Chapter 7

Final reflections

"When you qualify you get your *ishoba*. If you are a *thwasa*, you don't carry *ishoba*. Only the qualified sangomas carry." Bongani explains to me how to distinguish a sangoma from a *thwasa* in the overcrowded rondavel at the Gasa compound. For more than an hour on this sunny Saturday afternoon,[1] Mks Zinhle and a group of about seven *amathwasa* perform sangoma dances for us, encouraged by a growing number of spectators. The other *amathwasa* are standing in a semi-circle around the dancers, all dressed up in red, white, or blue cloths, joined by neighbours and passers-by, who, before they entered the rondavel, quickly wrapped an *ibhayi* around their shoulders. Everybody is singing along and clapping their hands on the beat of the drums. The dancing *amathwasa* carry weapons, a knobkerrie, and a wooden knife. Mks Zinhle carries a knobkerrie and a short stick with an oxtail-end, the *ishoba* that Bongani told us about. The moment that I think I understand, a young woman also with an *ishoba* appears at Mks Zinhle's side. "So, she is a sangoma too?" I ask him, "No", Bongani answers casually, "this is just for assistance, when you dance alone you don't feel right sometimes, so they decided to give her an *ishoba* too." With 'they' he refers to the ancestors, who determine (and justify) all sangomas' actions. That the ancestors' demands and wishes are capricious and far from straightforward dawns on me once again.

Figure 7.1 'Cattle' (money) for the ancestors next to the *ishobas*

[1] 26 April 2014.

Figure 7.2 Mks Zinhle plays the drums, *amathwasa* dance

Throughout the field study for this research, I have encountered many examples of flexibility in sangomas' practices and daily life, manifestations of their constant conforming with presumed ancestral wishes and demands. With hindsight, this pliability (from my etic point of view: to internal and external dynamics) might have surprised and triggered me the most.

In this last chapter, it is my intention to draw a number of general conclusions on the basis of the research data. Although the number of cooperating sangomas was rather small - three for the interviews and four for the healing sessions - and the area was limited to the Durban metropolitan, and the fieldwork was restricted to three periods of several weeks each, they are, in my opinion, adequate for formulating some sound remarks with a wider range, both geographically and longitudinally, especially in combination with other academic literature.

Here, I will therefore recapitulate the most important subjects of the previous chapters and present some final reflections on them. I will also explore what insights the used genealogical sampling method and Harvey Whitehouse's theory Modes of Religiosity brought us with regard to the transmission of knowledge during *ukuthwasa* and what that means for the execution of the sangomas' profession. The application of Hobsbawm & Ranger's theory on Invention of Tradition, Foucault's theory on Power, and Girard's Mimetic Desire theory on the research data was instrumental for a better understanding of the different dynamics that influence indigenous healing in South Africa. Oluwole's philosophy on the fundamental differences between Western and African paradigms of thought presented a helicopter view on the subject.

With the help of the various applied conceptual analyses I will further attempt to illustrate and explain why indigenous healing appeals to so many South Africans.

Overview

In the first chapter, I sketched in broad outlines the set-up of this research on how internal and external dynamics inform the indigenous healing system in South Africa by introducing its subject as well as the central research question. The sub-questions were presented and the main theory in this study: Whitehouse's on the transfer of specialist knowledge. I also positioned this research in relation to the academic literature and explained its relevance. In the second chapter, the field study, its limitations, and the genealogical sampling method were the central topics. I also gave an account of the decisions I made with regard to the cooperating sangomas, the collaboration with my key informant, the research ethics, and my data management.

Starting from the 'Healing Mr Mbele' case in the third chapter, I described what elements an indigenous healing process may consist of and, subsequently, I compared these elements to the 2012 interview data and academic literature on the specific subjects of diagnosis and healing. Internal dynamics with regard to these subjects are closely related to those with regard to transfer of indigenous (muthi) knowledge in the sangomas' training, which were the topic of the fourth chapter. I found many differences. That information led me to investigate what in fact is 'traditional' in 'traditional healing' and the possible reasons for THPs to hang on to this terminology.

