NEGOTIATING HEALING: THE PROFESSIONALISATION OF TRADITIONAL HEALERS IN KWAZULU-NATAL BETWEEN 1985 AND 2003

By

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DECLARATION

This dissertation denotes original work by the author and has not been submitted in any other form to another university. Where use has been made of the work of other authors and sources it has been accordingly acknowledged and referenced in the body of this dissertation.

The opinions expressed and the conclusions attained in this work are those of the author and are not necessarily to be attributed to the School of Development Studies.

Signature.....

Date.....

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
FAO	Food and Agricultural Organisation of the United Nations
HBC	Home Based Care
HBC	Human Immunodeficiency Virus
IFP	Inkatha Freedom Party
INA	Inyangas' National Association
INR	Institute for Natural Resources
KZN	KwaZulu-Natal
PHC	Primary Health Care
SAMDC	South African Medical and Dental Council
SEWU	Self Employed Women's Union
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
THO	Traditional Healers Organisation
THP	Traditional Health Practitioner
WHO	World Health Organisation

Traditional healers are one of the few groups in South Africa practising and maintaining African culture and history. Traditional healers therefore have to teach people about African culture, as well as HIV/AIDS, drug abuse and about loving the soil and using the soil to plant food, herbs and to grow livestock.

Ernest Gwala, KwaZulu-Natal Traditional Healers Council

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Introduction

This dissertation documents and analyses the professionalisation of traditional healers in KwaZulu-Natal between 1985 and 2003, focusing on the formation and development of the KwaZulu-Natal Traditional Healers Council as a case study.

After a long history of marginalisation, Traditional Health Practitioners (THPs) are starting to be recognised as an invaluable resource necessary for the health of South Africa's people. This emerging recognition has opened up exciting new opportunities for collaboration between traditional healers and western medicine, particularly as government and civil society confront the HIV/AIDS pandemic. New possibilities for collaboration between traditional healers and biomedicine are also being explored as botanists and scientists take a renewed interest in traditional plants and indigenous knowledge systems.

New threats and challenges, however, have also accompanied these new opportunities. The unequal relationship between traditional medicine and biomedicine has made traditional healers concerned about being subordinated to biomedicine in the national health care system. Traditional healers are also concerned that western researchers and pharmaceutical companies will exploit traditional medicines for their own benefit, and that the traditional healing community will receive little acknowledgement and remuneration for sharing their knowledge.

Moreover, traditional healing has come under renewed attack for encouraging harmful and destructive practices. For example, traditional healers have been accused of spreading the HIV virus through sharing razor blades between patients. They have also been accused of perpetuating the belief that sleeping with a virgin will cure a person of HIV/AIDS.

Although a significant amount of literature has been produced on the cosmology of traditional healing, and on collaboration between western medicine and traditional healers, very little research has been produced on the politics of indigenous healing, particularly the organisation of traditional healers and the movement towards the professionalisation of traditional healers in South Africa. The first objective of this dissertation is to begin to fill this gap by exploring how traditional healers in KwaZulu-Natal are using professionalisation, and claims to a professional identity, to respond to these new opportunities and challenges. The second objective of this research is to assess and analyse how successful traditional healers have been at achieving professionalisation, and at using professionalisation to secure new forms of recognition, new benefits and opportunities.

The first chapter of this dissertation provides a literature review while the second chapter goes on to outline the methodology of this research. Chapter three gives an historical contextualisation of the development and transformation of indigenous healing practices from the period of colonial contact. It looks at the historical roots of professionalisation amongst traditional healers in KwaZulu-Natal, exploring how competition between the white biomedical community and African healers encouraged the early organisation and professionalisation of African healers in the 1930s. The purpose of this chapter is to link the professionalisation of traditional healers today to a deeper historical struggle, whereby healers have used organisation, and claims to a professional status, to try and gain formal recognition and to protect their rights as health professionals. This chapter concludes by looking at how the unequal power relationship between traditional medicine and biomedicine has marginalised traditional healing and forced traditional medicine out of the city of Durban into the invisible and unregulated spaces of the informal economy.

Chapter four opens by tracing the re-emergence of traditional healing practices in Durban city since the mid 1980s. This chapter focuses on how a

process of struggle and negotiation over the establishment of a new market for traditional medicines in Durban has facilitated the organisation of the traditional healing community in KwaZulu-Natal. More broadly, the chapter looks at how the changing context of Durban, and the changing context of local governance in the late and post-apartheid period, has created an environment which has enabled traditional healers to organise and to work towards the formation of the KwaZulu-Natal Traditional Healers Council.

Chapters five and six both evaluate the progress made by the KwaZulu-Natal Traditional Healers Council as a professional body responsible for unifying, regulating and promoting traditional healing practice.
Chapter five describes the formation of the KwaZulu-Natal Traditional Healers Council, and analyses some of the key priorities and objectives of the Council. It argues that the Council's focus on a number of specific traditional and contemporary issues reveals the way in which traditional healers in KwaZulu-Natal are reaffirming an older identity, as well as reconstructing a newer and broader identity and sphere of practice, as traditional healers. Chapter five also evaluates two key problems within the Council, namely, the absence of an effective organisational structure and a general lack of capacity, which are preventing the Council from fulfilling its function as a professional body.

Chapter six looks at traditional healers' responses to the Council, exploring the reasons for traditional healers' support or opposition to the Council. The chapter emphasises that there are a number of divergent and conflicting views and attitudes within the Council and that these are a source of weakness and disunity within this body. The chapter goes on to argue that there is a tension between the more elitist herbalist- orientated leadership of the Council and muthi traders and traditional healers, and that this tension appears to correlate with gender and class divisions in the Council.

Chapter six also assesses the Council's relationship with the government and the Department of Health. This chapter argues that subtle differences

between the official function of the Council, and the complex and broader function expressed by its leadership, reveal tensions in the way government and traditional healers themselves understand the role of the Council and how far its authority and responsibilities should extend.

At present the KwaZulu-Natal Traditional Healers Council is still a new institution and in the early stages of establishing and developing itself. Its members and leadership are emerging from a history of marginalisation and have not had the opportunity to develop their practice and their organisational skills. The KwaZulu-Natal Traditional Healers Council, like other institutions of a similar nature, will take time to develop. Evaluating the progress made by the Council requires a longer- term framework. The focus of this research is to evaluate how the Council has approached and conceptualised its official responsibilities and problems as a professionalising body, and how it is developing the capacity and organisational structure to fulfil its responsibilities and resolve these difficulties.

The professionalisation of traditional healers creates new possibilities for traditional healers to participate in rebuilding the health of South African society. At present this process of professionalisation is still being negotiated in the realm legislation and discourse. The challenge lies in successfully implementing this process of professionalisation. The ability of the KwaZulu-Natal Council to successfully implement this process will play an important role in enabling traditional healers to engage in building and maintaining the health of South Africa's people.

Chapter 1: Literature Review

1.1 Introduction

> [I]n South Africa the right to health, and to define exactly what is meant by healing is contested. This is because there exist differentiated conceptions of health, and concomitantly differentiated systems of care and practice (Véronique Faure, 2002:2).

As this quote by Véronique Faure suggests, healing practices are not 'given', rather, they are negotiated within a particular cultural and technological paradigm, and contested by alternative or competing practices. Health and healing practices are infused with power relationships as different systems of healing compete and interact with each other. In South Africa, as in most of the world, the professional structure of biomedicine has enabled this particular paradigm of healing to dominate over other healing practices. This chapter begins by outlining the professionalisation of western biomedicine, showing how the very unequal power relationship between traditional healing and biomedicine in South Africa has led to the historical marginalisation of traditional healing. Over the past thirty years, however, this balance of power has slowly been changing in a number of African countries. This chapter describes the factors that have led to a positive change in both international and local attitudes towards traditional healing. Growing local and international awareness and recognition of traditional healing has contributed to the professionalisation of traditional healers across the African continent and more recently in South Africa. The final part of this chapter draws on a body of literature concerned with traditional healers, and various aspects of traditional healing in South Africa, to contextualise the transformations taking place in traditional healing as it moves towards professionalisation, and to understand how local and national factors have shaped this process of professionalisation amongst traditional healers in KwaZulu-Natal.

1.2 Defining traditional healing

A traditional healer is somebody who engages in indigenous medical practice. According to Xaba, indigenous medical practice "refers to the practices that izinyanga, izangoma and abathandazi...engage in when they treat people who come to them with physical, social and psychological problems" (Xaba, 2002:24). These practices are considered indigenous "not because they can be traced to a time in the distant past but because, to effect them, the practitioner invokes African conceptions of cosmology and cosmogony" (Xaba, 2002:24).

A number of terms are used to describe traditional health practitioners in South Africa. Some of the most commonly used terms are 'traditional healer', 'indigenous healer' and 'traditional health practitioner (THP)[1]. These terms provide a useful way of understanding and defining traditional healers as a single body. However these terms are also problematic because they group together a number of different kinds of traditional health practitioners, suggesting a singular history and identity for traditional healers. A deeper understanding of these terms must acknowledge that there are differences and contestations within the collective category of traditional healers.

In working towards a set of definitions that encompass a traditional healer, I have tried to draw on the terms traditional health practitioners themselves use to understand and define their identity. The Zulu term for indigenous healers is Abelaphi Bendabuko (Personal communication Ernest Gwala, 18 July 2003). According to the Constitution of the KwaZulu-Natal Traditional Healers Council; Abelaphi Bendabuko consists of three types of traditional healers. The first type of healer is known as a sangoma[2]. The sangoma, who is normally a woman, fulfills the role of a diviner. Izangoma specialize:

> in spiritual incantation to identify causes of disease, ill-omen and ill health of individuals. They indicate natural or supernatural ways to

[1] These terms are use interchangeably in this dissertation.

> health and constantly seek a certain pattern of behaviour to be followed by the individual to ensure a cure. They attend to the psychological needs and well being of individuals in the community[3].

Nowadays, however, many izangoma also function as izinyanga[4], the second type of healer. This type of healer, who is usually a male, is a herbalist who prepares and dispenses muthi. An inyanga:

> Specialise[s] in the use of herbs and certain animal parts (muthi) to treat diseases and illnesses. ...Treatment includes ensuring good luck, the success of crops in the fields, the health and well-being of cattle and the success of individuals in their daily endeavours[5].

Abathandazi or faith healers make up the third category of healer. "They invoke treatment through prayer", often over items used by the affected person, such as clothing. They can also administer simple remedies such as holy water. Faith healers "are not confined to the treatment of diseases only but extend to other personal and individual endeavours"[6].

The category of traditional healer also encompasses several other types of healer that are not included in the KwaZulu-Natal Council's definition. One of these is the Traditional Birth Attendant (TBA) who performs the functions of a midwife. Some izangoma are also TBAs but this role tends to be subsumed by their identity as izangoma. Traditional surgeons comprise another category of healers. Their central function is to perform the circumcision of male initiates.

There is one other group of traditional health practitioners, which I have chosen to include in the category of traditional healers. This group consists of individuals who collect and trade muthi, which is traditional medicine. Imithi or

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[2] The plural of sangoma is izangoma.
[3] Constitution of the KwaZulu-Natal Traditional Healers Council, 2001, Chapter 3, Clause 2.
[4] Izinyanga is the plural for inyanga.
[5] Constitution of the KwaZulu-Natal Traditional Healers Council, 2001, Chapter 3, Clause 2.
[6] Constitution of the KwaZulu-Natal Traditional Healers Council, 2001, Chapter 3, Clause 2.

muthi refers to the medicinal plants and animal parts used in traditional healing such as herbs, bark, bulbs, fat of animals and other animal body parts. Muthi can be used to produce both healing and destructive results.

Muthi traders provide a service similar to that of a pharmacist, although a number of traders also conduct consultations and mix medicines for clients. Some muthi traders have not undergone formal training as traditional healers, but they generally have a significant amount of informal knowledge about traditional medicines[7]. Muthi traders are important health care providers and they play a significant role in the politics of traditional healing in KwaZulu-Natal.

Traditional healers such as izinyanga, izangoma and abathandazi very clearly disassociate and distinguish themselves from abathakathi and charlatans. Abathakathi are witchdoctors and sorcerers who prepare medicines to produce destructive and harmful results. Charlatans are individuals, often pretending to be trained healers, who mislead clients by claiming "to possess powers that they clearly do not" (Xaba, 2002:24).

1.3 Towards a definition of professionalisation

Michel Foucault's writing (1987) on the relationship between knowledge, discourse and power offers an insightful way of understanding the dynamics behind the professionalisation of medicine in Britain and the United States. The professionalisation of medicine in Britain and the United States is intricately linked to the development of an elitist body of medical knowledge and a particular set of discourses about the body, about race, gender and medical technology. Western doctors' access to this body of knowledge and their participation in shaping this particular set of discourses around health and the body, has enabled these doctors to establish themselves as a

[7] The term muthi trader or muthi gatherer is used to refer to traders who have either formal or informal knowledge of traditional medicinal plants, it does not include individuals who may have entered the trade out of economic necessity, but who have no knowledge of traditional medicinal plants.

profession and has given biomedicine a considerable amount of power and authority within these societies.

The professionalisation of medicine in the West[8] has been brought about, and shaped, by a particular set of forces and by a particular group of practitioners who have had an economic and political interest in the professionalisation of their practice. Twumasi and Warren offer the following definition of professionalisation:

> Theorists of the professions argue that professionalisation is a historical process whereby people who occupy certain role-positions within the societal division of labour...tend to struggle to achieve a certain degree of autonomy and continually struggle to maintain that power. They organise their work activities, cultivate a distinct body of knowledge, and develop norms of practice and codes of conduct for the training and socialisation of members of the group. They also establish rules of conduct between themselves and the larger society (Twumasi and Warren, 1986:119).

Chavunduka defines a profession as having four essential characteristics:

(a) Autonomy: the profession retains a measure of independence through its right to regulate itself; both the profession as a whole and the professional as an individual are thus able to organise and carry out their work without undue interference from employer or their clients.
(b) Monopoly: the professional also has a statutory monopoly over a defined sphere of work; the monopoly is maintained by the profession's control over licenses to practice its particular kind of expertise
(c) Ideology of service: a code of ethics governing relations between a professional and the client and limiting competition between

[8] By the West I refer mainly to Britain and America.

professionals...Central to the code is an assumption that service should replace self-interest in the performance of professional duties. In return for social recognition...the profession is accountable to the public for providing the expected level of service

(d) Body of esoteric knowledge: a profession is responsible, as 'experts'...for applying a body of knowledge and skills in practice...for teaching and examining recruits to the professions and for promoting research so that the profession can reproduce both its membership and its claim to expert knowledge. The knowledge itself is normally structured in such a way to be susceptible to standardised instruction and use (Chavunduka, 1986:7).

There is one other important feature of a profession which Chavunduka neglects in the above definition, but which is mentioned in Goode's (1960) list of the traits that characterise the professions, and that is control of entry into a profession through a long duration of training and examinations (Goode, 1960 quoted in Hardy, 1998:68).

1.4 The medical profession and women

These definitions of professionalisation, however, fail to show the way in which the professionalisation of medicine in the West has led to the marginalisation of other groups of healing, many of which were occupied by women. The rise of the medical profession in Britain and America has led to the side-lining and exclusion of women from biomedicine, which has only started to be challenged towards the end of the twentieth century. Discrimination along the lines of gender is consequently another defining feature of the professionalisation of medicine in Britain and America.

1.5 The medical profession and the state

Although the medical profession remains fairly autonomous from state interference in its right to regulate itself, it is a serious misconception to understand the medical profession as autonomous from the state. On the contrary the medical profession in Britain and America is heavily dependent on state support, mainly in the form of legislation, for its privileged position within these societies. Any evaluation of the professionalisation of traditional healers requires an understanding of the dynamics between the state and the developing profession of traditional healing.

1.6 Changing international attitudes towards traditional medicine

According to Chavunduka, most of the research and literature on the medical profession has been produced in Britain and America. Sociological research on the professions can be dated back to Carr-Sanders (1933) in Britain and to Talcott Parsons (1951) and Everett Hughs (1958) in America (Chavunduka, 1986:7). Research on the professionalisation of traditional medicine in Africa has only emerged considerably later in the period of independence from the 1960s and 1970s onwards. According to colonial officials indigenous medicine was generally considered to have little or no value in African society. In fact it was portrayed as 'harmful', 'primitive' and based on 'superstition' and 'ignorance'. In most colonial African countries it was also outlawed by a series of Witchcraft Acts. These attitudes were reinforced by western biomedicine's monopoly over medicine and healing practices, a monopoly that denied any recognition to indigenous systems of healing. The emerging acknowledgement and interest in indigenous medicine as a profession has only been made possible in a post independence context, where African countries have had a chance to discard certain colonial ways of thinking.

Serious research into the professionalisation of traditional medicine has also been facilitated by a change in international health policy on traditional

medicine. At the end of 1977 The World Health Organisation (WHO) called a meeting on the "Promotion and Development of Traditional Medicine". The purpose of this meeting was to assemble expert representation of the major systems of traditional medicine to work together and suggest a plan of action to promote and develop the various aspects of traditional medicine (WHO, 1978:7). This meeting was convened in response to a resolution adopted by the Thirtieth World Health Assembly in 1977, which urged "*interested governments* to give adequate importance to the utilisation of their traditional systems of medicine *with appropriate regulations*", and requested the Director-General of WHO "*to assist member states in organising educational and research activities*" around traditional healing (WHO, 1978:7).

The Declaration of Alma Ata in 1978 with its emphasis on a holistic definition of health that included the environmental, social and spiritual aspects of an individual was a significant event for traditional health practitioners whose healing system was based on precisely such a holistic understanding of health. The 1978 Declaration of Alma-Ata conferred "international sanction and a high level go-ahead" on the subject of indigenous healers. The Declaration acknowledged the role traditional health practitioners play in primary health care and emphasised that "High priority should be given to the development of manpower in health…including traditional healers and birth attendants, *where applicable*". The Declaration also states that with "the support of the formal health care system" traditional health practitioners could "become important allies in organising efforts to improve the health of the community" (Pillsbury, 1982: 1826).

More recently the international health community has also begun to recognise the important role traditional healers can play in HIV prevention. Since the early 1990s the World Health Organisation has been advocating for the "the inclusion of traditional healers in national reproductive health and AIDS programs" (UNAIDS 2000 quoted in Leclerc-Madlala, 2002:62).

1.7 Understanding professionalisation in a post colonial African context

The Professionalisation of African Medicine (1986) edited by Chavunduka and Last provides the most comprehensive account of the movement towards the professionalisation of indigenous medicine in a range of post independent African countries. The volume explores the political, economic and social factors directing the move towards the professionalisation of indigenous medicine. One of the challenges facing newly independent African governments was how to improve the poorly developed health care systems in their countries. Encouraged by the World Health Organisation's recent support for THPs, African leaders began to consider the ways in which traditional healers could collaborate with national health care systems. *The Professionalisation of African Medicine* traces the involvement and integration of groups of traditional healers into the health care systems of different African countries and evaluates the successes and failures of these collaborations.

The development of a range of different kinds of national and regional traditional healers associations is also documented in this volume and the authors critically assess why many of these associations failed. There were certain common factors in the failure of a number of these associations. These factors included the inability of associations to gain any real government influence and the failure of associations to achieve broad based representation. Many associations were also weakened by power struggles and "personal cultism and factionism" (Chavunduka and Last, 1986: 65; 233). Bad financial management, poor organisation and a lack of appropriate leadership were viewed as other stumbling blocks (Chavunduka and Last, 1986:92).

The strengths and weaknesses of professionalisation are debated and the most appropriate forms of professionalisation for various African contexts are explored through this volume. The book also engages with debates around the integration and collaboration of western medicine and indigenous healers.

