grandmother' of all sangomas and the 'walking library', did not mention having an *inyamazane*.

Figure 6.7 Mks Ngidi shows the skin of her *inyamazane*, a python

Michael (the gardener) who introduced me to Mks Mgadi in March 2012, told me that she is a real sangoma because "she has been in the water". He referred to the story she told about the time that she had lived under water for a period of approximately six months. For Michael, this was the convincing argument that Mks Mgadi was a qualified sangoma. Of this research' interviewees only Mks Mbuyisa had a similar experience of being in the river for several months during her *ukuthwasa* and Bongani said that he was underwater for about a week. Even though Mks Bhengu and Mks Ngidi did not tell of such experiences they were introduced to me as qualified sangomas.

So, neither of these arguments seems to be a solid indication of somebody being a 'real' indigenous healer. When I asked *inyanga* Baba Cele how to make the distinction

[48] Meaning the 'bock that has to be hunted', in academic literature also known as 'familiar'; an animal that has to be hunted and sacrificed.

[49] Probably she meant a leopard, when Mks Mbuyisa told about her *inyamazane* she pointed at a toy animal on the floor of her consulting room which had a leopard marked skin.

he shrugged his shoulders and said: "you can only tell by experience."[50] Consequently, one may wonder how the executive board member of NUPAATHPSA is supposed to differentiate between a qualified THP and a quack on the basis of credentials, education, and a visit to the healing practice. And if there is any possible doubt whether registered THPs are indeed qualified, then registration is not to be regarded as a quality mark. Ultimately, the question remains if there is any distinction at all to be made between THPs and quacks.

Here, at the level of the association and the government, a few discrepancies between theory and daily routine, between 'programme' and 'practice' emerge. Firstly, the fact that the association wants all graduated indigenous healers to join the organisation and register and its claim to represent all THPs. Yet, the organisation acknowledges that about 25 per cent of the graduated indigenous healers does not want to register for various reasons (e.g. that the association is a government's tool and that their calling is 'personal'). Furthermore, applicants for membership are screened with regard to their training, graduation, and healing practice. The organisation claims that therefore membership can be considered as a quality mark but the distinguishing criteria remain vague and inconsistent. Recently, the government's implementation of the healthcare law (set up also to challenge malpractice in indigenous healing) meets the same obstacle; the THP Council is, as the association, not able to formulate and apply criteria to differentiate 'real' indigenous healers from quacks, 'chancers'. For the time being, registration as a quality mark therefore seems to be a bridge too far. Partly due to these registration problems the implementation of the law is going very slowly. Eventually, the desired differentiation may even prove to be fundamentally impossible.

The programme of regulating THPs' healing practices by registration and uniting them in a national association, fits perfectly on paper, but people and reality turn out to behave in an unruly manner. One cause for this could be that the mere problem of whether someone is a 'real' sangoma (and the distinguishing method) is from a paradigm in which explicability, checks, and proofs are important. This Western, scientific paradigm is also the basis of the latest healthcare legislation. Sangomas, however, live and think from within another paradigm, one that has experience and belief as important basic principles. Sophie Oluwole (2017) argues that reasoning within the Western (philosophical) paradigm can be characterised as oppositional and exclusive, for example a statement is either true or false or an object is either green or blue. Within the African paradigm, this Nigerian philosopher typifies logic as complementary and inclusive, for example whether you perceive the colour of an object as blue or green (or some other colour) or a statement as true or false (or both) may vary in diverse conditions and as a result of different experiences. The issue whether someone is a real sangoma is an example of such Western logic, it is presented as either the one or the other, just

[50] Conversation with Baba Cele, 13 August 2012.

these two options. Registration and the therefore required distinguishing strategy, are based upon an oppositional logic, intended to exclude from registration those who do not meet the criteria. In African logic, however, this issue might not be relevant at all, for the assessment of a sangoma's 'legitimacy' is also dependent on experiences and circumstances. Hence, Baba Cele's pragmatic advice to go and experience a healing in order to find out about the healer's competences.

Knowledge standardisation

Whereas the sangomas' autonomy in healing practice and in training of *amathwasa* used to be indisputable,[51] recently (and perhaps partially in the light of THP legislation) there seems to be an urge to standardise at least certain knowledge about *muthi*s for freshly graduated sangomas. Baba Cele's Traditional Medicine School is exemplary of this need for regulation, which is felt among leading figures of Traditional Medicine and in the THP association. The mere fact that Baba Cele's school started made me inquire whether the long-standing differences in knowledge transfer and healing practice were not appreciated anymore and whether there were any (or even serious) doubts about the scholarliness and professionalism of *gobela*s. Both these plausible suggestions were denied by Baba Cele and Bongani.

Although Baba Cele introduced the founding of his Traditional Medicine School as a possibility to offer graduated sangomas extra support in their knowledge of recognising, buying, and preparing *muthis*, my impression is that 'control' over the level of knowledge comes into this project to a certain degree too. My suggestion is nourished by Mbatha's claim (2017) that professionalisation in the form of knowledge standardisation may help eliminate inconsistencies and unethical behaviour in the indigenous healing system. By hosting freshly graduated sangomas from several *gobela*s, Baba Cele and the THP association gain an insight into the *muthi* knowledge content these *gobela*s teach their *amathwasa* as well as regarding the individual competences of the new sangomas. It is important information for the association, the body that represents the (quality of) indigenous healers. This process of standardisation, calculated or not, can be interpreted as an indulgent move towards the demands of contemporary society where a certificate proves one's competences. Even though it is not the case at present, these data could be used by the association or even by the government to assess the (training of) *gobela*s.

Not every *gobela*, however, will send her *amathwasa* to Baba Cele's school after graduation. So not every new sangoma will get this extra education, rounded off with a *muthi* certificate and, consequently, not every *gobela* can be screened this way. At the moment the autonomy of every single *gobela* and the content of her training is still respected, but if, in the long run, the required registration for all THPs is implemented, this (now optional) top-up training could become an obligatory and controlled part of the sangomas' training.

[51] As described in Chapter 4.

Thus, NUPAATHPSA in the *eThekwini* district cooperates in the establishment of standards (of knowledge) for graduated sangomas as well as in formalisation and officialising of the indigenous healer's profession. By introducing itself as a formal conversation partner, the organisation represents indigenous healers at municipal, provincial and governmental level.

Here I detect a certain ambiguity and tension in the association's modus operandi. On the one hand, the association claims to defend the autonomy of the *gobela*s in the training of their *amathwasa*; on the other hand, the collaboration with Baba Cele in his Medicine School at least shows that the fresh sangomas' level of muthi knowledge is considered more or less inadequate. Moreover, the association proclaims to protect the autonomy of sangomas in the execution of their healing practice, yet it is a government's accomplice in the process of THPs' registration. While registration for the government is as much a means to impose restrictions and obligations on indigenous healers as a tool to control them.

While general recognition and increased respect for the indigenous healing system may be effects of associations' efforts to deal with political dynamics in contemporary South Africa, I was curious how the THP Act influences individual indigenous healers in the execution of their practice. Illustrative is Mks Gasa's sangoma school and practice.

6.4.2 The 'calling' a business?

The sangomas' healing practice is flexible; many elements are liable to transformation and often this is explained in a positive way. The ability to adapt to changes in society and to demands of new times might be one of the main reasons that indigenous healing is an important player in the field of South African healthcare, at least in numbers of attending patients. On the other hand, the variety in the healing practices makes it problematic (on various levels) to distinguish between trained healers and self-proclaimed ones. A contrast needed in the face of increase of malpractice cases (Mbatha & Gqaleni, 2017). While for Baba Cele a discriminating element is in experiencing a healing session, for Mks Mbuyisa it is in the characteristic way the healing practice is executed: "it is not easy to determine who has a calling and who is doing business"[52]. Chancers, is her assumption, regard indigenous healing as a business and try to earn easy money. Feierman (2000) found in 'care' versus 'commodification' a similar ground for distinction among the Ghaambo in Tanzania.

One of the implications of the THP Act at the level of the individual healer is that healers, to quote Bongani, "have to shift their focus" and look at their healing practice as a business, in a commercial way. Whereas diagnosing and treating patients used to be the core aspect of the healing practice, a registered THP (in the future) also has to keep

[52] Interview 9 August 2012.

the records, write bills, give account to the government (for taxes) and ultimately even to healthcare insurance companies (in case a patient wants a refund) and to patients' employers (in case of a sick leave notice). Many indigenous healers, including Mks Gasa, however claim they want to place themselves in the service of the patients instead of running their healing practice business-like. All the same, in the way Mks Gasa runs her school and her healing practice we did recognise some commercial, business-like elements.

Mks Gasa: Legislation in the individual healing practice

To start with, the training of more than twenty *amathwasa* in itself is actually big business. The costs of this training, as I mentioned before, are about half an annual salary for every *thwasa*. Part of this money is spent on animals that are sacrificed to mark special events of the training, but the vast part of the money is for the *gobela*.

In a household of roughly thirty people (the *amathwasa* and the sangomas with their families) the housekeeping includes cleaning, maintaining the premises, washing and ironing the clothes, shopping, and preparing food. All inhabitants of Mks Gasa's compound have their own specific daily chores to do and things to learn in line with their level of training. Those who have recently started their *ukuthwasa* are with Mks Dudu to get their training and to learn what life as a sangoma is like. The longer a *thwasa* lives at the compound the more responsibility will come with the tasks. At first, for example, to bring food and drinks to visitors (e.g. researchers), later on to host patients and make them comfortable in the waiting room, to prepare them for their healing session, or to assist a senior *thwasa* in the performance of the healing ritual. Almost graduated *amathwasa* get to practise what they have learned under the watchful eyes of Mks Gasa herself. Everybody thus follows a strict regime, which makes Mks Gasa's school run smoothly, like a well-oiled machine.

Mks Gasa's healing practice mimics a medical doctor's office hours with the exception that there are no special hours. When somebody is not feeling well, he can come at any time. A *thwasa* will meet him and escort him to greet Mks Gasa and next to the waiting room. When one of the sangomas is ready for the session, a *thwasa* leads him into the consulting room, where the session starts by lighting a handful of *imphepo*. Often, patients have to come back for (a few) other healing sessions.[53] When several patients have to come for a similar healing session, they are scheduled for the same afternoon, one after the other, like production line work. Amathwasa watch these healing sessions closely to learn about similarities and distinctions and eventually they get the chance to perform such sessions themselves.

For many healing rituals special items are needed: special clothing, certain objects or offerings like drinks, food or live animals. When it comes to food and drinks the patient usually brings it along. In case of special offerings like certain clothing or live animals

[53] See Chapter 3 on the three healing dimensions: body, mind, and surroundings.

there are usually specific (ancestral) demands, for example with regard to the colour of the animal. Mks Gasa then arranges the appropriate animals and passes the expenses on to the patient. With regard to Mr Mbele's healing sessions; Mks Zinhle had bought a Xhosa attire for him, all kinds of beadwork in Xhosa colours, knobkerries, and other items that were needed for the sessions at the river and at his house, and Mks Gasa brewed the Zulu beer in the days prior to that sessions. Mr Mbele provided leopard skins (one he wore around his shoulders, others were on the chair and on the floor beside his bed) a chair, and several items for the session in the bedroom in his new house. Obviously, they had discussed what was needed and who would supply the various requirements. After the session in Mr Mbele's house the sangomas and *amathwasa* performed several dances in the living room for which they had brought all kinds of equipment: drums, anklets, a trumpet and so on. Additionally, a dinner was served for all people present, all *amathwasa* ate while sitting on the floor on their knees and hands, a table was set for the invited sangomas and for us, the guests. The dinner had been prepared by a number of Mks Gasa's *amathwasa* because Mr Mbele apparently needed assistance in his home. While the sangomas and Mr Mbele went to the beach, these *amathwasa* had gone to his house in Pietermaritzburg to prepare the food. As it turned out they also had brought the Zulu beer and taken care of the arrangement of the healing session display in the bedroom.