External processes involved in the interrelationship between indigenous healing, cosmopolitan healthcare, and institutionalised religion were highlighted in the fifth chapter and, in the sixth, the focus was on other external dynamics (historical, social, and political) that inform contemporary indigenous healing. Against a background of the country's apartheid history and the changing social position of sangomas, I sketched the implications of recent healthcare legislation on the individual healing practice and indigenous healing as an experiential system.

The major topic of this research is thus about dynamics that inform indigenous healing; in the course of the study, I tried to find out whether there are transformations in healing processes and, if so, in what parts of that process they occur and, ultimately, why these transformations take place. By application of the genealogical sampling method and comparison of the obtained data with academic literature, I was able to get a perception of longitudinal developments in knowledge transmission. I also detected many transformations and a few constant elements in the execution of healing practices, in rural and urban settings. We can trace back the transformations in the healing processes to both internal and external processes, which of course are related as indigenous healing is part of the South African society.

On the basis of the concluding remarks in the previous chapters, I will reflect on these topics, pursue the longitudinal findings, and formulate some expectations for the developments of indigenous healing as a system and its status, and the sangomas' future social position in South Africa.

7.1 Reflections on internal dynamics

My consideration of the transformations in healing processes start at the training for sangomas, *ukuthwasa*. In the 2012 interviews, we heard contradicting remarks on the uniformity of the (predominantly oral) transmission of knowledge during the training. The older generation confirmed consistency of knowledge transfer, the younger generation, however, emphasised that an apprentice in training only learns the basics. After graduation, a sangoma continues to develop her knowledge and skills, in what I called 'perpetual private revelation', through her own experiences and contacts with other indigenous healers, all of which is allegedly directed by the ancestors.

From all the remarks about the content of *ukuthwasa*, both in 2012 and 2014, I derived that, to a large extent, the knowledge transfer is accomplished in what Harvey Whitehouse calls the "imagistic mode of knowledge transfer"; in this mode, the transmission of procedural knowledge takes place by means of participation in rituals, other specific parts of knowledge are taught verbally.

In his book on the position of Africa in the World, Stephen Ellis (2011) argues that African religious ideologies are capable of absorbing all kinds of new elements, a huge flexibility owed to the fact that these religious systems are not founded on written sacred texts. A lack of dogma is a feature of oral tradition. Here, in my opinion, is a parallel with indigenous healing; firstly, because the transmission of knowledge during the sangomas' training and later in professional life is, for the greater part, oral and experiential. Secondly, the deficiency of a written *ukuthwasa* curriculum leads to an idiosyncratic training that is tailored to the individual needs of the *thwasa* (as believed to be indicated by the ancestors). Thirdly, as a result of the imagistic mode transfer of knowledge in the training, a sangoma is consequently at liberty and has the power to adjust healing processes to contemporary (local) possibilities and the requirements of every single patient. She actually has the opportunity to constantly reinvent her indigenous healing practice and execute it in an experiential, imagistic way. This explains part of the differences and transformations in sangomas' healing practices.

Ukuthwasa, consequently, is quite a different training than the education Western medical doctors get, where knowledge is transmitted in the doctrinal mode with a large amount of professional literature to study and uniform exams to pass. In *ukuthwasa*, transfer of theoretical knowledge seems not to be the primary element, there is more to it.

An (even more) important issue in *ukuthwasa* is what Mlisa calls the 'healing identity', the required sangomas' attitude that a *thwasa* acquires during the training. Therefore, a *thwasa* must learn to speak in a low voice, be humble, and at all times respectful towards her *gobela* and the ancestors. Plus, there is the element of a sangoma's behaviour towards patients and their families, for whom she has to be patient, understanding, comforting, and reassuring, because for patients the sangoma is the intermediary with

the ancestors, the messenger of the diagnosis, the performer of healing rituals and the provider of *muthis*. Throughout their entire training, *amathwasa* watch their trainers' healing activities and when ultimately they are allowed to perform a healing session themselves, they partly copy the *gobela*'s actions and add a few personal elements. These elements also account for variations in sangomas' healing practices.

With the acquired 'healing identity', *amathwasa* are prepared to occupy the social position of sangoma, another aim of *ukuthwasa*. In that position the performance of healing rituals is a major required skill, for that is, after all, why patients come to a sangoma, to be healed.

