Chapter 6

Indigenous healing in contemporary society

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

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

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

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

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

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

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

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

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

[2] In § 1.4.2.

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

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

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

Bongani Ntshangase, a present-day sangoma

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

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

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

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

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

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

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

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[3] Interview, 1 August 2012.

[4] Interview, 9 August 2012.

[5] Mks Bhengu trained one herself.

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

6.1 Historical dynamics

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

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

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

6.1.1 Apartheid era: Health, rich and poor

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

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

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

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

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

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[6] Interview, 9 August 2012.

[7] Ibid.

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

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

Bongani Ntshangase, education

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

[8] Interview, 1 August 2012.

[9] See also Chapter 5.

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

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

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

6.1.2 Apartheid era: Health, rural and urban

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

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

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

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

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

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

Figure 6.1 Palm reader advertising

Figure 6.2 Advertising enlargement cream and pills

Figure 6.3 Gandalf has a remedy for everything

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

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

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

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

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

[13] 13 August 2012.

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

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

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

6.1.3 After apartheid, attempt to legislate

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

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

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

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

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

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

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

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

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

[19] 1981.

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

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

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

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

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

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

6.2 Social dynamics

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

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

6.2.1 Accommodations to a changing society

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

Figure 6.4 Mks Ngidi's consulting room

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

Bongani Ntshangase, changing society

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

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

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

Figure 6.5 Bongani always carried his muthi bag

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

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

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

[23] See Chapter 4.

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

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

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

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

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

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

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

6.2.2 Stand against a changing society

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

[24] In August 2013.

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

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

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

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

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

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

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

One member of the IPTRAD team, ethnobotanist Professor Neil Crouch, is currently (in a sequel to the *muthi*-market book) involved in the complex regulatory processes that are needed to ensure that the commercialisation of components of the particular (medicinal) species will benefit the holders of the indigenous knowledge that informed the research and development process (Website Kloof Conservacy). The follow-up to the IPTRAD project is thus supportive of *inyanga*s and sangomas and their efforts to preserve their comprehensive indigenous knowledge for future generations.

On the one hand, there are projects to share and standardise *muthi* knowledge; on the other hand, there is a reverse motion, i.e. to protect *muthi* knowledge from various kinds of misuse. The interviewees told us e.g. about the secretiveness concerning specific *muthi* preparations. As reasons for this concealment they mentioned professional confidentiality and 'exclusive rights' for individual indigenous healers.

More recently, in the last two or three decades, yet another element has been involved in this matter. Indigenous healers try to guard their *muthi* recipes against the scrutinising eyes of the multinational pharmaceutical industry. They want to protect this indigenous knowledge in order to avoid the *muthis* becoming available in shops all over the world and exploited by Western companies without crediting the African indigenous healers' ownership (Masango, 2010). With regard to the subject of intellectual property rights of traditional medicines, Timmermans recommends preparing policies and strategies that "address and balance the various objectives and interests" (2003, p. 745). These should include issues such as "access regulation" and "differential treatment

[26] The Red Data List contains an indication on the degree of threat to a plant in the wild habitat, for example 'vulnerable', 'critically endangered', or 'extinct in the wild'.

of various categories of knowledge", furthermore she called "the involvement of all stakeholders" crucial.

Bongani Ntshangase told us about research on medicinal herbs executed by the pharmaceutical department of an American university. The researchers tried to find a remedy for a certain, frequently occurring, complication of HIV/AIDS. *Inyanga*s and sangomas from the *eThekwini* district showed the researchers a healing herb with the vernacular name of '*unwele*', *Lycopodiella cernua* (Ahlefeldt, et al., 2003, p. 52) and the way they prepare it to treat that complication. The researchers left and, after some time, a medicine with exactly the same mixture was on the market, produced by an American pharmaceutical company. The researchers had sold the recipe to the company, the company had patented it, not using the vernacular name '*unwele*' but 'Sutherlandia', another (botanic) name for the same medicinal plant. The indigenous healers that shared their indigenous knowledge did not get a penny of the profits that the company would gain by selling the medicine. They regarded this as unfair and theft of their specialist knowledge and, with support of the Zulu king, Goodwill Zwelithini, a lawyer raised the matter within the scope of indigenous knowledge ownership and intellectual property protection with the pharmaceutical company. Confronted with the threat of a lawsuit concerning the indigenous knowledge property rights, the company agreed to set up a pilot project to compare the effectiveness of the Western and the indigenous herbal medicine at several stages. In 2014, after four years of research,[27] two stages of this project were completed and the results, published in Pietermaritzburg, were interpreted positively by the indigenous healers. The results of the rest of the project should be published in the near future. In general, however, acknowledgement of a herbal medicine is rare. Lack of funding to carry out very expensive clinical trials is one reason, another important one is the fact that pharmaceutical assessment is in accordance with the Western, hegemonic model, which is unfavourably disposed to anything other than chemical medication.

As a consequence of such cases, indigenous healers have become aware of the value of their knowledge and the necessity to protect it as their indigenous property. Therefore, indigenous healers have resolved not to disclose the mixtures and the preparations of *muthis* to anybody (apart from their own inner THP circle) anymore. A side effect of secretiveness about a specific mixture's exact recipe is that there is no possibility to check its effectiveness, or to refute the healing claims of the prescriber. This strategy may thus arouse suspicion.

Sometimes, an awkward notion surrounds the term *muthi* because it is also used as an indication of or a synonym for witchcraft.[28] Therefore, and as a result of the apartheid era,

[27] As a part of the PEPFAR project.

[28] More about 'witchcraft' in the next pages.

muthi has a negative connotation for a part of the South African population. Moreover, this sceptical undertone resounds in the national press' attitude[29] towards indigenous healers. To cope with such negative coverage is a huge challenge for individual healers as well as for associations (Gqaleni, Hlongwane, & Khondo, 2010). I encountered an example of a more or less ambiguous attitude towards indigenous healing in one of the newspapers during the field study in 2012.

