Summary

This thesis investigates the changing healing practice of Zulu sangomas in KwaZulu Natal, South Africa. Indigenous healing in South Africa is currently at a crossroads. While the latest healthcare legislation accepts the traditional healthcare system as equal to cosmopolitan healthcare, the accompanying institutional developments present obligations and challenges for indigenous healers. While the legalisation is important for sangomas, certain valued characteristics of their much-frequented indigenous healing practices are now under pressure. This research seeks to detect where transformations in indigenous healing practices originate and it seeks to understand to what purpose adaptations in healing processes serve.

Sangomas are a specific group of indigenous healers, predominantly women, whose profession incorporates both religious and medical elements. In South Africa, the general discourse is on 'traditional' healthcare; in this thesis, however, owing to the connotations of the word traditional, preference is given to the phraseology 'indigenous' healing, with the exception of fixed expressions.

To explore the backgrounds of transformations in healing practices and the current status of traditional healthcare, collected data were analysed in the context of existing academic literature on indigenous healing in (South) Africa, both earlier studies (Callaway, 1884 (1870); Bryant 1949; Bryant 1966; Krige, 1965 (1936)) and more recent ones (Janzen, 1992; Erdtsieck, 2003; Van Binsbergen, 1991; Mlisa, 2010; Werbner, 2015). Analysis made clear that there are longitudinal changes in several aspects of the healing practice. The image of indigenous healing that emerges is one of a dynamic system. An apprentice's training is tailored to her individual situation (Mlisa, 2010; Van Beek, 2010). Every healer executes the healing practice in her own way (Erdtsieck, 2003; Mlisa, 2010) and adapts the healing procedures to the given context (Erdtsieck, 2003; Werbner, 2015).

The status of indigenous healing in contemporary South Africa is partly informed by its shifting relationship with various denominations of Christian churches (Oosthuizen, 1989; 1992) and its relationship with Western healthcare. Despite frictions and mistrust (Gumede, 1990; Botha, 2004), current legislation compels both healthcare systems to collaborate (Gqaleni et al., 2010; Ndzimande et al., 2014; Zuma et al., 2017). The effects of contemporary society and the institutionalisation of traditional healthcare, and how indigenous healers cope with the challenges of this change are subjects that exercise many minds. Along with the advantages of the latest healthcare law for indigenous healers, there are many frustrations regarding the government's indifference to the legislation's enactment (Ndzimande et al., 2014, Mbatha & Gqaleni, 2017).

When it comes to the transformations in indigenous healing, also in relation to the social context in which indigenous healers execute their practice, there is a gap in academic literature. The shifting relationships between indigenous healing, religious institutions, Western healthcare, and society in general have been described, but not how these phenomena affect indigenous healing practice. Too little attention has been paid to exactly what the transforms in indigenous healing practices and the underlying processes are. More research on those transformations and the dynamics involved is needed.

This thesis seeks to reduce this lacuna by:

- Exploring possible transformations in indigenous healing knowledge and in the transmission of this knowledge.
- Exploring possible transformations in sangomas' healing practices.

This is done by interviewing three generations of sangomas in rural and urban areas regarding: their 'calling' and training; their healing practice; cooperation with other (indigenous) healthcare workers; their social position and networks; and the way they teach their apprentices. Sangomas' healing practices were explored by attending patients' healing sessions, executed by diverse sangomas at various locations. The cooperating sangomas were selected from the key informant's comprehensive network in the Durban district. With regard to the interviews, the selected sangomas are Makhosi Bhengu, representing the older generation in the rural area; Mks Mbuyisa, representing the middle generation in an in-between area, and Mks Ngidi, representing the youngest generation in the urban area. The attended healing sessions were executed by Mks Zinhle, Mks Gasa, Mks Dudu, and two advanced initiates from Mks Gasa's sangoma school and by Mks Mkhize.