These patients do not necessarily have a physical illness or disease. In my view, a shift is taking place; nowadays, especially in the urban areas where clinics are near, some of a sangoma's patients come for treatment of a physical illness, but the majority wants therapy for psychosomatic problems or something bothering them, a lack of well-being, a feeling of discomfort. The holistic approach, which corresponds with the indigenous worldview, is what appeals to many South Africans. Indigenous healing (contrary to Western healthcare where in general the specific complaints of a patient are treated) deals in a holistic way with the patient, his family, his ancestors, and his social environment. Bongani once sketched the difference for me, he said: "If you have a headache and you go to a doctor, you get an aspirin and the headache disappears. But maybe the next day the headache comes again and you have to take another aspirin. If you attend a sangoma, she will diagnose and find out why you have the headache. And when it comes from the students you teach at school, the sangoma will come with you to the school to talk with those students. Because that is where the problem is and that has to be solved, an aspirin won't do that." Imagining a sangoma (or whatever doctor or therapist) appearing in a Dutch secondary school to talk to students about one of their teacher's headaches, made me smile. In the Western context I live in, such a visit is inconceivable. Bongani's example unintentionally emphasised the different paradigm from which I think and live.

In the indigenous healing context the patients expect the sangoma to find out what the cause of their affliction is, so that subsequently the appropriate measures can be taken and in the future similar complaints can be prevented.

In this perspective, the concept of healing is more than recovering physically or mentally, it is also understanding what was wrong and why that happened and feeling acknowledged as a person in a certain situation, being reassured that things can and will get better. Healing is often a treatment by a healer one trusts and believes in.

Sangomas are respected, partly due to their alleged ability to communicate with the ancestors. In a healing session the ancestors are believed to reveal the cause and remedy of the patient's problem to the sangoma. This distinguishing element is a religion-based assumption that traces back to their shared indigenous worldview. Many other religious symbols are used in the sangomas' healing practice, e.g. the invocation and praise of the ancestors and the use of multiple candles.

While Mlisa (2010), an indigenous healer herself, labels *ukuthwasa* as a religious phenomenon, on the basis of my data I tend to conclude that not only the training but indigenous healing is a religious rather than a medical phenomenon. Indigenous healers may be able to heal their patient in a physical way, but more and more frequently the healing is either mental, social, spiritual, or some combination of those. Furthermore, the core of the healing process is in the diagnosis, the alleged contribution of the ancestors.

It might be the use of the words 'healing' and 'health' that is deceptive for some; in the African context, health is a concept that not only concerns the physical and the mental domain, but also the social and environmental. Within the Western scientific paradigm, however, 'healing' is associated in the first place with a remedy or therapy for physical and mental afflictions. The connection to medicine at that point is obvious, but is confusing where the other domains are concerned.

7.2 Reflections on external dynamics

Decades ago, Ngubane (1977) observed that the indigenous view of illness and treatment was an elaborate, coherent system of ideas and practice. She suggested that it had sustained the people and offered them profound and adequate answers to their suffering brought by illness or misfortune and she stated that it endured even in the apartheid society.

Now, forty years later, South African society is in many aspects a different one. Yet, for numerous people the indigenous views on illness and healing still provide satisfying answers in times of misery, witness the fact that a majority of the South African population attends indigenous healers. Since the apartheid regime came to an end, sangomas have been allowed to execute their healing practices in the open again. In recent healthcare legislation, intended to provide healthcare for all South Africans, sangomas are acknowledged, their practices legalised and they are regarded as equal to those in the cosmopolitan healthcare system. For many sangomas, this is a major step because apartheid's hardship had left them with deep marks. The legalisation of their profession has boosted sangomas self-esteem, the execution of their practice, and their social status.

One would expect that in the present situation indigenous healers would be content. That is not the case, however. They are pleased with the government's recognition but, at present, the level of frustration regarding the legislation is considerable. Their disappointment concerns two topics, viz. the cooperation with CHS and the implications of the required registration. Firstly, although sangomas are generally positive with regard to medical doctors and are willing to cooperate, this attitude is not reciprocal. The new law does not change the Western healthcare workers' condescending attitude towards indigenous healing. Secondly, the implementation of obligatory registration for authorised execution of a healing practice is not getting off the ground. While registration intends to guarantee quality, there is no objective standard to use as an assessment.