A few days after the police shot 34 strikers (the largest number of casualties since the end of the apartheid regime) at the Marikana mines in 2012 an article in the *Sunday Times*[30] showed ambivalence towards *muthi* and indigenous healers. The article headed: *"Muti[31] 'protected' miners. Sangoma's hilltop rituals made protesters fearless in the face of police gunfire."*, and proceeded as follows:

> A mystery sangoma is believed to be behind the foolish courage displayed by striking miners during Thursday's deadly standoff. Undeterred by water cannons and teargas the miners crept through the bushes towards the police and charged straight into a heavy line of fire. The surviving miners are not talking, but Union officials, residents of Marikana and the police confirmed the presence of an unidentified sangoma who carried out rituals on the hill and dished out muti where workers had gathered throughout the week. It is said the man, who is from Eastern Cape, had provided muti to the protesters, and made them believe it would make them invincible. … Several of the strikers the Sunday Times spoke to yesterday were reluctant to talk about the sangoma, and some even denied his existence. 'I heard about that, but I don't want to talk about it.' Said one before walking away. […] A senior policeman who was in one of the police helicopters told the Sunday Times they had recorded the muti rituals on camera. […] While some argue that it was stupid to brave automatic gunfire in the manner in which the workers did on Thursday, some locals believe that, if it hadn't been for the muti rituals, many more would have been killed. […] Amcu[32] national organiser Dumisani Nkalitshana denied that their members used muti. 'We haven't heard any of our members telling us about that. We don't know anything about muti. We are Christians and we believe in God.' (*Sunday Times*, 2012)

The country was in shock after these events and the presidency announced a national week of mourning. Newspapers showed pictures of then President Jacob Zuma visiting wounded mineworkers in hospital. Policemen killing so many demonstrators raised questions like 'How come we are living in this kind of society?' and 'Is our country on the edge of a precipice?' Many South Africans felt as if the country's clocks had been wound back, memories of the apartheid period returning. Zapiro, a well-known South African cartoonist, articulated these feelings in a cartoon in the same paper.

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[29] At least in the Anglophone papers there is an ambivalent, but often explicit negative attitude towards indigenous healers and *muthi*.

[30] 19 August 2012.

[31] '*muti*': anglicised spelling of '*muthi*'.

[32] Association of Mineworkers and Construction Union, a South African trade union.

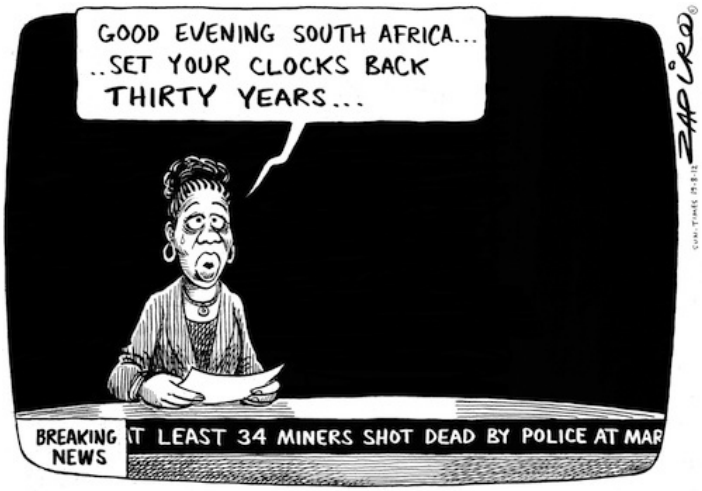

Figure 6.6 Marikana © 2012 - 2018 Zapiro (All Rights Reserved)
Originally published in the Sunday Times in 2012.
Used with permission. More Zapiro cartoons at www.zapiro.com

In looking for possible causes, the nation's eyes were not only set on the violence used by the police force and the accountable police officers (Mail & Guardian, 2017), many questions were also raised (maybe as diversionary tactics to hide the extreme amount of violence that was used) about the alleged reckless behaviour of the strikers. Why did the strikers seem unafraid of the police gunfire? What was the influence of the sangoma's rituals that were performed on the hilltop?[33]

Several passages in the article show an ambiguous attitude towards indigenous healers and *muthi*. The miners' behaviour is ridiculed by the journalist, several times in the article a '*muti* ritual' is mentioned and the reluctance to talk about the sangoma, all these elements add to the shroud of mystery hanging over this event that has become known as the Marikana massacre. Another thing that struck me in this article is the supposed contrast between indigenous healing and Christianity, as if the two are mutually exclusive. For many people, however, as I have shown, there is no contradiction between the two.

As emerged in the article about the Marikana massacre, indigenous healing is associated with secret rituals and mystery, reflecting suspicion and the widespread

[33] To find out what really happened on that disastrous Thursday and the preceding week of strikes, President Jacob Zuma appointed a commission of inquiry, chaired by retired judge Ian Farlam, which sat in public for 293 days, hearing evidence from miners, their bosses and the police, and reviewing all available recordings of the shooting and the days before. At the end of March 2015, the commission delivered its report to President Zuma but the conclusions were not published until the end of June 2015. Its conclusion: more inquiries are needed to find out what really took place on that day near the Lonmin mines. In August 2019, seven years after the incident, no one has been held accountable. The sangoma concerned was murdered before he could testify in court, no suspects have been arrested in this case.

belief in (and fear for) witchcraft. In 2013, the Pietermaritzburg High Court sentenced three men to 20 years in prison for the murders of two women. The men said that they suspected the women to be witches: "They said that the *muti* they would dig from the ground would ensure we would not be alive in three days' time […] We got scared […] that is when we got our weapons and started to hit them." The judge stated: "We live in a modern society where superstition and belief in witchcraft should not be viewed as a justification for murder." (IOL News, 2013) Newspaper articles with accusations of witchcraft, alleged body part trafficking (eNCA, 2017; IOL News, 2015),[34] cannibalism, and illegal and cheap abortions (eNCA, 2017) affect the general image of indigenous healing. In KwaZulu Natal, the belief in witchcraft does not seem to have a huge impact on social life, but in other provinces, like Gauteng, Mpumalanga, and Limpopo, every now and then cases of witch hunts are reported.

For an individual sangoma it is no use contradicting such allegations or defending themselves against these kinds of media reports. In such cases, Bongani told us, the THPs' association can take up the task of a trade union and be an advocate for its members. The organisation can do so because of its maxim that all members are qualified and registered indigenous healers. By issuing a communiqué, the association can refute certain ideas about indigenous healers (eNCA, 2017),[35] if needed nationwide.

[34] Trading parts of human bodies allegedly to be used as ingredients for *muthis*.

[35] Like in the case of body part trafficking, NUPAATHPSA explained in a communiqué that sangomas are not allowed to touch dead bodies, because of the strict purity rules they have to abide to.

6.3 Analysis: Why (not) accommodate?

Up to this point we have seen that the indigenous healing practice is informed by various kinds of external dynamics and processes. With the help of the genealogical sampling method, I have sketched an impression of longitudinal developments in sangomas' healing practices. Modifications that are applied by individual sangomas to conform to (the demands of) changing society; adaptations in attempt to increase the acceptability of the healing practice and strategic protection of the profession in general.

When we add these findings to those in the previous chapters on transformations in healing practice and *ukuthwasa* due to internal dynamics, it becomes clear that sangomas' training as well as practice can be characterised as flexible and experiential, in correspondence with Whitehouse's imagistic mode.