Figure 6.8 (left to right) Mks Ntombi and Mks Gasa watch Mr Mbele while thwasa Mngadi is securing the leopard skin, a *thwasa* fetches items for the next healing session and a *thwasa* cleans up the offerings' display of the former healing session

Operational elements like a regime with a strict assignment of tasks, healing sessions as if in a production line, the supply of essential parts of healing sessions (offerings, special

clothes), and passing on the costs are indicative of a business-like management. Though in Mks Gasa's case none of these elements are motivated by new governmental laws; the organisation of her healing practice is due to the size of the school and practice. Moreover, it is in the patients' advantage; the healing practice is always in operation and special requirements are taken care of by the sangomas. The number of *amathwasa* in Mks Gasa's school (business-like as it is) is nor a new element nor exceptional; in the 1960s and 1970s both Mks Bhengu and Mks Mbuyisa were trained by a *gobela* that had several *amathwasa*, in Mks Mbuyisa's case there were about 10 fellow *amathwasa*.

Occasionally the number of apprentices is an element of rivalry between *gobelas*; the more *amathwasa* a *gobela* has, the more prosperous she is and the more patients come to her healing practice (Mbatha & Gqaleni, 2017).

Mks Gasa is a registered sangoma and she runs her practice in a business-like way, but the way she runs it does not comply with the legislative demands of the THP Act. She does not keeps records or logbooks to provide accounts for the government, she doesn't write bills for her patients nor does she use fixed prices. Patients pay with whatever they have. We saw the same situation at the other sangomas' compounds while they too were registered THPs. In favour of the patient they run their healing practice as efficiently as possible and yet they won't turn their practice into the kind of business the law requires. Apparently the different levels of government are not yet able to enforce the accompanying financial restrictions, obligations, and accountability on these indigenous healers.

The government's recognition and legalisation of their profession leads to a growing self-confidence, a new kind of awareness and pride among sangomas. However, in spite of the noble intentions of the government's policy and the efforts the associations are putting in, one may wonder if the pursued aims are realistic and attainable. Because besides acknowledgement the THPAct also leads to significant frustration among individual indigenous healers. Conditions and restrictions laid down by the government are obviously not met by a substantial part of the THPs. Moreover, with regard to the registration they state it is encroaching too much on the THP's professional status, because part of the registration is to reveal when and where the indigenous healer was trained and by whom. According to Bongani, not every THP wants to bring this information into the open. Furthermore, while in the THPs' professional attitude it is important to protect the patients' identity and medical data, according to the new healthcare laws they have to keep a logbook of their healing practice. Plus, as to the fixed fee condition, many THPs do not want to charge their patient money, because they want their services to be accessible for all, rich or poor. Within the new legislation this is not allowed. On the contrary; every registered THP has a professional accountability for his income and has to pay income taxes based on these data.

The flexibility in execution of the healing practice that is an intentional and inherent part of an imagistic training (as we have concluded ukuthwasa is) is not appreciated, but

rather curtailed and frustrated by the implementation of the doctrinal conditions of Act 22, 2007. This law, apart from the profession's recognition, therefore seems to have too many drawbacks for any cooperative and obliging THP.

Moreover, there is the matter of the (graduated) THPs that do not want to apply for registration or are not allowed to become a member of the association because they can't prove they are graduated. They can charge patients whatever they want without having any accountability towards the government. It is no wonder that many THPs adopt a critical attitude towards the new legislation.

6.5 Concluding remarks

In this chapter I have explored how external (historical, social and political) dynamics inform the contemporary indigenous healing system in South Africa. After decades of illegality, sangomas can execute their practices in the open nowadays. Although their profession is legalised, effects of the apartheid era are still noticeable in the way the sangomas' healing practice is perceived in society; a part of the population regards indigenous healing as the healing system for the poor and illiterate. In the urban areas, where immense quantities of job seeking rural men felt miserable and uprooted, was an exponential growth in the number of THPs, some trained, some not. An alarming amount of reports of malpractice and unethical behaviour by (alleged) THPs led to necessary control and regulation. Both within the indigenous healing system by associations and outside the system in the form of governmental legislation. THP associations have an intermediary role between different levels of government and individual indigenous healers.

The longitudinal data in this research show that indigenous healing is flexible and experiential and that sangomas incorporate all kinds of contemporary elements in their healing practices. The healing practice is executed in what Whitehouse calls an 'imagistic way'. At the same time sangomas hold on to one old element, their intermediary role between patient and ancestors, an indigenous religious element. The combination of various transforming elements and one essential old element in the indigenous healing practice makes me conclude that the sangomas' practice can be characterised (in reference to Hobsbawm & Ranger's theory) as a constantly re-invented 'tradition'.

Such a specific combination of elements in the indigenous healing practice seems to be beneficial for sangomas; the intermediary element suggests a connection with the power, wisdom, and authority of the ancestors, while sangomas also show they are part of contemporary society. Yet, by holding on to the designation 'traditional healers', sangomas deliberately set themselves apart from that contemporary society. Their position in society can be typified as ambivalent and in a certain way that makes sangomas intangible. A position that suits them well; in the execution of their profession they want to go their own way and when they are criticised, they can easily motivate their actions by either the demands of 'changing society' or the alleged ancestors. In case the execution of their practice is at stake (*muthi* extinction, unethical behaviour of pharmaceutical industry, negative press) indigenous healers take an active stand against those processes in society.

The political dynamics of the last two decades in South Africa seem favourable for indigenous healing: the system is acknowledged and about to be integral part of national healthcare. Although THP associations cooperate with the government in its policy towards registration and standardisation, the implementation of the law meets with individual indigenous healers' opposition. They claim the THP Act's obligations and restrictions infringe too much on their healing practices and professional autonomy.

Part of the resistance is due to a collision of the western, scientific based doctrinal paradigm that is the basis for the new legislation and the, let's call it, 'African' paradigm. The law's regulations are intended to fight malpractice and unethical behaviour, but whether somebody is a 'real' sangoma or not is a question from a western point of view, and therefore within the African paradigm not useful. In this paradigm, whether someone is a genuine sangoma does not merely depend on a specific certificate, but is far more dependent on the person's attitude and skills, e.g. communication with patients (and allegedly the ancestors). It is the patient's experience with and belief in a sangoma's competence that is crucial. Ultimately, it is the patient that judges if he deems a specific healer 'worthy' of filling the social position of sangoma.

This way of thought however does not match with the purpose of the THP Act. The fact that the South African government requires sangomas to register (and consequently prove that they are graduated) in order to be acknowledged, indicates that this healthcare legislation is structured in accordance with the western, scientific, medical model; a model that is implicitly dominant, supreme and intolerant towards other models. By establishing this type of healthcare legislation, the government apparently also aims to meet international approval; it is a representation of South Africa as a modern country with an up-to-date, generally acknowledged medical system.

With regard to the programme-practice analysis I came across inconsistencies on governmental and associational level. The government, in passing new healthcare legislation, has taken action in regulation and control of THPs and found an accomplice in the THP associations. The role and attitude of the associations however is ambiguous: they claim to be the representatives and advocates for individual THPs, yet they incline their ear to the government's wishes. THP associations use the government's recognition of the THP profession to claim a respected position in society, and at the same time they urge their members to accommodate their healing practices to the government's demands, e.g. registration. Even though a significant number of the sangomas consider registration not beneficial for their practice and the privacy of their patients.

The government's intentions may be good, the implementation of the law is intricate and actual practice will show what will come of it. Up to now too many THPs consider it not beneficial to register. The tardiness of implementation, the government's inability to formulate adequate criteria for registration, and indigenous healers' reticence with regard to this top-down imposed policy prove according to Mbatha that this legislative process is "under imminent threat of becoming ineffectual and resisted by THPs associations and the general THP public" (2017, p. 64). Government and indigenous healers are in a vicious circle when it comes to Act 22's implementation, it is a paradoxical situation.

Now that the sangomas' healing practice has been officially recognised, sangomas all over the country are not eager to cooperate in the implementation of the THP Act. At the bottom line, it might be the case that the acknowledgement of indigenous health practices will be sufficient for the government as well as for the hesitant THPs. I

would not be surprised if, in the long run, both 'sides' leave the registration topic as it is, dangling in limbo. All actors involved in this process seem to have their reasons to stick to this status quo.

In the next chapter I sketch an overview of the findings of this research on internal and external dynamics that inform the experiential indigenous healing system in contemporary South Africa. I also expand these findings geographically and longitudinally. Next I would like to convey my expectations on the development of indigenous healing practices in future South Africa and the position of indigenous healers in South African society, along with some final reflections based on the entire study.

Chapter 7

Final reflections

"When you qualify you get your *ishoba*. If you are a *thwasa*, you don't carry *ishoba*. Only the qualified sangomas carry." Bongani explains to me how to distinguish a sangoma from a *thwasa* in the overcrowded rondavel at the Gasa compound. For more than an hour on this sunny Saturday afternoon,[1] Mks Zinhle and a group of about seven *amathwasa* perform sangoma dances for us, encouraged by a growing number of spectators. The other *amathwasa* are standing in a semi-circle around the dancers, all dressed up in red, white, or blue cloths, joined by neighbours and passers-by, who, before they entered the rondavel, quickly wrapped an *ibhayi* around their shoulders. Everybody is singing along and clapping their hands on the beat of the drums. The dancing *amathwasa* carry weapons, a knobkerrie, and a wooden knife. Mks Zinhle carries a knobkerrie and a short stick with an oxtail-end, the *ishoba* that Bongani told us about. The moment that I think I understand, a young woman also with an *ishoba* appears at Mks Zinhle's side. "So, she is a sangoma too?" I ask him, "No", Bongani answers casually, "this is just for assistance, when you dance alone you don't feel right sometimes, so they decided to give her an *ishoba* too." With 'they' he refers to the ancestors, who determine (and justify) all sangomas' actions. That the ancestors' demands and wishes are capricious and far from straightforward dawns on me once again.

Figure 7.1 'Cattle' (money) for the ancestors next to the *ishobas*

[1] 26 April 2014.

Figure 7.2 Mks Zinhle plays the drums, *amathwasa* dance

Throughout the field study for this research, I have encountered many examples of flexibility in sangomas' practices and daily life, manifestations of their constant conforming with presumed ancestral wishes and demands. With hindsight, this pliability (from my etic point of view: to internal and external dynamics) might have surprised and triggered me the most.

In this last chapter, it is my intention to draw a number of general conclusions on the basis of the research data. Although the number of cooperating sangomas was rather small - three for the interviews and four for the healing sessions - and the area was limited to the Durban metropolitan, and the fieldwork was restricted to three periods of several weeks each, they are, in my opinion, adequate for formulating some sound remarks with a wider range, both geographically and longitudinally, especially in combination with other academic literature.

