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.

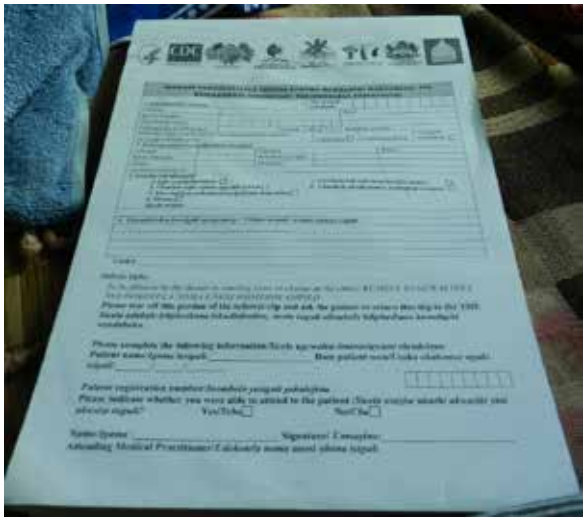

Figure 5.3 Referral form

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.