Indigenous healers fully acknowledge and endorse their profession's flexibility and variety, but even so they refer to their profession as 'traditional healing' in contemporary society. Moreover, the characterisation of sangomas' training and healing practice that emerge from this research data is quite the opposite of the connotations of 'tradition' (in common parlance) like stability, invariability, and constancy. It is a significant discrepancy, in my opinion, therefore, as previously mentioned, I once more zoom in on the subject of tradition. In light of the preceding, it seemed obvious to me that indigenous healers have ponderous arguments for hanging on to the term 'traditional'. With Foucault's theory on Power[36] in mind, I revisited Hobsbawm & Ranger's theories on 'tradition' to find out what other elements are involved in the dynamics of 'tradition' in a changing contemporary society.

6.3.1 Revaluation and re-invention

After the apartheid regime, which suppressed their cultural identity, black people in South Africa seized the opportunity to revalue their alleged tradition and culture. Although, following decennia of apartheid, it was not clear in all instances what exactly belonged to the cultures and customs of the various black peoples. Some customs were still known, others had passed into oblivion. Other aspects were left where they were because they were not regarded as useful or valuable anymore. Yet other customs or practices from the past were picked up and executed again, but now in a new setting. "People pick and choose from their culture those things which suit their present circumstances," Bourdillon observes (1993, p. 14), and in doing so they create new patterns that, in due course, might result in a new 'tradition'.

We saw an example of revalued tradition in a contemporary setting after Nelson Mandela's death,[37] when his grandson Mandla Mandela, as the oldest male descendant

[36] See Chapter 4.

[37] Nelson Mandela died on 5 December 2013, he was buried on 15 December in Qunu, Eastern Cape.

of the family, accompanied his grandfather's body on the several stages of his journey to the grave. Parts of this journey and the funeral (service) were broadcast live on television and, all around the globe, people were able to see the grandson explaining sotto voce to his grandfather where they were going and why, even when Mandela's body was transported by plane. This old Xhosa custom is called 'guiding the spirit home' and it was performed to ensure that Mandela's spirit would 'not wander' (IOL News, 2013).[38]

Another case in point occurred in recent years in the form of the performance of a so-called 'praise poet', heralding the arrival of then President Jacob Zuma, for the deliverance of his State of the Union in Parliament (Mail & Guardian, 2015).[39] The official role of the praise poet reaches back to times before the arrival of Christian missionaries in South Africa. In those days, the praise poet travelled with the king (or queen) and praised him wherever he went. Anyone who wanted to speak to the king had to speak to the praise poet first. One part of this poet's official role was the right to criticise the leader without fear of punishment. The praise singer that preluded the former President's State of the Union was selected annually taking into consideration a fair representation of the many cultures and languages in the country. A critical notion regarding the holders of power, however, was not appreciated in this situation. By resurrecting the praise poets, former President Jacob Zuma appealed to a certain part of the country's population, namely the people who value 'traditional ceremonies' and identify with old customs.

Within this motion of, what Thornton (2010) calls, 're-traditionalisation'[40] new possibilities presented themselves for sangomas; they were allowed to exercise their profession in a generally more visible way. Furthermore, the renewed interest in their healing skills led to an increasing demand for the services of these THPs, who consequently profited financially from these developments. The growing number of 'chancers' (Mail & Guardian, 2015),[41] especially in the urban areas might be interpreted as collateral damage in this process.

Hobsbawm & Ranger (1992) argue that what we assume to be traditional, for example a ritual which appears (or is claimed) to be old, has often been quite recently reshaped or re-invented and that this frequently occurs in rapidly changing societies. We pick and choose old elements to use in the construction of a new tradition, for a new purpose. The new (concept of the) ritual is seen as traditional because of an assumed 'old' element. In addition to the above-mentioned examples, I would like to give an illustration of re-invented tradition; the revival of *Nomdede* ceremonies in the province of KwaZulu Natal.

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[38] To prevent it from troubling some of the relatives after some time.

[39] In 2015, for the first time in history a female praise poet was selected.

[40] Revaluing cultural and 'traditional' roots of a specific group of people.

[41] People who were not called by the ancestors but nevertheless pretend to be a sangoma, taking a chance.

According to Krige (1965 (1936); 1968), the *Nomdede* ceremony used to be an agricultural fertility ceremony. In the mists of early spring, *Nomkhubulwane*, the Heavenly Princess, was believed to come to the fields. Early on one agreed morning, the young teenage girls would go to those fields, dressed in their brothers' clothes to herd the cattle.[42] They would bring calabashes with freshly brewed Zulu-beer to sprinkle on the soil where the crops were sowed. A small part of the fields was dedicated to *Nomkhubulwane*; it was a 'Garden for the Princess'. In the following weeks and months, the girls returned (with Zulu beer) to the fields a few times. While walking through the fields they sang songs for *Nomkhubulwane* and asked her to make the crops grow well. When it was almost time to harvest, the girls and their mothers walked through the fields once more, plucking some cobs and ears. Then they continued their way to the river where they buried the ears, roasted the cobs, and bathed, after which the girls and their mothers sang and danced and consumed the cobs (Hooghordel, 1999).[43]

The Zulu women and girls performed these rituals to appease and honour their Heavenly Princess. This annual ceremony was executed by the group of girls that were going to marry within the next year. They believed and expected *Nomkhubulwane* to take care of her people by applying her fertility influences (Berglund, 1990) not only on the crops, but also on the (young) women. Krige observed that the ceremonies were different in every region and that this ritual was still only rarely performed in the 1930s.

Kendall's (1999) investigation on rituals by Zulu sangomas in the 1990s revealed that *Nomkhubulwane's* rituals and *Nomdede* ceremonies were re-invented and revalued. In the new setting, the rituals and ceremonies did not necessarily take place in the crops fields, any location seemed suitable. Whereas the ritual used to be a preparation on a young girl's marriage, in the 1990s it was performed for the large groups of young girls (and their families) that have been the victims and survivors of rape. The position of these girls in their society was often problematic as they were ashamed, sometimes even blamed by and excluded from the community for what was done to them. Sangomas, in their role as keepers of the community, acknowledged these rape survivors' fate and performed rituals like *Nomkhubulwane's* and the *Nomdede* ceremony to cleanse them, so that after the ceremonies the girls could be included in their communities again, according to Kendall.

In the re-invented ritual, some elements (like the young girls and the notion of sexuality) have remained, others have vanished (the harvest and herding the cattle). The general idea that *Nomkhubulwane* takes care of her people is still clear in the 1990s performance of the rituals but in a way far beyond this idea in times past.

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[42] In the normal course of events, the boys herd the cattle, but on this specific day the girls sneak out before the boys notice.

[43] See also Hooghordel, 1999 for a further description of these rituals, the differences in literature and remaining questions.