Here, I will therefore recapitulate the most important subjects of the previous chapters and present some final reflections on them. I will also explore what insights the used genealogical sampling method and Harvey Whitehouse's theory Modes of Religiosity brought us with regard to the transmission of knowledge during *ukuthwasa* and what that means for the execution of the sangomas' profession. The application of Hobsbawm & Ranger's theory on Invention of Tradition, Foucault's theory on Power, and Girard's Mimetic Desire theory on the research data was instrumental for a better understanding of the different dynamics that influence indigenous healing in South Africa. Oluwole's philosophy on the fundamental differences between Western and African paradigms of thought presented a helicopter view on the subject.

With the help of the various applied conceptual analyses I will further attempt to illustrate and explain why indigenous healing appeals to so many South Africans.

Overview

In the first chapter, I sketched in broad outlines the set-up of this research on how internal and external dynamics inform the indigenous healing system in South Africa by introducing its subject as well as the central research question. The sub-questions were presented and the main theory in this study: Whitehouse's on the transfer of specialist knowledge. I also positioned this research in relation to the academic literature and explained its relevance. In the second chapter, the field study, its limitations, and the genealogical sampling method were the central topics. I also gave an account of the decisions I made with regard to the cooperating sangomas, the collaboration with my key informant, the research ethics, and my data management.

Starting from the 'Healing Mr Mbele' case in the third chapter, I described what elements an indigenous healing process may consist of and, subsequently, I compared these elements to the 2012 interview data and academic literature on the specific subjects of diagnosis and healing. Internal dynamics with regard to these subjects are closely related to those with regard to transfer of indigenous (muthi) knowledge in the sangomas' training, which were the topic of the fourth chapter. I found many differences. That information led me to investigate what in fact is 'traditional' in 'traditional healing' and the possible reasons for THPs to hang on to this terminology.

External processes involved in the interrelationship between indigenous healing, cosmopolitan healthcare, and institutionalised religion were highlighted in the fifth chapter and, in the sixth, the focus was on other external dynamics (historical, social, and political) that inform contemporary indigenous healing. Against a background of the country's apartheid history and the changing social position of sangomas, I sketched the implications of recent healthcare legislation on the individual healing practice and indigenous healing as an experiential system.

The major topic of this research is thus about dynamics that inform indigenous healing; in the course of the study, I tried to find out whether there are transformations in healing processes and, if so, in what parts of that process they occur and, ultimately, why these transformations take place. By application of the genealogical sampling method and comparison of the obtained data with academic literature, I was able to get a perception of longitudinal developments in knowledge transmission. I also detected many transformations and a few constant elements in the execution of healing practices, in rural and urban settings. We can trace back the transformations in the healing processes to both internal and external processes, which of course are related as indigenous healing is part of the South African society.

On the basis of the concluding remarks in the previous chapters, I will reflect on these topics, pursue the longitudinal findings, and formulate some expectations for the developments of indigenous healing as a system and its status, and the sangomas' future social position in South Africa.

7.1 Reflections on internal dynamics

My consideration of the transformations in healing processes start at the training for sangomas, *ukuthwasa*. In the 2012 interviews, we heard contradicting remarks on the uniformity of the (predominantly oral) transmission of knowledge during the training. The older generation confirmed consistency of knowledge transfer, the younger generation, however, emphasised that an apprentice in training only learns the basics. After graduation, a sangoma continues to develop her knowledge and skills, in what I called 'perpetual private revelation', through her own experiences and contacts with other indigenous healers, all of which is allegedly directed by the ancestors.

From all the remarks about the content of *ukuthwasa*, both in 2012 and 2014, I derived that, to a large extent, the knowledge transfer is accomplished in what Harvey Whitehouse calls the "imagistic mode of knowledge transfer"; in this mode, the transmission of procedural knowledge takes place by means of participation in rituals, other specific parts of knowledge are taught verbally.

In his book on the position of Africa in the World, Stephen Ellis (2011) argues that African religious ideologies are capable of absorbing all kinds of new elements, a huge flexibility owed to the fact that these religious systems are not founded on written sacred texts. A lack of dogma is a feature of oral tradition. Here, in my opinion, is a parallel with indigenous healing; firstly, because the transmission of knowledge during the sangomas' training and later in professional life is, for the greater part, oral and experiential. Secondly, the deficiency of a written *ukuthwasa* curriculum leads to an idiosyncratic training that is tailored to the individual needs of the *thwasa* (as believed to be indicated by the ancestors). Thirdly, as a result of the imagistic mode transfer of knowledge in the training, a sangoma is consequently at liberty and has the power to adjust healing processes to contemporary (local) possibilities and the requirements of every single patient. She actually has the opportunity to constantly reinvent her indigenous healing practice and execute it in an experiential, imagistic way. This explains part of the differences and transformations in sangomas' healing practices.

Ukuthwasa, consequently, is quite a different training than the education Western medical doctors get, where knowledge is transmitted in the doctrinal mode with a large amount of professional literature to study and uniform exams to pass. In *ukuthwasa*, transfer of theoretical knowledge seems not to be the primary element, there is more to it.

An (even more) important issue in *ukuthwasa* is what Mlisa calls the 'healing identity', the required sangomas' attitude that a *thwasa* acquires during the training. Therefore, a *thwasa* must learn to speak in a low voice, be humble, and at all times respectful towards her *gobela* and the ancestors. Plus, there is the element of a sangoma's behaviour towards patients and their families, for whom she has to be patient, understanding, comforting, and reassuring, because for patients the sangoma is the intermediary with

the ancestors, the messenger of the diagnosis, the performer of healing rituals and the provider of *muthis*. Throughout their entire training, *amathwasa* watch their trainers' healing activities and when ultimately they are allowed to perform a healing session themselves, they partly copy the *gobela*'s actions and add a few personal elements. These elements also account for variations in sangomas' healing practices.

With the acquired 'healing identity', *amathwasa* are prepared to occupy the social position of sangoma, another aim of *ukuthwasa*. In that position the performance of healing rituals is a major required skill, for that is, after all, why patients come to a sangoma, to be healed.

These patients do not necessarily have a physical illness or disease. In my view, a shift is taking place; nowadays, especially in the urban areas where clinics are near, some of a sangoma's patients come for treatment of a physical illness, but the majority wants therapy for psychosomatic problems or something bothering them, a lack of well-being, a feeling of discomfort. The holistic approach, which corresponds with the indigenous worldview, is what appeals to many South Africans. Indigenous healing (contrary to Western healthcare where in general the specific complaints of a patient are treated) deals in a holistic way with the patient, his family, his ancestors, and his social environment. Bongani once sketched the difference for me, he said: "If you have a headache and you go to a doctor, you get an aspirin and the headache disappears. But maybe the next day the headache comes again and you have to take another aspirin. If you attend a sangoma, she will diagnose and find out why you have the headache. And when it comes from the students you teach at school, the sangoma will come with you to the school to talk with those students. Because that is where the problem is and that has to be solved, an aspirin won't do that." Imagining a sangoma (or whatever doctor or therapist) appearing in a Dutch secondary school to talk to students about one of their teacher's headaches, made me smile. In the Western context I live in, such a visit is inconceivable. Bongani's example unintentionally emphasised the different paradigm from which I think and live.

In the indigenous healing context the patients expect the sangoma to find out what the cause of their affliction is, so that subsequently the appropriate measures can be taken and in the future similar complaints can be prevented.

In this perspective, the concept of healing is more than recovering physically or mentally, it is also understanding what was wrong and why that happened and feeling acknowledged as a person in a certain situation, being reassured that things can and will get better. Healing is often a treatment by a healer one trusts and believes in.

Sangomas are respected, partly due to their alleged ability to communicate with the ancestors. In a healing session the ancestors are believed to reveal the cause and remedy of the patient's problem to the sangoma. This distinguishing element is a religion-based assumption that traces back to their shared indigenous worldview. Many other religious symbols are used in the sangomas' healing practice, e.g. the invocation and praise of the ancestors and the use of multiple candles.

While Mlisa (2010), an indigenous healer herself, labels *ukuthwasa* as a religious phenomenon, on the basis of my data I tend to conclude that not only the training but indigenous healing is a religious rather than a medical phenomenon. Indigenous healers may be able to heal their patient in a physical way, but more and more frequently the healing is either mental, social, spiritual, or some combination of those. Furthermore, the core of the healing process is in the diagnosis, the alleged contribution of the ancestors.

It might be the use of the words 'healing' and 'health' that is deceptive for some; in the African context, health is a concept that not only concerns the physical and the mental domain, but also the social and environmental. Within the Western scientific paradigm, however, 'healing' is associated in the first place with a remedy or therapy for physical and mental afflictions. The connection to medicine at that point is obvious, but is confusing where the other domains are concerned.

7.2 Reflections on external dynamics

Decades ago, Ngubane (1977) observed that the indigenous view of illness and treatment was an elaborate, coherent system of ideas and practice. She suggested that it had sustained the people and offered them profound and adequate answers to their suffering brought by illness or misfortune and she stated that it endured even in the apartheid society.

Now, forty years later, South African society is in many aspects a different one. Yet, for numerous people the indigenous views on illness and healing still provide satisfying answers in times of misery, witness the fact that a majority of the South African population attends indigenous healers. Since the apartheid regime came to an end, sangomas have been allowed to execute their healing practices in the open again. In recent healthcare legislation, intended to provide healthcare for all South Africans, sangomas are acknowledged, their practices legalised and they are regarded as equal to those in the cosmopolitan healthcare system. For many sangomas, this is a major step because apartheid's hardship had left them with deep marks. The legalisation of their profession has boosted sangomas self-esteem, the execution of their practice, and their social status.

One would expect that in the present situation indigenous healers would be content. That is not the case, however. They are pleased with the government's recognition but, at present, the level of frustration regarding the legislation is considerable. Their disappointment concerns two topics, viz. the cooperation with CHS and the implications of the required registration. Firstly, although sangomas are generally positive with regard to medical doctors and are willing to cooperate, this attitude is not reciprocal. The new law does not change the Western healthcare workers' condescending attitude towards indigenous healing. Secondly, the implementation of obligatory registration for authorised execution of a healing practice is not getting off the ground. While registration intends to guarantee quality, there is no objective standard to use as an assessment.

Fundamental to both of these topics, in my opinion, is a friction between the Western and African worldview. From the Western point of view, a person is allowed to call himself a medical doctor if he has successfully completed his doctor's exams; he gets a certificate and is expected to be competent. In the African setting, a written certificate was seldom provided. At the end of the sangomas' training there is a graduation ceremony to which all her relatives, neighbours, and fellow sangomas are invited. All guests may test and experience the *thwasa*'s competence and, in the end, they all witness the *gobela* declaring that the *thwasa* successfully completed the training and is now a sangoma. In a small-scale society this procedure worked well, but in contemporary South African society the scale is much larger, especially in the urban areas, where people are not acquainted with each other. Therefore, evidence is needed

to prove the sangomas' competence. In the African setting, such evidence may be given in the form of the patients' experience or advertisement by word of mouth. Within the Western paradigm, the necessary qualifications are certificates and diplomas. The new South African healthcare legislation applies Western standards to assess indigenous healers and their healing practice; in order to be able to register, healers have to hand in certificates as a proof of their education. So far, however, such certificates do not exist. Initiatives like Baba Cele's *muthi* school indicate a certain level of conformity.

