

Part IV

**THE RESISTANCE OF THE SUBALTERN:
THE CASE OF MEDICINE**

Marginalized Medical Practice: The Marginalization and Transformation of Indigenous Medicines in South Africa

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INTRODUCTION

The collision of African political, economic, social, religious, and cultural practices with modern civilization has had an overwhelming and lasting impact on Africans. Within a short period of time, Africans were transformed from being peasants living on the produce of the land and their cattle to being forcibly incorporated into a universalistic, mono-economic, and mono-cultural world economic system. Together with such economic changes, their lives went through political, social, and cultural transformations through which the cultural, social, economic, and political practices and institutions were suppressed and marginalized.

This chapter is about the socio-cultural impact of the marginalization of African medical practices. It argues that modern development, which is intolerant of competing points of view, sought to change or supplant indigenous medical beliefs and practices with modern ones. Consequently, Africans find themselves constantly destabilized while the benefits derived from the holistic approach and the egalitarian nature of indigenous medicines are not being realized. Instead, Africans are subjected to modern practices, among which are the *invasive techniques* of "scientific" medicines.

This chapter also argues that, while some proponents of modern civilization believed in and practiced it like a religion, their dogmatism blinding them to the value of indigenous practices, others were motivated by economic competition, which spurred them to remove any form of competition emanating from indigenous practices. Among the historical bastions of development were political institutions represented by the state, the religious institutions represented by missionaries, and the medical and pharmaceutical institutions representing "scientific" medicine.

The argument in this chapter is divided into five sections. The first section

provides the theoretical trajectory of the arguments for and against development. The second section discusses the "ideal typical" African indigenous medical practices that had evolved before the advent of colonialism. The third section shows how African indigenous medical systems were undermined, circumscribed, and prevented. The fourth section addresses the consequences of the disruption of and the restrictions on indigenous medical practices. The last section is the conclusion.

DEVELOPMENT AND ITS MALCONTENTS

This chapter looks at "development" as a descendent of what has been referred to as "modern civilization." "Modern" in "modern civilization" refers to the epistemological foundation of the worldview that is considered "scientific." The concept "development" has been (and continues to be) a bone of contention and has metamorphosed from colonialism/imperialism, modernization or civilization, and development/underdevelopment/dependent development to globalization. However, it remains that development still largely refers to the Westernization of the world. That is, making the rest of the world conform to the economic, socio-cultural, and political norms that have developed in the "West."

The advocates of this view and their followers saw colonialism as a catalyst to bringing the advantages of development to people in other parts of the world (the "South").¹ They identified the economic, political, cultural, religious, and social institutions of the people in the "South" as a stumbling block to the potential progress realized in the "North"² (Hoselitz, 1960; McClelland, 1961; Inkeles and Smith, 1974). They prescribed ways and means to manipulate, alter, and destroy those institutions and aspects of the "South" that blocked progress to development (Huntington, 1968; Parsons, 1951). In pursuing such a project, they did not always agree among themselves. However, originating from people who held similar beliefs regarding the appropriateness of propagating the advantages of development, the critiques were meant to strengthen the argument for the proliferation of the practices, values, and institutions of development.

There were various detractors of the promise and the strategy of development. One set of opponents of modern civilization rejected the superiority of "modern" values and institutions implied in the propagation efforts. They renounced the claims of progress and popular welfare implied in neo-classical economics (Hobsbawm, 1963; Scott, 1976) and politics (Myrdal, 1968), as well as the displacement of traditional behavior and practices and their replacement with practices based on "rational" individualism (Hirschman, 1965). Instead, they tried to uncover the rationality of the behavior and institutions of the people in the "South" (Scott, 1976; Popkin, 1979).

The more radical critics identified the state as an arena of conflict that reflects power relations in society and not as a custodian of popular welfare or a representative of democratic sentiments (Baran, 1952; Frank, 1967; Cardoso, 1972). They argued that the causes of such conditions were not unrelated to the relations of the "center" and the "periphery." This group considers alienation, resistance, and protest in the "South" as an expression of the loss of control by ordinary people as opposed to the dominant groups (especially, ordinary people's relation to technology and the organization of work and life). This argument is best represented by the writers of the Frankfurt School (e.g., Marcuse, 1964, and Habermas, 1984).

Writers in the "South" and their supporters highlight the role of culture in development. They argue that the "scientific" proclivity of modern civilization leads to the technocratization of society, which not only does not serve popular interests but is inimical to them (Parekh, 1989; Verhelst, 1987; Nandy, 1987; Marglin, 1990; Nandy and Visvanathan, 1990). Gandhi decries the mechanization that was followed by technological inventions, and which turned humans "into helpless and passive victims of its inexorable momentum" (Parekh, 1989: 23). The social, cultural, and natural environmental deterioration is blamed on the bureaucratization of society that removes decisions from ordinary people and vests them in the bureaucratic institutions of the state. Consequently, Gandhi continues,

Modern man has become abstract and empty, he is not internally or organically related to others and his relations with them were not grounded in the sentiments of fellow feeling and good will. [. . .] Morality has been distorted, other people matter not because one cares for them but because the laws demand it, rather than a fulfillment of man's nature, morality is seen as a necessary but painful restriction on freedom, morality has been reduced to its barest minimum i.e., the need to prevent people from destroying one another. [. . .] A society of unrelated beings gets dominated by fear, hostility and tension [. . .]. Modern man spends most of his time trying to steady himself in a hostile and unsteady environment. He lives outside himself and exhausts himself physically and spiritually [. . .]. The exploitation of others was built into the foundation of modern civilization [. . .]. That is why modern civilization rests on and is protected by massive violence (against others, animals and the environment) (Parekh, 1989: 23, 24, 25).

While Gandhi throws light on the consequences of the technocratization of society, Banuri (1990) maintains that the development of the "South" has been disadvantageous,

not because of bad policy advice or malicious intent of advisers, nor because of the disregard of neo-classical wisdom, but rather because the project has constantly forced indigenous people to divert their energies from the *positive* pursuit of indigenously defined social change, to the *negative* goal of resisting cultural, political, and economic domination by the West. [Emphasis in original]

He goes on to insist that, to improve welfare in the "South," the West should stop imposing measures of "development" (such as "quality of life" indices) because such measures "disenfranchise people," "make it unnecessary for their opinion to be sought," and "make it impossible for them to change their preferences in the face of manifest problems."³ He insists that the right to define welfare and progress should be "unconditionally restored to indigenous people." Along the same lines, Verhelst (1987) insists that "poor people have a right to be poor" (i.e., to remain outside the "world system" that oppresses them). Banuri is, however, under no illusion that the people in the "South" will necessarily succeed where development professionals have failed, and maintains that, "unlike the latter, they will learn from their mistakes and they will adjust their behavior, instead of continually trying to rationalize their errors, or to justify their actions, their privileges, and their right to intervene."

This chapter is interested in that process of "disenfranchisement" that forced Africans to abandon what was useful in the indigenous cultural and medical systems for the products of "scientific" medicine. It argues that the universalizing process of development in South Africa disembedded Africans from their epistemological foundations. Consequently, the decentered Africans have lost and are losing some of the essential qualities of their cultural practices. One such cultural practice is a holistic view of health and illness and of the causes and cures of illnesses. The "scientific" medicine that has been imposed on them, however, not only ignores the remedies of indigenous medicines and practices but also seeks their suppression. Therefore, some of such remedies have been lost and are increasingly being diminished among the compendium of medicines consulted by Africans when they face "manifest (medical) problems." Consequently, the advantages of a *holistic, non-invasive, and egalitarian* medical system are being systematically undermined. Also, as a consequence, the possible benefits of the cooperation between indigenous medical practitioners and the practitioners of "scientific" medicine remain unrealized.

The chapter also maintains that "scientific" medicine has achieved its elevated position not because of its superior powers but because of the power of the state to proscribe and marginalize indigenous medicines and practices and also because of the dominant position of those who espouse modern

ideas of health and progress. There is a tendency among the critics of development to always impute ideological interests to its proponents. However, in South Africa, many of the zealous proponents of "scientific" medicine are spurred by the threat to their pecuniary interests. Such interests are presented in the ideology of modern civilization that does not accommodate other points of view.

INDIGENOUS AFRICAN SYSTEMS OF HEALING

Long before the advent of Europeans on the African landscape, Africans had developed "medical systems" that they used in the prevention and cure of diseases and illnesses. Those medical systems were founded on the archeology and epistemology of African religions. In such religions, a person is more than the body that stands in front of you but the personification of past, present, and future relations between the living and the dead. As such, those types of ailments and suffering that seem to have no evident cause and that defy recognized forms of relief are considered to originate from fractures in the relations among the living or between the living and the dead or the spirit world. Accordingly, the solutions for such suffering emerge from the restoration of the *status quo ante*.