Fundamental to both of these topics, in my opinion, is a friction between the Western and African worldview. From the Western point of view, a person is allowed to call himself a medical doctor if he has successfully completed his doctor's exams; he gets a certificate and is expected to be competent. In the African setting, a written certificate was seldom provided. At the end of the sangomas' training there is a graduation ceremony to which all her relatives, neighbours, and fellow sangomas are invited. All guests may test and experience the *thwasa*'s competence and, in the end, they all witness the *gobela* declaring that the *thwasa* successfully completed the training and is now a sangoma. In a small-scale society this procedure worked well, but in contemporary South African society the scale is much larger, especially in the urban areas, where people are not acquainted with each other. Therefore, evidence is needed

to prove the sangomas' competence. In the African setting, such evidence may be given in the form of the patients' experience or advertisement by word of mouth. Within the Western paradigm, the necessary qualifications are certificates and diplomas. The new South African healthcare legislation applies Western standards to assess indigenous healers and their healing practice; in order to be able to register, healers have to hand in certificates as a proof of their education. So far, however, such certificates do not exist. Initiatives like Baba Cele's *muthi* school indicate a certain level of conformity.

However, the government's demands seem to be a bridge too far when it comes to any modification or general coordination of the curriculum for the sangomas' training or the obligatory logbook with patients' records. At those points no governmental meddling is accepted, a *gobela*'s sovereignty (believed to be supported by the ancestors) in the training is pivotal, as is a sangoma's autonomy in her healing practice. Many sangomas do not intend to run their healing practice the way the government wants. They claim that they are 'called' to be a sangoma and thus at the ancestors' service. They are thus suggesting that any sangoma who complies with the legislative rules does not have a calling. In this perspective, the new legislation is counterproductive, for one of its aims was essentially to decrease malpractice (by distinguishing 'real' sangomas from 'quacks') through registration; registration was to be a certifying quality mark. Now, because of the law's accompanying obligations and restrictions, sangomas hesitate to cooperate and, consequently, for the time being, registration cannot be regarded as the intended quality mark. It may never be. Differentiation between 'real' sangomas and 'quacks' remains a problematic, if not impossible, assignment anyway. For it is the patient who decides which sangoma he believes to be trustworthy and competent with regard to his afflictions at a specific moment. It is a matter of subjective judgement and impossible to generalise.

In contrast with the rather reticent attitude regarding law-imposed changes in their healing practice, sangomas seem to react enthusiastically to opportunities that the changing society brings. When it comes to incorporation of contemporary means in their personal lives and professional practice, sangomas are not conservative or outdated at all.

Obviously, sangomas claim that all alterations in the healing practice are approved, or even instigated, by the ancestors, with whom they are in close contact. If all those (kinds of) observed transformations are initiated by the ancestors, I wondered who they are and what sangomas mean when they refer to the ancestors. Does a sangoma communicate with only one or more of her own predecessors, or does she communicate with the patient's ancestors? Or is 'the ancestors' a general designation, or rather an image? My impression is that a sangoma communicates with (the 'spirits' of) several of her own genealogical ancestors, and that they conceive them as real entities (with human characteristics) that are able to interfere in daily lives of all people. Bongani told us that in his case frequently several of his ancestors squabbled about which one of them

was to be regarded as the most influential. But often one of the ancestors is the most important (Nkabinde, 2008), as Mks Ngidi and Mks Bhengu told us in the interview. In a healing session the sangoma connects with her own ancestors, who in turn connect with the patient's ancestors to detect what the patient's problem is, which is subsequently reported to the sangoma: i.e. the diagnosis. That is why during the invocation all people that are present in the consulting room have to be introduced to the ancestors. A similar introduction was done when we came to interview the sangomas in 2012; we had to tell our names and where we came from, so that the sangoma's ancestors could connect with our ancestors, before giving their consent for the interview. The term 'the ancestors' is regularly used as a general designation, but a sangoma's communication is as a rule specifically with her own genealogical ancestors.