However, the government's demands seem to be a bridge too far when it comes to any modification or general coordination of the curriculum for the sangomas' training or the obligatory logbook with patients' records. At those points no governmental meddling is accepted, a *gobela*'s sovereignty (believed to be supported by the ancestors) in the training is pivotal, as is a sangoma's autonomy in her healing practice. Many sangomas do not intend to run their healing practice the way the government wants. They claim that they are 'called' to be a sangoma and thus at the ancestors' service. They are thus suggesting that any sangoma who complies with the legislative rules does not have a calling. In this perspective, the new legislation is counterproductive, for one of its aims was essentially to decrease malpractice (by distinguishing 'real' sangomas from 'quacks') through registration; registration was to be a certifying quality mark. Now, because of the law's accompanying obligations and restrictions, sangomas hesitate to cooperate and, consequently, for the time being, registration cannot be regarded as the intended quality mark. It may never be. Differentiation between 'real' sangomas and 'quacks' remains a problematic, if not impossible, assignment anyway. For it is the patient who decides which sangoma he believes to be trustworthy and competent with regard to his afflictions at a specific moment. It is a matter of subjective judgement and impossible to generalise.

In contrast with the rather reticent attitude regarding law-imposed changes in their healing practice, sangomas seem to react enthusiastically to opportunities that the changing society brings. When it comes to incorporation of contemporary means in their personal lives and professional practice, sangomas are not conservative or outdated at all.

Obviously, sangomas claim that all alterations in the healing practice are approved, or even instigated, by the ancestors, with whom they are in close contact. If all those (kinds of) observed transformations are initiated by the ancestors, I wondered who they are and what sangomas mean when they refer to the ancestors. Does a sangoma communicate with only one or more of her own predecessors, or does she communicate with the patient's ancestors? Or is 'the ancestors' a general designation, or rather an image? My impression is that a sangoma communicates with (the 'spirits' of) several of her own genealogical ancestors, and that they conceive them as real entities (with human characteristics) that are able to interfere in daily lives of all people. Bongani told us that in his case frequently several of his ancestors squabbled about which one of them

was to be regarded as the most influential. But often one of the ancestors is the most important (Nkabinde, 2008), as Mks Ngidi and Mks Bhengu told us in the interview. In a healing session the sangoma connects with her own ancestors, who in turn connect with the patient's ancestors to detect what the patient's problem is, which is subsequently reported to the sangoma: i.e. the diagnosis. That is why during the invocation all people that are present in the consulting room have to be introduced to the ancestors. A similar introduction was done when we came to interview the sangomas in 2012; we had to tell our names and where we came from, so that the sangoma's ancestors could connect with our ancestors, before giving their consent for the interview. The term 'the ancestors' is regularly used as a general designation, but a sangoma's communication is as a rule specifically with her own genealogical ancestors.

It is not easy to produce a forecast on how these matters with regard to healthcare legislation will develop in the coming years. One would expect the government to persevere in the national implementation of the latest law, but on the basis of the slowness of the recent proceedings, I have some doubts about the operation's completion.

What if the government does indeed enforce the obligatory registration for THPs to legally execute their healing practice? I expect that many sangomas (partly in contrast to other categories of THPs) will decide not to register after all, because for them the law infringes too much on their supposedly ancestor instructed healing practice. They do not see the need to officially register now that their profession is legalised by the government. Neither do they regard it as useful to create a document-based profile because they trust the patients' experience-based judgement. Government and sangomas operate from different paradigms, the Western based on science and control and the African with experience as an important factor.

In part, my doubts concerning the THP Act's national implementation have to do with structures in South African society. Van Kessel (2012), as a specialist on South African society, argues that even though good plans and financial means are plenty in South Africa, there is a shortage of governmental executing capacity. Thus, the implementation of this Act in society needs more than good intentions. The mere fact that the healthcare legislation is passed, does not mean that the implementation will be realised in the near future, due to (among other things) a general shortage of governmental staff.

Besides, there is another issue which makes me doubt the ultimate national implementation of Act 22, 2007. At the time of my fieldwork, Jacob Zuma was South Africa's president. In KwaZulu Natal, people were proud to have a Zulu as the nation's president and it made them very eager to comply with all the governmental demands.[2] I wonder what will happen now that Cyril Ramaphosa (born in Soweto) is president

[2] The percentage of indigenous healers that was registered through NUPAATHPSA for instance was considerably higher in KwaZulu Natal than in the rest of the country.

of South Africa. Will indigenous healers and their associations in KwaZulu Natal keep executing the government's requests diligently or was their law-abiding attitude instigated by the fact that the presidential seat was occupied by a Zulu? I doubt if the northern provinces will take the lead in encouraging sangomas to register, for the people in the northern provinces are generally known to be less susceptible to authority. Therefore, I expect that the campaign for registration will gradually decrease.

The present situation is in many aspects favourable for the parties involved, viz. the government, the THPs, and their patients. A major improvement for the government as well as the THPs is that indigenous healing is now recognised and legalised. Furthermore, for the national government, which currently has other priorities in repairing former president Zuma's legacy of nepotism and corruption, this legalisation entails an important money-saver on future national healthcare costs. The fact that, up to now, the government has not been able to facilitate an accurate registration system is in juxtaposition with many sangomas' hesitation to register. The patients benefit from the option of compensation from insurance companies, sick leave notes handed by indigenous healers and the sangomas' refusal to charge (often higher scale) fixed fees. Ultimately, the stipulation that THPs are obliged to register might become the big stick if there is an intolerable increase of malpractice and unethical behaviour. Maybe the most feasible solution will be to basically leave things just the way they are, in limbo.

In previous chapters I have applied the antipodal concepts religion-medicine, programme-practice, and tradition-changing society to analyse and clarify aspects of indigenous healing. In several respects it was useful to discuss certain elements of the indigenous healing practice that way, to a certain degree it helped me unravel and better understand the complexity of the subject. More importantly it made clear to me that in indigenous healing these oppositional concepts are not incompatible at all, which I found intriguing.

A sangoma's healing practice proves to be neither one, nor the other; time and again it is both, religion and healing, programme and practice as well as 'traditional' and part of contemporary, changing society. Sangomas eclectically select elements from all those models, religious, medicine, tradition etc., which makes their healing practice hard to define and regulate, particularly because the compilation of elements may vary per sangoma and from one healing to the other. I consider this one of the reasons for the popularity of indigenous healing and the respect for sangomas. With their fluid mix of different models' elements sangomas appeal to a great majority of the people in South Africa, whether a patient attaches value to tradition or is an admirer of modern technologies, whether the patient is young or old, urban or rural, a sangoma experientially modifies her healing practice to the patient's (unspoken) wishes.

Another reason for the lasting and expected future popular position that indigenous healing has in South African society, has to do with its holistic approach of patients. This approach is part and parcel of the African world view, shared by the majority of

the population. In this inclusive worldview there is no such thing as coincidence or chance; everything is intentional and therefore all occurrences have to be interpreted and explained. Indigenous healers have an eye, an ear, and a culturally appropriate remedy for psychosomatic disorders and existential crises. This is in contrast to Western healthcare clinics, where often no adequate treatment is available for those matters, which leaves the patients uncured and their questions unanswered.

7.3 Methodological analytical perspectives

To what extent this eclectic-model-mixing strategy will prove to be successful and durable in the long run is an open question. The flexibility and fluidity of the sangomas' practice, which triggered me from the start of this research, is definitely a strength, as I indicated. But it may also prove to be a weakness. For the hegemonic forces of the Western scientific (medical) model cannot be overestimated. This doctrinal model based on checks and evidence is intolerant towards any other model or system and therefore it will not acknowledge a more flexible (imagistic) system such as indigenous healing is.

Although sangomas incorporate in their healing practice many elements that are familiar to medical clinics and indigenous healthcare is recognised as equal to the cosmopolitan healthcare system, I do not expect the CHS to acknowledge sangomas' healing as a medical system. In fact, I think, based on Rene Girard's Mimetic Desire theory, that CHS' rejection of THPs will even intensify. Now that the indigenous healthcare system is recognised by law, the chances are that the CHS will increasingly consider THPs as rivals in the medical arena, a field where, according to many medical professionals, indigenous healing does not belong, for they maintain (from their Western medical paradigm) it is religion, maybe occult and certainly not scientific. Whereas the cosmopolitan healthcare system used to be the 'model' for indigenous healers, when its influence on policymakers and healthcare law's implementation is strong enough, it could become an 'obstacle' in the execution of their healing practices.

Through Foucault's theory on power and social relations we gained an insight into the power structures that surround indigenous healing. Apart from powers (like legislation and CHS) that affect the indigenous healing system from outside, inside the system sangomas themselves also use the concept of power. Within sangoma schools we recognised power relations between different levels of *amathwasa* and between trainer and apprentice.

Moreover, the claim that they have (access to) 'traditional, old' and private ancestral knowledge gives sangomas authoritative power within the circle of people that do not have that specific knowledge. That is, over all people that regard 'the ancestors' as an authority, which is a majority of the population. By holding on to that 'old' element sangomas emphasise their own distinguishing strength, the core of their profession and their special position in society.

Regardless of the fact that sangomas are respected by a considerable part of South Africa's population and that their profession is acknowledged by law, these indigenous healers cannot afford complacency; their current social position is vulnerable. They should give due consideration to the impact of repeated negative media reports (about witchcraft, body parts trafficking, etc.) on public opinion and other adverse forces in South African society. For a part of the population does not acknowledge the sangomas' power, based on the ancestors' authority and ancestral knowledge. Among those are

medical professionals and, what Bongani referred to as "learned people", the educated people that often have status and power in social and administrative spheres. In social power relations, language is often instrumental in definition, segregation, and control. It emerges in their claim that indigenous healing is for the poor and uneducated people, that it is occult and unscientific, all designations with negative connotations. This part of the population regards themselves superior to (those who make use of) indigenous healing. They relegate it to the realms of superstition, maintaining for example that it is neither verified, nor evidence based. Arguments that come straight from an oppositional discourse in which doctrinal transmission of knowledge and controlled execution of healing practice is considered the best, if not the only way.

It will therefore be a persistent challenge for sangomas, with their imagistic knowledge transfer and experiential practice, to withstand the hegemonic doctrinal way of thinking, on which the recent healthcare legislation is based. Since the sangomas' healing practice is in my opinion an example of what Oluwole (2017) calls "the African way of thinking" (i.e. complementary and inclusive) I expect sangomas will not fight the Western (medical and legislative) system or comply with it, but rather keep on 'juggling' with all available different models. And, to quote Mks Mbuyisa, bend like reeds in the wind of change.

It is their way of maintaining their power, to stay in control, and to avoid the regulatory tentacles of authorities. A tenacious way to autonomously determine the form in which they execute their imagistic healing practices and an attempt to safeguard a future for their indigenous knowledge and allegedly ancestor-initiated profession. Time will tell whether the sangomas' strategy will be effective and in what way these dynamic practices will evolve.