The system of medical knowledge that evolved was egalitarian and not all the preserve of specialists. As part of this system, the average person and household were exposed to general medical knowledge that enabled them to remain healthy and to cure minor ailments. Each household had a designated "medicine man" who looked after the health of the family. When the family's "medicine man" was not successful, the patient was referred to the professional medicine man. The practice of having a "medicine man" in each household ensured that medical knowledge and skills were widely available. The ready availability of medicines in plants and animals ensured the egalitarian nature of the system.

When an illness was considered to be more than just a body ailment and seemed to have no understandable material cause, a *sangoma* (diviner) and an *inyanga* (herbalist) were consulted.⁴ Steeped in the understandings of African cosmology and cosmogony as well as in the epistemology of African religion, *izangoma*⁵ and *izinyanga*⁶ practiced a holistic approach to medical treatment. The *sangoma* would identify the origins and causes of the ailments or sickness, would advise the family of the causes of the ailment and the necessary rites that had to be fulfilled, if any, and would then refer the ailing person to a medicine man who would help him or her. In the event that the solution to the ailment or suffering lay in the performance of certain rites, a designated person or the *sangoma* herself or himself could assist the person or the family in the performance of such rites.

In the event that the suffering required the interventions of an *inyanga*, a *sangoma* would refer the person to a qualified *inyanga*, who would provide him or her with the necessary medicines to cure the ailment. As part of their arsenal against ailments, *izinyanga* produced medicines from various types of plants, roots, and animals as well as mixtures of such plants and animal products. *Izinyanga* were assisted by their students in the procurement, preparation, and administration of medicines. Such assistance was part of the students' education, which was understood to take anywhere between ten years and a lifetime (Gumede, 1990: 154).

The causes of suffering for which *izangoma* and *izinyanga* were consulted ranged from *abathakathi* (wizards and witches), *izigigaba* (calamities or catastrophes), *izimila* (swellings and tumors), *imikhuhlane* (colds), *izishayo* (visitations), *imimoya emibi* (wanton spirits), to *abaphansi* (ancestral spirits) (Gumede, 1990: 43–47). There were specialists for the various kinds of ailments from which Africans suffered (Ngubane, 1977: 105–106).

Izinyanga and *izangoma* treated their patients both as in- and outpatients. The inpatient came to live with the indigenous healer at his or her home. Often, a relative accompanied the sick person and stayed with them at the healer's lodge until the sick person got well (Ngubane, 1977: 106). The presence of a relative during treatment provided emotional and psychological support to the sick person.⁷ The outpatients traveled between their home and the healer's residence or place of practice.

When *izangoma* were banned through various Anti-Witchcraft Acts (discussed below), the need for divination and healing did not suddenly disappear. Some of the work done by *izangoma* was taken over by *abathandazi* (Christian diviners) who, because they were a new phenomenon and largely unknown, could function under the cover of church garments. *Abathandazi* function in that liminal space between *izangoma* and Christian religious healers or mediums. Their knowledge is informed by (and balances) both African and Christian epistemology and cosmology. Their methods of intervention range from prayer, using the name of *Jesu* (Jesus) or *Mariya* (Mary, Jesus' mother), to the use of blessed water and other objects, as well as the use of indigenous medicines.

Most notable among *abathandazi* are Mr. Isaiah Shembe, the 1911 founder of *Isono LamaNazaretha* (the Nazareth Church), who became an eminent religious leader, prophet, and a prolific religious songwriter, as well as Mr. Maphithini Thusi (a child of *isangoma* [Gumede, 1990: 192] who in the 1930s founded the *eMakhehleni*⁸ Church, which adopted the Zulu code of living and social structure). There were many other *abathandazi* who worked during the times of Prophet Shembe and Prophet Thusi, and there have been many others since then. Those who became successful started their own African Independent Churches, such as the African Faith Mission, the African

Free Bapedi Church, the African Native Ndebele Church, the African St. John Baptising Church, and the New Jerusalem Church, among various other Zionist and Ethiopian churches. Many others did not start any churches but serviced the public from their own houses and even from the backyards of their rented houses.

Unlike "scientific" medicine—which requires a person to hand over the custody of their body to the experts to do with it what they like so that the patient learns nothing from his or her ailments, develops them again, and is treated in the same manner (Parekh, 1989: 27; Jarret-Kerr, 1960: 36–37)—the methods of treatment of indigenous medicines are less invasive and have greater advantages for the patient. Their advantage is that they assist people to "acquire a greater understanding and control of their bodies by explaining to them the causes and etiology of their ailments, how to prevent them and how they [are] integrally related to their way of life" (Parekh, 1989: 26–27). They also activate and energize the body's internal rhythms, resources, and built-in intelligence necessary for self-protection and healing. Scientific medicine, on the other hand does not

see ailments as a cry by an overworked body for rest and discipline, but as an unacceptable interference with its routine, requiring an immediate and effective response. The body is not allowed to cope with illness at its own pace. The body is turned into a battlefield where armies of ailments fight armies of chemicals in a deadly contest in which the body becomes the casualty (Parekh, 1989: 26–27).

The system of indigenous medicine that had developed prior to the arrival of Europeans on the African landscape had three main characteristics.⁹ It had a *holistic* approach to health and illness. Its *egalitarian* nature ensured that the medicines were readily available and that the knowledge was not the preserve of only specialists. Its methods of treatment were *non-invasive* and relied on the participation of patients in the healing process.

That system of healing was affected by the challenges to African culture and beliefs that were systematically introduced through labor, education, conversion, and the administration of African affairs by the state. This is the point to which we now turn.

THE "TROJAN HORSE" STRIKES

The marginalization of African religions, customs, and practices was methodical and was effected by means of the "Trojan Horses" of labor, Christianity, missionary education, and the roles that both the state as well as the medical and pharmaceutical establishments played. In reality, these four

processes were not always in harmony with one another. In fact, at times, colonizers and missionaries found themselves on opposite sides of important issues. However, what united them was the zeal to "develop" Africans (i.e., to change not only the manner in which Africans lived and behaved but also the way they looked). These four issues are considered separately here for analytical reasons. Together, they reveal that, in order to disembed Africans from their epistemological anchor and to entrench modern civilization, the integrity of African ideas of civilization, culture, and morality had to be discredited and destroyed.

Labor and the marginalization of African practices

Africans were distanced from their religious and cultural practices through the systematic erosion of those practices. One way in which this happened was by the forcible removal of Africans from their cultural setting and by compelling them to labor in the mines and factories. This section addresses the role played by forced labor and the work environment in distancing Africans from their practices. As Lord Selborne said, "There will be no surer way of teaching them [Africans] to work than by increasing their wants, and especially the wants of the women. These wants can be engendered, and are engendered constantly, by contact with whites; but education wisely directed, may do much to assist the movement."¹⁰ The wants to which Selborne refers are some of what Atkins (1993) refers to as "gates of misery." They were part of a larger strategy to deprive Africans of their means of livelihood so that they would seek employment either on farms or in urban areas. The accompanying strategy was to require that every African man above the age of 18 pay a certain amount in direct taxation to the central government.¹¹ The requirement was vigorously and implacably applied; the penalty for failure to pay taxes being imprisonment. Jabavu (in Schapera, 1967) discusses the case of men who were arrested while attending services in churches and of funeral processions that were disrupted due to men being arrested for failure to produce evidence of tax payment.

The mines and factories to which Africans were driven in order to fulfill their wants curtailed their freedom and degraded their humanity. The work they did was not only meaningless and unfulfilling but was also dehumanizing. The functions they performed at work were disembedded¹² from the social context that they left behind and only became meaningful in as much as the wage could be used to pay taxes, buy food, and pay rent. Their socialization into the rhythms of industry (such as living in cramped quarters and altering the relations between young and old) represented not only the denigration of their cultural practices but also their subjugation to the repressive "laws of industry."

Not only were Africans expected to work in disembedded conditions, they were also expected to dress differently (i.e., to discard their indigenous clothes and to wear "European" clothes). The command that "All [Africans] should be ordered to go decently clothed" (Magubane, 1979: 61) was made for various reasons. Christians and other Victorian Europeans considered Africans to be unclothed and, having been taught to be ashamed of their bodies, considered it scandalous that Africans should be allowed to walk "naked."

The requirement for Africans to wear European clothes brought the missionary and the clothing manufacturers closer together since the requirement served the economic interests of those who stood to benefit from selling clothing to Africans.¹³ The enforcement of a "dress code" was supported by other positive reinforcements that rewarded Africans for "washing their bodies" and covering their "nakedness." Not being arrested was reward enough. The fact that employers increasingly insisted that workers be "decently" clothed made it imperative for those seeking employment and those seeking to keep their employment to discard their African attire, if only for the duration of their employment. The demand for clothing was made even though it was detrimental to the lives of Africans.¹⁴

Africans were not only expected to change their outward appearance, they were also expected to change the manner in which they perceived themselves. The pass offices, labor bureaux, and other employment offices were disinclined to give work-seekers permits to Africans with African names. In order to get a permit, one had to fill out government forms that required a "Christian name," and this was understood to refer to an English or Afrikaans name. A Christian name, up until the 1990s, was a sign that one was a member of a church. Therefore, Africans were forced to buy church membership at a price, after which they would be given a baptism certificate with a Christian name. In the early days, when many Africans could not read and write, the official bureau took the Christian name from the baptism certificate or simply gave one to the African. While the names may have been forced on people initially and some may have even disliked their English or Afrikaans names,¹⁵ the urban environment made such names more acceptable than African names. Some even developed a dislike for their given African names.