These examples show ways that cultural elements are taken and given a new meaning and how 'tradition' can be reshaped or re-invented. "Traditions grow and change to suit the people who live by them", Bourdillon argues in his book on changing culture in Zimbabwe, and that "is particularly obvious in a rapid changing society, such as we find in African cities" (1993, p. 12).

Without reviewing all transformations in the training and healing procedure here, in my opinion the only element of the indigenous healing practice that remains unaffected is the 'diagnosis-ritual'; the invocation of the ancestors and the supposed ancestors' communication of the diagnosis. Therefore, in light of my research data, the indigenous healing practice with one old core element and many transformations could be considered as a reinvented tradition, even stronger: the indigenous healing practice is subject to continuous reinvention. Be it in the form of an application for an individual patient or as an adaptation to environment or time, sangomas' healing practices are constantly modified. The sole constant element is the sangomas' supposed intermediary role between the patient and the ancestors; the sangoma as contact and communicator with the ancestors.

6.3.2 Glocalisation

It is interesting to analyse why or, as Hobsbawm puts it, to what purpose the new elements are combined with precisely this old element of intermediary between the patient and the ancestors. Let me start with the most obvious reasons for the use of new elements in the healing practice; both sangoma and patient are part of contemporary society and therefore accustomed to the comforts, the technology and the communication of these days. It would be inconsistent for sangomas to abandon the available means from their healing practice (why not light a healing ritual in the dark river with your cell phone?). What is more, the sangoma would be less convincing for patients if she would exclude new elements from her practice. Then it would be as if she stands outside contemporary society altogether. Rather, it is exactly by the incorporation of such new elements that the indigenous healer gains the patients' credibility and authority.[44]

New elements that are tailored for the use in one's own setting, is what Robertson (1995) calls 'glocalisation'. The extraordinary thing about these dynamics is that especially by using new elements and adjusting them to one's indigenous setting, the identity is not affected but, on the contrary, confirmed. As if it proves that the identity is so strong that it can easily incorporate global phenomena, and yet stay 'the same'. With regard to sangomas' healing practices this is an important issue, for it shows that while indigenous healers use contemporary elements the prestige of the profession increases, exactly due to those elements. Thus, sangomas as well as their patients take advantage of the opportunities that are at hand.

[44] See also Ferguson, 1999.

At the same time, it is crucial for sangomas to also hold on to old elements; firstly, the supposedly intermediary role in the diagnosis, because that is their raison d'être. If it was not for this part of the healing practice the profession of sangoma (diviner in older texts) would not exist at all. And, secondly, and more peripherally, the professional clothes sangomas wear, like goatskin bracelets and leopard print cloths, because wearing those can be interpreted as a statement with which the sangoma sets herself apart from the community. Such clothes distinguish the sangoma from ordinary people, in fact they are a sign of status (Bourdillon, 1993), authority and therefore also an expression of power.

The combination of 'new' elements with the old elements makes indigenous healing special and interesting; it is performed by contemporary people who use up-to-date means, yet it is surrounded by an air of history and mystery. In their healing practice, sangomas unite the seemingly antipodal concepts of 'tradition' and 'changing society'; they stand with one foot in today's world, the other in history. They pose as a bridge between the present and bygone days, between the inhabitants of present-day South Africa's unbalanced society, and the (knowledge of the) ancestors who lived in times that are understood as steady and stable.

Besides, in the claim that they are 'called', able to communicate with and carry out the instructions of the ancestors, sangomas attribute authority, wisdom, and power to those ancestors over their own lives and that of their patients. It is beneficial for indigenous healers to emphasise their relationship with the ancestors belonging to the cultural cosmology and the concept of alleged tradition, it underlines their unchanging, powerful social position as long-standing mediators. The ancestors' authority and power also reflect on the mediating sangomas, whose status in society increases consequently.

However, the ancestors' authority is a phenomenon that is not acknowledged by people who do not share the African cosmology. People, like Western academics, who do not believe in possible intervention in this visible world by entities from an invisible world. For them, the discourse on 'tradition' and ancestors is based on an invalid argument pattern, an argument 'ad verecundiam' or 'argumentum ad autoritatum'. The authority that is appealed to is considered inappropriate.

A remarkable element in this is that the 'argumentum ad verecundiam', the appeal to an authoritative person or source, was originally not seen as an invalid argument but as a sign of modesty.[45] Currently, however, the element of modesty has vanished from this invalid argument pattern, it just expresses the defence of a stance by the, justified or not, appeal to an authority (Geerlings, 2007). In that case, the term 'argumentum ad autoritatum' is more in style. The used phraseology of course also reflects whether one's approach of the matter is emic or etic. In my opinion, the sangomas' appeal to the ancestors' authority (emic) might be based on such modesty, originating from their cosmology.

[45] The Latin word 'verecundia': modesty, respect.

One of Thornton's conclusions in his research in the Lowveld (2009, p. 32) is: "While [sangomas] are distinctively African, they are also part of modern South African society and cannot be relegated to the past." In the previous pages, I have exposed that this statement is valid for sangomas in the Durban district in 2014 as well; although embedded in Zulu ancestral beliefs, sangomas accommodate the execution of their healing practices to the demands of contemporary society and integrate new elements in their practices.

6.4 Political dynamics

Above I described that, in the apartheid era, sangomas' healing practices were illegal. One could be tempted to assume that in contemporary democratic South Africa the legalised indigenous healing practices are in smooth waters, but that is far from the truth. Now that indigenous healing has become more visible in society, it is consequently expected to meet current requirements.

It was the national government's goal to acknowledge indigenous healing via Act 22, 2007 and make it an integral part of the national healthcare system. One vital aim of this THP Act is to regulate the indigenous healing sector with a registration system; registration should be regarded as a quality mark. This way, the law anticipated what is, according to Mbatha, one of the major challenges of contemporary indigenous healing; the increase of malpractice. (2017).

NUPAATHPSA cooperated with various levels of government to achieve this (quality standard) goal, for example in stimulating THPs to register and in collaborating with Baba Cele in his *muthi* school, in an attempt to standardise *muthi* knowledge. Although the association's cooperative strategy may turn out to be beneficial for the indigenous healing system, it is questionable whether it will be favourable for the individual indigenous healer too.

Many individual sangomas are sceptical with regard to the obligations and other implications the new healthcare legislation imposes on their healing practice. Implementation of the THP Act will have a positive impact as well as negative consequences for indigenous healing as a system and the healer's practice. Eventually, one of the results of the Act will be that all registered indigenous healers will be allowed to issue legitimate sick leave notes for employees. Another positive turn is that, in time, health insurance companies will refund patients' bills from registered indigenous healers' consults.