The relationship between traditional healers' associations and the state is explored through a range of debates about the role of traditional healers in health care, the level of autonomy given to THPs, and the kinds of partnerships between the state and traditional health practitioners.

1.8 The professionalisation of traditional healers in South Africa

The Professionalisation of African Medicine provides an important source of contrast and comparison when reviewing the development of the KwaZulu-Natal Traditional Healers' Council. South Africa, however, has experienced a form of colonialism and oppression that is different to most of the other African countries documented in Chavunduka and Last's text. South Africa has a considerably larger settled white population compared to that of many other colonised African countries. As a consequence of this the health infrastructure is far more developed especially in urban areas, and doctors and nurses are more accessible. The relationship between western medicine and traditional healers is therefore different to what it is in many other African countries. In South Africa biomedicine has a much stronger and entrenched hold on ordinary people's lives and on government policies and thinking. The dominance of biomedicine in South Africa has also been accompanied by state discrimination and oppression directed towards traditional medicine. The professionalisation of traditional healers in South Africa has only been possible at a later stage than that of most other countries on the continent, with the breakdown of apartheid and the ANC's election to government in 1994.

The movement towards the professionalisation of traditional healers in South Africa has only really begun to gain momentum in the 1980s and 1990s. The entrenched association of traditional healers' practice with witchcraft has been the major obstacle preventing traditional healers from gaining state recognition and support. With the exception of the Natal Code of Law (1891), traditional health practitioners in South Africa have been criminalised and

prevented from practising. Repressive legislation, in particular the Witchcraft Suppression Act 50 of 1957 and the amended Act no 50 of 1970, made it an offence for "any person to exercise supernatural powers" or "to impute the cause of certain occurrences to another person" (Xaba, 2002:9). Legislation limiting black businesses has also prevented traditional healers from establishing formal practices. This restrictive environment has not stopped traditional healers from practising; rather it has pushed traditional medicine into the informal economy where it continues to operate today in a largely invisible and unregulated space.

The context of traditional healers in Natal/KwaZulu, however, differed to a certain extent from that of traditional healers in the rest of South Africa. Because of the Natal Code of Law (1891), a limited number of izinyanga were legally permitted to practice in the province. In fact during 1970s izinyanga were encouraged to form associations to enable the registration and licensing of traditional healers. This led to the development of a number of small and relatively weak healers' associations in KwaZulu-Natal with little co-ordination between them[9]. These associations only managed to license and register a limited number of izinyanga. During the 1980s the Inyangas' National Association was recognised by the Natal/KwaZulu government as the only official body representing izinyanga in the province. This attempt at registering traditional healers, however, was also largely unsuccessful (Cunningham, 1988:15). Throughout this period izangoma were completely outlawed from practising under the witchcraft Act.

The legacy of these attempts to register traditional healers in the 1970s and 1980s has resulted in the formation of a number of weak and unco-ordinated traditional healers associations. According to Mr. Jamile, Deputy President of the KwaZulu-Natal Traditional Healers Council, more than a hundred traditional healers associations operate in KwaZulu Natal (Interview with Mr. Jamile, Deputy President KZN Traditional Healers Council, 22nd January 2003). In South Africa today there are also a large number of traditional

[9] Public Hearings on Traditional Healers, 1997 Vol 3, No. 23.

healers who operate independently and who are not registered with any association (Freeman, 1991:2). There is very little literature that documents and analyses these associations. This is largely due to the informal and invisible nature of traditional medicine, the secrecy often associated with traditional healing practices, as well as police and state persecution. Furthermore, with the exception of certificates, most of the information about these organisations is conveyed through word of mouth rather than written documentation.

Although a significant amount of research has been produced on the ethnography, cosmology and practice of traditional healers (Bryant 1966, Berglund 1976 and Ngubane 1977), and on collaboration between traditional healers and the western health care system (Green 1994, Campbell 1998), as well as the role of healers in HIV/AIDS prevention (Green 1994, Leclerc Madlala 2002), there is very little research that takes as its central focus the politics of traditional healing, particularly the organisation of traditional healers and the movement towards the professionalisation of traditional healers in South Africa.

Despite this, a considerable amount of information on the politics of traditional healing can be found by looking at literature that focuses on a range of other concerns around which traditional healers are currently organising themselves. This includes literature on collaboration between traditional healers and the western health care system, literature on the role of traditional healers in HIV/AIDS prevention, research on traditional medicine as part of the informal economy and literature on traditional medicine and conservation.

Cunningham's research (1988), on the traditional medicinal trade in KwaZulu-Natal investigates the commercialisation of traditional medicine and the potentially devastating impact of over harvesting on the conservation and sustainability of many traditional medicinal species and the traditional medicinal economy. He argues that legislation aimed at preventing the

exploitation and sale of indigenous plant species, as well as legislation aimed at preventing the hawking of traditional medicines and the practising of unlicensed herbalists, has failed to prevent the exploitation of traditional medicinal plants (Cunningham, 1988: 15). Cunningham recommends the professionalisation of traditional practitioners as a way of controlling the exploitation and wastage of plants species and as a way of standardising and regulating the toxicity and dosage of traditional medicines (Cunningham, 1988:85,72). Cunningham's work is also important because it contextualises traditional medicine as a powerful economic force within the informal economy.

THE FAO's[10] Report (1998), on the "Marketing of Indigenous Medicinal Plants in South Africa" explores the commercial development of muthi as a way of combating the exploitation of wild medicinal plants. Focusing on the Durban muthi market as a case study the report concludes that the muthi market is at present under-developed and that development will only be possible if traditional healers move towards professionalisation through developing a common vision to lobby for government support. The report also stresses the need for the government to officially recognise the importance and economic potential of the muthi trade by creating "a conducive policy environment" to enable "market development" (Mander, 1998: 100, 102).

The FAO report has significantly influenced the Durban municipality's perception of the traditional medicinal trade. This report has contributed to a shift in the municipality's understanding of the trade from a management and health problem to an asset and an important economic development. This shift has contributed to the municipality's willingness to invest in the development of a new muthi market for traditional healers and traders.

In *AIDS and STDs in Africa: Bridging the Gap Between Traditional Healing and Modern Medicine* (1994) Green argues that traditional healers' efficacy in treating STIs can play a major role in HIV prevention, as exposure to STIs

[10] Food and Agriculture Organisation of the United Nations.

greatly increases the chances HIV infection. Green argues for collaboration between traditional healers and western medicine. According to Green, controlling the spread of HIV infection is not possible without developing or expanding "collaborative programs involving traditional healers who already see and treat most STD cases" (Green, 1994:80).

Drawing on his experience participating in two HIV/AIDS training workshops for traditional healers in South Africa in the early 1990s, Green illustrates the general willingness of traditional healers to collaborate and their receptiveness to biomedical training on HIV/AIDS and biomedical treatments and procedures (Green, 1994:39). In *Called to Heal (*1998), Schuster Campbell explores the interaction between traditional and modern ideas and practices of healing in the lives of prominent traditional healers in South Africa. Her work also emphasises the receptiveness of traditional healers to collaboration with the formal health system.

In his case study of Swaziland, Green shows the significant role traditional healers' organisations can play in facilitating collaboration between THPs and western health care. The Traditional Healers Organisation (THO) in Swaziland has worked collaboratively with the Ministry of Health as well as other nongovernmental organisations since the early 1980s "in areas such as diarrhoeal disease, breastfeeding, referrals for child immunizations, and AIDS/STDs" (Green, 1994:78-79). Campbell also draws on the example of the THO to show the success of collaboration between the Ministry of Health and traditional healers in Swaziland.

The THO in Swaziland has been more successful at facilitating collaboration than traditional healers organisations in South Africa. Green documents the problems experienced while trying to work through national traditional healers associations to conduct AIDS training workshops in South Africa. Green and his colleagues found it difficult to use the associations to recruit dedicated traditional healers for training as many traditional healers felt limited trust and

support for associations. Power struggles, politics and unstable leadership, key factors in the failure of many of the traditional healers associations documented by Chavunduka and Last, were also found to be factors contributing to the weakness of national traditional healers associations in South Africa (Green, 1994:221).

Both Campbell and Green's work focuses on well-respected and educated traditional healers. These healers are not necessarily representative of the majority of traditional healers in South Africa and Swaziland, who are less likely to be exposed to training and new ideas, and as a result, may be less open to collaboration.

Suzanne Leclerc-Madlala's research on HIV/AIDS (2002) highlights the way in which traditional healers are increasingly experiencing a need to professionalise in order to be accepted as "more equal and effective partners" in health care delivery, particularly in the area of HIV/AIDS. Like Green, Leclerc-Madlala argues that traditional healers have an important role to play in the in the fight against HIV/AIDS. "Unfortunately because of a lack of organisation and communication...traditional healers do not play the role they should" (Faure, 2002:4). The South African government has called on traditional healers to better organise themselves and to "foster greater cohesion amongst themselves" before it can engage in discussions with traditional healers on their role in health care delivery (Leclerc-Madlala, 2002:63).

Calls for the regulation of traditional healers, however, have not only come from those who believe that traditional healers can make a positive contribution to health care. Xaba (2002) documents a rise in political and social unrest and violence in South Africa during the 1980s, which contributed to the proliferation of charlatans who offered black South Africans medicines to help them cope in turbulent socio-economic and socio-political conditions. This rise in the number of charlatans, together with a number of witch killings

and muthi murders in the early 1990s, "led to calls for the prescription of indigenous medical practice" (Xaba, 2002:34). In March 1995 a Commission of inquiry was established into Witchcraft Violence. The Commission also drew attention to the need to regulate traditional healers in order to protect the general public[11].

Literature on traditional healing and traditional medicine as part of the informal economy has also provided a rich source of information on the way traditional healers are using forms of organisation to respond to changing political and economic conditions, and to assert their economic rights to trade and practice traditional medicine.

Stein Nesvåg (1999, 2002) documents the growth of the traditional medicinal market in Durban's Warwick Triangle. He explores the changing dynamics within the trade as well as the developing relationship between traditional healers and the Durban municipality. He argues that female muthi traders have transformed certain aspects of traditional medicinal trade and practice to allow them to enter the market, and that they have used 'tradition' to economically empower themselves.

Nesvåg also looks at traditional healers' and traders' mobilsation around the establishment of a new muthi market and their involvement in negotiations with the municipality around the construction of this market. Nesvåg's work traces how the development of the muthi market in Durban has encouraged a shift in traditional healing from an unregulated, to a partially regulated economic activity. This shift has been paralleled by a shift in the Durban municipality's relationship with traditional healers from a repressive to a more regulatory relationship.

The developing relationship between traditional healers and municipality, and the municipality's changing view of the muthi trade have also been influenced by transformations in the ideology and practice of local government in the post

[11] Public Hearings on Traditional Healers, 1997, Vol 3, No.23.

apartheid era. *Democratising Local Government: the South African Experiment* (2002) edited by Susan Parnell et al explores this new ideology and practice of local government. There are two aspects of this new local governance that have influenced the Durban municipality's relationship with traditional healers. The first is the importance of participatory democracy at the local government level, and the second is the new role of local government in economic development. These ideas are explored in greater detail in Chapter two.

1.9 Conclusion

A broad review of the literature and research on traditional healing in South Africa and internationally indicates that traditional medicine is in an exciting process of change, which is reshaping its relationship with biomedicine, as well as creating new possibilities for traditional healers to engage in health care and the well being their communities. A review of South African literature and research shows that there are specific gaps in research on traditional healing and that there is a need for more research on the professionalisation of traditional healers. Although the professionalisation of traditional healers in South Africa has been facilitated by a number of recent changes and developments that are outlined in this chapter, the professionalisation of traditional healers today is also part of a deeper historical process. Because of this there is a need for a more historically detailed and in depth focus on the history of traditional healers in KwaZulu-Natal, in order to understand the specifics of the relationship between traditional medicine and biomedicine in the context of colonial Natal. A historical perspective is also needed to understand the process of marginalisation that traditional healers have experienced, and to understand the impact of this legacy of marginalisation on their practice today.

Chapter 2: Methodology

2.1 Research objectives

The objective of this research was to document and to critically assess the professionalisation of traditional medicinal practice in KwaZulu-Natal, between 1985 and 2003, by focusing on the formation and development of the KwaZulu-Natal Traditional Healers Council as a case study. For the purposes of this study, professionalisation is defined as 1) formal recognition by government, which is written into legislation 2) the establishment of a national or provincial body of traditional healers to monitor, regulate and qualify traditional healers 3) the establishment of an official set of regulations for the practice of traditional healers, as well as a code of good conduct and 4) an understanding among traditional healers of themselves as health professionals.

2.2 Research questions

Listed below are the research questions that have informed this research. These questions move from documenting and understanding the processes that have shaped the professionalisation of traditional healers in KwaZulu-Natal, to critically evaluating and assessing one of the products of this process of professionalisation, the KwaZulu-Natal Traditional Healers Council.

- To document the process of professionalisation amongst traditional healers leading up to the formation of the KwaZulu-Natal Traditional Healers' Council.

- To understand the factors driving this process of professionalisation.

- To critically assess and evaluate the progress made by the KwaZulu-Natal Traditional Healers Council as a professional body responsible for

unifying, regulating and promoting traditional healing practice.

- To understand how traditional healers within the Council are using discourses of professionalisation and claims to new forms of legitimacy to construct a particular identity for themselves as health care professionals.

- To assess the extent to which the KZN Traditional Healers Council is fulfilling its functions as a professionalising body and is facilitating effective collaboration between traditional healers and the health care system.

- To provide recommendations where necessary on how the KwaZulu-Natal Council could operate more effectively.

2.3 The significance of this study

Although there is a significant amount of literature on the ethnography, cosmology and practices of traditional healers in Southern Africa (Bryant 1966, Berglund 1976 and Ngubane 1977), and on the subject of collaboration between western medicine and traditional healers (Green 1994, Campbell 1998, Leclerc Madlala 2002), very little research has focused on the politics of indigenous healing, particularly the organisation of traditional healers, and the movement towards the professionalisation of traditional healers in South Africa. The aim of this piece of research is to begin to fill this gap by examining the professionalisation of traditional healers in KwaZulu-Natal as a case study. To do this, reference has been made to: 1) historical literature on the professionalisation of traditional healers in this region (Flint 2001, 2002, Nesvag 1999, 2002 and Dauskardt 1991). 2) Literature on traditional healing and muthi trade as part of the informal economy and the organisation of healers around their economic rights as traditional health practitioners (Nesvag 1999, 2002). 3) Chavunduka's (1986) work which explores the experience of professionalisation in other African countries. 4) Literature which emphasises the link between professionalisation and conservation

(Mander 1998, and Cunningham 1988). 5) Literature which discusses the possibilities and problems associated with the professionalisation of traditional healers in South Africa (Leclerc-Madlala 2002, Muller 1992, Freeman 1992, Jung and Marroto 1992, Hess 2001 and Urbasch 2002).

Various sectors within the traditional healing community as well as various sectors in government, such the Health Department and nature conservation authorities, have been calling for the professionalisation of traditional healers in South Africa for a number of years[12]. Amongst these groups there is a growing awareness that traditional healers need to be formalised and regulated for them to be effectively engaged in health care provision and conservation initiatives. There is, however, a lack of research and understanding about the dynamics of professionalisation among traditional healers in South Africa, and the obstacles preventing traditional healers from being able to organise and regulate themselves more effectively. There is also a need to document how professionalisation is redefining the role of traditional healers, as well as reshaping the established power relationships between biomedicine and traditional healing. Research focused on these particular issues is also called for in order to guide future policy making on the regulation and control of traditional healers, and their relationship with the formal health care system.

2.4 Data collection

Relevant secondary sources were obtained through an extensive scan of literature on traditional healing, the professionalisation of traditional healing, and trade in traditional medicines in KwaZulu-Natal, in South Africa and other African countries. This was done using the University of Natal's Telnet catalogue system, Internet search engines and electronic journals. The

[12] The Health Department's growing support for the professionalisation of traditional healers is documented in Leclerc Madlala's (2002) work referred to in the previous chapter. Cunningham (1988, 1991) and Mander's (1998) research, also referred to in Chapter One discusses conservation authorities support for the professionalisation of traditional healers on the basis that it would enable the harvesting of medicines to be more effectively controlled.

interlibrary loan department at the Malherbe Library was used to access reports, books and journals not available in the Durban library. In addition, archival research was also conducted in the Durban and Pietermaritzburg archives. The secondary sources collected through this search were used to form the basis of the literature review.

Primary data was collected through eighteen structured and semi structured interviews. A snowball sampling technique, and to a lesser extent a random sampling technique, were used to locate a sample of traditional healers and other relevant stakeholders to interview. The contact details for various traditional healers in the Council were obtained through Thokozani Xaba, in the School of Development Studies at the University of Natal, Durban. Another member of staff in the Department supplied the general contact details of the Informal Trade Department in the eThekwini (Durban) Municipality, the General Secretary of SEWU[13], and the details of a municipal worker in the City Health Department who has worked closely with traditional healers for a number of years. Through these initial contacts, the details of other relevant stakeholders were obtained.

Using these contacts, five interviews were arranged with the leadership of the KwaZulu-Natal Traditional Healers Council. Two of these interviews were conducted telephonically; the other three were conducted at the Warwick Junction Project, a training and development center run by the municipality for informal traders. Three interviews were conducted with employees in the Durban municipality and one interview was conducted with a government employee in the Provincial Department of Health. Two interviews were also conducted with the leadership of SEWU. These interviews were conducted at the interviewees' place of work, either in Durban or Pietermaritzburg. The interviews were conducted in English and a tape recorder was used.

[13] SEWU stands for the Self Employed Women's Union. SEWU is a trade union for women who work as informal traders in Durban. SEWU has played an important role in organizing and mobilizing female muthi traders and traditional healers in the Durban muthi market.

Random sampling was used to select and interview three traditional healers during a visit to the Durban traditional medicinal market, located at Warwick Junction. In addition, a focus group with three traditional healers was also held at the Valley Trust in Botha's Hill, specifically to discuss the issue of a mutual referral system between traditional healers and the formal health care system. This focus group was arranged through a member of staff at the Valley Trust. A translator was used for these interviews as well as the focus group, and detailed notes were taken. Further data was collected through participant observation at a meeting of the eThekwini regional branch of the KwaZulu-Natal Council. This research was conducted over a seven-month period between January and July 2003.

Preparation for the interviews involved drawing up a set of questions or a broader set of themes, based on an initial reading of the relevant literature. Prior to beginning each interview, the interviewee was briefed on the nature of the research being conducted, and was asked if there were any questions they would like to raise. At this stage it was also ascertained whether the interviewee wished to remain anonymous or was prepared to have their name used. Permission to use a tape recorder or to take notes was also requested. In each case, permission was granted. Once completed, the interviews were then transcribed or more comprehensive notes were drawn up from the ones taken at the interview.

2.4.1 Difficulties encountered during data collection

One of the major difficulties encountered during the course of this research has been locating traditional healers and other relevant stakeholders to interview, and persuading traditional healers, particularly healers in the Council leadership, to agree to an interview. Due to other commitments, the leadership of the KwaZulu-Natal Traditional Healers Council, and traditional healers in general, often stated that they didn't have time to be interviewed.

Some of them were also reluctant because they did not see how they would benefit directly from the interview. On certain occasions where a time and place for interviews had been arranged, the interviewees cancelled at the last minute. It was easier to make contact with other traditional healers once I had interviewed a few key healers, who were prepared to assist in organising other interviews, or who were able to introduce me directly to other traditional healers.

Being able to conduct several conduct telephonic interviews provided a way of partly overcoming the difficulties of arranging a time and venue, although this method of communication also presented some new difficulties. Telephonic interviews tend to be shorter and more formal and the telephone can act as a barrier preventing the interviewer from really engaging with the interviewee. In the researcher's experience it is far more difficult to encourage the interviewee to open up, take their time, and give more detailed and personal information in telephonic interviews.