All the foregoing work-related factors conspired to ensure that urbanized Africans tended to move closer to the "modern" culture of the cities and away from their African religion and cultural practices. The recently arrived African who still held on to African religion and practices was increasingly considered a relic of the past (Mayer, 1961). Because he/she did not understand the ways of the city, he/she was considered "stupid" and "backward." The lack of understanding the city was thrown into the same

pot with his/her belief in African religion and practices and together produced an attitude that looked down upon African religious and cultural practices. How else could African religion and cultural practices be considered if the people who practiced them were considered "stupid" and "backward"? Claiming belief in African religion became the equivalent of claiming "stupidity" and "backwardness."

While compulsion was used to force Africans to discard their "nakedness," Christianity and education were used to make them sufficiently ashamed of their bodies and embarrassed by their own culture so that they would always be clothed, in the Christian sense. A discussion of this subject follows.

"Missions" and the marginalization of African religion

The stream of missionaries who descended upon Southern Africa were inspired, among other things, by the ideal of bringing light to the "dark continent" (see Gelfand, 1984). They condemned African beliefs as inferior to their own and instilled a spiritual dictatorship that mandated Christianity as the one and only true religion. They systematically worked towards uprooting and destroying all "heathen beliefs," customs, and practices in order to replace them with Christian ideals and Christian ways. In their campaign against heathen practices in South Africa, missionaries found support from the state¹⁶ and almost every European (miners, farmers, diamond diggers, and other fortune seekers) (Eiselen, in Schapera, 1967: 65). They, however, were on their own in spreading the gospel to Africans.

The activities of the missionaries did not go without opposition. Since they attacked the organization, customs, religion, and practices of Africans, their efforts were resisted. They were resisted because they exercised authority over converts in ways that challenged the authority of *amakhosi*¹⁷ (chiefs) and *izinduna*¹⁸ (headmen) (Eiselen, in Schapera, 1967: 69-70). They separated converts from their group and harbored them as refugees. In such internal colonies, called "missions," the missionaries had free reign to distance Africans from their institutions, culture, customs, and practices. The "mission" refugees were not sufficient. Missionaries continued to proselytize among those who had not decided to emigrate, mentally and physically. They used all manner of subterfuge to convert Africans. For instance, they used medical missionaries¹⁹ to draw Africans to Christianity (Gelfand, 1984: 20-21). While preaching the brotherhood of man, they instilled religious intolerance towards African religion and assaulted the organization of the African family, the socialization of children, as well as the rites of passage conducted at different stages of the lives of Africans. To lure Africans to the refugee camps of missions, some missionaries even dangled political and social rights (which were, supposedly, enjoyed by

"mission" Africans) in front of unconverted Africans (Eiselen, in Schapera, 1967: 80).

The triumph of the missionaries' work among Africans was realized in the proliferation of churches of different denominations among Africans, Christian Societies and Associations, as well as in the numbers of those who proclaimed themselves either "Christian" or "saved." The success of the "scare tactic" of threatening burning in an eternal fire of brimstone can be seen in the numbers of people who were "afraid of dying without being baptized" (Jarret-Kerr, 1960: 22). The many denominations and churches signified the numbers of Africans who had finally been persuaded that their own religion was nothing but obscurantism and superstition. Such people discarded their pagan ways and adopted "civilized" and Christian morals and conduct.

The manner in which better educated and Christian Africans see themselves *vis-à-vis* the poor and "uneducated" African was aptly captured in the comments of one of Mayer's respondents:

The difference between a Red man and myself is that I wear clothes like White people's, as expensive as I can afford, while he is satisfied with old clothes and lets his wife wear a Red dress. After washing, I smear Vaseline on my face: he uses red ochre to look nice. He is illiterate whereas I can read and write. I want to educate my children, but he just wants to circumcise his boys so that he should have a daughter-in-law. A Red man attends sacrifices but I attend church. I pray for my sins when I am sick. He knows nothing about sins and approaches a diviner for his illnesses. I was baptized, he was sacrificed for. I must not use any words that are obscene, but he uses any type of words, even in the presence of his elders without fear of rebuke (Mayer, 1961: 21).

It is doubtful whether many contemporary African Christians would express the differences between themselves and those who "do not believe" as clearly as Mayer's respondent.

However, the conversion to the new faith was not completely total. For many, the Christian message had to be tempered with the message of African epistemology, cosmology, and cosmogony. Through such a view, African Independent Churches (AICs) were born. The open acknowledgement of the value of African beliefs in AICs allowed the believer to claim both African beliefs and Christianity. As such, the believer who is a member of an AIC may not have a religious reason to deny consulting *izinyanga* or *izangoma*.

For the most part, the African leadership of the other Christian Churches (Methodists, Lutherans, Catholics, etc.) does not openly acknowledge the value of African traditional beliefs. Nonetheless, the behavior of "believers"

in these churches suggests a belief system that is much more nuanced than that which is preached by the church leaders. The behavior of African Christians, by and large, reveals that they do not subscribe to the Christian view that sees the world in terms of the polar opposites of "Christian" and "heathen." Such an environment leads to believers saying one thing and doing another. It is most likely that it is believers in such churches who would deny their consultation of *izinyanga* and *izangoma*.²⁰ The followers of Reverend Livingstone September are among those who have found comfort in a mixture of Christianity and the practice of African cultural healing rituals, and they are not ashamed to show it:

Reverend Livingstone September is a St. Joseph's Apostolic Church spiritual father and faith healer. People bring water, in various containers, to him to bless. Sometimes, owners of the containers of water even attach notes with special wishes that they expect fulfilled. People sprinkle the blessed water on whatever they want blessed or protected from evil, such as their homes, cars, themselves, etc.

Over and above the blessed water, people can get various medicines; such as ashes of burnt wood to cure sores and cancer, diluted vinegar for drinking and bathing which cures broken bones, help the paralysed walk, and the barren give birth. The reverend also helps people who have marital problems, do not get along with their employers, or cannot find work. A white rope worn around the waist helps in the prevention of worries, a red one across the forehead wards off bewitchment. (*Sunday Life Magazine*, 4 February 1996: 16-19).

From the outside, Reverend September's church looks like any other Christian church. But from close up, it appears quite different. Some of the practices conducted in the church may be considered by some to be even un-Christian.

This section has discussed the work of missionaries in converting Africans to Christianity. While many converted, many more tempered their conversion with African cultural practices, thus subverting the notion that the two forms of beliefs are mutually exclusive and that one is superior to the other.

The education of Africans

The missionaries' initial motivation to "educate" Africans was largely in order that they could learn to read the Bible. As Africans progressed in their education, and as this bore the fruit of more Christianized Africans, missionaries accelerated their advocacy for the education of Africans. As more

missionaries were allowed to establish schools and as more and more Africans were persuaded to go to school, increasing numbers of Africans became exposed not only to the new education but also to Christianity.²¹

Therefore, it was not accidental that the extent of one's education was measured in the distance that one had created between oneself and African indigenous religion and cultural practices. And, most importantly, evidence of continued belief in African religion and the performance of cultural practices became the mark of a lack of "education." It is clear how anyone who wants to be considered as educated would respond to the question of whether they are Christian or not.

Also, the association of education with "science" and the products of modern development, such as electricity, running water, and the modern transportation infrastructure impresses upon the educated African the distance that he/she should put between him/herself and the rural areas. Because he or she considers it to be "unscientific," the educated African disregards African epistemology, metaphysics, and axiology and their criticism of "science" and "Christianity." His or her world is the world founded on the epistemology of modern civilization. Is it any wonder, therefore, that teachers, nurses, doctors, and other educated Africans are disinclined to work in rural areas?

The medical establishment and African practices

Medical missionaries were used by the missions to draw Africans to Christianity (Gelfand, 1984: 20-21). They were the first to come across African beliefs and the use of indigenous medicines (Sundkler, 1948). While most of them, like their fellow brethren, condemned such beliefs and practices, some sought to understand the practices, if only to prove their uselessness or harmfulness. A few, however, found value in such beliefs and practices, so much so that Etherington (1987) refers to some such relations as "characterized by [. . .] mutual understanding." Such "mutual understanding," if not tolerance, is evident in Father Apolinaris's admonitions to Dr. Max Kohler:

The African lives in a world of his own and it will take a long time until the correct relation between a white physician and an African patient is established, which in most cases, I think, is the *sine-qua-non* of successful treatment. Doctor, for the time being you must be satisfied with being the last resort in the health problems of the African. Before they come to you they have been consulting their medical experts, especially the illegal diviner or *isangoma*. (in Schimlek, 1957: 91; emphasis in original)

Missionary doctor and medical superintendent at Charles Johnson Memorial Hospital in KwaZulu (Nquthu), Anthony Barker provides an explanation for the doctor who may need to know the difference between the African world (that about which Father Apolinaris talks) and his world:

For these men and women our medicine is too small. It is too cold, too materialistic. We should cease from scorning those who pass our hospitals for the care of the traditional medicine men, or seeing this moment as necessarily retrogressive. It is nothing of the kind, but rather a barometer of our failure to satisfy that part of a sick man's consciousness which he reserves for himself (Barker, 1959: 33-34).