It is not easy to produce a forecast on how these matters with regard to healthcare legislation will develop in the coming years. One would expect the government to persevere in the national implementation of the latest law, but on the basis of the slowness of the recent proceedings, I have some doubts about the operation's completion.

What if the government does indeed enforce the obligatory registration for THPs to legally execute their healing practice? I expect that many sangomas (partly in contrast to other categories of THPs) will decide not to register after all, because for them the law infringes too much on their supposedly ancestor instructed healing practice. They do not see the need to officially register now that their profession is legalised by the government. Neither do they regard it as useful to create a document-based profile because they trust the patients' experience-based judgement. Government and sangomas operate from different paradigms, the Western based on science and control and the African with experience as an important factor.

In part, my doubts concerning the THP Act's national implementation have to do with structures in South African society. Van Kessel (2012), as a specialist on South African society, argues that even though good plans and financial means are plenty in South Africa, there is a shortage of governmental executing capacity. Thus, the implementation of this Act in society needs more than good intentions. The mere fact that the healthcare legislation is passed, does not mean that the implementation will be realised in the near future, due to (among other things) a general shortage of governmental staff.

Besides, there is another issue which makes me doubt the ultimate national implementation of Act 22, 2007. At the time of my fieldwork, Jacob Zuma was South Africa's president. In KwaZulu Natal, people were proud to have a Zulu as the nation's president and it made them very eager to comply with all the governmental demands.[2] I wonder what will happen now that Cyril Ramaphosa (born in Soweto) is president

[2] The percentage of indigenous healers that was registered through NUPAATHPSA for instance was considerably higher in KwaZulu Natal than in the rest of the country.

of South Africa. Will indigenous healers and their associations in KwaZulu Natal keep executing the government's requests diligently or was their law-abiding attitude instigated by the fact that the presidential seat was occupied by a Zulu? I doubt if the northern provinces will take the lead in encouraging sangomas to register, for the people in the northern provinces are generally known to be less susceptible to authority. Therefore, I expect that the campaign for registration will gradually decrease.

The present situation is in many aspects favourable for the parties involved, viz. the government, the THPs, and their patients. A major improvement for the government as well as the THPs is that indigenous healing is now recognised and legalised. Furthermore, for the national government, which currently has other priorities in repairing former president Zuma's legacy of nepotism and corruption, this legalisation entails an important money-saver on future national healthcare costs. The fact that, up to now, the government has not been able to facilitate an accurate registration system is in juxtaposition with many sangomas' hesitation to register. The patients benefit from the option of compensation from insurance companies, sick leave notes handed by indigenous healers and the sangomas' refusal to charge (often higher scale) fixed fees. Ultimately, the stipulation that THPs are obliged to register might become the big stick if there is an intolerable increase of malpractice and unethical behaviour. Maybe the most feasible solution will be to basically leave things just the way they are, in limbo.

In previous chapters I have applied the antipodal concepts religion-medicine, programme-practice, and tradition-changing society to analyse and clarify aspects of indigenous healing. In several respects it was useful to discuss certain elements of the indigenous healing practice that way, to a certain degree it helped me unravel and better understand the complexity of the subject. More importantly it made clear to me that in indigenous healing these oppositional concepts are not incompatible at all, which I found intriguing.

A sangoma's healing practice proves to be neither one, nor the other; time and again it is both, religion and healing, programme and practice as well as 'traditional' and part of contemporary, changing society. Sangomas eclectically select elements from all those models, religious, medicine, tradition etc., which makes their healing practice hard to define and regulate, particularly because the compilation of elements may vary per sangoma and from one healing to the other. I consider this one of the reasons for the popularity of indigenous healing and the respect for sangomas. With their fluid mix of different models' elements sangomas appeal to a great majority of the people in South Africa, whether a patient attaches value to tradition or is an admirer of modern technologies, whether the patient is young or old, urban or rural, a sangoma experientially modifies her healing practice to the patient's (unspoken) wishes.