But a consequence of the new legislation is that the government wants indigenous healers to use fixed prices for consultations and healing sessions, just like in the WHS. While the THP association uses a standard fee for (Western) researchers in favour of the cooperating sangomas,[46] among individual THPs there is a lot of resistance towards what they call "treating indigenous healing like a business." With an appeal to the cultural ("we don't have the fee-structure in our culture") and religious connotation ("this is not a job, we had a calling") they reject this part of the Act, as Bongani told me. Indigenous healers fear that their services will become inaccessible for the poorer part of the population. In their opinion, patients should be able to pay with whatever they have. Moreover, the obligatory need to account for income and the accompanying tax payment encounter resistance among indigenous healers. Furthermore, the new law requires THPs to

[46] As described in Chapter 2.

keep a logbook in which they write their patients' names, their afflictions, and the prescribed medicine. This, too, incites opposition among the indigenous healers who want to protect their (patients') data. Obviously, their (full) cooperation with the law's implementation is in doubt.

In this last part of the chapter, I will explore what effects political dynamics have on contemporary indigenous healing. First, I will focus on the involvement of associations (typified by NUPAATHPSA) in the (forthcoming) implementation of the THP Act and next on how individual sangomas deal with the (possible) implications of this Act. Many earlier mentioned elements come together in this part.

The internal and external processes and dynamics and the way they are intertwined will be exemplified by descriptions of Mks Gasa's healing practice and Bongani's intellectual legacy.

Bongani Ntshangase, association

His grandfather, who was an *inyanga*, taught Bongani from childhood about the healing qualities of herbs, minerals, and fats. When the ancestors called him to be a sangoma, he felt he had to give up his 'Western' job to start his *ukuthwasa*. For this, in his case a top-up training to become a sangoma, he lived at a *gobela*'s compound in Mozambique. After his initiation, he left Mozambique and went back to Durban, where he set up his own healing practice that flourished. While he was practising as a sangoma in this urban area he grew more and more convinced of the importance for indigenous healers of being organised, if only to be united in discussions and negotiations with the (local, provincial, and national) government. Another reason is that he thought an organisation could offer many services to indigenous healers, like legal help in case of false accusations. Bongani dedicated himself to that cause and got involved in the merging of about thirty small networks to one provincial association and the foundation of NUPAATHPSA in KwaZulu Natal. In 2012, he was a member of the executive committee of the Durban metro branch of NUPAATHPSA with the portfolio of Public Relations; contacts with the Mayor, the Provincial Minister of Health and the press and supporting the chairman of the association at important meetings. In 2013, Bongani Ntshangase with his eloquence, humbleness, and charisma, was chosen to take the Chair from Baba Hlongwane. He was asked by the executive boards of the other NUPAATHPSA districts in KwaZulu Natal to collaborate, to help to bring them to the same (high) level of registration and organisation as in the eThekwini district. According to Bongani, the best way to achieve this was to show indigenous healers that being a member of the association would be favourable for them. He understood, however, the reluctance of a considerable part of the THP community towards registration. He knew that for some indigenous healers it is like they have to look at their healing practice in an entirely different way. He put it aptly: "When we are talking to learned people they say; 'treat it as a business'. But in our culture we don't have the fee-structure. When you have got a chicken, you pay with a chicken. Others have a goat or cattle and pay with that. This is a God's thing. Yet they want us to treat it as a business. It is like we are changing the whole system right now, shifting our focus."[47]

[47] Conversation with Bongani Ntshangase, Botanic Garden Durban, 30 July 2012.

6.4.1 Legislation and association

Bongani was convinced that the association could play an important role in increasing the acceptance of indigenous healing. In our conversations he gave multiple examples of the way NUPAATHPSA was in discussion with all kinds of (municipal and national) governmental departments about relevant issues. Within the association's executive board there was a division of tasks. Communication with external authorities like the municipal and provincial administrations was part of the assignment of the chairperson and the PR officer. The association wanted to validate the acknowledgement of indigenous health practitioners by being a conversation partner for the government. Some other goals were to promote the well-being of all Durban's inhabitants and to create a platform for the (re)presentation of cultural heritage of the Zulu people. On a regular basis there were meetings with the Mayor of Durban, the Minister of Health, and the Minister of Traffic.

Especially this latter one may be surprising, so I will provide two examples of how the association was engaged in this regard. Firstly, they were involved in the issue of safety on the roads in and around the city of Durban. In the past, many accidents happened near primary schools. The children were not careful enough when playing near and crossing the road where cars, especially minibuses, were driving far too fast. In 2012, at the association's suggestion, the municipality constructed four speed bumps in the roads near every primary school, to lower the traffic's speed as well as to ensure the children's safety. The second issue on which the association and the municipality were cooperating is what Bongani called 'hotspot cleansing'; sangomas performed certain rituals at sites where traffic accidents happened frequently. If somebody died at a specific location, according to Bongani's explanation, his spirit kept dwelling on that spot and attracted other spirits, so more accidents were prone to occur there. After consultations between municipality and association, sangomas were informed with regard to where these hotspots were and they went there to perform a ritual to guide away the spirits of the deceased motorists. Through the special ritual, the location was cleansed and less accidents were expected to happen there. Meetings with the Minister of Health were often about the THP Act, its implementation, and THP registration. NUPAATHPSA was successful in convincing the THPs (about 75%) to join the association. Among the association's persuasive arguments for registration were access to legal advice and representation at a governmental level. All members of the association were automatically registered as THP at the Municipal Department of Health.

Registration, a quality mark?

This implies that 25% of the qualified THPs were not registered (elsewhere in the country the percentage of not-registered THPs is considerably higher). Those not registered are either THPs that did not meet the association's criteria or they are self-appointed healers

(also called quacks, chancers) or initiated THPs who, for various reasons, do not want to register. I wondered how to differentiate between a graduated THP and a quack. I asked several people, including some indigenous healers, if there is something that may serve as a criterion for determining if a THP is 'real' or not. They all told me it is hard to find out if somebody is a quack. Bongani Ntshangase and Mks Mbuyisa stated that you have to ask the right questions, for example about the '*inyamazane*'[48]. If someone who calls herself a sangoma does not know what your question is about, you may assume she is a quack. Mks Mbuyisa's *inyamazane* is a tiger,[49] Mks Ngidi's (the youngest interviewee) and Bongani's is a python, they both hunted and killed these animals at the end of their *ukuthwasa*. But Mks Bhengu, whom everybody admired as the 'grandmother' of all sangomas and the 'walking library', did not mention having an *inyamazane*.

Figure 6.7 Mks Ngidi shows the skin of her *inyamazane*, a python

Michael (the gardener) who introduced me to Mks Mgadi in March 2012, told me that she is a real sangoma because "she has been in the water". He referred to the story she told about the time that she had lived under water for a period of approximately six months. For Michael, this was the convincing argument that Mks Mgadi was a qualified sangoma. Of this research' interviewees only Mks Mbuyisa had a similar experience of being in the river for several months during her *ukuthwasa* and Bongani said that he was underwater for about a week. Even though Mks Bhengu and Mks Ngidi did not tell of such experiences they were introduced to me as qualified sangomas.