The continued consultation of indigenous healers by Africans may be partly an index of the failure to satisfy the sick African's consciousness. It may also be partly due to the lack of confidence in "scientific" medicine, as medical missionary Jarret-Kerr noticed (1960: 30-32), and to the recognition of the power of indigenous medicines (1960: 43-44, 47-48).

In urban areas, the practices of indigenous doctors came in direct conflict with the practices of "scientific" doctors and pharmacists. Indigenous practitioners who wanted to be successful in urban areas modeled their practices after the practices of "scientific" medical practitioners. They set up their practices in towns and referred to themselves as "doctors." Those who produced medicines called themselves "pharmacists." The doctors of "scientific" medicine as well as pharmacists were financially threatened by such practices and demanded that the state proscribe the use of indigenous medicines.²² As will be mentioned below, the state pursued an ambiguous policy that resulted in the proliferation of indigenous practices in urban areas.

The doctors of "scientific" medicine were not alone in marginalizing indigenous healers. They worked hand in hand with psychologists and psychiatrists who were similarly threatened by *izangoma* and their practices. It is not an overstatement that psychologists and psychiatry have done very little or nothing for the African in South Africa. It is true also to state that, save for those confined in mental institutions, the African has generally not needed the services of psychologists or psychiatrists. In *izangoma*, Africans have psychologists and psychiatrists who not only come from the same cultural environment but who are also steeped in the belief systems of their patients. *Izangoma's* role in keeping many Africans sane during the darkest periods of apartheid rule has never been acknowledged and most probably never will be. The upheavals of the late 1980s and early 1990s not only destabilized the former state, they also destabilized people's psychological anchors. Here too, *izangoma* have not been recognized as contributors to the psychological stability of many during those turbulent times.

This lack of recognition stems from the marginalization of all indigenous practices. It has deprived the practitioners both of systems of psychological help along with the advantages arising from the cross-pollination of these practices. Here too, the cooperation that one sees between practitioners trained in the "scientific" method and the practitioners of eastern forms of psychiatric treatment, such as yoga, is not replicated in South Africa or anywhere in Africa. The general South African psychiatrist, if he or she has dared to search, has seen nothing valuable in the indigenous systems. Jungian psychotherapist Dr. Verah Buhrman is among the minority who think:

Ritual and skill of black healers are not the mumbo-jumbo or witchdoctor's magic some whites think but are based on the same sound principles that underlie Western Psychology. Contact between black and white healers should be approached in a spirit of mutual respect [. . .]. There is the use of dreams by the black traditional healer to get contact with the unconscious mind. It is of powerful value in giving another dimension to healing—the aid of the ancestral spirits [. . .] (*Sunday Express*, 13 January 1985).

Unlike Dr. Buhrman, Dr. Barker, and Father Apolinaris, the doctors of "scientific" medicine and psychotherapy were willing to abandon the principles of scientific investigation (i.e., making deductions from observable facts) and propound their uninformed beliefs and superstitions regarding indigenous medicines and practices. The marginalization of indigenous medicines had little to do with their efficacy or their hygiene and more to do with the religious and cultural superstitions of doctors as well as the threat posed by competition from indigenous healers.

The results of the activities and campaigns of missionaries and the medical establishment can be appropriately realized in the legislation that was enacted over time.

The state and African practices

The South African state (in all its former incarnations) played an active and ambiguous role in the marginalization of African practices. On the one hand, the state was influenced by missionaries and the medical establishment to curtail the practices of *izinyanga* and *izangoma*, and became interested in protecting Africans from the "primitive ill" perpetrated by *izangoma* and *izinyanga*. On the other hand, reconciling the state's ideologies of separate development and apartheid meant that some African cultural practices had to be tolerated. In Natal, *izinyanga* were recognized and licensed from as early as the 1890s through the Natal Code (Section 268 of the Natal Code of Native Law, No. 19 of 1891) and the Zululand Proclamation (No. 7 of 1895).

However, those practices that were purely religious and psychological (i.e., practices of *izangoma* and other mediums) were prohibited and criminalized. Thus the practice and trade in "philtres, charms, divining and witchcraft" were prohibited. The Natal Code was, however, a compromise between the demands of missionaries and the imperative to maintain some semblance of African culture as well as a rational response to the shortage of doctors of "scientific" medicine in Natal. The Natal Code, however, restricted African herbalists to treating only Africans and only in African areas.

While the recognition of *izinyanga* did not herald an era of full acceptance and support, it created an environment that fostered the survival of medical practices in urban areas. The Natal Code created conditions for indigenous medical practitioners to apply for annually renewable licenses.²³ A provision was made for practitioners to charge *ugxa* (consultation fees) between two, six, and ten shillings, and to charge for other services as well, if necessary. The exorbitant license fees (initially one pound, but which was later raised to three pounds) discouraged many from applying.²⁴ The restrictions placed against the practice of indigenous medicines were not sufficient for missionaries. In the early 1910s, the Natal Missionary Conference opposed (and worked for the reversal of) the decision to license indigenous medical practitioners.

Over the years, missionaries, the medical establishment and the pharmaceutical industry found common cause in the prohibition and marginalization of indigenous medical practice. Together, they put pressure on the state to curtail the practice. In 1912, the license fee for indigenous medical practitioners was raised three times and the chiefs (on whose recommendations licenses were renewed) were encouraged not to recommend renewal of licenses (Dauskardt, 1994). To stop *izinyanga* from competing with practitioners of "scientific" medicine and pharmacists, the Black Administration Act (No. 38 of 1927) formally restricted the advertising of indigenous medicines (Nesvag, 1999). The Medical, Dental and Pharmacy Act (No. 13 of 1928) was enacted to restrict the economic functions of herbalists (by recognizing biomedicines only) as well as to stop the activities of the organizations of indigenous medical practitioners, which sought to defend indigenous medical practitioners and to strengthen their position.

Competition between indigenous practitioners and the practitioners of "scientific" medicines and pharmacists had led to indigenous practitioners advertising themselves, through their "mail-order" advertising, as "doctors" and "chemists." Complaints and appeals to the state by modern medical practitioners and pharmacists resulted in Proclamation No. 168 of 1932, which prohibited *izinyanga* from "assuming the European title of 'doctor' or 'chemist'" and restricted the issuing of new licenses to the order of the Minister of Public Health.

The apartheid government, which came to power in 1948, continued with the steps of the previous governments. The Witchcraft Suppression Act (No. 3 of 1957) re-established the government's position of recognizing indigenous medical practice as part of the "cultural heritage" of Africans and the suppression of the practice of divining.²⁵ The Pharmacy Act (No. 53 of 1974) was passed to protect pharmacists from competition from indigenous pharmacists ("herbalists").²⁶ The Medical, Dental and Supplementary Services Act (No. 56 of 1974) was introduced to replace the Medical, Dental and Pharmacy Act (No. 13 of 1928). The Homeopaths, Naturopaths, Osteopaths and Herbalists Act (No. 52 of 1974) was passed to regulate the activities of medical practitioners who were not officially considered to be doctors or pharmacists. The Associated Health Services Act (No. 63 of 1982) established the Associated Health Service Professions Board to control homoeopathic activities.

There are three major consequences of the actions of the missionaries, the medical and pharmaceutical industries, as well as of the state. The first was that the prohibition of *izangoma* meant that each *inyanga* had to do his own divining.²⁷ Also, some *izangoma* applied for licenses as *izinyanga* (Berglund, 1976: 190)²⁸ and had to prescribe medicines for the ill and injured.²⁹ Second, the practice of divining was driven underground, and in urban areas—despite gallant resistance from some of the members—even *izinyanga* were eventually marginalized. The marginalization of *izinyanga* and the driving underground of *izangoma* impressed upon African practitioners the need to protect their practices. Therefore, from as early as 1930, indigenous doctors Solomon Mazibuko³⁰ and Mafavuke Ngcobo established the Natal Native Medical Association (later known as the Natal Inyangas Association), which sought to protect the interests of indigenous practitioners as well as to campaign for the acceptance of indigenous medical practices.