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Appendix A

Zulu - English

gobela	trainer
ibhayi, (pl: amabhayi)	cloth
idlozi, (pl: amadlozi)	ancestor
indluhlola	consulting room
inhlola	diagnosis
inyanga	herbalist
iphahla	v-shaped twig for stirring
iqxana (Xhosa)	crown, 2 layer
ishoba	oxtail staff
isiphandla	goatskin bracelet
izinhlola	bones for divining
muthi	medicine/medicinal herbs
sangoma	diviner, healer
thwasa, (pl: amathwasa)	apprentice
ukuthwasa	training to become sangoma
umgqwambo	goatskin cross
umnqwazi (Xhosa)	crown, 1 layer
umxele (Zulu)	crown for males, 1 layer

English – Zulu

ancestors	idlozi, amadlozi (pl)
apprentice	thwasa, amathwasa
bones for divining	izinhlola
cloth	ibhayi, amabhayi (pl)
consulting room	indluhlola
crown 1 layer	umnqwazi (Xhosa), umxele (Zulu, for males)
crown 2 layers	iqxana (Xhosa, for married)
diagnosis	inhlola
goatskin bracelet	isiphandla
goatskin cross	umgqwambo
medicine/ med. herbs	muthi
oxtail staff	ishoba
trainer	gobela
training	ukuthwasa
twig for stirring	iphahla

Appendix B

Manual for interviews, in English and Zulu

Being sangoma:

- How long have you been a sangoma?
- What way were you 'called' to be a sangoma?
- What was your response to this calling?
- How did you choose your tutor/school?
- Can you tell me about your initiation-time, the processes, the ukuthwasa?
- Can you tell me about the initiation ceremony?
- Life as a sangoma, what does it look like? Can you describe it?
- Does 'being sangoma' run in your family? Do you have ancestors who were sangoma?
- What ancestors are particularly important to you and in what way?

Healing processes and the transfer of knowledge:

- What way is the knowledge transferred from teacher to pupil?
- In what way do you transfer knowledge to your pupils.
- What differences are there compared to the way you were trained?
- Does every sangoma have his/her own way of healing?
- Do healing processes change through time? According to patient? Are there differences in village and town?
- Could you describe to me what happens/goes on if someone is feeling not well and wants to be healed and comes to you? What do you experience?

Sangoma and society:

- Do you refer your patients to other sangoma's, to inyanga's, to western doctors and vice versa?
- Do sangoma's specialize in any kind of way or of healing? What is your speciality?
- Do you feel respected by society? By whom (not)?
- Of which network(s) of sangoma's are you part of?
- Are you a member of an association of sangoma's? Why (not)? Why this?
- Did you register as a sangoma? Why (not)?

In Zulu

Ukuba iSangoma:

- Singakanani isikhathi osusisebenze njenge Sangoma?
- Iyiphi indlela owabizwa ngayo kulomsebenzi?
- Ubizo lwakho walamukela kanjani?
- Wathola kanjani ukuthi kufanela uthwase kuphi, uthwasiswe ubani?
- Ake uchaze ukuthi ngesikhathi ungenwa indlozi kwakwenzakalani kuwena, kuze kufike lapho usuyongena entwaseni?
- Awungichazele ngemicimbi eyenziwa umuntu osentwaseni?
- Impilo yakho njengoba uyiSangoma ungayichaza ngokuthi impilo enjani?
- Ubungoma ingabe buwufuzo kuwena, noma ukhona kwabadala owayeyiSangoma?
- Iliphi idlozi elibalulekile kuwena, libaluleke ngani?

Izindlela zokwelapha, nokudlulisela ulwazi:

- Ulwazi ludluliselwa kanjani ukusuka kuGobela luya eThwaseni?
- Wena uludlulisa kanjani ulwazi uluyisa emaThwaseni akho?
- Ukhona umehluko phakathi kwendlela wena owaThwasa ngayo , nendlela wena oThwasisa ngayo?
- Ingabe zonke iZangoma zinezindlela zazo zokwelapha?
- Ingabe izindlela zokwelapha zishintsha ngokwezikhathi, noma ngokweziguli, ngokwasemaphandleni, noma ngokwa semaDolobheni?
- Ungachaza ukuthi uma umuntu egula eza kuwena, kwenzakalani kuwena?

Sangoma kanye noMphakathi:

- Ingabe iziguli zakho uyazidlulisela kwesinye iSangoma, iNyanga noma kuDokotela wase Ntshonalanga?
- Ingabe iZangoma zinawo umsebenzi ezingochwepheshe kuyona (specialize), kuwena imuphi ongungoti kuwo?
- Ingabe umphakathi uyakuhlonipha yini njengeSangoma, Njengamaphi amazinga abantu?
- Njengoba izangoma zisebenza ngezindlela ezingafani (njengokubhula) wena ungena kuluphi uhlobo?
- Ikhona inhlangano yabelaphi oyilunga layo, ukwenzeleni lokhu, yini ukhethe lenhlangano yakho?
- Ubhalisile njengeSangoma esisemthethweni, Ukwenzeleni lokhu?

Summary

This thesis investigates the changing healing practice of Zulu sangomas in KwaZulu Natal, South Africa. Indigenous healing in South Africa is currently at a crossroads. While the latest healthcare legislation accepts the traditional healthcare system as equal to cosmopolitan healthcare, the accompanying institutional developments present obligations and challenges for indigenous healers. While the legalisation is important for sangomas, certain valued characteristics of their much-frequented indigenous healing practices are now under pressure. This research seeks to detect where transformations in indigenous healing practices originate and it seeks to understand to what purpose adaptations in healing processes serve.

Sangomas are a specific group of indigenous healers, predominantly women, whose profession incorporates both religious and medical elements. In South Africa, the general discourse is on 'traditional' healthcare; in this thesis, however, owing to the connotations of the word traditional, preference is given to the phraseology 'indigenous' healing, with the exception of fixed expressions.

To explore the backgrounds of transformations in healing practices and the current status of traditional healthcare, collected data were analysed in the context of existing academic literature on indigenous healing in (South) Africa, both earlier studies (Callaway, 1884 (1870); Bryant 1949; Bryant 1966; Krige, 1965 (1936)) and more recent ones (Janzen, 1992; Erdtsieck, 2003; Van Binsbergen, 1991; Mlisa, 2010; Werbner, 2015). Analysis made clear that there are longitudinal changes in several aspects of the healing practice. The image of indigenous healing that emerges is one of a dynamic system. An apprentice's training is tailored to her individual situation (Mlisa, 2010; Van Beek, 2010). Every healer executes the healing practice in her own way (Erdtsieck, 2003; Mlisa, 2010) and adapts the healing procedures to the given context (Erdtsieck, 2003; Werbner, 2015).

The status of indigenous healing in contemporary South Africa is partly informed by its shifting relationship with various denominations of Christian churches (Oosthuizen, 1989; 1992) and its relationship with Western healthcare. Despite frictions and mistrust (Gumede, 1990; Botha, 2004), current legislation compels both healthcare systems to collaborate (Gqaleni et al., 2010; Ndzimande et al., 2014; Zuma et al., 2017). The effects of contemporary society and the institutionalisation of traditional healthcare, and how indigenous healers cope with the challenges of this change are subjects that exercise many minds. Along with the advantages of the latest healthcare law for indigenous healers, there are many frustrations regarding the government's indifference to the legislation's enactment (Ndzimande et al., 2014, Mbatha & Gqaleni, 2017).

When it comes to the transformations in indigenous healing, also in relation to the social context in which indigenous healers execute their practice, there is a gap in academic literature. The shifting relationships between indigenous healing, religious institutions, Western healthcare, and society in general have been described, but not how these phenomena affect indigenous healing practice. Too little attention has been paid to exactly what the transforms in indigenous healing practices and the underlying processes are. More research on those transformations and the dynamics involved is needed.

This thesis seeks to reduce this lacuna by:

- Exploring possible transformations in indigenous healing knowledge and in the transmission of this knowledge.
- Exploring possible transformations in sangomas' healing practices.

This is done by interviewing three generations of sangomas in rural and urban areas regarding: their 'calling' and training; their healing practice; cooperation with other (indigenous) healthcare workers; their social position and networks; and the way they teach their apprentices. Sangomas' healing practices were explored by attending patients' healing sessions, executed by diverse sangomas at various locations. The cooperating sangomas were selected from the key informant's comprehensive network in the Durban district. With regard to the interviews, the selected sangomas are Makhosi Bhengu, representing the older generation in the rural area; Mks Mbuyisa, representing the middle generation in an in-between area, and Mks Ngidi, representing the youngest generation in the urban area. The attended healing sessions were executed by Mks Zinhle, Mks Gasa, Mks Dudu, and two advanced initiates from Mks Gasa's sangoma school and by Mks Mkhize.

Relevance of the study

Firstly, this thesis is to be considered as a contribution to the academic debate on knowledge transfer in education. The way in which knowledge is transmitted during training influences the way graduates execute their practice. It shows that this is the case for indigenous healers in South Africa; training as well as practice are experiential. Secondly, this research is relevant in its representation of the contemporary status of indigenous healing in South Africa, even though the data for this research were gathered among a limited number of sangomas in a restricted area. In many ways, sangomas are just like any other professional group of indigenous healers (such as inyangas). In the cases that sangomas' attitudes may differ from that of other indigenous healers it is indicated. Thirdly, this study is an academic treatise about a topical subject with high social relevance in contemporary South Africa. The institutionalisation of Traditional

Medicine affects not only the healing practices of medical doctors and indigenous healers, but also the lives of the 80 per cent of the population that attend those healers. The significance of this research and its analysis is, in addition to the insiders' perspective in recent South African academic studies on how sangomas deal with the challenges of the changing society (Mbatha & Gqaleni, 2017), in its outsider's perspective. Both views should be regarded as complementary.

Set up of the research

Research questions

The analysis of the data collected in fieldwork in combination with academic literature on sangomas' healing practices revealed that indigenous healing practices change due to internal dynamics, viz. the transfer of knowledge and sangomas' individual healing identity, as well as due to processes external to the traditional healing system, namely in the form of adaptations to other institutions and to contemporary society.

These considerations led to the main research question of this thesis:

How do internal and external dynamics inform 'traditional' healing as an experiential system in contemporary South Africa?

The supporting questions address the domains of internal and external dynamics. With regard to internal dynamics:

- How do processes of diagnosis and healing characterise the traditional healing practice?
- What dynamics and contradictions are in the curriculum and knowledge transfer of sangomas' training?

Then, the scope widens to external dynamics that affect traditional healing.

- What dynamics are involved in the interrelationship between (cosmopolitan) healthcare, religion (indigenous and institutionalised), and indigenous healing?
- How do historical, social, and political processes inform contemporary indigenous healing?

Research location

The research was done among sangomas in the province of KwaZulu Natal, more precisely in the Durban metro district. Sangomas' compounds in rural as well as in (semi-) urban areas were visited for interviews and the healing sessions were executed at compounds in the urban area and at locations that were significant for a specific patient's healing process: Mtamvuna river estuary and the patient's home in Pietermaritzburg.

The field research took place in February-March 2012, July-August 2012, and April-May 2014. The aim in the first period was to get acquainted with the area and to make contact with (people who knew) Zulu sangomas and who were willing to collaborate in the research. During the second period, three sangomas were interviewed and several other indigenous healers were visited to better understand the challenges the healers face. A key aspect of the third period was attending patients' healing sessions.

Methodology

The genealogical sampling method, i.e. comparing data from subsequent generations of sangomas, was used in order to find out whether sangomas' healing practices transform longitudinally. The element of 'location' was added to this concept in order to determine whether differences in healing practices occur in relation to the area where they are performed. Moreover, this method was applied to gain an insight into the transmission processes of healing knowledge and to investigate the consistency of this knowledge transfer from teacher to pupil.

This study is a qualitative research in the shape of a case study. Mr Mbele's healing procedure (a detailed description is in Chapter 3) serves as a model of contemporary indigenous healing, internal dynamics in healing practice, and knowledge transfer converging with external (institutional) processes that apparently influence present-day sangomas and their healing practices.