Collecting data about events that occurred in the past can create another set of problems that can limit the ability of the researcher to collect accurate and detailed information. Because the struggles and negotiations around the construction of a new muthi market in Durban had taken place a few years ago, some of the key stakeholders involved in these negotiations had left the Department of Informal trade, and were not available for interviews. In addition, the leadership of SEWU, and other traditional healers involved in these negotiations, often could not remember the details and sequence of these events clearly since they had occurred in the past.

Among the traditional healers interviewed there was a general tendency to highlight the strengths and successes of the Council and underplay or ignore the weaknesses of this organisation. This was particularly the case with the leadership of the Council who were unwilling to talk about the weaknesses and divisions within the Council, as discussing these issues may have

jeopardised their own positions within the Council leadership. In general, traditional healing tends to be a relatively closed and secretive occupation and it is difficult to get traditional healers to talk about their most pressing issues. To try and assemble a more complete picture, a number of different representatives within the Council were interviewed, as well as ordinary traditional healers, muthi traders and municipal workers who have had contact with the KwaZulu-Natal Council. As a result of this it was possible to obtain a range of perspectives from stakeholders within and beyond the Council.

Language barriers have also affected the quality of the communication between myself, as the researcher, and the interviewee. The interviews with the leadership of the KwaZulu-Natal Traditional Healers Council were conducted in English, which is a second or third language for these individuals. As a result of this, there is the possibility that certain questions may have been misinterpreted or misunderstood. It was found that when speaking in a second language, there is also a tendency for interviewees to simplify answers. Consequently, some of the subtlety and nuances of the responses may have been lost. Although a translator was used to conduct the interviews with ordinary traditional healers, this may have also led to the loss of specific details and nuances in the course of translation.

2.5 Data analysis

An interpretative approach was used to analyse the data as this was seen to be most suited to the qualitative nature of the research design. In the analysis and interpretation of this data I followed the five steps suggested by Terre Blanche and Durrheim in *Research in Practice: Applied Methods for the Social Sciences* (1999). The first step involved familiarising myself with the data while it was being collected, and developing and identifying general ideas and problems. This was followed by a second closer reading of the data that led to the development of more detailed themes. These themes were then coded and organised into six different clusters, which formed the basis

for the chapters. At this stage the literature informing and framing each chapter was brought in. Chapter three drew on the work of Flint (2001,2001), Nesvåg (1999, 2002) and Dauskardt (1991). Chapter four also drew on Nesvåg (1999,2002) as well as Skinner (2000). Chapter five was framed by the work of Chavunduka (1986), Mander (1998), Leclerc-Madlala and Muller (1992), while chapter six again drew on research by Chavunduka (1986), as well as Freeman (1992), Jung and Marroto (1992), Hess (2001) and Urbasch (2002). The relationship between the different clusters, as well as the relationship between themes in the same cluster, was also analysed. The last step involved writing up the data and carefully editing the written material.

2.6 Ethical considerations

As a researcher from a different cultural and racial background there was a need to be sensitive to the fact that language and race could become barriers during the interview. There was also a particular need for sensitivity when discussing questions around HIV/AIDS, especially when talking about the way traditional healers are accused of contributing to the spread of the disease. While being sensitive to these issues, it was important to also ensure that they did not prevent me as a researcher from raising certain topics or choosing not to probe certain issues. I had to be sensitive to these issues while simultaneously trying to guide the interviewee into giving an honest response based on their experience.

Some of the traditional healers interviewed assumed that I would be writing a piece that would simply promote the KwaZulu-Natal Traditional Healers Council. There was therefore a need to be honest and clear about the purpose and the nature of the research from the beginning.

Another ethical consideration encountered was how to ensure that this research, produced through the assistance of traditional healers in the Council, is accessible to traditional healers and the KwaZulu-Natal Traditional

Healers Council. In order to make this research available I have decided to donate a copy of this dissertation to the eThekwini committee of the KwaZulu-Natal Traditional Healers Council.

2.7 Limitations of the study

Because this is a qualitative study, focused on a small number of in-depth interviews, the findings may not necessarily be representative of the opinions and attitudes of the broader population of traditional healers in KwaZulu-Natal or South Africa. This limits the applicability of the research. The advantage of qualitative research is, however, that it is able to provide a richer and more in-depth perspective on a particular subject, which was the objective of this study.

Chapter 3: From politically powerful healers to successful venture capitalists: the transformation of African healers in the nineteenth and twentieth century

3.1 Introduction

It is important to see the organisation and professionalisation of traditional healers and muthi traders today as part of a deeper historical process whereby healers have used organisation, and claims to a professional status, to gain formal recognition and to protect their rights as health professionals. This chapter attempts to do this by exploring the historical roots of professionalisation amongst traditional healers in KwaZulu -Natal, looking at how competition between the white biomedical community and African healers encouraged the organisation and professionalisation of African healers in the 1930s.

3.2 The development of a colonial response to traditional healing in the colony of Natal

The professionalisation and organisation of traditional healers is not a recent development. Since the early twentieth century South African healers have claimed a status as professionals and have organised themselves in response to attacks from the white biomedical community. In her doctoral thesis on African healers in South-eastern Africa, Flint argues that the competition that developed between the biomedical community and African healers in the early part of the twentieth century played an important role in the development of African ideas of medical authority and contributed to the professionalisation of both African and western medical practitioners (Flint, 2001:167).

Although Zulu society used many different names for their medical and spiritual specialists, under colonial rule, African healers came to be

categorised by both whites and blacks into two main groups. The term sangoma was used to refer to those healers who were possessed clairvoyant powers, which enabled them to communicate directly with the ancestors, while the term inyanga was used to refer to healers who primarily used muthi. Although traditional healers today often perform both of these roles, in the early nineteenth century these healers were distinguished from each other by the fact that only izangoma could diagnose illness while an inyanga would consult patients based on a sangoma's referral or the patient's self diagnosis. Flint stresses that this distinction is particularly significant because "it provided the basis for colonial understanding and the Natal governments approach towards African medicine" (Flint, 2001:203).

The interaction and interest between African healers and biomedicine that had marked the early years of colonial contact in South-eastern Africa gave way to a growing hostility towards African healers as the colonial government came to perceive this group as a powerful political threat to colonial rule. Several Xhosa uprisings in the region during the nineteenth century "demonstrated to British colonists the ability of healers to mobilize public opinion and action for anti-colonial purposes" (Flint, 2001:204). Motivated by concern over African healers' role in assisting "the development and maintenance of independent or powerful chieftains" the Lieutenant Governor banned consultation with, and practice of, African healers under anti-witchcraft laws from 1862 onwards (Flint, 2001:204).

By the 1880s, colonial officials were forced to acknowledge that anti-witchcraft laws were having little impact in changing the behaviour and belief system of African subjects. Officials then decided to impose biomedicine onto the African community as a way of drawing Africans away from indigenous healers. This strategy also proved impractical, however, as the colonial government lacked the resources and staff to offer biomedical services to the entire African community.

The colonial government of Natal then decided to license "African healers who posed the least threat to the colonial state and most closely resembled biomedical practitioners." This decision was enacted through the 1891 Code of Native Law[14], which "decriminalised and allowed for the licensing of a limited number of inyanga" (Flint, 2001:205). While the Zululand Proclamation (No.VII of 1895) set out the conditions under which izinyanga were allowed to practice for gain. Practice as a sangoma was outlawed and punishable through fines and imprisonment (Nesvåg, 1999:64).

Despite this restrictive legislation many unlicensed izinyanga continued to practice as this offence was difficult to police. Nesvåg emphasises that people seemed to prefer unlicensed izinyanga as they often charged considerably less than their licensed contemporaries (Nesvåg, 1999:65). The licensing of izinyanga led to the commercial growth of their practice "Licensed inyangas saw the possibilities of accumulating wealth and reputation from travelling around as itinerant doctors" (Nesvåg, 1999:65). Another significant change brought about by this legislation was the fact that izangoma began to offer the services of an inyanga, as well as a diviner, in order to obtain a licence. (Berglund, 1976:190 quoted in Nesvåg, 1999:65).

Flint emphasises that "the licensing of healers was unique to the colony of Natal and Zululand, and these remained the only areas in South Africa where African healers were licensed and allowed to practice openly" (Flint, 2001:205). The decision to allow a limited number of izinyanga to practice was directly linked to the development of a particular legal and ideological system of governance in the colony, known as indirect rule. Mamdani describes indirect rule as a system defined by a dual legal order, which enforced a separate but subordinate state structure for natives based on customary African law. He goes on to argue that the creation of indirect rule first developed in the southern African colonies, particularly in the colony of Natal (Mamdani, 1996:111). Although indirect rule ceded only superficial power to African chieftains, it provided a space in which a limited number of

[14] The legislation pertaining to traditional healers was laid out in Chapter 14 in Law 19 of

traditional healers were permitted to practice. This historical advantage may explain why traditional healers in KwaZulu-Natal today continue to lead traditional healers in the rest of the country, by being the first province to form a provincial Traditional Healers Council.

3.3 The urbanisation and commercialisation of traditional medicine: the growth of the traditional medicine trade in Durban

Despite the restrictions imposed on practicing traditional medicine by the Natal Native Code, a flourishing trade in traditional medicines began to develop in Durban at the end of the nineteenth century to service the growing black urban population in the city. Black men from the rural areas were forced into migrant wage employment in Durban as a result of hut taxes, and legislation such as the 1913 Land Act and the 1923 Native (Urban Areas) Act, which undermined the agricultural sustainability of the black rural population (Dauskardt, 1991: 88). By 1904 Durban's African population officially numbered just under nineteen thousand. This population consisted mainly of African men who worked as washermen, dockworkers, ricksha pullers and domestic workers (La Hausse, 1996:39). The absence of adequate social and welfare services for this growing black population, as well as their continued strong ties with the rural areas, created a great demand for the services of traditional healers and muthi traders (La Hausse, 1996:39 and Dauskardt, 1990; 88).

Durban experienced a flourishing black informal trade in the first three decades of the twentieth century, of which traditional medicine was an important part (Nesvåg, 2002:284). Muthi traders, izinyanga and izangoma began trading in traditional medicines and providing health services at various economic and social nodes in the city from the early 1900s (Nesvåg, 2002: 285). Urbanisation gave healers access to new sources of patronage, clients and income (Flint, 2001:207). During this period muthi was a predominantly male activity. The migrant labour system, pass laws and various other

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1891, Natal (Nesvåg, 1999:64).

restrictions made it difficult for women to enter urban areas (Nesvåg, 2002:285).

The urbanisation of African healing and medicines posed new challenges but also offered new opportunities for traditional healers and muthi traders. "Urbanisation, and the competition that accompanied it, thus required comodification, commercialisation and changes in therapeutic techniques" (Flint, 2002:208). By commercialising their practice African healers were able to adapt and take advantage of Durban's urban capitalist economy. The ability of the traditional medicinal industry to adjust and restructure itself, reveals a dynamism and flexibility within traditional healing practice.

Dauskardt illustrates how the growth of commercialism and competition in Johannesburg's traditional medicinal industry, together with restrictive legislation during the first half of the twentieth century, led to the restructuring of this industry. Traditionally izinyanga in rural areas had relied mainly on plants, barks and roots which they had gathered themselves from the local environment. In urban areas, however, access to the necessary range of plants was not available and this led to the development of a network of commercial gatherers involved in the large scale harvesting of plants from rural areas. (Dauskardt, 1991: 94). Similar restructuring occurred in the Durban traditional medicinal industry during this same period, as rural women began to take over the harvesting of medicinal plants from traditional healers and traders in the city. These women brought large sacks of herbal medicines into Durban by train where these medicines were then sold to traders and healers. This quickly developed into a commercial trade in muthi. Muthi gatherers collecting large amounts of specific herbs or animal fats were often able to hawk these specialised items for significant profits (Flint, 2001:207).

This restructuring process also involved the commercial processing and packaging of traditional medicines (Dauskardt, 1991: 95). Responding to increased pressure and competition from the pharmaceutical industry, African

healers began to develop mail order businesses to increase their market. Traditional healers in Durban ran a number of these successful mail order businesses. Muthi was mixed and processed in small factories "and sold as specific cures or remedies in bottles or boxes in the same way as pharmaceutical sector products" (Nesvåg, 1999:82). Dauskardt notes, "before the 1940s, a number of processed or natural herbal medicines could be purchased from around the country" (Dauskardt, 1991: 95). This restructuring was also accompanied by the development of a new set of traditional medicines and remedies to assist Africans cope with the experiences and problems of early urban life in the city (Nesvåg, 1999: 82).

African healers were also able to extend their client base by incorporating new forms of healing that they had learnt from other healers and from white chemists and doctors. "They appealed to modernity by borrowing the implements and language of biomedicine and science. Some izinyanga bottled herbs, and used preservatives, stethoscopes, thermometers, and other modern equipment." Healers began to advertise in new ways by erecting signboards outside their practices and by distributing leaflets. Healers also began to expand their knowledge of medicines by adding Indian herbs to their pharmacopoeia (Flint, 2001:207-210).

3.4 The development of fierce competition between black healers and biomedical doctors

3.4.1 The Medical, Dental and Pharmacy Act of 1928

The commercial success of izinyanga in Natal and Zululand began to constitute a serious threat to the white medical community, especially as the number of biomedical professionals in the union increased (Flint, 2002:208). The restructuring of traditional medicine allowed traditional healers to significantly extend their client base. Many traditional healers treated not only African, but also white and Indian patients. Instead of competing against each

other white doctors " began to turn in racial solidarity against all other types of African practitioner". "By offering a diagnosis as well as umuthi, izinyanga attracted the hostility of white doctors who claimed the exclusive rights to 'diagnosis' and 'rational' therapy". Doctors demanded that izinyanga should be limited to dispensing muthi and that their client based should be limited to Africans (Flint, 2002:208-216).

Mobilized by these concerns the white medical community formed themselves into the South African Medical Association in 1926 and began to lobby the government to end government licensing of African herbalists. These efforts "resulted in the passage of The Medical, Dental and Pharmacy Act of 1928, which eliminated all types of medical practitioners not acknowledged by the association". Only currently licensed izinyanga in Natal were exempted. The 1928 Act was highly significant because it laid the foundation "for the official recognition of biomedicine alone in South Africa" (Dauskardt, 1994 quoted in Nesvåg, 1999:79). The Act intended to decrease the number of izinyanga by revoking licenses that had not been renewed within three months and by forcing new applicants to apply through the Minister of Public Health, who was aligned with the biomedical community, and therefore unsympathetic to African healers (Flint, 2001:216).

The medical community was supported in these demands by the pharmaceutical industry in South Africa, which was also in competition with African healers. The pharmaceutical sector saw the potential of tapping into the large and growing African market and had begun to try and attract black customers. African healers responded to this commercial threat by further trying to broaden their customer base (Dauskardt, 1994 quoted in Nesvåg, 1999:79). In the early 1930s the Pharmaceutical Society became even more alarmed as the muthi trade appeared to boom with an increasing number of muthi traders and customers entering Durban and a growing number of new mail-order businesses (Nesvåg, 1999:80). In response to these commercial threats Durban chemists successfully lobbied for legislation in the 1920s and

1930s "that outlawed the use of 'European medicines' by licensed inyanga", restricted the advertising of black medicines, and which outlawed izangoma and izinyanga from taking on the European title of doctor or chemist (Flint, 2001:216 and Nesvåg, 1999:87).

3.4.2 The formation of the Natal Native Medical Association

In response to this repressive legislation traditional healers and muthi traders began to organise themselves in order to protect their right to practice against the growing hegemony of biomedicine and the state. Around 1928 there was a "surge of urban traditional healer associations", as the 1928 Act "posed a serious threat" to the practice and trade of traditional healers. The majority of these attempts at professionalisation failed. However, there was one organisation, the Natal Native Medical Association, that managed to achieve some degree of success (Nesvåg, 1999:82).

The Natal Native Medical Association was formed in 1930 by Solomon Mazibuko and Mafavuke Ngcobo (Nesvåg, 1999:83). In an attempt to win government recognition for their organisation, "the association sought to 'professionalize' African medicine by using many of the same tactics as their White counterparts". They "organised themselves into an elite group that monopolised a distinct body of knowledge", they strived to enforce codes of conduct, establishing exams for izinyanga, issuing them with certificates and they sought to convince the government of the value of their services to the black community at large. Finally they set themselves up in contrast to the sangoma or 'witch doctor' arguing that their organisation sought to preserve traditional healing practices from the corruption and degradation of untrained quacks (Flint, 2001: 218).

It is significant to note that it has been izinyanga, such as those in the Natal Native Medical Association, rather than izangoma, who have used various forms of organisation, and claims to professionalisation, to fight for their rights

as health professionals, despite the fact that izangoma were effected earlier and more harshly by discriminatory legislation. This may suggest that there is a stronger organisational culture among izinyanga. The concept of professionalisation developed by the Natal Native Medical Association brought izinyanga together in a common cause, but it was also built on entrenching divisions within the broader traditional healing community. By setting izangoma up as 'witchdoctors', in opposition to the legitimacy of izinyanga, the Natal Native Medical Association excluded izangoma, who tended to be women. As a result of this, the Association promoted a male dominated culture of professionalism.

The Natal Native Medical Association was able "to organise strong opposition to the Natal Pharmaceutical Society in their struggle for medical rights" (Nesvåg, 1999:83). The Association fought to have various sections of the 1928 Act amended, "which they claimed were in conflict with their legitimate profession." They argued that the Act made it very difficult for any African healer to obtain a new license. The Association also objected to the clauses that demanded the cancellation of old licenses,[15] which were not renewed within two months (Nesvåg, 1999:83). The Natal Native Medical Association constructed an identity for themselves as health professionals, and called on this identity and the medical rights associated with this identity, to protest against discriminatory legislation affecting their practice:

> The Government failed to, [sic] protect the undefended and unrepresented natives. The opinion and views of the Native Leaders were not sought and this has become nothing else than *the deprivation of the native medical rights*... We are a *profession* and we do not wish to become political agitators what we want is to appeal to the Union government in a constitutional policy, and push through the right channel...There is no justification of the Act except upon the grounds

[15] Licenses issued under the old legislation, the Natal Code of Law.

> of professional jealousy and commercial rivalry, which is one of the chief causes of uneasiness between Europeans and Natives.[16]

The Natal Native Medical Association, however, remained relatively powerless in the face of the growing influence and monopoly of biomedicine in South Africa during this period. Traditional healers and medicinal traders were unable to achieve any kind of state support, a key feature necessary for professionalisation. In fact, the South African government at that time refused to recognise any of the traditional healer and trader associations that had emerged in response to the 1928 Act, including the Natal Native Medical Association (Nesvåg, 1999: 82). Although the Natal Native Medical Association persevered, the disadvantaged position of its members as traditional healers and as black men in an increasingly segregated and unequal society, eventually forced the Association into silence. Despite the fact that the Association was unsuccessful in it's attempts to change discriminatory legislation, it did manage to lobby "authorities at all levels in Durban, Pietermaritzburg and Cape Town" and its "efficiency and professionalism" must have impressed a number of authorities within government (Nesvåg, 1999:88).

The 1928 Act led to a drastic decline in the number of licensed healers from 1,000 in 1928 to 566 in 1932, while in Durban only four izinyanga managed to survive until 1940 to serve a population of 66,993 Africans (Flint, 2001:216). Not only were practising izinyanga significantly affected by the 1928 Act, those involved in the informal trade of traditional medicines were also pushed underground or out to the developing townships by this legislation. Indian businessmen slowly began to fill the supply gap, opening up muthi shops in the Indian business district around Grey Street (Nesvåg, 2002:286) "The development of repressive and regulatory systems made it almost impossible to trade [in muthi] from the 1940s up to the early 1980s" (Nesvåg, 2002:287). The informal and unregulated nature of traditional healing and trade in traditional medicines, however, has enabled this practice to continue

[16] Letter to the CNC, 20April 1931 in CNC 50A 43/25 in Nesvåg, 1999: 84. Nesvåg's

underground or out in the developing townships beyond the city, as well as in the hidden spaces within white suburbs (Cunningham, 1991:201).