It is in the light of the foregoing discussion that Vachon's (1983) caustic remarks regarding the development mission become understandable:

our sanctimonious missions of civilization, development, conscientization, modernization, social change, democratization, liberation, social justice and even of co-operation and international solidarity, are often Trojan horses vis-à-vis the traditions of Africa, Asia and the Americas. It is in the sense that, in the name of literacy, the oral traditions of the local people are destroyed; in the name of agricultural reform, of the best distribution of land, wages and full employment, we destroy their original, non-monetary economic culture which is bound in a co-operative partnership with Mother Earth; in the name of our democracies, we destroy their *dharma*-cracies; in the name of the acquisition of national sovereignty and the Nation State, we destroy their anti-state organizations; in the name of a democratic taking of power, we destroy their original consensual political culture of leaders without power;

that finally, in the name of human rights, we destroy their traditional judicial world which sees man not as a subject of rights but primarily as a subject of grace, of gratitude and cosmic responsibility (Verhelst, 1987: 18).

And, in the name of "scientific" medicine, indigenous systems of medicine have been systematically undermined and destroyed, with far-reaching consequences.

SUBVERTING THE "TROJAN HORSE"

The efforts to marginalize African religion, customs, and practices were not completely successful. While the destruction of the old ways of life facilitated labor, education, and Christianization, as well as distanced Africans from their systems of medical practice, resistance to such destruction, albeit disarticulated by disembeddedness, was relatively successful. The success was in large part due to the socioeconomic conditions of Africans. However, in order to respond to the changed conditions of Africans, indigenous medical practice and medicines had to be transformed. This section highlights the socioeconomic conditions of Africans that led to the successful resistance of indigenous medical practice and the conditions that led to the transformation of the practice.

The socioeconomic and socio-political environment from the mid 1980s to the mid 1990s produced high levels of political violence and violent crime (Sitas, 1986; Mare and Hamilton, 1987). The economy was in a recession³¹ and consequently many people lost their jobs while many others could not find work.³² The drought during this period seems to have pushed large numbers of people out of rural areas to seek opportunities in urban areas.³³ The political conflict between the two main political parties in KwaZulu-Natal, coupled with the rising level of property crimes owing to the poor economic conditions, left most people feeling vulnerable (Mare and Hamilton, 1987: 181–216). Consequently, the demand for indigenous medicines to be used as protection against the consequences of the recession, as well as against crime and violence, increased. Such demand resulted in changes in indigenous medicines themselves. Medicines were improved and made to respond to the new socioeconomic and socio-political conditions of Africans at the time.

There were two notable sets of changes that occurred. The first set of changes related to the use of indigenous medicines. The second set of changes related to the practice itself. This discussion is limited to medicines used to procure employment and to protect property and oneself from both physical and metaphysical harm.

New medicines in old bottles

Changes in the use of medicines reflected the manner in which people felt vulnerable and the various needs for protection during a time when there were high rates of violence and crime and the state institutions seemed unwilling or unable to address their concerns.

A job by any means

The first set of changes had to do with people consulting practitioners. The recession saw large numbers of people losing their jobs as well as many being put on reduced-time. The numbers of the jobless swelled as recent graduates failed to find employment. It became harder and harder to find employment, particularly permanent employment. Those who were looking for work could rely on the extra advantage that indigenous medicines gave them to find employment. For instance, there were medicines to make one attractive to employers. Since during this time better-educated Africans could apply for employment—which meant that they could be called for interviews, many used indigenous medicines, such as *isimatisane* (*Odenlandia corymbosa*),³⁴ not only to make themselves attractive to employers but also to enable them to "sweet-talk" them. *Isimatisane* and love charms were used by those who were lucky enough to be employed and who still wanted to keep their employment.

Also, known forms of medicines were modified to respond to new conditions, and new medicines, which did not exist before, were developed to respond to such conditions. An example of a known medicine that was modified for use in the new environment was medicine used in courting women. Normally, young men would break a small piece off of the medicinal root and keep it under his tongue while talking to a woman. The medicine was supposed to make his voice sound musical to the woman and thus make the woman fall in love with him. During the 1980s and 1990s, the same medicine was prescribed for people going for interviews. At interviews, the medicine was expected to make the voice of the interviewee sound musical to the interviewers and, in this way, make them choose the person for the job.

The following case reveals that people in troubled relations with their employers seek solutions from indigenous medicines, as well as the potential threat to indigenous healers when their medicines fail to produce the desired results.

A Mpumalanga security guard is reported to have gunned down a 78 year-old traditional healer, Mrs. Eldah Mokoena, and critically wounded her supplier, the 70 year-old Mr. Nelson Sibiya, after claiming that Mrs.

Mokoena gave him the wrong "medicine." The man had problems at work that affected his relationship with his employer. He wanted "medicines" to help him improve relations with his employer. Mokoena is supposed to have told the man that, if he washed himself with the "medicine," the relationship with his employer would improve. Police spokeswoman, Sergeant Thabisile Gama, reported that the "medicines" "apparently did not have the desired effect, and in a rage, the man went to Mokoena's home and accused her of witchcraft, [. . .] shot her four times, killing her instantly." He then went to Mr. Sibiyi's house, accused him of supplying the wrong "medicine," "fired seven shots hitting Sibiyi in the body and jaw." The man later handed himself over to the police and surrendered his 9mm pistol.³⁵

What is important in this case is that the man sought relief for his troubles in indigenous medicines. For him to have done so, he must have either witnessed or heard of indigenous medicines producing such relief. While the report does not mention the name of the "medicine" used, various medicines that in the past had been used to make men likeable to women were modified during the 1980s and 1990s to make people get and keep employment.

Property shield in the time of need

The high rates of crime and violence, as well as the seeming reluctance and inability of the police to curb it, led many to seek the powers of indigenous medicines to protect themselves as well as their property. It is during this time that medicines to protect such property as one's house and car, as well as one's family, proliferated. The case of Doom's car provides evidence for what people did when they lost their property and found that the police could not help them. Doom was born in Greytown and grew up in the Durban townships. After working for sometime, he started a taxi business with his co-worker, Zitha, a man from the Midland of KwaZulu-Natal. One day, Doom's taxi was stolen from his yard and he tried to use the help of indigenous healers to find it.

After trying a few "seers," a fellow taxi owner advised him to see a man from an informal settlement outside Umlazi. Doom was not encouraged when he saw the shack in which the man was living. However, since he had traveled a long way, he went in to see the man. The man was something between a *sangoma* and *umthandazi*. He used water divination but did not call the names of *Jesu* and *Mariya*. Instead, he called on Doom's relatives to help reveal where the car was. He gave Doom a calabash full of water and asked him to look for his car in the water. When Doom looked at the water, he saw a "picture" of a white minivan parked under a red plastic port behind a shack. After some discussion and after the man had consulted his own ancestors, the

man asked Doom to accompany him to go get the car. Doom was surprised at this since most "seers" only tell you where you can find your property.

They took a taxi to Durban and then to Inanda. After traveling on foot a long distance from where the taxi had dropped them, they came to a ravine across which was the red carport, but the minivan was not under it. They asked a woman who was washing clothes at a tap nearby whether she had seen a white minivan parked under the red carport. She said that the driver of the minivan was her younger brother and that he was a "troublemaker." She even told them that she suspected that her brother and his friends had stolen the minivan. They told the woman that the minivan belonged to Doom. On their way back, Doom reported the matter to the police in Inanda, who told him that there was nothing they could do since he (Doom) did not know where the thief was. When he got to Umlazi, he again reported the matter to the police, who told him that the matter was outside their jurisdiction. After numerous attempts of staking out the red carport, neither Doom nor Zitha managed to get the minivan back. On one of their visits, they discovered that the minivan had been chopped up and sold for parts. The two front doors under the red carport told the story.

During the mid-1980s and the early 1990s, when violent crime engulfed large parts of South Africa, people who lost their property could not rely on the police. Indigenous medical practitioners served both to protect people's property as well as to find it when lost. In the case above, Doom found out what happened to his car although he did not find either his car or the man who stole it. If Doom wanted to punish the person who stole his minivan, he would not have gone to the police. The police had already demonstrated their impotence to him. Like many others, he would have both sought out and punished the person himself, assisted by either relatives or friends, or he would have sought such assistance from the powers of indigenous medicines.

The body of iron

The ubiquitous crime and violence that seemed poised to strike at any person anywhere impressed on many the need for protection should they become victims of crime and violence. One way in which this was done was to use *intelezi* to ensure that bullets would not penetrate a person's body. *Intelezi* was used to strengthen and protect warriors during wars. In the 1980s and 1990s, it was used to protect ordinary people from violence. The case of Madlangala, who needed protection from some people who wanted to take his house, provides evidence for the use of medicine to protect both one's body and house. Madlangala and his wife were asked by an elderly neighbor to look after her because she could not look after herself. To thank them, she bequeathed her only possession, her house, to them. The woman passed away a year and seven months after the date of the will. After the woman

passed away, her niece came, claiming to be the woman's daughter, and demanded to get the woman's body so that she could get it buried. After about a week of arguing, Madlangala gave the body to the niece.