The research design is interpretative, characterised by continuous comparison of the field study data, both mutually and with academic literature. In an analysis cycle of induction and deduction, the data obtained during fieldwork was assessed for correspondence with literature on the subject and, vice versa, whether literary elements and claims can be identified in the field study observations was deduced. It is also a constant process of interpretation and (emic) checks in order to gain an in-depth understanding of contemporary indigenous healing in South Africa. This procedure was intensified by the fact that the field study was done in three separate periods.

Plan of the book

Subsequent to the introductory and methodological chapters (Chapters 1 and 2), each chapter deals with one of the supporting research questions, first on internal dynamics (Chapters 3 and 4) and then on external dynamics that inform contemporary indigenous healing (Chapters 5 and 6). The subjects are approached from different angles and interpretative theories are used for analysis. In order to get a better grip on the data and to bring underlying contrast to the surface, sets of antipodal concepts are used for each of the perspectives.

In Chapter 3, the focus is on the execution of the sangomas' healing practice, specifically, on what happens when a patient comes to a sangoma for healing. Mr Mbele's healing procedure is a connecting thread in the description of processes of

diagnosis and healing, the key elements in every healing session. Comparison of this process with other healing sessions provided an extensive account of what happens in an indigenous healing procedure, often a number of sequential sessions. It also revealed the uniqueness of the patient's treatment in the constant interaction between sangoma, ancestors, and patient. Of particular note are the amount of time and effort that sangomas devote to the healing of their patients and the attention they give to the patients and their relatives. Also significant is the notion that the ancestors' communication and the interpretation of the diagnosis is strictly the prerogative of the attending sangoma. This is both a strength and a weakness in indigenous healing; the sangoma has a powerful position but there is no way to check her claims.

A central topic in Chapter 4 is the internal dynamics and contradictions in the curriculum and knowledge transfer in sangomas' training. Transfer of (*muthi*) knowledge, the diagnosis, and the healing identity emerged as the most important elements in the training. The data in this research indicate that there is no steady curriculum for any of these three elements. The type and amount of (*muthi*) knowledge transmitted during the training turns out to be individually attuned, and the performance of the diagnosis and the healing identity are heavily influenced by the sangoma's personal expression and the presumed demands of the ancestors. The training of sangomas and the *muthi* knowledge that is transferred are concluded to be idiosyncratic and experiential. After the training, sangomas continue to develop and expand their know-how in knowledge exchange with other indigenous healers (and) allegedly inspired by the ancestors, a 'perpetual private revelation'. They use this new knowledge in their healing practice and in the training of their apprentices.

Application of Whitehouse's theory (2004) on the transmission of specialist knowledge made clear that both the sangomas' training and the execution of the indigenous healing practice are executed in an imagistic mode, i.e. that indigenous healing is an experiential, imagistic system.

Another important topic within the indigenous healing system is the dynamics in the organisation of THP associations. The old community-based networks are replaced by larger scale associations that are organised after the Western model, with executive committees and regional meetings. These transformations aim for government acknowledgement and thus to dovetail with the Western healthcare system.

As the sangomas' healing practice is a mix of religious and medical elements, Chapter 5 explores what dynamics are involved in the interrelationship between (Western) medicine (CHS), (institutionalised) religion, and indigenous healing. The relationship between CHS and indigenous healing is characterised by dynamics that originate from the different paradigms that the two healthcare systems are imbedded in: an evidence-based scientific paradigm and an experience-based paradigm. Although both

healthcare systems are to be regarded as equal according to healthcare legislation, the CHS is hegemonic. And because power defines knowledge, the Western (healthcare) discourse determines not only if, but also in what way and under what circumstances indigenous healers will be acknowledged.

There are signs of indigenous healing's conforming with the CHS in the organisation of the healing practice and association, and in attempts to standardise *muthi* knowledge and the creation of a referral form. Nevertheless, application of Girard's Mimetic Desire theory shows that the more the indigenous healing system approaches the CHS model, the stronger the CHS's rejection of indigenous healing will become. Acknowledgement by the CHS is only to be anticipated if indigenous healing discards its distinct individuality.

Whereas the discourse on indigenous healing is in medical terms, in a Western scientific view the sangoma's healing practice consists predominantly of religious elements. To sangomas, their profession is primarily a matter of healing, a term that, in this context, proves to have a much wider definition than merely medical.

Indigenous healing's relation with institutionalised religion seems to have improved in the decades after apartheid. Many Christian churches are showing interest in indigenous healing and there is an exchange of knowledge and practices. This mutual interest might be an effect of the influence of the African Independent Churches, in which African custom and culture is combined with Christian doctrine. For numerous sangomas and many of their patients who are members of mainline Christian churches or of AICs, (institutionalised) religion and indigenous healing are not oppositional, but go hand in hand.

How historical, social, and political dynamics inform the contemporary indigenous healing system in South Africa is the topic of Chapter 6. After decades of illegality, sangomas can now execute their practices in the open. However, apartheid's effects are still noticeable in the way the sangomas' healing practice is perceived in society. Longitudinal data in this study show that indigenous healing is flexible and experiential: all kinds of contemporary elements are incorporated in the healing practices. Sangomas hold on to one old, indigenous religious element: their intermediary role between patient and ancestors. Their healing practice can be considered, in reference to Hobsbawm's theory (1992), as a constantly re-invented 'tradition'. Sangomas' position in society can be typified as ambivalent and in a certain way that makes them intangible, which seems to suit them well.

Exponential growth in the number of THPs and an alarming number of reports of malpractice or unethical behaviour by (alleged) THPs led to necessary control and regulation. While THP associations cooperate with the government in its policy towards registration and standardisation, the implementation of the THP Act meets with individual indigenous healers' opposition. They state the law's obligations and restrictions infringe too much on their healing practices and professional autonomy.

In their view, it is up to the patient to judge, based on experience, whether a healer is 'worthy' of filling the social position of sangoma.

The implementation of the law is intricate and hitherto many THPs have considered it not beneficial to register. The tardiness of implementation, the government's inability to formulate adequate criteria for registration, and indigenous healers' reticence with regard to this top-down imposed policy endanger the effectivity of this legislative process (Mbatha & Gqaleni, 2017). Now that their healing practice has been officially recognised, sangomas are not eager to cooperate in the implementation of the THP Act. Their profession's acknowledgement may suffice for the THPs as well as for the government, all actors involved have their reasons for sticking with this status quo.

Some final reflections on the findings of this study are presented in Chapter 7, along with expectations with regard to the development of indigenous healing practices in South Africa. Two grounds for indigenous healing's ongoing appeal to a majority of South Africans are described. Firstly, in the indigenous healing perspective, the concept of healing is more than recovering physically or mentally, it is also understanding what the cause of the affliction is, so that the appropriate measures can be taken and similar complaints can be prevented in the future. Nowadays, especially in urban areas, many patients want therapy for psychosomatic problems or something bothering them, a lack of well-being, a feeling of discomfort. Indigenous healers have an eye, an ear, and a culturally appropriate remedy for psychosomatic disorders and existential crises. Healing is often a treatment by a healer one trusts and believes in. Secondly, in their healing practice, sangomas eclectically select elements from all kinds of models: religion and healing, 'traditional' and contemporary, changing society. The compilation of elements may vary per sangoma and from one healing to another. Whether a patient attaches value to tradition or is an admirer of modern technologies, whether the patient is young or old, urban or rural, a sangoma experientially modifies her healing practice to the patient's (unspoken) wishes.

To what extent this eclectic-model-mixing strategy will prove to be successful and durable in the long run is an open question. The flexibility and fluidity of the sangomas' practice is definitely a strength, but it may also prove to be a weakness. The hegemonic forces of the Western scientific (medical and legislative) model cannot be overestimated. This model based on checks and evidence is intolerant towards any other model or system and therefore it will not acknowledge a more flexible (imagistic) system such as indigenous healing is.

Therefore, despite the profession's acknowledgement and their continued popularity, sangomas cannot afford complacency; their current social position is vulnerable. They should give due consideration to the impact of repeated negative media reports (about witchcraft, body parts trafficking, etc.) on public opinion and other adverse forces in

South African society. The part of the population that does not acknowledge the sangomas' power, which is based on the ancestors' authority and ancestral knowledge, includes people who have status and power in social and administrative spheres. Many of them relegate indigenous healing to the realms of superstition, maintaining that it is neither verified, nor evidence based.

It will therefore be a persistent challenge for sangomas, with their imagistic knowledge transfer and experiential practice, to withstand the hegemonic doctrinal way of thinking, on which the present healthcare legislation is based. Since the sangomas' healing practice can be regarded as an example of what Oluwole (2017) calls "the African way of thinking" (i.e. complementary and inclusive), these indigenous healers are unlikely to fight the Western (medical and legislative) system, or to comply with it. They will probably keep on 'juggling' with all available different models and bend like reeds in the wind of change. It is their way of maintaining their power, to stay in control, and to avoid the regulatory tentacles of authorities. A tenacious way to autonomously determine the form in which they execute their imagistic healing practices and an attempt to safeguard a future for their indigenous knowledge and allegedly ancestor-initiated profession.

Samenvatting

Dit proefschrift onderzoekt de veranderende genezingspraktijk van Zulu sangoma's in KwaZulu Natal, Zuid-Afrika. Op dit moment staat de inheemse genezingspraktijk in Zuid-Afrika op een kruispunt. Waar de nieuwste gezondheidswetgeving het traditionele gezondheidszorgsysteem accepteert als gelijkwaardig aan de kosmopolitische gezondheidszorg, brengen de bijbehorende institutionele ontwikkelingen verplichtingen en uitdagingen met zich mee voor inheemse genezers. Hoewel de legalisatie belangrijk is voor sangoma's, staan als belangrijk beschouwde kenmerken van hun goed bezochte inheemse genezings-praktijken nu onder druk. In dit onderzoek wordt geprobeerd te traceren waar de transformaties in inheemse genezingspraktijken hun oorsprong vinden en te begrijpen waarom aanpassingen in de genezingsprocessen worden doorgevoerd.

Sangoma's zijn een specifieke groep inheemse genezers, voornamelijk vrouwen, wier beroep zowel religieuze als medische elementen bevat. In Zuid-Afrika gaat het algemene discours over 'traditionele' gezondheidszorg, in deze dissertatie wordt echter, vanwege de connotaties van het woord traditioneel, de voorkeur gegeven aan de term 'inheemse' genezing, met uitzondering van vaste uitdrukkingen.

In de verkenning van de achtergronden van transformaties in de genezingspraktijk en de huidige status van de traditionele gezondheidszorg werden de verzamelde gegevens geanalyseerd in samenhang met de bestaande academische literatuur over inheemse genezing in (Zuid-)Afrika, zowel eerdere studies (Callaway, 1884 (1870); Bryant 1949; Bryant 1966; Krige, 1965 (1936)) als meer recente (Janzen, 1992; Erdtsieck, 2003; Van Binsbergen, 1991; Mlisa, 2010; Werbner, 2015). De uitkomst van de analyse maakte duidelijk dat er longitudinale veranderingen zijn in verschillende aspecten van de genezingspraktijk. Het beeld dat van inheemse genezing ontstaat is er een van een dynamisch systeem. De opleiding van de leerling is afgestemd op haar individuele situatie (Mlisa, 2010; Van Beek, 2010). Elke genezer voert de genezingspraktijk op haar eigen manier uit (Erdtsieck, 2003; Mlisa, 2010) en past de genezingsprocedures aan de gegeven context aan (Erdtsieck, 2003; Werbner, 2015).