So, neither of these arguments seems to be a solid indication of somebody being a 'real' indigenous healer. When I asked *inyanga* Baba Cele how to make the distinction

[48] Meaning the 'bock that has to be hunted', in academic literature also known as 'familiar'; an animal that has to be hunted and sacrificed.

[49] Probably she meant a leopard, when Mks Mbuyisa told about her *inyamazane* she pointed at a toy animal on the floor of her consulting room which had a leopard marked skin.

he shrugged his shoulders and said: "you can only tell by experience."[50] Consequently, one may wonder how the executive board member of NUPAATHPSA is supposed to differentiate between a qualified THP and a quack on the basis of credentials, education, and a visit to the healing practice. And if there is any possible doubt whether registered THPs are indeed qualified, then registration is not to be regarded as a quality mark. Ultimately, the question remains if there is any distinction at all to be made between THPs and quacks.

Here, at the level of the association and the government, a few discrepancies between theory and daily routine, between 'programme' and 'practice' emerge. Firstly, the fact that the association wants all graduated indigenous healers to join the organisation and register and its claim to represent all THPs. Yet, the organisation acknowledges that about 25 per cent of the graduated indigenous healers does not want to register for various reasons (e.g. that the association is a government's tool and that their calling is 'personal'). Furthermore, applicants for membership are screened with regard to their training, graduation, and healing practice. The organisation claims that therefore membership can be considered as a quality mark but the distinguishing criteria remain vague and inconsistent. Recently, the government's implementation of the healthcare law (set up also to challenge malpractice in indigenous healing) meets the same obstacle; the THP Council is, as the association, not able to formulate and apply criteria to differentiate 'real' indigenous healers from quacks, 'chancers'. For the time being, registration as a quality mark therefore seems to be a bridge too far. Partly due to these registration problems the implementation of the law is going very slowly. Eventually, the desired differentiation may even prove to be fundamentally impossible.

The programme of regulating THPs' healing practices by registration and uniting them in a national association, fits perfectly on paper, but people and reality turn out to behave in an unruly manner. One cause for this could be that the mere problem of whether someone is a 'real' sangoma (and the distinguishing method) is from a paradigm in which explicability, checks, and proofs are important. This Western, scientific paradigm is also the basis of the latest healthcare legislation. Sangomas, however, live and think from within another paradigm, one that has experience and belief as important basic principles. Sophie Oluwole (2017) argues that reasoning within the Western (philosophical) paradigm can be characterised as oppositional and exclusive, for example a statement is either true or false or an object is either green or blue. Within the African paradigm, this Nigerian philosopher typifies logic as complementary and inclusive, for example whether you perceive the colour of an object as blue or green (or some other colour) or a statement as true or false (or both) may vary in diverse conditions and as a result of different experiences. The issue whether someone is a real sangoma is an example of such Western logic, it is presented as either the one or the other, just

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

these two options. Registration and the therefore required distinguishing strategy, are based upon an oppositional logic, intended to exclude from registration those who do not meet the criteria. In African logic, however, this issue might not be relevant at all, for the assessment of a sangoma's 'legitimacy' is also dependent on experiences and circumstances. Hence, Baba Cele's pragmatic advice to go and experience a healing in order to find out about the healer's competences.

Knowledge standardisation

Whereas the sangomas' autonomy in healing practice and in training of *amathwasa* used to be indisputable,[51] recently (and perhaps partially in the light of THP legislation) there seems to be an urge to standardise at least certain knowledge about *muthi*s for freshly graduated sangomas. Baba Cele's Traditional Medicine School is exemplary of this need for regulation, which is felt among leading figures of Traditional Medicine and in the THP association. The mere fact that Baba Cele's school started made me inquire whether the long-standing differences in knowledge transfer and healing practice were not appreciated anymore and whether there were any (or even serious) doubts about the scholarliness and professionalism of *gobela*s. Both these plausible suggestions were denied by Baba Cele and Bongani.

Although Baba Cele introduced the founding of his Traditional Medicine School as a possibility to offer graduated sangomas extra support in their knowledge of recognising, buying, and preparing *muthis*, my impression is that 'control' over the level of knowledge comes into this project to a certain degree too. My suggestion is nourished by Mbatha's claim (2017) that professionalisation in the form of knowledge standardisation may help eliminate inconsistencies and unethical behaviour in the indigenous healing system. By hosting freshly graduated sangomas from several *gobela*s, Baba Cele and the THP association gain an insight into the *muthi* knowledge content these *gobela*s teach their *amathwasa* as well as regarding the individual competences of the new sangomas. It is important information for the association, the body that represents the (quality of) indigenous healers. This process of standardisation, calculated or not, can be interpreted as an indulgent move towards the demands of contemporary society where a certificate proves one's competences. Even though it is not the case at present, these data could be used by the association or even by the government to assess the (training of) *gobela*s.

Not every *gobela*, however, will send her *amathwasa* to Baba Cele's school after graduation. So not every new sangoma will get this extra education, rounded off with a *muthi* certificate and, consequently, not every *gobela* can be screened this way. At the moment the autonomy of every single *gobela* and the content of her training is still respected, but if, in the long run, the required registration for all THPs is implemented, this (now optional) top-up training could become an obligatory and controlled part of the sangomas' training.

[51] As described in Chapter 4.

Thus, NUPAATHPSA in the *eThekwini* district cooperates in the establishment of standards (of knowledge) for graduated sangomas as well as in formalisation and officialising of the indigenous healer's profession. By introducing itself as a formal conversation partner, the organisation represents indigenous healers at municipal, provincial and governmental level.

Here I detect a certain ambiguity and tension in the association's modus operandi. On the one hand, the association claims to defend the autonomy of the *gobela*s in the training of their *amathwasa*; on the other hand, the collaboration with Baba Cele in his Medicine School at least shows that the fresh sangomas' level of muthi knowledge is considered more or less inadequate. Moreover, the association proclaims to protect the autonomy of sangomas in the execution of their healing practice, yet it is a government's accomplice in the process of THPs' registration. While registration for the government is as much a means to impose restrictions and obligations on indigenous healers as a tool to control them.

While general recognition and increased respect for the indigenous healing system may be effects of associations' efforts to deal with political dynamics in contemporary South Africa, I was curious how the THP Act influences individual indigenous healers in the execution of their practice. Illustrative is Mks Gasa's sangoma school and practice.