A week later, the niece came to claim the house. When Madlangala refused to vacate the house, she went away threatening to return with "people who would force you out." Fearing for his family's well-being, Madlangala and his family consulted an *inyanga* in Stanger, who told them that, if the threat was real, they, together with their house, needed protection. Their bodies were strengthened with the application of medicines into incisions that had been made on all the major joints of their bodies. He then promised them to come to strengthen their house as well as the old woman's house the following weekend. He indeed came on a Saturday evening of that weekend. After dark, he began by sprinkling "fortified medicine" inside and outside of Madlangala's house. He then buried some of the medicines in the four corners of the house. They went to the old woman's house at the corner where he repeated the same process. He then promised them: "no one will touch you now."

The following Thursday the woman arrived at the house with three minibus vans. Six men clad in long overcoats—a mark of armed men during the heyday of armed attacks on people's houses—disembarked from the different cars and approached the old woman's house. By this time, Madlangala had asked his wife and children to go stay with relatives at Umlazi. (His wife refused to leave but sent the children to the relatives.) He had told some of the men from his village that he thought he would be attacked that evening. Four of the men came—armed with guns, one of which was given to Madlangala—to wait for the attack with him. The six men in overcoats came to the house and knocked. Their leader asked for a Mr. Mkhize's house. Madlangala asked them which Mkhize they were referring to since there were quite a few in the area. The leader said that the Mkhize they were looking for was a taxi owner. Madlangala told them that he did not know any Mkhize who owned taxis. The leader mumbled something about "the wrong house" and then they left, got into the minibus van, and took off.

According to Madlangala, the men were lucky because there was a gun pointing at each and every one of them. If they had tried to attack, none of them would have survived. He believes that what made them lose their plan to attack was the fortification of the house on the previous Saturday. He said that the fortification "confused them" and that "they babbled like babies." "We could have killed them all, and they would not have known what happened."

In this case, the fortification of Madlangala's family as well as his houses seems to have worked in protecting them from a planned assault. What

appears to have happened to the men who came in the minibus vans is commonly known as *ukudungeka kwengqondo* (befuddlement of the mind),³⁶ which is understood to be induced by certain types of indigenous medicines. In this case, it was used to protect Madlangala's family's property and lives.

New practices for new problems

Changes to the practice were evident in two areas. The hard economic conditions in rural areas coupled with the drought forced large numbers of women into the informal economy. Some of these women traded in ingredients used in preparing and producing indigenous medicines. On the other hand, the economic conditions in urban areas led many to establish themselves as "indigenous" healers when they had neither the training nor the know-how.

Chopping trees for survival

The second set of changes occurred in the practice of indigenous medicines. Economic conditions were difficult for most Africans in the mid-1980s and early 1990s but were felt even harder in rural areas that relied on remittances from people working in urban areas. Over the years, rural communities could resort to supplementing remittances with food grown in their fields. However, the drought of the early 1990s eliminated that option (Padayachee, 1997). It was during this time that many women, forced by poverty in rural areas, were catapulted into the "informal economy." Most women sold fruit and vegetables. But many started cutting indigenous medical plants for sale in urban areas. The entry of these women into the economy changed the nature of harvesting indigenous plants and the manner in which medicines were sold. Anyone could then buy medicines from the women in the Durban's established Muthi Market³⁷ and then set themselves up as indigenous healers. The sales of indigenous medicines proved very lucrative for many sellers.³⁸

According to *amakhosi* who participated in the 1915 hearings,³⁹ a healer or diviner traditionally found indigenous medicines through the help of his or her ancestors. Once the medicines had been found, rituals for harvesting—such as prayer and giving thanks to the ancestors—were performed. In most cases, the person would only harvest the part of the tree or plant (such as bark, leaves, roots, etc.) that he or she needed. The rest of the tree would be saved for future use. Medicines were harvested at particular times of the year, mostly during the time when harvesting would do the least damage to the tree or plant. The "just-in-time" nature of such use meant that people harvested only the medicines they needed.

However, the entry of large numbers of women who were only traders and not healers or diviners completely changed such a relationship with the

environment. Interested in the money they received for the medicines, praying to the ancestors for the medicines would not be the first thing that came to their minds. To lower their transport costs to urban areas, it became necessary for them to transport the medicines in bulk. Competition with others meant that medicines were harvested throughout the year and that the whole tree or plant would be harvested instead of its primary parts. Such processes resulted in the over-exploitation of indigenous medicines and threatened the survival of some species (Cunningham, 1992).

Charlatans and their magic cures

There were also people who entered the practice as practitioners when, in fact, they had not gone through the training or been called to the practice. The worsening economic conditions led many to set themselves up as indigenous medical practitioners. People who, for one reason or another, did not want to go to hospitals, were susceptible to being taken advantage of by such self-styled "traditional healers." The case of Mrs. Ndlovu shows how charlatans promised false relief to a woman suffering from cervical cancer.

Mr. and Mrs. Ndlovu were married for about twenty-nine years and had four children and five grandchildren. By and large, except for colds and the flu, they had not had any serious illnesses in the family, until Mrs. Ndlovu fell ill early in 1994. Initially she complained about a stomach-ache that kept her awake at night and did not seem to respond to painkillers. A neighbor suggested that she be taken to a hospital for examinations. She would have none of that. She feared that the doctors would say that she had either ulcers or, even worse, cancer, and that they would then operate on her.⁴⁰ Mr. Ndlovu also considered an operation as a dicey undertaking.⁴¹ They both agreed, instead, to see an *inyanga*.

After trying a few healers without success, Mr. Ndlovu was prepared to go to a Zanzibari *inyanga* who lived in Phoenix—an Indian township east of Kwamashu. He had been told that this *inyanga* had cured many people's illnesses. On the afternoon of the visit, Mr. Ndlovu came to ask me to accompany them to the *inyanga* in Phoenix. When we got to the *inyanga's* house in Phoenix, the *inyanga* was away. We had waited for about fifteen minutes when a new white 7-series Mercedes Benz arrived. I did not quite get to see what the *inyanga* looked like, since we were ushered into a waiting area before he got out of his car.

While we waited, I noticed a certificate that declared that the *inyanga* was a member of the United African Herbalists Organization. A card pinned next to the certificate boasted that the *inyanga* cured all sorts of illnesses and diseases, that even he cured AIDS and had medicine for "Lotto Luck" and "Casino Luck." When we went into his consulting room, the *inyanga* asked Mr. Ndlovu whether he wanted *ukubhula* (i.e., divination to find out what

the problem was with his wife and family]. Mr. Ndlovu agreed. He was to use *abalozi*⁴² to find out what was wrong with Mrs. Ndlovu and with Mr. Ndlovu's family. The *inyanga* then left the room and a boy (about 15) walked in. The young man started spraying and smearing concoctions on the small drums (situated inconspicuously at one corner of the room) through which the *abalozi* were to speak. After the spraying and smearing, the *inyanga* came in and the boy left the room. The *inyanga* then asked the drums to speak. After some time, a voice came through the drums greeting Mrs. Ndlovu. It was a raspy young woman's voice, which spoke slowly and deliberately. It told Mrs. Ndlovu what was wrong with her and that her condition was a result of a jealous neighbor. Mrs. Ndlovu asked how she could get help and the voice told her that the *inyanga* was going to help her.

Before we could leave, Mrs. Ndlovu was "strengthened against evil spirits" and given medicines to use at her house; Mr. Ndlovu had to pay R310.00 (R50.00 for divination and R260.00 for the rest). The *inyanga* guaranteed that Mrs. Ndlovu was going to be well within six days. This astonished me: no *inyanga* ever creates such stringent conditions for his or her medicine to work. Six days later, Mrs. Ndlovu's stomach pains were completely gone and the swelling in her legs was going away. But two days after that, her legs were swollen again. Mr. Ndlovu did not know what else to do. After further visits to numerous other "healers," Mrs. Ndlovu's condition did not improve. She was, eventually, admitted to a hospital in Durban, where radiation therapy was administered to her. However, she passed away not too long after admission to the hospital.

Mrs. Ndlovu's case reveals how some of the self-styled "healers" work. They claim to have solutions to all the problems that people present to them.⁴³ They invariably claim to have "medicines" that address people's shortage or lack of money, good luck, employment, and good social relations. Further, their charges are exorbitant. Quite a few have "certificates" that claim to be from some "association" or "organization" of "traditional healers." They are notorious for claiming to use human body parts in their medicines. Speculation over the use of body parts cast away in bushes, over which parts were used for what, as well as over the effect of such "medicines" captivated the nation in the early 1990s. The discovery of mutilated bodies (especially the bodies of children) during this time added to the increasing calls for the proscription of all forms of indigenous medical practice.