De status van inheemse genezing in het hedendaagse Zuid-Afrika wordt mede bepaald door de veranderende relatie met diverse kerkgenootschappen (Oosthuizen, 1989; 1992) en de relatie met de westerse gezondheidszorg. De huidige wetgeving dwingt, ondanks wrijvingen en wantrouwen (Gumede, 1990; Botha, 2004), beide zorgsystemen samen te werken (Gqaleni et al., 2010; Ndzimande et al., 2014; Zuma et al., 2017). Niet alleen de effecten van de hedendaagse samenleving en de institutionalisering van de traditionele gezondheidszorg, maar ook hoe inheemse genezers omgaan met de uitdagingen van dit tijdsgewricht, zijn onderwerpen die velen bezighouden. Naast de

voordelen van de nieuwste zorgwet voor inheemse genezers zijn er ook veel frustraties over de onverschilligheid van de overheid rondom de implementatie van de wetgeving (Ndzimande et al., 2014; Mbatha & Gqaleni, 2017).

Als het gaat om de transformaties in de inheemse genezing, mede in relatie tot de sociale context waarin inheemse genezers hun praktijk uitvoeren, is er een lacune in de academische literatuur. De verschuivende relaties tussen inheemse genezing, religieuze instellingen, Westerse gezondheidszorg en de maatschappij in het algemeen zijn beschreven, maar niet hoe dit de inheemse genezingsprak-tijken beïnvloedt. Er is te weinig aandacht besteed aan wat er precies verandert in de inheemse genezingspraktijk en wat de onderliggende processen zijn. Meer onderzoek naar die transformaties en de bijbehorende dynamiek was nodig.

Deze dissertatie probeert bij te dragen aan vermindering van deze leemte door:
- het verkennen van mogelijke transformaties in inheemse genezingskennis en in de overdracht van deze kennis.
- het verkennen van mogelijke transformaties in de genezingspraktijken van sangoma's.

Dit gebeurt door drie generaties sangoma's, in landelijk en stedelijk gebied, te interviewen met betrekking tot hun 'roeping' en opleiding, hun genezingspraktijk, eventuele samenwerking met andere (inheemse) genezers, hun sociale positie en netwerken en de manier waarop zij hun leerlingen onderwijzen. De genezings-praktijken van sangoma's werden verkend door het bijwonen van genezings-sessies van patiënten, uitgevoerd door diverse sangoma's op verschillende locaties. De aan het onderzoek meewerkende sangoma's werden geselecteerd uit het uitgebreide netwerk van de sleutelinformant in het district Durban. Voor de interviews zijn geselecteerd; de sangoma's Makhosi Bhengu, voor de oudere generatie op het platteland; Mks Mbuyisa, voor de tussengeneratie in een half stedelijk gebied en Mks Ngidi, voor de jongste generatie in het stedelijke gebied. De bijgewoonde genezingssessies werden uitgevoerd door Mks Zinhle, Mks Gasa, Mks Dudu en twee gevorderde leerlingen van Mks Gasa's sangoma-school en door Mks Mkhize.

Relevantie van het onderzoek

In de eerste plaats kan dit proefschrift worden beschouwd als een bijdrage aan het academisch debat over kennisoverdracht in onderwijs. De manier waarop kennis wordt overgedragen tijdens een opleiding is van invloed op de manier waarop afgestudeerden hun praktijk uitvoeren. Het laat zien dat dit het geval is voor inheemse genezers in Zuid-Afrika; zowel de opleiding als de praktijk zijn ervaringsgericht. Ten tweede is dit onderzoek relevant als representatie van de hedendaagse status van inheemse genezing in Zuid-Afrika, ook al zijn de gegevens voor dit onderzoek verzameld onder

een beperkt aantal sangoma's in een beperkt gebied. In veel opzichten verschillen sangoma's, als beroepsgroep, niet van andere beroepsgroepen van inheemse genezers (zoals inyanga's). Wanneer de situatie van sangoma's anders is dan die van andere inheemse genezers wordt dit aangegeven. Ten derde is deze studie een academische verhandeling over een actueel onderwerp met grote maatschappelijke relevantie in het hedendaagse Zuid-Afrika. De institutionalisering van de Traditionele Geneeskunde heeft niet alleen invloed op de genezingspraktijken van artsen en inheemse genezers, maar ook op het leven van de bevolking (ongeveer 80 procent) die deze genezers bezoekt. Het belang van dit onderzoek en de analyse ervan is, naast het perspectief van de insiders in recente Zuid-Afrikaanse academische studies over hoe sangoma's omgaan met de uitdagingen van de veranderende samenleving (Mbatha & Gqaleni, 2017), in het perspectief van de buitenstaander. Beide visies kunnen als complementair worden beschouwd.

Opzet van het onderzoek

Onderzoeksvragen

De analyse van de tijdens veldwerk verzamelde gegevens in combinatie met de academische literatuur over de genezingspraktijken van sangoma's bracht aan het licht dat de inheemse genezingspraktijken veranderen door interne dynamieken, d.w.z. met betrekking tot de overdracht van kennis en de individuele genezingsidentiteit van sangoma's, maar ook door processen buiten het inheemse genezingssysteem, namelijk in de vorm van aanpassingen aan andere instellingen en aan de hedendaagse samenleving.

Dit leidde tot de belangrijkste onderzoeksvraag van deze thesis:

Hoe wordt in het hedendaagse Zuid-Afrika 'traditionele' genezing als een ervaringsgericht systeem beïnvloed door interne en externe dynamieken?

De ondersteunende vragen richten zich op de domeinen van de interne en externe dynamieken. Met betrekking tot de interne dynamiek:

- Hoe kenmerken processen van diagnose en genezing de inheemse genezingspraktijk?
- Welke dynamieken en tegenstrijdigheden zijn er in het curriculum en de kennisoverdracht van de sangoma's?

Vervolgens wordt de blik verbreed naar de externe dynamieken die van invloed zijn op inheemse genezing.

- Welke dynamieken zijn betrokken bij de onderlinge relatie tussen (kosmopolitische) gezondheidszorg, religie (inheems en geïnstitutionaliseerd) en inheemse genezing?

- Hoe wordt de hedendaagse inheemse genezing beïnvloed door historische, sociale en politieke processen?

Onderzoek locatie

Het onderzoek werd gedaan onder sangomas in de provincie KwaZulu Natal, in het district Durban. Sangoma's in zowel landelijke als (semi-)stedelijke gebieden werden bezocht voor interviews, de healing sessies werden uitgevoerd op het terrein van sangoma's in het stedelijke gebied en op locaties die van belang waren voor het genezingsproces van een specifieke patiënt: de monding van de rivier Mtamvuna en het huis van de patiënt in Pietermaritzburg.

Het veldwerk vond plaats in februari-maart 2012, juli-augustus 2012 en april-mei 2014. Het doel in de eerste periode was om de omgeving te leren kennen en in contact te komen met (mensen die) Zulu sangomas kenden en bereid waren mee te werken aan het onderzoek. In de tweede periode werden drie sangomas geïnterviewd en werden verschillende andere inheemse genezers bezocht om een beter inzicht te krijgen in de uitdagingen waar de genezers voor staan. In de derde periode was het belangrijkste onderdeel het bijwonen van de genezingssessies van de patiënten.

Methodologie

Om erachter te komen of de genezingspraktijken van sangoma's longitudinaal transformeren werd de 'genealogical sampling' methode gebruikt: het vergelijken van gegevens van opeenvolgende generaties sangoma's. Aan dit concept werd het element 'locatie' toegevoegd om te bepalen of er verschillen in genezings-praktijken voorkomen in relatie tot het gebied waar ze worden uitgevoerd. Bovendien werd deze methode toegepast om inzicht te krijgen in de overdrachts-processen van kennis over genezing en om de consistentie van deze kennisoverdracht van leraar naar leerling te onderzoeken.

Deze studie is een kwalitatief onderzoek in de vorm van een case-study. De genezingsprocedure van Mr Mbele dient als model voor de hedendaagse inheemse genezing; de interne dynamiek in de genezingspraktijk en de kennisoverdracht komen samen met externe (institutionele) processen die de huidige sangoma's en hun genezingspraktijken blijkbaar beïnvloeden.

De onderzoeksopzet is interpretatief, gekenmerkt door een voortdurende vergelijking van de gegevens van de veldstudie, zowel onderling als met academische literatuur. In een analysecyclus van inductie en deductie wordt beoordeeld of de gegevens die tijdens het veldwerk zijn verkregen overeenkomen met de literatuur over het onderwerp en, omgekeerd, werd onderzocht of literaire elementen en claims kunnen worden herkend in de waarnemingen van de veldstudie. Het is ook een constant proces van interpretatie en (emic) controles om een diepgaand inzicht te krijgen in de hedendaagse inheemse genezing in Zuid-Afrika. Dit proces werd zelfs geïntensiveerd door het feit dat het veldonderzoek in drie afzonderlijke periodes werd uitgevoerd.

Opzet van het boek

Na de inleidende en methodologische hoofdstukken (hoofdstuk 1 en 2) gaat elk hoofdstuk in op een van de ondersteunende onderzoeksvragen, eerst over interne dynamieken (hoofdstuk 3 en 4) en vervolgens over externe dynamieken die de hedendaagse inheemse genezing beïnvloeden (hoofdstuk 5 en 6). De onderwerpen worden vanuit verschillende invalshoeken benaderd, interpretatieve theorieën worden gebruikt voor de analyse. Om meer grip te krijgen op de gegevens en om onderliggend contrast aan de oppervlakte te brengen, wordt voor elk van de perspectieven een conceptuele analyse toegepast.

In hoofdstuk 3 ligt de focus op de uitvoering van de genezingspraktijk van de sangoma's, op wat er gebeurt als een patiënt bij een sangoma komt voor genezing. De genezingsprocedure van Mr Mbele is een rode draad in de beschrijving van de processen van diagnose en genezing, de belangrijkste elementen in elke genezingssessie. Vergelijking van dit proces met andere genezingssessies leverde een uitgebreid verslag op van wat er gebeurt in een inheemse genezingsprocedure, vaak een aantal opeenvolgende sessies. Het liet ook het unieke karakter zien van de behandeling van de patiënt, de constante interactie tussen sangoma, voorouders en patiënt. Van belang zijn de hoeveelheid tijd en moeite die sangoma's besteden aan de genezing van hun patiënten en de aandacht die ze geven aan de patiënten en hun familieleden. Opmerkelijk is dat de communicatie van de voorouders en de interpretatie van de diagnose strikt genomen het voorrecht van de behandelende sangoma is. Dit is zowel een kracht als een zwakte in de inheemse genezing; de sangoma heeft een machtspositie, maar er is geen manier om haar beweringen te controleren.

Centraal in hoofdstuk 4 staan de interne dynamieken en tegenstrijdigheden in het curriculum en kennisoverdracht in de opleiding van sangoma's. Overdracht van (*muthi*) kennis, de diagnose en de genezingsidentiteit kwamen naar voren als de belangrijkste elementen in de training. De gegevens in dit onderzoek geven aan dat er voor geen van deze drie elementen een vast curriculum bestaat. Het type en de hoeveelheid (*muthi*) kennis die tijdens de training wordt overgedragen blijkt individueel te zijn afgestemd, en de uitvoering van de diagnose en de genezingsidentiteit worden sterk beïnvloed door de persoonlijke expressie van de sangoma en de veronderstelde eisen van de voorouders. De training van sangoma's en de (*muthi)* kennis die wordt overgedragen, blijken persoonlijk en ervaringsgericht te zijn. Na de training blijven sangoma's hun kennis ontwikkelen en uitbreiden, door kennisuitwisseling met andere inheemse genezers en in een voortdurend proces van persoonlijke openbaring; 'perpetual private revelation', steeds, naar verluidt, geïnspireerd door de voorouders. Ze gebruiken deze nieuwe kennis in hun genezingspraktijk en in de opleiding van hun leerlingen.