6.4.2 The 'calling' a business?

The sangomas' healing practice is flexible; many elements are liable to transformation and often this is explained in a positive way. The ability to adapt to changes in society and to demands of new times might be one of the main reasons that indigenous healing is an important player in the field of South African healthcare, at least in numbers of attending patients. On the other hand, the variety in the healing practices makes it problematic (on various levels) to distinguish between trained healers and self-proclaimed ones. A contrast needed in the face of increase of malpractice cases (Mbatha & Gqaleni, 2017). While for Baba Cele a discriminating element is in experiencing a healing session, for Mks Mbuyisa it is in the characteristic way the healing practice is executed: "it is not easy to determine who has a calling and who is doing business"[52]. Chancers, is her assumption, regard indigenous healing as a business and try to earn easy money. Feierman (2000) found in 'care' versus 'commodification' a similar ground for distinction among the Ghaambo in Tanzania.

One of the implications of the THP Act at the level of the individual healer is that healers, to quote Bongani, "have to shift their focus" and look at their healing practice as a business, in a commercial way. Whereas diagnosing and treating patients used to be the core aspect of the healing practice, a registered THP (in the future) also has to keep

[52] Interview 9 August 2012.

the records, write bills, give account to the government (for taxes) and ultimately even to healthcare insurance companies (in case a patient wants a refund) and to patients' employers (in case of a sick leave notice). Many indigenous healers, including Mks Gasa, however claim they want to place themselves in the service of the patients instead of running their healing practice business-like. All the same, in the way Mks Gasa runs her school and her healing practice we did recognise some commercial, business-like elements.

Mks Gasa: Legislation in the individual healing practice

To start with, the training of more than twenty *amathwasa* in itself is actually big business. The costs of this training, as I mentioned before, are about half an annual salary for every *thwasa*. Part of this money is spent on animals that are sacrificed to mark special events of the training, but the vast part of the money is for the *gobela*.

In a household of roughly thirty people (the *amathwasa* and the sangomas with their families) the housekeeping includes cleaning, maintaining the premises, washing and ironing the clothes, shopping, and preparing food. All inhabitants of Mks Gasa's compound have their own specific daily chores to do and things to learn in line with their level of training. Those who have recently started their *ukuthwasa* are with Mks Dudu to get their training and to learn what life as a sangoma is like. The longer a *thwasa* lives at the compound the more responsibility will come with the tasks. At first, for example, to bring food and drinks to visitors (e.g. researchers), later on to host patients and make them comfortable in the waiting room, to prepare them for their healing session, or to assist a senior *thwasa* in the performance of the healing ritual. Almost graduated *amathwasa* get to practise what they have learned under the watchful eyes of Mks Gasa herself. Everybody thus follows a strict regime, which makes Mks Gasa's school run smoothly, like a well-oiled machine.

Mks Gasa's healing practice mimics a medical doctor's office hours with the exception that there are no special hours. When somebody is not feeling well, he can come at any time. A *thwasa* will meet him and escort him to greet Mks Gasa and next to the waiting room. When one of the sangomas is ready for the session, a *thwasa* leads him into the consulting room, where the session starts by lighting a handful of *imphepo*. Often, patients have to come back for (a few) other healing sessions.[53] When several patients have to come for a similar healing session, they are scheduled for the same afternoon, one after the other, like production line work. Amathwasa watch these healing sessions closely to learn about similarities and distinctions and eventually they get the chance to perform such sessions themselves.

For many healing rituals special items are needed: special clothing, certain objects or offerings like drinks, food or live animals. When it comes to food and drinks the patient usually brings it along. In case of special offerings like certain clothing or live animals

[53] See Chapter 3 on the three healing dimensions: body, mind, and surroundings.

there are usually specific (ancestral) demands, for example with regard to the colour of the animal. Mks Gasa then arranges the appropriate animals and passes the expenses on to the patient. With regard to Mr Mbele's healing sessions; Mks Zinhle had bought a Xhosa attire for him, all kinds of beadwork in Xhosa colours, knobkerries, and other items that were needed for the sessions at the river and at his house, and Mks Gasa brewed the Zulu beer in the days prior to that sessions. Mr Mbele provided leopard skins (one he wore around his shoulders, others were on the chair and on the floor beside his bed) a chair, and several items for the session in the bedroom in his new house. Obviously, they had discussed what was needed and who would supply the various requirements. After the session in Mr Mbele's house the sangomas and *amathwasa* performed several dances in the living room for which they had brought all kinds of equipment: drums, anklets, a trumpet and so on. Additionally, a dinner was served for all people present, all *amathwasa* ate while sitting on the floor on their knees and hands, a table was set for the invited sangomas and for us, the guests. The dinner had been prepared by a number of Mks Gasa's *amathwasa* because Mr Mbele apparently needed assistance in his home. While the sangomas and Mr Mbele went to the beach, these *amathwasa* had gone to his house in Pietermaritzburg to prepare the food. As it turned out they also had brought the Zulu beer and taken care of the arrangement of the healing session display in the bedroom.

Figure 6.8 (left to right) Mks Ntombi and Mks Gasa watch Mr Mbele while thwasa Mngadi is securing the leopard skin, a *thwasa* fetches items for the next healing session and a *thwasa* cleans up the offerings' display of the former healing session

Operational elements like a regime with a strict assignment of tasks, healing sessions as if in a production line, the supply of essential parts of healing sessions (offerings, special

clothes), and passing on the costs are indicative of a business-like management. Though in Mks Gasa's case none of these elements are motivated by new governmental laws; the organisation of her healing practice is due to the size of the school and practice. Moreover, it is in the patients' advantage; the healing practice is always in operation and special requirements are taken care of by the sangomas. The number of *amathwasa* in Mks Gasa's school (business-like as it is) is nor a new element nor exceptional; in the 1960s and 1970s both Mks Bhengu and Mks Mbuyisa were trained by a *gobela* that had several *amathwasa*, in Mks Mbuyisa's case there were about 10 fellow *amathwasa*.

Occasionally the number of apprentices is an element of rivalry between *gobelas*; the more *amathwasa* a *gobela* has, the more prosperous she is and the more patients come to her healing practice (Mbatha & Gqaleni, 2017).

Mks Gasa is a registered sangoma and she runs her practice in a business-like way, but the way she runs it does not comply with the legislative demands of the THP Act. She does not keeps records or logbooks to provide accounts for the government, she doesn't write bills for her patients nor does she use fixed prices. Patients pay with whatever they have. We saw the same situation at the other sangomas' compounds while they too were registered THPs. In favour of the patient they run their healing practice as efficiently as possible and yet they won't turn their practice into the kind of business the law requires. Apparently the different levels of government are not yet able to enforce the accompanying financial restrictions, obligations, and accountability on these indigenous healers.