In sum, the period 1980–94 saw indigenous medical practice play a role in assisting Africans to cope, first, with the repression and, later, with the rise in crime and violence. Changes in the practice of indigenous medicines around this time pertained to the use of medicines to procure and keep employment, the use of medicines to protect oneself as well as one's relatives and property

from crime and violence, and to the proliferation of charlatans who preyed on a besieged, unsuspecting population. As this period drew to a close, there were calls for the proscription of the indigenous medical practice.

Calls to proscribe indigenous medical practice

People's increased resort to indigenous medical practice between the mid-1980s and early 1990s, coupled with the distorted coverage by a sensationalist mass media,⁴⁴ spurred interest in the practice from various quarters. Such interest led to a call to proscribe indigenous medical practice. The proliferation of charlatans and the seemingly burgeoning specter of "witch killings" and "muti killings" resulted in calls for the proscription of witchcraft, such as that made in the *Ralushai Commission Report* (discussed below).⁴⁵ During this period, numerous studies (such as that conducted by the Institute for Multi-Party Democracy) were conducted and conferences (such as the conference on the Witchcraft Suppression Act of 1957, called by the "Gender Commission") as well as hearings were held in order to determine the dangers of indigenous medical practice.

Most notable among the calls for some control over the practices of indigenous healers was the report of the Ralushai Commission. In 1996, after a spate of "witch killings," the Northern Province government instituted a commission of inquiry, chaired by Professor N. V. Ralushai, to investigate the reasons behind and the causes of the widespread "witch killings." The report presented a plethora of macabre practices in human mutilation, which some of the "traditional healers" supposedly practiced. Among the recommendations of the commission were 1) the institution of a code of conduct for traditional healers; 2) the liberation of people through education from belief in witchcraft; 3) the institution of different penalties for witches and those who sniff them out; and 4) the criminalization of the forced collection of money required to pay *izangoma*.

In 1998, the Institute for Multi-Party Democracy (IMPD) initiated a review of the Anti-Witchcraft Act of 1957 by talking to stakeholders in various communities, particularly the affected Northern Provinces. In 1999, the IMPD issued a discussion document entitled *Witchcraft Summit, Towards New Legislation*, in which it recommended and drafted a Witchcraft Control Act meant to replace the Anti-Witchcraft Act. Among the recommendations were the creation of "special witchcraft courts as appendages to the formal court system" to work with the Departments of Health and Justice, as well as the imposition of fines for people "making reckless or self-serving witchcraft accusations and on those found actually practicing witchcraft."

In 1999, the Commission on Gender Equality hosted the Legislative Reform Conference, which sought to make recommendations on the

reform of the Witchcraft Suppression Act of 1957. Among the key presentations made at the conference were those from Dr. Esther Njiro, the advocate Seth Nthai, and Professor Ralushai. Dr. Esther Njiro, the director of the Centre for Gender Studies at the University of Venda, presented a paper entitled "Witchcraft as Gender Violence in Africa," in which she argues that the "smelling of witches," who are mainly females, by youth (who are mainly males) is a form of gender violence (Njiro, 1999). Advocate Nthai's paper contrasted the manner in which previous governments had treated "traditional healers" and appealed to the government established in 1994 not to address its relations with "traditional healers" in the same manner (Nthai, 1999). Professor Ralushai briefly discussed the findings of the commission over which he presided in 1996.

The recommendations from the Ralushai commission, the IMPD's Witchcraft Summit, and the Commission on Gender Equality's Legislative Reform Conference were largely for controls to be exercised on the practices of indigenous practitioners, especially those accused of either practicing or "smelling" those who practice witchcraft. The recommendations included the establishment of traditional courts to adjudicate matters related to witchcraft, the establishment of traditional police to investigate witchcraft-related crimes, and the sentencing of people who practice witchcraft or those who "smell out" the witches.

Calls for the normalization of indigenous medical practice

The second response, however, appealed for the "normalization" of indigenous medical practice, pointing to the benefits that would be lost should the practice be banned. There were three aspects to the second response. First, the government instituted its own review of existing legislation that pertained to indigenous medical practice, such as the Anti-Witchcraft Act of 1957. On 4 August 1998, the Select Committee on Social Services tabled its report with recommendations relating to indigenous medical practice. One of the most important recommendations was for the "formation of a statutory national traditional medical council."

The second aspect of the second response was the establishment of "research centers" that sought to identify the biological properties and medicinal advantages of various indigenous medicines. Most notable among these was the establishment of a collaborative Medical Research Council-supported project between the pharmacology departments of the Universities of Cape Town and the Western Cape to test plants supplied to them by indigenous healers for medicinal qualities.⁴⁶

The third aspect on the second response was an attempt by practitioners to institutionalize indigenous medical practice.⁴⁷ First was the establishment of

indigenous medical hospitals. In Durban, five "Traditional Hospitals" were established between 1994 and 1998. Since the "traditional hospitals" did not get subsidies from the government and relied only on fees paid by patients, they soon found it difficult to continue operating. Owing to lack of funds, all five hospitals had ceased to function by the year 2000. Second was the acceptance of indigenous medical practice by some employers and the agreement to allow indigenous medical practitioners to claim against medical aid funds.⁴⁸ Third was the establishment of the KwaZulu-Natal Traditional Healers' Council (KZNTHC). The KZNTHC brought together various Traditional Healer's Associations from KwaZulu-Natal.⁴⁹ One of its major functions is to give practical tests to its members before they are issued with the Health Ministry-recognized "certificates of competence" as well as "membership cards."⁵⁰

In sum, the socioeconomic conditions of Africans and the lack of support from state institutions were such that Africans had to rely on the protections of indigenous medical practices. The proliferation of charlatans during this time led to calls for the proscription of witchcraft, which to many meant the proscription of indigenous medical practice. The call for proscription was accompanied by a call for the normalization of indigenous medical practice. The process of normalizing indigenous medical practice was supported by the state, some research institutes, and the practitioners themselves.

CONCLUSION

This chapter has argued that agents of modern development sought to marginalize the medical practices of Africans. Such agents included, but were not limited to, missionaries, the medical and pharmaceutical establishments as well as the state. The marginalization they sought was implemented through the processes of labor, religion, education, and law. While the attempts at marginalization achieved some success, they also faced resistance. For our purposes, resistance took the form of people either refusing to be converted or tampering with the Christian message by inserting African religious and cultural practices. Such practices included the use of indigenous medical services.

What contributed greatly to the successful resistance was both the non-responsiveness of state institutions to the needs of Africans as well as their socioeconomic conditions. However, the practices of the mid-1980s to the mid-1990s were such that calls were made for the proscription of witchcraft. Since no distinction was made between indigenous medical practice and witchcraft, all forms of indigenous medical practice were threatened by such calls for proscription. One response to such calls was a different call, one for the "normalization" of indigenous medical practice.

The "normalization" of indigenous medical practices has thus far meant the normalization of the practices of *izinyanga* and the shunning of the practices of *abathandazi*. The Select Committee recommended the exclusion of *abathandazi* (Christian spiritual healers) "because they are not traditional in nature and their training and accreditation is unclear and ill-defined." The exclusion of *abathandazi* was rooted in the lack of knowledge and understanding of their practices by the Select Committee. Was this not the main reason for the exclusion of *izangoma* by previous legislation? Thus, we have gone full circle from the Natal Code of Native Law (No. 19 of 1891), which legalized the practices of *izinyanga* and banned the practices of *izangoma*. However, today, while the practices of *izangoma* are accepted, the practices of *abathandazi* are banned. This is despite the work done on the value of the practices of *izangoma* and *abathandazi* in diagnosing the causes of illness, in resolving psychiatric disorders, as well as in treating mental illness.⁵¹

The normalization of indigenous medical practices may produce far-reaching changes in the practice of indigenous healing. However, not only is such "normalization" based on an old understanding of indigenous medical practice, and fails to take account of its transformations and commodification, but it is also predicated on indigenous medical practitioners subjecting themselves and their practices to "scientific" tests. Such a view presupposes the superiority of one form of medical system over another. While there are fields in which "scientific" medicine is far superior to indigenous medicine, there are other fields in which indigenous medicines are unrivalled. Therefore, the medical emancipation of Africans from unnecessary suffering will be realized when indigenous medical practice is recognized and accepted as a form of medical help in its own right and as an occasional alternative to "scientific" medicine. Such recognition should include the establishment and support of necessary institutions and facilities for indigenous medical practice. The social emancipation of Africans will be assured when their cultural practices are allowed to flourish and be useful to them if and when Africans deem so.

The lack of communication between the two systems, which owes its origin to the reluctance of "scientific" medicines to interface with indigenous medicine, is such that people in South Africa suffer and die from illnesses and diseases that might be mediated and cured were the two medical systems to combine their efforts or, at least, to recognize each other. The benefits that Gumede (1990) and others have reaped from their collaboration with indigenous healers remain accessible only to the maverick fringe and assist only those desperate enough to try anything. The program in which indigenous healers and "scientific" doctors cooperate in the healthcare of the residents of the ODI District (run by Associate Professor D. J. Oberholzer of the University of Pretoria's Department of Psychiatry) was certainly groundbreaking (Ober-

holzer, 1985). As such, despite the successive reports of the World Health Organization (1978 to 1983) on collaboration between the two fields of medicine, the South African public continues to be denied the benefits of such collaboration as well as other related medicines and treatment.