Relevance of the study

Firstly, this thesis is to be considered as a contribution to the academic debate on knowledge transfer in education. The way in which knowledge is transmitted during training influences the way graduates execute their practice. It shows that this is the case for indigenous healers in South Africa; training as well as practice are experiential. Secondly, this research is relevant in its representation of the contemporary status of indigenous healing in South Africa, even though the data for this research were gathered among a limited number of sangomas in a restricted area. In many ways, sangomas are just like any other professional group of indigenous healers (such as inyangas). In the cases that sangomas' attitudes may differ from that of other indigenous healers it is indicated. Thirdly, this study is an academic treatise about a topical subject with high social relevance in contemporary South Africa. The institutionalisation of Traditional

Medicine affects not only the healing practices of medical doctors and indigenous healers, but also the lives of the 80 per cent of the population that attend those healers. The significance of this research and its analysis is, in addition to the insiders' perspective in recent South African academic studies on how sangomas deal with the challenges of the changing society (Mbatha & Gqaleni, 2017), in its outsider's perspective. Both views should be regarded as complementary.

Set up of the research

Research questions

The analysis of the data collected in fieldwork in combination with academic literature on sangomas' healing practices revealed that indigenous healing practices change due to internal dynamics, viz. the transfer of knowledge and sangomas' individual healing identity, as well as due to processes external to the traditional healing system, namely in the form of adaptations to other institutions and to contemporary society.

These considerations led to the main research question of this thesis:

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

The supporting questions address the domains of internal and external dynamics. With regard to internal dynamics:

- How do processes of diagnosis and healing characterise the traditional healing practice?
- What dynamics and contradictions are in the curriculum and knowledge transfer of sangomas' training?

Then, the scope widens to external dynamics that affect traditional healing.

- What dynamics are involved in the interrelationship between (cosmopolitan) healthcare, religion (indigenous and institutionalised), and indigenous healing?
- How do historical, social, and political processes inform contemporary indigenous healing?

Research location

The research was done among sangomas in the province of KwaZulu Natal, more precisely in the Durban metro district. Sangomas' compounds in rural as well as in (semi-) urban areas were visited for interviews and the healing sessions were executed at compounds in the urban area and at locations that were significant for a specific patient's healing process: Mtamvuna river estuary and the patient's home in Pietermaritzburg.

The field research took place in February-March 2012, July-August 2012, and April-May 2014. The aim in the first period was to get acquainted with the area and to make contact with (people who knew) Zulu sangomas and who were willing to collaborate in the research. During the second period, three sangomas were interviewed and several other indigenous healers were visited to better understand the challenges the healers face. A key aspect of the third period was attending patients' healing sessions.

Methodology

The genealogical sampling method, i.e. comparing data from subsequent generations of sangomas, was used in order to find out whether sangomas' healing practices transform longitudinally. The element of 'location' was added to this concept in order to determine whether differences in healing practices occur in relation to the area where they are performed. Moreover, this method was applied to gain an insight into the transmission processes of healing knowledge and to investigate the consistency of this knowledge transfer from teacher to pupil.

This study is a qualitative research in the shape of a case study. Mr Mbele's healing procedure (a detailed description is in Chapter 3) serves as a model of contemporary indigenous healing, internal dynamics in healing practice, and knowledge transfer converging with external (institutional) processes that apparently influence present-day sangomas and their healing practices.

The research design is interpretative, characterised by continuous comparison of the field study data, both mutually and with academic literature. In an analysis cycle of induction and deduction, the data obtained during fieldwork was assessed for correspondence with literature on the subject and, vice versa, whether literary elements and claims can be identified in the field study observations was deduced. It is also a constant process of interpretation and (emic) checks in order to gain an in-depth understanding of contemporary indigenous healing in South Africa. This procedure was intensified by the fact that the field study was done in three separate periods.

Plan of the book

Subsequent to the introductory and methodological chapters (Chapters 1 and 2), each chapter deals with one of the supporting research questions, first on internal dynamics (Chapters 3 and 4) and then on external dynamics that inform contemporary indigenous healing (Chapters 5 and 6). The subjects are approached from different angles and interpretative theories are used for analysis. In order to get a better grip on the data and to bring underlying contrast to the surface, sets of antipodal concepts are used for each of the perspectives.