3.5 Conclusion

The transformation taking place in traditional healing today, as it moves towards professionalisation, is part of a deeper historical legacy of adaptation and ingenuity within the traditional healing community, which has developed partly in response to the impact of colonial contact. The urbanisation and commercialisation of traditional medicine has enabled traditional healing to survive and thrive in an often hostile urban capitalist economy. As a result of these changes traditional medicine has also undergone a process of restructuring which has resulted in the large scale harvesting of muthi, the processing of traditional medicines and the development extensive mail order systems for medicines in the 1930s and 1940s. Yet the success and the dynamism of traditional healing during this period also brought it into fierce conflict and competition with European doctors and pharmacists.

The failure of the Natal Native Medical Association must be understood in the context of the vastly unequal power relationship between traditional medicine and biomedicine in South Africa during this period. Biomedicine used the powerful arguments of science, rationality and race to set itself up as the only legitimate healing system. It was also able to use its state support and influence to encourage the promulgation of discriminatory legislation against traditional healers and muthi traders to strengthen its own position. This ideological conflict between traditional and biomedical healing systems in Natal, was deeply rooted in economic conflict and competition, as these two systems of healing competed for the growing urban health market. Consequently traditional medicine has been forced to retreat into the invisible and unregulated space of the informal economy in order to continue practising.

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emphasis.

Chapter 4: The struggle for space in the city: the organisation and mobilisation of traditional healers and muthi traders in Durban city

4.1 Introduction

This chapter looks at how the changing context of Durban city, and the changing context of local governance in the late and post apartheid period, created an environment which enabled traditional healers to organise and to work towards the formation of the KwaZulu-Natal Traditional Healers Council. The previous chapter concluded that repressive legislation moved traditional healing underground into the invisible and unregulated spaces of the informal economy between the 1940s and 1980s. This chapter begins by outlining the political, economic and spatial changes that have allowed traditional healing and muthi trading to re-emerge in Durban city after the mid 1980s. It then goes on to explore how a process of struggle and negotiation over the establishment of a new market for traditional medicines in Durban has facilitated the organisation of traditional healers and muthi traders in KwaZulu-Natal. It investigates how aspects of the Durban municipality's informal economy policy, together with emerging ideas about the role of local government in the post apartheid period, have influenced and enabled the organisation and professionalisation of traditional healers and muthi traders in the province. This chapter shows how the traditional healing community's interaction with the Durban municipality has enabled this community to develop forms of organisation and mobilsation, which have paved the way for traditional healers to move towards professionalisation.

4.2 The re-emergence of muthi trading and traditional healing in the city and the development of a local government response

Although traditional healers and muthi traders were pushed out of Durban city between the 1940s and the early 1980s, the relaxation of influx control and informal trading laws during the 1980s led to a re-emergence of traders and traditional healers in the city during the 1990s. As muthi traders and traditional healers began to re-establish themselves in the city they also began to form various associations in an attempt to strengthen their trading rights and their status as traditional healers.

It is impossible to document the resurgence of organisation among traditional healers and muthi traders in Durban city, without providing an overview of the other dramatic political, spatial and economic changes taking place in the city during the same period. One of the most significant changes was the growth of informal trade, and the development of a local government response to this informal trade. The participation of traditional healers and muthi traders in various struggles and negotiations around their economic and social rights as informal traders and practitioners of traditional medicine, has played a pivotal role in facilitating and mobilising the organisation of the traditional healing community in the city.

During the early 1980s a significant shift began to take place in the Durban City Council's approach to informal street trading. This shift was facilitated by the completion of two official studies into street trading in Durban. The Market Survey in 1983 and the Hawker Report in 1984 both "marked a watershed in official policy towards street trading in Durban and later, in other South African cities" (Nesvåg, 2002:288). These reports argued for a more flexible and tolerant approach to street trading (Nesvåg, 2002:288-289).

This shift was also partly attributed to changes at national level, particularly the 1987 White Paper on Privatisation and Deregulation. This important state

document indicated a national move towards accepting and encouraging black small business development (Nesvåg, 2002: 289). Important political and spatial changes within the city were also challenging more conservative Council policies. The collapse of influx control in 1986 encouraged massive black urbanisation, while "escalating unemployment, organised mass resistance and strong international pressure" together with a "general international move towards economic liberation and [an] increasing focus on the informal sector" also led to the deregulation and formalisation of street trading (Nesvåg, 2002:288).

Despite the early initiatives of the Market Survey and Hawker Report, Nesvåg argues that the deregulation of street trading in Durban has been shaped by "confusion and conflict" because of the absence of a "clearly articulated management policy". He goes on to argue that this period of deregulation has also been associated with "official passiveness, or incompetence" with regard to managing the street trader problem (Nesvåg, 2002:295). He claims that street trader organisations have repeatedly complained about "a lack of representation and consultation" in the developments affecting them and he stresses that the relationship between traders' organisations and the Department of Informal Trade has always been tense. In conclusion he points out that street trading is still considered by many officials as a sign of urban decay, and as a result, policy concerned with regulation and control has continued to be shaped by "apartheid ideology and practice" (Nesvåg, 2002:296).

Nesvåg's critique tends to focus on the more conservative and unsuccessful aspects of the Council's interaction with traders, but Durban Council has also embarked on some dynamic initiatives to improve the environment of traders. These dynamic initiatives reflect a forward thinking and developmental component within the City Council. In a study comparing the relationship between local government and street traders in Johannesburg, Durban, Pretoria and Cape Town, Skinner argues that the Durban Council has been

the most successful in securing concrete gains for its street traders (Skinner, 2000:5).

Skinner argues that the establishment of the Department of Informal Trade and Small Business Opportunities in 1993 "was identified by street traders and their organisational leaders as a turning point in the city's approach to street traders." The establishment of this Department has played a fundamental role in making local government in Durban accessible to street traders (Skinner, 2000:14).

Skinner also emphasises that the City Council has politically prioritised informal trading (Skinner, 2002:5). The dedication of an entire department to informal trade has given informal trading the greatest institutional status out of the four cities surveyed. This institutional status has contributed to this department's ability to secure comparatively large financial resources for infrastructural development (Skinner, 2002:5-13). The construction of the new muthi market for traditional healers is part of a much larger urban upgrading project in the Warwick Avenue area, pioneered by the Durban municipality (Skinner, 2000:18). These developments indicate that street trading in Durban is being acknowledged and managed as an issue of small business and local economic development rather than as an issue of police control (Skinner, 2000:13).

Although the City Council only formulated its new informal economic policy towards the end of the 1990s, elements of this policy are evident in the Council's interaction with traders during the 1990s. This chapter will show that the relationship between the traditional healing community and the Durban municipality was more complex and constructive than the relationship presented in Nesvåg's critique. At times during negotiations with the traditional healing community the Council resorted to apartheid style tactics; however the municipality's formation of an Umbrella Body, as a channel through which to liase with traditional healers and other stakeholders around

the construction of the new muthi market, also embodied new ideas about participatory democracy and the importance of involving local government in economic development.

4.3 Reclaiming the city: the influx and organisation of muthi traders and traditional healers in the 1990s

Towards the end of the 1980s Durban began to experience a significant increase in street trading as a result of the policy of deregulation adopted by Durban local authorities (Nesvåg, 2002:289). Traditional healers and muthi traders, along with a range of other informal traders began to reclaim economic space within the city. In the early 1990s an informal pavement market, spread out around the Russell Street area, began to fill up with muthi traders and traditional healers (Nesvåg, 1999:122,136). By 1996 there were about 400 retail stores in this informal muthi market with an estimated 200-300 traders carrying out business at one time (Institute of Natural Resources, 1996 quoted in Nesvåg, 2002:289).

4.4 The changing gender dynamics in the market and the influence of SEWU

During this period the gender dynamics within the muthi trade were also in a process of transformation. Women who had previously been rural gatherers and who had entered Durban on a temporary basis began trading in the city on a more permanent basis (Nesvåg, 1999:135). Initially these women had supplied traditional medicines directly to the izinyanga and izangoma operating in the city. Because gatherers supplied muthi on credit they often had to wait up to several months to be paid back (1st Interview with Tobias Mkhize, City Health Department, 16th January 2003). Women gatherers therefore decided to become retailers themselves and began trading in the city on a more permanent basis (1st Interview with Tobias Mkhize). As a result of these changes, female muthi traders and traditional healers have come to

dominate the muthi trade in the city centre. A study conducted in 1996 by the Institute for Natural Resources revealed that approximately 80 percent of traders involved in the muthi trade in Durban were women (Institute of Natural Resources, 1996 quoted in Nesvåg, 2002:291).

The establishment of a branch of SEWU (Self-Employed Women's Union) amongst the women in Russell Street in 1994 also played a fundamental role in reshaping the gender dynamics of the muthi trade (Nesvåg, 1999:137). According to Khoboso Nthunya, General Secretary of the Durban branch of SEWU, it was through training provided by SEWU that female muthi traders and traditional healers began to understand their rights to improved working conditions (Interview with Khoboso Nthunya, General Secretary of SEWU, 1st February 2003). SEWU played an important role in developing female muthi traders' confidence and political skills (Stein Nesvåg, 1999: 139). Skinner also argues that the continued pressure SEWU placed on the municipality for the construction of a new muthi market has played a role in encouraging the Council to prioritise street trading (Skinner, 2000:18).

As SEWU was establishing itself amongst the women in Russell Street, other traditional healers associations and organisations were also beginning to emerge. While conducting a study on traditional healers in 1992, Tobias Mkhize, an official from the City Health Department, identified between ten and twelve associations operating in the muthi market area. These associations differed politically and geographically, with members being drawn to various associations because of political or geographical ties (1st Interview with Tobias Mkhize). Some of these associations were new while others were already established and were simply recruiting new members in the informal market area. There was also an intense power struggle amongst these organisations over membership and space within the informal market area (1st Interview with Tobias Mkhize).

Traditional healers used organisations to control and designate space in the

market, forcing traders to become members in order to obtain a space on the pavement from which to sell their goods, regardless of the fact that the land actually belonged to the municipality. Many of these associations did not operate in the interests of their members. They encouraged new members to join them in order to benefit from their membership fees, which often went directly into the organisational leader's pockets, rather than being used for the benefit of the organisation's members.

Although these early traditional healers organisations had a reputation for being corrupt, there were also a number of legitimate associations led by respected and well- known traditional healers who were concerned with maintaining the standards of their practice. These associations were beginning to realise that they could use organisations as a means of gaining recognition by local government and as a channel through which to negotiate and improve their current position.

4.5 The formation of the Umbrella Body

Towards the end of 1995 the City Health Department facilitated the formation of an Umbrella Body for traditional healers and muthi traders in Durban known as the Environmental Health Services Spiritual/Traditional Healers Umbrella Body for the Metro (Nesvåg, 1999:139). Ten traditional healers' associations present in the city's informal muthi market were represented on this Umbrella Body together with individuals, muthi gatherers and nature conservationists. The Umbrella Body took over from SEWU as the main negotiating body for the development of the new muthi market. The formation of the Umbrella Body drew together a number of different traditional healers' organisations and established one body of stakeholders for local government to negotiate with (Nesvåg, 1999: 140).

Traditional healers began to realise that by forming themselves into organisations they could gain official recognition through the Umbrella Body

and participate in negotiations around issues affecting them. As a result, the number of traditional healers' organisations increased after the formation of the Body. Tobias Mkhize explained that each time the Umbrella Body met, new traditional healers' organisations joined these meetings. By 1998 there were sixteen different traditional healers' organisations under the Umbrella Body (Mkhize, 1998:7).

The Umbrella Body brought traditional healers in the province together in a way that encouraged them to work collectively and to envision common goals. The Body defined itself as an association that represented and embraced "all the associations, organisations and individuals dealing with Spiritual and Traditional Practices" [17]. The Body also defined itself as playing an important co-ordinating and networking role[18].

The Umbrella Body gave traditional healers an opportunity to begin agreeing upon and establishing a common set of standards, a code of good practice and a professional status for traditional healing. The aims and objectives of the Umbrella Body, as stated in their constitution, included many of the qualities or features associated with the professionalisation of medicine. The Umbrella Body sought to establish a professional identity for traditional healers around many of the same regulations and concerns that the Natal Native Medical Association had begun establishing a professional identity around in the 1930s. The standardisation and the maintenance of quality services are expressed in the Umbrella Body's constitution, together with concern for maintaining the status and respect owed to traditional healers[19]. The Umbrella Body's constitution also includes several aims and objectives, which reflected a growing awareness and concern among traditional healers, gatherers and the other stakeholders in the Body around broader environmental, economic and medical debates associated with the muthi trade[20].

[17] Constitution of the Umbrella Body, 1996, Chapter 2.
[18] Constitution of the Umbrella Body, 1996, Chapter 3, Clause 1.
[19] Constitution of the Umbrella Body, 1996, Chapter 3, Clause 4.
[20] Constitution of the Umbrella Body, 1996. Chapter 3, Clause 3 and 5.

4.6 The politics of gender and power in the struggle for the new market

Although SEWU was the first organisation to mobilise muthi traders around the establishment of a new muthi market, as negotiations progressed, SEWU decided to sideline itself from this process. SEWU 's decision to step back was the result of an intense power struggle between the organisation and the Umbrella Body over who should lead the process of negotiations for the new muthi market. This power struggle highlights a number of divisions along the lines of gender and status within the traditional healing community. According to Tobias Mkhize SEWU played an important role in shifting the politics of the market away from ethnic and regional lines towards making gender the central dividing and defining issue (Nesvåg, 1999: 139). These divisions continue to influence the politics of the KwaZulu-Natal Traditional Healers Council today.

SEWU took the lead in the initial phase of negotiations with the municipality over the establishment of a new muthi market in 1995 (Interview with Thandiwe Zulu, 14th February 2003). At this time SEWU was the most influential and organised association working with muthi traders and healers. Khoboso Nthunya estimates that at the time of these initial negotiations approximately 60 percent of female muthi traders and traditional healers were members of SEWU (Interview with Khoboso Nthunya).

After the formation of Umbrella Body a Street Committee was also established with male traders and SEWU members to represent traders in Russell Street. A powerful male trader was chosen to chair this committee. "This body was seen by the state as more suitable to represent Russell Street traders then SEWU, which was only for women and had no specialist competence on traditional healing." The Street Committee gave male traditional healers the opportunity to express their interests, however because of power struggling within the committee SEWU decided to slowly withdraw and "it soon became

a male dominated body" (Nesvåg, 1999: 141).

SEWU also decided to withdraw from the Umbrella Body because of power struggling, and, in 1996, decided to lobby the municipality for the construction of a new market through its own established channels in the City Council. This decision had significant consequences for SEWU and sidelined the organisation, for a period of time, from the negotiating process.

Stein Nesvåg argues that the power struggle between SEWU, the Umbrella Body and the Russell Street Committee was essentially a struggle over who would lead the process of negotiations with municipality. Although SEWU had taken the lead in the negotiations, its organisational structure, which represented women traders only, did not offer " a representative body of stakeholders" for the municipality to negotiate with around the construction of the new market. For this reason the municipality decided that it would be more appropriate for the Umbrella Body to lead these negotiations (Nesvåg, 1999:150-1). The municipality's decision to use the Umbrella Body as the main channel through which to lead the negotiations was not a malicious or purposeful attempt to exclude women. It was essentially a circumstantial decision based on the fact that the Umbrella Body provided the most representative and suitable channel through which to negotiate with the traditional healing community and other relevant stakeholders.

It was SEWU's own decision to withdraw from the negotiating process. This decision, however, was also prompted by the way the members of SEWU were treated by their male colleagues in the Street Committee and Umbrella Body. SEWU members felt that male traditional healers looked down on them and treated them like children because they had less formal training and experience. For a considerable period of time these women had been in confrontation with the men who controlled the Street Committee, and it was for this reason that they withdrew from this organisation (Nesvåg, 1999:151). SEWU's political organisation, which was democratic, forceful and gave

women a chance to speak out, contrasted sharply with the type of male leadership that had been present in the Russell Street market before the emergence of SEWU. This "contrast represented a clash between 'modern' urban trade unionism, versus the traditional rural-based authority of elder men" (Nesvåg,1999: 153-4). This power struggle also highlighted a conflict between the higher status of well-established male traditional healers and the lower status of many of the female traders who had recently entered the market and who were less experienced. The gendered way in which female muthi traders and traditional healers were treated by their male colleagues also contributed to the withdrawal of SEWU from the negotiating process.

Although SEWU later rejoined the Umbrella Body and the Street Committee, and continues to work with these structures to ensure the daily running and organisation of the market, SEWU's partial marginalisation from the negotiating process has weakened the organisation (Stein Nesvåg, 1999:149). As a result of being sidelined in this process many female traders have lost faith in the organisation, and consequently SEWU has lost a considerable amount of its membership (Interview with 2nd Female Muthi Trader, 28th May 2003).

Even though certain gendered norms were being reinforced through SEWU's interaction with some of the male traders in the Umbrella Body and the Russell Street Committee, traditional gendered roles were also being reshaped and redefined within the Umbrella Body. The reshaping of these roles is clearly evident in the Body's decision to elect a female traditional leader, Patience Koloko, as president of the Umbrella Body.

4.7 The Umbrella Body as mediator: resolving power struggles amongst the leadership of the traditional healing community

Although the Umbrella Body sought to unify all stakeholders in the muthi trade, it was initially beset by internal tensions as a result of power struggles

and differences between organisations and their leaders. According to Tobias Mkhize, these power struggles were ultimately resolved as the Umbrella Body forced traditional healers to overcome their differences and to work together. The meetings of the Umbrella Body, leading up to the formation of the Council, fostered collaboration, which helped the leaders of organisations to better understand each other (1st Interview with Tobias Mkhize).

Madlamini Khumalo, a muthi trader and the president of SEWU during this period, presents a different picture of the Umbrella Body. She suggests that the power struggling in the Body was never resolved and was a feature of the Body throughout its existence (Interview with Madlamini Khumalo, President of SEWU, 23rd January 2003). The differing perspectives offered by Mkhize and Khumalo most likely reflect their own relationships with the Umbrella Body. As the key player in the Body's formation and as its co-ordinator, it is expected that Mkhize would emphasise the Umbrella's success at resolving conflict. As a representative of SEWU, which sidelined itself from the Umbrella Body shortly after its formation, it is understandable that Khumalo would emphasise the Body's failure to resolve conflict.

Power struggling between organisations appears to have been a dominant feature of traditional healers' organisations since their emergence in the informal muthi market in Durban during the late 1980s and 1990s. Power struggles are also identified by Chavunduka and Last as one of the most common problems confronted by other African traditional healers' associations. In my own opinion it is unlikely that struggles over power would have been resolved completely by the formation of the Umbrella Body. Rather, I think the Umbrella Body played an important role in defusing and mediating tensions and power struggles. The Umbrella Body's role as mediator was successful in that it facilitated negotiations for the establishment of a new muthi market and enabled traditional healers and muthi traders to work well enough together to lead to the formation of a provincial Traditional Healers Council.

4.8 The influence of new ideas of local governance on the functioning of the Umbrella Body

Negotiations between traditional healers and the Durban municipality took place during a period of significant institutional restructuring and transformation within local government (Hall and Robbins, 2002: 43). In the past local authorities have been severely constrained by national government, however the new constitution of South Africa establishes local government as an equal sphere of government (Hall and Robbins, 2002: 44). This new authority has been accompanied by a range of new responsibilities for local government that have influenced the way in which the municipality has come to understand and interact with traditional healers. Local government has been tasked with responsibility of encouraging economic and social development as well as facilitating public participation within the different spheres of local government.