The government's recognition and legalisation of their profession leads to a growing self-confidence, a new kind of awareness and pride among sangomas. However, in spite of the noble intentions of the government's policy and the efforts the associations are putting in, one may wonder if the pursued aims are realistic and attainable. Because besides acknowledgement the THPAct also leads to significant frustration among individual indigenous healers. Conditions and restrictions laid down by the government are obviously not met by a substantial part of the THPs. Moreover, with regard to the registration they state it is encroaching too much on the THP's professional status, because part of the registration is to reveal when and where the indigenous healer was trained and by whom. According to Bongani, not every THP wants to bring this information into the open. Furthermore, while in the THPs' professional attitude it is important to protect the patients' identity and medical data, according to the new healthcare laws they have to keep a logbook of their healing practice. Plus, as to the fixed fee condition, many THPs do not want to charge their patient money, because they want their services to be accessible for all, rich or poor. Within the new legislation this is not allowed. On the contrary; every registered THP has a professional accountability for his income and has to pay income taxes based on these data.

The flexibility in execution of the healing practice that is an intentional and inherent part of an imagistic training (as we have concluded ukuthwasa is) is not appreciated, but

rather curtailed and frustrated by the implementation of the doctrinal conditions of Act 22, 2007. This law, apart from the profession's recognition, therefore seems to have too many drawbacks for any cooperative and obliging THP.

Moreover, there is the matter of the (graduated) THPs that do not want to apply for registration or are not allowed to become a member of the association because they can't prove they are graduated. They can charge patients whatever they want without having any accountability towards the government. It is no wonder that many THPs adopt a critical attitude towards the new legislation.

6.5 Concluding remarks

In this chapter I have explored how external (historical, social and political) dynamics inform the contemporary indigenous healing system in South Africa. After decades of illegality, sangomas can execute their practices in the open nowadays. Although their profession is legalised, effects of the apartheid era are still noticeable in the way the sangomas' healing practice is perceived in society; a part of the population regards indigenous healing as the healing system for the poor and illiterate. In the urban areas, where immense quantities of job seeking rural men felt miserable and uprooted, was an exponential growth in the number of THPs, some trained, some not. An alarming amount of reports of malpractice and unethical behaviour by (alleged) THPs led to necessary control and regulation. Both within the indigenous healing system by associations and outside the system in the form of governmental legislation. THP associations have an intermediary role between different levels of government and individual indigenous healers.

The longitudinal data in this research show that indigenous healing is flexible and experiential and that sangomas incorporate all kinds of contemporary elements in their healing practices. The healing practice is executed in what Whitehouse calls an 'imagistic way'. At the same time sangomas hold on to one old element, their intermediary role between patient and ancestors, an indigenous religious element. The combination of various transforming elements and one essential old element in the indigenous healing practice makes me conclude that the sangomas' practice can be characterised (in reference to Hobsbawm & Ranger's theory) as a constantly re-invented 'tradition'.

Such a specific combination of elements in the indigenous healing practice seems to be beneficial for sangomas; the intermediary element suggests a connection with the power, wisdom, and authority of the ancestors, while sangomas also show they are part of contemporary society. Yet, by holding on to the designation 'traditional healers', sangomas deliberately set themselves apart from that contemporary society. Their position in society can be typified as ambivalent and in a certain way that makes sangomas intangible. A position that suits them well; in the execution of their profession they want to go their own way and when they are criticised, they can easily motivate their actions by either the demands of 'changing society' or the alleged ancestors. In case the execution of their practice is at stake (*muthi* extinction, unethical behaviour of pharmaceutical industry, negative press) indigenous healers take an active stand against those processes in society.

The political dynamics of the last two decades in South Africa seem favourable for indigenous healing: the system is acknowledged and about to be integral part of national healthcare. Although THP associations cooperate with the government in its policy towards registration and standardisation, the implementation of the law meets with individual indigenous healers' opposition. They claim the THP Act's obligations and restrictions infringe too much on their healing practices and professional autonomy.

Part of the resistance is due to a collision of the western, scientific based doctrinal paradigm that is the basis for the new legislation and the, let's call it, 'African' paradigm. The law's regulations are intended to fight malpractice and unethical behaviour, but whether somebody is a 'real' sangoma or not is a question from a western point of view, and therefore within the African paradigm not useful. In this paradigm, whether someone is a genuine sangoma does not merely depend on a specific certificate, but is far more dependent on the person's attitude and skills, e.g. communication with patients (and allegedly the ancestors). It is the patient's experience with and belief in a sangoma's competence that is crucial. Ultimately, it is the patient that judges if he deems a specific healer 'worthy' of filling the social position of sangoma.

This way of thought however does not match with the purpose of the THP Act. The fact that the South African government requires sangomas to register (and consequently prove that they are graduated) in order to be acknowledged, indicates that this healthcare legislation is structured in accordance with the western, scientific, medical model; a model that is implicitly dominant, supreme and intolerant towards other models. By establishing this type of healthcare legislation, the government apparently also aims to meet international approval; it is a representation of South Africa as a modern country with an up-to-date, generally acknowledged medical system.

With regard to the programme-practice analysis I came across inconsistencies on governmental and associational level. The government, in passing new healthcare legislation, has taken action in regulation and control of THPs and found an accomplice in the THP associations. The role and attitude of the associations however is ambiguous: they claim to be the representatives and advocates for individual THPs, yet they incline their ear to the government's wishes. THP associations use the government's recognition of the THP profession to claim a respected position in society, and at the same time they urge their members to accommodate their healing practices to the government's demands, e.g. registration. Even though a significant number of the sangomas consider registration not beneficial for their practice and the privacy of their patients.

The government's intentions may be good, the implementation of the law is intricate and actual practice will show what will come of it. Up to now too many THPs consider it not beneficial to register. The tardiness of implementation, the government's inability to formulate adequate criteria for registration, and indigenous healers' reticence with regard to this top-down imposed policy prove according to Mbatha that this legislative process is "under imminent threat of becoming ineffectual and resisted by THPs associations and the general THP public" (2017, p. 64). Government and indigenous healers are in a vicious circle when it comes to Act 22's implementation, it is a paradoxical situation.

Now that the sangomas' healing practice has been officially recognised, sangomas all over the country are not eager to cooperate in the implementation of the THP Act. At the bottom line, it might be the case that the acknowledgement of indigenous health practices will be sufficient for the government as well as for the hesitant THPs. I

would not be surprised if, in the long run, both 'sides' leave the registration topic as it is, dangling in limbo. All actors involved in this process seem to have their reasons to stick to this status quo.

In the next chapter I sketch an overview of the findings of this research on internal and external dynamics that inform the experiential indigenous healing system in contemporary South Africa. I also expand these findings geographically and longitudinally. Next I would like to convey my expectations on the development of indigenous healing practices in future South Africa and the position of indigenous healers in South African society, along with some final reflections based on the entire study.