In Chapter 3, the focus is on the execution of the sangomas' healing practice, specifically, on what happens when a patient comes to a sangoma for healing. Mr Mbele's healing procedure is a connecting thread in the description of processes of

diagnosis and healing, the key elements in every healing session. Comparison of this process with other healing sessions provided an extensive account of what happens in an indigenous healing procedure, often a number of sequential sessions. It also revealed the uniqueness of the patient's treatment in the constant interaction between sangoma, ancestors, and patient. Of particular note are the amount of time and effort that sangomas devote to the healing of their patients and the attention they give to the patients and their relatives. Also significant is the notion that the ancestors' communication and the interpretation of the diagnosis is strictly the prerogative of the attending sangoma. This is both a strength and a weakness in indigenous healing; the sangoma has a powerful position but there is no way to check her claims.

A central topic in Chapter 4 is the internal dynamics and contradictions in the curriculum and knowledge transfer in sangomas' training. Transfer of (*muthi*) knowledge, the diagnosis, and the healing identity emerged as the most important elements in the training. The data in this research indicate that there is no steady curriculum for any of these three elements. The type and amount of (*muthi*) knowledge transmitted during the training turns out to be individually attuned, and the performance of the diagnosis and the healing identity are heavily influenced by the sangoma's personal expression and the presumed demands of the ancestors. The training of sangomas and the *muthi* knowledge that is transferred are concluded to be idiosyncratic and experiential. After the training, sangomas continue to develop and expand their know-how in knowledge exchange with other indigenous healers (and) allegedly inspired by the ancestors, a 'perpetual private revelation'. They use this new knowledge in their healing practice and in the training of their apprentices.

Application of Whitehouse's theory (2004) on the transmission of specialist knowledge made clear that both the sangomas' training and the execution of the indigenous healing practice are executed in an imagistic mode, i.e. that indigenous healing is an experiential, imagistic system.

Another important topic within the indigenous healing system is the dynamics in the organisation of THP associations. The old community-based networks are replaced by larger scale associations that are organised after the Western model, with executive committees and regional meetings. These transformations aim for government acknowledgement and thus to dovetail with the Western healthcare system.

As the sangomas' healing practice is a mix of religious and medical elements, Chapter 5 explores what dynamics are involved in the interrelationship between (Western) medicine (CHS), (institutionalised) religion, and indigenous healing. The relationship between CHS and indigenous healing is characterised by dynamics that originate from the different paradigms that the two healthcare systems are imbedded in: an evidence-based scientific paradigm and an experience-based paradigm. Although both

healthcare systems are to be regarded as equal according to healthcare legislation, the CHS is hegemonic. And because power defines knowledge, the Western (healthcare) discourse determines not only if, but also in what way and under what circumstances indigenous healers will be acknowledged.

There are signs of indigenous healing's conforming with the CHS in the organisation of the healing practice and association, and in attempts to standardise *muthi* knowledge and the creation of a referral form. Nevertheless, application of Girard's Mimetic Desire theory shows that the more the indigenous healing system approaches the CHS model, the stronger the CHS's rejection of indigenous healing will become. Acknowledgement by the CHS is only to be anticipated if indigenous healing discards its distinct individuality.

Whereas the discourse on indigenous healing is in medical terms, in a Western scientific view the sangoma's healing practice consists predominantly of religious elements. To sangomas, their profession is primarily a matter of healing, a term that, in this context, proves to have a much wider definition than merely medical.

Indigenous healing's relation with institutionalised religion seems to have improved in the decades after apartheid. Many Christian churches are showing interest in indigenous healing and there is an exchange of knowledge and practices. This mutual interest might be an effect of the influence of the African Independent Churches, in which African custom and culture is combined with Christian doctrine. For numerous sangomas and many of their patients who are members of mainline Christian churches or of AICs, (institutionalised) religion and indigenous healing are not oppositional, but go hand in hand.