An awareness of these new responsibilities is evident in the formation and functioning of the Umbrella Body. The formation of the Body, to negotiate the establishment of a new muthi market, revealed the Council's recognition of the importance of traditional healing and the muthi trade as an economic and developmental issue. The Umbrella Body also tried to put into practice ideas of participatory democracy. Instead of having policy imposed upon traditional healers, the Umbrella Body sought to encourage the participation of all its stakeholders in this process of negotiation by operating through the medium of workshops.

The Umbrella Body's structure also encouraged inter-sectoral collaboration between different stakeholders. Through the Body, traditional healers were able to engage with nature conservationists, City Health as well as other Departments in the municipality. Skinner argues that, "for the interests of street traders to be secured, trader organisations need to have the capacity to

engage with political processes" (Skinner, 2000:12). The Umbrella Body provided muthi traders and traditional healers with a vital channel through which to engage with political processes around issues that affected them.

4.9 The planning and development of the Durban muthi market

In 1996 concrete planning for a new muthi market was initiated through the Umbrella Body (Nesvåg, 1999:141). A commissioned survey conducted by the INR on the trade in traditional medicines in Durban area revealed that R170 million was generated annually by the market. These findings provided important political impetus for the upgrading and development of the muthi trade (1st Interview with Tobias Mkhize).

In April 1997 the various stakeholders within the Umbrella Body agreed to situate the new market on an unfinished bridge over Berea Station and next to Russell Street (Nesvåg, 1999:148). Construction started in late 1997 and the traders began moving into the market in May the following year, although the market was only officially opened in October of 1998 (Nesvåg, 1999:148).

4.10 The new muthi market: the formalisation of traditional healing and muthi trade in Durban City

The establishment of the new muthi market has resulted in a formalisation of traditional healers and muthi traders within the Durban municipality. With the infrastructural and social benefits of the new market, traders and healers have had to take on the responsibility of more formalised businesses, complying with rents, permits and regulations. Traditional healers' and traders' attitudes towards formalisation have also changed in this process. Rather then viewing 'formalisation' as a way for the municipality to control and exploit traders, and seeing informality as a means of escape from this control, traders have begun to see formalisation as a form of protection against new competition. Organised traders agreed that once they were given a new market, that they

would support the new street trading by-laws (Nesvåg, 1999:143). Nesvåg stresses that organised traders were concerned about economic competition caused by new traders who would fill their old places once they had moved to the new market (Nesvåg, 1999:143). Organised traders hoped that these new informal trading by-laws[21] would limit the number of new traders, and in so doing protect them from competition. Organised traders were determined to "protect their own interests even to the degree where it meant imposing and supporting a regulatory environment which they themselves had fought" in the past (Nesvåg, 1999:143).

4.11 Conclusion

The participation of traditional healers and muthi traders in various struggles and negotiations around their economic and social rights as informal traders and traditional health practitioners has played a pivotal role in facilitating and mobilising the organisation of the traditional healing community in the Durban City. The Umbrella Body has enabled traditional healers to work together and has paved the way for traditional healers to move towards professionalisation and the formation of the KwaZulu-Natal Traditional Healers Council.

Negotiations around the establishment of a new muthi market have also facilitated other forms of organisation and formalisation among traders and traditional healers. With the structural and economic benefits of the new muthi market, traders and healers have had to take on the responsibility of more formalised businesses, complying with rents, permits and regulations. Although there is still some resistance to this, muthi traders' and traditional healers' attitudes towards formalisation are changing. Formalisation is no longer simply perceived as a form of repression and control, but is also seen as a means through which to achieve greater economic security, improved working conditions and recognition as professionals.

[21] The new trading by-laws regulated informal trade by requiring traders to register, and to pay a monthly fee for their site and other municipal services.

These processes have helped to unify the traditional healing community, but they could also reinforce existing divisions and tensions within this community. SEWU's decision to sideline itself from the process of negotiations partially represents the marginalisation of the interests of female gatherers in this process. These tensions are also reinforced within the muthi market as established traders attempt to use formalisation as a way of protecting their interests against those of newer unorganised traders. In both these cases, the disadvantaged groups tend to be female gatherers who have no formal training as izinyanga or izangoma. The forms of organisation and formalisation, which have emerged as a result of these developments, may reinforce not only divisions within the traditional healing community, but also gendered divisions within the informal economy as well.

The process leading up to construction of the new muthi market for traditional healers traces a shift in the Durban municipality's interaction with traditional healers from a repressive to a regulatory relationship. This shift correlates with the beginning of a movement within traditional healing practice in Durban from an informal to a more formalised occupation. These developments at local government level, in turn, parallel a movement towards the formalisation and professionalisation of traditional healers at a provincial and national level of government.

Chapter 5: Renegotiating the boundaries of healing identity and practice: The formation and early development of the KwaZulu-Natal Traditional Healers Council

5.1 Introduction: The formation of the KwaZulu-Natal Traditional Healers Council

The KwaZulu-Natal Traditional Healers Council is the culmination of a number of different processes and struggles around the right of traditional healers to formal government recognition. At a local government level the KwaZulu-Natal Council has been facilitated by the convergence and discussion created by the Umbrella Body. The creation of the Council has also been facilitated by the close political relationship between traditional leaders and traditional healers in the province[22]. At a national level the formation of the KwaZulu Natal Council is the result of a prolonged process of lobbying on the part of traditional healers, as well as an extensive process of negotiation between the government and traditional health practitioners. A number of traditional healers' associations in South Africa have been petitioning the government for formal recognition and the removal of discriminatory legislation regarding traditional healers since the 1980s. Amongst these traditional healers there has been a growing sense of their right to formal recognition from government and to some kind of financial support for the value of the health services they provide.

With the exception of the South African Traditional Healers Council[23], the associations involved in this lobbying process approached government individually and in an unorganised and random capacity. The National Health Department stressed that there was "a great need for the Department to be able to liase and negotiate with a national body" representing all groups of

[22] The 1996 National Council of Traditional Leaders Bill makes reference to the establishment of a National Council of Traditional Healers. Stakeholders discussing the Bill decided that there was first a need to establish provincial Councils in order to pave the way for a national Council (Personal communication Thokozani Xaba, 5th September 2003).

[23] The South African Traditional Healers Council was formed in Johannesburg in 1986 and had a number of traditional associations affiliated to it (Chief Zungu, 1992: 25-6).

traditional healers in South Africa, before serious discussions on the recognition of traditional healers and their role in health care delivery could begin (Muller, 1992:31). Consequently the government called on traditional healers to begin organising themselves more effectively and to begin fostering "greater cohesion amongst themselves". At the same time traditional healers were also increasingly experiencing a need to professionalise in order to be accepted as "more equal and effective partners" in health care delivery, particularly in the area of HIV/AIDS (Leclerc-Madlala, 2002:63).

The government has assisted traditional healers in this task by laying down a legislative framework to enable the professionalisation of traditional healers. The drafting of The Traditional Health Practitioners Bill (2003) represents a fundamental step towards the formal recognition of traditional healers in South Africa. This Bill provides for the establishment of an Interim Traditional Health Practitioners Council. The objectives and functions of the Council are to "assist in the promotion of health", to "ensure quality of health care in traditional health practice", and to "protect and service" the interests of the public[24].

The Bill provides for the establishment of a "regulatory framework to ensure the efficacy, safety and quality of traditional health care services" and " for control over the registration, training and practice" of traditional health practitioners"[25]. The Bill will exercise these provisions through the Interim Traditional Health Practitioners Council. The Council is also tasked with a broader set of responsibilities concerned with guiding "the occupation of traditional health practice". These include promoting and developing traditional health practice by encouraging research, maintaining the dignity and integrity of traditional healing, determining policy on traditional healing and advising and consulting with the Health Department and other authorities[26]. Traditional healers in KwaZulu-Natal have publicly participated in the drafting of the Bill through attending meetings between the KwaZulu-Natal

[24] Traditional Health Practitioners Bill, 2003, Chapter II Clause 5.

[25] Traditional Health Practitioners Bill, 2003 Preface.

[26] Traditional Health Practitioners Bill, 2003, Chapter II Clause 5.

Council and the Department of Health where healers have been able to give input into the content of the Bill.

In response to the Traditional Health Practitioners Bill several provincial Traditional Healers Councils have been formed to assist the national Interim Council in its responsibilities. KwaZulu-Natal was the first province to form such a Council. The rapid formation of the KwaZulu-Natal Traditional Healers Council was facilitated by the Umbrella Body, which brought traditional healers in the province together and created a platform for discussion and debate amongst traditional healers. In 1996, precipitating the first draft of the Traditional Health Practitioners Bill, traditional healers in the Umbrella Body discussed the formation of a professional Board or Council for indigenous practitioners. After this discussion the Umbrella Body agreed to send two delegates from the Department of City Health to meet with the Deputy Director General of Health in KwaZulu -Natal to discuss this initiative. This was followed by a series of meetings, which, in conjunction with the introduction of the Traditional Health Practitioners Bill, culminated in the formation of the KwaZulu-Natal Traditional Healers Council in 1999[27]. The Department of City Health acted as a consultant, co-ordinator and facilitator during this entire process (Mkhize, 1998:9).

The formation of the KwaZulu-Natal Traditional Healers Council represents a significant step towards the integration of traditional healers in the province under a single regulatory framework. The development of the Council also represents a reassertion of the status of traditional health practitioners, and an assertion of their rights to official recognition by the government.

The professionalisation of traditional healers raises a number of important questions: why should traditional healers professionalise?; what is their role in contemporary society?; how should traditional healers professionalise their practice?; is professionalisation the most suitable form of organisation for traditional healers? These questions intersect with a range of contemporary

debates concerning the role of traditional healers in the health care system and the relationship between traditional healers and the state. An analysis of the objectives and aims of the KwaZulu-Natal Council, as well as the challenges facing the Council, provides a good entry point into many of these debates around the professionalisation of traditional healers and their role in contemporary South Africa.

5.2 The function of the KwaZulu-Natal Traditional Healers Council

Mr. Jerry Mhlongo, president of the KwaZulu-Natal Council, describes the Council as a body which exists to unite, educate, control and regulate traditional healers and to prevent persons practising as traditional healers without appropriate qualifications (Interview with Mr. Jerry Mhlongo, President of the KZN Traditional Healers Council, 28th January 2003). Prior to the establishment of the Council many traditional healers were particularly concerned about the number of charlatans fronting as legitimate healers. They were also concerned about trained traditional healers abusing their authority by forming associations simply to benefit from the subscriptions (Interview with Mr Jamile, Deputy President of the KZN Traditional Healers Council, 22nd January 2003). Legitimate traditional healers felt that such individuals were discrediting the reputation and status of traditional healing. This was one of the key concerns motivating these traditional healers to support professionalisation and the establishment of a formal body to regulate healers and root out charlatans. By concerning themselves with defining the boundaries of legitimate healing practice against what they considered illegitimate, traditional healers engaged in one of the fundamental features that has also marked the process of western medical professionalisation.

The function of the KwaZulu-Natal Council is to assist the national Interim Council in the execution of its responsibilities. The provincial Council will therefore be responsible for examining, monitoring and registering traditional healers in KwaZulu-Natal. Within the leadership of the Council, however,

[27] The Umbrella Body continued to exist and operate up until 2001 when it became the

there is a broader and more complex understanding of the responsibilities of the Council. This leadership understands the Council as a body, which is there to protect and assist traditional healers in legal matters such as accusations of malpractice. This leadership also sees the Council as playing a role in developing the social and economic capacity of traditional healers by educating and equipping them with the skills and resources necessary to care for patients effectively. The Council is also viewed as a channel through which to begin re-establishing and re-asserting a traditional healing culture and practice that has been marginalised in the past (2nd Interview with Ernest Gwala, Public Relations Officer, eThekweni regional Committee, KZN Council 19th February 2003).

The subtle differences between the official function of the Council, which is to control and regulate traditional healing practice, and the complex and broader function of the Council expressed by its leadership, reveals a potential tension between the way government and traditional healers themselves understand the role of the traditional healers in society and how far their authority, power and responsibilities should extend. This tension will be looked at in greater detail in the following chapter under the Council's relationship with the Department of Health.

5.3 Structure of the Council

The KwaZulu-Natal Traditional Healers Council is a provincial body with an executive committee of fifteen members. Membership is open to all qualified izinyanga, izangoma and abathandazi (faith healers), at a membership fee of R200, which must be renewed annually (1st Interview with Tobias Mkhize). After the enactment of the Bill traditional healers in the province will be given one year to register themselves with the KwaZulu-Natal Council. All traditional healers who have not registered after this period of time will be criminalised from practising under the Traditional Health Practitioners Act. Before traditional healers are allowed to register with the Council they have to

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eThekwini regional committee of the KZN Traditional Healers Council.

undergo an examination supervised by the Council to ensure that they are adequately qualified. The examination procedure and the nature of the qualifications required are being debated at present, and will be discussed in greater detail in the following chapter.

The KwaZulu-Natal Council is currently divided up into seven regional councils that parallel the seven regions of the province (Interview with Mr Mhlongo). Each region is in turn divided up into a number of districts. In each region there is a regional committee, which is responsible for organising the traditional healers in their region (1st Interview with Ernest Gwala). In future the Council is planning to do away with the regions and follow local municipal structures instead. The KwaZulu-Natal Council will therefore establish eleven district councils that will parallel the municipal council structures in the province (Interview with Jerry Mhlongo).

5.4 Redefining the boundaries of traditional healing

> Traditional healers are one of the few groups in South Africa practising and maintaining African culture and history. Traditional healers therefore have to teach people about African culture, as well as HIV/AIDS, drug abuse and about loving the soil and using the soil to plant food and herbs and to graze livestock (Ernest Gwala, KZN Traditional Healers Council).

This quote by one of the regional leaders of the KwaZulu-Natal Traditional Healers Council identifies some of the key concerns and priorities of the Council. The Council's focus on a number of specific traditional and contemporary issues reveals the way in which traditional healers in this province are reaffirming an older identity, as well as reconstructing a newer and broader identity and sphere of practice, as traditional health practitioners. The construction of this new identity will be explored through analysing some of the key priorities and concerns of the Council.

5.4.1 The quest for political representation

Traditional healers in the KwaZulu-Natal Council are increasingly coming to see political representation as a key, which can potentially open up access to resources for the Council and influence in policy making. This new awareness is evident in the Council's request for better representation on government structures. Ernest Gwala, a committee member of the eThekwini region of the Council, said that the Council wants to be represented at local, provincial and national levels. The Council also wants a specific minister for traditional healers at national and provincial level. Locally, the Council wants representation on all government sectors, including a representative on the municipal Council (1st Interview with Ernest Gwala).

The Council's request for representation on government structures, suggests that traditional healers' understanding of their position within the state and South African society, has broadened to include not only formal recognition by government, but also political representation. This demand seems to suggest that the Council wants to establish itself as a politically powerful institution that can draw strength and influence from other government structures. It also suggests that traditional healers feel there is a need to be politically powerful in order to secure a certain degree of recognition and authority.

This is a very ambitious demand and it is unlikely to be completely realised. It seems to indicate that traditional healers perceive themselves as politically more important than they are perceived by government, revealing a tension between the narrower understanding of the Council held by government, and the broader more ambitious understanding of the role of the Council held by its leadership. Representation on government structures will give the Council greater political power, but this representation will also feed into and reinforce the well-established traditional power and legitimacy of healers. Representing

traditional healers in government structures brings traditional authority and legitimacy into government. This may be a source of concern to the ANC government since traditional healers are closely aligned to the IFP dominated traditional leadership in KwaZulu-Natal.

5.4.2 The Council's HIV/AIDS Policy

Although traditional healers' practices are often associated with the spread of HIV, a significant group of traditional healers in KwaZulu-Natal have in fact been pioneers in HIV/AIDS prevention and management. For the past eight years a number of traditional healers in the province have been participating in and running AIDS training workshops through the AIDS Foundation, (Interview with Queen Ntuli, Secretary KZN Traditional Healers Council, 26th May 2003). These traditional healers have expressed a strong commitment to the fight against HIV/AIDS.

Within the Department of Health there has also been a growing awareness of the invaluable role that traditional healers can play in HIV/AIDS prevention and education. Motivated by this new awareness the Department has begun to organise training workshops for traditional healers (Interview with Queen Ntuli). Before 1999, the Department of Health worked with traditional healers through their Primary Health Care programmes, however the Department came to realise that there was a need to appoint a specific portfolio to organise and co-ordinate the training of traditional healers. This specific portfolio was formed in 1999 and situated in the Provincial HIV/AIDS Action Unit. In 2000 the Provincial Department of Health trained the first group of thirty traditional healers in HIV/AIDS, STIs, TB, diarrhoea and other common aliments. These traditional healers were trained as master trainers who were then requested to go out and train other traditional healers in their districts. The Department of Health assisted these master trainers in this process by providing finances and a member of staff to facilitate these training sessions (Interview with Margaret Shangase, Assistant Director provincial HIV/AIDS

Action Unit, 18th June 2003). Queen Ntuli estimates that more than 10 000 traditional healers in KwaZulu-Natal have received some form of training either through workshops run by the AIDS Foundation or through the Department of Health (Interview with Queen Ntuli).

HIV/AIDS is also a priority for traditional healers in the Council. Through their work with patients and their families, traditional healers have a valuable and unique insight and experience into the devastating impact of HIV/AIDS. A number of traditional healers in the Council leadership, like Queen Ntuli, were part of the initial group of master trainers, trained by the Department, and remain active in training other traditional healers in areas such as AIDS awareness and counselling, home based care, STIs and TB. Ntuli and her colleagues distribute free condoms and advise their patients on the importance of having a blood test. They also try to involve the patient's family by counselling them to prevent stigma and teaching them about home based care skills (Interview with Queen Ntuli).

The Council has also created several structures to tackle issues around HIV/AIDS. Each region of the Council has an AIDS forum, which exists to provide a platform for discussion around HIV/AIDS. The KwaZulu-Natal Traditional Healers Council also has an HIV/AIDS Unit that includes a research section, and an HIV/AIDS provincial task team. The function of this task team is to ensure that there is proper communication between the Department of Health, the national Interim Council of Traditional Healers and the KwaZulu-Natal Council on all issues relating to HIV/AIDS (Interview with Margaret Shangase).

HIV/AIDS is having a significant impact on the resource base and financial position of many traditional healers. The pandemic has drastically increased the morbidity and mortality of the South African population. The government's delay in rolling out a comprehensive treatment programme, including antiretrovirals, together with the under resourced condition of South Africa's

public health system has driven many AIDS patients to seek the assistance of traditional healers. Other AIDS patients turn to traditional healers first. In these cases the lack of services and resources in the public sector means that traditional healers often cannot refer patients to state hospitals but have to treat the patients without any assistance from state institutions. Patients frequently stay with the traditional healer for an initial period of their treatment so the healer has to provide food and accommodation for the patient. I have also been told that traditional healers cannot refuse a patient if they are unable to pay for their treatment (Interview with Queen Ntuli). This is placing both a financial and a psychological burden on traditional healers.

The South African government's emphasis on Home Based Care (HBC) has been heavily criticised by social welfare and feminist scholars for the way it out-sources the burden of care from state institutions onto primary care givers, the majority of whom are poor black women. Because a large number of AIDS patients are brought to traditional healers after dismissal from hospital or as an alternative to visiting the hospital, the government's HBC policy can be equally heavily criticised for the way it out-sources this burden of care onto traditional healers.