Another reason for the lasting and expected future popular position that indigenous healing has in South African society, has to do with its holistic approach of patients. This approach is part and parcel of the African world view, shared by the majority of

the population. In this inclusive worldview there is no such thing as coincidence or chance; everything is intentional and therefore all occurrences have to be interpreted and explained. Indigenous healers have an eye, an ear, and a culturally appropriate remedy for psychosomatic disorders and existential crises. This is in contrast to Western healthcare clinics, where often no adequate treatment is available for those matters, which leaves the patients uncured and their questions unanswered.

7.3 Methodological analytical perspectives

To what extent this eclectic-model-mixing strategy will prove to be successful and durable in the long run is an open question. The flexibility and fluidity of the sangomas' practice, which triggered me from the start of this research, is definitely a strength, as I indicated. But it may also prove to be a weakness. For the hegemonic forces of the Western scientific (medical) model cannot be overestimated. This doctrinal model based on checks and evidence is intolerant towards any other model or system and therefore it will not acknowledge a more flexible (imagistic) system such as indigenous healing is.

Although sangomas incorporate in their healing practice many elements that are familiar to medical clinics and indigenous healthcare is recognised as equal to the cosmopolitan healthcare system, I do not expect the CHS to acknowledge sangomas' healing as a medical system. In fact, I think, based on Rene Girard's Mimetic Desire theory, that CHS' rejection of THPs will even intensify. Now that the indigenous healthcare system is recognised by law, the chances are that the CHS will increasingly consider THPs as rivals in the medical arena, a field where, according to many medical professionals, indigenous healing does not belong, for they maintain (from their Western medical paradigm) it is religion, maybe occult and certainly not scientific. Whereas the cosmopolitan healthcare system used to be the 'model' for indigenous healers, when its influence on policymakers and healthcare law's implementation is strong enough, it could become an 'obstacle' in the execution of their healing practices.

Through Foucault's theory on power and social relations we gained an insight into the power structures that surround indigenous healing. Apart from powers (like legislation and CHS) that affect the indigenous healing system from outside, inside the system sangomas themselves also use the concept of power. Within sangoma schools we recognised power relations between different levels of *amathwasa* and between trainer and apprentice.

Moreover, the claim that they have (access to) 'traditional, old' and private ancestral knowledge gives sangomas authoritative power within the circle of people that do not have that specific knowledge. That is, over all people that regard 'the ancestors' as an authority, which is a majority of the population. By holding on to that 'old' element sangomas emphasise their own distinguishing strength, the core of their profession and their special position in society.

Regardless of the fact that sangomas are respected by a considerable part of South Africa's population and that their profession is acknowledged by law, these indigenous healers cannot afford complacency; their current social position is vulnerable. They should give due consideration to the impact of repeated negative media reports (about witchcraft, body parts trafficking, etc.) on public opinion and other adverse forces in South African society. For a part of the population does not acknowledge the sangomas' power, based on the ancestors' authority and ancestral knowledge. Among those are

medical professionals and, what Bongani referred to as "learned people", the educated people that often have status and power in social and administrative spheres. In social power relations, language is often instrumental in definition, segregation, and control. It emerges in their claim that indigenous healing is for the poor and uneducated people, that it is occult and unscientific, all designations with negative connotations. This part of the population regards themselves superior to (those who make use of) indigenous healing. They relegate it to the realms of superstition, maintaining for example that it is neither verified, nor evidence based. Arguments that come straight from an oppositional discourse in which doctrinal transmission of knowledge and controlled execution of healing practice is considered the best, if not the only way.

It will therefore be a persistent challenge for sangomas, with their imagistic knowledge transfer and experiential practice, to withstand the hegemonic doctrinal way of thinking, on which the recent healthcare legislation is based. Since the sangomas' healing practice is in my opinion an example of what Oluwole (2017) calls "the African way of thinking" (i.e. complementary and inclusive) I expect sangomas will not fight the Western (medical and legislative) system or comply with it, but rather keep on 'juggling' with all available different models. And, to quote Mks Mbuyisa, bend like reeds in the wind of change.

It is their way of maintaining their power, to stay in control, and to avoid the regulatory tentacles of authorities. A tenacious way to autonomously determine the form in which they execute their imagistic healing practices and an attempt to safeguard a future for their indigenous knowledge and allegedly ancestor-initiated profession. Time will tell whether the sangomas' strategy will be effective and in what way these dynamic practices will evolve.