How historical, social, and political dynamics inform the contemporary indigenous healing system in South Africa is the topic of Chapter 6. After decades of illegality, sangomas can now execute their practices in the open. However, apartheid's effects are still noticeable in the way the sangomas' healing practice is perceived in society. Longitudinal data in this study show that indigenous healing is flexible and experiential: all kinds of contemporary elements are incorporated in the healing practices. Sangomas hold on to one old, indigenous religious element: their intermediary role between patient and ancestors. Their healing practice can be considered, in reference to Hobsbawm's theory (1992), as a constantly re-invented 'tradition'. Sangomas' position in society can be typified as ambivalent and in a certain way that makes them intangible, which seems to suit them well.

Exponential growth in the number of THPs and an alarming number of reports of malpractice or unethical behaviour by (alleged) THPs led to necessary control and regulation. While THP associations cooperate with the government in its policy towards registration and standardisation, the implementation of the THP Act meets with individual indigenous healers' opposition. They state the law's obligations and restrictions infringe too much on their healing practices and professional autonomy.

In their view, it is up to the patient to judge, based on experience, whether a healer is 'worthy' of filling the social position of sangoma.

The implementation of the law is intricate and hitherto many THPs have considered it not beneficial to register. The tardiness of implementation, the government's inability to formulate adequate criteria for registration, and indigenous healers' reticence with regard to this top-down imposed policy endanger the effectivity of this legislative process (Mbatha & Gqaleni, 2017). Now that their healing practice has been officially recognised, sangomas are not eager to cooperate in the implementation of the THP Act. Their profession's acknowledgement may suffice for the THPs as well as for the government, all actors involved have their reasons for sticking with this status quo.

Some final reflections on the findings of this study are presented in Chapter 7, along with expectations with regard to the development of indigenous healing practices in South Africa. Two grounds for indigenous healing's ongoing appeal to a majority of South Africans are described. Firstly, in the indigenous healing perspective, the concept of healing is more than recovering physically or mentally, it is also understanding what the cause of the affliction is, so that the appropriate measures can be taken and similar complaints can be prevented in the future. Nowadays, especially in urban areas, many patients want therapy for psychosomatic problems or something bothering them, a lack of well-being, a feeling of discomfort. Indigenous healers have an eye, an ear, and a culturally appropriate remedy for psychosomatic disorders and existential crises. Healing is often a treatment by a healer one trusts and believes in. Secondly, in their healing practice, sangomas eclectically select elements from all kinds of models: religion and healing, 'traditional' and contemporary, changing society. The compilation of elements may vary per sangoma and from one healing to another. Whether a patient attaches value to tradition or is an admirer of modern technologies, whether the patient is young or old, urban or rural, a sangoma experientially modifies her healing practice to the patient's (unspoken) wishes.

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

Therefore, despite the profession's acknowledgement and their continued popularity, sangomas cannot afford complacency; their current social position is vulnerable. They should give due consideration to the impact of repeated negative media reports (about witchcraft, body parts trafficking, etc.) on public opinion and other adverse forces in

South African society. The part of the population that does not acknowledge the sangomas' power, which is based on the ancestors' authority and ancestral knowledge, includes people who have status and power in social and administrative spheres. Many of them relegate indigenous healing to the realms of superstition, maintaining that it is neither verified, nor evidence based.

It will therefore be a persistent challenge for sangomas, with their imagistic knowledge transfer and experiential practice, to withstand the hegemonic doctrinal way of thinking, on which the present healthcare legislation is based. Since the sangomas' healing practice can be regarded as an example of what Oluwole (2017) calls "the African way of thinking" (i.e. complementary and inclusive), these indigenous healers are unlikely to fight the Western (medical and legislative) system, or to comply with it. They will probably keep on 'juggling' with all available different models and bend like reeds in the wind of change. It is their way of maintaining their power, to stay in control, and to avoid the regulatory tentacles of authorities. A tenacious way to autonomously determine the form in which they execute their imagistic healing practices and an attempt to safeguard a future for their indigenous knowledge and allegedly ancestor-initiated profession.