Traditional healers in the Council base their right to financial support from government on the argument that they provide an invaluable public service. Traditional healers subsidise the state by taking on the costs of treating patients who are unable to pay for their treatment and by subsidising the training of new traditional healers (Interview with Queen Ntuli). They also argue that access to financial support, as well as other kinds of medical resources such as condoms and home based care kits, will enable them to engage more effectively in health care, especially in the care and treatment of HIV/AIDS patients. Chavunduka and Last emphasise that professionalisation can enable traditional healers to benefit from the distribution of national resources (Chavunduka and Last, 1986:269). Access to financial support is one of the key motivations behind the drive towards professionalisation

amongst traditional healers in KwaZulu-Natal. Traditional healers in the Council are trying to use their newly recognised status as traditional health practitioners to claim access to new resources and financial benefits.

5.4.3 Training as a key function of the Council

The Council views teaching and educating as their main role in the fight against HIV/AIDS. In commitment to this the eThekwini branch of the Council has drawn up a document, which outlines the AIDS training programme to be used in the eThekweni region. This document commits the Council to train its members, who are then requested to train other traditional healers who will be responsible for training the communities in which they live. The document also calls on traditional leaders and traditional leaders' Councils to participate in this training (1st Interview with Ernest Gwala). It is significant to note that both the Council and the Department of Health have been influenced by the USAID traditional healer training projects that took place in South Africa during the early 1990s, and that were based on the concept of developing master trainers[28].

The Council's emphasis on training and education around the issue of HIV/AIDS reflects a broader commitment to training and education in the Council. For the leadership of the Council training and education is seen as one of the key functions of the Council. Training is seen as a way of developing and empowering the traditional healing community, as well as combating and correcting incorrect practices within this community.

Even though there is a strong commitment to training in the Council there are a number of difficulties with the implementation of both the Council's and the Department of Health's training programmes. The training conducted by the Council tends to be centered in Durban. At present these training sessions are also organised sporadically rather than regularly. There is a need for the Council to try and take training out into other areas of the province especially

[28] These training projects were referred to in Green's research in Chapter One.

rural and peri-urban areas on a regular basis. Transport costs are another obstacle preventing traditional healers from accessing training (Interview with Margaret Shangase). Financing transport for traditional healers to attend training sessions would provide a way of significantly increasing the number of healers who are able to access training. Although the Department of Health assists in financing training sessions, more financial assistance is needed to enable the Council to conduct training sessions on a more regular basis throughout the province.

5.4.4 Protecting indigenous knowledge systems and medicines

Traditional healers in the Council are also constructing a professional identity for themselves around the issue of control over the use of indigenous medicines and knowledge systems. This is an area where traditional healers are considerably disadvantaged by the unequal power relationship between traditional healing and western biomedicine. The traditional healers in the Council argue that researchers and pharmaceutical companies are 'exploiting' and 'plundering' traditional medicines and traditional healers' knowledge of how to mix and use these medicines. Traditional medicines such as the African potato and isibhaha[29] are currently being sold under foreign brand names in South African pharmacies. High prices are often charged for these medicines ranging from R100-R150 (1st Interview with Ernest Gwala).

A survey conducted by the FAO in 1998 on the medicinal trade in KwaZulu-Natal confirms that there is an "an imbalance in support for indigenous medicine" with research and development into traditional medicines "directed at bio-prospecting and pharmacological investigations", and that very little effort has been made to develop "the current markets, their associated products, infrastructure and market players" (Mander, 1998:4).

According the Jerry Mhlongo, the Council wants to be the sole owner of intellectual property rights regarding traditional medicinal plants (Interview

[29] Isibhaha is a traditional medicine made from the aloe plant. It is administered externally for wounds and skin irritations. It can also be taken internally for its antiseptic properties

with Mr Mhlongo). The Council believes that the most effective way to protect traditional medicine from exploitation is through giving the Council exclusive rights to register and patent traditional medicines (1st Interview with Ernest Gwala).

There is also a strong financial motivation behind these demands. The FAO survey emphasises that there is "a large and growing local and international demand for medicinal plants", and that this demand is unlikely to decrease with a rise in levels of education and formal health care (Mander, 1998: 4). The Council is aware of this market potential and consequently supports the commercialisation and exportation of traditional medicine provided that it controls these processes and receives financial benefits. However, the Council is not currently working towards securing intellectual property rights, as its attention has been focused on more grass roots needs such as establishing the organisation, building capacity and securing funding.

Even after the Council has established itself it is unlikely that it will have the capacity or financial resources to undertake the necessary research on traditional medicines to be able to apply for patents. This is an area where an equal partnership between the Council and various formal research institutes could benefit traditional healers considerably. Chavunduka and Last emphasise that professionalisation can benefit traditional healers by giving them greater institutional recognition. Professionalisation puts traditional healers in a stronger position to fight for entry into medical institutions and to participate in the funding, teaching and research taking place in these institutions. Greater institutional recognition would be a significant benefit for traditional healers who under current law remain "excluded from entry into institutions sanctioned by the South African Medical and Dental Council (SAMDC) to train registered health professionals" (Urbasch, 2002:8).

Professionalisation is also likely to benefit traditional healers by enhancing the status of research on traditional medicines and by enabling this research to be

treated seriously and to be given the necessary funds and institutional support that it requires (Chavunduka and Last, 1986:268). Chavunduka argues that the establishment of a Traditional Medical Practitioners Council in Zimbabwe made research into traditional medicines easier and more accessible than in the past. By formally acknowledging the work of traditional healers, the Council has helped to break down the stigma associated with traditional healing during the colonial period, and this has made traditional healers more open and willing to discuss and share their work (Chavunduka, 1992:12).

The benefits offered by professionalisation are slowly starting to be seen in several developing partnerships between traditional healers and universities in South Africa. At the University of Cape Town a project known as TRAMED is currently collecting and analysing the pharmacological components of plant substances used by local healers with the aim of establishing "a national data-base on the pharmacopoeia and use of traditional plants" (Karim 1994 quoted in Leclerc-Madlala, 2002:67-68). In November 2000 a project known as the Traditional and Complementary Health Initiative (TCHI) was launched at the University of Natal Medical School. The project aims to encourage closer working relations between traditional healers and the medical profession and also aims to find "ways to bridge the gap between traditional medicine and biomedicine in order to improve HIV prevention and AIDS care" (Leclerc-Madlala, 2002: 67).

5.5. Building the Council: successes and failures

5.5.1 The Challenge of achieving majority representation within the Council

Although the KwaZulu-Natal Council has made significant progress in establishing a legislative and theoretical framework for a unified provincial organisation of traditional healers in KwaZulu-Natal, in practice the Council is still relatively weak. The Council's membership is small and does not yet represent a majority of traditional healers in the province. According to Mr.

Mhlongo, in January 2003 the KwaZulu-Natal Traditional Healers Council had 1200 members (Interview with Jerry Mhlongo). According to the FAO, however, there were estimated to be between 7 600 to 15 600 traditional healers operating in KwaZulu-Natal in 1998 (Mander, 1998:76).

Because the Council is a new organisation, and is still developing its organisational capacity, it is too soon to expect it to have secured its full membership. Any evaluation of the progress made by the Council needs to take into account the fact that organisations such as the KwaZulu-Natal Traditional Healers Council take time to develop. At this stage however it is possible to begin evaluating how the Council is laying down the foundation of its organisational structure and how it is attempting to build channels to reach traditional healers on the ground.

The Council's ability to achieve a representative membership will significantly depend on the organisations ability to foster awareness and support for itself amongst traditional healers. Even though there is a general awareness of the existence of the Council there appears to be a lacuna of more specific communication about the function of the Council and the support it can offer traditional healers.

The seven regional committees of the Council are responsible for establishing communication networks with the traditional healers in their regions. The Council leadership, however, has acknowledged that there appears to be a communication break down between these regional committees and traditional healers on the ground (1st Interview with Ernest Gwala). Information about the Council is conveyed mainly through Council meetings, which take place in each region. It is only traditional healers who attend these meetings who are properly informed about the Council. (Interview with Mquansa, Makhathini, Researcher for the KZN Council, 9th May 2003) This communication break down may also be compounded by the fact that many traditional healers are non-literate and therefore do not have access to written

information about the Council.

The KwaZulu-Natal Council needs to find a way of encouraging traditional healers to attend its meetings. These regional meetings are the first point of contact between ordinary healers on the ground and the Council. At present the majority of traditional healers in the province do not attend the Council's meetings (Interview with Queen Ntuli). Furthermore many healers who attend meetings are not signed up members of the Council (1st Interview with Ernest Gwala). Traditional healers are often very busy and are not prepared to relinquish the opportunity cost of missing a day's consultation. Other traditional healers cannot afford the travelling expenses required in order to attend the meeting.

This communication break down is closely linked to the Council's failure to bring in and work with other traditional healers' associations in the establishment of the Council, and has contributed to a certain amount of resistance to the Council (Interview with Mquansa Makhathini). Although The Traditional Health Practitioners Bill will to some degree enforce membership of the Council, the Council also needs to find a way of conveying the importance and value of attending meetings to traditional healers.

Traditional healers' poor attendance at meetings is also linked to the fact that they lack information about these meetings. The Council needs to identify and develop other communication channels to bridge the gap between traditional healers on the ground and the regional or the district meetings of the Council. Ernest Gwala, a committee member of the eThekwini regional Council emphasised that the eThekwini regional Committee was keen to organise radio programmes about the Council on the popular Zulu radio station, Khosi fm, in order to inform the community about what the Council is doing and to educate the public about traditional healing practices. Gwala also felt that it would be good for the Council to communicate through newspapers (2nd Interview with Ernest Gwala, 19th February 2003).

5.5.2 Building capacity within the Council

Chavunduka and Last note that one of the problems with newly formed, government sponsored national healers' organisations is that they tend to be inexperienced in the necessary bureaucratic and organisational workings required of such a body. Traditional healers also need to be taught a new set of skills in order to function in the new organisation (Chavunduka and Last, 1986:263). Building capacity is one of the most significant challenges the KwaZulu-Natal Traditional Healers Council currently faces. The Council is tasked with the responsibility of developing its leadership as well as the broader traditional healing community, who are all prospective members of the Council (1st Interview with Ernest Gwala).

The City Health Department has assisted the Council in building organisational capacity by providing training to committee members on the administrative functioning of the Council (2nd Interview with Tobias Mkhize, 3rd June 2003). The City Health Department has played an important role as a facilitator in the Council's formation and development, however the Council will also have to develop partnerships with, and draw on the expertise of a range of different bodies such as government departments, research institutions and NGOs, in order to develop the necessary capacity to register and regulate traditional healers in the province effectively. Building this capacity will require a long-term framework.

A lack of capacity has contributed to several organisational and management problems within the Council. Firstly, the Council has failed to receive any financial assistance from the government or other sectors, as there is a lack of confidence in the capacity of the Council to manage these finances. The AIDS Foundation has granted the Council funding of R100 000, although the Foundation has refused to hand over this grant because the organisation was

concerned about the capacity of the Council to manage these funds correctly (Interview with Margaret Shangase). The Council was asked to draw up a business plan detailing how these funds would be spent but the Council leadership lacked the skills to complete this plan (2nd Interview with Tobias Mkhize). The AIDS Foundation will only hand over these funds once they have a detailed account of how the money will be spent (Interview with Margaret Shangase). This incident emphasises that the Council leadership still needs to develop many of the skills that it requires as a professionalising body, such as the skills required to draw up funding proposals and business plans, as well as the skills required to access and use information and new technologies (1st Interview with Ernest Gwala).

Securing funding from the government, or other sectors, is a key concern of the Council leadership. The Council leadership believes that a lack of funding and a lack of access to resources, are the biggest obstacles preventing traditional healers from providing an effective health care service (Interview with Queen Ntuli). If funding is received by the Council its will be prioritised for use in a number of specific areas. Firstly it will be designated to provide training for the Council's membership and leadership. Secondly it will be channelled towards developing traditional hospitals, clinics and mobile clinics where communities can receive traditional treatments (1st Interview with Ernest Gwala).

The Council's inability to compile a database of its membership is another example of the organisation's lack of capacity. Without a database the Council is unable to access any demographic information about its members that may be needed in skills assessment and training programmes. It is essential that the Council develop the skills and capacity to compile a comprehensive database of its membership, as this database will be essential in enabling the Council to monitor and regulate traditional healers in the province, and to ensure that unlicensed healers do not practice (Interview with Queen Ntuli).

5.5.3 The search for public legitimacy: traditional healers and control of the media

Fassin and Fassin argue that part of the process of professionalisation for traditional healers is a search for new forms of legitimacy (Fassin and Fassin, 1988 353). They emphasise that traditional healers, whose legitimacy has in the past been located within the space of the traditional, are now also striving to achieve rational-legal, and other forms of legitimacy. This search for new forms of legitimacy is also evident in the KwaZulu-Natal Traditional Healers Council. The Council is currently attempting to develop a public legitimacy for itself, by trying to exert a certain amount of control and influence over the media's representation of traditional healers.

Prior to the formation of the Council, and during the Council's earliest phases, the misrepresentation of traditional healers through the publishing of unverified stories about witchcraft was a significant problem for traditional healers (2nd Interview with Ernest Gwala). During the early 1990s there were a number of 'witch killings' and 'muthi killings', which received distorted and sensationalist coverage by the media (Xaba, 2002: 34). The fact that the media often did not clearly distinguish between legitimate traditional healers and impostors who practised witchcraft concerned the Traditional Healers Council.

The Council has managed to control this problem by sending a moratorium to the local media, including the S.A.B.C and the Independent Newspapers, requesting the media not to publish anything about the traditional healing community without consulting the Council first (2nd Interview with Ernest Gwala). The Council has also urged the South African police to consult the Council first if they discover a supposed healer with human body parts (2nd Interview with Ernest Gwala). In this way the Council, as a body representing all traditional healers in the province is given the opportunity to disassociate itself from the actions of a particular individual and to condemn those actions.

If the person apprehended is a member of the Council, the Council is given the public opportunity to discipline and denounce its members' actions.

The Council is also interested in using the media to establish a popular legitimacy within the traditional healing community itself. This is evident in the eThekwini regional committee's interest in organising radio programmes about the Council on Khosi fm, and in local newspapers, in order to inform the community about what the Council is doing and to educate the public about traditional healing practices (2nd Interview with Ernest Gwala).

Fassin and Fassin argue, "new forms of legitimacy produce new authorities for legitimisation"(Fassin and Fassin, 1988 356). In the case of the KwaZulu-Natal Traditional Healers Council, traditional healers are working through the media to achieve a popular legitimacy in the eyes of the general public.

5.6 Conclusion

The KwaZulu-Natal Traditional Healers Council represents a fundamental step towards the professionalisation of traditional healers in KwaZulu-Natal. The formation of the Council has provided traditional healers with a platform to begin broadening, re-affirming and re-negotiating their identity as traditional health practitioners. Traditional healers are also using claims to professionalisation to demand greater political representation and access to economic resources. The Council's focus on a number of specific issues reveals the way in which traditional healers in this province are reaffirming an older identity, as well as reconstructing a newer and broader identity and sphere of practice, as traditional health practitioners. The Council's concern with protecting and developing indigenous knowledge systems illustrates this. The Council is using its traditional identity and authority to claim ownership of the intellectual property rights of traditional medicines and knowledge systems in KwaZulu-Natal. Simultaneously the Council is also interested in engaging with contemporary ideas, such as the commercialisation and export of

traditional medicines, in order to develop the new economic potential of traditional medicines.

In assessing the progress made by the KwaZulu-Natal Traditional Healers Council, the context of the Council and of traditional healers in South Africa must also be taken into account. The Council is still a relatively new body. Its members and leadership are emerging from a history of marginalisation and have not had the opportunity to develop their practice and their organisational skills. The KwaZulu-Natal Traditional Healers Council, like other institutions of a similar nature, will take time to develop. One of the significant challenges facing the Council is the challenge of building capacity. The Council needs to build capacity in order to develop its organisational structure and to ensure proper financial management. In addition, the Council needs to build capacity to be able to fulfil its function as a professionalising body, responsible for the registration, examination and regulation of traditional healers in KwaZulu-Natal. To function successfully as a professionalising body, representing all traditional healers in KwaZulu-Natal, the Council also needs to gain the trust and support of the broader traditional healing community. This is the one of the central focuses of the following chapter, which explores some of the divisions and tensions within the Council, and the broader traditional healing community.

Chapter 6: Creating a unified organisation: mediating tensions within and beyond the Council

6.1 Introduction

This chapter analyses the dynamics between different groups of traditional healers within the Council and between the Council, the broader traditional healing community and the Department of Health. The chapter begins by outlining traditional healers' responses to Council and the areas of support and resistance to the Council. The chapter goes on to look at some of the divisions and areas of tension in the Council, and in the broader healing community, exploring how these divisions reflect particular power dynamics in the Council as well as divergent ideas about the future of traditional healing and appropriate traditional healing practice. The chapter explores how the Council has tried to manage these divisions and areas of tension and where it has been successful or failed. The final section of this chapter explores the relationship between the KwaZulu-Natal Council, the Department of Health and the government. This section argues that the Council's support for a mutual referral system reveals differences and tensions in the Health Department's understanding of professionalisation, and traditional healers own understanding of the function and possibilities of professionalisation.

6.2 Understanding traditional healers' responses to the KwaZulu-Natal Council

Traditional healers support the KwaZulu-Natal Traditional Healers Council because they see the Council as a channel through which to achieve government recognition. Queen Ntuli, secretary of the Council, said that traditional healers supported the idea of the Council because it gave traditional healers official recognition (Interview with Queen Ntuli). Ernest Gwala acknowledged that some traditional healers' associations felt that the Council had usurped their power, but he also stressed that others saw the

Council as an institution, which had given traditional healers a voice to government (1st Interview with Ernest Gwala).

Traditional healers who support the Council believe that the Council will be able to assist them in gaining access to training, resources and other opportunities. These traditional practitioners feel that the Council has put traditional healers together and enabled them to work with each other (Interview with Inyanga Mthimkhulu, 28th May 2003). A number of muthi traders support the Council because they believe that the Council will be able to assist them to obtain permits to harvest traditional medicine and that the Council will be able to prevent the police from harassing traders (Interview with Muthi trader 1 and Muthi trader 2, 28th May 2003).

Many traditional healers also expect the Council to provide opportunities for traditional healers to collaborate with the formal health care sector. One of the izinyanga interviewed in the course of this research said that he wanted the Council to help him get permission to work hand in hand with hospitals. He stressed that if traditional healers and doctors could work together and share information that they would be able to heal any kind of sickness (Interview with Inyanga Mthimkhulu).

Traditional healers' opposition to the Council stems from a resistance to change, as well as the need to maintain a 'traditional' identity. This opposition is based on an understanding that the nature of traditional healing is unsuited to the kind of restructuring required by professionalisation. Yet it is misleading to simply associate professionalisation with a desire for change, and opposition to professionalisation with resistance to change. These two perspectives are part of a broader debate about whether professionalisation is a suitable institution or structure for traditional healers. In *The Professionalisation of African Medicine,* Staugard argues against professionalisation and the integration of traditional medicine into the formal health care system, emphasising that such institutional changes would

damage or destroy the unique character of traditional medicine. Staugard also argues against professionalisation on the basis that it will disrupt traditional healers' socio-cultural position in their communities (Staugard, 1986: 67).

In South Africa the individualistic and personal nature of certain aspects of traditional healing practice, where ancestors visit a traditional healer in their dreams, communicating to them the correct medicines to use for each patient, make certain traditional healers cautious of organising. Some traditional healers believe that organising in a group is untraditional and against the wishes of the ancestors (1st Interview with Ernest Gwala). The relatively high level of competition and secrecy associated with traditional medicinal trade and practice in KwaZulu-Natal also makes certain traditional healers weary of having too much contact with other traditional healers (Mander, 1998:50).