The losers in this are the users of indigenous medicines who, unlike the users of "scientific" medicines, which benefit from state subsidies for research and development, solicit the services of a system that has been suppressed, undermined, never funded, and not properly researched. The effect of marginalization is that some of the accumulated knowledge of cures remains unresearched, poorly developed, and continues to be lost.⁵² As a result, some of the users of indigenous medicines continue to die unnecessarily from curable diseases. Their emancipation lies in the establishment and support of institutions for the research, development, and propagation of appropriate indigenous medical practices.

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Notes

- 1 The "South" refers to the group of African, Asian, and Latin American countries considered to be at various stages of the development trajectory followed by the "North."
- 2 The "North" refers to the countries of Northern Europe and North America that are considered to be far ahead of others in the development trajectory. This group of countries includes Japan, Australia, and New Zealand. These countries are sometimes referred to as the "West."
- 3 Marglin maintains that "once people are reduced to quantifiable targets, it is difficult to take their freedom seriously" (Marglin and Marglin, 1990: 140).
- 4 This paper uses examples found among *AmaZulu*. Similar examples are found among other African ethnic groups.
- 5 Plural for *sangoma*.
- 6 Plural for *inyanga*.
- 7 Something that is denied to the patients at "scientific" institutions.
- 8 *Emakheheleni* literally means "at the place of the grandfathers or ancestors."
- 9 Indigenous medical practice also had a darker side. *Abathakathi* (who were variously referred to as wizards, witches, witchdoctors, etc. by missionaries) used their knowledge of indigenous medical practice to harm others or to help those who wanted to harm others (Bryant, 1966; Douglas, 1970; Marwick, 1970; Niehaus, 1995; Ashforth, 2000).
- 10 These are the words of the High Commissioner for South Africa and

- Governor of the Transvaal and Orange River Colony from 1905 to 1919, Lord Selborne (in Magubane, 1979: 62). On the new wants of Africans, see also Schapera, 1947: 122.
- 11 This form of direct taxation—which did not distinguish either by ability to pay or by age—was paid by no other group of people in South Africa (Jabavu, in Schapera, 1967: 286).
 - 12 See Marglin (1990: 217–282) for a discussion of how Judeo-Christian and Greek traditions disembed meaning from work.
 - 13 This does not necessarily mean that the missionary and the industrialist always saw eye to eye. In fact, they sometimes got in each other's way.
 - 14 A report in the newspapers found that clothing was "dangerous to the Native" because it "deprived them of the vitamins from the sun which are lacking in their diet." (*Daily News*, 6 December 1937).
 - 15 One of the slogans of workmen in the streets or on railway lines goes: "Abelungu o swine. Basibiza ngo Jim." Literally, "White people are swine. They call us Jims" (i.e., they give us English names).
 - 16 Without the state weakening and corrupting African institutions of rulership and administration, and without the state forcing Africans through the "gates of misery" (Atkins, 1993), missionaries would have found a much more resilient population supported by strong and vibrant institutions.
 - 17 The singular for *amakhosi* is *inkosi*.
 - 18 The singular for *izinduna* is *induna*.
 - 19 To be sure, medical missionaries provided an invaluable service to Africans when the state did not concern itself with their medical needs.
 - 20 Ari Sitas (1995: 77, 85) tells the story of Phumelele Nene (a Christian) who, when the crop she had planted wilted, sought answers from, among many sources, an *inyanga*. Of relevance here is that someone who was a Christian had consulted an *inyanga*.
 - 21 Schools normally started with prayer (usually "The Lord's Prayer") and ended with prayer. The teaching was infused with Christian beliefs and morality, to which students were expected to adhere or, at least, to behave as though they did.
 - 22 For similar reasons, doctors of western medicine opposed the training of Africans in Western medicine.
 - 23 Natal was the only province that allowed the licensing of *izinyanga*.
 - 24 Among the reasons for licensing was a combination of raising funds for the colonial government, limiting the number of practitioners, and pressure from the white population for curtailment.
 - 25 See also Gumede, 1990: 135.
 - 26 In order to attract more customers, some herbalists had been found to also stock "scientific" medicines.
 - 27 Normally, *izangoma* are restricted to divining and *izinyanga* are restricted to prescribing cures.
 - 28 See also Preston-Whyte and Beall (1985: 31) who provide evidence of a male *inyanga* who petitioned against female *izinyanga* being granted licenses.
 - 29 Combining the two practices proved lucrative during the time when license fees were becoming prohibitive. Because the person would normally be proficient in one or the other practice, increasing fuzziness and slippage

increasingly characterized the practice. The practice of combining the two aspects of treatment has survived to this day and is one of the main reasons for the proliferation of charlatanry.

- 30 Indigenous doctor Solomon Mazibuko became the life president of the association until his death in 1986, at 116 years of age, when he was buried at his residence in Ndedwe district. He was a veteran of two wars, the South African War and World War I, during which he served in France (Gumede, 1990: 179, 217).
- 31 *South African Reserve Bank Quarterly Bulletin* (June 1995).
- 32 *South African Reserve Bank Quarterly Bulletin* (March 1994).
- 33 The severity of the drought was such that South Africa received an IMF Compensatory and Contingency Financing Facility of \$850 million to support "the balance of payments following decline in agricultural exports and the increase in agricultural imports caused by the prolonged drought" (Padayachee, 1997: 31-32).
- 34 Hutchings (*et al.*) says that the leaves of *isimatisane* are chewed as protective charms when passing the hut of an enemy (1996: 294).
- 35 *Independent on Line*, 29 March 2000, and *African Eye News Service*.
- 36 There are numerous other examples of what happens to people who are exposed to this condition. These include attackers who search in vain for houses that have "disappeared" and others who find inanimate objects (such as pools of water or forests) where they expect to find houses. In some cases, the attackers find themselves shot at from the "pool" or "forest." Bryant (1966) mentions *izimpundu* as the medicine that was used to confuse *abathakathi* (19-20).
- 37 A market for indigenous medicines at *eMatsheni*, which was situated at the Victoria Street beer hall, was closed by the Durban Corporation in 1920 after complaints from doctors, pharmacists, and *amakhosi* (traditional leaders). (See the Chief Native Commissioner's report CNC-193-149/1915). Today's "Muthi Market" on Russel Street over the Warwick Junction was started in 1990 and formalized in 1998.
- 38 In 1997, the Provincial Minister of Traditional and Environmental Affairs estimated that trade in indigenous medicines in the province was worth R61 million a year (*Daily News*, 14 May 1997).
- 39 See the Chief Native Commissioner's report (CNC-193-149/1915).
- 40 The Zulu word for an operation is *ukuhlinza*, a word that is also used to refer to the act of killing and cutting open a cow, goat, or sheep.
- 41 People in the township normally hear of an operation only when something has gone wrong. There is not much interesting and, therefore, worth talking about in the case of an operation that went without a hitch.
- 42 Africans believe that the spirits of the dead live among us and that the dead, who know all and see all, can be conjured to speak to the living. The use of *abalozu* (ventriloquists) is one way of conjuring the dead.
- 43 In fact, by and large, this is a measure of someone who is not very helpful to the people who consult him or her.
- 44 An article entitled "Human parts that heal," based on hearsay, provides an example of how the alleged practices within a small community can be presented as though they applied to the whole country (*Mail & Guardian*, 9 Dec. 1994). Another article had prices for various body parts (*Mail & Guardian*, 9 October 1998).
- 45 Since many people could not distinguish between witchcraft and indigenous medical practice, such calls were understood to refer to the proscription of indigenous medical practice as well.
- 46 The project is popularly known as the 50-50 project because royalties will be shared equally between the universities and people providing the plants (*Mail and Guardian*, 5 March 1998).
- 47 Such attempts became possible because the Select Committee on Social Services, which reviewed the *Anti-Witchcraft Act* of 1957, recommended the institutionalization of traditional medical practice.
- 48 In its investigations, the Select Committee found that the electricity-providing para-statal (Eskom) was reported to be recognizing medical certificates from indigenous medical practitioners (*Select Committee on Social Services Report*, 4 August 1998).
- 49 Although the relationship is not clearly delineated presently, the KZNTHC is likely to be the KwaZulu-Natal organ of the "Statutory National Traditional Healers Council," the formation of which was proposed by the *Select Committee on Social Services* in 1998.
- 50 Chavunduka (1992: 70) suggests that certification will be a sure way to prevent charlatans from operating.
- 51 See, for instance, among others, Chavunduka (1992: 70-71), Peek (1991), Kiev (1964) and Maclean (1971).
- 52 A good example here is the knowledge of traditional birth attendants, which has been usurped by "scientific" medicine.