Toepassing van de theorie van Whitehouse (2004) over de overdracht van specialistische kennis maakte duidelijk dat zowel de training van de sangoma's als de uitvoering van de inheemse genezingspraktijk in een 'imagistic' modus worden uitgevoerd, dat inheemse genezing een ervaringsgericht, 'imagistic' systeem is.

Een ander belangrijk onderwerp binnen het inheemse genezingssysteem is de dynamiek in de organisatie van THP-verenigingen. De oude gemeenschaps-netwerken worden vervangen door grootschaligere verenigingen die naar westers model zijn georganiseerd, met uitvoerende commissies en regionale bijeenkomsten. Deze transformaties zijn gericht op erkenning door de overheid en op aansluiting bij het Westerse gezondheidszorgsysteem.

Aangezien de genezingspraktijk van de sangoma's een mix is van religieuze en medische elementen, wordt in hoofdstuk 5 onderzocht welke dynamieken betrokken zijn bij de onderlinge relatie tussen (Westerse) geneeskunde (CHS), (geïnstitutionaliseerde) religie en inheemse genezing. De relatie tussen CHS en inheemse genezing wordt gekenmerkt door een dynamiek die voortkomt uit de verschillende paradigma's waarin de twee zorgsystemen zijn ingebed; een evidence-based wetenschappelijk paradigma en een ervaringsgericht paradigma. Hoewel beide gezondheidszorgsystemen volgens de gezondheidswetgeving als gelijkwaardig moeten worden beschouwd, is het CHS een hegemonie. En omdat macht kennis definieert, bepaalt het westerse (zorg)discours niet alleen of, maar ook op welke manier en onder welke omstandigheden inheemse genezers worden erkend.

Tekenen dat inheemse genezing zich aanpast aan het CHS zijn te vinden in zowel de organisatie van de genezingspraktijk en de beroepsvereniging, als in de poging om de kennis over *muthi* te standaardiseren en de ontwikkeling van een verwijzingsformulier. Desalniettemin toont de toepassing van Girards 'Mimetic Desire' theorie aan dat hoe meer het inheemse genezingssysteem het CHS-model benadert, hoe sterker de afwijzing van de inheemse genezing door het CHS zal worden. Erkenning door het CHS is alleen te verwachten als de inheemse genezing zijn duidelijke eigenheid opgeeft.

Hoewel het discours over inheemse genezing in medische termen is, bestaat de genezingspraktijk van de sangoma's, vanuit een westerse wetenschappelijke gezichtspunt, voornamelijk uit religieuze elementen. Voor sangoma's zelf is hun beroep in de eerste plaats een kwestie van genezing of heling, termen die in deze context een veel bredere definitie blijken te hebben dan alleen de medische.

De relatie van de inheemse genezing met geïnstitutionaliseerde religie lijkt in de decennia na de apartheid te zijn verbeterd. Veel christelijke kerken tonen interesse in inheemse genezing en er is een uitwisseling van kennis en praktijken. Deze wederzijdse interesse kan een gevolg zijn van de invloed van de Afrikaanse Onafhankelijke Kerken, waarin Afrikaanse gewoonten en cultuur worden gecombineerd met de christelijke leer. Voor sangoma's en veel van hun patiënten die lid zijn van een van de denominaties

van christelijke kerken, zijn (geïnstitutionaliseerde) religie en inheemse genezing niet tegenstrijdig, maar gaan ze gemakkelijk hand in hand.

Hoe historische, sociale en politieke dynamieken het hedendaagse inheemse genezingssysteem in Zuid-Afrika beïnvloeden, is het onderwerp in hoofdstuk 6. Na decennia van illegaliteit kunnen sangomas tegenwoordig hun praktijken in het openbaar uitvoeren. In de manier waarop de genezingspraktijk van de sangomas door de samenleving wordt gezien, zijn de effecten van de apartheid echter nog steeds merkbaar. Longitudinale gegevens in deze studie tonen aan dat inheemse genezing flexibel en op ervaring gericht is: allerlei hedendaagse elementen worden in de genezingspraktijk verwerkt. Sangoma's houden vast aan één oud, inheems religieus element, hun bemiddelende rol tussen patiënt en voorouders. Hun genezingspraktijk kan, onder verwijzing naar de theorie van Hobsbawm (1992), beschouwd worden als een steeds opnieuw uitgevonden 'traditie'. De positie van sangoma's in de samenleving kan getypeerd worden als dualistisch, en op een bepaalde manier maakt dat hen ongrijpbaar, wat hen goed lijkt uit te komen.

Exponentiële groei van het aantal THP's en een alarmerende hoeveelheid meldingen van wanpraktijken of onethisch gedrag door (vermeende) THP's leidden tot de noodzakelijke controle en regulering. Terwijl de THP-verenigingen met de overheid samenwerken in hun beleid ten aanzien van registratie en standaardisatie, stuit de uitvoering van de THP-wet op weerstand van individuele inheemse genezers. Zij stellen dat de verplichtingen en beperkingen van de wet een te grote inbreuk maken op hun genezingspraktijken en professionele autonomie. Naar hun mening is het aan de patiënt om op basis van ervaring te beoordelen of een genezer 'waardig' is om de sociale positie van sangoma in te nemen.

De uitvoering van de wet is complex, tot nu toe vinden veel THP's het niet gunstig om zich te laten registreren. De traagheid van de implementatie, het onvermogen van de overheid om adequate criteria voor registratie te formuleren en de terughoudendheid van de inheemse genezers ten aanzien van dit, van bovenaf opgelegde, beleid brengen de effectiviteit van dit wetgevingsproces in gevaar (Mbatha & Gqaleni, 2017). Nu hun genezingspraktijk officieel is erkend, staan sangoma's niet in de rij om mee te werken aan de uitvoering van de THP-wet. Wellicht volstaat de erkenning van hun beroep voor THP's en voor de overheid, alle betrokken partijen hebben hun redenen om aan deze status quo vast te houden.

Enkele slotbeschouwingen over de bevindingen van deze studie worden gepresenteerd in hoofdstuk 7, naast enige verwachtingen met betrekking tot de ontwikkeling van inheemse genezingspraktijken in Zuid-Afrika. Er worden twee redenen beschreven waarom inheemse genezing aantrekkelijk is voor een meerderheid van de Zuid-Afrikanen. In de eerste plaats is het concept van inheemse genezing meer dan alleen

maar genezen, het is ook begrijpen wat de oorzaak van de aandoening is, zodat de juiste maatregelen kunnen worden genomen en soortgelijke klachten in de toekomst kunnen worden voorkomen. Tegenwoordig willen veel patiënten, vooral in de stedelijke gebieden, een behandeling voor psychosomatische problemen of iets wat hen dwars zit, een gebrek aan welzijn, een gevoel van onbehagen. Inheemse genezers hebben een oog, een oor en een cultureel passende remedie voor psychosomatische stoornissen en existentiële crisissen. Genezing is vaak een behandeling door een genezer die men vertrouwt en waarin men gelooft. Ten tweede, in hun genezingspraktijk selecteren sangomas op een eclectische manier elementen uit allerlei modellen, religie en genezing, 'traditie' en de hedendaagse, veranderende maatschappij. De samenstelling van de elementen kan per sangoma en per genezing verschillen. Of een patiënt nu waarde hecht aan traditie of een aanhanger is van moderne technologieën, of de patiënt jong of oud is, stedelijk of landelijk, een sangoma past, op basis van haar ervaring, haar genezingspraktijk aan op de (onuitgesproken) wensen van de patiënt.

In hoeverre deze eclectische strategie op de lange termijn succesvol en duurzaam zal blijken te zijn, is een open vraag. De flexibiliteit en fluïditeit van de praktijk van de sangoma's is zeker een sterk punt, maar het kan ook een zwakte blijken te zijn. De hegemoniale krachten van het westerse wetenschappelijke (medische en wetgevende) model kunnen namelijk niet worden overschat. Dit op controles en bewijsvoering gebaseerde model is onverdraagzaam ten opzichte van elk ander model of systeem en zal daarom een flexibeler, 'imagistic' systeem, zoals inheemse genezing is, niet erkennen.

Daarom kunnen sangoma's, ondanks de erkenning van het beroep en hun aanhoudende populariteit, niet achterover leunen; hun huidige sociale positie is kwetsbaar. Ze moeten zich bewust zijn van de impact op de publieke opinie van zowel negatieve berichten in de media (over hekserij, handel in lichaamsdelen, enz.), als van andere stromingen in de Zuid-Afrikaanse samenleving. Tot het deel van de bevolking dat de macht van de sangomas (gebaseerd op het gezag van de voorouders en vooruderlijke kennis) niet erkent, behoren mensen die status en macht hebben op sociaal en bestuurlijk gebied. Velen van hen beschouwen inheemse genezing als bijgeloof, argumenterend dat het niet wetenschappelijk is.

Het zal voor sangoma's een uitdaging blijven om met hun 'imagistic' kennisoverdracht en ervaringsgerichte praktijk de doctrinaire denkwijze, waarop ook de huidige zorgwetgeving is gebaseerd, te weerstaan. Aangezien de genezingspraktijk van sangoma's kan worden beschouwd als een voorbeeld van wat Oluwole (2017) 'de Afrikaanse manier van denken' (d.w.z. complementair en inclusief) noemt, is het niet waarschijnlijk dat deze inheemse genezers tegen het westerse systeem in opstand komen, noch dat ze zich ernaar voegen. Ze blijven waarschijnlijk 'jongleren' met elementen uit de verschillende beschikbare modellen. Meebuigend, als rietstengels in de wind van de verandering.

Het is hun manier om aan hun macht vast te houden, om het zelf in de hand te hebben en weg te blijven van de regulerende tentakels van de autoriteiten. Volhardend, om autonoom de vorm te bepalen waarin ze hun genezingspraktijken uitvoeren en een toekomst veilig te stellen voor hun inheemse kennis en hun beroep, waarvan wordt aangenomen dat het door de voorouders is geïnitieerd.

Curriculum Vitae

Gerda Jeanette Hooghordel was born in Ermelo, the Netherlands in 1962. She graduated from high school in Harderwijk in 1980. In 1988 she obtained her propaedeutic diploma at the social academy and her MSc in Theology from Utrecht University (the Netherlands) in 1996. In 2003 she completed the first-degree teacher training course in Religion and Philosophy of Life. Since 2009 she worked on her PhD research on Zulu sangomas in South Africa.

In addition to her studies, Gerda always worked in various positions. First in hospital St Jansdal, Harderwijk, HRM administration and acting head of Admission and Surgery Planning (from 1982 to 2003). As a student assistant at the Department of Social Sciences and Religious Studies of the Catholic Theological University of Utrecht 1993-1996. Later as mentor and teacher of religion and philosophy at a secondary school (CCNV) in Harderwijk (2003 to 2018). Currently, she works independently as an existential counsellor from her company 'Zinnig gesprek' (Meaningful conversation).

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