The legacy of previous traditional healers associations, which collected membership fees from traditional healers with the promise of various benefits, but which gave them nothing in return, has created a sense of distrust in traditional healers' associations or bodies. There is a certain amount of unwillingness amongst traditional healers to pay the Council's R200 joining fee (Interview with Queen Ntuli). Some muthi traders and traditional healers, especially those at the lower end of the value chain in traditional healing practice, also struggle financially to pay this membership fee. The unstable and fluctuating incomes associated with informal trade mean that healers and traders may join for their first year, but may not be able to renew their membership the following year (Interview with Margaret Shangase). The Council needs to ensure that it is able to achieve both a representative and a sustainable membership.

6.3 Mediating conflict and tension in the Council

6.3.1 The relationship between the Council and other traditional healers associations

Power relations and differing perspectives between different groups within the traditional healing community have also shaped traditional healers' responses to the Council. Within the Council, and the broader traditional healing community, there are a number of divergent views on professionalisation, the question of changes within traditional healing practice, the role of the Council, and the role of traditional healers in health care. These divergent views reflect a heterogeneity, which, according to Fassin and Fassin, is characteristic of traditional healers. Fassin and Fassin stress that this "extraordinary heterogeneity" within the healing community has developed because of indigenous medicine's non-institutionalized background. They go on to argue, like Staugard, that the kind of institutionalization demanded by professionalisation is incompatible with such heterogeneity (Fassin and Fassin, 1988:354).

In contrast to Fassin and Fassin, Chavunduka and Last argue that traditional healers will be forced to professionalise in order to preserve the unique character of traditional medicine. They argue that the politics of medicine requires "a degree of professionalisation among healers of all kinds", stressing that traditional healers need to professionalise paradoxically "so that they can survive as a relatively disorganised group in an increasingly bureaucratic society" (Chavunduka and Last, 1986:269).

These divergent views create an environment of dynamism and debate within the healing community but they are also a source of conflict and disunity, and prevent traditional healers in the Council from being able to come together and agree on various issues and policies. At present the Council is struggling to manage and mediate these divergent views. This lack of management is

creating conflicts and areas of tension between the Council leadership and various sectors in the traditional healing community. One area of particular concern is the conflict in the Council over the role of other traditional healers associations, and their relationship with the Council. Finding a way to integrate and recognise these associations is one of the most significant problems and challenges the Council currently faces.

Shortly after being elected as president of the KwaZulu-Natal Traditional Healers Council in 1999, Mr. Mhlongo ordered all other traditional healers associations in the province to be disbanded and called for their members to join the Council (2nd Interview with Tobias Mkhize). There was no mandate for this decision in the Council's constitution nor did Mhlongo actually have the authority to make such a decision. Tobias Mkhize suggests that Mhlongo probably made this decision with the understanding that the Council needed to be treated as a priority and that membership to other associations would dilute the power of the Council (2nd Interview Tobias Mkhize).

To clarify the situation the Council held a meeting at Stanger, which was attended by Neville Gwula, the chief lawyer drafting the Traditional Health Practitioners Bill, and the Minister of Health. Questions were raised as to why it was first proposed that the associations should be dissolved. Gwula stressed that the Council and the traditional healers associations should both co-exist and this was then accepted by the meeting (Interview with Mquansa Makhathini).

The decision to disband the associations has caused a considerable amount of conflict, concern and confusion within the Council and within the broader traditional healing community. This decision has aggravated the power struggle between the leadership of other traditional healers associations and the leadership of the Council and has created a certain amount of resistance towards the Council (Interview with Margaret Shangase).

This experience with the associations also indicates that there may be certain problems with the Council's leadership style, which appears from this incident to be fairly autocratic and top down rather than negotiable and discursive. Such a top down approach disregards the authority and legitimacy of the leaders of other traditional healers associations, exacerbating the power struggle between the Council and these associations. There is a need for a change in leadership style within the KwaZulu-Natal Council if the leadership of other associations is to be brought successfully into the Council. A more successful strategy would be for the Council to work through the existing networks of the associations to inform traditional healers about the Council and to gain trust and legitimacy amongst ordinary traditional healers on the ground. The associations could assist the Council as powerful and useful partners (Interview with Margaret Shangase).

It will take a number of years for the Council to regain the trust of traditional healers' associations and to develop a partnership with these associations. If the Council fails to successfully integrate and recognise these associations it could be an indication that the Council is incompatible with the kind of heterogeneity existent within the traditional healing community in KwaZulu-Natal.

6.3.2 The Council's attitude towards the processing of traditional medicines

The diverse opinions and positions of traditional health practitioners in the KwaZulu-Natal Traditional Healers Council are also reflected in the current debates within the Council around the processing of traditional medicines. Mr. Mhlongo, president of the Council, has stressed that the Council considers it wrong to process traditional medicines as this practice is considered unafrican. (Interview with Mr. Mhlongo) There are, however, several traditional healers in the Council's regional committees who support the processing of muthi. In addition there are a significant number of muthi traders who also

support of the processing of muthi.

Mr. Mhlongo's response to the question of processing muthi reflects the way the leadership of the Council is constructing an identity, which not only looks to contemporary issues but which also looks to the past, at a historical and mythologised understanding of traditional healing. At the same time Mr. Mhlongo's position on the processing of traditional medicines seems to contradict his positive attitude towards the commercial growth and exportation of traditional medicines. Furthermore the Council's objective of official recognition, the standardisation of practices and environmentally friendly harvesting methods implies the need for traditional healers to accept the processing of traditional medicines rather than reject this practice (Interview with Thulani Nzama, Department of Informal Trade Durban Metro, 14th May 2003).

There are several dynamics that shape traditional health practitioners attitudes towards the processing of muthi (2nd Interview with Tobias Mkhize). A belief that traditional medicine loses its potency unless it is prepared fresh is one of the main factors contributing towards resistance to processed muthi. At a meeting of the eThekwini regional committee an elderly male traditional healer addressed the audience telling the traditional healers present that they should not buy muthi off the streets because it is old, instead he urged them to collect fresh muthi from the wild (eThekwini regional committee meeting, KZN Council, 19th February 2003, Durban).

Queen Ntuli also stressed that the Council was opposed to processed muthi because traditional medicinal plants needed to remain fresh in order to work effectively. If traditional medicine is made into a tablet, some of the potency of the medicine is lost along the way. This is because the medicine works not only through its chemical composition but also because it is accompanied by supernatural healing powers from the healer's ancestors. In order to ensure these supernatural healing powers, traditional medicines must be harvested

and prepared in accordance with specific rules and rituals. Processed medicines lose their supernatural healing powers and therefore do not work as effectively (Interview with Queen Ntuli). Resistance to the processing of traditional medicine also stems from an understanding that associates processing with incorrect harvesting methods and over harvesting. Gwala suggests that traditional healers who say that muthi should be gathered fresh, are not necessarily opposed to the processing of muthi. What they mean by saying this is that muthi should be gathered according to various traditional rites and procedures so that the plants are not destroyed by over-harvesting (1st Interview with Ernest Gwala).

Although there is a significant amount of opposition to the processing of traditional medicines within the leadership of the Council, there is also a significant constituency of muthi traders and traditional healers who support the processing of traditional medicines. This support and interest in the processing traditional medicines is evident in the establishment of a small muthi processing business, known as Isinthu imithi yesizulu, at the Durban muthi market.

Six muthi traders and traditional healers operating from the Durban muthi market formed Isinthu imithi yesizulu in 2002 with assistance from the Institute of Natural Resources. Isinthu imithi yesizulu reveals a more flexible and market orientated approach to trade in traditional medicines and traditional medicinal practice, compared to that of the provincial leadership of the KwaZulu-Natal Traditional Healers Council. Ms Ngcobo, one of the six business partners of Isinthu, explained that she and her partners started Isinthu imithu yesizulu because they wanted to change the looks and presentation of muthi. Unprocessed muthi is exposed to the elements at traditional healers' stalls and, as a result, expires easily, causing wastage of stock and a loss of revenue (Interview with Ms Ngcobo, Sangoma, 13th February 2003). Processing therefore offers these traders a way of increasing the shelf life of their product.

Mrs Ngcobo and her business partners felt that the muthi they sold was the same as westernised medicine, except that it was not processed in the same way. They also knew that patients often disliked the way in which unprocessed muthi was administered. They felt that processed muthi would be more acceptable and convenient to use by patients, especially for a younger generation of patients (Interview with Ms Ngcobo).

The processing of muthi is an area where the Council is likely to come into conflict with muthi traders and traditional healers who have a more market orientated perspective of traditional healing. The processing of traditional medicine offers significant economic advantages to muthi traders and traditional healers as it increases the shelf life of the muthi and adds economic value to the product. For those situated at the lower end of the value chain in the muthi trade, processing offers an important means of increasing the economic value of their goods. When I asked Ms Ngcobo whether she considered it unafrican to process muthi she replied that times are changing and that at the end of the day it is important for people to be able to adapt (Interview with Ms Ngcobo).

These debates around the processing of muthi reveal a potential tension between the more elitist concerns of the Council's leadership and the economic survival of those trading muthi on the streets of Durban. These tensions also seem to correlate with divisions of gender and status in the traditional healing community. Well-established older male izinyanga tend to be more likely to oppose the processing of muthi as they are concerned with creating a professional identity founded on re-establishing and recreating the traditional aspects and rituals of traditional healing practice. In contrast female izangoma and muthi traders are more likely to support processing because it offers them new economic opportunities. For muthi traders their stature is less dependant on the image and rituals of traditional healing practice. Muthi traders' livelihoods require them to be more flexible, dynamic and more open

to change, as their economic position is more precarious than that of well-established male izinyanga.

6.3.3 Developing a framework for testing and examining traditional healers

In establishing a professional status for traditional healers through an organised body, Chavunduka and Last emphasise that one of the greatest challenges will lie in deciding on the particular content of a formal training programme and qualifications for traditional healers (Chavunduka and Last, 1986:267). Agreement must be reached between traditional health practitioners on the question of who should be considered a traditional healer, who should be registered and who should not (Freeman, 1992:3). According to the KwaZulu-Natal Council's constitution only duly qualified izinyanga, izangoma and abathandazi are permitted to become members of the Council. The Council's constitution defines a duly qualified inyanga as having undergone no less than five years training under a qualified inyanga, and an sangoma as having undergone no less than one year of training under a qualified sangoma. The Council's constitution also requires applicants to undergo a written or partially written examination [30].

These regulations will however disqualify a particular segment of traditional healers and muthi traders within the traditional healing community. Firstly, many traders and traditional healers operating at the muthi market in Durban city do not have formal training as traditional healers, although most have a wealth of informal knowledge and training. Secondly, if no provision is made for oral examinations, illiterate healers and traders will be impeded from registering with the Council. A survey conducted in 1995 by the City Health Department revealed that 36 percent of traders in the informal market area are illiterate (Mkhize, 1998:4). The Council's regulations, if enforced, are therefore likely to affect a considerable percentage of healers and traders.

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[30] The Constitution of the KZN Traditional Healers Council, 2001, Chapter 3 Clauses1-3 and Chapter 7 Clause 1.

Although no provision is made for their membership in the constitution, the Council leadership acknowledges that muthi traders can, and in fact, must, become members of the Council, as they can only obtain their harvesting licenses through the Council (1st Interview with Ernest Gwala). The Council is however opposed to traders mixing traditional medicines and dispensing these medicines to patients as they feel some of these traders are not qualified to do so. The Durban regional committee of the Council is presently in the process of negotiating with local government for the construction of a warehouse where gatherers would be able to sell their medicines wholesale to izinyanga and izangoma (Interview with Mr Mhlongo).

The Council hopes that if this plan is approved it will curb the problem of gatherers dispensing and retailing muthi directly to patients. Forcing gatherers to sell wholesale to izinyanga and izangoma is likely to disadvantage gatherers, however, by restricting their access to the market and reducing the amount they are able to earn. This could create a considerable amount of conflict and resistance between the Council and muthi gatherers and traders. Since black women constitute the majority of the muthi traders and gatherers in this province they are once again likely to be disproportionally affected and disadvantaged by this decision.

Although the Council's constitution states that traditional healers will have to undergo a written or partially written examination, the Council has decided that it will also test healers orally (Interview with Margaret Shangase). This will be a significant benefit for traditional healers who are illiterate. The apparent discrepancies between the constitutions regulations and the Council's actual decisions regarding testing and membership seem to indicate that the regulations laid down in the 2001 constitution were drawn up at a time when the Council was new, more exclusive, and less in touch with the realities of its future members. The more recent decisions made by Council leadership regarding testing and membership, reflect a growing awareness that the Council has to become more flexible and less exclusive if it is to successfully

bring the traditional healing community in the province together. The discrepancies between the constitution's regulations and the leadership's understanding of these regulations also suggests that the question of who is eligible to become a member of the Council is still being debated and contested by the Council leadership.

Closely linked to the question of who should be included in the Council and who should be excluded, is the question of how to test the healing practices of traditional healers, particularly izangoma and abathandazi (faith healers) who tend to work within a spiritual rather than a scientific paradigm. In the past traditional healers operated in the realm of traditional legitimacy, with professionalisation, however, traditional healers tend to operate in both the realm of the traditional and the rational-legal. This duality causes difficulties in devising exactly how to register traditional healers, as what defines a legitimate healer according to traditional legitimacy may differ from rational-legal legitimacy (Jurg and Marrato, 1992:17).

The training of traditional healers is also problematic. Most healers train with a master trainer, rather than attending a formal institution. Knowledge is generally passed down orally in discussions between trainer and pupil (Hess, 1992:24). Local variations and interpretations of this knowledge may also be taught. There is no written canon of knowledge about traditional healing in South Africa as there is with Asian and Eastern indigenous medicines. This makes the standardization of knowledge, one of the key features of professionalisation in the West, difficult to achieve (Hess, 1992:24).

According to the Council leadership izinyanga will be tested based on their ability to identify and use traditional medicines correctly for various diseases and complaints. To test the qualifications of izangoma the Council is using a community, elder and trainer reference system. The trainer of a sangoma is required to register his or her apprentice with the Council. On applying to the Council the newly trained healer must provide the signature of their trainer or

the head induna of the area. The authority of this individual is then seen to certify the applicant's training and personal reputation (Interview with Queen Ntuli) The Council also requires the newly qualified sangoma to be known in their local area. It is therefore the community, as well as authoritative figures in this community, who certify the qualifications the new sangoma.[31]

Deciding on a standardised syllabus and set of qualifications could become a potential site of conflict and disagreement within the KwaZulu-Natal Council and could possibly lead to certain groups of healers feeling misrepresented or marginalised. In the concluding chapter of their book, Chavunuka and Last warn against a pattern of professionalisation that has happened in many of the African countries documented in their work, in which 'technical herbal expertise' has tended to dominate over other forms of indigenous knowledge:

> there is an inherent danger that traditional medical knowledge will be defined simply in terms of its technical herbal expertise, that this expertise will in turn be recognised only for its empirical pharmacognosy, without reference to the symbolic and ritual matrix within which it is used-still less, the social matrix in which those rituals and symbols have meaning at any particular time or place (Chavunduka and Last, 1986:267).

The already existing division between the top leadership Council, consisting mainly of male izinyanga, and ordinary traditional healers on the ground, consisting mainly of female izangoma and muthi traders, suggests that there may indeed be a tendency towards a pharmacological framework for testing and qualification, since such a framework would be most compatible with the herbalist orientated work of izinyanga. There are several indications that the Council could be prone to favouring such a framework. The Council is involved in several medical research projects, which focus on the

[31] I have not been able to access information on the Council's procedure for qualifying abathandazi or faith healers. Most likely they will also be qualified on a similar basis to that of izangoma, however in the case of faith healers their patients will certify the quality of their healing abilities while their reputation and standing in their communities will also qualify them.

pharmacological aspects of traditional medicine, suggesting a tendency in the Council to focus on technical herbal expertise. In addition there may be pressure from doctors to develop a testing and qualifying framework around pharmacological knowledge, as it is more recognised and understood by biomedicine. However the Council's use of a community and trainer review system for izangoma suggests that the Council is also open to other frameworks for testing. Further research is needed to discover whether these other frameworks will be subordinated to technical herbal expertise.

6.3.4 Gender within the Council

The attitudes of the Council's top leadership towards the processing of traditional medicines, which is mainly supported by female traders, and towards untrained muthi gatherers who are also predominantly female, reveals a potential bias in the Council towards a more elitist male dominated segment of the traditional healing community, as opposed to a more popularist female dominated segment of this community. There is a need to investigate whether this potential bias is limited to female muthi traders or whether it is also present within the leadership of the Council.

A number of leaders in the KwaZulu-Natal Traditional Healers Council, including the president and vice president held leadership positions in the Inyangas' National Association[32] (Interview with Mquansa Makhathini) Harriet Ngubane stresses that in South Africa the role of an inyanga tends to be filled by a man while the role of a sangoma tends to be filled by a woman (Ngubane, 1981:361). As an inyangas' association, prominent male traditional healers dominate the INA, and a transfer of leadership from the INA to the KwaZulu-Natal Traditional Healers Council appears to be therefore a transfer of male dominated leadership. At the same time it is incorrect to assume that male dominance is simply being reproduced in traditional healers' institutions. As I argued in Chapter two gender dynamics within the traditional healing community are also being challenged and reshaped. This

[32] The Inyangas' National Association is an association for izinyanga within the province of KwaZulu-Natal.

was clearly demonstrated by the election of a woman, Patience Kholoko as president of the Umbrella Body in 1996.

Chavunduka and Last argue that one of the common features of professional traditional healer associations in Africa is the tendency for these associations to be "more strictly herbalist in background" drawing their founders or leaders "from the herbalist end of the healing spectrum"(Chavunduka and Last: 1986: 262-3). The top leadership of the KwaZulu-Natal Traditional Healers Council, having been drawn from the INA, seems to confirm this. This holds potential ramifications for izangoma who are generally female and form the majority of the Council's membership.

At present women only comprise twenty percent of the Councils leadership, filling three positions out of fifteen on the Council's executive committee. The positions they fill include chairperson of the Council's HIV/AIDS Unit; secretary; and representative of the abathandazi (faith healers) on the Council (Interview with Queen Ntuli). Women are also present on the eThekwini regional committee of the Council (Interview with Thulani Nzama).

Despite the under representation of women, voting for the leadership of the Council was done through democratic procedures (Interview with Queen Ntuli). This means that fewer women were nominated, or, if they were, that they were not elected. This could be due to an adherence to traditional gendered roles in the Council, in which men are leaders and women are quiet followers. It could also be due to the fact that women are seen to be less qualified by their male counterparts. Although female traditional healers are not equally represented, the fact that there are some women on the executive committee in key positions is a significant step towards gender equality.

6.4 The Council's relationship with the government and the Department of Health

6.4.1 Negotiating the terms of collaboration: the KwaZulu-Natal Council's relationship with the Department of Health

Although the formal health care system in South Africa is increasingly coming to realise that traditional healers have an important role to play in health care, that role is still being debated and contested. The subject of collaboration between traditional medicine and biomedicine raises a number of important questions and debates. These debates are concerned with the role of traditional healers in health care in South Africa. Linked to these debates is the question of how traditional healers can professionalise themselves in order to fulfil this role most effectively. For doctors and medical staff the question of whether traditional healers offer care of adequate quality, and the question of how efficacious traditional healing practices and treatments are, remain key concerns (Freeman, 1992:2). Traditional healers engaging in these debates are concerned that the unequal relationship between traditional healing and biomedicine will subordinate them to western medicine. One of the key questions for healers is how they can use professionalisation to engage in health care as equal partners with doctors. The following section of this chapter contextualises these broader debates by looking at the potential for establishing a mutual referral system between traditional healers and the formal health system in South Africa.

