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The handle http://hdl.handle.net/1887/3151634 holds various files of this Leiden University dissertation.

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Title: Reeds in the wind of change: Zulu *sangomas* in transition
Issue date: 2021-03-30

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'.

[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*,

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[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

[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

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[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.