There has been a significant shift in the attitude of the National Department of Health towards traditional healers over the last 15 years. According to Margaret Shangase, Deputy Director of the Traditional Healers Portfolio in the provincial HIV/AIDS Unit, both the provincial and national Departments of Health accept traditional healers as partners and support them fully. The Department of Health acknowledges that traditional healers work at grass roots level and are able to reach many communities, which government health services cannot reach. Traditional healers are respected figures in their

communities who command the authority and respect to educate these communities. The Department of Health feels that if they are able to empower traditional healers they will be able to use them as partners in health education and service provision (Interview with Margaret Shangase).

This developing partnership between healers and the Department has also created new sources of tension and disagreement; mainly around the way the Department and healers themselves understand their role in health care services. The question of whether the formal health system should refer patients to traditional healers is one of the areas of potential conflict between traditional healers and the Health Department. The Department of Health supports a system of collaboration where traditional healers refer patients to hospitals and clinics, and where traditional healers assist the Department as partners in HIV/ AIDS and PHC prevention and education. At present the Department of Health does not support referrals from the formal health system to traditional healers primarily because of a lack of research and regulation around the dosage and efficacy of traditional treatments. The Department stresses that it is up to the patient to decide whether they wish to consult a traditional healer after their treatment in the formal health system (Interview with Margaret Shangase).

The majority of traditional healers in the Council, however, would like a mutual referral system to be established between traditional healers and doctors (Interview with Margaret Shangase). Traditional health practitioners' view the establishment of a formal mutual referral system as an important aspect of the formal recognition owed to them for the health care services they provide. They feel that it will allow them to engage with doctors on a more equal basis and that it will give them the authority and the opportunity to be more actively involved in health care.

Traditional healers view a mutual referral system as a positive initiative that will benefit both traditional health practitioners and western doctors (Interview

with Inyanga Mthimkhulu). Traditional healers are aware that that clinics have resources and skills that are not accessible to healers. Referring patients enables healers to indirectly tap into those resources.

After receiving some type of training traditional healers are generally keen to refer patients in the case of TB, diarrhoea and vomiting (THP focus group, 8th July 2003, Valley Trust). In certain instances, such as HIV/AIDS, traditional healers said that they would treat the patients themselves first and then also refer them. If they suspected that a patient had HIV or AIDS they would firstly counsel the patient, then give the patient a traditional medicine known as Imbiza, which boosts the immune system and fights opportunistic infections. After this they would refer the patient to the clinic. In the case of flu, asthma and temperature these healers said that they would again first treat the patient themselves as well as refer them to a clinic or hospital (THP focus group, 8th July 2003, Valley Trust).

In these particular cases traditional healers understand the treatment provided by doctors and clinic staff as something, which facilitates, supplements and complements their own treatment. Traditional and western medical interventions are viewed as different stages in the treatment process rather than being unrelated interventions. The work of Harriet Ngubane also emphasizes the complementary perspective of African healers who accept "Western-type agencies of cure as additional to their own" or even as "alternative in certain instances" (Ngubane, 1981:362). Traditional healers' complementary perspective on treatment helps us to understand why many healers view a mutual referral system as something that can benefit and enrich African healing practice as well as western medicine. The exclusive position of western biomedicine, however, tends to make it hostile to other systems of healing.

Although there are areas of common interest, traditional healers in the Council understand their role and responsibility as being distinct from that of western

doctors. Amongst these traditional healers there is an acknowledgement that the western health system is better equipped to treat and cure certain diseases but there is also a belief that traditional healers have certain advantages over biomedicine. Furthermore traditional healers tend to criticise biomedicine for focusing on the symptoms of disease while neglecting to solve the root causes of ill health.

One of the key advantages of traditional healing is the in depth and personal relationship between practitioner and patient that is an integral part of such healing practices. Traditional healers in the Council complain that western doctors are too busy to counsel their patients properly or even to explain what is wrong with the patient (Interview with Queen Ntuli). Traditional healers feel that they can play a very important role in counselling patients. They also feel that they can give a better quality of care in terms of patient doctor relationships. Traditional healers also argue that they can increase the life span and health of HIV positive patients through using traditional immune boosting treatments such as the African potato and by educating the patient to eat traditional foods, which are high in nutritional value (1st Interview with Ernest Gwala).

Traditional healers' request for a mutual collaborative relationship with western doctors is limited by the fact that there is no legislative framework to guide this relationship. In South Africa there are currently no pieces of legislation or government bodies to direct and shape the process of collaboration and interaction between traditional healers and the western health care system (Interview with Mquansa Makhathini). The Traditional Health Practitioners Bill situates traditional healers within the Health Department, however is does not specify the nature of the relationship between traditional healers and the Department. Furthermore some of the discriminatory legislation against traditional healers continues to operate. In fact, according to legislation relating to the SAMDC, doctors are not legally permitted to refer patients to traditional healers (Interview with Mquansa

Makhathini). In addition traditional healers remain "excluded from entry into institutions sanctioned by the South African Medical and Dental Council...to train registered health professionals" (Urbasch, 2002:8).

In addition there are a number of other significant barriers obstructing doctors and clinics from referring patients to traditional healers. These obstacles stem from the informal and unregulated way in which traditional healers currently operate in South Africa. Doctors feel incapable of referring patients to healers because they have no information about the different traditional specialists operating in their area, nor do they understand how traditional healing works. Another area of difficulty is the fact that a minority of traditional healers still claim that they can cure AIDS. Although traditional medicine is moving towards professionalisation, the regulatory structures set out in the Traditional Health Practitioners Bill will take a number of years to implement. At present there are therefore no active structures in place to monitor and ensure good practice and standards within traditional healing. This is of particular concern to doctors and clinic staff when confronted with the question of referring patients to healers. Furthermore doctors and clinic staff argue that they cannot refer patients because they lack research on the efficacy of traditional treatments.

Opposition to a mutual referral system also stems from a lack of information and prejudice on the part of western practitioners. Traditional healers in the Council argue that doctors are misinformed about traditional healing practice (Interview with Queen Ntuli). Traditional healers believe that there is a need to engage with western practitioners and to inform and educate them about traditional healing practices and medicines.

Although the majority of traditional healers in the Council support the establishment of a mutual referral system, there are some healers who remain opposed to collaboration, arguing that the unequal relationship between the two systems of healing will subordinate traditional healing to biomedicine.

Staugard argues that professionalisation and collaboration could lead to the risk of "imposing some of the analytical, biomedical concepts of modern medicine" onto traditional healers. In traditional medicine in South Africa, preventative activities and thinking dominate. The professionalisation of traditional healing could lead to the imposition of the modern health sector's curatively biased way of thinking and working onto traditional healing. Staugard emphasises that "It is modern medicine which must widen its analytical views and conceptions and learn from the synthesising and holistic views of traditional medicine" (Staugard, 1986:68).

Traditional healers view the establishment of a mutual referral system as one part of a broader set of demands for contact and exchange of resources and information between traditional healers and the health care system. Traditional healers want to be able to access resources from clinics and hospitals particularly resources needed for AIDS education and home based care, such as condoms, gloves, plastic bedsheets and cream for bedsores (Interview with Queen Ntuli).

Amongst some traditional healers in the Council there is an awareness that a mutual referral system will take a number of years to develop. These traditional healers feel that a change first needs to take place in the attitudes and understanding of western medical practitioners towards traditional healing (Interview with Queen Ntuli).

The successful implementation of the Traditional Health Practitioners Bill should play a pivotal role in enabling a mutual referral system to be established between the health care system and traditional healers. The Bill, which provides for the registration, training and practice of traditional health practitioners, will make it possible to draw up a list of registered and properly qualified traditional healers for every region or district. This could serve as a guideline for doctors and clinic staff when a patient needs to be referred to a traditional healer. The absence of certified standards and qualifications in

traditional medicinal practice is one of the major reasons preventing the referral of patients from doctors to traditional healers. By providing for the establishment of a body to regulate the efficacy, safety and quality of traditional health care services, the Bill offers the possibility of some kind of control over standards and quality of traditional healing. This will open up new possibilities for the establishment of a mutual referral system over a long-term period.

6.4.2 Autonomy and interdependence: Negotiating the relationship between the KwaZulu-Natal Council and government

The Traditional Health Practitioners Bill creates the framework for a new relationship between government and traditional healers in South Africa (2nd Interview with Tobias Mkhize). According to the Bill the interim and provincial Traditional Healers Councils fall under the Department of Health. Although the relationship between the Health Department and traditional healers has changed, it is still an unequal relationship and the balance of power is in favour of Department of Health. The Traditional Health Practitioners Bill allows the government to maintain control over a range of issues relating to the practice of traditional healing (Interview with Mquansa Makhathini). For example, the Bill gives the national minister of Health the discretion to choose the chairperson of the interim Traditional Health Practitioners Council[33].

There are a number of traditional healers in the Council who support Chavunduka and Last's argument that professionalisation through a statutory body can give the government too much control over the activities of traditional healers through laws and regulations (Chavunduka, 1992:13). These traditional healers want the Council to stand as an independent body and to have the authority be able to make its own decisions (Interview with Margaret Shangase).

The Traditional Health Practitioners Bill creates the potential for a new power

[33] The Traditional Health Practitioners Bill. 2003, Chapter 2, Clause 8a.

struggle between the traditional healers in the KwaZulu-Natal Council, and the government, over control of the Council and control over decision making around traditional healers, their practice, and the terms of their recognition by government. There is a contradiction in these healers' demands for greater independence and authority from the government, and simultaneously the Council's fundamental dependence on government for its existence, particularly the Council's need for financial support from government.

At present however it is unlikely the Council would have the capacity and organisational structure to stand independently. In fact the Council needs government structures and support in order to develop and to build its capacity. The demand for greater autonomy, like the Council's request for greater political representation, is overly ambitious and unrealistic for the Council's current context. In moving towards greater equality with the formal health care sector traditional healers will have to accept compromise on a number of issues. Traditional healers will also have to acknowledge that their legacy of marginalisation will take a long time to change, and will have to be challenged on a number of levels.

There is also a political dimension to the potential power struggling between traditional healers in the province and the National Department of Health. As the custodians of African culture and tradition, traditional healers in KwaZulu-Natal are closely aligned with traditional leaders, and consequently the IFP in the province. There is a political dimension to the relationship between traditional healers in KwaZulu-Natal, who have strong links to IFP and the National Department of Health, which is dominated by the ANC. Within the national ANC government there could be some concern with ceding too much power to an already influential group with close alliances to the IFP.

Conclusion: A way forward for the KwaZulu-Natal Traditional Healers Council

Traditional healing in South Africa is undergoing a significant transformation as it moves towards professionalisation. This transformation involves a shift in traditional healing from an informal status where it was unrecognised and undervalued, to a context where it is increasingly being recognised and acknowledged for the important health services it provides. The shift in government and institutional attitudes towards traditional healing is reflected in the drafting of the Traditional Health Practitioners Bill, and the subsequent establishment of the interim Council of Traditional Healers and the KwaZulu-Natal Traditional Healers Council. The Traditional Health Practitioners Bill grants government recognition to traditional healing. It also provides the framework to bring traditional healing into the formal economy where it will be regulated and developed. The drafting of the Traditional Health Practitioners Bill marks a key step in the movement towards the professionalisation of traditional healers in South Africa.

The transformations taking place in traditional healing today are the result of a confluence of factors at local, national and international levels. The recognition of traditional healers has been made possible by the changing context of South African governance and society. Chapter two documented how changes at a local government level have facilitated the organisation and regulation of traditional healers in Durban. Challenges confronting South Africa at a national level, such as the HIV/AIDS pandemic and the underdeveloped condition of our health care system, have forced government and western medicine to acknowledge that traditional healers need to play a far more active and important role in health care provision, and that they need to be professionalised in some way in order to do this most effectively.

The monopoly that biomedicine has held over national health care systems is slowly starting to weaken as international health policy acknowledges the role

of traditional healers and their contribution to a holistic conception of health. There has been a loss of faith in the power of biomedicine, which has been accompanied by a growing interest in alternative systems of health and healing. In South Africa the grip of biomedicine has also begun to weaken with the post apartheid government's interest in the African Renaissance, which entails looking to African culture and ideas to find solutions to contemporary problems. Traditional healers have also played an invaluable role in their own transformation, through their efforts lobbying and negotiating with the government, and through developing an identity and a role for themselves as traditional health practitioners.

Traditional healers in KwaZulu-Natal are using the Council, and the newly found recognition offered by the Traditional Health Practitioners Bill, to begin constructing a new identity for themselves as health practitioners in contemporary South Africa. The Council's focus on a number of specific traditional and contemporary issues reveals the way in which traditional healers in this province are reaffirming an older identity, as well as reconstructing a newer and broader identity, and sphere of practice, as traditional health practitioners.

Although the legislative framework providing for the professionalisation of traditional healers has been developed, to a large extent this framework has not yet been operationalised. It is the responsibility of the Interim Traditional Healers Council and the provincial Councils to put the regulations laid out in the Bill into practice. In KwaZulu-Natal this responsibility rests with KwaZulu-Natal Traditional Healers Council, which operates as a professional body for traditional healers in the province.

Although the KwaZulu-Natal Traditional Healers Council displays a number of the characteristics that define a profession, the Council also appears to be renegotiating some of the other key features associated with professionalisation. The KwaZulu-Natal Council has considerably less

autonomy than that of the South African Medical and Dental Council. The Department of Health and the government retain a greater degree of control over the decisions and recommendations of the Council at a provincial and national level. In addition the KwaZulu-Natal Traditional Healers Council is more dependent on the government for financial support. There is a tension between the Council's demands for greater independence and authority from the government, and simultaneously its fundamental dependence on government for its existence. This tension is linked to differences in the Health Department's understanding of professionalisation, and traditional healers own understanding of the function and possibilities of professionalisation. The Health Department views professionalisation as a way to regulate traditional healing, protect the public, and enhance health care services. Traditional healers however hold a broader and more influential understanding which sees professionalisation as a way of accessing new sources of power and resources, protecting traditional healers from exploitation and disintegration, and ensuring that traditional healing is able to control its own future (Chavunduka and Last, 1986:260).

The examination procedure and qualifications established by the Council are other areas where the KwaZulu-Natal Council also appears to be in the process of renegotiating the terms of professionalisation. The Council brings together a diverse range of traditional health practitioners with a large range and level of skills. As a result of this the Council has had to develop a more flexible approach to testing and qualifying traditional health practitioners. This is seen in the Council's use of elder and community referrals to qualify izangoma, the use of oral examinations, and the Council's decision to include muthi traders and gatherers in the Council. The way in which the KwaZulu-Natal Council appears to be renegotiating some of the features of professionalisation, seems to confirm Chavunduka and Last's argument (1986) that traditional healers will have to find new ways to professionalise, ways which allow traditional healing to maintain some of its distinctive character.

In assessing the progress made by the KwaZulu-Natal Traditional Healers Council, the context of the Council and of traditional healers in South Africa must also be taken into account. The Council is still relatively new body. Its members and leadership are emerging from a history of marginalisation and have not had the opportunity to develop their practice and their organisational skills. The KwaZulu-Natal Traditional Healers Council, like other institutions of a similar nature, will take time to develop. Evaluating the progress made by the Council requires a longer- term framework. What this dissertation has attempted to do, however, is to evaluate how the Council has approached and conceptualised its official responsibilities and problems as a professionalising body, as well as the broader set of objectives and responsibilities expressed by the Council's leadership.

Divisions within the Council, and within the broader traditional healing community, are significant problems that have marked the Council's early development. The Council's initial dismissal of other traditional healers associations has created a sense of distrust towards the Council and has led to power struggling between the Council and the leadership of these associations. In order to function successfully as a professionalising body, the Council must be able to build its membership and to gain to the trust and legitimacy of ordinary traditional healers on the ground. To achieve this the Council will have to find ways of bringing the other traditional healers associations, as well as other dissenting groups within the traditional healing community, into the Council. The Council may have to change the autocratic and top down elements in its leadership style, in order to achieve this, and embrace a more negotiable and discursive leadership style.

Besides the associations, there are a number of other tensions and divisions within the Council. Divergent attitudes within the Council towards the processing of traditional medicines reveal a potential tension between the more elitist concerns of the Council's leadership, consisting mainly of male

izinyanga, and the economic survival of mainly of female izangoma and muthi gatherers who trade muthi on the streets of Durban. These tensions seem to correlate with divisions of gender and status in the traditional healing community. The differing perspectives in the Council on the processing of traditional medicine reveal that there are a number of different perspectives within the traditional healing community on how to bring traditional medicine into the twenty-first century, and how to ensure its continued survival and success. The Council must find a way to unify the traditional healing community while still maintaining some of the distinctive heterogeneity and diversity associated with this community.

Although these tensions and divisions are significant, there are also signs that the Council is adopting a more flexible and inclusive approach in order to accommodate a number of different constituents within the traditional healing community. It is significant that the KwaZulu-Natal Council decided on a single body for izinyanga, izangoma and abathandazi rather than having a separate or semi-separate body for each category of healer. It is also significant that the Council has included muthi traders and gatherers, although their terms of their inclusion are still a matter of debate. The Council's use of more flexible testing and qualification procedures also indicates that the Council holds the potential to be an inclusive body that is able to represent a broad spectrum of the traditional healing community. The Council has managed to bring a range of different groups within the traditional healing community into its structure, even though the divisions and tensions between these groups have not always been resolved.

One of the major challenges facing the Council is the need to build capacity. Capacity is needed in order to develop a strong organisational structure and to ensure proper financial management. A lack of capacity within the Council is at present one of the major factors preventing the Council from obtaining funding from the government and civil society. The Council leadership stress that a lack of funding, and difficulties in accessing resources, are the biggest

obstacles preventing traditional healers from providing an effective health care service.

Developing partnerships with other institutions and sectors of government offers the Council an important opportunity to begin to build such capacity. The Council has been successful at developing a number of partnerships with various other bodies and sectors to assist it with research and organisational and skills development. The Council's partnership with Durban City Health is a key example of this.

The Council has also been able to form partnerships with the Nelson Mandela Medical School and the Medical Research Council. These partnerships offer the Council a potential entry point into formal medical institutions and the opportunity to begin engaging in serious research on traditional medicines. Traditional healers' marginalised position within biomedicine and their lack of scientific medical training however suggests that these partnerships may be marked by inequality. This is a difficulty, which the Council needs to be particularly aware of. Also, as Chavunduka and Last have warned, there is a danger that professionalisation will lead to a focus on technical herbal expertise and that the other rich aspects of traditional knowledge and ritual will be neglected. The Council needs to find ways to work around these difficulties and potential inequalities.

The Council's ability to develop its current partnerships and its ability to form strategic new partnerships, with research institutions and various sectors of government, will play an important role in determining the Council's ability to develop itself and to build its skills and organisational capacity.

The Council's leadership has also succeeded at developing a culture of training and education within the Council. The Council leadership has been responsive to training, and has shown a willingness to work with formal health care system. The Council has also facilitated the training of a number of

traditional healers in the province by working together with the provincial Department of Health and Durban City Health.

Even though the KwaZulu-Natal Council has managed to achieve a degree of success in a number of areas, some of the Council goals and demands, such as achieving greater political representation, greater autonomy, obtaining intellectual property rights and establishing a mutual referral system between traditional healers and the formal health care system, are currently overly ambitious and unrealistic. Firstly, the KwaZulu-Natal Council lacks the capacity and resources to realise these ambitions. Secondly although traditional healers have gained a degree of formal recognition, as a result of their historical legacy, they continue to remain in a position of disadvantage in relation to biomedicine. Since traditional healing is currently in a process of transformation it holds the potential to eventually strengthen its institutional position enough to achieve these goals, however, the most suitable strategy for the Council at present is to focus on its more achievable and realistic objectives and use these to develop the Council before trying to tackle these more ambitious demands.

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